VOLUME I

RESEARCH COMPONENT

Literature Review

How can attachment theory help us to understand the relationships of adults diagnosed with a psychotic illness? A theoretical review.

Research Paper

What can mothers who have experienced psychosis, tell us about their experience of parenting? An Interpretative Phenomenological Analysis.

Submitted By

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A thesis submitted to The University of Birmingham
for the degree of
DOCTORATE IN CLINICAL PSYCHOLOGY

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Overview

This thesis is submitted in partial fulfilment of the requirements for the degree of Doctorate of Clinical Psychology (Clin.Psy.D.) at the University of Birmingham. The thesis consists of two volumes, a research and a clinical volume.

Volume I

Volume I is the research component of the thesis. This volume comprises of three chapters. The first chapter is a theoretical review, which explores how attachment theory helps to explain the relationships of adults diagnosed with a psychotic illness. Published peer reviewed journal articles which are written in the English language and draw upon attachment theory to explain: 1) mother-child relationships, 2) how trauma experiences help us to understand the attachment styles of adults diagnosed with a psychotic illness, 3) relationships to mental health services and named workers, and 3) peer relationships of adults diagnosed with a psychotic illness are reviewed. The review found that people who have experienced psychosis are more likely to have an insecure avoidant or insecure anxious attachment style. The clinical implications for parents, their children and mental health services are considered.

The second chapter is a qualitative study, which explores the experience of parenting in the context of psychosis for mothers diagnosed with schizophrenia. Individual interviews were conducted with five mothers' with a diagnosis of schizophrenia who all experienced episodes of psychosis during their offspring's childhood. The data was analysed using Interpretative Phenomenological Analysis. Four phenomenological themes emerged from the analysis: 1) Negative experiences of being mothered, 2) Challenges of being a mother with a severe mental illness, 3) Powerlessness and 4) I have a purpose in life, I am a mother. Implications for mental health services are offered.

The third chapter consists of a Public Domain Briefing document. This document offers an accessible summary of the theoretical review and empirical paper.

Volume II

Volume II of the thesis comprises of five Clinical Practice Reports (CPRs) produced by the author and based on work in clinical settings during training. CPR 1 presents a Cognitive-Behavioural formulation and a Psychodynamic formulation of a 31-year-old British male presenting with anxiety, detained at a Medium Secure Forensic Service following an index offence of assault. CPR 2 presents the case of a 20-year-old Afro-Caribbean male, diagnosed with substance misuse and psychosis, detained at a Medium Secure Forensic Service following an index offence of murder. A comprehensive assessment, Cognitive Behavioural formulation, intervention for substance misuse and outcome evaluations are presented. CPR 3 presents a single case experimental design of a 14-year-old male diagnosed with a severe learning disability and a working diagnosis of Tourette 's syndrome. He was referred to the psychology team for a functional analysis of his motor and verbal tic-like behaviours. An analogue experimental design is presented. CPR 4 presents a small-scale service evaluation project, evaluating the feasibility of a risk assessment tool piloted on an inpatient older adult ward. CPR 5 presents an abstract of an oral presentation. It details a case study of a 17-year-old male diagnosed with bipolar disorder. The psychological assessment, formulation, intervention and evaluation of the work are presented.

Throughout volumes I and II all names and information identifying clinical clients, research participants and mental health services have been changed to maintain anonymity and confidentiality.

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CHAPTER ONE

LITERATURE REVIEW

HOW CAN ATTACHMENT THEORY HELP US TO UNDERSTAND THE RELATIONSHIPS OF ADULTS DIAGNOSED WITH A PSYCHOTIC ILLNESS? A THEORETICAL REVIEW.

ABSTRACT

This theoretical literature review assesses relevant literature regarding how attachment theory can aid our understanding of the relationships of adults diagnosed with a psychotic illness and the implications of this.

The literature was searched systematically so that all relevant literature in this area was included. The search yielded fourteen relevant journal articles, one discussion article and thirteen empirical studies. Three articles explore the primary-caregiver and child relationships of adults diagnosed with a psychotic illness in the context of attachment relationships. Seven articles investigate attachment theory within the context of therapeutic relationships in both inpatient and out-patient services for people who have experienced psychosis. One article explores how a person's attachment style helps us to understand the peer relationships and social functioning of people experiencing a first episode of psychosis. Two articles focus on how interpersonal events, such as trauma experiences, may contribute to the development of attachment styles in people diagnosed with a psychotic illness.

The review argues that attachment theory has a useful role to play in explaining the relationships of adults diagnosed with a psychotic illness. It brings together evidence for a relationship between insecure anxious and insecure avoidant attachment styles and people diagnosed with a psychotic illness. Furthermore, it indicates that adult attachment styles can be developed from early life experiences rather than as a result of psychosis itself and can be altered by later life events, such as a secure therapeutic relationship. Most importantly, the review suggests that mental health services and professionals can play a role in changing unhelpful attachment relationships in this client group. Implications of attachment theory for parents diagnosed with a psychotic illness and their children and mental health services are considered. The review concludes with the implications for future research.

Keywords: *Attachment theory; psychosis; schizophrenia; adult relationships; mental health services; mental health professionals.*

1. INTRODUCTION

1.1 Context of the literature review

Bowlby (1973) argued that children and adolescents require a secure base to return to for protection and comfort before they can explore their world. This is provided by an attachment figure, usually the child's primary-caregiver. By twelve months the child and their primary-caregiver develop attachment relationships which are dependent upon the primary-caregiver's response to their child's needs (Ainsworth, Blehar, Waters, & Wall, 1978). Bowlby, (1979) suggested that these attachment experiences are internalised into working models of rules and beliefs of how people view themselves and how they expect others to interact within their social relationships, which are carried into their adulthood (Bowlby, 1979). These adult attachment styles consist of secure attachment; insecure-avoidant attachment, insecure-anxious (ambivalent or preoccupied) attachment (Ainsworth et al., 1978) and disorganised attachment styles (Main & Soloman, 1986). Adults with a secure attachment style are likely to develop a positive image of the self and others and are comfortable with forming relationships (Bartholomew & Horowitz, 1991; Waters, Merrick, Treboux, Crowell, & Albersheim, 2000). As children they experienced a secure child-primary-caregiver attachment style because their primary-caregiver was emotionally and physically available to their needs. Adults with an insecure-anxious attachment style are likely to develop a negative self-image and an overly demanding interpersonal style to get their needs met (Bartholomew & Horowitz, 1991). As children they experienced an insecure-ambivalent child-primary-caregiver attachment style, because their primary-caregiver provided unpredictable responses to their needs (Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001). Adults with an insecure-avoidant attachment style are likely to develop a positive self-image and a negative image of others and reject interpersonal relationships (Bartholomew & Horowitz, 1991). As

children, they experienced an insecure-avoidant child-primary-caregiver attachment style because their primary-caregiver often rejected their needs (Bartholomew & Horowitz, 1991). Adults with a disorganised attachment style develop poor emotional regulation skills and social skills and may have difficulties forming and maintaining strong relationships. As children, their parents provided inconsistencies in their care, for example, being both caring and frightening. Attachment behaviours, which consist of ways an individual regains contact with their attachment figure when they are distressed, (Bowlby, 1973), influence adult interpersonal relationships (Drayton, Birchwood, & Trower, 1998; Berry, Wearden, & Barrowclough, 2007a); psychosocial functioning in adulthood (Berry et al., 2007a); as well as how people manage stress. Adult attachment styles can be altered by significant life events, such as stressful or traumatic events (Berry, Barrowclough, & Wearden, 2009).

Psychosis is an umbrella concept for a group of psychotic disorders including schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder and non-affective psychoses (National Institute of Clinical Excellence, 2013). Psychosis affects approximately 3% of the British population with over 100,000 people being treated for psychosis every year (Kirkbride et al., 2011). It is generally characterised by a loss of contact with reality with significant changes in a person's thoughts, perceptions, feelings and behaviour (National Institute of Mental Health, 2013). People diagnosed with or who experience a psychotic illness are likely to experience positive symptoms of the illness which consist of hallucinations, delusions, disorganised speech and behavioural disturbances such as distress. Individuals are also likely to experience negative symptoms of the illness including poor memory, poor motivation and poor self-care (National Institute of Clinical Excellence, 2013).

A large amount of research on attachment and mental health indicates that insecure attachment styles are a risk factor for the development of psychosis (Berry, Wearden, Barrowclough, & Liversidge, 2006a; Dozier, 1990; Dozier, Cue, & Barnett, 1994; Dozier & Lee, 1995; Dozier, Stevenson, Lee, & Velligan, 1991; Mickelson, Kessler, & Shaver, 1997; Myhrman, Rantakallio, Isohanni, Jones, & Partanen, 1996; Pickering, Simpson, & Bentall, 2009). The literature suggests that people diagnosed with a psychotic illness are approximately three times more likely to have an insecure anxious and avoidant attachment style compared to non-clinical control groups (Read & Gumley, 2008). For example, a study conducted on inpatient males found that within a sample of male participants diagnosed with schizophrenia, 27% had an insecure anxious attachment style compared to 10% of people in the non-clinical control group and 57% had an avoidant attachment style compared to 17% of people in the non-clinical control group (Ponizovsky, Nechamkin, & Rosca, 2007). Research also shows that people who have experienced psychosis have difficulties developing interpersonal relationships (Berry, Barrowclough, Byrne, & Purandare, 2006b; Daniel, 2006; Macdonald, Sauer, Howie, & Albiston, 2005; Schomerus et al., 2007), and adult attachment styles may be good predictors of this difficulty (Berry et al., 2007a). Interpersonal relationships are an important prognostic indicator for outcome in psychosis and it is therefore important to examine the role of attachment theory in the development of relationships of those who experience psychosis. Research in this field however appears to be disparate and ad hoc and to date there is no review synthesising the findings and implications of research investigating attachment theory and the relationships of adults diagnosed with a psychotic illness. This review therefore aims to summarise and draw out the implications of the existing literature investigating how attachment theory aids our understanding of the relationships of adults diagnosed with a psychotic illness.

1.2 Aim of the review

This literature review is a theoretical review, which was considered pertinent for this topic because it reviews a theory and its implications. It aims to address the following objectives:

1. To explore how attachment theory has been applied to the literature focusing on the relationships of adults diagnosed with a psychotic illness.
2. To determine what attachment theory tells us about adults diagnosed with a psychotic illness and:
    a) Parent and child relationships.
    b) Relationships with mental health services and named workers.
    c) Peer relationships.
    d) Additional factors involved in the development of attachment styles.

These relationships were investigated as a result of the literature identified from the search.

3. To address the quality of the research and assess how robust the empirical evidence is to aid our understanding of this topic.
4. To consider the implications of this review for future research, theory and practice.

2. SEARCH CRITERIA

2.1 Inclusion criteria

To meet the above aims, an electronic database search was employed. Databases Psycinfo, Embase, Medline and Web of Science were searched from 1987 to 2012. The following inclusion criteria were applied to the search:

1. Articles written in the English language.
2. Articles focusing on adults diagnosed with a psychotic illness including schizophrenia (consisting of paranoid type, disorganised type, catatonic type, residual type, undifferentiated type), schizophreniform disorder, schizoaffective disorder, delusional disorder, brief psychotic disorder and drug induced psychosis.
3. Peer reviewed journal articles (excluding dissertation abstracts and books).
4. Articles referring to how attachment theory explains the relationships of adults diagnosed with a psychotic illness.

2.2 Search strategy

A systematic search was conducted to ensure all relevant research in this area was included in the review (see figure 1 for details of the search strategy). Exploded terms ‘paranoid schizophrenia’ and ‘schizophrenia’ include the term ‘psychosis’ in the search (see appendix A for details of the exploded search terms).

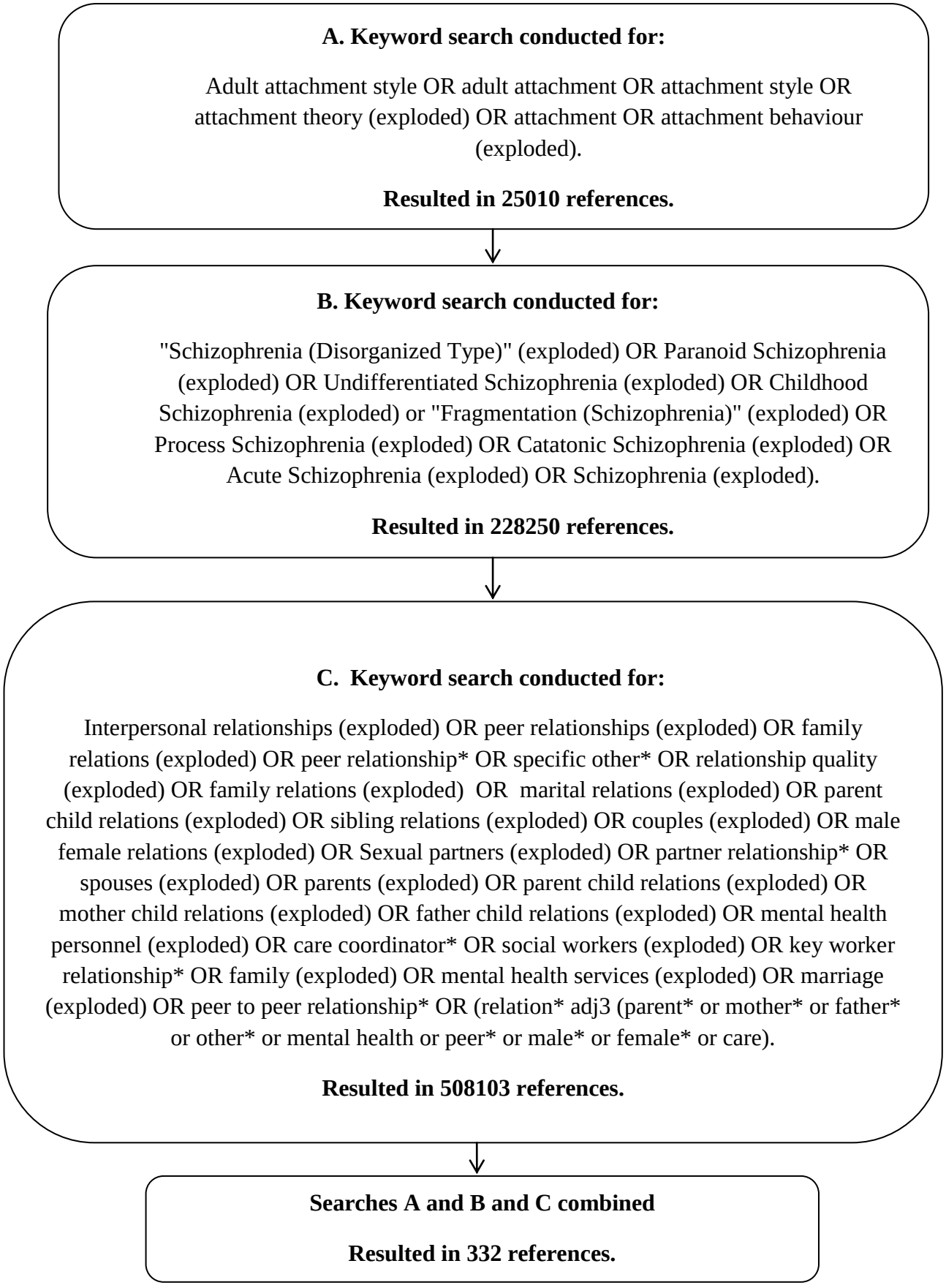


Figure 1: Search strategy

Combining searches A, B and C found three-hundred-and-thirty-two references. Applying the inclusion criterion “English language”, “adults”, “peer reviewed journal articles” and removing duplicates gave a total of two-hundred-and-fifty-six articles.

2.3 Exclusion criteria

The article titles and abstracts were assessed to determine whether they were appropriate for the review. Some articles were retrieved for full inspection because it was difficult to determine their relevance from the title and abstract. Articles were excluded if they included the following:

1. Non-clinical participant sample.
2. Participant sample who were not diagnosed with a psychotic illness.
3. Studies that focused on symptomology rather than how attachment theory helps explain the relationships of adults who have experienced psychosis.

Twelve journal articles were identified. The reference lists of these articles were reviewed to find further relevant articles. Two additional articles were found, giving a total of fourteen articles to review (see figure 2 for a summary of the selection process and details of the exclusion criteria).

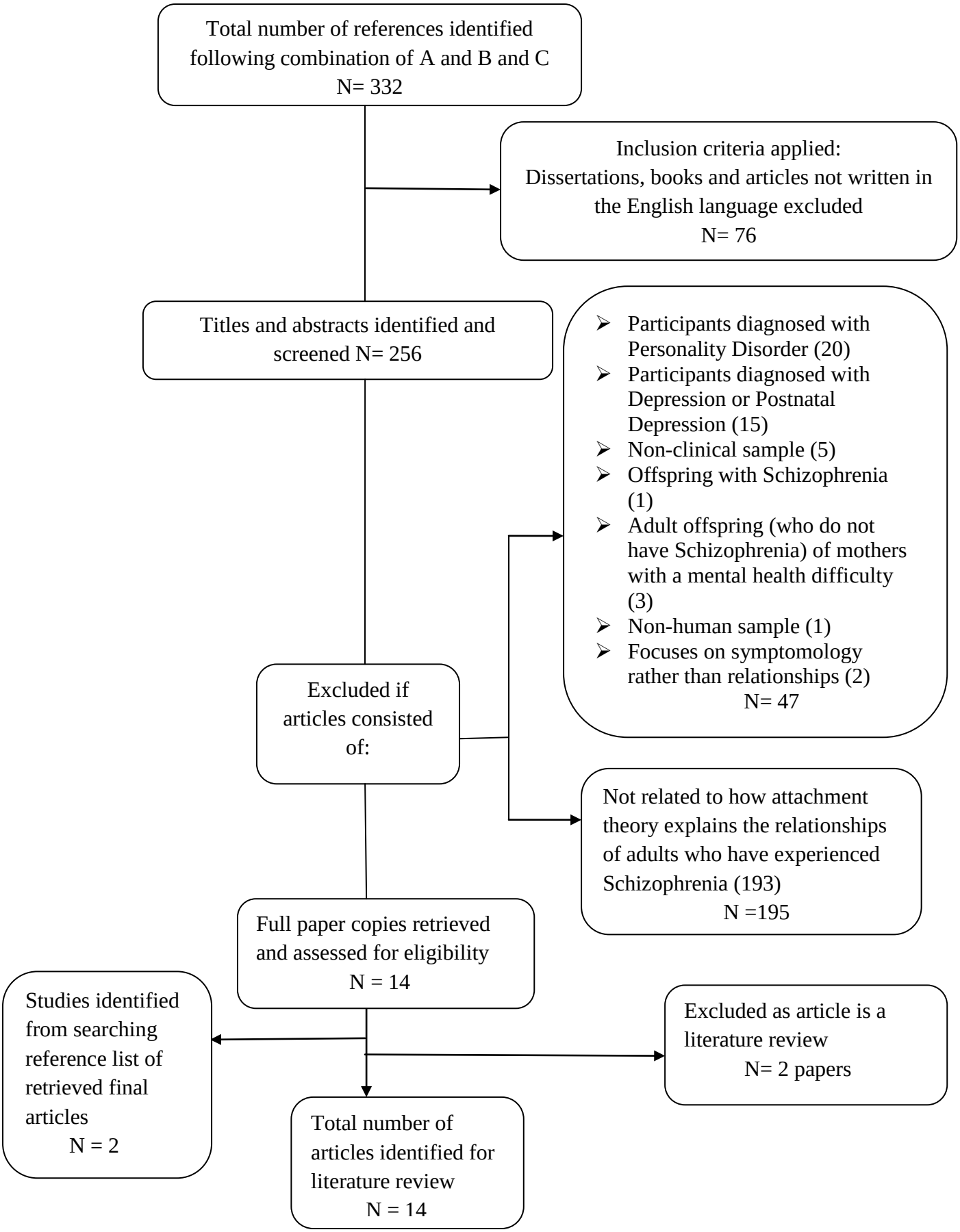


Figure 2: Paper selection process

3. OVERVIEW OF SEARCH FINDINGS

3.1 Overview of literature identified

Of the fourteen identified articles, one discussion article examined the relationships of psychiatric staff to clients in light of attachment theory (Adshed, 1998). The remaining empirical articles explored how attachment theory helps explain the relationships of adults diagnosed with a psychotic illness (Arbuckle, Berry, Taylor, & Kennedy, 2012; Berry, Barrowclough, & Wearden, 2009; Berry, Wearden, & Barrowclough, 2007b; Berry, Wearden, & Barrowlough, 2008; Blackburn, Berry, & Cohen, 2010; Catty et al., 2012; Couture, Lecomte, & Leclerc, 2007; Graham & King, 2005; Kvrgic, Beck, Cavelti, Kossowsky, Stieglitz, & Vauth, 2011; Picken, Berry, Tarrier, & Barrowclough, 2010; Riordan, Appleby & Faragher, 1999; Rogosch, Mowbray, & Bogart, 1992; Tyrrell, Dozier, Teague, & Fallot, 1999). Twelve empirical studies were quantitative studies and one was a pilot study that employed a qualitative research methodology (Graham & King, 2005).

The identified articles focused on one of three types of relationships: mother-child relationships; relationships with mental health services and professionals; and peer relationships. In addition to direct relationships, two articles investigated the relationship between stressful experiences, such as trauma, and attachment styles, which may impact on the development of interpersonal relationships. In the body of this review, the author has grouped together the articles by type of relationship and the literature is discussed according to their overarching themes.

In section 4.1, three articles investigating mother-child relationships are discussed. Riordan et al. (1999) explored the interactions of two groups of mothers diagnosed with schizophrenia or affective disorders, with their children. Rogosch et al. (1992) explored individual differences in parenting attitudes of mothers diagnosed with schizophrenia or

affective disorders, within a developmental model, to determine parenting attitudes. Graham and King (2005) explored the caregiving attachment of mothers diagnosed with schizophrenia during their child's bedtime routine.

In section 4.2, two empirical articles focusing on the association between trauma histories and adult attachment styles of adults diagnosed with schizophrenia, schizotypal or delusional disorder (Berry et al., 2009) and psychosis and substance misuse are discussed (Picken et al., 2010).

In section 4.3, seven empirical articles and one discussion article explore how attachment theory explains the relationships of adults diagnosed with a psychotic illness with mental health services and named workers. They investigate whether the person's social network size, attachment style and team attachment have an impact on the quality of therapeutic relationships (Catty et al., 2012); whether attachment styles within general relationships relate to attachment relationships to mental health professionals (Berry et al., 2007b); and whether the person's attachment styles in general relationships are consistent with their attachment to their named mental health worker (Arbuckle et al., 2012) and inpatient services (Blackburn et al., 2010). They also focus on how attachment styles help or hinder therapeutic relationships (Berry et al., 2008; Kvrgic et al., 2011) and whether the attachment styles of clients and their named workers have an impact on their therapeutic relationship and client functioning (Adshed, 1998; Tyrrell et al., 1999).

In section 4.4, one article explores how attachment theory helps explain the social functioning and peer relationships of adults experiencing a first episode of psychosis (Couture et al., 2007).

3.2 Assessing the quality of the studies

The selected articles have varying aims and methodology, making it difficult to assess them using one quality assessment tool. They were therefore divided and compared for methodological quality using quality indicators guided by Fowkes and Fulton (1991) for quantitative articles, and Elliott, Fischer and Rennie (1999) for the qualitative article (see appendices B and C for the summarised criteria).

The articles were assessed against a 0-2 point system (Fowkes & Fulton, 1991) indicating no problem (0), minor problem (1) and major problem (2) for each criterion. A percentage quality score was allocated. The articles were assessed as good quality if they scored between 1% and 34%, average quality if they scored between 35% and 67% and poor quality if they scored between 68% and 100%. Two articles were deemed as of good quality (Berry et al., 2008; Catty et al., 2012). The remaining eleven articles were of average quality (Arbuckle et al., 2012; Berry et al., 2007b; Berry et al., 2009; Blackburn et al., 2010; Couture et al., 2007; Graham & King, 2005; Picken et al., 2010; Rogosch et al., 1992; Tyrrell et al., 1999; Kvrgic et al., 2011; Riordan et al., 1999). No articles were assessed as poor quality (see appendices D and E for quality comparisons).

The majority of the articles lacked a control group, a longitudinal design, and were prone to referral selection bias. Some researchers acknowledged a small sample size; however the majority did not report a power calculation, making it difficult to determine the effects of the sample size. A variety of standardised measures to assess attachment styles were used[1], yet some of these had problematic validity and most were self-report measures, making the

[1] Including: Psychosis Attachment Measure; Adult Attachment Interview (Main & Goldwyn 1984), Parental Bonding Instrument (Parker, Tupling, & Brown, 1979) and the Attachment Style Questionnaire.

results prone to reporting bias. The Adult Attachment Interview (Main & Goldwyn, 1984) was used in some studies to assess adult attachment styles. It asks participants to draw on their memories to generate an understanding of their relationship with their parents, before they are classified with an attachment style. This approach can be problematic because people diagnosed with a psychotic illness are likely to have memory difficulties (Heinrichs & Zakzains, 1998) and more specifically autobiographical memories, which questions the accuracy of the findings. With these limitations in mind, it is important to be cautious of the results when interpreting the findings. The author has synthesised the findings of the studies, keeping in mind the quality of the studies.

4. ATTACHMENT THEORY AND HOW IT IS USED IN ARTICLES TO HELP US TO UNDERSTAND THE RELATIONSHIPS OF ADULTS DIAGNOSED WITH A PSYCHOTIC ILLNESS.

4.1 How does attachment theory help us to understand the mother-child relationship of mothers diagnosed with a psychotic illness?

The literature highlights that a mother's caregiving style is accessed from her own internal working model of relationships, which is developed from her own attachment relationship with her primary-caregiver (George & Soloman, 1996). The literature suggests that people diagnosed with a psychotic illness are more likely to have impairments in social functioning than those with other psychiatric disorders, which are likely to impact upon the mother-child interaction, the mother's emotional availability to her children's needs, and upon the development of her children's attachment style. Therefore the quality of parenting of mothers diagnosed with a psychotic illness has implications for the clinical outcomes of their children, rather than just the illness itself.

Riordan et al. (1999) conducted a study comparing two groups of mothers who had recovered from an acute post-partum illness, to investigate their parenting interaction. Eight mothers in group one were diagnosed with schizophrenia or schizoaffective disorders and eighteen mothers in group two were diagnosed with affective disorders, consisting of severe depression, mild to moderate depression and bipolar disorder[2]. Riordan et al. (1999), observed a video of the mothers' interaction with their children, which was rated using the Global Rating Scale (Murray, 1988). They found that mothers' diagnosed with schizophrenia had

[2] Six women were diagnosed with severe depression, six women were diagnosed with mild to moderate depression and six women were diagnosed with bipolar disorder

lower levels of interaction with their children compared to mothers' diagnosed with affective disorders, because they were more self-absorbed, unresponsive to their children's needs, insensitive, flaccid, intensive, silent and less demanding of their children. This in turn resulted in their children demonstrating an insecure avoidant attachment style as their interaction with their mother was minimal, serious and less exciting. Riordan et al. (1999) suggest that the lower levels of interaction of mothers diagnosed with schizophrenia may be due to the side effects of ant-psychotic medication such as tiredness, and negative symptoms of schizophrenia, such as poor motivation. The design of the study, however, could not adequately test this idea because the study did not include a mentally well control group to compare the illness severity of the schizophrenia group. This study was assessed as of average quality due to a lack of control group and a diagnostically diverse affective disorder group. The researchers also acknowledged that the Global Rating Scale (Murray, 1988) is generally used for women diagnosed with less severe mental illnesses, which questions the accuracy of their findings. In conclusion this study demonstrates that mothers diagnosed with schizophrenia can be detached to the needs of their children which may affect the attachment style their children develop. It is however, difficult, at this stage, to determine whether their parenting style is due to their mental illness, the severity of their illness, or their own attachment style. In either case, parenting interventions may help mothers who have recovered from an acute post-partum illness to interact positively with their children; which may help their children to develop better mental health outcomes.

Rogosch et al. (1992) explored variations in parenting attitudes of forty-eight inpatient mothers of children aged twelve or younger, diagnosed with schizophrenia, schizoaffective

disorder or affective disorders, using a developmental model to predict differences in parenting attitudes. Following completion of questionnaires[3] assessing the mother's own childhood experiences, their current social context, personality and characteristics of their children, two developmental pathways, being a proximal and distil pathway, were identified. For the proximal pathway, Rogosch et al. (1992) found that mothers who experienced severe mental health difficulties developed less sensitive parenting attitudes than those who experienced less severe mental health difficulties. This finding adds to Riordan et al. (1999) study, because it indicates that illness severity has a negative impact on the mother's parenting style, as they may be preoccupied with their symptoms, making them emotionally unavailable for their children. For the distil pathway, Rogosch et al. (1992) explored whether the mother's understanding of their own parenting experience impacted upon their parenting style and upon their social interaction. They found that the mothers' own childhood experiences, such as maternal un-involvement predicted their own parenting attitudes and interaction with their children and their interactions within social relationships. They found that maternal un-involvement led to low self-esteem which led to less sensitive and unresponsive parenting styles. Rogosch et al (1992) also found that emotional support from the mothers' social network increased their self-esteem which predicted better parenting attitudes. This study was assessed as average quality, because, as Rogosch et al. (1992) acknowledge, a longitudinal study with a larger sample size is needed to demonstrate 'developmental causal processes'. Both studies indicate that there are multifaceted aspects impacting on the mother's parenting role and their attachment to their children, rather than

[3] Current Living Situation Questionnaire; Early Life Questionnaire; Children's Reports of Parental Behaviours Inventory; Sensitivity to Children Questionnaire Self-Esteem Scale; Social Support Questionnaire; Child Behaviour Checklist

just the illness itself. These aspects include the severity of the illness, the type of illness, their preoccupation with symptoms and their own childhood up-bringing and attachment styles.

Research highlights that mothers diagnosed with a psychotic illness generally have social and emotional interaction deficits, suggesting that they are likely to have difficulties managing their children's needs when their children are distressed. Graham and King (2005) conducted semi-structured interviews with five mothers diagnosed with schizophrenia; living with a child aged ten or below, recruited from Community Mental Health Teams (CMHTs) to investigate how they managed the attachment experiences, such as separation anxiety, of their child during bedtime. Three themes emerged from thematic analysis which consisted of 1) bedtime strategies and effectiveness; 2) maternal responsiveness and 3) understanding of the child's experience of bedtime. Graham and King (2005) found that four mothers' expressed difficulties recognising and understanding their child's needs, possibly because they themselves were distressed. They also felt frustrated and angry about their ineffective strategies in implementing bedtime routines. Most of the participants reflected on their own mother's parenting style, expressing that they wanted to be better mothers than their own mother. Despite this motivation the mother's mental health difficulties and the impact of medication on their energy levels affected their ability to meet their child's needs which contributed to the strains involved in managing their child's anxieties. Again, these researchers demonstrate that the quality of parenting in mothers diagnosed with schizophrenia may be fractured due to the severity of their illness and impact of medication, which can lead to attachment difficulties and emotional regulation difficulties in their children. These findings cannot be generalised to the quality of parenting at all times because the study focused on the mother's interaction with their child at bedtime. These participants also completed an adapted version of the Parental Bonding Instrument (PBI: Parker, Tupling, &

Brown, 1979) to determine their own parenting style. The results of the PBI found that four mothers rated themselves in the optimal parenting category (high care, low over-protection), which is in contrast to their narratives, indicating self-report bias. Although they used this measure, Graham and King (2005) did not acknowledge the quantitative element of their research. This study was rated as of average quality due to its limited generalizability and limited information about ethical procedures and credibility checks. Taken together, all three studies indicate strongly that mothers diagnosed with schizophrenia may benefit from enhanced parenting skills groups and parenting support groups.

The literature above indicates that mothers diagnosed with schizophrenia draw on their own experience of being parented in their parenting role, which if negative, may have a negative impact on the quality of their mothering role and upon their self-esteem and social interaction. It also indicates that the severity of the mothers illness may have a negative impact on motherhood, implying that mothers diagnosed with schizophrenia may be emotionally absent to their children's needs, making their children vulnerable to the development of insecure attachment styles, which later can be associated with interpersonal difficulties and mental health difficulties. All of the articles in this section are rated as average quality as the studies were unable to examine causal relationships and discounted confounding variables.

4.2 How do trauma experiences help us to understand the attachment styles of adults diagnosed with a psychotic illness?

The review thus far has provided some indication that early attachment experiences of mothers diagnosed with schizophrenia are important in shaping their subsequent interaction with their children. The articles however, have not directly considered whether specific early interpersonal experiences, such as traumatic events, have an impact on the development of an individual's attachment style. The trauma literature indicates that people who have experienced childhood trauma are at increased risk of developing insecure attachment styles and fearful relationships in later life, affecting their ability to positively engage in relationships (Waters et al., 2000). The articles here, explore whether this is the case for adults diagnosed with a psychotic illness.

Research has found that people who have experienced psychotic disorders such as schizophrenia are more likely to have experienced traumatic events and Post-Traumatic Stress Disorder (PTSD) during their lifetime, which can influence their attachment styles (Read, Van Os, Morrison, & Ross, 2005) in adult relationships. Berry et al. (2009) examined the impact of parental caregiving and trauma related experiences to the attachment styles of eighty people diagnosed with schizophrenia, schizotypal or delusional disorder, recruited from inpatient and community services. They administered attachment measures[4] and trauma measures[5] to the participants who were separated into four groups: 1) twenty-six people who experienced childhood trauma such as parental over-control with significant caregivers; 2) twelve people who experienced adulthood trauma with significant others; 3) twenty-eight people who experienced traumatic events with no significant others involved; and 4) fourteen

[4] Psychosis Attachment Measure, Parental Bonding Instrument (Parker et al., 1979).
[5] Trauma History Questionnaire

people who did not experience traumatic events. Berry et al. (2009) found higher levels of adulthood anxious attachment styles in people who experienced childhood trauma in relationships involving significant others, however, this finding was not maintained when depression was controlled. Furthermore, these individuals also experienced trauma during their adulthood, making it difficult to know whether the effects were due to childhood or adulthood trauma. There was no relationship between early traumatic events and insecure avoidant attachment styles. This study indicates that childhood traumatic events involving important others may contribute to the development of insecure anxious attachment styles, which may contribute to anxious adult relationships and interpersonal difficulties, as well as increasing a person's vulnerability to developing mental health difficulties in later life. The researchers however acknowledged that the associations between attachment styles and trauma experiences were bidirectional due to the design of the study. This study was assessed as average quality due to no longitudinal design and control group.

Like Berry et al. (2009), Picken et al. (2010), investigated the association between trauma events and adult attachment styles adopting a cross-sectional design. They explored whether exposure to traumatic events would result in higher levels of self-reported avoidant attachment and anxious attachment styles. They administered trauma[6] and attachment measures[7] to one-hundred-and-ten people diagnosed with both psychosis and substance misuse, however only forty-six participants completed all measures. The participants were a control group of a large randomised controlled trial study. Like Berry et al. (2009), Picken et al. (2010) found that an anxious attachment style was positively associated with the number of experienced traumatic events during the participant's childhood, and in addition to Berry et

[6]Posttraumatic Stress Diagnostic Scale, Informant Trauma Questionnaire
[7] Psychosis Attachment Measure (PAM)

al. (2009) study, severity of symptoms of Post-Traumatic Stress Disorder (PTSD). Those with an avoidant attachment style however reported less traumatic events. These findings indicate an association between stressful life events and insecure anxious attachment styles in this participant group. Picken et al. (2010), acknowledge that the direction of this finding cannot be ascertained due to the cross-sectional design of the study. They therefore suggest a bidirectional connection between trauma, PTSD and attachment styles. They suggest that trauma experiences may influence insecure attachment styles and insecure attachment styles may have an impact upon how people cope with trauma and symptoms of PTSD, which may impact upon interpersonal relationships. This study was assessed as average quality due to a small sample size and as the validity of the measures was not addressed.

The trauma and attachment literature reviewed here, indicates a relationship between stressful life events and insecure anxious attachments styles. The studies demonstrate that early exposure to trauma events are likely to increase a person's vulnerability to the development of insecure anxious attachment styles, which are likely to have a negative impact on a person's ability to engage in relationships. Furthermore, perceived stressful life events in adulthood may be a contributing factor to insecure anxious attachment styles. The findings of the literature indicate that it may be beneficial to assess and incorporate trauma experiences into therapeutic work, as they provide an indication about an individual's attachment style.

4.3 How can attachment theory help us to understand the relationships of adults diagnosed with a psychotic illness to mental health services and named workers?

The literature indicates that adults diagnosed with a psychotic illness have higher levels of insecure attachment styles, in comparison to non-clinical groups and people diagnosed with affective disorders (Berry et al., 2008). The literature has used attachment theory to explore the relationships of adults diagnosed with a psychotic illness, highlighting that attachment theory is important in this area for many reasons. Firstly, people diagnosed with a psychotic illness are more likely to have insecure attachment styles (Ponizovsky et al., 2007; Read & Gumley, 2008), which are related to difficult interpersonal relationships with significant others (Berry et al., 2006a; Bartholomew & Horowitz, 1991; Rosenberg & Bartholomew, 1993). Secondly, attachment behaviours, which are behaviours that result in the individual regaining contact with their attachment figure (Bowlby, 1973) are activated when a person is distressed, such as during episodes of psychosis, which are often characterised by high levels of interpersonal difficulties (Berry et al., 2008). Thirdly, "attachment theory has been argued to provide a theoretical basis for the research finding that a good therapeutic alliance is the best predictor of good (mental health) outcome" (Catty et al., 2012, p. 18). Taken together, the implications are that people diagnosed with a psychotic illness may have an insecure attachment style and may therefore have difficulties forming close relationships with mental health services and professionals, impacting on therapeutic relationships and treatment outcome.

The literature regarding adult attachment styles, also known as attachment states of mind as assessed by the Adult Attachment Interview (Main, Kaplan, & Cassidy, 1985), indicate that adults with a secure attachment style develop positive therapeutic relationships with their named mental health worker (Daniel, 2006; Waldinger, Seidman, Gerber, Allen, &

Hauser, 2003). The literature indicates that they are more compliant with treatment (Dozier, 1990) compared to people with insecure attachment styles who are likely to have difficulties trusting others, negatively impacting on the formation of therapeutic relationships with their named workers' (Catty et al., 2012). Research has found that people with severe mental health difficulties are likely to confide in members of their social network rather than with mental health professionals (Catty et al., 2005), which may hinder their therapeutic relationships as they may be more trusting of their social network. This appears to be particularly prominent for clients under the care of CMHTs rather than inpatient services due to easier access to their social network. Catty et al. (2012) conducted a cross-sectional survey with ninety-three clients under the care of CMHTs, diagnosed with schizophrenia and bipolar disorder (fifty-three participants) and depression, anxiety and personality disorders (forty participants). They assessed whether there is an association between the client's social network size and their ability to form relationships, with the quality of therapeutic relationships with their named mental health worker. The participants also completed a series of questionnaires[8] which assessed whether their attachment style; quality of therapeutic relationships; social characteristics, and level of clinical functioning were associated with their relationship to the CMHT as a whole. They found that the quality of therapeutic relationships is not influenced by the number of close friends and family a person has in their social network. This suggests that the therapeutic relationship is built in collaboration with the client and their named worker rather than influenced by their social relationships, indicating that this client group can differentiate between therapeutic relationships and personal relationships. Catty et al. (2012)

[8] The Social Network Schedule, The Scale to Assess the therapeutic relationship in community mental health care (STAR: McGuire-Sneickus et al., 2007); Team Attachment Questionnaire; Global Assessment of Functioning, the Manchester short assessment of quality of life Schedule for the evaluation of individual quality of life.

also found a strong association between therapeutic relationships and team attachment, finding that team attachment was linked with having a positive, established relationship with their named worker. Team attachment was also associated with poor client functioning, indicating that those with severe mental illnesses had better team attachment. Of all the attachment styles, Catty et al. (2012) found a significant association between anxious attachment styles and poor team attachment, concluding that those with an anxious attachment style would find it difficult to develop positive attachment relationships with services experiencing regular change because they may find relating to organisational change and being subject to frequent transitions themselves, difficult. This study was assessed as of good quality mainly due to its large sample size, sample selection process and validation of measures, making the results more reliable.

Berry et al. (2008) and Kvrgic et al. (2011) add to the literature regarding attachment styles and therapeutic relationships of adults diagnosed with a psychotic illness. Berry et al. (2008) conducted a prospective study from the perspectives of staff and ninety-six people diagnosed with psychosis to explore the association between insecure attachment styles and positive and negative symptoms of psychosis; therapeutic relationships; and interpersonal difficulties. Kvrgic et al. (2011) conducted a cross-sectional designed study and investigated the adult attachment styles of one-hundred-and-twenty-seven people diagnosed with schizophrenia or schizoaffective disorder, under the care of CMHTs, to help recognise factors involved in developing strong therapeutic relationships. Berry et al. (2008) and Kvrgic et al. (2011) both found a significant association between avoidant attachment styles and positive symptoms of schizophrenia; however the direction could not be ascertained due to the observational design of the studies. Berry et al. (2008) found an association between avoidant attachment style and negative symptoms of psychosis, unlike Kvrigic et al. (2011). Berry et

al. (2008) also found an association between overly demanding behaviour and high levels of an anxious attachment style, and overly-hostile behaviour with high levels of an avoidant attachment style. This finding indicates that attachment styles may impact upon the interpersonal styles and social functioning of adults diagnosed with schizophrenia.

In regards to therapeutic relationships, Kvrigic et al. (2011) and Berry et al. (2008) both found an association between avoidant attachment styles and difficult therapeutic relationships. Berry et al. (2008), found a significant negative correlation between avoidant attachment styles and therapeutic alliance, rated by participants and staff. Similar results were obtained when the severity of illness was controlled, which indicates that attachment style, rather than a person's illness per se, provides a good predictor for therapeutic engagement. Kvrigic et al. (2011) concluded that avoidant attachment styles are risk factors for the development of poorer quality therapeutic relationships. Kvrgic et al. (2011) found that people with anxious attachment styles had high levels of service engagement, possibly due to the urge to have their needs met. This indicates that an insecure anxious attachment style is a good predictor for service engagement which is in contrast to Catty et al. (2012) findings that participants with an anxious attachment style develope poor team attachment. There is, however, a possibility that anxieties may be heightened and service engagement may decrease if there are inconsistencies in care, such as being seen by various professionals due to the current climate of the NHS. Berry et al. (2008), however, did not find such an association, which indicates that Kvrigic et al. (2011) findings should be interpreted with caution. Berry et al. (2008) study was assessed as of good quality due to its longitudinal design and inclusion of a comparison group. The researchers also addressed the validity of the measures. Kvrigic et al. (2011) study was assessed as of average quality due to no control group and comparison group.

These findings indicate that attachment styles can have a detrimental effect on the therapeutic alliance. Mental Health services may therefore benefit from assessing a client's attachment style before conducting therapeutic work, to give an indication of the potential challenges in their therapeutic relationship. Furthermore, the studies indicate that this client group require secure, consistent attachment figures in their therapeutic relationships to help them to develop better interpersonal styles, which may have a positive effect on their social functioning. Therefore, having a consistent named worker who stays with the client for a large duration of time could be positive.

With attachment to mental health services in mind, Blackburn et al. (2010) conducted a cross-sectional designed study with people diagnosed with schizophrenia (sixty-nine people), bipolar disorder (five people) and substance misuse (three people), residing in an inpatient rehabilitation service. They assessed whether the participants attachment styles impacted upon their engagement with the service. Following completion of symptom related and attachment related questionnaires[9], Blackburn et al. (2010) found that participants who had high levels of insecure avoidant and anxious attachment styles associated with severe depression, had limited attachment with inpatient services. They suggest that inpatient services may have difficulties meeting the needs of participants with insecure avoidant attachment styles because these individuals are more likely to deny mental health difficulties and ignore the value of close relationships in helping their difficulties, possibly resulting in disengagement with services. Those with an insecure anxious attachment style may perceive the therapeutic styles of staff as rejecting when staff cannot immediately attend to their needs

[9] Service Attachment Questionniare, Psychosis Attachment measure, The Calgary Depression Scale for Schizophrenia (Addington, Addington, & Schissel,1990); The Psychotic Symptoms Rating Scale (PSYRATS) (Haddock, McCarron, Tarrier, & Faragher, 1999)

due to the busy inpatient environment. Interestingly, this study demonstrated no link between positive symptoms of psychosis and attachment style, suggesting that positive symptoms of a person's mental illness do not impact upon their attachment style or vice versa. This is in contrast to Berry et al. (2008) and Kvrgic et al. (2011) findings. Balckburn et al. (2010) study was assessed as average quality due to the possible selection bias and as the researchers acknowledged that they excluded participants who were severely ill which may have influenced their findings. Again, the recommendation here is that services should benefit from routinely assessing attachment styles to inform how they can best meet the client's needs.

In conclusion, the literature reviewed shows a link between insecure attachment styles in adults diagnosed with a psychotic illness and difficult therapeutic relationships. Tyrrell et al. (1999) take this further by assessing the internal working models of fifty-four out-patients' diagnosed with schizophrenia and bipolar disorder, and twenty-one of their named workers. They used the Adult Attachment Interview (Main & Goldwyn, 1984) to determine whether the internal working models of both groups of people impacted upon their therapeutic relationship and client functioning. Tyrrell et al. (1999) found that participants who had an avoidant attachment style had better therapeutic relationships when working with named workers who had a less avoidant attachment style themselves. Participants who reported a less avoidant attachment style in comparison to their named worker's more avoidant attachment style, reported a stronger therapeutic alliance and higher level of life satisfaction. This study indicates that clients have a better therapeutic relationship and better mental health outcomes when they are matched with clinicians who have a dissimilar attachment style to their own. This study was assessed as average quality and Tyrell et al. (1999) acknowledged that a longitudinal study is needed to assess whether the different attachment styles of clients and their named worker has a long-term impact on the therapeutic relationship and on the client's

wellbeing. More research needs to be conducted in this area before any suggestions can be put forward.

The researchers above have discussed the difficulties with insecure attachment styles and therapeutic relationships, which can be construed as negative. However, Adshed (1998) highlighted that mental health staff can potentially change the attachment style of people diagnosed with schizophrenia by providing a stable and secure attachment figure to the individual. This is demonstrated in studies conducted by Berry et al. (2007b) and Arbuckle et al. (2012). These researchers investigated the attachment styles of fifty-eight out-patients (Berry et al., 2007b), and twenty-four inpatients in a rehabilitation setting (Arbuckle et al., 2012) who experienced psychosis. They examined whether self-reported attachment styles with significant others in general relationships were consistent with their therapeutic relationship with their named worker (Berry et al., 2007b; Arbuckle et al., 2012) and mental health teams (Arbuckle et al., 2012). Staff within both studies completed an informant version of the Psychosis Attachment Measure to obtain their perspectives about the participants' attachment styles. The participants of both studies rated themselves as having an insecure avoidant and anxious attachment style with close others in general relationships, in their relationships with their named worker's (Berry et al., 2007b; Arbuckle et al., 2012) and to mental health teams (Arbuckle et al., 2012), in both settings. Berry et al. (2007b) and Arbuckle et al. (2012) found that participants reported less anxious and avoidant attachment styles in their relationships with their named worker's in comparison to their general relationships, suggesting that they had a more secure relationship with their named worker. Both studies were assessed as average quality and should be interpreted with caution due to the small sample size which limits generalizability.

The literature in this section highlights that mental health services can provide a secure base for people diagnosed with a psychotic illness. This may help them to modify and review their own attachment styles and alter their internal working models and cognitive structures, which may impact on how they view themselves in interpersonal relationships. Furthermore, attachment assessments (both for the patient and staff), may be beneficial prior to therapy to aid the therapeutic alliance as dissimilar styles seem to work best. The articles, however, have generally demonstrated inconsistent findings in the role of attachment styles and therapeutic relationships. For example Berry et al. (2008) and Kvrigic et al. (2011), found an association between avoidant attachment styles and positive symptoms of psychosis, however Blackburn et al. (2010) did not find this. This indicates the need for future research. Furthermore, all of the literature in this section was assessed as of average quality apart from Catty et al. (2012) and Berry et al. (2008), which were assessed as good quality. Therefore robust research including larger samples, validation of measures and follow-up designs are needed in this area.

4.4 How does attachment theory help us to understand the peer relationships of adults diagnosed with a psychotic illness?

It has been suggested that attachment styles can change over time in different life stages and with different relationships. The above articles have focused on adult samples, some of whom have experienced psychosis for many years, giving little attention to those in the first stage of psychosis. The article reviewed here draws on attachment theory to help understand the social functioning and peer relationships of young adults experiencing a first episode of psychosis. This is important to consider as it provides us with an indication of how the onset of psychosis is related to the attachment styles and relationships of this client group.

The literature indicates that people experiencing a first stage of psychosis demonstrate deficits in social functioning such as making friends and obtaining employment (Courter et al., 2007). Courter et al. (2007), investigated whether attachment styles contribute to the social functioning of ninety-six participants experiencing a first episode of psychosis aged between fifteen and thirty-five, compared to a non-clinical control group. The participants completed the Attachment Style Questionnaire, to determine their adult attachment style. Courter et al. (2007) found that more participants in the clinical group demonstrated an insecure anxious attachment style in comparison to the control group. Participants in the clinical group displayed high levels of uneasiness with closeness and a need for approval by others, which negatively impacted on their quality of life, how they behaved in the community and upon their independent living skills. Although the finding of this study does not directly indicate that the participant's attachment style was triggered by schizophrenia, it does indicate that the participant's insecure attachment styles negatively impacted upon their social functioning and peer relationships. The researchers appear vague about the study findings and implications; however interventions aimed at increasing social functioning and

peer interaction for this client group may lead to better functioning in later life. The need for more research in this area is highlighted before firm clinical implications can be suggested. This article was assessed as of average quality due to a small sample size and as confounding variables in the control group, e.g. substance use, were not controlled.

5. DISCUSSION AND IMPLICATIONS

5.1 Summary and Overview

Based on the research reviewed, it is evident that attachment theory can help us to understand the relationships of adults diagnosed with a psychotic illness in all of the investigated areas. The reviewed articles regarding mother-child relationships indicate that some mothers diagnosed with a psychotic illness demonstrate low and unresponsive levels of interaction with their children. This level of interaction may be a result of a difficult attachment relationship they developed with their own primary-caregiver as a child, which may impact on their self-esteem and on their ability to parent. Furthermore, difficult attachment relationships between a mother and her children may be exacerbated by the severity of her illness rather than as a result of psychosis per se. The articles indicated that positive social support, however, can predict positive parenting attitudes in mothers with a diagnosis of a psychotic illness.

The articles reviewed regarding relationships to mental health services and m

Named workers indicate that adults diagnosed with a psychotic illness are likely to have an insecure anxious or avoidant attachment style. Having an insecure attachment style may have an impact on the therapeutic relationship between the client and their named worker as well as how they perceive the working nature of the NHS. For example, clients' with an insecure anxious attachment style may perceive staff working in busy environments as rejecting, because staff may not attend to the client's needs as much as they would like them to. The articles also indicate that insecure attachment styles are associated with certain characteristics such as hostility, which contribute to a person's ability to form and maintain relationships. Despite these difficulties, the articles clearly demonstrate that positive

relationships with mental health services and named workers may facilitate secure attachment styles, which have positive implications for intervention and positive wellbeing.

The reviewed article regarding social functioning and peer relationships found that people experiencing a first stage of psychosis were likely to have an anxious attachment style. Having an anxious attachment style can have a negative impact on social functioning and the formation of peer relationships.

Furthermore the articles reviewed regarding trauma and attachment styles indicate that people diagnosed with a psychotic illness are more likely to have experienced trauma during their lifetime, than those with other disorders. The articles lend to the hypothesis that traumatic life events (especially during childhood) are likely to lead to the development of insecure attachment styles which may increase a person's vulnerability to the development of a severe mental illness in later life. Psychosis in its own right may be perceived as a traumatic experience which may also precede the development of an insecure attachment style, therefore being a consequence (as well as a cause) of psychosis. The literature reviewed here however demonstrated a relationship between traumatic life events and insecure anxious attachment styles, demonstrating the need for more research such as longitudinal cohort studies, to demonstrate whether there is a link between traumatic life events and insecure avoidant attachment styles.

Taken as a whole, the literature reviewed here indicates that people diagnosed with a psychotic illness are more likely to have an insecure anxious or avoidant attachment style, which is likely to be a vulnerability factor for the development of psychosis. This insecure attachment style may be a result of a negative or inconsistent attachment relationship with their primary-caregiver. The literature however could not determine this link due to the design of the studies. Longitudinal cohort research which includes a measure of attachment and

examines later psychopathology is needed to determine the relationship between insecure attachment styles and psychosis. As well as being a potential cause of psychosis, Courter et al. (2007) findings indicate that insecure attachment styles could be a consequence of psychosis as those experiencing a first stage of psychosis had an insecure anxious attachment style compared to a mentally well control group. This attachment style may make important life events such as peer relationships and engagement with services much more difficult.

Although this literature review has highlighted an association between insecure attachment styles and psychosis; the wider literature indicates that an insecure attachment style may be a predisposing factor for other mental health difficulties including anxiety (Berry et al., 2007a; Klykylo & Kay, 2012), depression, eating disorders and borderline personality disorder, (Berry et al., 2007a). For example, research has found that women diagnosed with depression and bipolar disorder reported minimal attachment to their mother (Goodwin, 2003) indicating a developmental relationship between insecure attachment styles and depression. Research has also found that people diagnosed with personality disorders have a childhood history of trauma and emotional neglect (Herman, Perry, & Kolk, 1989), which may be a predisposing factor for insecure attachment styles. Therefore the literature regarding attachment styles and psychosis are currently illuminating issues which are generally true of attachment styles and mental health issues more generally. Berry et al. (2008) and Kvrgic et al. (2011), however both found a significant association between avoidant attachment styles and positive symptoms of schizophrenia, indicating a unique relationship between insecure attachment styles and psychotic experiences. The implications of the review are discussed in section 5.2 and 5.3.

5.2 Implications for parents diagnosed with a psychotic illness and their children

The literature firstly helps us to understand that people diagnosed with a psychotic illness are more likely to develop poor social functioning due to having an insecure attachment style, diagnosis of a psychotic illness or due to a combination of the two. Secondly, the literature draws upon the mother-child relationship of mothers diagnosed with a psychotic illness and indicates that they may require emotional support from their social network, which may increase their self-esteem and help them to develop adaptive parenting attitudes (Rogosch et al., 1992). Emotional support may also help them to develop a secure attachment style with their children which may lead to better mental health outcomes for them. Thirdly, the literature indicates the importance of promoting meaningful and consistent relationships in terms of parenting skills, as negative parenting styles may contribute to the development of insecure attachment styles in their children (Riordan et al., 1999). Mothers diagnosed with a psychotic illness may therefore benefit from parenting groups and psychoeducation regarding interaction with their children to promote positive parenting styles. Fourthly, the literature shows that mothers who have experienced psychosis have concerns about the impact of medication induced sedation and relapse on their care-giving style (Graham & King, 2005). This indicates the need for their parenting role to be carefully considered in care planning which may include careful medication monitoring, effective treatment, and education about the effects of a severe mental illness on their daily functioning. Services may also consider conducting family therapy work, psychological work and attachment focussed work to develop more effective attachment relationships with their children.

5.3 Implications for mental health services

This review indicates that adults diagnosed with a psychotic illness may have a more secure relationship with their named mental health workers in comparison to their general social relationships (Arbuckle et al., 2012; Berry et al., 2007b). This finding implies that mental health professionals may help clients to alter their internal working models and develop better interpersonal styles by providing them with a secure base (Adshed, 1998) which may lead to better mental health outcomes (Catty et al., 2012). However, in practice, clients are likely to have more than one named worker with inconsistencies in their care. Services should therefore help clients to have one consistent named worker which may have positive effects on service engagement and mental health recovery. Furthermore, the reviewed articles demonstrate that insecure attachment styles have an impact upon service engagement (Berry et al., 2008; Kvrig et al., 2011; Blackburn et al., 2010). This implies the importance of mental health professionals engaging with this client group to obtain a therapeutic rapport before commencing with therapeutic work. These suggestions however, may be difficult to implement in the current climate of the NHS due to the organisational time pressures which can be perceived by adults with an anxious attachment style as rejecting (Blackburn et al., 2010). This raises questions about the impact services may have on a client's mental health recovery, as they may perceive the climate of the NHS as stressful, which may have a negative impact on their symptoms of psychosis.

The literature also suggests that clients with insecure attachment styles may benefit from working with mental health professionals with less insecure attachment styles (Tyrell et al., 1999), because they would be better adapted to respond to their client's needs. Services may therefore benefit from assessing the attachment styles of professionals as well as clients

to obtain a “perfect match”. The impact of mental health outcome within this area warrants further research.

It is possible that clients who have an insecure attachment style will be perceived as hostile and demanding by staff (Berry et al., 2008). It might be useful for mental health professionals to understand their client’s attachment style and why their client has developed an insecure attachment style by, for example, taking a detailed past history. Knowledge of the client’s relationship style may provide professionals with a wider understanding of the client’s difficulties, which may enhance team cohesiveness and minimise team blaming. It may also help professionals build a positive therapeutic relationship with their client.

6. LIMITATIONS AND FUTURE RESEARCH

6.1 Limitations of reviewed articles and future research

This review has highlighted some valuable clinical implications; however there are some methodological assumptions in connection with section 3.2 that need to be considered. The articles reviewed here did not ascertain the direction of the relationship between attachment styles and psychosis as the majority of the articles adopted a cross-sectional design. Longitudinal research examining the direction of the relationship between attachment styles and psychosis is needed to determine whether insecure attachment styles are a cause or consequence of psychosis or whether they can be both. Furthermore the literature indicated a link between insecure attachment styles and a range of mental health difficulties, suggesting that it is not a specific risk factor for psychosis, but can cause mental health issues across the board. To adopt a clear understanding of the relationship between insecure attachment styles and psychosis, birth cohort studies measuring the attachment styles and mental health outcome of people from birth to adulthood at regular time intervals would be beneficial. Direct observations of mother-child interaction as well as completion of attachment measures such as the parental bonding instrument would help identify the relationship between attachment styles and psychosis.

Research has touched on the attachment styles of mental health professionals and clients when focusing on the therapeutic alliance. Further research exploring attachment styles of mental health professionals (Arbuckle et al., 2012) would be beneficial to explore whether their attachment style impacts upon the therapeutic relationship.

Future research assessing the client's attachment style upon admission to mental health services as well as during their therapeutic alliance would be beneficial as it would help professionals acknowledge any difficulties with service and therapeutic engagement

(Arbuckle et al., 2012). It may also give useful information about how to engage with clients, enabling mental health services to meet their needs and improve mental health outcomes.

The literature on adult attachment styles indicates that there are two types of insecure avoidant attachment styles: dismissive-avoidant attachment style and fearful-avoidant attachment style (linking to childhood disorganised attachment style), (Bartholomew & Horowitz, 1991). The articles did not distinguish between the two types of avoidant attachment styles. This indicates the need for further research to identify whether an insecure dismissive attachment style and an insecure fearful attachment style is associated with the relationships of adults diagnosed with a psychotic illness (Wan, Moulton, & Kathryn, 2008).

The quality comparison checks found that the majority of the studies were of average quality, indicating the need for more robust research. A small number of studies employed a follow-up design, highlighting that longitudinal research, with more than one follow-up period are needed to assess differences in attachment styles over time. Longitudinal prospective designs including observations of professionals and clients within their therapeutic relationship may also be beneficial (Tyrell et al., 1999), as it may ascertain whether therapeutic relationships play a part in altering the client's attachment style over time. The majority of the studies did not have a clinical control group; therefore research including control groups would aid our understanding of the influence of schizophrenia on the client's attachment style in all relationships. Some of the research included comparison groups; however such groups consisted of heterogeneous diagnoses indicating a need for homogenous control groups.

6.2 Limitations of current review and future research

The current review is a theoretical review, exploring how attachment theory has been applied in the literature to help explain the relationships of adults diagnosed with a psychotic

illness. The review, therefore, did not critique in detail the robustness of the measures used to measure attachment styles and the methodology applied to the research. A systematic review would be useful to critique the quality of the attachment measures used to assess attachment styles.

This review focussed on mother-child relationships, relationships to mental health services and peer relationships of adults diagnosed with a psychotic illness as a result of the literature that is currently available. A limited number of articles were yielded which focussed on the topic under review. The author was therefore broad about what articles were included. As the review is a theoretical review, the author included studies that referred to attachment theory rather than those that directly measured attachment styles because the author was curious about the associations of attachment theory and how it is applied in the literature to aid our understanding of the relationships of adults diagnosed with a psychotic illness. It is anticipated that other types of relationships are just as pertinent for this client group, indicating the need for future research to explore other relationships of adults diagnosed with a psychotic illness, such as romantic relationships and father-child relationships. The limited research on mother-child relationships and peer relationships indicates the need for more research in this area.

Furthermore this review included articles which focused on adults diagnosed with a psychotic illness rather than a specific psychotic illness such as schizophrenia. The author added psychotic disorders as an inclusion criterion as a majority of the research has focused on psychosis. It was also anticipated that this inclusion criteria would provide an accurate reflection of all of the research in this area rather than limiting it to a specific illness like schizophrenia. However upon reflection it would be useful to conduct similar reviews investigating research focusing on the relationships of adults diagnosed with specific

psychotic illnesses to obtain a holistic understanding of psychosis, attachment styles and relationships.

7. CONCLUSION

This review aimed to explore how attachment theory has been applied to the literature to aid our understanding of the relationships of adults diagnosed with a psychotic illness. Three articles were reviewed about the mother-child relationships; one discussion article and seven empirical articles were reviewed about the relationships of adults diagnosed with a psychotic illness to mental health services and named workers, and one article was reviewed about the social functioning and peer relationships of adults experiencing a first episode of psychosis. Two articles were reviewed about the impact of trauma events on an adult's attachment style and social functioning. The review demonstrates that people diagnosed with a psychotic illness often have insecure attachment styles which appear to have a negative impact on mother-child relationships, relationships to mental health services and peer relationships. It appears that insecure attachment styles may be developed prior to their diagnosis, and indeed research (not reviewed here) demonstrates a link between insecure attachment and mental health difficulties later in life (Dozier, 1990; Dozier et al., 1994; Dozier & Lee, 1995; Dozier et al., 1991), however longitudinal research needs to be conducted to explore this link. This review also indicates that as well as early mother-child relationships, trauma factors are important to consider in the development of attachment styles, however the literature shows that attachment styles can be modified by a secure relationship with a named worker. The research further demonstrates that services may meet the client's needs better if they know the client's attachment style and their named worker's attachment style prior to therapeutic work, so that clients and named workers can be matched accordingly. Specific interventions focusing on attachment relationships and also the needs of parents being treated for psychosis, may create better clinical outcomes for both clients and

their children. Overall, attachment styles and relationships are important to consider and should be more carefully assessed, considered and further researched.

REFERENCES

Addington, D., Addington, J., & Schissel, B. (1990). A depression rating scale for schizophrenics. *Schizophrenia Research, 3,* 247 – 251. doi.org/10.1016/0920-9964(90)90005-R

Adshed, G. (1998). Psychiatric staff as attachment figures understanding management problems in psychiatric services in the light of attachment theory. *British journal of psychiatry,172,* 64-69. doi:10.1192/bjp.172.1.64

Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of Attachment: A Psychological Study of the Strange Situation.* Hillsdale, NJ: Erlbaum

Arbuckle, B., Berry, K., Taylor, L. J., & Kennedy, S. (2012). Service user attachments to psychiatric key workers and teams. *Social Psychiatry and Psychiatric epidemiology, 47,* 817-825. doi:10.1007/s00127-011-0388-2

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles amongst young adults. A test of a four category model. *Journal of Personality and Social Psychology, 61,* 226-244

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

Bowlby, J. (1979). *The making and breaking of affectional bonds.* London: Tavistock

Berry, K., Barrowclough, C., Byrne, J. & Purandare, N (2006b). Coping strategies and social support in old age psychosis. *Soc Psychiatry Psychiatr Epidemiol*, 41(4), 280-4. doi:10.1007/s00127-005-0023-1

Berry, K., Wearden, A., Barrowclough, C., & Liversidge, T. (2006a). Attachment styles, interpersonal relationships and psychotic phenomena in a non-clinical student sample. *Personality and Individual Differences, 41,* 717-718. doi:10.1016/j.paid.2006.03.009

Berry, K., Wearden, A., & Barrowclough, C. (2007a). A review of the role of adult attachment styles in psychosis: unexplored issues and questions for further research. *Clinical Psychology Review, 27,* 458-475. doi:10.1016/j.cpr.2006.09.006

Berry, K., Wearden, A., & Barrowclough, C. (2007b). Adult attachment styles and psychosis: an investigation of associations between general attachment styles and attachment relationships with specific others. *Social psychiatry and psychiatric epidemiology, 42,* 972-976. doi:10.1007/s00127-007-0261-5

Berry, K., Barrowclough, C., & Wearden, A. (2008). Attachment theory: A framework for understanding symptoms and interpersonal relationships in psychosis. *Behaviour research therapy, 46,* 1275- 1282. doi:10.1016/j.brat.2008.08.009

Berry, K., Barrowclough, C., Wearden, A. (2009). Adult attachment, perceived earlier experiences of care giving and trauma in people with psychosis. *Journal of mental health, 18(4),* 280-287. doi:10.1080/09638230701879185

Blackburn, C., Berry, K., & Cohen, K. (2010). Factors correlated with client attachment to mental health services. *The journal of nervous and mental disease, 198*(8), 572 – 575. doi:10.1097/NMD.0b013e3181ea16d6

Catty, J., Cowan, N., Poole, Z., Ellis, G., Geyer, C., Lissouba, P., . . . Burns, T. (2012). Attachment to the clinical team and its association with therapeutic relationships, social networks, and clinical well-being. *Psychology and Psychotherapy: Theory, research and practice, 85,* 17 – 35. doi:10.1111.j.2044-8341.2010.02011

Couture, S., Lecomte, T., & Leclerc, C. (2007). Personality characteristics and attachment in first episode psychosis: impact on social functioning. *The journal of nervous and mental disease,195(8),*631-639. doi: 10.1097/NMD.0b013e31811f4021

Daniel, S. I. F. (2006). Adult attachment patterns and individual psychotherapy: a review. *Clinical Psychology Review, 26,* 968-984. doi:org10.1016/j.cpr.2006.02.001

Dozier, M. (1990). Attachment organisation and treatment use for adults with serious psychopathological disorders. *Development and Psychotherapy, 2,* 47-60. doi.org/10.1017/S0954579400000584

Dozier, M., Cue, K. L., & Barnett, L. (1994). Clinicians as caregivers: Role of attachment organisation in treatment. *Journal of Consulting and Clinical Psychology, 62,* 793-800. doi:10.1037/0022-006X.62.4.793

Dozier, M., & Lee, S. (1995). Discrepancies between self and other report of psychiatric symptomology. Effects of dismissing attachment strategies. *Development and Psychopathology, 62,* 793-800. doi.org/10.1017/S095457940000643X

Dozier, M., Stevenson, A. L., Lee, S. W., & Velligan, D. I. (1991). Attachment organisation and familial over involvement for adults with serious psychopathological disorders. *Development and Psychopathology, 3,* 475-489.doi.org/10.1017/S0954579400007641

Drayton, M., Birchwood, M., & Trower, P. (1998). Early attachment experiences and recovery from Psychosis. *British journal of clinical psychology, 37,* 269 – 284. doi: 10.1111/j.2044-8260.1998.tb01385.x

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38,* 215-229. doi:10.1348/014466599162782

Fowkes, F. G. R., & Fulton, P. M. (1991). Critical appraisal of published research: introductory guidelines. *British Medical Journal, 302,* 1136-1140

Garety, P. A., Kuipers, E., Fowler, D., Freeman, D., & Bebbington, P. E. (2001). A cognitive model of the positive symptoms of psychosis. *Psychological Medicine, 31,* 189-195. doi.org/10.1017/S0033291701003312

George, C. & Soloman, J. (1996). Representational models of relationships: links between caregiving and attachment. *Infant Mental Health Journal, 17,* 198-216. doi:10.1002/(SICI)1097-0355(199623)

Graham, K., & King, R. (2005). Caregiving attachment in mothers with Schizophrenia: theoretical issues and pilot of an empirical investigation of maternal interaction with children at bedtime. *Austrailian e-journal for the advancement of mental health, 4(3),* 1-9

Haddock, G., McCarron, J. Tarrier, N.,Faragher, E. B. (1999). Scales to measure dimensions of hallucinations and delusions: the psychotic symptom rating scales (PSYRATS). *Psychological Medicine, 29(04),* 879-889.

Heinrichs, R. W., & Zakzains, K. K. (1998).Neurocognitive deficit in Schizophrenia: a quantitative review of the evidence. *Neuropsychology, 12,* 426-445. doi.org/10.1016/j.schres.2010.08.003

Horowitz, L. M., Rosenberg, S. E., & Bartholomew, K. (1993). Interpersonal problems, attachment styles, and outcome in brief dynamic psychotherapy. *Journal of Consulting and Clinical Psychology, 61,* 549-560. doi:10.1037/0022-006X.61.4.549

Kirkbride, J. B., Errazuriz , A., Croudace, T. J., Morgan, C., Jackson, D., McCrone, P., (. . .), Jones, P. B. (2011). Systematic Review of the Incidence and Prevalence of

Schizophrenia and Other Psychoses in England. Department of Health Policy Research Programme.

Klykylo, W. M., & Kay, J. (2012). *Clinical Child Psychiatry*. Third edition. Chichester: Wiley & Sons.

Kvrgic, S., Beck, E.M., Cavelti, M., Kossowsky, J., Stieglitz, R. D., & Vauth, R. (2011). Focusing on the adult attachment style in Schizophrenia in community mental health centres: validation of the Psychosis Attachment Measure (PAM) in a German-speaking sample. *International journal of social psychiatry, 58(4),* 362-373. doi:10.1177/0020764011399004

Macdonald, E., Sauer, K., Howie, L., Albiston, D. (2005). What happens to social relationships in early psychosis? A phenomenological study of young people's experiences. *Journal of Mental Health, 14,* 129–143. 10.1080/09638230500060052

McGuire-Snieckus, R., McCabe, R., Catty, J., Hansson, L., & Priebe, S. (2007) 'A New Scale to Assess the Therapeutic Relationship in Community Mental Health Care: STAR.' *Psychological Medicine 37(1),*: 85–95.

Main, M, & Goldwyn, R. (1984). Adult Attachment Interview: Scoring and classification system. Unpublished manuscript. University of California

Main, M. & Solomon, J. (1986). Discovery of a new, insecure-disorganized/disoriented

attachment pattern. In: Brazelton, T.B. and Yogman, M., Editors, 1986. Affective development in infancy, Ablex Publishing Corporation, Norwood, NJ, pp. 94–124.

Mickelson, K. D., Kessler, R. C., & Shaver, P. R. (1997). Adult attachment in a nationally representative sample. *Journal of Personality and Social Psychology, 73,* 1092-1106. doi:10.1037/0022-3514.73.5.1092

Myhrman, A., Rantakallio, P., Isohanni, M., Jones, P., Partanen, U. (1996). Unwantedness of a pregnancy and schizophrenia in the child. *British Journal of Psychiatry,169* (5), 637-640. doi:10.1192/bjp.169.5.637

National Institute of Clinical Excellence (2013). *Psychosis and Schizophrenia in adults: treatment and management.* National Collaborating Centre for Mental Health Commissioned by the National Institute for Health and Care Excellence.

Parker, G., Tupling, H., & Brown, L. B. (1979). A parental bonding instrument. *British Journal of Medical Psychology, 52,* 1 – 10. doi:10.1111/j.2044-8341.1979.tb02487.x

Picken, A. L., Berry, K., Tarrier, N., & Barrowclough, C. (2010). Traumatic events, posttraumatic stress disorder, attachment style, and working alliance in a sample of people with Psychosis. *The journal of nervous and Mental Disease, 198(10),* 775-778. doi:10.1097/NMD.0b013e3181f4b163

Pickering, L., Simpson, J., Bentall, R. (2009). Insecure attachment predicts proneness to paranoia but not hallucinations. *Personality and Individual Differences, 44(5),* 1212-1224.

Ponizovsky, A., Nechamkin, Y., & Rosca, P. (2007). Attachment patterns are associated with symptomatology and course of schizophrenia in male inpatients. *American Journal of Orthopsychiatry, 77,* 324–331. doi:10.1037/0002-9432.77.2.324

Read, J., & Gumley, A. (2008). Can attachment theory help explain the relationship between childhood adversity and Psychosis? *New directions in Psychotherapy and relational psychoanalysis, 2,* 1-35

Read, J., Van Os, J., Morrison, A. P., & Ross, C. A. (2005). Childhood trauma, psychosis and Schizophrenia: A literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica, 112,* 330-350. doi:10.1111/j.1600-0447.2005.00634.x

Riordan, D., Appleby, L., Faragher, B. (1999). Mother-infant interaction in post-partum women with schizophrenia and affective disorders. *Psychological Medicine, 29(4),* 991-995

Rogosch, F., A., Mowbray, C., T., & Bogat, G.,A. (1992). Determinants of parenting attitudes in mothers with severe psychopathology. *Development and psychopathology, 4,* 469-487

Schomerus, G., Heider, D., Angermeyer, M., C., Bebbington, P., E., Azorin, J. M., Brugha T., & Toumi, M. (2007). Residential area and social contacts in schizophrenia. *Social Psychiatry and Psychiatric Epidemiology, 42,* 617–622. doi.org/10.1017/S0033291707001778

Tyrrell, C. L., Dozier, M., Teague, G. B., & Fallot, R. D. (1999). Effective treatment relationships for person with serious psychiatric disorders: the importance of attachment states of mind. *Journal of Consulting and Clinical Psychology, 67,* 725-733. doi:0022-006X/99

Waldinger, R. J., Seidman, E. L., Gerber, A. J., Allen, J. P., Hauser, S. T. (2003). Attachment and core relationship themes: wishes for autonomy and closeness in the narratives of securely and insecurely attached adults. *Psychotherapy Research, 13(1),* 77-98. doi: 10.1093

Wan, M. W., Moulton, S., & Kathryn, M. A. (2008). A review of mother–child relational interventions and their usefulness for mothers with schizophrenia. *Archives of Women's Mental Health, 11(3),* 171-179

Waters, E., Merrick, S., Trebouz, D., Crowell, J., & Albersheim, L (2000). Attachment security in infancy and early adulthood: a 20-year longitudinal study. *Child Development, 71,* 684-689. doi:10.1111/1467-8624.00176

CHAPTER TWO

RESEARCH PAPER

WHAT CAN MOTHERS WHO HAVE EXPERIENCED PSYCHOSIS TELL US ABOUT THEIR EXPERIENCE OF PARENTING? AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS.

ABSTRACT

Background: The number of people diagnosed with a severe mental illness who become parents is increasing. To date, a majority of the research conducted in this area is quantitative research which has mainly focused on the negative aspects of parenting, such as how parents diagnosed with a severe mental illness respond to their children's needs, the risk factors associated with hurting their children and the likeliness of their children developing a severe mental illness. In the last twenty years some qualitative research exploring the experience of parenting for mothers or fathers diagnosed with a severe mental illness has been conducted, however like some of the quantitative research, a majority of the qualitative research has focused on the difficulties of parenting in the context of a severe mental illness. This study is a qualitative study which explores the parenting experience of mothers diagnosed with schizophrenia. It aims to add to the limited qualitative literature on parental mental health. It also offers a novel contribution to the literature because it focuses on the potential strengths and positive aspects of parenting in the context of psychosis as well as the potential difficulties, from the mother's perspective.

Method: Five women who are mothers diagnosed with schizophrenia and have experienced psychosis during their children's childhood were interviewed using a semi-structured interview schedule. The interview schedule was separated into five areas which focused on the women's own childhood relationship with their primary caregiver; their experience of mental illness; their experience of parenting; and their experience of parenting whilst experiencing psychosis. Each interview was audio recorded, transcribed and analysed using Interpretative Phenomenological Analysis (IPA).

Results: Four superordinate themes emerged from the analysis of the data: (1) *negative experience of being mothered*, (2) *challenges of being a mother with a severe mental illness, (3) powerlessness and (4) I have a purpose in life, I am a mother.*

Discussion: This study demonstrates that mothers diagnosed with schizophrenia encounter difficulties in their parenting role, which impacts upon their relationship with their children. Despite these difficulties the participants also expressed pride and happiness in their parenting role, which gave them a new purpose and meaning in life. This paper concludes with recommendations for clinical practice followed by limitations and recommendations for future research.

Keywords*: Motherhood, Parenting, Psychosis, Schizophrenia, Interpretative Phenomenological Analysis.*

1. INTRODUCTION

1.1 Background

Recently, research has indicated an increase in the number of people experiencing serious mental illnesses who become parents (Evenson, Rhodes, Feigenbaum, & Solly, 2008; Miller, 1997; Oyserman, Mowbray, Meares, & Firminger, 2000). A community survey conducted in Britain found that 63% of women who experience psychosis are mothers (Seeman, 2002). This rise may be due to deinstitutionalisation, increasing community interventions and better treatment outcomes (Seeman, 2002). The literature indicates that mothers diagnosed with schizophrenia are vulnerable to episodes of psychosis and "frequently experience interpersonal problems, mood problems, cognitive problems, and behaviour problems that interfere with optimal parenting" (Seeman, 2002, p. 39). Furthermore, anti-psychotic medication to alleviate symptoms of psychosis induces sedation, which impacts upon their quality of parenting (Seeman, 2002). Overall, research highlights the impact of psychosis on the role of motherhood, often in a negative way.

A majority of the research conducted on parents with a severe mental illness is quantitative, some of which has focused on the effects of maternal mental illness and the potential to harm their children (Jennings, Ross, Propper, & Elmore, 1999; Gamer, Gallant, Grunebaum, & Cohler, 1977; Goodman & Brumley, 1990). Research has also focussed on the likeliness of their children developing severe mental health difficulties themselves. Hans, Auerbach, Styr, and Marcu (2004) found that children of at least one parent diagnosed with schizophrenia, are more likely to develop a mental illness than children of parents who are not diagnosed with schizophrenia. Some quantitative studies have focussed on how parents with a severe mental illness respond to their children's needs. For example, Wan, Warren, Salmon and Abel (2008) found that mothers diagnosed with either schizophrenia or depression were

similarly responsive to their children's needs, but mothers diagnosed with schizophrenia showed less frequent positive responses, such as mirroring, and non-responses, such as no verbal or behavioural acknowledgment of their children's behaviour.

The focus on parents difficulties associated with severe mental illnesses tells us little about the positive aspects of the mother and children interaction and how to support mothers who experience psychosis. Within the last twenty years, some qualitative research has been conducted on the experience of parenting within the context of a serious mental illness. Qualitative research is appropriate in this area because it aims to obtain an experiential account of the meaning participants apply to particular situations. Some of the qualitative research, like the quantitative research mentioned above has focused on the negative aspects and risk issues of parenting in the context of a severe mental illness.

Bassett, Lampe and Lloyd (1999) explored mothers' experiences of parenting children under age five in the context of a severe mental illness. Participants were asked about the difficulties they experienced, what helped to manage them, and whether they felt supported by mental health services. The emergent themes consisted of: *trauma of hospitalisation, fear of losing residency, social isolation, care of the child if mother becomes ill, stigma of mental illness, accessing community resources, dissatisfaction with mental health services* and *the importance of their relationship with their children*.

With the parents' experience in mind, Ackerson (2003) conducted a qualitative study with twelve mothers and one father diagnosed with various diagnoses, to explore how they coped with the dual demands of parenting and a severe mental illness. The participant's children were young adults. Ackerson (2003) found that the participants' reported both difficulties and pride in being a parent. Nicholson, Sweeney, and Geller (1998) explored the experience of parenting children under the age of thirteen, from the perspective of mothers

with a severe mental illness and their care co-ordinators. Participants attended focus groups to discuss the difficulties mothers diagnosed with a severe mental illness encountered. Nicholson et al. (1998) found that the participants experienced conflict through meeting the dual challenges of parenting and living with a mental illness within: *the stigma of mental illness; day-to-day parenting; custody of and contact with children*; and *managing a mental illness*.

In contrast to the studies mentioned above which predominantly focused on mothers experience of parenting in the context of a severe mental illness, Evenson et al. (2008) conducted a qualitative study on the experiences of fathers who experienced psychosis. They found that psychosis affected the parenting style of fathers in negative ways, through hospitalisation, medication, and fear about their children's mental health. They also found that psychosis had a positive impact on fatherhood because the participants experienced pride in their fathering role, which gave them a sense of purpose and motivation to change their life. They also felt that their children were supportive, understanding and empathic towards them.

To summarise, research on parents diagnosed with a severe mental illness has mainly focused on mothers, of young children, who have a range of diagnoses within the participant sample. This indicates that research focusing on mothers with a homogenous mental health difficulty, of children of all ages, rather than younger or older children, would be important to contribute to the literature. The research above also suggests that it is illness per se rather than other factors that have a detrimental effect on the parenting style of mothers diagnosed with a severe mental illness. This may be because previous research has not explored other potential factors. Therefore qualitative research exploring factors such as the participant's own experience of being parented, which may or may not have an impact on their parenting style, may provide a richer understanding about their illness and experience of parenting in the context of psychosis. Furthermore the research described above has predominantly focused on

the difficulties of parenting in the context of a severe mental illness. Research focusing on the positives of parenting in the context of psychosis, as well as of how parents coped within that context is required to add to the literature. This research could also help in highlighting the resources this client group draw upon to manage this situation, as well as the support that they need.

1.2 The current study

The current study aims to add to the limited qualitative literature on parental mental illness and will examine the mothers' experience of parenting whilst experiencing psychosis. It will offer a novel contribution to the literature because the study will focus on positives and strengths within the mother-child relationship as well as the potential difficulties, from the mothers' perspective. It will also focus on the mothers' own childhood experiences and relationships with their own parent/carer to provide an understanding of their own experience of being parented. This study aims to add to the existing literature by increasing the knowledge base of parenting in the context of psychosis which clinical services can draw upon. This may help services to tailor their input to the needs of parents in the context of severe mental illnesses, and the needs of their children, which could subsequently improve patient care.

1.3 Research question

The study will attempt to answer the principle research question:

What can mothers who have experienced psychosis, tell us about parenting, in the context of psychosis?

2. METHOD

2.1 Design

A qualitative design was employed for this study because the focus on meaning and how people make sense of a particular experience was central (Willig, 2001). Individual semi-structured interviews were used to collect the data. Interpretative Phenomenological Analysis (IPA) was used to analyse the data.

2.2 Participants

Participants were recruited from Community Mental Health Teams (CMHTs) and Assertive Outreach Teams (AOTs), using a purposive sampling method. Purposive sampling is a standard procedure for IPA orientated research (Reid, Flowers, & Larkin, 2005). Here, participants are specifically selected to fit the inclusion criteria and meet the aims of the study, because they provide insight into the research topic (Smith, Flowers, & Larkin, 2009). The researcher aimed to recruit between three to six participants, which are an appropriate sample size for IPA studies (Smith et al., 2009), (see figure 3 for the participant inclusion and exclusion criteria).

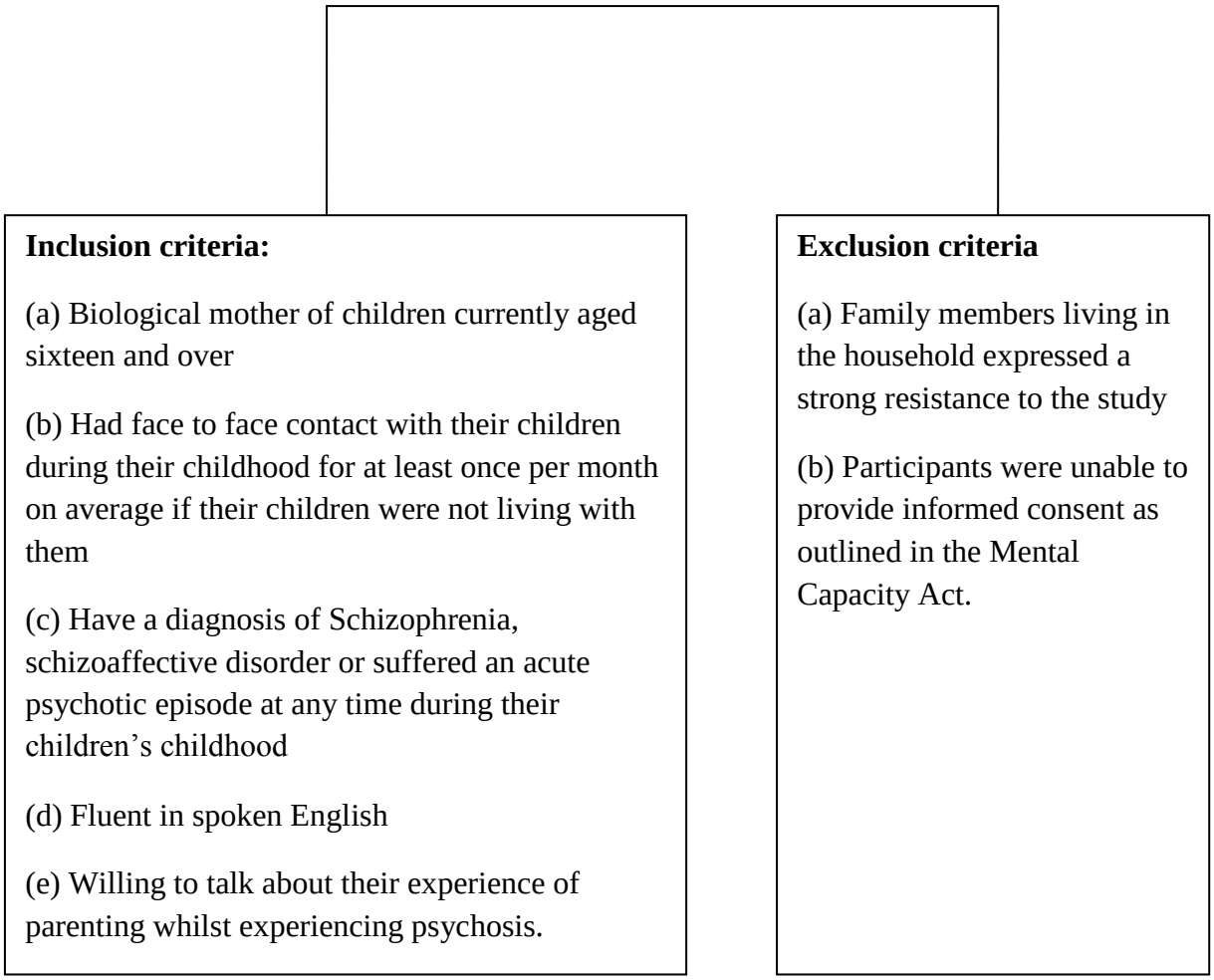


Figure3: Participant inclusion and exclusion criterion

Twelve potential participants were identified. One participant was unwell during recruitment and was not approached. Of the eleven participants who were approached, five participants agreed to take part (see table 1 for participant information). Participants were recruited from a Mental Health Trust in an area which consists of an ethnically and culturally diverse population. This is reflected in the participant sample.

Table 1*:* Participant information

Participant pseudonym	**Age**	**Ethnicity**	**Diagnosis**	**Experience of schizophrenia**	**Years known to MH service**	**Marital status and current living conditions**	**Child details**	**Frequency of contact with children during their childhood**
Marjorie	62	White British	Previous: Schizophrenia Current: Depression with anxiety and paranoia	Experienced psychosis in her early 20s, after the birth of her third child. One hospital admission.	37 years	Widow lives alone, regular contact with children	F (45) M (44) M (38)	All lived within same household. Eldest daughter lived with paternal grandmother until age 7, then lived with Marjorie.
Monika	53	Afro-Caribbean	Previous and current: Paranoid Schizophrenia	Experienced psychosis in her late 30's, ten years after the birth of her third child. Four hospital admissions.	16 years	Single mother lives alone, regular contact with children	M (34) F (32) F (27)	All lived within the same household.
Naureen	57	Asian Indian – Punjabi	Previous: Schizophrenia & depression Current: Schizophrenia	Diagnosed with schizophrenia aged 43 for four months, 10 years after birth of youngest child. Two hospital admissions.	24 years	Widow lives with two daughter son known to MH services diagnosed with schizophrenia	F (38) F (37) M (31) F (30) F (24)	Naureen's fourth daughter lives with her sister-in-law, others live in same household.
Fiona	47	British Black Afro-Caribbean	Previous: Bipolar Disorder. Current: Schizophrenia & Depression.	Diagnosed with post-natal depression and schizophrenia aged 25 after birth of youngest child. Many hospital admissions.	23 years	Single mother lives alone, regular contact with son and youngest daughter, no contact with eldest daughter	F (29) M (27) F (22)	All within the same household
Julia	47	British Black Afro-Caribbean	Previous: Paranoid Schizophrenia Current: Bipolar Disorder.	Diagnosed aged 17 before her daughter was born.	30 years	Single mother, lives alone daily contact with daughter	F (19)	Within same household

2.3 Materials

A brief demographic questionnaire (appendix F) was used to collect relevant background information for each participant. A semi-structured interview schedule (appendix G) was utilised to explore the participant's experience of motherhood whilst experiencing psychosis. This interview schedule was developed in close collaboration with the supervisors of this study, after reviewing the literature on parenting and psychosis. The schedule aimed to facilitate obtaining an in-depth account of the participant's experiences of their own upbringing, mental illness, parenting in the context of psychosis, and the meaning they applied to these experiences. Questions were non-directive, non-ambiguous and open ended, to encourage the participants to tell their own story and elaborate on their response so their experience and meaning of these phenomena could be shared with the interviewer. Sensitive questions, such as their experience of parenting whilst experiencing psychosis, were situated towards the end of the interview schedule, to establish rapport between the participant and the interviewer before these questions were asked.

A pilot interview was conducted to determine the appropriateness of the questions. Significant changes were not made to the interview schedule based upon the pilot interview; therefore this interview was included in the final analysis. However some of questions were rearranged to obtain a better flow and questions about the participant's relationship with her children were directed to all of her children rather than those who were subject to her symptoms of psychosis.

2.4 Procedure

Ethical approval was granted from the NHS National Research Ethics Service. Participants were recruited from CMHTs and AOTs (see figure 4 for the recruitment process).

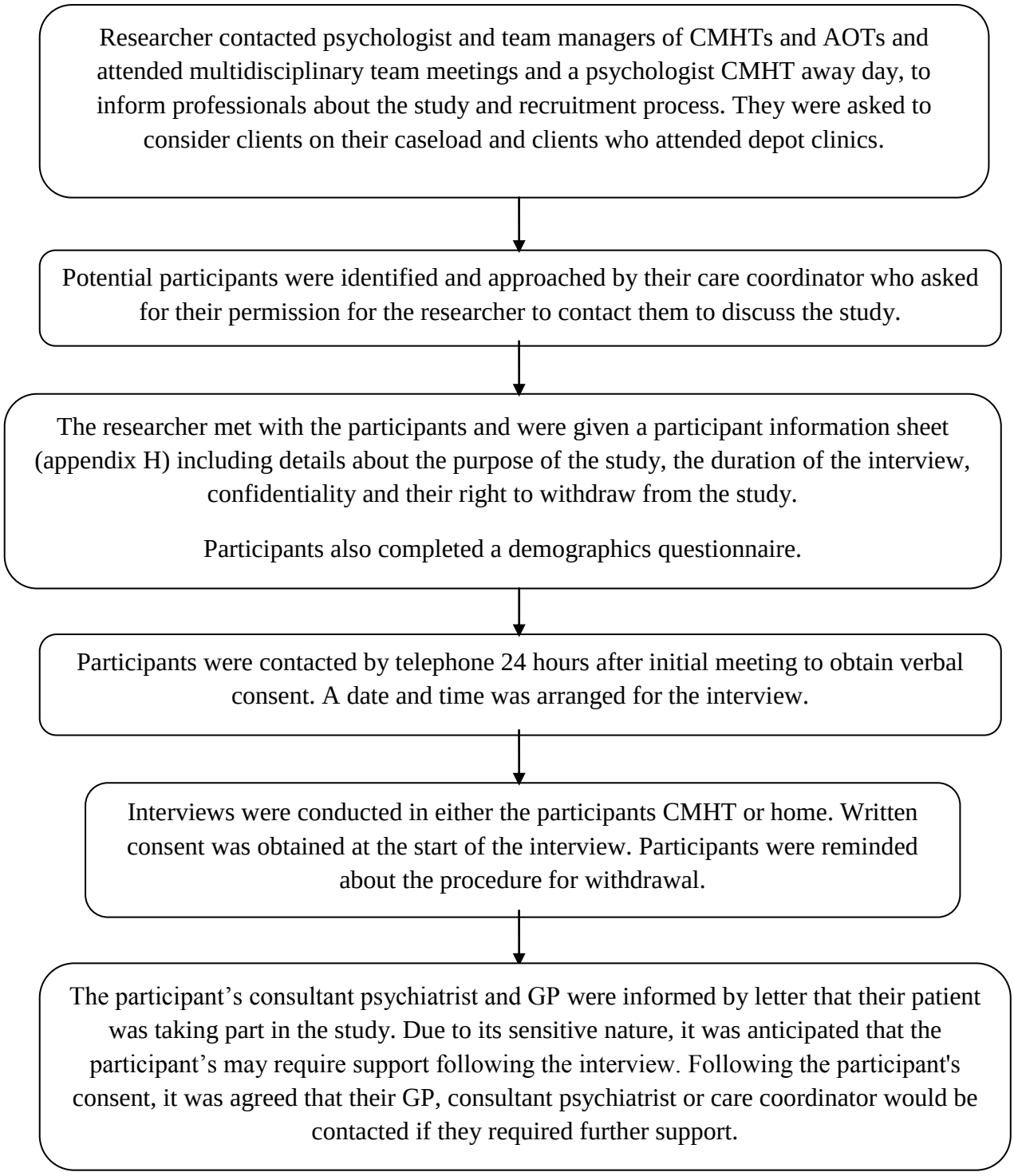


Figure 4: Recruitment process

2.5 Interviews

Interviews took place at the participant's chosen location, which was either at their home or at their CMHT base. Written consent (see appendix I) was obtained at the start of the

interview and the participants were reminded that the researcher could contact their GP, care co-ordinator or consultant psychiatrist on their behalf if they were distressed during or after the interview and required additional support. A semi-structured interview schedule was used to guide the interview and the interviews were audio recorded using a digital recorder. The interviews lasted approximately 90 minutes. Immediately following the interview, the participants were given the opportunity to reflect on the interview. They were asked if they required additional support, however no one opted for this. The participants were also reminded of their right to withdraw from the study prior to data analysis; however no one opted to do this.

The interviews were transcribed verbatim and all personal data were anonymised. Pseudonyms were used to protect the participants' identity. Participants were given the opportunity to review their transcripts and indicate whether there were parts of the interview that they would like to be excluded from quotation; however no one opted to do this.

2.6 Interpretative Phenomenological Analysis (IPA)

The transcripts were analysed using Interpretative Phenomenological Analysis (IPA). IPA is a qualitative approach which examines how people make sense of their lived experiences (Smith, Flowers & Larkin, 2009). It has been informed by philosophical knowledge of phenomenology, hermeneutics and idiography. IPA is phenomenological because it focuses on what a certain experience is like for the person under study and should be carefully examined in the way that it occurs (Smith et al., 2009). IPA is interpretative (hermeneutics, theory of interpretation), because the researcher makes sense of the person's narratives and understanding of their experience. IPA is idiographic in that it "wants to know in detail what the experience for this person is like, and what sense this particular person is making of what is happening to them" (Smith et al., 2009, p. 3).

IPA was selected as the most appropriate method of qualitative analysis for the current study because it aims to obtain a detailed understanding of the women's experience and perceptions of being a mother whilst experiencing psychosis (Willig, 2008). There are recommended guidelines for IPA analysis which can be applied in a flexible way. The data was analysed in four stages, guided by Smith et al. (2009) and Willig (2008), (see figure 5 for a step by step account of the analysis).

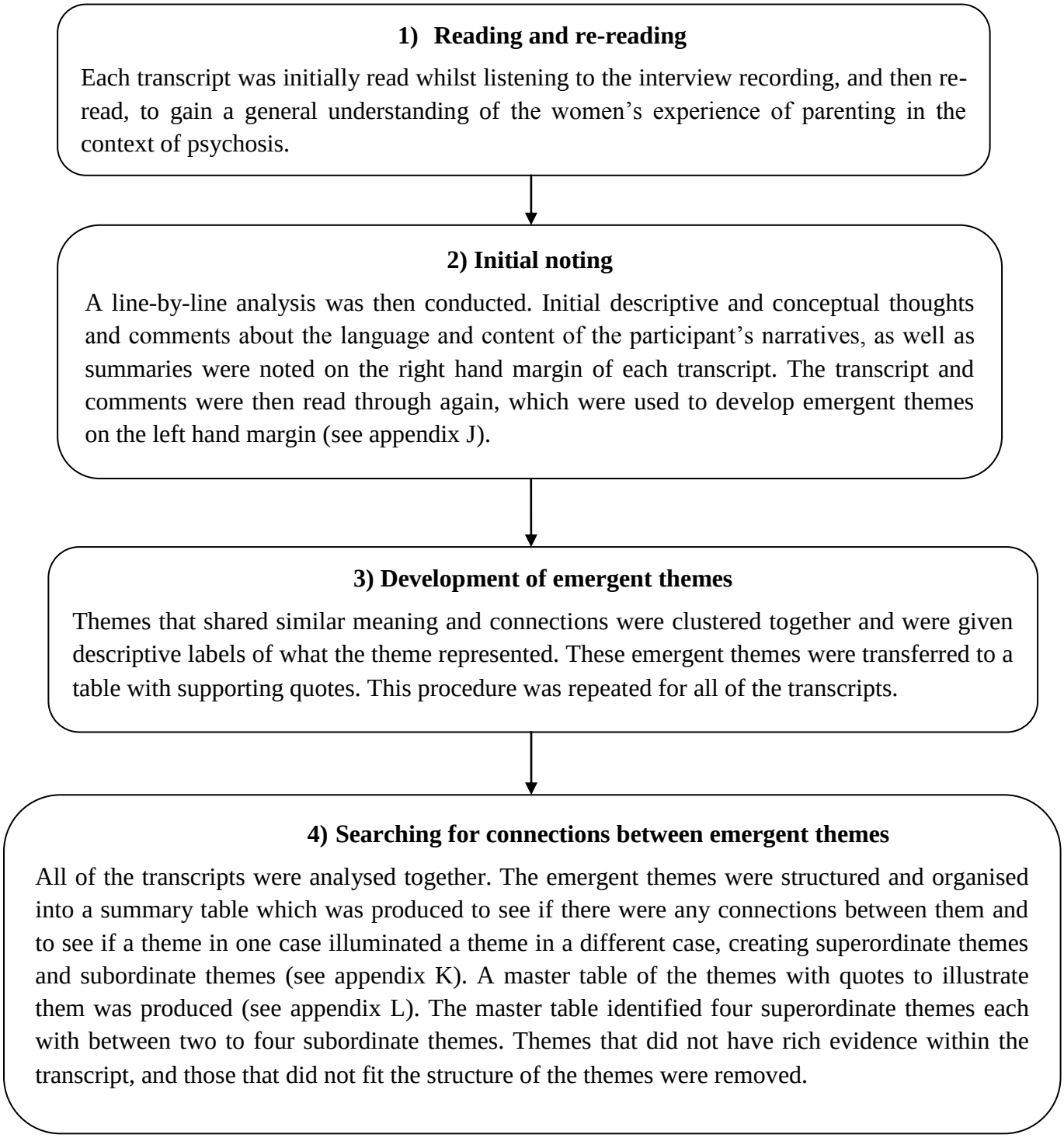


Figure 5: Flow diagram of IPA analysis

2.7 Credibility and owning ones perspective

Credibility checks guided by Elliot, Fisher & Rennie (1999) were conducted throughout the analysis. Each stage of the analysis was reviewed with two research supervisors of the study, both Clinical Psychologists with extensive knowledge and experience of using IPA and of psychosis. Emergent themes were discussed and reviewed accordingly in agreement with all parties. A final list of superordinate themes and subordinate themes was created following these discussions. This process of triangulation helped to improve credibility of the analysis. The researcher kept a reflective diary throughout data collection and analysis to allow for transparency.

The researcher reflected on how her role as a Trainee Clinical Psychologist, and her own cultural background, potentially impacted on the research and analysis. Throughout clinical training the researcher had some opportunity to work clinically and academically in the area of psychosis, however this was limited. The researcher developed an interest in this area and was keen to pursue this further. She was, however, aware of her own expectations and was committed not to impose this on the research and was open-minded to the participant's experiences. Furthermore, as a Trainee Clinical Psychologist completing a doctoral research, the researcher was aware of her drive to learn a new concept and complete the research in limited time. She became aware of the different concept of research interviews and IPA analysis in comparison to clinical interviews, which was learnt through the process of data collection.

In regards to her own cultural background, being Asian Indian, the researcher became aware that Naureen was of the same cultural background. This made the researcher determined to remain objective and obtain the same curiosity as those of a different ethnic background may employ if cultural topics were part of the participant's narrative. However,

it seemed that Naureen expected the researcher to be aware of her experience in reference to her cultural belief and the researcher was therefore limited to explore questions in ways that someone without this knowledge would have done. The reader must be mindful of these aspects.

3. RESULTS AND ANALYSIS

3.1 Themes

From the analysis of the participants' accounts of parenting whilst experiencing psychosis, four superordinate phenomenological themes emerged: *1) Negative experiences of being mothered 2) Challenges of being a mother with a severe mental illness 3) Powerlessness and 4) I have a purpose in life, I am a mother*. Each superordinate theme included subordinate themes (see table 2). The superordinate themes were recognised by all of the participants, with varying levels of participant convergence and divergence of the subordinate themes. Each of the themes are explored below and have been illustrated with verbatim extracts from the participants interviews. Due to word restrictions and for the purpose of transparency, additional participant extracts pertinent to each theme have been included in table 3 (appendix M).

Table 2: Superordinate and subordinate themes

Thematic level	**Theme 1**	**Theme 2**	**Theme 3**	**Theme 4**
Superordinate theme	**1) Negative experiences of being mothered**	**Challenges of being a mother with a severe mental illness**	**2) Powerlessness**	**3) I have a purpose in life, I am a mother**
Subordinate theme	1a) Own mother-child relationship	2a) Parenting role exacerbates symptoms of psychosis	3a) Powerless to mental illness and mental health services	4a) Happiness, pride and purpose
	1b) Conflict between negative maternal relationships and needing support once a parent	2b) Experience of psychosis challenges parenting role	3b) Controlled within romantic relationships	4b) Finding strength
		2c) Mismatch between the support required and support received	3c) Lack of autonomy in parenting role and choices	4c) Close and supportive children
		2d) Role reversal and misunderstanding	3d) Taking control	

1) Negative experiences of being mothered

All of the participants described their own experience of being parented during their childhood. Three participants reflected on the negative experiences they encountered with their own mother and the implications this relationship had on their own emotional development and upon their own parenting style (subordinate theme 1a). The participants appeared to experience conflict between not wanting to accept their mother's support in caring for their children, and their children developing a relationship with their grandmother (subordinate theme 1b). It appeared that they did not want their children to be exposed to the

same negative experience they had encountered. The following quotes by Monika and Fiona demonstrate negative experiences of being mothered:

> Monika: I was the one that my parents didn't like that much…
>
> Interviewer: …Why didn't they like you?
>
> Monika: I don't know. She (mum) just said I was the worst child she's got (Monika 76-80).

> Fiona: If something goes wrong or if something goes missing out the house (PAUSE) and my mum wanted to know who it was she'd beat us all…mum did all the beating not me dad
>
> I: Ok and how often would you get a beating?
>
> Fiona: it depends really, at times when things go wrong in the house especially when things went missing, money (Fiona 120-131).

1a) Own mother-child relationship

Monika, Julia and Fiona described what appeared to be an insecure attachment relationship with their parents, due to the negative experiences they encountered. An insecure attached relationship is when a child's primary-caregiver provides inconsistent, abusive or neglectful approaches to their care which is likely to result in the child developing a negative view of themselves or others. This is likely to affect their future emotional wellbeing and how they interact with others. These participants reported experiencing physical abuse (Monika and Fiona); poverty induced criminal behaviour (Julia); and strict parenting rules, such as

being told how to behave with little opportunity to express their own opinions (Julia, Fiona, and Monika), during their childhood:

> Monika: She had a favourite who she liked the most and who she…may get punished all the time even though it weren't their fault and things like that. And it was always me.
>
> Interviewer: Was that punishment just from your mum or dad as well?
>
> Monika: Mostly mum. She's sort of told him to beat me or something because I'd been bad or talked too much or what not…
>
> Interviewer: For what reasons would your dad beat you?
>
> Monika: Because we talk when not supposed to (LAUGHS)
>
> Interviewer: … and when you say beat you, what would he do?
>
> Monika: He would get like electric cable and things like that and the belt buckle or things like that. You know, really a bad beating 'til you're cut up, cut and all the stuff like that (Monika 320-341).

> Fiona: How would you describe your mum and dad?
>
> Fiona: They were strict
>
> Interviewer: They were strict? In what way?
>
> Fiona: We used to get beatings.
>
> Interviewer: …Why would you get a beating?
>
> Fiona: If something goes wrong or if something goes missing out the house (PAUSE) and my mum wanted to know who it was she'd beat us all (Fiona 276-282).

Julia: … I mean I remember going into erm BHS and my mum putting coat on me and a coat on my sister and telling us to go, go down the stairs and out, out… that has affected me psychologically (Julia 453-458).

Following and related to these experiences both Fiona and Monika described developing negative emotions towards their mother, (in Monika's case towards both parents), such as hatred and emotional distance; which appeared to impact upon their emotional relationship with their parent(s):

Fiona: At them times I used to hate her

Interviewer: Why?

Fiona: For beating me (Fiona 186-190).

Monika: I would say it was a bad relationship because it's like we don't…I don't know them (Monika, 120-122).

These early developmental experiences and relationships appeared to negatively impact upon the participants' self-beliefs and identity, potentially having consequences on their parenting style. Julia described herself as "evil", Fiona described herself as "serious" and Monika described herself as being "disliked":

Julia: We went to church so I knew how evil I was (LAUGHS)…

Interviewer: …why have you called yourself evil?

Julia:…because of my mum shoplifting and you know if, if we went shoplifting and she was there and she would be like, you could hear her, she say "oh go over there and do this or do that" so I contributed to it while I was older, but I got to an age where I say "no I'm not doing it, it's wrong" (Julia 185-195).

Fiona: She'd beat all of us

Interviewer: …What was that like for you?

Fiona: I think it affected me at school really coz I was always a serious person…don't laugh very much…shy, never talked much…so it did affect me at school, the way I was brought up (Fiona 135-149).

Monika: They bought me up with this feeling that nobody likes you… (Monika 589).

As a consequence of the childhood physical abuse and negativity that they experienced, Julia and Monika demonstrated determination to give their children a better experience than they had themselves. They showed motivation to parent their children in ways that would promote better opportunities in life, to facilitate healthier emotional wellbeing and mental health. This is described by Monika:

Monika: In my childhood… my parents sort of singled me out like that, saying that I was the worst kid she's got...sometimes when things went wrong it wasn't my fault, I'd still used to get the beatings for it and she would say, you can beat this one but not beat that one. I wouldn't do that because it messes up your child's mind...when you're growing up, you feel inferior and things like that. And I says I'm not going to do that

because probably in life, probably my children will be doing things that I've achieved… I've achieved anything in growing up my children. So, I mustn't make a mess of it (Monika, 1000-1011).

It seems that the participants' negative childhood experiences gave them clear ideas about parenting strategies that they should avoid, to give their children a positive start in life.

1b) Conflict between negative maternal relationships and needing support once a parent

The participant's reflections about their own negative childhood experiences with their mother seemed to impact upon their expectation of their mother's relationship (as a grandparent) with their children. Julia, Fiona and Monika disclosed feelings of conflict between needing their mother's support for child-care and feeling apprehensive about their mother's involvement. It seemed that they wanted to protect their children from experiencing the negativity and abuse that they had experienced:

Julia: I didn't want my mum to bring up my daughter and have her have the negativity that my, that was put in my ear…all my life from my Mum (Julia 1358-1361).

Although motivated not to have her mother involved in her children's life, Fiona described unwillingly having to accept her mother's support to manage her children as she did not receive support from elsewhere, despite in some cases explicitly requesting this:

> Fiona: I didn't want me mum to look after them....coz of the way she brought us up. But then, you, you see the care workers wouldn't, erm, the um, psychiatric nurses wouldn't listen. I wanted them to put them kids away until I was well enough, they wouldn't do it...I didn't want me mum to have them...coz of the way she brought, she brought us up sick…and she did hit my kids, she used to beat them as well (Fiona 1316-1333).

Fiona wanted services to arrange to protect and care for her children whilst she was mentally unwell. However, as she did not receive that support, she had to rely on her mother's input, exposing her own children to the abuse that she experienced from her mother.

In contrast to Fiona's experience, Julia, although initially apprehensive about her mother's support, was, upon reflection, grateful for her mother's involvement, especially during the acute phase of her illness:

> Julia: That's the good part of my mum… she's never deserted me in all the terrible things that I've done (Julia 1598-1599).

She realised that without her mother and sister's support her daughter may have been put into care by social services, which would hinder her ability to fulfil her role as a mother:

> Julia: And my mum and me sister as well, if it wasn't for them you know that wouldn't have, when I would have had Edith, she would have gone into care (Julia 1819-1821).

In summary, this theme captures the participants' reflections of their own experiences of being parented. Monika, Julia and Fiona had grown up in a strict living environment and in addition to this Monika and Fiona experienced emotional and physical abuse and Julia experienced emotional abuse and neglect. Julia and Monika reflected on their own difficult and abusive childhood experiences and their strong wish to provide a different experience for their children. It is common for grandparents to help care for their grandchildren and in the case of the participants here, their mental health issues created a need for their own parents to look after their grandchildren even more so. This however, was recognised by the participants as placing their children in danger of suffering the same negative experiences that they themselves experienced. The participants described conflict between their wish for a different, more positive childhood for their children and the necessity to leave their children with their grandparents when they were unwell and needed support. This is something they would not ordinarily have chosen but they often viewed it as a choice between this or giving their children over to care. It would appear that they were 'stuck between a rock and a hard place.'

2) Challenges of being a mother with a severe mental illness

The participants described a circular relationship between motherhood and psychosis. They reflected on how their mothering duties exacerbated the symptoms of psychosis (subordinate theme 2a), which is described below by Fiona:

> Fiona: The midwife came, she said I'm not resting because I feel, I think, wouldn't rest, so everything just came down upon me and then I became ill (687-689).

As well as noticing the impact of motherhood on their illness, the participants described how their symptoms of psychosis also challenged their role and responsibilities of motherhood (subordinate theme 2b):

> Naureen: I used to tell my daughter, "I'm sorry, I can't look after you properly because I'm not well" (Naureen 1424-1425).

The participants reflected on their experience of support to assist with the challenges of their illness and parenting role. They described a mismatch between the support they wanted from their social network and mental health services, and the support that they received. They also described being apprehensive about asking for and accepting such support due to the threat that it may bring to them and to their role as a mother, for example, of their children being taken into care by social services (subordinate theme 2c). The participants also reflected upon being cared for by their children when they were unwell because they neglected themselves and could not adequately fulfil their parental duties, describing role reversal. Despite this support from their children, the participants felt that their children did

not understand how their experience of psychosis impacted on their thoughts and behaviour and therefore felt misunderstood by them (subordinate theme 2d), which potentially challenged their mother-child relationship.

2a) Parenting role exacerbates symptoms of illness

All of the participants experienced psychosis following the birth of their children, apart from Julia who experienced psychosis in her late teens. Fiona, Julia and Marjorie described ways in which their parenting role exacerbated the symptoms of their illness, which in a circular relationship then affected their ability to parent, which further exacerbated the symptoms of their illness and their ability to parent. This circular relationship between their illness and parenting role may potentially affect the development and wellbeing of their children. Julia and Fiona reflected on how their responsibilities of motherhood, such as breastfeeding and associated housework, negatively impacted on their energy levels, which, they felt, exacerbated the symptoms of their illness:

> Julia: I was breastfeeding, so that was, I was losing my sleep, so that was making me high… (Julia 1192-1195).

> Fiona: When you got children and housework to do you're supposed to rest even if you gets a little kip
>
> Interviewer: So not resting does that have an effect upon your mental health?
>
> Fiona: yes…because you know when you've just had a baby…you are supposed to take to your bed...I never…I was up and down. Washing sheets every morning,

because all me milk came out on the bed. Hoovering, washing dishes (Fiona 1567-1579).

Fiona had expectations of resting following birth, and, it would seem that she was not prepared for the roles and responsibilities of parenting. She felt that the intensity of her parenting chores exacerbated her symptoms of schizophrenia, which resulted in her relapsing:

Interviewer: Do you think your role as a mum affected your mental illness?

Fiona: Yea it did because every time I did too much I'd have a relapse (Fiona 1959-1960).

All of the participants felt that the multiple demands of parenting whilst experiencing psychosis made it difficult for them to cope directly with their children. Where possible, some of the participants made practical changes to look after themselves so that they would be able to maintain care for their children in the long term. Marjorie utilised the support of her friend when she was acutely unwell, because she recognised that her illness impacted on her ability to cope with being a mother:

Marjorie: I got support from friends, Jane, she um told me to go, go, and come and stop with her for some time, and spend some time with her and I did, and then I felt I was ok and I went back (Marjorie 897-899).

In contrast, it appeared that the other participants were isolated as they did not receive any support from their social network when they were acutely unwell. They therefore did not

have the option to make practical changes to look after themselves, which may have negatively impacted on both their illness and on their ability to parent:

Interviewer: Were you getting any support from anywhere?

Naureen: No...

Interviewer: …from family, friends?

Naureen: No.

Interviewer: What about from your husband?

Naureen: He just go to work and that's it.

Interviewer: So there was no support?

Naureen: No (Naureen, 643-652).

The participants narratives here, indicated that the stressors and demands of being a parent made them vulnerable to further episodes of psychosis, which in turn (as described in subordinate theme 2b), had a negative impact upon their ability to parent and potentially on their children's mental wellbeing and behaviour.

2b) Experience of psychosis challenges parenting role

During episodes of psychosis, all of the participants felt that they were unable to look after their children due to their positive and negative symptoms of psychosis. For example, Naureen felt that she could not sufficiently parent her children because she was experiencing auditory hallucinations:

Naureen: I couldn't have no relationship with my children.

Interviewer: No?

Naureen: No.

Interviewer: In what way? Why…why couldn't you have a relationship?

Naureen: I was…I was, um (PAUSE) I was on my own with my voices…

I didn't want to know my children (1587-1599).

Interviewer: How did you cope with hearing these voices and being a mum?

Naureen: I couldn't look after the children (1496-1499).

The participants' narratives further demonstrated some of the day to day difficulties they experienced due to their illness when trying to fulfil their parenting role. There appeared to be a struggle between trying to please and care for their children and manage the symptoms of their illness. This is described by Monika when she decided not to go to school parents evening due to the acute symptoms of her illness:

Interviewer: Did it (not going to parents evening) affect your relationship with your children?

Monika: I think it did because, um, all the other parents went and they and they didn't have a parent there. So, they sort of felt left out. But if I had went and I was in that state, it would still have been a…you know what I mean? It would have been bad, really sad because I'd go there and they might think, "Oh, mum's not well and she's coming here" (Monika 1386-1396).

Rather than having a direct impact on her motherhood duties, Fiona felt that her illness had a significant impact on her physical and emotional wellbeing which indirectly challenged

her ability to parent. Fiona described being physically absent from her children due to the severity of her illness and being reliant on her mother to look after her:

> Interviewer: What was your interaction like with them (children) when you were unwell?
>
> Fiona: I don't know, I don't know. I was in bed. When I was at my mum's I was always, I was bed ridden… sometimes they were downstairs I was upstairs, I don't see them at all (Fiona 1808-1819).

Similarly, Julia described how her illness impacted on her parenting role because it affected her ability to carry out her daily tasks independently:

> Julia: …at that stage, erm, I wouldn't be cooking, I wouldn't be cleaning I wouldn't be hand washing…you can't function you get to a stage when you can't function you can't cook you can't clean, you're not caring for yourself…
>
> Interviewer: So did that have an impact on you caring for Edith?
>
> Julia: It would, yes (Julia 1412-1428).

In contrast to Fiona, Julia also described how her illness, which appeared to have a mood element at times, had a positive impact on her interaction with her daughter because it gave her the confidence to engage in more activities with her daughter, something she may have struggled with when she was not experiencing symptoms of psychosis. This indicates that Julia found some aspects of her illness helpful in her parenting role:

Julia: It (psychosis) makes me more creative and you, and you do things and…but I think when I'm high I do things and I get things done. It (SHORT PAUSE) makes me do things, that I normally wouldn't do (Julia1923-1924).

When reflecting on their parenting role in the context of their illness, Naureen, Monika, Julia and Fiona, described hospitalisation as having a negative impact on the development of their relationship with their children. Julia felt that her illness and her need to go into hospital "disrupted" her daughter's life:

Julia: I would have liked to have spent more time with Edith and that would have meant not relapsing and going into hospital…and disrupting her life so much (Julia 1762-1765).

Similarly, Fiona and Monika felt that being physically absent from their children would have a negative impact both on their relationship and on their children's safety, which in Fiona's case led her to abscond from hospital:

Fiona: When I found out where I was (SHORT PAUSE) I used to break out…and go to me mum and dads…to be with me kids…(Fiona, 815-827)

Interviewer: So, when you were in hospital, who were they with?

Monika: They was on their own. Tracey's dad must have come and have a look to see if they was alright. But else, none of my family came to see them (Monika, 509-512).

As well as hospitalisation, Naureen and Fiona described how taking medication hindered their role as mothers:

> Naureen: I had this (depot) injection, made me sleepy all the time…I couldn't look after the children… I just lied down all the time. Now, my daughter comes, she said, "give me the food" I said, "go make it yourself" (Naureen, 1490-91, 1504-1505).

> Fiona: I was helpless towards, for, for, to my, to my kids…I couldn't do nothing for them
>
> Interviewer: Why…?
>
> Fiona: Medication.
>
> Interviewer: What was the effect of the medication?
>
> Fiona: I was on too much (Fiona 1453-1461).

> Fiona: When you are on a lot of, of medication… you don't know what's going on in your mind (Fiona 1491-1493).

It appeared that the amount of medication Naureen and Fiona were taking negatively impacted upon their physical energy levels, and, for Fiona, upon her cognitive ability to parent.

In summary this theme highlighted the breadth of the challenges these mothers faced in their parenting role such as the symptoms of their illness, hospitalisation and the side

effects of their medication. It appeared that these factors pulled back their willingness to parent.

2c) Mismatch between the support they wanted and the support they received

Julia and Monika described a mismatch between the support that they wanted and the support that they received from their social network during their illness. Although they received support, there appeared to be a mismatch between what Julia and Monika and their social network perceived as supportive. Julia's family felt that medication and hospitalisation were important for her recovery; however, Julia initially perceived this as overwhelming. Upon reflection, Julia recognised that her family were being supportive and had her best interest at heart:

> Interviewer: Did you get any support during this time, from your social networks?
>
> Julia: Well, their, their idea of helping me is medication…"take your medication, Julia and you'll be ok".
>
> Interviewer: And is that your idea of help?
>
> Julia: It is now…not then…I just wanted people to leave me alone, to leave, go away and leave me alone and do my own thing (Julia 1058-1070).
>
> Julia: I see it as abuse but they see it as helping me (Julia 1050-1051).

Julia also described what appeared to be feelings of resentment towards her mother, initially blaming her mother for being sectioned. There, again, appears to be a mismatch between what she and her mother perceived as supportive. Julia initially had a different view to her mother because she believed that she did not need to be sectioned under the Mental

Health Act. However, Julia later recognised that her mother was actually supportive when she was acutely unwell, because if Julia had not been sectioned she may have taken her own life:

> Julia: I've always held it against her, that I think my life could have been different if I'd never been sectioned because, but I can't say that because, erm, a lot of the time, erm, with the overdoses, if my mum hadn't come to save me, I'd be dead now and Edith wouldn't be here (Julia 380-383).

Julia and Monika were somewhat apprehensive about seeking and accepting mental health services support because they were concerned that social services would take their children away:

> Interviewer: Would you have liked services to have helped you?
> Monika: If they did, probably took my child anyway if they were that young. They probably would have taken them away (Monika, 1226-1228).

Monika's narrative clearly illustrate a dilemma of needing treatment and recognising this but being in a position where she was afraid to ask for treatment because her children might have been removed from her care.

2d) Role reversal and misunderstanding

All of the participants described a further challenge of motherhood during the acute stage of their illness in the form of role reversal with their children taking on the parenting

role and caring for their mother when they neglected themselves. This is described clearly by Julia:

> Julia: I remember her putting food in my mouth as well, you know when I, when I wasn't well, her wanting me you know (PAUSE) her wanting me to eat (Julia 1364-1366).

It also appeared that the participants felt that their children did not fully understand the nature of their illness and the impact it had upon their social functioning and upon their role as mothers which was a further challenge. Marjorie and Fiona particularly reflected on the emotions that were evoked in their children, such as sadness following exposure to their behaviour, due to their limited understanding of mental illnesses:

> Marjorie: They all used to cry because they couldn't understand why mum was so poorly (Marjorie 1706-1707).

> Fiona: Bringing up me daughter at the age of seven, she was scared of me… to see the way I was (Fiona 1672-1676).

In addition to the negative emotions that were evoked in their children, Naureen's narratives demonstrated that her children's limited knowledge about her mental illness contributed to them somewhat resenting her. They appeared to think that she was neglecting her role because she did not fulfil her expected motherhood duties:

> Naureen: My older daughter said, "You were sick all the time and wasn't looking after us"…I don't know what to say…It wasn't my fault (Naureen 975-985).

It seemed that Naureen felt somewhat sad and guilty about her daughter's perceptions of her illness, "it wasn't my fault", which would perhaps impact on their mother-child relationship and potentially upon her daughter's emotional development.

In summary, this theme captures the participants' reflections of their experience of parenting whilst experiencing psychosis. The participants realised that the stressors of parenting exacerbated the symptoms of their mental illness. They also described situations in which the symptoms of their illness and related issues such as hospitalisation and medication somewhat clouded their role as mothers. They were, however, with the right social support, able to balance their needs to facilitate wellbeing and to help them to be a mother. Regardless of this support, it appeared that the severity of the participant's illness at times disenabled them to fulfil their motherhood role which enforced their children to look after both themselves and their mother. Despite the caring nature of their children, some of the participants felt misunderstood by their children at times.

3) Powerlessness

Powerlessness appeared to be a dominant theme for all of the participants. They described powerlessness in their role as mothers in the context of psychosis, because they often felt that they had limited freedom of choice in their parenting role:

> Monika: When you got the mental illness, you don't, you don't get choices (Monika 1226-1227).

The participants described feelings of entrapment by both the symptoms of their mental illness and the involvement of mental health services (subordinate theme 3a). The participants also described a lack of autonomy in their parenting role (subordinate theme 3b), and some also felt trapped and powerless in their romantic relationships (subordinate them 3c). Although powerless, the participants tried to exert some power (subordinate theme 3d).

3a) Powerless to mental illness and mental health services

Monika, Julia, Marjorie and Fiona described feeling powerless to their illness. They felt controlled by their symptoms because they did not know how they were going to act on a daily basis, which Monika described as "being driven by this force" (line 421). On some occasions this lack of control appeared to pose a risk to their own wellbeing as described by Naureen, who was non-compliant with her medication following the commands of the auditory hallucinations she experienced:

> Naureen: The voices used to tell me that these tablets are poison. They want to kill me…then I put them in the bin (Naureen 658-662).

This excerpt illustrates that there were times when Naureen felt powerless to resist her voices which could have a negative impact on her mental health, her relationship with her children and on the safety of herself and her children.

Monika and Marjorie described how their symptoms of schizophrenia had a direct impact on their behaviour and therefore posed a risk to their children. Monika explained being commanded by the auditory hallucinations to go out and leave her young children at home to look after themselves. It appeared that Monika could not think about the consequences of leaving her children alone when she experienced severe psychotic symptoms. This indicates that the symptoms of her illness not only challenged her parenting role but also had an impact on the safety of her children.

Monika: I kept wandering off.

Interviewer: When you "wandered" off what happened to your children?

Monika: They were just left in the house (Monika 487-489).

Marjorie also noticed how her symptoms of psychosis posed a risk to her children because she had thoughts of "putting a pillow over her [child's] head" (Marjorie line 1359), however she did not act on this.

Due to being powerless by her illness, Monika said that she was unaware of what was going to happen to her children as a consequence of her actions:

> Monika: Schizophrenia is a very, a very bad thing…if you're a parent coz (PAUSE) coz, you don't know what's going to happen to you from day to day…you don't know what's gonna happen with your children when you're taken ill, or what's gonna, what you, what's, what your gonna do, well I didn't, I never had thoughts of hurting my children…But, sometimes you have thoughts of hurting yourself and things like that and what would happen to them and all that (Monika 1442-1454).

As a consequence of their illness, Julia and Fiona appeared to feel powerless and somewhat trapped by mental health services. They described a sense of loss and disempowerment due to being unwell because they lost their children and their rights:

> Julia: 'Cause erm I remember Mum, her walking away with my Mum. My Mum come in for Edith and seen her little, little hand fall on to Nana and walking on, walking up the road and then me staying in the property and then it came to sectioning (Julia 1430-1433).

> Fiona: I was, I was somewhere where I shouldn't be…the way they (mental health professionals) put me in hospital…but my mum used to always call them to take me away (Fiona 1906-1910).

Once admitted to hospital it appeared that Monika felt trapped within the hospital environment because she was there against her free will, which reinforced feelings of powerlessness:

Interviewer: What was it like being in hospital?

Monika: It was horrible. I didn't want to be there (Monika, 514-515).

These narratives illustrate that the participants initially felt powerless as a result of their symptoms and experience of psychosis. This sense of powerlessness appeared to be exacerbated by mental health services because some of the participants felt hospitalised against their will.

3b) Controlled within romantic relationships

Monika, Naureen and Fiona felt powerless and trapped within their romantic relationships, which highlights the multiple stressors and adversity these participants had to manage. Monika experienced domestic violence from her children's father and described living in fear of him. She described entrapment within this abuse as her family did not support her:

Monika: I stayed there because when he used to keep beating me up, I went home and I asked my mum if I could move back in because he was beating me up and things like that. And she says, she says "No." So, I had to stay there. And when he went to prison, then I left (Monika 257-261).

Like Monika, Naureen described feeling controlled by her husband. On one occasion she attempted to end her life as a result of her husband's behaviour, potentially because this was the only way she felt she could escape entrapment at the time:

> Naureen: I came and um my sister-in-law came and um (PAUSE) other friend came and, um, telling, he was telling my, if my brother died, that I can't go to their fune- funeral either. My husband was telling me that and I got so upset (LOUDER VOICE)...I took the tablets… depression tablets and, and drink that. I wanted to die (Naureen 360-370).

Rather than feeling directly controlled within their romantic relationships, Fiona and Julia described having limited choice regarding the nature of their romantic relationship, because their families stepped in:

> Fiona: He took me to me mum and dads and erm, me mum and dad break up the relationship...
>
> Interviewer: Why was that?
>
> Fiona: I don't know, they didn't want him to see me or the kids…but I was ill at the time so I didn't know what was going on (Fiona 586-592).

It appears that Fiona felt helpless and powerless not only by the symptoms of her illness but also by the power her mother exerted, which is an overlapping lack of control. You would imagine that this level of control affected her self-confidence and her interactions within interpersonal relationships. Such control resulted in her children being raised by a single parent.

3c) Lack of autonomy in parenting role and choices

Naureen described powerlessness and lack of autonomy before and during motherhood. It seems that her parenting role was enforced upon her by her husband, which questions whether she had a desire to become a mother:

> Naureen: My husband said, "If you're not gonna have…if you're not going to get pregnant, I'm going to get married again" (Naureen 846-847).

Naureen also described lack of autonomy in her direct parenting role because choices were made about her children without her consent. For example, Naureen's daughter was taken by her sister-in-law and the role of an aunty rather than a mother was imposed on her:

> Naureen: I didn't like my sister-in-law to take my children. I didn't like that…because I wanted to look after them myself…I couldn't help, I couldn't help it because my husband used to send them (Naureen 1046-1053).

Naureen's excerpts indicate that people who have experienced schizophrenia are not only potentially controlled by their illness, mental health services, and romantic relationships, but may also be vulnerable to abuse and control by others, such as their family. This can, as illustrated here, threaten their parenting role. Naureen's excerpts illustrate how the collectivistic values of her family hindered her freedom of choice as a mother.

3d) Taking control

Although the participants felt controlled and powerless in many aspects of their life, Julia, Fiona and Monika demonstrated creative ways to exert control during times of

powerlessness. As described above (page 80), Monika waited for her husband to go to prison and then left the family home with her children. Julia described escaping to another city to avoid being sectioned:

> Julia: my mum, my mum would, my mum, says, oh the sym, would, would know and she'd contact my CPN, she'd contact my social worker, then they'd come and section me, to cart me off…so I just took some money and… I disappeared to London…I just wanted to get away… from them because I was going to get, a, the, I was going, erm, I, I was gonna, I was gonna end up in hospital… (Julia 674-679).

To assert some control when sectioned, Fiona absconded from hospital to put her children to bed at night:

> Fiona: I used to break out (of hospital)…come out in me night clothes…and go to me mum and dads…to be with me kids (Fiona, 815-817).
>
> Interviewer: …why were you breaking out?
>
> Fiona: to be with my children…I was somewhere where I shouldn't be (Fiona 1903-1906).

These excerpts demonstrate that despite the sense of powerlessness many of the participants experienced in many aspects of their lives, they continued to try and exert some control to be with their children and do what was best for their own mental health and their children's wellbeing.

In summary, this theme captures the multifaceted experiences of powerlessness the participants experienced as a result of their mental health difficulties and social circumstances. It demonstrates the participants' vulnerability to experience abuse from others, yet demonstrates creativity and determination to regain power and control to fulfil their role a mothers, despite their circumstances.

4) I have a purpose in life…I am a mother

The participants' narratives indicated that becoming a mother evoked emotions of happiness and pride, as well as providing them with an identity and purpose in life (subordinate theme 4a):

> Monika: Having the children and growing them up were the best parts of life (Monika 868-869).

In addition to happiness and pride, the participants described developing strength and commitment to be a good mother despite the symptoms they experienced of their illness (subordinate theme 4b). They further described feelings of closeness to and support from their children (subordinate theme 4c), especially when acutely unwell.

4a) Happiness, pride and purpose

It appeared that Fiona, Monika, Marjorie, and Julia were not aware, beforehand, of the practicalities of becoming a mother, this is described by Monika:

> Interviewer: So, you said you were overwhelmed when you had Carl (son). Tell me more about that. What was the overwhelming feeling about?
> Monika: I don't know. It was just…like I didn't know much about um…with them days, you didn't know much about having a child and childbirth then. My parents had not talked to me about them things like that (Monika 717-722).

However, despite their lack of knowledge about motherhood, Monika and Julia described immense happiness and joy about becoming a mother:

> Monika: When I had him…it was just so amazing. I can't believe it. I was just so over-joyed (Monika 717-725).

> Julia: Ah she's the best thing that has ever happened to me (Julia 1799).

Marjorie, Monika, Julia and Fiona described a positive relationship with their children. They particularly reported that they were very proud of their children's achievements:

> Marjorie: I was always pleased with Debby. She achieved so much (Marjorie 1395).

> Monika: I felt proud of my children. I love them (Monika 860-861).

Fiona and Monika felt that they played a part in their children's academic and personal achievements, which further indicated pride in their parenting role. This is described by Fiona:

> Fiona: Because my eldest daughter, I grew her up at home, until it was time for her to go to nursery and school, and she was reading at the age of two, like two years old (Fiona 887-889).

Monika was also proud of her children because they were proud of her, despite her illness. This was important for Monika because she was not judged or perceived in negative ways by her children, despite her behaviour during the acute symptoms of her illness:

> Monika: I'm just proud that they're, that they're still proud of me because most or sometimes…sometimes in a situation like that, something, children won't be proud of your mum after what's happened to you, you know what I mean? But they, they don't think like that (Monika 1259-1263).

Before becoming a mother Julia felt "hopeless", potentially due to lacking purpose in life, and had attempted to end her life on more than one occasion:

> Julia: I remember setting fire to my flat; I wanted to kill myself... I was very suicidal, I would take overdoses… in them days, I had nothing to live for (Julia 811-813).

However, having children changed her perspective on life because it gave her hope for her future and a new purpose in life:

> Julia: I didn't care if I lived or died…but once Edith was born, had, I wanted to be here for her (Julia 1334-1337)

It appeared that having a child gave Julia an identity (as a mother) and a reason to live. Motherhood may have directly saved Julia's life because she no longer wanted to commit suicide.

4b) Finding strength

Marjorie and Monika described immense strength and motivation to maintain their parenting role whilst experiencing psychosis. They both described finding strength to look after their children and recover from their illness, despite the challenges that they encountered from their illness, because their children needed them as a mother.

> Marjorie: I'm strong…you know, and (PAUSE), I have to be strong, I have to be strong, you know I do break down a lot…but I try not to in front of the children (Marjorie 1847-1851).

Monika explained that recovery from the illness itself had the potential to make her a stronger person. It appeared that this originates from the need to prove to others that she can be a good mother despite her illness. Monika reflected on her need to prove to others that she is "normal", which suggests that she wanted to challenge the stigma associated with mental illness:

> Monika: Sometimes when you have, when you have a breakdown, sometimes when, when you've recovered sometimes, it can make you a bit stronger. And you're thinking about certain things. Well, that's what I find anyway…because you've got a lot to prove more than other people especially when you, when you wanna to be normal, you've got a lot more to prove than other people. So, you have to be… (PAUSE) you have to think, you have to be strong… (Monika 1244-1254)

The participants fought hard to retain their parenting role, especially when faced with a threat that their children were going to be taken away from them. This is demonstrated by Marjorie who fought for custody of her daughter as she feared that her ex-partner was going to take her daughter away due to poor living circumstances:

> Marjorie: He was gonna take Sheila away from me…and I wouldn't let him…and um, I said no no no, so I took him to court and I, um, we had to appear in court and um Sheila was old enough to know who she wanted (Marjorie 551-557).

The excerpts in this subtheme demonstrate the motivation and strength these participants exhibited to fulfil their parenting role, despite the challenges they faced. Sometimes it appeared that recovery and the challenges faced fuelled this strength.

4c) Close and supportive children

It appeared that the participants' strength and motivation to be a good parent was complemented by their relationship with their children. Monika, Fiona, Marjorie and Julia's narratives indicate that they valued their relationship with their children because they perceived their children as close and supportive:

> Interviewer: How do you think your experience of schizophrenia helped you in your role as a mother?
>
> Monika: …it made my children be a bit closer to me because they're more caring…because of the situation (Monika 1279-1285).

Interviewer: What have you learnt as a person from your experience of schizophrenia that's helped you develop your relationship with your children?

Fiona: my kids are close to me…even though they know about my illness it's made them close to me (Fiona 1855-1861).

Monika indicated that her illness, to some degree, had a positive impact on her relationship with her children because it taught them practical skills. Monika particularly noticed the difference in her children, following her illness, as described below:

Monika: before I was ill and I used to do everything in the house. Like they don't want to help you out and things like that. But when you're ill, they tend to help more, you know. Be a bit more supportive, I suppose (Monika 1290-1293).

These excerpts indicate that the participants' illnesses enabled their children to be more supportive, both emotionally and practically and may have taught their children useful life skills.

This theme captures pride, joy and happiness the participants experienced in their parenting role. It demonstrates the purpose parenting gave them to their life, as well as, to some extent, a supportive network and a positive emotional bond with their children, which appeared to be scarce earlier in their life. This theme also demonstrates the participants' strength, will-power and a desire to continue to fulfil their role as a mother and protect their children, despite being unwell. The participants' excerpts suggested that their illness enhanced the mother-child relationship as it appeared to enforce a caring/parenting role within their children, which raises questions about what this was like for their children.

4. DISCUSSION

This study explored the experiential meaning of motherhood for mothers who experienced psychosis. Four superordinate themes emerged from the analysis, which illuminated the meaning of parental relationships in the context of psychosis, as well as the strengths and difficulties these participants exhibited and encountered within their parenting role.

Negative experiences of being mothered

The superordinate theme of *negative experiences of being mothered* highlighted how the participants recognised the importance of their childhood relationships with their primary-caregiver on their own emotional development. Three participants described experiencing childhood physical abuse, neglect and/or maternal strict attitudes from their primary-caregiver, which they understood to have a negative impact on their self-identity and wellbeing. The literature demonstrates a link between negative and traumatic childhood experiences with their primary-caregiver and later psychosis (Read, Van Os, Morrison & Ross, 2005; Mullen, Martin, Anderson, Romans, & Herbison 1996). In particular research has found a significant association between childhood physical abuse and adulthood psychosis (Read et al., 2005; Neria, Bromet, Sievers, Lavelle & Fochtman, 2002), and strict maternal attitudes during a child's early years and a diagnosis of schizophreniform disorder (Cannon, Caspi & Moffit, 2002). Research has also found a significant association between childhood abuse and positive symptoms of schizophrenia such as auditory hallucinations and paranoid ideations (Read, Agar, Argyle, & Aderhold, 2003; Read & Argyle, 1999) which were experienced by three participants in the current study. According to the literature, the data certainly supports the theory that childhood abuse and neglect may be understood as predisposing factors for the development of schizophrenia for these participants.

Upon reflection of their own childhood experiences of being parented, the participants recognised that the quality of parenting between a child and their primary-caregiver is important for a child's emotional wellbeing, which is similar to the findings of Wan et al. (2008) study. Two participants related their childhood experiences to their own parenting style and demonstrated determination to do something different to not affect their children in the way their parents' maltreatment of them had affected their wellbeing. This is consistent with research both with fathers (Evenson et al., 2008) and mothers, (Graham & King, 2005) who experienced psychosis. This positive attitude appeared to be a protective factor against the development of schizophrenia as Schiffman et al., (2002) found that children who had a positive relationship with their parents were less likely to develop schizophrenia. Following their negative experiences of being parented, the participants reflected upon the consequences of their children being cared for by a grandparent who, if they had not experienced psychosis and needed support, would not have entrusted their children's care to. Within the general UK population grandparents provide 35% of childcare in single parent families when mothers return to work, when their grandchildren start school and during the school holidays (Stratham, 2011). The current findings indicate that these participants needed grandparent support more than the norm, potentially due to their mental illness.

Interestingly, most of the literature to date has looked at the relationship between people who experience psychosis and parenting difficulties, speculating a direct link between these factors. The current study suggests that whilst it may be the case that some difficulties associated with psychosis, such as command hallucinations, were recognised by three participants as negatively impacting on their parenting ability, the relationship between parenting difficulties in the context of psychosis is likely to be more complex than that suggested by previous research (Gamer et al., 1977; Goodman & Brumley, 1990; Hans et al.,

2004; Jennings et al., 1999). The findings of the current study indicate that parenting difficulties may be attributed to the mother's own childhood experiences which may be understood by attachment theory. The literature indicates a link between childhood trauma, and insecure attachment styles in people who experience psychosis (Berry et al., 2009; Picken et al., 2010). This is likely to be related to negative self-beliefs (Bartholomew & Horowitz. 1991), and parenting difficulties (Rogosch et al., 1992) which were experienced by the current participants.

Challenges of being a mother with a severe mental illness

The superordinate theme of *challenges of being a mother with a severe mental illness* further highlighted the challenges these mothers' encountered due to their negative experiences of being parented. The participants demonstrated motivation to protect their children from their mother's negative parenting style, yet were faced with a dilemma when choosing to accept their mother's support due to the limited positive support available. The research indicates that mothers diagnosed with schizophrenia require guidance, support and social and emotional connectedness to facilitate positive parenting to manage motherhood (Reupert & Maybery, 2007) because they have less adequate and less sensitive parenting styles compared to mothers with other mental health difficulties (Oyserman et al., 2000; Rogosch et al., 1992; Riordan et al., 1999). Furthermore the availability of a large, positive support network may provide mothers diagnosed with schizophrenia with emotional and practical support to help them to manage motherhood better than those with a small support network (Rogosch et al., 1992). All of the participants apart from Marjorie, had a limited support network, provided by their parents which they perceived as negative but had to accept when ill as they had no one else to turn to. According to the literature, a majority of the

participants were deprived of facilitating positive parenting because they had limited positive guidance to develop positive parenting skills.

In regards to support the participants expressed ambivalence about accepting professional support to manage their illness due to the fear of having their children taken into care. This finding is similar to mothers (Nicholson et al., 1998; Ackerson, 2003) and one father (Ackerson, 2003) diagnosed with a severe mental illness. This finding is in contrast to fathers experiencing psychosis (Evenson et al., 2008) potentially because mothers are usually the primary-caregiver, therefore this threat is directed towards them rather than fathers. The participants may have compromised their parenting role and the safety of their children as a consequence of their fear for a number of reasons. For example, they may have chosen to keep quiet about their difficulties and symptoms and would therefore not get the optimal support from their mental health team. Their fear of mental health services may have made them even more reliant on their support network which was in some cases a small and potentially negative network.

Due to the severity of their illness and potentially negative support network, some of the participants could not always fulfil their motherhood role and experienced role reversal. This is consistent with the experience of mothers and one father with a severe mental illness (Ackerson's, 2003) and fathers with psychosis (Evenson et al. 2008). Research on young carers of parents with a severe mental illness demonstrate that children often have limited understanding of parental mental illness (Mordoch, 2010), feel responsible for their parents' actions (Foster, 2010) and perceive their parents mental illness as having a negative effect on them (Valiakalayil, Paulson, & Tibbo, 2004). The literature indicates that positive social support to facilitate emotional support and positive parental guidance (Reupert & Maybery,

2007; Rogosch et al., 1992) could promote positive attitudes and potentially reduce the likelihood of role reversal.

As well as highlighting the challenges associated with social support, this theme also illuminated the challenges associated with illness severity and parental duties. The participants felt that the symptoms of their illness reduced the quality of parenting which was exacerbated by their parenting duties, describing a circular relationship between parenting and psychosis. This circular relationship can be understood by the Stress Vulnerability model (Zubin & Spring, 1977), which emphasises that factors such as genetics, temperament and trauma may make individuals vulnerable to the development of schizophrenia. However, stress factors, such as socio-economic deprivation, relationship difficulties and single parenthood can trigger a psychotic episode or relapse. This model is applicable to the current participants because many described factors that would increase vulnerability and risk of psychosis (e.g. childhood trauma), as well as stressors including romantic relationship breakdown. According to the model, the biological and practical aspects of becoming a mother as well as parenting demands (e.g. breast feeding, lack of sleep) could be viewed as stressors and could make these participants more vulnerable to experiencing a relapse. Furthermore, not being effective parents due to the severity of their illness could impact on their children's behaviour, which could be difficult to manage and increase the likelihood of a relapse.

Due to the severity of their illness, four participants were hospitalised which negatively impacted upon the mother-child relationship. This finding has previously been shown by Seeman, (2002) and is similar to that of mothers (Nicholson et al., 1998) and fathers (Evenson et al., 2008) who experienced psychosis, as they also felt that hospitalisation disrupted both the lives of and their relationship with their children. Similarly, Nicholson et

al. (1998) found that hospitalisation was distressing for their participants, because they were concerned about childcare arrangements. The current findings go beyond those of Nicholson et al. (1998) by illuminating some of the reasons why participants were reluctant to allow their parents to look after their children, for example their experiences of abuse from their own parents. In contrast to the current findings, Ackerson (2003) found that parents who had a strong social support network managed better when hospitalised than mothers who were socially isolated. Therefore hospitalisation may be better accepted by those who are reassured that their children will be safe, rather than in fear of them being exposed to abuse. In light of illness severity the participants felt that medication had a negative impact on their parenting ability because it reduced their energy levels. Nicholson et al. (1998), Seeman (2002), Rogosch et al. (1992) and Graham and King (2005) found that tiredness hindered the participants' practical motivation to be a good parent.

Powerlessness

The superordinate theme of *powerlessness* found that some of the participants felt powerless by the positive symptoms of psychosis, such as command hallucinations and paranoid ideations which at times, placed them and their children at risk. For example, Marjorie had thoughts of suffocating her daughter as a result of command hallucinations. This experience is different to that of parents diagnosed with affective disorders (Riordan et al., 1999; Wan et al., 2008) and is in line with research indicating that parents with psychosis encounter difficulties specific to the positive symptoms of schizophrenia (Evenson et al, 2008).

Furthermore the participants felt powerless by their social circumstances. Social rank theory (Gilbert, 1992) proposes that people's feelings and behaviour are influenced by social groups and their social status (Byrne, Birchwood, Trower & Meaden, 2006). Allison, Harrop,

& Ellett (2013) found that people with a first episode of psychosis felt that they had a low social status, felt inferior to others and felt trapped by external life events such as their support group and social circumstances, which was experienced by the study participants. The participants appeared to feel deprived by poor living conditions and trapped by external life events, such as negative parental and romantic relationships and family involvement regarding treatment choices such as hospitalisation. Nicholson et al. (1998) found that the participant's family can become a stressor because they take over their responsibilities without consulting them, which was certainly experienced by the current participants.

The theme of powerlessness indicated the adversities and difficulties the participants experienced, which may exacerbate their symptoms of psychosis, further reducing their ability to parent. Despite such powerlessness, motherhood helped some of the participant's exert power in ways they found most effective. For example Marjorie took practical steps for self-care to provide efficient care for her children, often calling on support from friends she found positively supportive. Fiona did what she could to re-gain power and interact with her children by absconding from and avoiding hospital to protect her children from their grandparent's negative parenting style. The participants indicated strength to exert control in ways that they knew best under the circumstances. This is in contrast to Wan et al. (2008) findings that mothers diagnosed with schizophrenia were withdrawn from their children and were non-respondent to their children's needs.

I have a purpose in life, I am a mother

Despite the challenges and negativities these participants encountered in their life, four participants expressed pride in being a mother with three perceiving motherhood as a purpose in life. These findings are consistent with the experiences of parents diagnosed with severe mental illnesses (Ackerson, 2003; Deegan, 1993; Osyerman et al., 2000) and psychosis

(Evenson et al., 2008; Lewis, 1986). Research has also highlighted that parenting can be a valued status giving people self-worth (Oysterman et al., 2000). Motherhood may therefore be an alternative to the role of a client perhaps because it gave the participants a new focus on life, away from the difficulties during episodes of psychosis. With the role of motherhood come responsibility and a sense of purpose but also a sense of achievement. These are important in giving meaning to life, thus being a positive aspect for the participants. Participants also described strength to do their upmost to provide their children with the best opportunities in life. Reciprocated support, acceptance and understanding from their children helped them to cope with their illness and enjoy motherhood. This finding is in contrast to Goodman & Brumely (1990) findings that mothers who experienced psychosis were emotionally withdrawn from their children. This finding may have been due to the quantitative nature of the study which may have missed something important.

Summary

This study highlighted the complex relationship between motherhood and psychosis, which unlike previous research, indicates that it is more complicated than a direct link between parenting difficulties and schizophrenia. The participants highlighted difficulties in their own developmental history which may well have impacted on their parenting style. Some issues can more readily be attributed to illness such as limited positive support, psychotic symptoms such as command hallucinations, which according to the literature are significant for women diagnosed with schizophrenia than other conditions, and associated powerlessness. Despite these difficulties the participants demonstrated strength to be good mothers which offers a novel contribution to the literature because much of the literature has focussed on the potential harm to their children. This study found more difficulties than strengths of parenting whist experiencing psychosis, indicating that social adversities and

stressful life events may make motherhood in the context of psychosis difficult. The reluctance of seeking support from mental health services due to the fear of their children being removed from them, meaning that they do not perhaps take up all of the help they could get, as well as not having a positive social support, appeared to make motherhood harder.

4.1 Implications for clinical practice

The study findings highlighted important clinical implications for mental health services. Most importantly the study findings indicate that mothers diagnosed with schizophrenia would benefit from being considered as a distinct client group upon contact with mental health services. This way mental health services would be able to manage their care plan and tailor their treatment to help them facilitate their parenting role and manage the symptoms of their illness.

The study found that the participant's symptoms were exacerbated by the duties and responsibilities of motherhood. Mothers diagnosed with schizophrenia would therefore benefit from professionals liaising with family support workers to provide them with practical support for their daily duties. They would also benefit from professionals liaising with child services to identify childcare facilities such as play groups, support at children's centres and regular child paly and stay, to make time for themselves. Regular planned time away from their children may help mothers diagnosed with schizophrenia manage the stress associated with parenting. Professionals could also put an advance directive action plan in place for childcare arrangements if these women had a relapse and were admitted to hospital.

The study findings illuminated that the participant's difficulties were often exacerbated by their small and often negative social support network. The literature indicates that the difficulties mothers diagnosed with a severe mental illness encounter are exacerbated by the lack of social support (Coverdale & Turbott, 2000; Miller & Finnerty, 1996). Mothers

diagnosed with schizophrenia would therefore benefit from mental health professionals liaising with child and family services to identify family support groups or social activities that they can attend to increase their social network and potentially the support around them when needed.

The study also highlighted that it is not safe to assume that children can be left with their grandparents when their mother needs extra support or hospitalising, which is often assumed by services. Mothers diagnosed with schizophrenia would benefit from a psychological assessment and formulation of their difficulties, the support available to them and the impact of that support on their children. It would also be important for psychologists to share the formulation with the multidisciplinary team to facilitate a collective understanding of the women's difficulties and promote positive intervention.

The study participants experienced negative childhood relationships with their parents which impacted upon their mental wellbeing and on their ability to parent. They may therefore benefit from attending attachment focussed parenting groups to re-create positive attachment styles with their children to protect them from future psychopathology. Mothers diagnosed with schizophrenia may also find parenting support groups helpful to develop positive parenting styles. For example the Positive Parenting Programme: Triple P (Sanders, 2000) has been shown to be applicable and effective with mothers who have experienced severe mental health difficulties (Brunette, Richardson, White, Bemis & Eelkema, 2004).

Some of the participant's described non-compliance with medication due to the negative impact it had on their energy levels and on their ability to parent. Non-compliance with medication may increase the likelihood of hospitalisation for these women which in turn would lead to separation from their children. Psychiatrists and Community Psychiatric Nurses need to be aware of the systemic implications of prescribing medication to mothers and

should monitor the side effects and compliance with medication and change medication where necessary.

Some of the participant's children took the role of caring for them when they were acutely unwell. Support for children as young carers may be important for those whose mothers are suffering from this type of illness.

4.2 Limitations

Methodological considerations should be taken into account before firm conclusions can be made. In line with IPA methodology, the study findings are based on the experiences of a small, purposive participant sample, and the researcher's interpretation of their experiences. It is therefore difficult to generalise the findings to all mothers diagnosed with schizophrenia.

Furthermore, the participant sample included mothers who had minimal contact with their children of at least once a month on average. High rates of children of mothers with a severe mental illness are taken into care by social services (Kohl, Jonson-Reid & Drake, 2011; Park, Solomon & Mandell, 2006). The researcher was therefore mindful not to exclude mothers who had such experiences. Upon reflection however, this criterion may have created inconsistencies in the quantity and quality of all of the participant's relationship with their children, which could have an impact upon the participant's narratives of their experience. Following information about the study, the participants volunteered to take part, indicating the potential for self-selection bias. Of all the mothers who participated, none of their children had been taken into care by social services; which questions whether they would have

consented if they had encountered potentially traumatic experiences[10]. It is anticipated that the participant themes would be different for those who had their children removed from their care, as they may have experienced severe symptoms of psychosis and encountered more adverse life events than the current sample, potentially putting their children's lives at risk. This questions whether the current sample was a mild sample compared to other mothers diagnosed with schizophrenia.

Additionally, this study specifically included mothers of children aged sixteen or over during recruitment but of whom had experienced psychosis at any time during their offspring's childhood. The participants' were therefore reliant on their memories to reflect on their experiences. This may have been difficult as the literature indicates that people diagnosed with schizophrenia have memory difficulties (Heinrichs & Zakzains, 1998) and autobiographical memories, which may be distorted (Berna, Bennouna-Greene, Potheegadoo, Verry, Conway & Danion, 2011). This questions whether the participants' accounts captured the true essence of meaning of their experiences, which may have been more likely if they were directly interviewed during their off-spring's childhood. Despite this, the participants managed to provide clear and lengthy accounts of their experience of parenting in the context of psychosis.

[10] Marjorie's daughter and Naureen's daughter were cared for by family members, however they maintained daily contact with their children.

4.3 Future research

Future research could investigate the parenting experience of mothers diagnosed with schizophrenia, who have had to give up caring for their children. As described above, this research may illuminate different themes and potentially highlight what could be done to prevent this and to better support these mothers.

To date little research has focused on the parent-child perspectives of parenting in the context of psychosis. Dyadic studies exploring the parent and child's perspective of parenting and being parented is required to obtain a holistic understanding of the impact of parenting on the family, and to identify ways to support the family during acute stages of parental illness.

Quantitative research on severe mental illness and parenting suggests a relationship between schizophrenia and poor parenting styles, when in truth it appears to be much more complex. Most of the study participants described trauma experiences at some stage during their lifetime. It can be suggested that they have poor attachment styles which may impact on the quality of their parenting style. Longitudinal cohort studies exploring early attachment styles and later psychosis and adult attachment styles could add to the literature on attachment styles and psychosis and help identify whether there is a link between childhood upbringing, attachment styles and psychosis. Furthermore studies using the Adult Attachment Interview for mothers diagnosed with schizophrenia could help identify their attachment style which may help to understand parenting attitudes.

The study findings indicate that mothers diagnosed with schizophrenia would benefit from interventions from mental health services that would help them to facilitate their parenting role. Future research reviewing interventions for this client group would help identify evidence based interventions and potential training for staff.

5. CONCLUSION

This study examined the potential strengths and difficulties of parenting in the context of psychosis for five mothers diagnosed with schizophrenia. The participants experienced some parenting difficulties, such as hospitalisation, due to the symptoms of their illness. The participants at times felt vulnerable due to their illness and a lack of a positive support network, which had a negative impact on parenting. Despite such difficulties the participants experienced pride in parenting which helped them to develop strength to manage the challenges of parenting whilst experiencing psychosis. They demonstrated motivation to be physically and emotionally available to their children, often in contrast to their own childhood experiences of being parented. This study adds to qualitative studies in this area because it focussed on mothers who experienced symptoms of schizophrenia during their offspring's childhood, rather than a severe mental illness per se. In doing so, it highlighted the consequences of the symptoms of schizophrenia on their parenting role, such as intrusive thoughts to harm their children. Furthermore, this study invited the participants to reflect on their childhood experience of being parented which helped identify other factors such as early trauma which could be an important contributing factor to parenting difficulties in the context of psychosis.

6. REFERENCES

Ackerson, B. J. (2003). Coping with the dual demands of severe mental illness and parenting: The parent's perspective. *Families in Society, 84,* 109 – 118. doi: 10.1606/1044-3894.69

Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978). Patterns of Attachment: A Psychological Study of the Strange Situation. Hillsdale, NJ: Erlbaum

Allison, G., Harrop, C., & Ellett, L. (2013). Perception of peer group rank of individuals with early psychosis. *British Journal of Clinical Psychology, 52,* 1-11.

Bassett, H., Lampe, J., & Lloyd, C. (1999). Parenting: Experiences and feelings of parents with mental illness. *Journal of Mental Health, 8,* 597 – 604. doi:10.1080/09638239917067

Berna, F., Bennouna-Greene, M., Potheegadoo, J., Verry, P., Conway, M. A. & Danion, J. M. (2011). Impaired ability to give a meaning to personally significant events in patients with schizophrenia, *Consciousness and Cognition, 20,* 703–711

Berry, K., Barrowclough, C., Wearden, A. (2009). Adult attachment, perceived earlier experiences of care giving and trauma in people with psychosis. Journal of mental health, 18(4), 280-287. doi: 10.1080/09638230701879185

Bowlby, J. (1979). The making and breaking of affectional bonds. London: Tavistock

Brunette, M. F., Richardson, F., White, L., Bemis, G., & Eelkema, R. E. (2004). Integrated family treatment for parents with severe psychiatric disabilities. *Psychiatric Rehabilitation journal, 28,* 177-180.doi: 10.2975/28.2004.177.180

Byrne, S., Birchwood, M., Trower, P. E., & Meaden, A. (2005). A casebook of cognitive behaviour therapy for command hallucinations. UK: Routledge.

Cannon, M., Caspi, A., & Moffitt, T. (2002). Evidence for early childhood, pan-developmental impairment specific to schizophreniform disorder. Archives of General Psychiatry, 59, 449–456.

Cassady, J., & Shaver, P. R. (2nd ed). (1999). Handbook of attachment, theory, research, and clinical applications. New York: The Guilford Press

Coverdale, J. H., & Turbott, S. H. (2000). Sexual and physical abuse of chronically ill psychiatric outpatients compared with a matched sample of medicaloutpatients. Journal of Nervous and Mental Disease, 188, 440–445

Deegan, P.E. (1993). Recovering our sense of value after being labeled mentally ill. *Journal of Psychosocial Nursing and Mental Health Services. 31, 4,* 7–11.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38,* 215 – 229. doi: 10.1348/014466599162782

Evenson, E., Rhodes, J., Feigenbaum, J., & Solly, A. (2008). The experience of fathers with Psychosis. *Journal of Mental Health, 17*(6), 629-642. oi:10.1080/09638230701506259

Foster, K. (2010). 'You'd think this roller coaster was never going to stop': experiences of adult children of parents with serious mental illness. *Journal of Clinical Nursing, 19,* 3143-3151. doi: 10.1111/j.1365-2702.2010.03293.x

Friedman, S., Smith, L., Fogel, D. (2002). The incidence and influence of early traumatic life events in patients with panic disorder: a comparison with other psychiatric outpatients. *Anxiety Disorders, 16,* 259–272

Gamer, E., Gallant, D., Grunebaum, H. U., Cohler, B. J. (1977). Children of Psychotic Mothers Performance of 3-Year-Old Children on Tests of Attention. *Archives of General Psychiatry, 34(5),* 592-597. doi:10.1001/archpsyc.1977.01770170102010.

Goodman, S., & Brumley, E. (1990). Schizophrenic & Depressed mothers: Relational deficits in parenting. *Developmental Psychology, 26,* 31 – 39. doi:10.1037

Graham, K., & King, R. (2005). Caregiving attachment in mothers with Schizophrenia: theoretical issues and pilot of an empirical investigation of maternal interaction with children at bedtime. Austrailian e-journal for the advancement of mental health, 4(3), 1-9

Hans, S. L., Auerbach, J. Q., Styr, B., & Marcu, J. (2004). Offspring of parents with Schizophrenia. Mental disorders during childhood and adolescence. *Schizophrenia bulletin, 30*

Holowka, D., King, S., Saheb, D., Pukall, M., & Brunet, A. (2003). Childhood abuse and dissociative symptoms in adult schizophrenia. *Schizophrenia Research, 60*, 87–90

Jennings, K. D., Ross, S., Propper, S., & Elmore, M. (1999). Thoughts of harming infants in depressed and non-depressed mothers. *Journal of Affective Disorders, 54(1-2),* 21-28

Kohl, P. L., Jonson-Reid, M., & Drake, B. (2011). Maternal mental illness and the safety and stability of maltreated children. *Child Abuse Neglect, 35(5),* 309–318. doi:10.1016/j.chiabu.2011.01.006.

Lewis, C. (1986). *Becoming a father.* Milton Keynes: Open University Press

Miller, L. J., & Finnerty, M. (1996). Sexuality, pregnancy, and childrearing among women with schizophrenia-spectrum disorders. *Psychiatric Services, 47,* 502-505

Miller, L. J. (1997). Sexuality, reproduction and family planning in women with schizophrenia. *Schizophrenia Bulletin, 23,* 623 – 635.

Neria, Y., Bromet, E., Sievers, S., Lavelle, J., & Fochtman, L. (2002). Trauma exposure and PTSD in psychosis. Journal of Consultant Clinical Psychology, 70, 246–251.

Nicholson, J., Sweeney, E. M., & Geller, J. L. (1998). Focus on women: Mothers with mental illness: The competing demands of parenting and living with mental illness. *Psychiatric Services, 49,* 635 – 642.

Mordoch, E. (2010). How children understand parental mental illness: "you don't get life insurance. What's life insurance." *Journal of Canadian Child Adolescent Psychiatry, 19(*1), 19-25

Mullen, P. E., Martin, J. L., Anderson, J. C., Romans, S. E., Herbison, G. P.(1996). The long-term impact of the physical, emotional, and sexual abuse of children: a community study. *Child Abuse Neglect, 20(1),*7-21.

Oyserman, D., Mowbray, C. T., Meares, P. A., & Firminger, K. B. (2000). Parenting among mothers with a serious mental illness. *American Journal of Orthopsychiatry, 70,* 296 – 315. doi:10.1037/h0087733

Park, J. M., Solomon, P., Mandell, D. S. (2006). Involvement in the child welfare system among mothers with serious mental illness. *Psychiatric Services, 57,* 493–497.

Picken, A. L., Berry, K., Tarrier, N., & Barrowclough, C. (2010). Traumatic events, posttraumatic stress disorder, attachment style, and working alliance in a sample of

people with Psychosis. The Journal of Nervous and Mental Disease, 198(10), 775-778. doi: 10.1097/NMD.0b013e3181f4b163

Read, J., & Argyle, N. (1999). Hallucinations, delusions and thought disorders among adult psychiatric inpatients with a history of child abuse. Psychiatric Services, 50, 1467–1472.

Read, J., Agar, K., Argyle, N., Aderhold, V. (2003). Sexual and physical assault during childhood and adulthood as predictors of hallucinations, delusions and thought disorder. *Psychology and Psychotherapy: Theory Research and Practice, 76,* 1–22.

Read, J., Van Os, J., Morrison, A. P., & Ross, C.A. (2005). Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica, 112,* 207-213. doi: 10.1111/j.1600-0447.2005.00634.x

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience. *The Psychologist, 18(1),* 20 – 23

Paul Gilbert, P. (2000). *The relationship of shame, social anxiety and depression: The role of the evaluation of social rank.* John Wiley & Sons, Ltd.

Reupert, A., & Maybery, D. (2007). Families Affected by Parental Mental Illness: A Multiperspective Account of Issues and Interventions. *American Journal of Orthopsychiatry, 77*(3), 362–369. doi: 10.1037/0002-9432.77.3.362

Riordan , D., Appleby, L., Faragher, B. (1999). Mother-infant interaction in post-partum women with schizophrenia and affective disorders. *Psychological Medicine, 29*(4), 991-995

Rogosch , F., A., Mowbray, C., T., & Bogat, G.,A. (1992). Determinants of parenting attitudes in mothers with severe psychopathology. *Development and psychopathology, 4,* 469-487

Ross, C., Anderson, G., Clark, P. (1994). Childhood abuse and positive symptoms of schizophrenia. *Hospital & Community Psychiatry, 45,* 489–491

Sanders, M. R. (2000). Triple P-Positive Parenting Program as a public health approach to strengthening parenting. *Journal of Family Psychology, 22(4),* 506–517. doi:10.1037/0893-3200.22.3.506

Schen, C. R. (2005). When mothers leave their children behind. *Harvard review of psychiatry, 13(4),* 233-243. doi:10.1080/10673220500243380

Smith, J,. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, method and research.* London: Sage

Seeman, M., V.(2002). Women with Schizophrenia as parents *Primary Psychiatry, 9(10),* 39-42

Stratham, J. (2011). *Grandparents providing childcare.Briefing paper.* Childhood wellbeing research centre.

Wan, M. W., Warren, K., Salmon, M. P., & Abel, K. M. (2008). Patterns of maternal responding in postpartum mothers with Schizophrenia. *Infant Behaviour & Development, 31,* 532-538.doi: 10.1016/j.inbeh2008.04003

Willig, C. (2001). *Introducing qualitative research in psychology: adventures in theory and me*. Buckingham: Open University Press

Willig, C. (2008). *Introducing qualitative research in psychology*. London: Open University Press. 2nd Edition.

Willinger,U., Diendorfer-Radner,G., Willnauer,R., Jorgal,G., Hanger. (2005). Parenting stress and parental bonding. *Journal of Behavioural Medicine, 31*(2), 63-9

Valiakalayil, A., Paulson, L.A., & Tibbo, P. (2004). Burden in adolescent children of parents with schizophrenia - The Edmonton High Risk Project. *Social Psychiatry and Psychiatric Epidemiology 39(7),* 528-535.

Zemencuk, J., Rogosch, F., & Mowbray, C. T. (1995). The seriously mentally ill woman in the role of parent: characteristics, parenting, sensitivity and service needs. *Psychosocial rehabilitation journal, 18,* 77-92. doi:10.1037/h0095499

Zubin, J. and Spring, B. (1977) Vulnerability: A New View on Schizophrenia Journal of Abnormal Psychology 86, 103-126

Chapter Three

Public Domain Briefing Document

This document provides an overview of the thesis submitted in partial fulfilment of the requirements for the degree of Doctorate of Clinical Psychology (Clin.Psy.D.) at the University of Birmingham. It consists of two components: a theoretical review exploring how attachment theory is applied to the literature to aid our understanding of the relationships of adults who have experienced psychosis, and an empirical study, which explores the experience of parenting of mothers who have experienced schizophrenia.

Literature review:

How can attachment theory help us to understand the relationships of adults who diagnosed with a psychotic illness? A theoretical review.

Introduction

Attachment theory (Bowlby, 1973), proposes that the relationship a child develops with their primary-caregiver, influences their psychological development and how they view themselves and others in their childhood and adulthood. Children who develop a secure attachment style with their primary-caregiver are likely to develop a positive view about themselves and others. Children who develop an insecure attachment style with their primary-caregivers are likely to develop a negative perspective about themselves and others, which may have a negative impact on the development of relationships in adult life. The literature indicates two insecure attachment styles in adulthood: 1) insecure-avoidant attachment style, where adults are likely to develop a negative image of others and reject interpersonal relationships (Bartholomew & Horowitz, 1991)., and 2) insecure-anxious attachment styles, where adults are likely to develop a negative self-image and an overly demanding interpersonal style to get their needs met (Bartholomew & Horowitz, 1991). A large amount

of research indicates that insecure attachment styles are a risk factor for the development of schizophrenia (Berry, Wearden, Barrowclough, & Liversidge, 2006a; Dozier, 1990; Dozier, Cue, & Barnett, 1994; Dozier & Lee, 1995; Dozier, Stevenson, Lee, & Velligan, 1991; Mickelson, Kessler, & Shaver, 1997; Myhrman, Rantakallio, Isohanni, Jones, & Partanen, 1996; Pickering, Simpson, & Bentall, 2009). The research also demonstrates that people diagnosed with schizophrenia have difficulties developing interpersonal relationships (Berry, Barrowclough, Byrne, & Purandare, 2006b; Daniel, 2006; Macdonald, Sauer, Howie, & Albiston, 2005; Schomerus et al., 2007), and that adult attachment styles may be good predictors of this difficulty (Berry et al., 2007a). To date there is no review synthesising the findings and implications of research investigating attachment theory and the relationships of adults diagnosed with schizophrenia.

Aim

A theoretical review was considered important for this topic because it reviews a theory and its implications. This theoretical review aimed to summarise and draw out the implications of all of the relevant literature regarding how attachment theory aids our understanding of the relationships of adults diagnosed with a psychotic illness.

Search strategy

A systematic search was conducted which resulted in one discussion article and thirteen empirical studies focusing on: 1) mother-child relationships, 2) relationships to mental health services and professionals and 3) peer relationships. Articles exploring the role of trauma events on the development of attachment styles were also reviewed.

Findings

Taken as a whole, the literature reviewed here highlights that adults diagnosed with a psychotic illness are likely to have an insecure avoidant or anxious attachment style which

may be a contributing factor to severe mental health problems and difficulties in social interaction. Furthermore, having an insecure attachment style following a diagnosis of schizophrenia may make important life events such as peer relationships and engagement with services much more difficult.

Empirical Paper:

What can mothers who have experienced psychosis, tell us about their experience of parenting? An Interpretative Phenomenological Analysis.

Background

The literature indicates an increase in the number of people experiencing serious mental illnesses who become parents (Evenson, Rhodes, Feigenbaum, & Solly, 2008; Miller, 1997; Oyserman, Mowbray, Meares, & Firminger, 2000). A majority of the research in this area is quantitative, which has mainly focused on the effects of maternal mental illness and the potential to harm their children (Jennings, Ross, Propper, & Elmore, 1999; Gamer, Gallant, Grunebaum, & Cohler, 1977; Goodman & Brumley, 1990). Although some qualitative research has been conducted, this has predominantly focused on the difficulties of parenting in the context of a severe mental illness for mothers of young children who have a range of diagnoses. This suggests that research focusing on mothers with the same mental health difficulty, of children of all ages, rather than younger or older children, would be useful to contribute to the literature.

Aim

This study aimed to explore the parenting experience of mothers who have experienced psychosis, of children of all ages, to contribute to the literature. It aimed to explore the strengths as well as the potential difficulties of the mother-child relationship in the context of psychosis.

Method

A qualitative design was adopted. Participants consisted of five mothers diagnosed with schizophrenia who had experienced psychosis during their child's childhood. Semi-structured interviews were conducted to explore their own childhood relationship with their own primary-caregiver; their experience of mental illness; their experience of parenting; and their experience of parenting whilst experiencing psychosis. Interviews were recorded and then transcribed. The data was analysed in detail using Interpretative Phenomenological Analysis (IPA), which examines how people make sense of their lived experiences (Smith, Flowers & Larkin, 2009). Transcripts were read and re-read to get a feel for the data. Initial thoughts and comments were noted in the right hand margin, which were used to identify emergent themes which were noted in the left hand margin. All transcripts were analysed together and themes that shared similar meanings were clustered together, resulting in the final set of superordinate and subordinate themes.

Findings

Four superordinate themes emerged from the analysis which consisted of: 1) Negative experiences of being mothered 2) Challenges of being a mother with a severe mental illness 3) Powerlessness and 4) I have a purpose in life, I am a mother. Each of these themes included subordinate themes, see table 1.

Table 1: Superordinate and subordinate themes

Thematic level	**Theme 1**	**Theme 2**	**Theme 3**	**Theme 4**
Superordinate theme	**4) Negative experiences of being mothered**	**Challenges of being a mother with a severe mental illness**	**5) Powerlessness**	**6) I have a purpose in life, I am a mother**
Subordinate theme	1a) Own mother-child relationship	2a) Parenting role exacerbates symptoms of psychosis	3a) Powerless to mental illness and mental health services	4a) Happiness, pride and purpose
	1b) Conflict between negative maternal relationships and needing support once a parent	2b) Experience of psychosis challenges parenting role	3b) Controlled within romantic relationships	4b) Finding strength
		2c) Mismatch between the support required and support received	3c) Lack of autonomy in parenting role and choices	4c) Close and supportive children
		2d) Role reversal and misunderstanding	3d) Taking control	

Conclusion

The study found that participants experienced pride in being a mother as well as strength to manage the challenges of parenting in the context of psychosis and to interact positively with their children. They also experienced difficulties due to their illness, such as stress and hospitalisation, and felt that this had a negative impact upon their parenting role. The participants also often felt powerless in regards to their mental illness and in some cases, in their relationships with their family. Despite such difficulties the mothers showed

motivation to be emotionally and physically available and loving towards their children, often in contrast to their own childhood experiences of being parented.

References

Berry, K., Barrowclough, C., Byrne, J. & Purandare, N (2006b). Coping strategies and social support in old age psychosis. Soc Psychiatry Psychiatr Epidemiol, 41(4), 280-4. doi:10.1007/s00127-005-0023-1

Berry, K., Wearden, A., & Barrowclough, C. (2007a). A review of the role of adult attachment styles in psychosis: unexplored issues and questions for further research. Clinical Psychology Review, 27, 458-475. doi:10.1016/j.cpr.2006.09.006

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

Berry, K., Wearden, A., Barrowclough, C., & Liversidge, T. (2006a). Attachment styles, interpersonal relationships and psychotic phenomena in a non-clinical student sample. Personality and Individual Differences, 41, 717-718. doi:10.1016/j.paid.2006.03.009

Daniel, S. I. F. (2006). Adult attachment patterns and individual psychotherapy: a review. Clinical Psychology Review, 26, 968-984. doi:org10.1016/j.cpr.2006.02.001

Dozier, M. (1990). Attachment organisation and treatment use for adults with serious psychopathological disorders. Development and Psychotherapy, 2, 47-60. doi.org/10.1017/S0954579400000584

Dozier, M., Cue, K. L., & Barnett, L. (1994). Clinicians as caregivers: Role of attachment organisation in treatment. Journal of Consulting and Clinical Psychology, 62, 793-800. doi:10.1037/0022-006X.62.4.793

Dozier, M., & Lee, S. (1995). Discrepancies between self and other report of psychiatric symptomology. Effects of dismissing attachment strategies. Development and Psychopathology, 62, 793-800. doi.org/10.1017/S095457940000643X

Dozier, M., Stevenson, A. L., Lee, S. W., & Velligan, D. I. (1991). Attachment organisation and familial over involvement for adults with serious psychopathological disorders. Development and Psychopathology, 3, 475-489.doi.org/10.1017/S0954579400007641

Evenson, E., Rhodes, J., Feigenbaum, J., & Solly, A. (2008). The experience of fathers with Psychosis. Journal of Mental Health, 17(6), 629-642. doi:10.1080/09638230701506259

Gamer, E., Gallant, D., Grunebaum, H. U., Cohler, B. J. (1977). Children of Psychotic Mothers Performance of 3-Year-Old Children on Tests of Attention. Archives of General Psychiatry, 34(5), 592-597. doi:10.1001/archpsyc.1977.01770170102010.

Goodman, S., & Brumley, E. (1990). Schizophrenic & Depressed mothers: Relational deficits in parenting. Developmental Psychology, 26, 31 – 39. doi:10.1037

Jennings, K. D., Ross, S., Propper, S., & Elmore, M. (1999). Thoughts of harming infants in depressed and non-depressed mothers. Journal of Affective Disorders, 54(1-2), 21-28

Macdonald, E., Sauer, K., Howie, L., Albiston, D. (2005). What happens to social relationships in early psychosis? A phenomenological study of young people's experiences. Journal of Mental Health, 14, 129–143. 10.1080/09638230500060052

Mickelson, K. D., Kessler, R. C., & Shaver, P. R. (1997). Adult attachment in a nationally representative sample. Journal of Personality and Social Psychology, 73, 1092-1106. doi:10.1037/0022-3514.73.5.1092

Miller, L. J. (1997). Sexuality, reproduction and family planning in women with schizophrenia. Schizophrenia Bulletin, 23, 623 – 635.

Myhrman, A., Rantakallio, P., Isohanni, M., Jones, P., Partanen, U. (1996). Unwantedness of a pregnancy and schizophrenia in the child. British Journal of Psychiatry,169(5), 637-640. doi:10.1192/bjp.169.5.637

Oyserman, D., Mowbray, C. T., Meares, P. A., & Firminger, K. B. (2000). Parenting among mothers with a serious mental illness. American Journal of Orthopsychiatry, 70, 296 – 315. doi:10.1037/h0087733

Pickering, L., Simpson, J., Bentall, R. (2009). Insecure attachment predicts proneness to paranoia but not hallucinations. Personality and Individual Differences, 44(5), 1212-1224.

Read, J., & Gumley, A. (2008). Can attachment theory help explain the relationship between childhood adversity and Psychosis? New directions in Psychotherapy and relational psychoanalysis, 2, 1-35

Schomerus, G., Heider, D., Angermeyer, M., C., Bebbington, P., E., Azorin, J. M., Brugha T., & Toumi, M. (2007). Residential area and social contacts in schizophrenia. Social Psychiatry and Psychiatric Epidemiology, 42, 617–622. doi.org/10.1017/S0033291707001778

Smith, J,. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, method and research.* London: Sage

Appendix A: Details of exploded search terms

Keyword search A

Attachment theory exploded to include psychological theories, attachment behaviour, emotional development, emotional security, object relations, parent-child relations, psychosocial development and separation anxiety. **Attachment behaviour** exploded to include bonding, behaviour, abandonment, attachment disorders, attachment theory, dependency, intimacy, love, object relations, parent child relations, postpartum depression, postpartum psychosis, psychological distance, separation anxiety, separation individuation, separation reactions and stranger reactions.

Keyword search B

"Schizophrenia (Disorganized Type)" exploded to include Hebephrenic schizophrenia. **Paranoid Schizophrenia** exploded to include schizophrenia, paranoia (psychosis), paranoid personality disorder and psychosis. **Undifferentiated Schizophrenia** exploded to include schizophrenia. **Childhood Schizophrenia** exploded to include childhood psychosis and schizophrenia. **"Fragmentation (Schizophrenia)**" exploded to include thought disturbances. **Process Schizophrenia** exploded to include process psychosis and schizophrenia. **Catatonic Schizophrenia** exploded to include schizophrenia and catatonic. **Acute Schizophrenia** exploded to include acute psychosis, schizophrenia and postpartum psychosis. **Schizophrenia** exploded to include chronic schizophrenia, dementia praecox, pseudopsychopathic schizophrenia, reactive schizophrenia, simple schizophrenia and psychosis.

Keyword search C

Interpersonal relationships exploded to include personal relations, family relationships, friendship, kinship, marital relations, interpersonal attraction, interpersonal compatibility, interpersonal interaction, psychological distance, relationship quality, relationship satisfaction and self-expansion. **Peer relations** exploded to include interpersonal interaction, peer pressure, friendship, peer counselling, peer evaluation, peers, relationship termination, sociometry and teasing. **Family relations** exploded to include family dynamics, family life, interpersonal relationships, family conflict, marital relations, parent child relations, parental role and sibling relations. **Relationship quality** exploded to include friendship, interpersonal relationships, marital satisfaction and relationship satisfaction. **Family relations** exploded to include family dynamics, family life and interpersonal relationships. **Marital relations** exploded to include marital adjustment and family relations. **Parent child relations** exploded to include parental influence, family relations, parenting, father child relations, mother child relations and parental attitudes. **Sibling relations** exploded to include family relations. **Couples** exploded to include cohabitation, dyads, family, romance, significant others, social dating and spouses. **Male family relations** exploded to include heterosexual interaction, interpersonal interaction and social skills. **Sexual partners** exploded to include psychosexual behaviour, sexual intercourse, sexual risk taking and sociosexual orientation. **Spouses** exploded to include married couples, mates, family members, husbands, wives, couples, in-laws, parents and significant others. **Parents** exploded to include family members, adoptive parents, fathers, foster parents, homosexual parents, mothers, single parents, single parents and surrogate parents**. Parent child relations** exploded to include parental influence, family relations and parenting. **Mother-child relations** exploded to include maternal behaviour and parent child relations. **Father-child relations** exploded to include parent child relations,

childrearing practices, father child communication, parental attitudes, parental role and permissive parenting. **Mental health personnel** exploded to include health personnel, clinical psychologists, psychiatric hospital staff, psychiatric nurses, psychiatric social workers, psychiatrists, psychotherapists, school psychologists, clinicians, counsellors, educational personnel, impaired professionals, medical personnel, mental health, mental health personnel supply, occupational therapists, professional personnel, personal therapy, professional supervision, psychologists, social workers and therapists. **Social workers** exploded to include personnel, psychiatric social workers, psychologists, rehabilitation counsellors, sociologists, therapists and vocational counsellors. **Family** exploded to include biological family, extended family, family of origin, interracial family, military family, nuclear family, schizophrenogenic family, step family, co-dependancy, cohabitation, divorce, divorced persons, dysfunctional family, empty nest, family background, family crises, family history, family members, family planning, family relations, family structure, kinship, living arrangements, marital separation, marital status, marriage, transgenerational patterns, widowers, widows and working women**.** **Mental health services** exploded to include health care services, community mental health services, clinical practice, community mental health centres, community services, counselling, health care administration, health service needs , integrated services, long term care, mental health, mental health parity, mental health programs, outreach programs, prevention, psychiatric hospital programs, quality of care, quality of services, school counselling, school casework, social services, student personnel services, support groups, twelve step program, health care delivery and health care policy. **Marriage** exploded to include endogamous marriage, exogamous marriage, monogamy, polygamy, remarriage, same sex marriage, family, life changes, marital status, marriage rites and romance.

Appendix B

Summarised quality comparison criteria for quantitative papers guided by Fowkes and Fulton (1991)

- Whether the research objectives are clearly stated
- Whether the study design is objectively stated
- Whether the study design is appropriate for the objectives of the study
- Whether the study sample is representative

  - Source of sample clearly documented

  - whether the selected participants are representative of the study population

  - Sampling method clearly documented

  - sampling method appropriate for the study (were the studies subject to referral bias)

  - Sampling size clearly documented

  - Whether the sample size had sufficient power to detect meaningful results (was it large enough to be representative)

  - Inclusion/exclusion criterion documented

  - Non-respondents (to the invitation) documented

- Whether the control group is acceptable

  - Control or comparison group adequate for the study

  - Source of control/comparison group characteristics similar to participants

  - was the matching process of e.g. age and sex (in case control studies) carried out correctly? Was the process of randomisation (controlled studies) truly assessed to ensure they were properly randomised?

- Whether the control/comparison group has comparable characteristics to the group under study and assessed

- Quality of measurements and outcome

  - Whether the validity of the measurements are documented

  - Reproducibility – is there evidence of the repeatability of the measurements in the article

  - Blindness – whether the participants or researchers collecting the data are blind to the purpose of the research

  - Quality control – whether the accuracy and repeatability of observers and measurements have been checked, and whether random checks have been conducted to identify errors in data recording

- Completeness

  - Whether compliance throughout the study has been documented

  -whether proportion of drop outs and deaths have been documented, assessed and explored

- Whether missing data has been documented

- Distorting influences

  - Whether subjects have been exposed to extraneous treatment, have these been identified and the results interpreted accordingly (only in controlled trials)
  - Confounding factors accounted for

Appendix C

Summarised quality comparison criteria for qualitative papers guided by Elliott, Fischer and Rennie (1999).

To be determined as a methodological sound study the paper must include:

- An explicit scientific context and purpose (research questions)
- Appropriate methodology according to the aims of the study
- Ethical principles regarding the participants are fulfilled
- Procedure of data gathering, analysis etc. specified
- Appropriate discussion about implication of research data
- Limitations acknowledged
- Clarity of presentation (well organised, technical terms clarified)
- Contribution to knowledge within discipline under study
- Description of the author's theoretical, methodological or personal orientation relevant to the research is provided
- Descriptive and demographic data about the sample is provided
- Authors provide examples of the data is provided within the analysis
- Credibility checks are provided
- An integrated summary of the analysis is provided
- Resonating with readers - the material is presented in an accurate way to aid understanding

Appendix D: Quantitative quality comparison assessment (Fowkes & Fulton, 1991).

	Arbuckle Berry Taylor & Kennedy (2012)	Berry Wearden & Barrowc-lough (2007)	Berry Barrowcl-ough & Wearden, (2008)	Berry Barrowc-lough & Wearden (2009)	Blackburn Berry Cohen (2010)	Catty Cowan Poole Ellis (2012)	Couture Lecomte & Leclerc (2007)	Kvrgic Beck Cavelti Kossowsky Stieglitz & Vauth (2011)	Picken Berry Tarrier & Barrowclough (2010)	Riordan Appleby Faragher (1999)	Rogosch Mowbray & Bogart (1992)	Tyrrell Dozier Teague Fallot (1999)
Research objective explicitly stated	0	0	0	0	0	0	0	0	0	0	0	0
Design stated	++	++	0	++ (not stated)	0	0	++	++	++	++	++	++
Design appropriate to objectives	+	+	0	+	0	0	+	0	0	++	+	+
Source of sample documented	0	0	0	0	0	0	0	0	0	0	0	0
Source of sample – selected participants representati ve of study population	0	0	0	0	0	0	+	0	0	++	0	0
Sampling method documented	++	++	++	++	+	0	+	0	++	++	+	++
Sampling	++	++	++	++	++	++	0	0	0	0	0	++

method appropriate for study												
Size of sample documented	0	0	0	0	0	0	0	0	0	0	0	0
Size of sample had sufficient power	++	+	+	+	++	0	++	++	++	NA	++	++
Inclusion/ exclusion criteria documented and appropriate	+	0	0	0	++	0	0	0	++	0	0	++
Statement about non-respondents	0	++	0	++	++	0	++	++	0	0	0	++
Control/ comparison group adequate for study	++	++	+	++	++	++	0	++	+	+	++	++
Source of control/comparison group similar to participants	NA	N/A	0	NA	NA	NA	0	N/A	+	+	NA	NA
Matching process carried out correctly/	NA	NA	+	NA	NA	NA	+	N/A	0	0	NA	NA

Randomisation properly randomised												
Controlled/ comparison group have comparable characteristics?	NA	0	++	NA	NA	NA	+	N/A	+	+	NA	NA
Validity of measure-ments documented	++	0	0	++	+	+	+	+	++	NA	++	++
Evidence of repeatability of measures	++	0	+	+	+	+	0	0	+	++	++	+
Participants and researchers blind to purpose of study	++	++	++	++	++	++	++	0	++	0	++	++
Quality control	++	0	0	+	0	++	+	0	+	0	++	+
Complete-ness: Compliance throughout study	0	0	0	0	0	0	0	0	0	0	0	0
Drop outs	0	++	0	0	++	0	0	++	0	0	0	++
Missing data addressed	++	++	0	0	++	0	0	++	0	++	+	++
Exposed to	++	++	++	++	++	++	++	++	+	++	++	++

Extraneous treatments												
Contamination (one group is affected by the other)	+	NA	NA	NA	NA	NA	NA	NA	0	0	NA	NA
Changes over time documented	+	+	+	NA	NA	0	NA	++	+	NA	NA	++
Extraneous/ confounding variables identified/ accounted	+	+	0	0	+	0	+	+	0	++	+	0
Distortion reduced by analysis	+	+	+	+	+	+	+	+	+	+	+	+
Score	28/48 58%	23/48 48%	16/52 30%	21/44 48%	23/44 52%	12/46 26%	19/50 38%	19/46 41%	19/52 36%	20/50 40%	21/44 48%	30/46 65%

Appendix D

Key	**Meaning**
++ (2 points)	Major problem
+ (1 point)	Minor problem
0 points	No problem
NA	Not applicable

Appendix E: Qualitative Quality assessment (Elliott, Fischer & Rennie (1999).)

	Graham & King (2005)
Explicit scientific context (area of impact addressed)	0
Description of the author's theoretical, methodological or personal orientation relevant to the research is provided	++
Research questions specified	0
Sampling procedure described	0
Description of participants	0
Demographic qualities of the sample provided	0
Ethical principles fulfilled (consent, confidentiality etc.)	++
Data gathering procedures described	0
Audiotaping procedures described	++
Transcription procedures described	++
Data analysis described	+
Coding techniques described	++
Description of the data provided in the analysis	0
Triangulation and credibility checks	++
Description of process	0
Appropriate discussion	0
Limitations of study acknowledged	0
Clarity of presentation (well organised and clearly written)	0
Contribution to readers knowledge	0
Coherence – integrated summary of analysis provided	0
Accomplishing general vs. specific research tasks	0
Resonating with readers	0
Score	13/22 = 59%

Appendix E

Key	**Meaning**
++ (2 points)	Major problem
+ (1 point)	Minor problem
0 points	No problem
NA	Not applicable

Appendix F

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Demographics questionnaire for Mother

Name……..

Age……..

Ethnicity……..

1. How many children do you have?

……
……

2. Were you married or in a relationship at the time?

.....
.....

3. At what age did you come into contact with mental health services?

……
……

4. a. Did you experience episodes of psychosis whilst your son/daughter was growing up?

.....
.....
.....

4. b. If so how many episodes did you have and how long did they last?

.....

4.c. How many times were you in hospital?

.....

What medication were you taking at the time?

.....

What was your diagnosis at the time?

……

……

5. What is your current diagnosis?

……

What medication are you currently taking (if any)?

.....

Name of CMHT

……

……

6. Name of care coordinator

……

Name of Consultant Psychiatrist

……

Number of years known to mental health services

……

Name and address of GP

……

……

Appendix G

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Interview Schedule for mother

Introduction questions

Can you tell me about you and your family?

- Where did you grow up?
- Who were you living with as a child?
- What was your relationship like with you and your parents/carer/significant other?
- How many siblings do you have and what was your relationship like with them?
- How old were you when you had your first child?
- Who was living with you when you had your children?
- Were you married, in a relationship etc. at the time?
- Did you receive any support from your parents/carers/siblings etc. in bringing up your children? If so was this helpful?

Section 1

1. What mental health difficulties have you experienced? What name would you like to give to your mental health difficulty throughout the interview?

   Follow up questions:

   - Can you please describe these difficulties?
   - How old were you when you first experienced these difficulties?
   - What services were you in contact with in relation to these difficulties?
   - When did you experience these difficulties in relation to becoming a mother (before, after, during)?

2. How would you describe your relationship with your children?

Follow up questions:

- What was your relationship like with your children when they were first born?
- How did your relationship with your son or daughter develop?
- Can you tell me about what parts of your relationship with your son/daughter that you valued and enjoyed?
- What was strong in your relationship with your children?
- What helped you to be strong in your relationship with your children?
- What do you think was more challenging in this relationship?
- What or who helped you to manage those challenges?
- Was there anyone or anything that wasn't helpful at those challenging times?
- Are there any key services/landmarks/voluntary agencies/people that were or were not helpful at the time, e.g. school, health services etc.
- Looking back now can you identify anything or anyone else that could have helped at that time?
- Looking back now, is there anything that you would do differently?
- What are you proud of in your role as a parent?

<u>Section 2</u>

3. Can you tell me what it was like to be a mother whilst you were experiencing X?

Follow up questions:

- How do you think having X helped you to be a mother?
- How do you think having X hindered you (or had a negative affect) in your role as a mother?
- How do you think your X (difficulties) helped you to develop your relationship with your child?
- How did your X affect the development of your relationship with your child in a negative way?
- Were there ever any times when you were away from your son/daughter (for long or short periods of time)? If so, how did you manage this experience?

- How did your role as a mother affect your X in a good way?
- How did your role as a mother affect your X in a bad way?
- Is there anything you would have liked to have been different?

4. What has being a parent with X taught you about yourself?
    - Is there anything that you would like to let people know about your experiences?
5. Is there anything else you want to tell me that I have not asked you about?

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Appendix H

Participant Information Sheet

Title of project: What can mothers who have experienced psychosis, tell us about their experience of parenting, in the context of psychosis?

Researcher: Jaymini Chauhan, Trainee Clinical Psychologist, University of Birmingham.

The current research project is being undertaken as part of a doctorate in Clinical Psychology at the University of Birmingham.

Thank you for your interest in this research study. It would be very helpful for us as mental health professionals to know more about being a parent who has experienced psychosis. It would be particularly helpful to know about the positive factors within your relationship with your child as well as of the difficulties and challenges faced at the time and what helped you to manage these challenges.

The aim of this study is to spend some time with mothers to find out about their experience of parenting whilst suffering from psychosis.

Before you decide whether you want to take part you need to understand why the research is being done and what it will involve for you. Please take some time to read the following information carefully. Ask the researcher if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What does the study involve?

The study will involve interviewing mothers who have suffered from psychosis, to explore their experience of parenting. The questions will be centred on the mother's experience and on the strengths and positives within the mother and child relationship, as well as of any difficulties which may have been encountered and how these were faced.

What is the purpose of this research?

The purpose of this research is to:-

1. Obtain an account of the mother's experience of parenting in the context of psychosis.
2. Obtain an account from the mother about the factors that have been important for enabling the parenting role.

3. Explore what resources both internal and external the mother drew upon during their experience of parenting in the context of psychosis.

4. Explore how the mother describes the impact of their mental health difficulty on their attachment to their children.

5. Explore what implications the participants account of their experiences have for supporting service users and services

Why have I been invited to take part?

You have been invited to take part because you have been identified by your Community Mental Health Team as a mother who has suffered from psychosis and had regular contact with your child throughout their childhood.

Do I have to take part?

Once you have been approached and fully informed about the study, you will have 24 hours to decide if you want to take part. The researcher, Jaymini Chauhan, will contact you one day after the initial meeting to find out whether you would like to take part in the research study. Participation is entirely voluntary.

What will happen if I do not want to carry on with this study after agreeing?

You are free to withdraw from the study at any time without giving any reasons. After you have completed your interview you will be given up to four weeks to withdraw your entire interview or parts of your interview data to be analysed. You can do this by contacting the researcher.

What will I have to do if I agree to take part?

If you agree to take part you will be asked to talk to the researcher, Jaymini Chauhan, about your experience of parenting in the context of psychosis. This will take approximately 60 minutes of your time and will be conducted in a place that you feel most comfortable in. It is likely that this will either be at your home, or in an interview room at your Community Mental Health Team. Your participation will be anonymous and your personal identity will not be stored with your comments.

What will I be asked in the interview?

You will generally be asked to talk about your experience of parenting whilst suffering from psychosis. The questions will be centred on your own account of being a parent in the context of psychosis and about the strengths and positives of your relationship with your children, well as of any difficulties and how you dealt with these.

Who will know what I say in the interviews?

The researcher, Jaymini Chauhan, who will conduct the interview with you, Jaymini Chauhan's academic supervisor, Dr Elizabeth Newton and trust collaborator, Dr Kate Harris, will know what you have said in the interview. Once the interview has been completed, it will be transcribed and all your personal data will be made anonymous.

Who will know that I am taking part in this research?

Your Care coordinator, Consultant Psychiatrist and other professionals of whom you have had contact with in your team will be aware that you are participating in this study. With your consent your GP will also need to be informed about your participation. Your data will not be made available to these professionals.

What are the possible disadvantages and risks of taking part?

It is possible that the interview may reveal sensitive information depending on your experience. If this is the case the interviewer, Jaymini Chauhan, will attend to your needs and will only continue with the interview if you feel comfortable to do so. If your distress continues the interviewer will ask for your consent to contact your GP and/or another relevant professional to provide you with extra support. If you feel distressed following completion of the interview you are advised to talk to your care co-ordinator or the researcher about this.

What are the possible benefits from taking part?

You will be given a £10 High street voucher for your participation.

There are no other direct benefits however it is hoped that you will feel your experiences have been listened to and valued. Your contributions will also add to the research base which will help to develop better services and support for mothers who have suffered from psychosis.

What will happen to the results of the research study?

On completion of the research study, your responses will be analysed by the researcher and written up for publication. This will include the publication of direct quotes, however these will be anonymised.

Please indicate on the consent form if you would like an accessible copy of the research upon completion.

Will my taking part in the study be kept confidential?

It will not be possible to offer complete confidentiality because direct quotes from the interviews will be published. You will not be identified from the quotes as your personal data will be anonymised and you will be given an alias to protect your identity.

You will be offered the opportunity to review your transcripts and indicate whether there are certain parts of the interview that you would not like to be used as quotes in the final write up.

You will be given the opportunity to review your extracts from your own interviews before the extracts are used for publication.

Expenses and payments

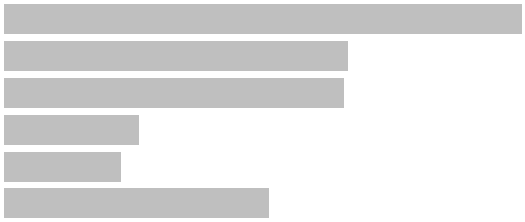
If the interviews are not conducted in your home, you will be reimbursed of any travel expenses. You will also receive a £10 High Street voucher for taking part in this study.

Who do I ask for more information?

This information is for you to keep. If you have any further questions or would like further information, please contact the researcher of the project for more information (see details below).

Further information and contact details.

If you would like any further information, please contact the researcher:



Appendix I

Consent Form

Title of project: What can mothers who have experienced psychosis tell us about their experience of parenting, in the context of psychosis?

Researcher: Jaymini Chauhan, Trainee Clinical Psychologist, University of Birmingham

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time during the research interview, without giving reason. I understand that if I complete the interview I will have up to four weeks to withdraw my consent to either analyse my entire interview or parts of my interview. I will do this by contacting the researcher. I understand that I will not be able to withdraw my interview after this four week period. ☐
3. I understand that the research interview will be recorded, transcribed and analysed. ☐
4. I understand that my GP and/or Consultant Psychiatrist (if applicable) will be informed that I am participating in this research. ☐
5. I understand that my care coordinator or my GP will be informed if I become distressed during the interview. ☐
6. I understand that the data collected during the study will be looked at by the researcher (Jaymini Chauhan) and Dr Elizabeth Newton from the University of Birmingham. I understand that the data will also be looked at by the researcher's employing Trust supervisor, Dr Kate Harris. I give permission for these individuals to have access to my data. ☐
7. I understand that all of my personal data will be kept confidential at all times. This information will be kept separately to my data in a secure cabinet. ☐
8. I understand that direct quotes from my interview will be included and published in any write up of the data, but my name and any other information that can make me identifiable will not be included in the write up. ☐
9. I understand that I have the choice to review my transcript and indicate whether there are certain parts of the interview that I would not like to be used as quotes in the final write up. ☐

10. I understand I can contact the researcher at any time if I need further information. ☐

11. I agree to take part in the above study. ☐

Name of Participant (please print)	Signature	Date

(1 copy for volunteer; 1 for researcher)

Appendix J Transcript with initial thoughts and emergent themes

Own childhood poverty (67-68) Unloved as a child (72 – 82, 84 - 87) Insecure attachment with own mother- Unloved and victimised as a child (76-87) Own experience of abuse as child (89-		I: Yeah, you wouldn't have experienced that, would you? MONIKA: No. I: Did you grow to like it in the end? MONIKA: Yes. (BOTH LAUGH) I: Okay. So, what was the reason for coming to England? MONIKA: My parents came to work. I: OK. So, what was your relationship like with your brothers and sisters? MONIKA: (PAUSE).Well, it was (LONG PAUSE) It was, it was alright. Well, with, with me…I was the sort of person my parents didn't like that much, do you know what I mean? I: sorry, I had difficulty hearing you. You were sort of what sorry? MONIKA: I was the one that my parents didn't like that much. I: Okay. MONIKA: You know what I mean so… I: Tell me more about that. Why didn't they like you? MONIKA: I don't know. She just said I was the worst child she's got. She told this woman in front of me anyway. I: Oh. And how old were you? MONIKA: And she had a favourite who she liked the most and who she…may get punished all the time even though it weren't their fault and things like that.	*Dismissing negative emotion* by laughing Inability to talk about relationship with siblings. *Difficulty answering the question.* Difficult relationship. Talked about relationship with parents not siblings. *Blaming herself for parents not liking her, felt unloved?* "I was the one," "didn't like" *Giving limited information, expecting interviewer to understand* Wanting to know more as Monika gave limited information *Referring to mother (she not mum),* worst child, difficult relationship with mum? This women *telling strangers* Punished as a child Dismissed question, favourite, parents' categorised children, no unconditional love? Envious of the favourite one? Always got punished, odd one out?

97) Strict upbringing (98-99) Physically abuse as a child (102-105) Physical abuse impacting on social development and self- esteem (113-116)		And it was always me. I: Was that just mum or dad as well? MONIKA: Mostly mum. She's sort of told him to beat me or something because I'd been bad or talked too much or what not. I: So, she told your dad to beat you? MONIKA: Yeah. I: Alright. Did mum ever beat you? MONIKA: No, she always tell my dad to do it. I: And dad would beat you? MONIKA: Yeah. I: For what reasons would dad beat you? MONIKA: Because we talk when not supposed to (LAUGHS) I: Gosh. And when you say beat you, what would he do? MONIKA: He would get like electric cable and things like that and the belt buckle or things like that. You know, really a bad beating 'til you're cut up, cut and all the stuff like that. I: And did your other brothers and sisters experience that at all? MONIKA: Yeah, they did. I: Yea MONIKA: But my mum always said, "Don't beat this one," or, "Don't do it to that one." You know what I mean? I: Oh. And how did that make you feel? MONIKA: It made me feel bad because I don't think we really deserved it you know.	Abusive relationship with mum. beat me. Belief "I am a bad person" – deserve to be punished, justifying mums bad behaviour? *Verbal abuse from mum* Physical abuse from dad following mum 's command Physically abused as child – development of negative image, illness? Wanting to know reasons *Little act for severe punishment. Strict upbringing, strict rules* *Using humour to cover negative emotions* Description of materials used to beat Monika Severe beating, "until you're cut up" sense of anger in description, no obvious emotions – tying to cover up emotions? Collective experience, Controlling mother Mum having control of who got hurt, choosing which child will be hurt Feeling inferior, hurt, punishment unjustified Bad, *talking as a collective, strong belief that her and her siblings did not deserve to be hurt*, extreme punishments for behaving like children

Appendix K: Participant list of emergent themes

Monika: Final list of themes

1) Negative experience of being mothered
    - emotional poverty: parents perceived as strangers (122-129, 160-163, 165-168)
    - Own experience of physical abuse as a child 89-97, 102-105
    - felt Unloved and victimised as a child 76-87, 84-87, 142-144
    - Development of negative and inferior self, 113-116, (122-124, 292-294, 872-873 (unable to form close relationships), 1015-1022
    - Determination to parent children differently to own parenting experience 1000-1011, 990-993 1000 - 1011

2) Challenges of being a mother with a severe mental illness
    - Absent mother, 486-489, 509-512
    - Controlled by illness 603-606, actions driven by a "force" 412-422, 424-426
    - inability to cope with illness 622-623, 797 -802
    - Misunderstood by children 431-434
    - Emotional and physical disengagement from child 487-489, 1386-1396
    - Trapped by illness and hospitalisation, 514-521, 1217-1222, 1226-1228), Trapped: disliked hospital environment 514-520
    - "Neglecting" children (during illness) 1364-1368
    - Schizophrenia reduces self-esteem in role as a mum 1275-1278
    - Schizophrenia has negative role on social functioning and parenting 1317-1320, 1322-1325, 1349-1353, 1442-1454, 1349-53
    - Hospitalisation increasing anxieties about children's acre 1156-1157
    - Feel like a failure in parenting role with illness 1275-1278
    - Illness makes parenting role "worse" 1301-1303
    - Schizophrenia has a negative effect on role as mum: Schizophrenia is bad 1442-1454, not knowing is scary 1147-1450

3) Positive Experiences of parenting
    - Enjoyment in nurturing children 710 – 716
    - Secure/close relationship with own children 642-658, 673-675, 275-278
    - Proud of children 860-861, 967-971
    - Care and support from children 679-683, 1290-1293, 912-916, 921-922, 1279-1285, 1378-1381
    - Parenting role is the "best part of life" 868-869
    - Accepted by children 921-925
    - Pride and enjoyment in being a mother 711 – 713, 723-725
    - 842-850 communication enhances positive relationships
    - Sense of purpose in parenting role 887-891
    -
4) Finding strength 1036-1044,1059-1064, 1079-1084, 1237-1241, 1244-1248, 1250-1255, Resilience and inner strength (to cope with parenting role and domestic abuse (730-742), resilience and inner strength (a need to prove self) 1059-1064, 1069-1073, 1081-1084

5) Support
    - Sibling support versus yearning for parental support 1094-1097, 1194-99
    - wanting more support with parenting role 370-373
    - Anxiety about services taking children away 1168-1175

Appendix L

Example of master themes

1. Negative experiences of being parented

Own mother-child relationships

Fiona: if something goes wrong or if something goes missing out the house (PAUSE) and my mum wanted to know who it was she'd beat us all seven of us
I: she'd beat all…?
Fiona: all seven of us
I: all seven of you. Who did the, so who, who'd beat you more?
Fiona: me mum
I: your mum
Fiona: mum did all the beating not me dad
I: Ok and how often would you get a beating?
Fiona: it depends really at times when things go wrong in the house especially when things went missing, money (120-131).

Fiona: How would you describe your mum and dad?
Fiona: They were strict
Interviewer: They were strict? In what way?
Fiona: We used to get beatings.
Interviewer: …Why would you get a beating?
Fiona: If something goes wrong or if something goes missing out the house (PAUSE) and my mum wanted to know who it was she'd beat us all.

Fiona: She'd beat all of us
Interviewer: …What was that like for you?
Fiona: I think it affected me at school really coz I was always a serious person…don't laugh very much…shy, never talked much…so it did affect me at school, the way I was brought up (Fiona 135-149).

Monika: She had a favourite who she liked the most and who she…may get punished all the time even though it weren't their fault and things like that. And it was always me.
I: Was that just mum or dad as well?
Monika: Mostly mum. She's sort of told him to beat me or something because I'd been bad or talked too much or what not.
I: So, she told your dad to beat you?
Monika: Yeah.
I: Alright. Did mum ever beat you?
Monika: No, she always tell my dad to do it.
I: And dad would beat you.
Monika: Yeah.
I: For what reasons would dad beat you?
Monika: Because we talk when not supposed to (LAUGHS)
I: Gosh. And when you say beat you, what would he do?

Monika: He would get like electric cable and things like that and the belt buckle or things like that. You know, really a bad beating 'til you're cut up, cut and all the stuff like that (69-84)

I: For what reasons would dad beat you?
Monika: Because we talk when not supposed to (98-99)

Julia: … I mean I remember going into erm BHS and my mum putting coat on me and a coat on my sister and telling us to go, go down the stairs and out, out, so me being, that has affected me psychologically.

Julia: We went to church so I knew how evil I was (LAUGHS)…
Interviewer: …why have you called yourself evil?
Julia:…because of my mum shoplifting and you know if, if we went shoplifting and she was there and she would be like, you could hear her, she say "oh go over there and do this or do that" so I contributed to it while I was older, but I got to an age where I say "no I'm not doing it it's wrong" (Julia 185-195).

Monika: They bought me up with this feeling that nobody likes you… (Monika).
Monika: In my childhood… my parents sort of singled me out like that, saying that I was the worst kid she's got...sometimes when things went wrong it wasn't my fault, I'd still used to get the beatings for it and she would say, you can beat this one but not beat that one. I wouldn't do that because it messes up your child's mind...when you're growing up, you feel inferior and things like that. And I says I'm not going to do that because probably in life, probably my children will be doing things that I've achieved… I've achieved anything in growing up my children. So, I mustn't make a mess of it (Monika, 1000-1011).

Conflict between negative maternal relationships and needing support once a parent

Julia: I wanted to be more positive
I: Yeah
Julia: I wanted Edith to be able to say no
I: Yeah
Julia: And not be a yes person (1363-1367)

Julia: Ermm, I didn't want, my mum to bring up my daughter and have
her have the negativity that my, that was put in my ear
I: Right
Julia: All my life from my Mum (1358-1361).

Julia: (PAUSE). Ermm, I saw other, other mums, whose children, on
the ward whose children were with, were with foster carers and… been adopted, other moms on the ward and their kids being brought to
visit them so I was very grateful to have my Mum and my sister looking after my daughter (1879-1884).

Monika: Because I made sure, I wasn't the type of

mother that sort of like bought them expensive things. I would rather…had quality time with them. We can't go to the pictures. We just sit in the settee, cover and the quilt, buy popcorn, have a drink, watch the TV, and we all pretend we're at the pictures and things like that (930-935).

Monika: They brought me up with this feeling that nobody likes you… Your parents don't know how to treat you like you're special, you're going to grow up just feeling like nobody's going to treat me special. And you don't think yourself as being special. So, you grow up with this inferiority complex and you don't get on with people very well because you feel…you don't feel like you're good enough (Monika).
Monika: I feel really gutted because if it was up to me and I was in a good frame of mind and had a younger child, I would have looked after them (1206-1208).

I: would your parents have been more, just as involved if you did not have a mental illness?
Fiona: no they wouldn't have been involved.
I: right and is that, so has, so has the, so the reason that they've, correct me if I'm wrong, so the reason that they got involved… so why did they get involved, was it because you had schizophrenia?
Fiona: yes
I: so if they didn't, if you didn't have schizophrenia they would not have been that involved?
Fiona: no
I: so has having schizophrenia…is that a positive then about having schizophrenia or would you have rather not have them involved?
Fiona: I didn't want them to be involved (1870-1883).

Fiona: because if it wasn't for my parents I couldn't be a mother.
I: why, if, why, why not?
Fiona: I would have loose me kids
I: you would have lost your kids?
Fiona: yes
I: and was that because you had a mental illness?
Fiona: yes
I: why would you have lost your kids?
Fiona: I was, I was in a bad way. I would have loose them if it wasn't for me parents.
I: why, why would you lose them?
Fiona: I would.
I: why?
Fiona: I was in no fit state to look after them (1642-1655).

Appendix M: Theme extracts

Theme	Extract
<u>Superordinate theme 1: Negative experiences of being mothered</u> 1a. Own mother and child relationship	Fiona: If something goes wrong or if something goes missing out the house (PAUSE) and my mum wanted to know who it was she'd beat us all seven of us I: She'd beat all…? Fiona: All seven of us I: All seven of you. Who did the, so who, who'd beat you more? Fiona: Me mum I: Your mum Fiona: Mum did all the beating not me dad I: Ok and how often would you get a beating? Fiona: It depends really at times when things go wrong in the house especially when things went missing, money (120-131). Monika: She had a favourite who she liked the most and who she…may get punished all the time even though it weren't their fault and things like that. And it was always me. I: Was that just mum or dad as well? Monika: Mostly mum. She's sort of told him to beat me or something because I'd been bad or talked too much or what not. I: So, she told your dad to beat you? Monika: Yeah. I: Alright. Did mum ever beat you? Monika: No, she always tell my dad to do it. I: And dad would beat you. Monika: Yeah. I: For what reasons would dad beat you? Monika: Because we talk when not supposed to (LAUGHS) I: Gosh. And when you say beat you, what would he do? Monika: He would get like electric cable and things like that and the belt buckle or things like that. You know, really a bad beating 'til you're cut up, cut and all the stuff like that (69-84) I: For what reasons would your dad beat you? Monika: Because we talk when not supposed to (98-99)
1b. Conflict between negative maternal relationships and needing support once a parent	Julia: I wanted to be more positive I: Yeah Julia: I wanted Edith to be able to say no I: Yeah Julia: And not be a yes person (1363-1367) Monika: They brought me up with this feeling that nobody likes you… Your parents don't know how to treat you like you're special, you're going to grow up

	just feeling like nobody's going to treat me special. And you don't think yourself as being special. So, you grow up with this inferiority complex and you don't get on with people very well because you feel…you don't feel like you're good enough (Monika). Julia: (PAUSE). Ermm, I saw other, other mums, whose children, on the ward whose children were with, were with foster carers and… been adopted, other moms on the ward and their kids being brought to visit them so I was very grateful to have my Mum and my sister looking after my daughter (1879-1884). Monika: Because I made sure, I wasn't the type of mother that sort of like bought them expensive things. I would rather…had quality time with them. We can't go to the pictures. We just sit in the settee, cover and the quilt, buy popcorn, have a drink, watch the TV, and we all pretend we're at the pictures and things like that (930-935). Julia: Ermm, I didn't want, my mum to bring up my daughter and have her have the negativity that my, that was put in my ear I: Right Julia: All my life from my Mum (1358-1361). I: Would your parents have been more, just as involved if you did not have a mental illness? Fiona: no they wouldn't have been involved. I: Right and is that, so has, so has the, so the reason that they've, correct me if I'm wrong, so the reason that they got involved… so why did they get involved, was it because you had schizophrenia? Fiona: Yes I: So if they didn't, if you didn't have schizophrenia they would not have been that involved? Fiona: No I: So has having schizophrenia…is that a positive then about having schizophrenia or would you have rather not have them involved? Fiona: I didn't want them to be involved (1870-1883). Fiona: Because if it wasn't for my parents I couldn't be a mother. I: Why, if, why, why not? Fiona: I would have loose me kids I: You would have lost your kids? Fiona: Yes I: And was that because you had a mental illness? Fiona: Yes I: Why would you have lost your kids? Fiona: I was, I was in a bad way. I would have loose them if it wasn't for me parents. I: Why, why would you lose them? Fiona: I would. I: Why?

	Fiona: I was in no fit state to look after them (1642-1655). Monika: I feel really gutted because if it was up to me and I was in a good frame of mind and had a younger child, I would have looked after them (1206-1208).
Superordinate theme 2: Challenges of being a mother with a severe mental illness 2a. Parenting role exacerbates symptoms of illness 2.b Experience of Psychosis challenges parenting role	Fiona: Coz I remember I have my family and the children, I aint got no time for me self. It's like I'm only doing things for them. I didn't have time to watch telly I: and why was it important for you to have time to yourself? Why, what, why was that important for you as a person, what did it, what did it… Fiona: Coz I wasn't spending much time for me self I: And why was that important, why did you need to spend time on your own? Fiona: To look after me self properly (1923-1932). Fiona: Being ill and having kids around you is not, is not easy coz the kids can make you become ill especially if they are young and you aint got no support like your family (Fiona 2129-2131). I: Okay (PAUSE). How do you think your, your voices helped you to develop your relationship with your child? Naureen: Not good. I: No? Naureen: No. I: What…what wasn't good? Naureen: I couldn't have no relationship with my child. I: No. Naureen: No. I: In what way? How…how couldn't you have a relationship? Naureen: I was…I was, um (PAUSE) I was on my own with my voices. I: Okay. Naureen: I didn't want to know my children (1587-1599). Naureen: I couldn't look after the children (when experiencing the voices and being a mum) (1499). Monika: (PAUSE) Maybe after having being ill, trying to get back to being better to show, to prove to them that I can be alright, I can get better. It must be really bad for a parent to be like that. You've got your children and then afterwards, they've got to hear people talk and say, your mum's this and your mum's that (1059-1064). Monika: (PAUSE). Well, sometimes when you have when you have a breakdown, sometimes when, when you've recovered sometimes, it can make you a bit stronger. And you're thinking about certain things (1244-1248). Naureen: No, it didn't help me. Just…just make me worse. I: Okay. (PAUSE) how did you cope with it? How did you cope with having these voices and being a mum? Naureen: I couldn't look after the children (1496-1499).

2d. Role reversal and misunderstanding	Marjorie: I was just feeling that I was unwell all the time, uh, that I couldn't look after Debby, sorry, Tom or Sheila, well I didn't have Sheila if you remember, so I couldn't look after Tom. So Samantha my sister, she took Tom and looked after him for me (953-956). Marjorie: Debby was sitting right beside me I: Yea Marjorie: And just getting her and… I: And doing what to her? Marjorie: Putting a pillow over her head, or something like that (1355-1359). Interviewer: So what was the reason that you went to live with Harry? Marjorie: Because I couldn't cope…with the child…I couldn't cope, it was too much for me (753-758). I: Do you think you've changed in your role as a mum after you heard the voices? Naureen: No then I had this injection, this injection made me sleepy all the time (1488-1491). I: No. But how did you cope with the feelings you were having about yourself, the tiredness, the lack of concentration? Naureen: It's terrible. I: How did you cope? Naureen: I just lied down all the time and all. Now, my daughter comes. She said, "Give me the food." I said, "Go make it yourself" (1500-1505). Naureen: Well, they're looking after me now anyway (1132). Monika: yea. She's the one that cares for me when I'm sick, when I'm ill. Because she says she wouldn't let me go out without putting my make up on before I go (679-681). Monika: And my daughters and son used to get upset and all of the things like that because they couldn't understand and things like that, going and making a fool of myself, and things like that (431-434). Fiona: well I remember one day I was at home with Emma and Ian. And they saw me my illness what was going on. They didn't understand. They just saw me doing certain things I: What were you doing? Tell me Fiona: I can't remember, they were watching me. I: You can't remember what you were doing? Fiona: No, and then they went and got me mum (1729-35).
3. Powerlessness 3a. Powerless in relation to mental	Naureen: Voices, I couldn't help the voices (1659).

illness and mental health services	Julia: But all I remember is my mom coming for Edith whenever I'm in that, whenever I've reached that stage and then the services coming for me then I'd be in hospital (1490-1492). I: Is there anything that you would do differently? Monika: (LONG PAUSE) I don't know about that. Would I have had a choice though? Probably there wouldn't have been a choice if I could have done anything different. You know, I don't think there would have been because (PAUSE) that I really could have done differently (1217-1222). Monika: It was horrible. I didn't want to be there (hospital). Because I liked I liked to be out in the fresh air and things like that. And the other people there…oh, people. Because I, I didn't really like to be around people whether they was ill or whether they was alright. I just liked to be on my own with, in my own comfort zone, just me and my family, you know (514-520).
3b. Controlled within romantic relationships	Monika: Well, when I left him, he came to Brighton to find me. He said, when I find you, well if I, he told somebody when he finds me, he's going to kill me or something like that. When he found me I thought…when he came to the house, I opened the door, I didn't realise it would have been him. He came in and I was so scared (359-364). Monika: I stayed there because when he used to keep beating me up, I went home and I asked my mum if I could move back in because he was beating me up and things like that. And she says, she says "No." So, I had to stay there. And when he went to prison, then I left (257-261). Naureen: She wouldn't give me my daughter back (1172).
3c. Lack of autonomy in parenting role and choices	Naureen: from a young age, coz I went to India, I didn't want to take my younger daughter to India in case she get sick, so I leave her, left her with my sister in law I: ok Naureen: and then she wouldn't, I came back and she won't give me back I: why not? Naureen: she wanted to keep her (233-240). Naureen: So my son missed his sister because they were the same age. I: And what was that like for you? Naureen: Uh, I didn't like it. I: And so, what did you do? You didn't like it. So what did you do? Naureen: She wouldn't give me my daughter back. I: No. Did you do it anything to help your son? Naureen: I couldn't help my son. I: No. Naureen: Hm. I: Okay. Why couldn't you help him? Naureen: How could I help, because he needs someone to play with the same age

3d.Taking control	(1174-1178). Fiona: So this is why, when I found out where I was (SHORT PAUSE) I used to break out (of hospital) I: What do you mean? Fiona: Come out in me night clothes, because it was just there at the back of Doris road off Shaw road I: So you used to leave the hospital? Fiona: And go to me mum and dads I: In your night clothes? Fiona: To be with me kids I: In your night gown? Fiona: In my night clothes, bare feet and the police would come for me I: How often would you do that? Fiona: (LAUGHS). I just did I: Why? That might sound like a really silly question Fiona: Because I was under pressure, I didn't want to be (inaudible 40.25) I: And what was making you go home? Fiona: To be with me kids (815-831). Fiona: All I wanted, I, where, where they put me at the time, I think it was on a lock up ward, I wanted to get out, and the only cure was to jump through the window (1500-1502).
4a. Happiness, pride and purpose	Fiona: Because my eldest daughter, I grew her up at home, until it was time for her to go to nursery and school, and she was reading at the age of two, like two years old (887-889). Monika: I had a good relationship with all my children. And Mary as well, because (PAUSE) I felt proud of my children. I love them (860-861). Julia: Mum would say oh you know Edith would take her videos out and put them back in to the right, er, my mum thought Edith could read or she was a genius but it was just games that we used to play, I'd just put them back into the correct case and put them things like that and she did art and she went to to do a national diploma (1501-1506). Monika: Well, I'm proud of myself because I brought up my children to be caring, understanding people (1237-1238). Julia: Taking overdoses and I remember getting needled once, injecting myself with needles, thinking I could inject myself and kill myself, I remember being in the bath and flinging the fire in, sitting with the fire plugged in in the bath and the water coming up to the electric bar, then it went out, so in them days, I took, as I say, I didn't care if I lived or died, but I stopped all that when I had Edith… (826-831). I: Ok, why, why did you, why were there so many suicidal attempts, what, why,

4b. Finding strength 4c. Close and supportive children	why did you want to end your life? Julia: I had no life, I wasn't working, erm, I had no friends (834-836). Monika: My mind sort of tells me, if I'm not going to be strong for myself, I have to be strong for them because they need me…even if I'm ill sometimes, I'll try to get better quick because I don't want them to suffer, not having me there, they need me because they've got nobody else (1037-1044). Monika: my daughters and son used to get upset and all of the things like that because they couldn't understand and things like that, going and making a fool of myself (431-433). Naureen: Well, they're looking after me now anyway (1132). Monika: They just accept me for who I am (921). Fiona: But even though they know about my illness it's made them close to me (1860-1861). Monika: Probably, it made my children be a bit closer to me because they're more caring because they're more caring because of the situation (1283-1285). Monika: (PAUSE) I've valued, I've valued because like I, I, I'm ill, like I was ill. Um, like, um, instead of them being…thinking really bad thing about it, they've been really supportive towards me (912-915). Monika: It's sort of they just accept me for who I am. I'm still the mum that they enjoyed (921-922). Fiona: Well some of their kids would hate their mum but they never (1848-1849). Fiona: bringing up me daughter at the age of 7, she was scared of me. I: Mia is this? Fiona: yea I: ok. What, was, what was she scared of? Fiona: to see the way I was. I: tell me about the way you were because you've mentioned that a few times Fiona: coz I remember when I went to me mums, that's when, I break a bottle (1672-1680).