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**Managing to be intimate:
Trying to find the balance in research
and therapeutic practice**

Submitted by

Deborah Kemp

**Professional Doctorate in Counselling
Psychology**

City University

March 2013

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Acknowledgements

I would like to take this opportunity to firstly thank my research participants for your generous contribution to my research project. I have felt moved and inspired by your wisdom. I hope that I have honoured your words and presented a good enough account of your experiences.

My course colleagues have been an amazing source of friendship, support and challenge over the three years of the doctoral programme. I would like to give you a special thank you. I have felt energised in your presence and you have helped give me strength and the self-confidence to proceed.

I would also like to thank the City University staff for your kindness, advice and support during the research process and the Doctoral Programme as a whole. In particular, I would like to thank my research supervisor, Dr Deborah Rafalin, for your inspiration, motivation, challenge and helpful feedback. The supervisors of my work placements have also contributed so much to my personal development and confidence over the course of the Doctoral Programme. I would like to thank them and, in particular, Dr Kate Scales.

Finally, I would like to thank my partner, family and friends who have been a constant presence for relief, escape, inspiration and hope. Thank you for your belief in me, helping me to keep on track and to prioritise.

City University Declaration

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Abstract

This portfolio presents my qualitative research, which used Interpretative Phenomenological Analysis (IPA) to explore mothers' experiences of having an adult daughter in personal therapy through nine semi-structured interviews. Mothers were unanimously supportive of their daughter's therapy and identified generally beneficial, if limited, outcomes. They reported increases in their daughters' anger and criticism towards them and improvements in closeness and communication. Theorising and questioning activities about the cause of their daughters' difficulties and her need for therapy were common sense-making processes, underpinned by feelings of guilt, anxiety and confusion. Forgetting, accepting, focusing on progress, negotiating intimacy with their daughters and regulating information-sharing with others are examples of how mothers managed the process. A dynamic cycle of discussion with their daughters and personal reflection sometimes led to re-evaluation and changes in mothers' behaviour, attitude and self-awareness. From the findings I highlight the complexity and suggest ways that mothers and daughters can be better supported. Transferability issues that must be taken into consideration when applying the findings and areas for future research are also discussed.

As a Trainee Counselling Psychologist, I have resonated with the challenges of *self-acceptance*, *use of self* and *struggles with authenticity* and *finding a good enough balance*. These themes tie the research together with a publishable paper and client study. The publishable paper is my attempt to synthesise the findings from my research for the audience of the *Journal of Family Therapy*. I address the ways in which mothers manage the process of having an adult daughter in personal therapy and how these findings could inform individual and systemic practice. The client study presents an integrative and relational therapeutic approach with Nathan, a client diagnosed with Bipolar Disorder, who struggled with feelings of inadequacy. I explore the process issues of avoidance, parallel process and fluctuation in mood, and critically evaluate how I have developed professionally.

Preface

Within this portfolio, three components come together to mark my journey of professional and personal development, research discovery and reflexivity.

I will firstly present my doctoral research, which explored the mother's experience of her daughter's therapy and how she manages this process (I use the term therapy and therapist throughout this portfolio to refer to a range of different counselling and psychotherapy ventures, and systemic, psychological, counselling or psychotherapeutic practitioners). Interpretative Phenomenological Analysis (IPA) (see Smith, Flowers & Larkin, 2009) was used to attempt to gain access to the unique meanings of nine mothers, who generously shared their emotional and relational experiences with me.

I found that mothers were generally very supportive of their daughter's therapy. They shared experiences of improvements in the relationship but also acknowledged their struggles to manage their changing relationship with their daughter, in terms of intimacy and power. Theorising and questioning activities regarding the daughter's difficulties and her need for therapy appeared to form a significant part of the experience for some mothers, underpinned by feelings of powerlessness, confusion, guilt and sadness. A pattern of post-therapy discussions with daughters, followed by self-reflection and re-evaluation, describes a process augmenting personal change for some mothers. Changes took the form of increased self-awareness, empathy, tolerance and behavioural change. Contributions to the extant theory and literature are discussed in this component, as well as quality and transferability issues and contributions to counselling psychology practice.

The second component of this portfolio is a publishable paper, detailing certain aspects of my doctoral research, titled: *A qualitative study of the mother's experience of having an adult daughter in therapy and how she manages the*

process. I chose to present this paper because I think that it holds helpful insights for therapeutic practice that can add to existing research that informs about working therapeutically with mothers and daughters. I focus upon the different ways that mothers managed their daughter being in therapy, highlighting their sense-making activities, cognitive coping-strategies and ways of managing relationships. I also refer to the finding within my research that the mothers differed in their responses to their daughters' stories and the mediating role this appeared to play in determining personal growth for mothers. Socio-cultural factors influencing the mothers' experience of having a daughter in personal therapy and how they managed the process are also acknowledged. Recommendations for practice are included, with particular reference to systemic practice (e.g. Bowen, 1978) and mindfulness techniques (Linehan, 1993).

The final component of the portfolio is a clinical case study titled: *Managing the use of self within the therapeutic relationship*. I present the case of Nathan, a client with a diagnosis of Bipolar Disorder, whom I saw within a psychological secondary-care setting. In this piece of work I reflect upon my developing use of self, my attempts to take risks in order to connect with Nathan, and the tensions, struggles and dilemmas that arose as a consequence. Helping Nathan to find a balance in his life, and alternative ways of managing his fluctuating moods and levels of confidence, also enabled me to reflect on the parallel process – as I struggled with my feelings of inadequacy and the “imposterism” (Clance, 1985) that I felt about myself as a developing professional.

Self-acceptance

I valued my participants' attempts to share openly with me their relationships with their daughters, their unrelenting support of their daughters and, in some cases, their self-doubts and emotional pain that arose as a result of their daughters being in therapy. I felt aware of how mothers understandably fought against their feelings of inadequacy and what could be interpreted as their internalised scripts of mother-blame, in order to maintain their self-compassion and their identities as “good enough mothers” (Winnicott, 1962). For mothers who appeared to be experiencing significant life stressors, or who struggled with intimacy in the

mother-daughter relationship, self-protective measures were sometimes sought. Indeed, mothers shared an array of coping skills that they utilised in order to manage their experience of their daughter being in therapy, highlighting the resourcefulness and resilience of these women, as well as the range of different experiences of therapy and meanings attached to it.

In my work with Nathan, exploring his coping mechanisms – helpful and unhelpful – and contributing to his repertoire was essential for the development of his self-confidence and self-efficacy. His struggles to manage his sense of failure, self-loathing and inadequacy were ongoing. Yet, for the first time during his therapy, these painful experiences were heard in-depth and I strongly attempted to respond to them with compassion.

My research and clinical practice has bought my attention even more closely to my own resources for coping with familiar “stories” of inadequacy, the ongoing nature of these stories and how I can be mindful of them (Harris, 2007). These stories can influence my work as a therapist and as a researcher, sometimes preventing me from taking therapeutic risks and adding to the “muddy ambiguity” involved in the process of reflexivity during research (Finlay, 2002).

Use of Self

In the research, mothers seemed unsure about the extent to which they wanted to know and be known by their daughters. Ambivalence about closeness, and struggling to hear their daughter’s pain, were other related themes that appeared to lend themselves to an overarching theme of use of self or perhaps struggles with authenticity. These themes resonate for me in terms of my personal process as a Trainee Counselling Psychologist and have influenced my awareness of the co-constructed nature of the research process. For example, I have become more aware of the complex interpersonal dynamics that may have evolved within the “research couple” (Rizq, 2008) and affected the encounter, especially given the potential for mother-therapist and mother-daughter transference relationships.

These themes also came to life in my work with Nathan, a man for whom intimacy was understandably risky and associated with loss and pain. Managing the intimacy and being able to truly use myself in the work with Nathan involved

complex reflection and re-evaluation. It meant not only confronting issues of avoidance with Nathan, but also addressing my feelings of sexual attraction, relationships in my personal life and utilising supervision and personal therapy in order to explore in more depth my own fears around intimacy.

Finding a good enough balance

The theme of “finding a good enough balance” seems to resonate on a number of levels within my research practice, research findings and clinical practice. For the mothers in my research, finding ways of managing their relationships with their daughters appeared to involve finding a balance between self-protection and closeness. Both of these aspects seemed to be equally important and to involve some tension and ambivalence. Finding a balance between acceptance and challenge during discussion with their daughters also stood out in the mothers’ accounts. Even if mothers did not agree with their daughters’ version of events entirely, it seemed to be beneficial for mothers to be able to accept their daughters’ different perspectives and to find meaning and insights from them.

This area relates to my therapeutic work with clients such as Nathan, as hearing and validating the individual’s unique, subjective experience is crucial. At the same time, being able to challenge and offer alternative perspectives can be equally important. Holding different perspectives in mind, including those of different parts of the person, as well as those of other present or absent-but-present family members, involves finding a balance, or a tolerance of plurality and ambiguity , which is key to the practice of counselling psychology (Cooper & Mcleod, 2011; Kasket, 2012). I have discovered that similar approaches are necessary during the research process (Rafalin, 2010). For example, it has been necessary for me to hold the multiple stories of the participants in mind, to identify similarities and differences between accounts, and to present an account that finds a good enough balance between these stories and a good enough balance of description and interpretation based upon these stories.

My work with Nathan has been another example of how I have struggled to find and to accept a good enough balance in my approach as a Trainee Counselling Psychologist. In particular, it has been challenging to find a balance between using

my knowledge to help teach Nathan new techniques but also to stay with Nathan's painful experiences and to convey that his experiences are tolerable. This piece of work has been particularly transformative as it has enabled me to discover more about the kind of Counselling Psychologist that I aspire to be, and helped me to become more appreciative of and confident about the knowledge and expertise that I already have to offer.

The themes of self-acceptance, use of self and finding a good enough balance are important aspects of my personal and professional development, and are also highly relevant to the existential experiences of my clients and research participants. Therefore, these themes tie together the three aspects of this portfolio into a whole, representing my learning and my professional contribution to the field of counselling psychology thus far.

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Chapter 1: Doctoral Research:

The mother's experience of having an adult daughter in therapy and how she manages the process

1.1. Introduction

Within psychological discourse there is a movement away from understanding humans on fundamentally individualistic terms, and a greater movement towards the appreciation of human inter-subjectivity and “being in relation” (Boston Change Process Study Group; 2010; Fox, 2012; Mearns & Cooper, 2005; Sugarman, 2010). This holds relevance for psychological therapies as the context of therapy, in particular, the family environment, is inextricably intertwined with the individual in therapy. There is increasing concern in the therapeutic arena about how an individual's therapy impacts upon significant others and is impacted by the external context (Social Exclusion Taskforce, 2008; Lemma, 2003; Wagstaff, 2010). Furthermore, national guidelines about involving family members and carers in adult treatment in service evaluation and research emphasise the importance of psychologists listening to parents who informally care for their adult-child with mental health difficulties (Mental Health Research Network, 2012; National Treatment Agency for Substance Misuse, 2008).

The individual's relationship with their mother has been central to psychological theory and practice since the eve of modern day psychotherapy. It is argued that mothers have been powerfully scrutinised and blamed for the pathogenesis of psychological problems in their offspring in the light of psychological theories of human development (e.g. Sheppard, 2000; van Mens-Verhulst, 1995). In a world that stigmatises mental health difficulties (Huxley; 1993), stigmatises those who seek therapy (Ben-Porath, 2002; Jorm & Wright, 2008) and blames the mother for its cause (Bowlby; 1969; Freud, 1933; Klein, 1952; Winnicott, 1962), what is known about the experience of the mother who watches their adult-child embark upon personal therapy? In particular, what is known about the experience of a mother who has an adult daughter in therapy; the daughter

who represents a part of the mother, both in physical resemblance, and as their “protégé”, as a woman (van Mens-Verhulst, 1995)?

There is a scarcity of knowledge that informs us about the experience of a mother who has an adult daughter in therapy. A key task of my research is to target this gap and to contribute to the body of knowledge acknowledging the mother’s perspective in order for us to better understand and support these women and their daughters. Hearing directly from mothers, and reclaiming the womanhood that has been “silenced” through the expectation to uphold the “mothering ideal” is also recommended in the literature (Nice, 1992).

I stress that I do not want to increase any stigma experienced by daughters by making them feel to blame for their mother’s experience due to their choice to be in therapy. Therefore, like Corrigan and Miller (2004), I want to replace the word *burden* that is used in the literature with *impact* in relation to the emotional impact on family members who have adult-children with mental health difficulties, who may or may not be accessing professional services. I emphasise that I do not associate negativity with anyone choosing to go to therapy. In fact, I believe very strongly the opposite; it is a brave choice to undertake therapy, considering the stigma it holds in society, as well as the common fears about what might or might not be uncovered in the process. Therapy can be an important step towards fulfilling one’s potential and towards understanding family relationships, which I, as a Trainee Counselling Psychologist and as a daughter who has been in therapy herself, am actively encouraging of.

I recognise that by focusing upon the mother’s contribution to their child’s difficulties and precluding the father’s contribution, the main body of literature has upheld “a sexist bias” (Lamb, 2004; Phares, 1992). As I have purely attended to the mother’s experience of her adult daughter being in therapy, I could be accused of being indirectly responsible for reinforcing traditional gender roles which stipulate that mothers are primarily responsible for their children’s well-being and are therefore to blame for their daughter going to therapy. However, from a feminist angle, it could be viewed that in order for the balance of power to shift, there is a greater need for the voice of the oppressed to be heard and complexity acknowledged so that stigma based on limited and prejudicial views can be

challenged. Indeed, the drive for more “women-centred” accounts is underpinned by the desire to validate the experience of women and not to pathologise (Arendell, 2000; Nicholson, 1986). Recognising and celebrating complexity is a key task of counselling psychology research (Kasket, 2012), which I aim to fulfil.

Saying this, I am aware of the important contribution made in the literature that addresses the father’s perspective (e.g. Nystrom & Svensson, 2004) and also of studies that have not segregated mothers and fathers, but have instead presented parents’ accounts of their adult-child’s mental health difficulties and experiences of mental health professionals (e.g. Lindgren, Astrom & Graneheim, 2010). I will discuss in subsequent sections how my methodological decision-making curtailed a heterogeneous participant group (see *Method* section).

From a social-constructionist angle, gender can be viewed as a framework for interpreting how we evaluate others, ourselves and all we encounter, and as a system that changes over time and space (Hare-Mustin & Marecek, 1988). By specifying *mother* – a role that has been described as inherently engendered and engendering (McMahon, 1995) – I hope that through this research something about the psychological position of women, within their socio-historic context, may also be gleaned (Elvin-Nowak, 1999). At the same time, I recognise the importance of understanding the complexities to the label of *woman* and of *mother* and the subjective meanings and experiences inherent within these labels (Sheppard, 2000).

To begin with, I will endeavour to cast the subject matter in the light of theory and research that can help us to understand what it means to be a mother of an adult daughter. I will then describe different theories that are used to make sense of the processes that occur in therapy and during life transitions, which acknowledge intra-psychic as well as contextual factors. Before looking at the existing research pertaining to the experience of mothers who have had children and adult-children in therapy, I will look at the research regarding parents of adult-children who experience mental health difficulties. In advance of introducing my research aims, I will review how my research may help to fill in the gaps in the knowledge base, and discuss the relevance of this research proposal for the world

of counselling psychology and how it could enhance existing knowledge, training and practice.

1.1.1. Motherhood and the mother-daughter relationship

Becoming a mother involves dramatic lifestyle changes and concurrent identity modifications (Smith, 1999; Stern & Bruschweiler-Stern, 1998). These vicissitudes occur against a socio-political and cultural backdrop of expectation about the need to be a “good enough mother” (Winnicott, 1962). There is a substantial literature base dedicated to understanding what it means to be a mother, which I have summarised below within three key bodies of research and theory: “Psychoanalytic and Developmental”, “Social constructionist and Feminist” and “Self-in-Relation”. Within these same categories, I refer to findings regarding the mother-daughter relationship. This relationship has been given increasing attention across the life-course, particularly given the lengthening of life expectancy and the finding that this relationship is often a lifelong bond of support and mutual responsibility (Bojczyk, Lehan, McWey, Melson & Kaufman, 2011; Charles, Frank, Jacobson & Grossman, 2001; Chodorow, 1989; Elder, Kirkpatrick, Johnson & Crosnoe, 2003). By providing this review, I aim to set the stage for focusing upon the experience of motherhood and the mother-daughter relationship.

Psychoanalytic and developmental

Psychoanalytic and developmental theories about the mothering role have centralised the role of security and nurturance in the primary caregiver-child (usually mother-child) relationship as core to healthy physical and psychological growth (e.g. Bowlby, 1969; Freud, 1933; Hershberg, 2006; Klein, 1952; Winnicott, 1962). Disturbance in the quality of this early relationship has been associated with childhood maltreatment (Crittenden, 1992; Schechter, Brunelli, Cunningham & Baca, 2002). It has also been connected with developmental, mental health and interpersonal difficulties (Beatie, 1988; Bowlby, 1969; Freud, 1933; Klein, 1952; Schore, 1997; Winnicott, 1962) and intergenerational transmissions of insecure attachment patterns (Fonagy, Leigh Kennedy, Mattoon & Target, 1995).

A long-standing assumption about the mother-daughter relationship in the psychoanalytic and developmental literature is that it is the most complicated and

problematic of all parent-child relationships (Charles et al., 2001; Firman & Firman, 1989; Freud, 1933; Shrier et al., 2004). An important characteristic of the mother-daughter relationship is that this couple share the same gender and familiar body, which influences the belief that mothers are their daughters' main object of identification and role model, sometimes throughout their lives (Balsam & Fischer, 2004; Beatie, 1988; Fenchel, 1998; Hershberg, 2006; Shrier et al., 2004; van Mens-Verhulst, 1995).

Managing increasing psychological separation and autonomy is said to be a challenging part of the developmental process in the mother-daughter relationship, along with elements of fusion, strong feelings of attachment, connection and mutuality (Beatie, 1988; Shrier et al., 2004). Illuminating the intersubjective nature of the separation-individuation process, Benjamin (1990) suggests that there is ongoing tension between separation and connection. Through recognising the separate mind of another, one experiences recognition, mutual understanding and greater connection. However, in doing so, one has to acknowledge limitations of the self and let go of omnipotence. This complex process may contribute to theory suggesting that mutual identification between mother and daughter results in a two-way intimacy which can be emotionally intense and sometimes highly ambivalent (Beatie, 1988; Firman & Firman, 1989; Freud, 1933). Findings of identification in the mother-daughter relationship have also been found in the qualitative research literature (Bojczyk et al., 2011; Charles et al., 2001).

Much of the early psychoanalytic theories (Erikson, 1950; Freud, 1933) posited that women's rate of development is slower and inferior to that of men because of the difficulty for women in separating and individuating from their mother (although this was subsequently critiqued – see Chodorow, 1978). In describing the "oedipal triangle", Freud (1933) made the point that a strong external intervention (i.e. the father) is needed in order to break the bond between mother and daughter in order to set the daughter up on the road to adulthood. Some link the recognition of the oedipal triangle to the creation of "the third", or the ability to reflect upon yourself in relation to others from an observer's perspective (Britton, 1989) and to appreciate multiple voices (Benjamin, 2009).

Beatie (1988) advises that recognising the particular hazards in psychosexual development for women can help us to understand why women are more prone to developing certain psychopathology than men (e.g. eating disorders, depression), particularly at critical stages of separation from mother and family. She suggests that daughters may struggle to separate and individuate because mothers invest more energy in their daughters than in their sons – as a narcissistic extension of themselves – and so tend to feel more threatened and become more controlling if daughters fall short of their ideals. However, Beatie (1988) also stresses that it is important not to simplistically blame mothers for daughters' "failures in separation and individuation" (p.456) but to understand that causes of all psychopathology are multi-determined.

Charles et al.'s (2001) examination of interviews with 72 mother-daughter dyads identified different groups of mothers utilising Hauser's (1984) definitions of "enabling" and "constraining" mothers. Enabling mothers were described as mothers who communicated acceptance as well as supported and showed interest in their daughters' perspective. Constraining mothers were those who used withholding, devaluing and judgemental behaviours that conveyed negative evaluations of their daughters. Within the constraining group a sub-group was identified that was less actively constraining, which was labelled as "constraining-indifferent" A group of enabling, but situationally stressed and less emotionally available, mothers were also identified. Charles et al. (2001) concluded that the mother's working model of separation-individuation, based upon memories of her relationship with her mother, was part of a "matrix of psychological and interpersonal conflicts within which daughters separate from and attain autonomy in relation to their mothers" (p. 724). Importantly, this piece of research highlighted the absence of homogeneity in mother-daughter relationships. However, by focusing purely upon psychological factors, other factors contributing to the separation-individuation process, such as biological or contextual factors, were left unexamined.

Social constructionist and feminist

For social constructionists (e.g. McNab & Kavner, 2001; Oakley, 1974; Rich, 1977; Sheppard, 2000; Woollett & Phoenix, 1991), women are seen to be conditioned through social institutions and ideologies – mothers are made; they are not born. Psychoanalytic and developmental theories and research are viewed as largely accountable for the derivation of mother-blame and the guilt and shame arising in mothers who feel solely responsible for their child's well-being (e.g. see McNab & Kavner, 2001; van Mens-Verhulst, 1995 & Sheppard, 2000). "Instinctual drives" towards motherhood described in the psychoanalytic and developmental literature have been viewed by feminists as instrumental in establishing the ideology that motherhood is natural, thus pathologising women who remain childless (Woollett & Nicolson, 1998; Woollett & Phoenix, 1991). Sheppard (2000) stresses the need to understand how wider cultural beliefs and ideologies shape the social construction of motherhood and ideas about good parenting, and how this obscures the vision of the social context of parenting. This includes how media representations and social policy responsible for imposing normative expectations of parenting have been informed by "scientific claims to knowledge" within psychological discourse.

Feminist interpretation assigns the finding that guilt is more gender-specific to women (Izard, 1977) to gender role socialisation (Elvin-Nowak, 1999; Gilligan, 1982). In other words, it has been suggested that women's internal sense of responsibility, moral code and identity is founded upon their primary responsibility for family relationships (Boney, 2002; Elvin-Nowak, 1999). Discussions in the research about guilt experienced by working mothers (Boney, 2002; Elvin-Nowak, 1999; Parker, 2005) and divorced mothers (Boney, 2002; Elvin-Nowak, 1999) suggest that their guilt is reinforced through social and religious norms and through work and financial institutions. This leads women to define their self-worth on the basis of upholding gender-roles based upon the dominant socio-cultural script (Boney, 2002). Attempts to be an all-giving mother are said to lead to guilt, depression and, significantly, "loss of self" (Welburn, 1980). Thereby, the social construction of motherhood, defined by historical, social and psychological definitions of the self, permeate the descriptions of self as woman and mother (McNab & Kavner, 2001).

Particularly for women caring for children who have little material or social support, such as mothers with physical disabilities or those from minority groups, mothering has the potential to be an isolating, emotionally damaging experience (Nice, 1992). Single mothers, lesbian mothers and those dependent on welfare are also amongst those subjected to what Arrendell (2000) has termed “deviancy discourses of mothering”, which is said to have a marginalising and stigmatising result. It is argued in the literature that the perception that Western women might have the ability to take responsibility is based on the illusion of freedom of choice and control, where in actuality there are a significant number of barriers to suitable child care and working arrangements (Elvin-Nowak, 1999; Parker, 2009).

In contrast, a piece of recent qualitative research, using Interpretative Phenomenological Analysis (IPA), found that mothers diagnosed with depression actively resisted viewing themselves as all bad (Wagstaff, 2010). Although there were moments where mothers took on the identity of “bad mother”, the availability of more hopeful images of themselves provided counterbalance. All of the women in the study found ways of justifying themselves as mothers, protecting their self-esteem and coping with shame. Given the same sample size (n=5) and their specific characteristics, it is important not to presume generalisability to all mothers. However, this research supports others’ findings (e.g. Arrendell, 2000; Chodorow, 1999; McMahon, 1995), thus highlighting the enormity of the role of motherhood in the lives of women, and that self-esteem may be powerfully wrapped up in the identity of motherhood. This suggests that mothers may be likely to devote considerable energy into managing their identity and the pressures to conform to the “mothering ideal”.

There is concern that by internalising the dominant discourse of “ideal mother”, therapists may passively accept that mother-blaming fits their client’s reality and perpetuate beliefs about mother-blame (Caplan & Hall, 1989). Sheppard (2000) ascertains that findings within psychological research are always limited due to samples over-representing white, middle-class, American mother-infant pairs and the exclusion of socio-cultural contexts. Given the relative ease of material existence for these mothers, she highlights how the results are not generalisable to mothers living different lifestyles. Although self-reflexive and showing an

awareness of the influence of her own experience of mother-blame upon her understanding, it could be argued that Sheppard's account lacks a balanced commentary about personal responsibility in mothering, evident in other social-constructionist accounts of mothering (see McNab & Kavner, 2001). Therefore, she may be in danger of placing women in the role of "victim" within a patriarchal society (see below for further critique of feminist writings).

Refocusing onto the mother-daughter relationship, van Mens-Verhulst (1995) argues that unhealthiness and unhappiness in mother-daughter relationships is due to patriarchy forcing separation and disconnection between mothers and daughters (and women in general). Mothers can be viewed as caught in a paradox between the power and responsibility inherent in the mothering role versus their powerlessness as women in a patriarchal society (Gilligan, 1982; McNab & Kavner, 2001). Suleiman (1988) suggests that the mother splits off her "human part", with its inevitable imperfections, in an effort to preserve her self-respect and self-image as "ideal mother". This leads to self-alienation and physical and emotional exhaustion. This might strain the mother-daughter relationship and avert the opportunity for the daughter to learn about her mother's subjectivity (van Mens-Verhulst, 1995). Disinterest, depression or anger, masking shame and anxiety, may also present themselves as the mother struggles to protect her daughter from knowing about the complexities of womanhood (Sayers, 1993).

Sayers (1993) claims that mothers deny their daughter's pain or anger because they have not received the relationship context that allows them to know or act upon their own painful feelings. Surrey (1993) suggests that due to the mother-blaming culture, mothers take on blame and responsibility and act to try to change feelings rather than encourage daughters to express and become empowered themselves. Identification with the mother may result in the daughter's overdeveloped sense of responsibility for the mother (Surrey, 1993). Surrey suggests that this leads to the building of "cheery denial" and superficiality in the mother-daughter relationship, where both deny each other's pain.

In Stiver's (1991) writings about psychotherapy with adult women, she said that women had conflictual and intense relationships with their mothers, and were likely to be critical of their mothers and struggle against being like them. She cited

Lewis and Herman's (1986) explanation about the foundation of the daughter's outrage towards her mother. Herman and Lewis (1986) suggest that the main source of the daughter's outrage is her mother's devaluation by her father's attitudes and behaviours towards her. This anger about her mother not trying harder to fight against this denigration leads the daughter to "identify with the aggressor" (Herman & Lewis, 1986). Shrier et al. (2004) stress that clinical experience has been used in psychoanalysis to theorise about "normal" female development, rather than viewing these findings within the context of the complexity of cases presented.

Miller (1990) describes how mothers of daughters who had been sexually abused struggle to hear and to acknowledge their daughter's experience, which amounts to a "virtual attack on their daughter's sense of reality" (p.140). In other words, Miller suggests that for a mother to allow her daughter her own point of view, it would be threatening for the mother's perception of herself and of the mother-daughter relationship. Indeed, it is reported that mothers can find it immensely painful to live with the idea of not having been able to prevent their daughter's suffering and experience multiple losses, ongoing guilt and "unhealable" emotional pain rooted in the myth of "perfect mother" (Carvalho, Galvo & Cardoso, 2009; Pretorius, Chauke & Morgan, 2011). Miller (1990) saw the key issue at all times in her therapeutic work with this group of mothers and daughters as, *"whose version of reality [the mother's or the daughter's] is going to be accepted as true?"* (p.139). These findings are illuminated by qualitative research, where it is claimed that mothers emotionally distance themselves from their daughter's emotional distress (Daly, 2005) and separate out their perspectives from their daughter's in order to protect themselves from their daughter's accusations and their own self-blame (Johansson, Anderzen-Carlsson, Ahlin & Andershed, 2010).

Self-in-relation

Self-in-relation theorists (e.g. Jordan, 1991; Miller, 1991; Surrey, 1993) posit that there is a difference between male and female development as the female's primary experience of the self is relational, with interdependence and mutuality being prioritised over separation. Women are seen to value deep empathic

connections with others and to identify strongly with roles that involve enhancing the psychological well-being of others, such as nurturing, caring and mothering (Gilligan, 1982; Miller, 1991; 2008). It is argued that traditional male-dominated models of human psychology (e.g. Erikson, 1950; Freud, 1933) are not applicable to understanding females, nor are they relevant for non-western cultures where interdependence and family connection take precedent over autonomy (Shrier, Hsu & Yang, 1996).

The mother-daughter relationship has been described as the most intense intergenerational relationship in terms of emotional connection and interdependence (Fischer, 1991) and as a powerful connection because of the enormity of aspects of life connecting them (Surrey, 1993). Due to this, it is a tie with boundaries that open and close intermittently, at different times along the life span (van Mens-Verhulst, 1995). Bernstein (2005) stresses that the course of female development is non-linear and that women re-visit, re-examine and re-synthesise representations of “self-versus-mother” and “self-with-mother” over their lifetime. Dahl (1995) suggests that the process of psychic integration of the tie to the mother is never complete and that a hallmark of the adult female psychic organisation is related to the daughter’s ability to allow repeated “reverberations within herself” of representations of the bond with the mother through an ongoing internal dialogue.

Van Mens-Verhulst (1995) and Shrier et al. (2004) highlight the movement from feminist discourse, which places women in the role of victim towards an increasing recognition of agency and acknowledgement of women’s complicity within a patriarchal society. Van Mens-Verhulst (1995) suggests that by attending to the socio-cultural context and holding on to the “mothering” and “daughtering” perspectives, the *“individualisation pitfall”* can be avoided. In other words, there is a risk that blaming the mother for lack of agency or wisdom may result in further propagation of mother-blame. Brown (1990) and Groen (1993) stress the importance of contextualising the mother-daughter relationship and seeing it as a situated dance, influenced by a number of different factors, including family, ethnicity, culture, society and time. Fischer (1986) argues for recognition of the *complexity* of mother-daughter relationships and describes them as “both holding

on and letting go”, urging against viewing them in terms of autonomy and separation or dependency and closeness.

1.1.2. The mother-daughter relationship across the life span

The majority of the literature about the mother-daughter relationship has been about the early years and the late periods of life (Shrier et al., 2004). However, there are consistent findings in the qualitative and quantitative research that there is persistent intimacy in the mother-daughter relationship throughout the life span (Bojczyk et al., 2011; Henwood, 1997; O’Reilly & Abbey, 2000; Rossi & Rossi, 1990). It is suggested that life-cycle transitions in the mother-daughter relationship are characterised by patterns of re-evaluation, re-definition and re-negotiation as mother and daughter attempt to manage changing roles and statuses (Bengston & Kuypers, 1971; Fischer, 1981). I will review some of the research pertaining to the adult mother-daughter relationship, with a focus on young adult daughters and middle-aged mothers, as this is more comparable with the sample I have used in my research (for examples of research regarding the mother-daughter relationship later in life, see Fingerman, 1998 & Lefkowitz & Fingerman, 2003).

Walker and Thomas (1983) investigated the association between intimacy and aid in 132 pairs of younger (young adult daughters and middle-aged mothers) and 107 pairs of older (middle-aged daughters and older mothers) generations of daughters and mothers from the same family. Intimacy was viewed as a multi-dimensional construct, which included feelings of closeness, enjoyment, satisfaction and a feeling that the relationship was important. Proximal aid included helping during illness, advice and shopping. Distal aid included giving money and gifts. They administered mothers and daughters with three questionnaires which measured: a) perception of intimacy, b) frequency of aid and c) frequency of contact. Two multiple regressions on intimacy were performed for each relationship separately for aid and contact.

The findings from Walker and Thomas’ (1983) study suggest that aid and contact are not predictive of intimacy in mother-daughter relationships. Although proximal aid to mother was positively associated with intimacy for both generations, frequency of contact was negatively associated with intimacy. Walker

and Thomas suggest that proximal aid to the mother may indicate a discretionary relationship i.e. that aid is offered because one cares. The authors did not hypothesise why the negative association between frequency of contact and intimacy may be. It could be that this finding indicates that mother-daughter relationships that had more contact experienced more ambivalent feelings involving obligation or worry. Indeed, it has been suggested that frequency of contact is associated with increased conflict across generations (Akiyanna & Antonucci, 1996). As the sample was self-selecting, it may be that only those mothers and daughters with relatively “good” relationships offered to participate. It is possible that as the study was based on two generations of mothers and daughters within the same family, intergenerational patterns of relating may have biased the data.

Recent evidence highlights ongoing asymmetry in the mother-daughter relationship throughout the lifespan, which reflects a parent-child relationship (Bojczyk et al., 2011). When investigated in depth using qualitative methods of enquiry, Bojczyk et al. found that closeness was relatively unidirectional in terms of mother’s influence, modelling and emotional support towards daughter. Along with closeness, Bojczyk et al. found that mothers and daughters acknowledged relationship tensions, which mainly occurred during adolescence. The majority of daughters blamed these tensions upon their mothers being too judgemental, which was in contrast to the perspective of mothers who did not report that their judgement of their daughters was problematic. Both mothers and daughters conveyed ambivalent feelings about separation and individuation. Mothers’ responses indicated “a push/pull conflict”, whilst daughters voiced tensions between their excitements about freedom versus guilt about leaving their mothers.

This was an impressive piece of research as it involved the synthesis of information based on in-depth interviews of 24 mother-daughter pairs (mothers: mean age = 53.38, range = 41-61; daughters: mean age = 25.57, range = 21-38). However, again as this research required both mother and daughter to take part, there may have been a bias towards positive mother-daughter relationships, as more estranged pairs would have been less likely to participate. The researchers acknowledged the impact of life events that influenced the relationships between

mother and daughter, and suggested that future research into such life events would be beneficial. This was mainly in relation to commonly experienced life events, e.g. retirement, menopause. The present research project is concerned with a mother's experience of her daughter being in therapy, which can also be constructed as a life event for both daughter and mother.

Although being in therapy does not necessarily equate with having diagnosable mental health difficulties, it is likely that a significant number of individuals who undertake therapy will have experienced mental health difficulties. In the following section I have reviewed the experience of mothers who have an adult-child with mental health difficulties. This is because for a significant number of mothers who have had an adult-child in personal therapy, it is possible that their experience of their adult-child's mental health difficulties will be inextricably intertwined with this process.

1.1.3. Experience of mothers who have an adult-child with mental health problems

The majority of the literature related to parents who have adult family members with mental health problems focuses on family members with chronic mental health problems (e.g. Johansson et al., 2010; Schwartz & Gidron, 2002). This corresponds to the tendency within psychological research and clinical case studies to focus on "pathological" examples at the expense of the "normal" (e.g. Shrier et al., 2004; Smith, 1999). Although a number of studies about parents who have adult-children with mental health problems refer to "parents", the majority of participants in the studies are mothers (Johansson et al., 2010). It has also been found that mothers who have adult-children with mental health problems are most likely to take the primary caregiving role (e.g. Grandon, Janero & Lemos, 2008).

Worry and ambivalence

Positive and negative emotional experiences (Lefkowitz & Fingerman, 2003), tensions within the relationship (Birditt et al., 2009) and a moderate degree of worry (Hay, Fingerman & Lefkowitz, 2007, 2008) are commonly experienced in parent-adult-child relationships. The emotional impact and ever-present sense of responsibility and worry for their children is a prevalent theme in the literature about mothering (e.g. Elvin-Nowak, 1999) and parenting of adult-children with

mental health difficulties (Johansson et al., 2010; Mohr & Regan-Kubinski, 2001; Pejler, 2001) and chronic physical illness (Rassamen, Dunning, Cox & O'Connell, 2008). The unrealistic expectations and pressures that women place upon themselves to achieve the mothering ideal is reported to have devastating effects on women's self-esteem, health and well-being (Jackson & Mannix, 2004) and can be complicated by feelings of ambivalence about where the boundaries of responsibility for their children are drawn, especially when children reach adulthood (e.g. Elvin-Nowak, 1999).

An adult-child's failure to achieve "normative adult status", (i.e. marital status, educational attainment and employment status) and financial independence, along with the mother's stage in the life-cycle, has been found to be predictive of a mother's ambivalent assessment of the parent-adult-child relationship (Birditt, Lefkowitz, Miller & Fingerman, 2009; Pillemer & Suitor, 2002). Research also suggests that increased ambivalence in parent-adult-child relationships is associated with greater worry (Hay, Fingerman & Lefkowitz, 2008). These findings suggest that mothers who have adult-children with severe mental health difficulties may experience a significant amount of worry and ambivalence.

Guilt, shame and stigma

There has been an important drive towards raising awareness of mental health difficulties, including recent media and political action challenging negative stereotypes and promoting more positive and hopeful images of those with mental health difficulties (e.g. "Time to Change" Campaign launched in the UK in October 2007). Although a 2.4% improvement in public attitude has been reported since the "Time to Change" campaign was launched (Time to Change, 2008), stigma towards individuals that experience mental health difficulties is still evident (Vogel & Wade, 2009).

Social stigma is said to comprise of feelings of fear, guilt and shame triggered during social interactions (Goffman, 1963). Stigmatising "marks" can be visible or invisible and have become associated with negative evaluations and stereotypes (Jones et al. 1984). It is argued that stigma exists when labelling,

negative stereotyping, exclusion and discrimination co-exist within a power situation that allows these processes to occur (Link & Phelan, 2001).

According to Corrigan (2004), stigma influences those with mental health difficulties to hide their concerns and to avoid seeking help in order to prevent the negative consequences of stigma. Separate from stigma attached to those with mental health difficulties is the stigma towards those who seek help from professional services (Vogal & Wade, 2009). Research suggests that people tend to stigmatise someone who is depressed who is seeking help (i.e. view them as more emotionally unstable, less interesting and less confident) more readily than someone who is depressed but not seeking help (Ben-Porath, 2002). For members of the majority group who associate with members of a stigmatised group, research suggests that these individuals experience what Goffman (1963) terms “courtesy stigma” or, in other words, “stigma-by association” (Whitley & Kite, 2010). It has been shown that parents of children with mental health problems experience “courtesy stigma”, which involves an internal sense of shame or embarrassment and discrimination and rejection and avoidance by others who blame parents for causing the problem (e.g. Corrigan & Miller, 2004). For example, in response to negative stereotyping and labelling, parents of adolescents with Attention Deficit Hyperactivity Disorder (ADHD) employ “courtesy stigma management strategies” (such as avoidance or activities aimed at enhancing the social perceptions of others) which increases existing stress levels (Koro-Ljungberg & Bussing, 2009). It could be suggested that parents of adults who seek help for their mental health problems might also experience “courtesy stigma”.

Mothers of children with mental health problems report feeling negatively judged as mothers and made to feel guilty by others, including mental health professionals (e.g. Daly, 2005; Jackson & Mannix, 2004; Johansson et al., 2010; Lindgren, Astrum & Hallgren Graneheim, 2010; Pejler, 2001). They also report feeling guilty about their child’s mental health problems (Jackson & Mannix, 2004; Mohr & Regan-Kubinski, 2001). Researchers have found it hard to separate out the extent to which the mother’s guilt is a result of the messages of blame communicated through the environment, or her own feelings of not being good enough (Jackson & Mannix, 2004; Mohr & Regan-Kubinski, 2001). For example,

Mohr & Regan-Kubinski (2001) describe how parents' narratives about their adult-children with chronic mental health difficulties reveal that they do not entirely buy in to self-condemnation and express that they know that they were not to blame for their child's mental health difficulties. However, shame, self-accusation and negative judgements of their actions or inactions as parents were repeatedly expressed in this study's focus groups (Mohr & Regan-Kubinski, 2001).

In their qualitative study titled, *Giving voice to the burden of blame*, Jackson and Mannix (2004) report that several mothers felt strongly that they were blamed by professionals, including professional counsellors from whom they sought support in order to resolve their family problems. They used words such as "abused", "humiliated", "uncomfortable" and "hostile" to describe their encounters with professional counsellors and told how their experiences impacted upon their engagement with services. It also led them to resist seeking support from friends and family for fear of being blamed. It was reported that in some of the mothers' stories, it was evident that they had internalised the mother-blaming attitudes of those around them and blamed themselves for things that were outside of their control (Jackson & Mannix, 2004).

This persuasive feminist account provides some useful guidance for professionals working with mothers to help foster their engagement with services. The 20 mothers in the sample had children of 17 years old and over and so drew from a number of experiences across their child's lifespan. However, it is unclear as to any differences in their experiences of professional services that they had as a new mother, for example, in comparison to as a parent of a young adult. On reviewing the literature, shame, as used in this research and other research (Corrigan & Miller, 2004), does not clearly delineate whether it is the result of public stigma (i.e. general public avoiding individuals who have family members with mental health problems) or self-stigma (internal sense of shame about having a family member with mental health problems, leading the individual to hide from the public).

The relationship between shame and avoidance is complex (Corrigan & Miller, 2004). Furthermore, the avoidant behavioural response to self-stigma might result in "a self-fulfilling prophesy", as prediction of rejection might lead to

reduction in social contact and loss of intimacy in relationships over time (Sheppard, 2000). To complicate the picture further, research suggests that relatives suffer more due to their concern about their family member experiencing stigma (vicarious impact of stigma) than they do about their own experience of stigma (e.g. Wahl & Harman, 1989).

Intersubjectivity theory suggests that “mutually reinforced stigma dynamics are co-constructed” and “involve the interaction of two or more subjective worlds” (Fox, 2012, p.38). Fox suggests that stigmatisation can “lie between” personal subjectivities, influencing personal meanings and the organising principles of experience. She discusses the relationships between parents of children with mental health difficulties and therapists, where stigmatisation can contribute to ruptures in and disengagement from therapeutic alliances. This highlights that the stigma experienced by parents of adult-children with mental health difficulties is multi-faceted.

Despite the prevalence of stigma experienced by this group, there is less literature to account for the significant number that do not report experiencing stigma. Corrigan and Miller (2004) suggest that the other half of family members, who do not endorse public or self-stigma, may respond to stigma with “righteous anger” or indifference. By restricting individuals to respond to pre-identified stereotypes of stigma (i.e. shame, blame or fear of contamination), the research may limit our understanding of family members that may suffer more as a result of other stigma (i.e. stereotypes about individuals with mental health problems being either incompetent or dangerous) (Corrigan & Miller, 2004).

Different factors have been found to account for the varied experience of stigma amongst family members who care for individuals with mental health difficulties. The role of cultural factors in the experience of stigma has been discussed in the literature. For example, Matthews, Corrigan, Smith and Rutherford (2003) found evidence to suggest that different cultural groups hold diverse perceptions about stigma related to mental health problems. Cultural factors are just one of the features found to influence the perception of impact in female family members of adults with severe mental health problems, and others include

perceived stigma, family disruption, client dependence, caregiver strain and resourcefulness (Zauszniewski, Bekhet & Suresky, 2008).

Zauszniewski et al.'s (2008) findings, based on questionnaire data from a sample of 60 (30 African American, 30 Caucasian) adult females, suggest that race/ethnicity, the age and diagnosis of the family members with mental health difficulties and whether the women provided direct personal care (e.g. lived with family member with mental health difficulties) influence the perception of impact. Mothers reported greater impact than sisters, daughters and wives, which may have been related to mothers feeling more responsible or the fact that they were more often the main caregiver (Goodman, 2004). Caucasian women reported greater impact than African-American caregivers. Folkman and Moskowitz's (2000) research was used to make sense of these findings. Folkman and Moskowitz found lower self-reported subjective impact in African-American caregivers of dementia patients in comparison with Caucasian caregivers. They explained this in terms of perceived benefit or reward from caregiving in the African-American sample and that these findings reflected important coping mechanisms.

Zauszniewski et al. (2008) found that the perception of resourcefulness, in female family members of adults with severe mental health problems, was closely associated with the characteristics of the family member (i.e. age and time elapsed since diagnosis), but not with the female's personal characteristics (e.g. age or education). In fact, as time lapsed post-diagnosis, female family members' resourcefulness increased. Zauszniewski et al. (2008) suggest that this increase may indicate that resourcefulness increases with age in response to having a family member with a severe mental health problem. This is in line with research findings about the development of resilience over time in parents of adult-children with mental health difficulties (Marsh et al., 1996).

Zauszniewski et al.'s (2008) research highlights the influence of contextual factors on perceived stigma, impact and resourcefulness. As these findings were based on self-report measures it would have been interesting to see how the subjective experience of stigma, impact and resourcefulness compared with other measures, such as frequency counts of contact, type and amount of help provided. It would also have been useful to have used a culturally-based measure or brief

interview to help untangle the contribution of cultural beliefs towards coping resources and meaning-making which impact upon the individual's perception of impact and resourcefulness.

Gerkenmeyer, Perkins, Day, Scott and Wu's (2011) study investigated differences in the perception and impact of stigma in mothers caring for children with mental health problems. They used a model based upon Lazarus and Folkman's transactional theory of stress and coping (Lazarus, 2000) that assumes stress is the result of perceived demands in a given transaction, outweighing perceived coping resources (Lazarus, 2000). The level of depression experienced by mothers was found to be dependent upon the appraisal of threat in the environment (e.g. subjective distress, stigma and feeling blamed) and on the perception of available resources (e.g. family empowerment, social support and perceived control). The mothers who perceived stigma and blame in their environment experienced the most threat and were most depressed. Mothers who perceived themselves as having less available resources were also more depressed. I will also refer to Gerkenmeyer et al.'s (2011) study in the next section (see *The experience of having an adult-child in personal therapy*).

I include here an illuminating study from the chronic illness literature by Rassamen et al. (2008). The experience of having an adult-child with mental health problems has been compared in the literature to parents of children who experience chronic physical illness (e.g. Mohr & Regan-Kubinski, 2001). This study is particularly relevant as it is specifically related to the mother-daughter relationship. Rassamen et al. (2008) used Grounded Theory to analyse interview data from 20 adult daughters with type 1 diabetes (aged 20-36), five mothers, one partner, one sibling and five health professionals. Other sources of information were also used in the analysis, including documents and newspapers.

Rassamen et al. (2008) describe how mothers of daughters with diabetes feel guilty, frustrated, angry and upset in response to blaming reactions from others. As a consequence, mothers become more protective of their daughters, take on even greater responsibility for their daughter's diabetes management and find it difficult to relinquish this responsibility. The behaviours of mothers, motivated by guilt and self-blame, are described by the term "undoing", a defence

mechanism that aims to atone and compensate for perceived wrongdoings (Mandler, 1975). Over-compensation has also been reported by mothers of suicidal adolescents, who, due to feelings of guilt, failure and blame, doubt their parenting abilities (Daly, 2005).

Rassamen et al. (2008) also describe a “mother-daughter guilt dynamic”. Seeing the pain that their mothers endured because of their diabetes led daughters to feel “bad”, “guilty”, “like a burden” and the need to take responsibility for themselves. Neither mother nor daughter discussed guilt feelings with each other or with health professionals. Sometimes the guilt feelings impacted upon communication as it led daughters to avoid their mothers and to disregard or ignore recommendations for their diabetes-management. The “hiding away” of issues, rather than open discussion of them, thus exacerbated the guilt dynamic.

Unfortunately, it is unclear from the analysis how sources of information other than the interviews were amalgamated into Rassamen et al.’s (2008) theory. No demographic details about the mothers, partners, siblings or health professionals were included, which may have contributed to a clearer understanding of the dynamics within the relationships and enabled greater transferability of this theory.

Grief and emotional pain

A reoccurring theme in the literature about parents who have an adult-child with severe mental health difficulties is the process of grief (e.g. Godress et al., 2005). Parents share their struggle to come to terms with the loss of their child’s potential to lead a “normal” life and hardship whilst making sense of the lost future that they imagined for their child (Mohr & Regan-Kubinski, 2001; Ryan, 1993). Pejler (2001) describes how the narratives of parents who have an adult-child with severe mental health difficulties convey ongoing grief and sorrow, which is consistent with experiences of “chronic sorrow”. As cited in Pejler (2001), Eakes, Burke and Hainsworth (1998) describe “chronic sorrow” as a “periodic reoccurrence of permanent pervasive sadness or other grief-related feelings associated with a significant loss” (p. 199).

Daly's (2005) study about the mother's experience of having a child who is suicidal suggests that the experience of grief is also a painfully resonating theme in this group of mothers. Daly (2005) conducted a thematic analysis using interview data from six mothers (range: 32 to 45 years old) who had adolescent children (range: 12 to 16 years old) who were suicidal. The analysis revealed six themes: failure as a "good" mother, the ultimate rejection, feeling alone in the struggle, helplessness and powerlessness in the struggle, cautious parenting and keeping an emotional distance. Multiple losses were reported, including: loss of peace, loss of hope and loss of themselves – as the mother they thought they were. A process of constantly questioning where the child they had raised and cared for had gone was described by mothers, as well as an ongoing grieving process for the loss of the child they once knew, and for the suffering they saw their child experiencing.

As some of the mothers were members of support groups this may indicate a bias in the data, as such mothers would have had more time to reflect upon their experiences in the presence of others, and to feel more comfortable doing so. It is acknowledged by Daly (2005) that similarities between the mothers' accounts may have been over-exaggerated, presenting more of a universal experience than actually existed. Furthermore, the mothers who had attended support groups and already shared their experiences with others may have presented more of their shared, combined experiences anyway.

Johansson et al. (2010) performed a study in Sweden about the everyday experiences of 16 mothers who had an adult-child suffering from chronic mental health problems using an inductive qualitative content analysis. The majority (11 out of 16) of the adult-children lived away from home. The main theme described by the mothers was that their child was always on their mind. Mothers focused on how they managed the long-term responsibility for their adult-child, and how it required permanent adaption and experiencing highly stressful situations, which involved a high degree of sorrow and uncertainty. However, Johansson et al. found that despite the significant impact of having an adult-child with chronic mental health problems, some of the mothers reported "seeing light in the darkness", which gave them hope for the future, and that they found pleasure in "small, usually taken-for-granted things". Mothers also reported a sense of security in their

mothering roles and trust in their ability to manage situations once they had developed insight into their child's difficulties.

Strategies used by mothers to help them to cope included trying to stay grounded in the present moment, focusing on the factual situation, social support and the use of support groups, which provided a sense of belonging. Openness was viewed as a survival strategy and those who were able to talk freely, described gaining strength and acknowledgement of shared experiences with others. These findings are consistent with other studies that report a process of parents coming to terms with their child's difficulties and the use of social support from family, the church and other families in similar situations (e.g. Pejler, 2001).

Johansson et al.'s (2010) study is pertinent to my research, as their depth of analysis and interpretation strives to connect with the lived experience of mothers of adult-children, primarily daughters (13 out of 16 adult-children were daughters), who have a range of different mental health problems and levels of independence. Unfortunately, I have struggled to find studies of a similar ilk that have taken place in the UK. Research suggests that depending on the resources available to support coping (e.g. social support and empowerment), experiences differ (Gerkenmeyer et al., 2011). Swedish and UK systems have essential differences, alongside potential differences in cultural meanings attached to mental illness. Therefore, I am unsure how transferable these findings are to the UK.

Experience of enrichment and personal growth

A life-course perspective provides an alternative perspective for understanding the mother's experience of having an adult daughter with mental health difficulties. It suggests that life events can act as triggers for psychosocial transitions which precipitate changes in perception of the self and the world, resulting in changes in one's behaviour and relationships (Sugarman, 2010). From this approach development is seen as involving both gains and losses (Joseph, 2012), and a framework for understanding the experience of loss accompanying events that might seem to be positive as well as "post-traumatic growth" (Calhoun & Tedeschi, 2006) is provided. The experience of having an adult-child with mental health difficulties can be viewed as a life event which offers the opportunity to change

constructively, to strengthen family relationships and to develop resilience (Marsh et al., 1996).

Johansson et al.'s (2010) study contributes to the research (e.g. Aschbrenner, Greenberg, Allen & Mallik Seltzer, 2010; Schwartz & Gidron, 2002) which attends to the potential for personal growth and life enrichment which can arise out of the experience of having an adult-child with mental health problems. For example, having a child with mental health difficulties has been associated with a deepening sense of self-awareness and inner strength (Aschbrenner et al., 2010; Marsh et al., 1996; Schwartz & Gidron, 2002), and a greater sensitivity, empathy, tolerance and non-judgement towards others (Muhlbauer, 2002).

As highlighted previously in relation to the perception of stigma and blame, the role of perception is a significant factor in determining the subjective experience of having an adult-child with mental health problems (Schwartz & Gidron, 2002). Schwartz and Gidron (2002) use Victor Frankl's (1984) notion that finding meaning is a way to survive unavoidable suffering, to make sense of how parents of adult-children with mental health problems are able to create meaning and purpose in their lives, which can result in personal growth. They conducted a study in Israel using questionnaire data from 93 parents who cared for their adult-child with mental health difficulties at home. They found evidence for positive outcomes occurring as a result of caregiving for an adult-child, which included that caregiving can be an enriching, meaningful experience that can heighten personal resilience and self-worth. Evidence also revealed that the experience of fulfilment in the parental role and from learning about themselves was more gratifying than receiving assistance and support to care for their child.

Interestingly, demographic variables or perception of subjective impact (emotional impact), objective impact (amount of caregiving) or rating of the severity of the adult-child's mental health difficulty did not affect the assessment of gratification of caregiving. The authors suggest that the parent's perception of the caregiving experience as rewarding was a function of how they perceived their role and responsibility in the situation - how they "create meaning". Schwartz and Gidron (2002) advised a note of caution as the parents involved in the study were from a support group and were perhaps more emotionally ready to participate. The

majority were also mothers who were not otherwise employed and so caregiving was their “only job”.

For mothers whose children decide to go into therapy in adulthood, it is possible that this poses a transitional phase in their experience of parenthood and in their lives. Appraisal of the situation, personal life-cycle stage as well as other contextual factors, may play a role in how mothers make sense of and manage this experience. In the following section I review some of the theories and research that provide further frameworks for thinking about the impact of therapy on the individual and family.

1.1.4. The therapeutic change process: The reciprocal impact of context

The majority of psychological theory and literature discusses human experience, and by extension, change that takes place in therapy, in “fundamentally individualistic terms” (Sugarman, 2010, p. 291). The nature of these changes has been addressed behaviourally, cognitively and affectively and the process of change revealed as heterogenous, non-linear and as taking place both in and outside of therapy (Hanna & Ritchie, 1995; Krause et al., 2007). Within counselling psychology (Sugarman, 2010) and mental health services (Social Exclusion Taskforce, 2008; Wagstaff, 2010) there is an increasing emphasis on understanding the individual within their context and the reciprocal impact of context upon the therapeutic process.

Several stages of individual change taking place during therapy have been identified within the research, many of which have been found to transverse different psychotherapeutic models (Krause et al., 2007). In the early stages, key changes have been found to include a help-seeking stage pre-therapy (Krause, 2005) and the development of hope once therapy has commenced (Frank, 1982; Howard, Luegar, Maling & Martinovich, 1993; Yalom, 1995). Following these early steps, initial cognitive changes such as critical self-perception (Krause, 1992) and “unfreezing” of patterns of interpretation have been identified (Martens, 1991), including a process whereby clients become progressively less defensive and more open to experiencing (Du Plock, 2010; Krause et al., 2007; Rogers, 1967). Acceptance by the client of the problem in psychological terms (Krause, 2005) and

of their personal responsibility related to the problem (Bittner, 1981) are well-known processes that have been found to augment therapeutic change. The growth of insight (Hanna & Ritchie, 1995; Kumari, 2011), the construction of new theories about oneself and one's relationships (Krause et al., 2007), perception of self-efficacy (Bandura, 1977) and increasing psychological mindedness (Krause et al., 2007) have also been recognised as important outcomes of the therapeutic process.

Rogers (1961), the forefather of humanistic philosophy underpinning counselling psychology, highlighted the impact of therapy upon the individual and their family context. He described how the therapeutic process, which enables a person to become more fully and more deeply themselves, results in them finding greater satisfaction in realistic family relationships and facilitates the same process in other family members. Rogers viewed the change process in therapy as dependent upon an individual experiencing "core conditions" of empathy, non-judgement and genuineness within a special type of relationship.

However, Rogers has been criticised for his narrow view of the factors contributing to therapeutic change (Jørgensen, 2004). For approximately the last forty years, researchers have been trying to identify significant moments within therapy that provide windows into the inner working of this change process (e.g. Boston Change Process Study Group, 2010; Elliot & Shapiro, 1992; Hill, Thompson & Williams, 1997; Lyra, 2011; Stiles, 1997). For example, the BCSG (2010) describe inter-subjective "moments of meeting" between the therapist and client that are responsible for the "moving along" process which alters the client's "implicit relational knowing" or in other words, their way of being with others.

The study of common factors (i.e. that the effectiveness of different therapies does not vary) has highlighted a number of non-specific factors that influence therapeutic outcome, including extra-therapeutic factors (for a useful review, see Jørgensen, 2004). Lambert's (1992) controversial meta-analytic review of over 40 years of outcome studies suggests four primary factors that influence successful therapeutic outcome (Lambert, 1992). Extra-therapeutic factors (including social support and fortuitous events) accounted for 40% of positive therapy outcome, the therapeutic relationship for 30%, hope and expectancy

factors for 15%, and therapeutic model or technique for 15% of positive psychotherapy outcome. This suggested that the highest percentage of influence upon the therapeutic process is extra-therapeutic, emphasising the importance of examining the social context in which therapy takes place.

Despite this awareness, the impact of the adult's social context on therapeutic outcome appears to be under-researched. Systems theory, used to understand family dynamics and the process of change in individual and family therapy (Dallos & Draper, 2005; Duvall, 1977; Haley, 1973; Jackson, 1957; Watzlawick, Beavin & Jackson, 1967), helps us to think about how the therapeutic process both impacts upon and is impacted by the individual's context. Jackson (1957) suggests that changes in the "symptoms" of one member of the family (part of the system) encounter resistance within the system. This highlights that family systems strive to maintain homeostasis. Glasser (1963) found that when therapy ends, family members can make vigorous attempts to return to the roles and family dynamics present before therapy commenced. However, the principle of "circularity", coined by Watzlawick et al. (1967), stresses the interdependence of actions in families and in other relationships. Therefore, when an individual changes, connected relationships necessarily change and this in turn impacts on individuals (Duvall, 1977; Haley, 1973).

Current research reinforces how an individual being in therapy has important implications for significant others (e.g. Bedics, Henry & Atkins, 2005; Murray, 2007; Smerud & Rosenfarb, 2011) and that the therapeutic process is impacted by significant others (e.g. Murray, 2007; Pereira, Lock & Oggins, 2006; Smerud & Rosenfarb, 2011). Bedics et al. (2005) shared their findings, which were based on the changes in an important relationship associated with being in therapy (62% romantic relationships) reported by 45 patients (range = 24-64 years, 77% women, 95% Caucasian). Data was collected using 2 measures, including a self-report measure of interpersonal behaviour and an observer-rated therapeutic process scale.

Bedics et al.'s (2005) findings revealed a consistent association between observed therapist warmth and changes in the patient's behaviour towards their significant other. Early in the course of therapy, therapist warmth predicted both

an increase in affiliative behaviour towards the significant other and a decrease in hostility when the relationship was at its best. Therapist warmth was also associated with changes in the level of interdependence in the patient-significant other relationship, and patients reacting to their significant other with less submission. The exploratory process in therapy was associated with decreases in hostility at the beginning and end of therapy. The associations between therapeutic process and patients' behaviour towards their significant other were not significantly associated when the relationship was rated at its worst.

These findings from Bedics et al.'s (2005) study draw attention to the impact of the therapeutic process on the individual and their significant relationships. It is unclear from the description of the significant others rated by the patients who 33% of these people were. Therefore, it is difficult to distinguish between changes that may have been more relevant to romantic as opposed to parent-adult-child relationships. Furthermore, the data was amalgamated across relationship type and gender, so isolating the associations between therapeutic process and change in specific relationships is not possible. As the results are correlational, it cannot be assumed that therapy was the only cause of change in the patient-significant other relationships.

Murray's (2007) qualitative study explored how the significant other's experience of their partner's individual therapy and therapist affected the therapeutic change process. Murray provides revealing insights into the experience of being in a close relationship with someone who is in therapy, which is highly relevant to the present research. She attends to the process of therapy over time, its impact on a significant relationship and does not limit the findings to the experience of significant others whose partners had severe mental health difficulties. Eight couples (mainly heterosexual, 5 married, 3 co-habiting) who had been romantically involved for two to eight years took part. Murray (2007) used a semi-structured interview technique with the significant others in order to elicit rich descriptions of their thoughts and feelings about their partner's therapy. She also briefly interviewed the person who had been in therapy. The data was then coded using Auerbach and Silverstein's (2003) qualitative research technique.

Murray (2007) found that having a partner in therapy provoked both positive and negative feelings in the significant other, and whilst the positive feelings appeared to facilitate the therapeutic change process, the negative feelings did not seem to interfere or to have a negative impact on the romantic relationship. Most couples found that the therapy led to improvements in overall closeness and communication. Another important finding was that open post-therapy discussions between partners seemed to aid the therapeutic process and to deepen their relationship. Murray's research supports an earlier piece of research that revealed how significant others experienced "deeper and more meaningful communication" with their partner who was in therapy, along with vicarious therapeutic benefit (Brody & Farber, 1989).

The limitations of Murray's (2007) study are well-discussed. She recognises that a self-selected sample were used, which perhaps indicates a high proportion of positive relationships, as both partners were willing to participate and were probably more likely to have had a helpful experience of therapy. It is unclear as to how the interview data from the partner in therapy and the significant other were amalgamated and whether there were any differences between the experiences of the partners in terms of changes in communication and closeness. Furthermore, the ways in which significant others managed their experience of their partner being in therapy was not the focus of this study. Therefore, it is not possible from this study to gain an in-depth understanding of the processes involved in responding to or coping with the experience of having a significant other in therapy.

The literature reveals the many different dimensions and layers underpinning the experience of the therapeutic process that inevitably impacts upon the individual in therapy and their close others. In the following section I explore the literature that helps to shed light upon the experience of mothers who have adult daughters in therapy, including invaluable insights provided by mothers who have children in therapy.

1.1.5. The mother's experience of having a child in therapy

Although still lacking, there is a greater supply of research that informs about the experience of having a child in therapy in comparison to having an adult-child in therapy. Findings about having a child in therapy provide some insight into the factors that may influence the experience of having an adult-child in therapy. However, there are significant differences between having a child and having an adult-child in therapy, which limits the extent to which these findings can be extrapolated to understanding the experience of having an adult-child in therapy. I will discuss these limitations in the next section following the review of the literature related to the experience of having a child in therapy.

Clinical experiences of child psychotherapy have discussed how parents feel hurt and guilty about their child's need for therapy (Furnan, 1995). Parents are said to resent the therapist for "taking over" and disrupting the family system and to feel criticised and misunderstood by the therapist (Bornstein, 1948). McCarthy (1989) described how when children showed improvements in therapy this threatened a parent's self-perception and sense of self-adequacy as a parent. Anna Freud (1966) suggested that "envious attacks" occur when parents feel that the therapeutic relationship is positive. In these instances, the parent might aggravate "loyalty conflict" between analyst and parent within the child, negatively impacting the therapeutic process (Daniel & Jenkins, 2010).

In contrast to the psychoanalytic literature based on clinical experience, a U.S. questionnaire-based small sample study of 51 parents (42 female caregivers) of 5-11 year-old children in therapy suggested that parents mainly experienced positive feelings towards the child therapist and felt hopeful, understood and grateful (Nevas & Farber, 2001). Questionnaires used included ones that assessed parental attitudes and feelings about seeking professional psychological help. The lack of negative feelings about their child's therapy was described as striking. The researchers suggest that the skewed findings may have been due to the self-selecting participants whose children had remained in therapy and had greatly benefited. Therefore, parents were more likely to have seen improvements in their child and to think well of the therapist's effectiveness. In addition, it was an inclusion criteria for participation in the study that the parents had been involved

in their child's therapy. The parents had met with the therapist either on their own, for individual counselling, or with their child and were therefore more likely to have experienced therapeutic benefit themselves.

Along with other limitations (e.g. restricted data collection possible from a questionnaire), Nevas and Farber's (2001) findings are more transferable to parents who have had direct involvement in their child's therapy. This impedes comparison of these research findings with research related to more traditional psychoanalytic therapies where assumptions about the sanctity of the child-therapist relationship preclude parental involvement (Nevas & Farber, 2001). Overall, this study emphasises the need for a parent-therapist alliance in effective therapy for children. It is recognised that this relationship can help the parent to manage their feelings and expectations towards the therapy and the therapist, and that this can result in parents being respectful and helpful partners in their child's therapy (Nevas & Farber, 2001). This is supported by other research (e.g. Holmboe, Iversen & Hanssen-Bauer, 2011) which suggests that having an understanding of services, perceiving that an appropriate number of consultations are offered and easy access to the therapist outside of appointments helps to predict parents' satisfaction with child and adolescent mental health services.

As previously referred to, Gerkenmeyer et al.'s (2011) study, which investigated levels of depression in mothers caring for children with mental health problems, also considered mothers' appraisal of whether they felt services were helping. Interestingly, this was not found to be a significant factor influencing the severity of depression in mothers in comparison with other factors influencing mothers' well-being. Results in this study may have been biased as it was a convenience sample of mothers whose children were using a community mental health service. It has been suggested in the literature that parent satisfaction about services is generally very high and that mothers' expectations about services are usually met (Gerkenmeyer, Austin & Miller, 2006). Perhaps this is because mothers do not understand that they could expect better mental health services, as there is a lack of social awareness about what can be provided. Social desirability could also help to explain these findings because parents may fear negative

consequences as a result of criticising the services that they use (Gerkenmeyer et al., 2006).

1.1.6. The mother's experience of having an adult-child in therapy

There are essential differences between the experience of parents of children and the parents of adult-children who enter therapy. The parents of children often decide to initiate therapy for their children (Rosenbaum, 1994) and must consent for their child to receive therapy (British Psychological Society, 2009). Parental participation in their child's therapy is recognised to be a crucial factor in determining its success (Delaney & Engles-Scianna, 1996; Nevas & Farber, 2001), ensuring continued engagement and preventing early termination (Holmboe et al., 2011). However, Daniels and Jenkins (2010) write that even for child clients, various reasons are given for not wanting to involve their parents, and these reasons are often based upon concerns that parents might jeopardise the process, and fear and conflicts with the idealised view that parents should be the protectors.

Mothers whose children decide to enter therapy in adulthood may not have a say and there is little research evidence to illustrate how they might feel about this experience, their involvement or lack thereof. Adult-children may choose not to disclose their therapy and parents may be excluded from involvement in their adult-child's therapy due to legal restrictions about confidentiality and ethical guidelines about informed consent when their child reaches adulthood (British Psychological Society, 2009). Research has found that parents of adult-children with chronic mental health difficulties can find significant problems communicating with care providers and gaining access to information (Muhllbauer, 2002). Although parents can feel relief that their adult-child is safe and taken care of within a community-based care-setting, some feel 'shut out', and ambiguous in their role of carer when they feel that their views of their child's needs are not taken into consideration (Pejlert, 2001). Although this is not directly related to the parents' experience of having an adult-child in therapy, it provides some indications of how some parents may feel about not being involved in their adult-child's therapy.

Hatcher and Hatcher (1983) are convinced that, “no matter how helpful the treatment, no matter what promise of a happier life it may hold, therapy may drive a kind of wedge between the spouse or parent and the family member in treatment” (p. 75). These researchers report from a survey they completed that spouses and parents of psychotherapy patients are affected by the time, money and intimacy that they share with the unknown therapist and also by their own fantasies and anxieties. Hatcher and Hatcher (1983) recognise that therapy often disrupts patterns of problem-solving between spouses or parents and children, and that changes required by the patient in therapy may be contrary to the interests of the spouse or parent. Interestingly, the researchers also notice that the further along the patient’s treatment was, the more mellow the respondents became. The greatest level of agitation was experienced by parents and spouses at the beginning, decreased as nothing catastrophic happened and then gratitude was expressed during and towards the end. This indicates a temporal change or a process, rather than a static impact of having an adult family member in therapy.

Hatcher and Hatcher’s (1983) research took a different approach to reporting clinical experience directly by collecting information from 20 in-depth questionnaires and trying to tap a broad range of experience. The researchers acknowledged that they used their assumptions about certain “expectable effects” of therapy on the lives of spouses and family members to guide their examinations of the questionnaires. It may be that this limited their findings as they may have missed exceptions to the rule and focused upon confirming evidence.

Lindgren et al.’s (2010) study provides insights about the lived experience of professional care and caregivers amongst six parents (five mothers, all married, all employed, all had other children) of adults who self-harm. The adults were daughters aged 21-25 that were all receiving outpatient services. The majority of the daughters lived independently in the community and one returned home during times of crisis. Lindgren et al. used semi-structured interviews and a phenomenological hermeneutic approach, which prioritises reflexivity and openness to the material, alongside an in-depth interpretative process. Their analysis of participant narratives revealed themes that included feelings of being accused, broken, invisible, confused, lost, excluded (related to feelings of

powerlessness) groping in the dark, isolation and alienation. Moments of peace and respite, where situations with healthcare professionals were understood and resolved, and hope was inspired, were also mentioned (Lindgren et al., 2010).

Interestingly, Lindgren et al. (2010) compared parents' experience of their daughters' professional care and caregivers to a "limit situation", a phrase coined by Jaspers (1932). Limit situations are moments, usually accompanied by dread, guilt or acute anxiety, where the human mind confronts an inescapable situation, from which it must seek to create meaning or "higher more reflected modes of knowledge" (Thornhill, 2011). In order to do so, Jaspers defined a process of "existential communication", whereby the freedom of consciousness to overcome its limits and, hence, to find new meanings can only occur through intense communication with others (Thornhill, 2011). However, trying to communicate, seek answers and further information about their daughters' difficulties from mental health professionals was described as an act that fostered feelings of powerlessness (Lindgren et al., 2010). Therefore, parents tried to seek help from others (e.g. friends, relatives) in order to access the support they required. Other research in this area suggests that seeking answers and support from professionals can be problematic, particularly as it potentially increases risk of experiencing stigma (Jackson & Mannix, 2004).

Lindgren et al.'s (2010) research is illuminating as it provides rich interpretation of the experience of parents, the majority of whom were mothers that had adult daughters receiving professional care. Lindgren et al. allude to how daughters' self-harming behaviour influenced the whole family (e.g. difficulties arose in the parental relationship) and the behaviour of parents towards their daughter (e.g. "tip-toeing around her"). However, as Lindgren et al. focus on the participants as "parents" as opposed to mothers and their children as "adults" as opposed to daughters, this does not allow us to make sense of how the experience of their daughter receiving professional care impacted their relationship with themselves (e.g. at the level of identity), or with their daughters.

Lindgren et al. (2010) use the broad category of "professional care and caregivers", which includes experiences of daughters' care during inpatient, outpatient, child, adolescent, and adult psychiatric care, acute and emergency care

and primary care. This overview provides a wealth of information that is understandably challenging to separate out and to analyse discretely according to type of care. Unfortunately, this makes it hard to garner the specific impact of different types of professional care and caregiving on mothers. Furthermore, as with Jackson and Mannix's (2004) study, given that experiences were grouped together over the lifespan, it is difficult to establish whether there were any differences between mothers' experiences of having a child as opposed to an adult daughter in personal therapy.

The experiences of mothers who have adult daughters in therapy and how they manage this process remains an unexplored area. For mothers who do not live with their daughters or have close relationships with them, how comparable is their experience to mothers who reside with their daughters or who have close relationships with them? By addressing the experiences of mothers and their relationships with their adult daughters, this research hopes to provide insights that will help to illustrate how mothers are impacted as a result of their daughters being in therapy and how they manage this process. As the majority of the research that I have reviewed has not taken place in the UK but has been carried out within different occupational, socio-cultural and political contexts, it is unclear to what extent the existing research findings can transfer to the experience of mothers in the UK.

I aim to provide insights from mothers who do not only have daughters with chronic mental health issues, but may have daughters without an identifiable mental health condition or with mild to moderate difficulties. I hope that this will help to address the range of circumstances under which daughters may go into therapy and how this context may impact upon the mother's individual experience. Furthermore, as I will be hearing the mother's perspective and do not require both mother and daughter to be present, it is hoped that this may eliminate the bias towards purely hearing from mothers who have a positive relationship with their daughter.

1.1.7. Rationale for the research

For Counselling Psychologists working with mothers who have adult daughters in therapy, it is hoped that a greater understanding of this phenomena might aid therapists to empathically relate to such mothers and help them to make sense of their experiences and to formulate their difficulties. For Counselling Psychologists working with daughters, this research may aid the therapist in assisting their client to explore their relationship with their mothers in greater depth. From a feminist perspective, Nice (1992) and Rich (1973) highlight how the more we can learn from female history, the less we can generalise about the failure of mothers to cherish and encourage their daughters. It is hoped that by informing therapeutic work and training with a greater awareness of the mother's perspective that this might also play a role in challenging the discourse of mother-blame that prevails in our society (McNab & Kavner, 2001; van Mens-Verhulst, 1995).

Mothers provide a significant source of support for daughters across the lifespan (Bojczyk et al., 2011), especially if their social contacts have declined in connection with their mental health difficulties (Johansson et al., 2010). By fostering the acknowledgement of complexity in the lives of mothers and in their relationships with daughters, this research aims to contribute to the development of mutuality and understanding in mother-daughter relationships. Furthermore, it is important to realistically assess social support available for the individual and "how the lack of support may collude with patient's own ambivalence about embarking on therapy" (Lemma, 2003, p.155). Therefore, it is also hoped that the findings of this research may be able to inform support provided for mothers of daughters in therapy.

1.2. Methodology

In this section, I will explain the processes I went through whilst carrying out this research in order to provide a clarifying and transparent account of the method. Before doing so I aim to: explain my reason for choosing IPA (Willig, 2008; Smith, Flowers & Larkin, 2009) as the methodology, to inform the reader of my epistemological position in relation to this methodology and to provide a reflexive account of myself as a researcher.

1.2.1. Research design

This study used a qualitative research design in order to investigate the research question: ***What is the mother's experience of having an adult daughter in therapy and how does she manage this process?*** Data was collected from a small, homogenous sample of participants using semi-structured interviews. The data was then analysed using guidance on carrying out research using IPA (Smith et al., 2009; Willig, 2008).

1.2.2. Rationale for research method

As I was concerned with developing an in-depth understanding of each research participant, it would have been less appropriate to use quantitative than qualitative research methods. This is because quantitative methods tend to focus on factors and relationships which are observed in large numbers of people. Quantitative methods are particularly useful methods for generalising about phenomena or for isolating and controlling specific variables (Yardley, 2000). My aim was not to generalise across mothers about their experience of having a daughter in therapy, or to provide a statistically representative sample. Instead, I hoped to access individual meanings, in order to gain an in-depth understanding of my participants' experiences of "being in the world", and to celebrate the complexity and uniqueness of each account. In qualitative research methods the researcher is interested in learning about the participant's psychological world and understanding the content and complexity of meaning, rather than taking measures of frequency (Smith, Harre & Van Langenhove, 1995). These methods appeared to be most suited to my aims.

I chose IPA as the qualitative research method as it is renowned for its use in elucidating the experiences of the experts – the research participants – and learning from these insights (Reid, Flowers & Larkin, 2005). IPA is concerned with complexity, process and novelty (Smith & Osborn, 2008). Commitment to detail, depth of analysis and concern with the particular are also characteristics of IPA (Reid et al., 2005). These facets were essential to this research project as I was looking for an in-depth understanding of the experiences, understandings, perceptions and views of each research participant. In order to access the participants' expert knowledge, I wanted to use a method that would facilitate the mother in telling her story. Establishing rapport with research participants, and using flexible data collection instruments such as semi-structured interviews, are key ways that IPA seeks to allow complexity and ambiguity to unravel (Willig, 2008).

As Grounded Theory is usually seen as the main alternative method for someone considering using IPA (Smith et al., 2009), it is important to reflect upon why this method was not my choice. Both IPA and Grounded Theory aim to produce a sort of "cognitive map" that might be representative of a person or a group's view (Willig, 2001). They also both start off by analysing individual cases, then integrate their findings using systematic data reduction (Willig, 2001). However, rather than seeking to produce an objective theory or a core category, as with Grounded Theory, IPA allows the point of view of the participant to remain paramount (Charmaz, 1991; Glaser, 1967). This fits with the aim of this research, which is one of curiosity and exploration about the subjective experience of individuals over and above the development of a parsimonious, general and explanatory theory. IPA is also more likely than Grounded Theory to provide an in-depth, nuanced analysis of a smaller number of participants and to attend to the convergence and divergence between participants (Smith et al., 2009).

Like IPA, discourse analysis (DA) is interested in language and discourse, but for several reasons, I believe that DA would not have been an appropriate choice of method for this project. DA is sceptical about being able to map verbal reports on to underlying cognitions (Potter & Wetherall, 1987) and instead views verbal reports as behaviours deserving of functional analysis in their own right (Smith,

Flowers & Osborn, 1997). DA is more concerned with what people *do* with their talk and writing and the cultural discourses they draw on in the process (Potter & Wetherall, 1995), rather than trying to gain deeper insight into the *erlebnis* (lived experience) of participants.

Although like DA, IPA is concerned with context i.e. how the individual makes sense of their experience within a particular context, DA has a stronger commitment to social constructionism and deconstruction. Like the intentions of this research, IPA is concerned with gaining access to the personal experience and cognitions, or in other words, the participants' meaning-making processes and what they think and believe about the phenomenon in question (Smith, Jarman & Osborn, 1999). Although viewed as changeable and hard to pin down, IPA suggests that this information can be accessed via prolonged engagement with the text and a process of interpretative activity.

1.2.3. Overview of IPA

IPA most clearly came into focus in the research world following Smith's (1996) publication in *Psychology and Health*. In this article Smith argued for an experiential and qualitative approach to psychology and the revival of pluralism within the discipline (Smith et al., 2009). IPA is the qualitative research method which Smith strongly advocated and he continues to do so (Smith, 2011). IPA is a descriptive and interpretative qualitative research method, underpinned by the ideas of phenomenology, hermeneutics and idiography (Smith, 2004). It is particularly influenced by the works of Husserl (1927, 1970), Sartre (1943), Merleau-Ponty (1945) and Heidegger (1927). Given the central focus on mental activity, IPA could be viewed as closely aligned to social cognition and the original conception of cognitive psychology as the science of meaning and meaning-making brought about by Bruner (Smith, 2004). However, IPA sets itself apart, given its use of qualitative research methods, in contrast to quantitative and experimental approaches used to examine mental processes in mainstream cognitive psychology.

Phenomenology

Phenomenology has been described as a radical approach to philosophy (Moran, 2000). The practice of phenomenology is the attempt to get to the truth about

matters and to describe a phenomenon as it manifests itself to the consciousness of the experiencer. In order to do this, the phenomenon must be understood from within, and be freed from judgement or cultural imposition before explanation can be given (Moran, 2000). Husserl (1970) thought that the ability to gain access to 'essences' – the structure underlying experience – was extremely effortful, as it is all too easy to slip back into the "natural attitude" or the everyday way of seeing things. Therefore, a process of bracketing, or "epoche" – an attempt to abstain from assumptions and to try to see the thing in "their appearing" for the first time – is necessary (Langridge, 2007).

According to Sartre (1943) and Merleau-Ponty (1945), phenomenology is about moving beyond empiricist, psychological assumptions about human existence, towards capturing and understanding life in the manner in which it is lived – through the body and through language. Heidegger (1927) phrased it as "being-in-the-world". He viewed humans as caught up in the world in which they are thrown, and, hence, they cannot be separated from it.

By highlighting objective, empiricist science as "idealisation", Husserl (1970) also negated the subject-object distinction. He threw light on the need for a holistic approach to the understanding of the relationship between objectivity and consciousness, which stressed the mediating role of the body in perception. Similarly, Merleau-Ponty (1945) stressed how phenomenology seeks to describe and not to explain and that science can only ever be a "second-order expression" of the phenomenon it describes.

These are some of the ideas in phenomenology that are most relevant to IPA. In IPA there is a focus upon the perception of experience for the individual, but at the same time an acknowledgement that as humans are immersed in the world around them, they cannot be separated from it or from the meanings and knowledge that they create (Larkin, Watts & Clifton, 2006).

Hermeneutics

Hermeneutics, or interpretation, can be conceived of as a search for "a deeper and/or fuller understanding of the meaning" in accounts or other forms of human communication (Willig, 2012, p.8). Willig (2012) writes about the ubiquitous act of

interpretation and emphasises that it takes place whether we intend it to or not. Hermeneutics is inevitably informed by the epistemological position of the interpreter and their assumptions about what is or is not important.

Two different approaches to the interpretative task have been described in the literature (e.g. Langridge, 2007; Ricoeur, 1970; Smith et al., 2009; Willig, 2012): a “hermeneutics of suspicion” and a “hermeneutics of empathy”. A “hermeneutics of suspicion” seeks to uncover the hidden or unconscious meaning beneath what is thought to be the “superficial manifestation” (Willig, 2012). In this approach, interpretation is driven by a formula or hypothesis about what might be found and from here an explanation is given in order to explain the finding. The interpreter in this instance is like a detective, who retains an expert position in relation to the unknowing person or data under investigation.

Rather than trying to unearth hidden meanings, a “hermeneutics of empathy” attempts to stay as much as possible with how a phenomenon presents itself and tries to understand it and to develop an “insider’s perspective” (Conrad, 1987). Through a process of attention to the whole and to parts of it, the interpreter tries to amplify meaning in order to gain a fuller understanding of the phenomenon in question, and to ground this process as much as possible in the data itself. A “hermeneutics of empathy” does not try to explain the reason why a phenomenon exists, but the process of meaning-making may result in the phenomenon becoming more apparent and recognisable to the interpreter (Willig, 2012). Therefore, hermeneutics of empathy goes beyond description and adds meaning whilst trying to clarify and understand what is under investigation.

Ricoeur (1970) suggests that both suspicion and empathy are necessary in order to explicate meaning. “Play” has been described as “a way of being” when undertaking research analysis (Ricoeur, 1970). Play is said to involve in-depth concentration where we can lose ourselves in another world and approach new ways of seeing, doing and being (Gadamer, 1975). Langridge (2007) describes Ricoeur’s (1970) suggestion that through playful engagement with text, new layers of meaning can be actualised, and key essences reached. A middle point between a “hermeneutics of suspicion” and a “hermeneutics of empathy” is recommended in the practice of IPA by Smith et al. (2009).

IPA subscribes to a relativist ontology, which means that it is interested in exploring the subjective world of the research participant, but it is not searching for an objective truth (Willig, 2008). It acknowledges that what research participants say has personal significance and “reality” (Smith et al., 1995) but that in order to gain access to this reality, a dynamic process of interpretative activity between participant and researcher is necessary (Smith & Osborn, 2008). This is known as the “double hermeneutic”, whereby the research participant is making sense of their world and the researcher is making sense of the participant making sense of their world (Smith & Osborn, 2008).

Ponterotto (2005) explains that through intense interaction and dialogue both the researcher and research participants might hope to reach deeper insights (hermeneutical discovery) about the *erlebnis* of the phenomenon in question. IPA does not regard the researcher’s influence to be a bias that needs to be extracted. Instead, the researcher is viewed as the primary analytic instrument required for making sense of the participant’s experience. IPA recognises that data is gathered in the context of human interaction, that it is socially constructed and that meanings are negotiated between the researcher and research participant (Denzin, 1995; Lewis, 2008). Smith et al. (2009) also refer to “bracketing”, but in a cyclical sense. They suggest that as it is impossible to be aware of all one’s preconception in advance, an ongoing approach to reflective practice is required, which will also hopefully facilitate positive engagement with the participant in research.

In order to come closer to the lived experience of the individual and to produce a richer analysis, the role of the researcher in IPA is paramount. Finlay (2005) urges researchers to draw from Merleau-Ponty’s (1945) ideas of embodiment and Husserl’s ideas (1927, 1970) about intersubjectivity, to help researchers to understand their participants using a “reflexive, embodied empathy”. She posits that in order to grasp something of the Other, as a “living, lived body”, researchers must also attend to their own bodies, as this is directly involved in a corporeal “intersubjective intertwining” throughout the research process. Lewis (2008) also stresses the need for researcher empathy, warmth and non-judgement in qualitative research, as without these qualities, the flow of narrative, especially with emotional content, may be disrupted. The researcher’s

personal ability to gain access to the insights of the participants is integral to the process of data collection in IPA.

Combining descriptive phenomenology and hermeneutic approaches to research enquiry is not without its tensions. It has been suggested that ethical concerns increase hesitation amongst researchers to engage in interpretation (as discussed by Willig, 2012). For example, as previously acknowledged, through the process of interpretation, meaning is inevitably transformed, thereby incorporating something of the interpreter or reader within it. This brings into question power relationships, as when interpretation is driven by a “hermeneutic of suspicion”, the researcher may be perceived to hold the “expert” position, thereby silencing the participants’ meanings. This potential abuse of power has recently been termed “interpretive violence” (Willig, 2012). Nonetheless, these concerns do not appear to have hindered the increasing “dominance” of IPA (Langridge, 2007, p. 122), nor the “turn towards interpretation” in recent years (as explored by Willig & Stainton Rogers, 2008). In support of interpretative approaches to research inquiry, Willig (2012) suggests that qualitative psychologists are driven by the desire to give voice to oppressed groups and are therefore more sensitive to the risks of overlaying the participant’s voice with the researcher’s.

Langridge (2007) references Rapport’s (2005) findings about descriptive and interpretivist phenomenologists. Rapport suggests that descriptive phenomenologists believe that unified meaning can be accessed, and described in its appearing. In comparison, Rapport explains that interpretivists believe that as meaning is unique, it cannot be described and can only be accessible through a process of interpretation. Despite these different approaches to how the researcher might gain access to meaning, Smith et al. (2009) argue that the hermeneutic and the phenomenological do not conflict and that IPA would always involve interpretation. Although at the core of IPA is a phenomenological attention to the individual experience, the two main aims in IPA involve: the production of a coherent, psychologically informed description, followed by a more speculative interpretative analysis situating the participant’s account and commenting upon the person’s sense-making processes (Larkin et al., 2006).

Idiography

Idiography, a practice concerned with developing an in-depth, detailed understanding of particular, experiential phenomena, has profoundly influenced the practice of IPA (Smith et al. 2009). This approach contrasts with the nomothetic approach, which has been the traditional method of psychological research. The *nomothetic* approach focuses upon large samples and being able to generate theories about human behaviour and to apply it on a large scale. It has been criticised for its approach to data analysis (e.g. see Lamiell, 1987) as results are aggregate and it is impossible to retrieve individual information. As a result of the influence of idiography, IPA uses purposively selected participants and small samples. IPA's analytic procedure, which involves moving through each participant on a case-by-case basis in a detailed and systematic way before generating more general statements, can also be traced back to its idiographic underpinnings. This approach allows for the retrieval of individual information so that claims made can be evaluated and justified.

It has been argued that the greater the depth of understanding about the particular, the closer we become to the universal (e.g. Warnock, 1987). This suggests that the idiographic approach taken in IPA can not only help us to touch upon the uniqueness of individual experience, but also allows us to glimpse into the shared human experience. This is made more possible through a close analysis of nuances of what is specific and common between cases and then connecting findings with the psychological, professional and experiential knowledge and experience of the researcher.

1.2.5. Congruence between IPA and counselling psychology (CoP)

CoP embraces the complexity of life itself, with its paradoxes and challenges (Kasket & Gil-Rodriguez, 2011). It strives to marry the roles of empirical-scientist and subjective-reflective practitioner by adhering to the rigorous demands of the scientific community, whilst also prioritising the therapeutic relationship (Division of Counselling Psychology, 2005). Therefore, finding a methodological approach that enables this struggle to be acknowledged and celebrated is important for the Counselling Psychologist in order to ensure personal and professional integrity!

Finlay (2011) highlights succinctly how phenomenological qualitative research methods, such as IPA, offer a bridge between research and practice for therapists. Phenomenology fits with the skills and values of therapeutic practice. For example, the open and non-judgmental stance befitting the humanistic underpinnings of CoP matches the “phenomenological attitude” required in the research process (Kasket, 2012). Researchers, like Counselling Psychologists, seek to put aside their existing ideas and assumptions and be filled with curiosity and wonder as they engage in the “reductive-reflective dance” (Finlay, 2011).

Recognising plurality and diversity is at the core of research and practice in CoP (Cooper & Mcleod, 2011; Rafalin, 2010), and the endeavour of IPA also has this emphasis. Remaining curious and flexible so that one can be open to new possibilities and alternative explanations is an important phenomenological stance to uphold as a Counselling Psychologist and this subscribes to the role of the researcher in IPA. At the same time, I acknowledge the virtues in other methods that could be used to study this subject matter and recognise that data collected and conclusions drawn using other methods could be equally valid and useful for CoP research (Kasket, 2012; McAteer, 2010).

I will go on to address the limitations of IPA in the discussion chapter, with particular attention to those relevant to this research project.

1.2.5. Epistemological standpoint

There is considerable flexibility and variability in the epistemological positions open to an IPA researcher. Larkin et al. (2006) cited Michael (1999), who referred to IPA as an emerging new paradigm described as “epistemological eclecticism”. Larkin et al. (2006) cogently explain that the frames that we use in order to “make sense” of any one analysis must be coherent and clearly positioned. Therefore, I will attempt to provide an illustration of my relationship with the knowledge creation process. This is a helpful practice, as it encourages me to take a step back and to gain some degree of perspective on my philosophical position which will undoubtedly influence my understanding of the undertaking of the research process. At the same time, I am aware that trying to classify one’s epistemological position, or, indeed, that of any method, can be simplistic and it may not be possible for an unequivocal epistemological position to be held (Willig, 2001).

I agree with Finlay (2002) that the researcher, the world and the researcher's experience of the world, is all intertwined and that a process of reflexivity is needed in order to disentangle these different aspects, and to try to understand more about the interaction. I seek to embrace my humanness (Walsh, 1995) and not to disqualify the "tangle", nor to reduce the complexity of it. This also fits with my identity as a Counselling Psychologist as discussed above and a phenomenological holistic approach to the understanding of the relationship between objectivity and consciousness (Moran, 2000). For example, I resonate with Heidegger's perception of "being-in-the-world", which echoes the idea of the inseparability of subject and object and fits with my understanding of the co-constituted nature of the research process.

My epistemological position fits in some ways with a symbolic-interactionist perspective. I value what Blumer (1969) wrote about how meaning is derived through social interaction. He, along with others espousing this tradition (e.g. Meltzer, Petras & Reynolds, 1975; Stryker, 1980), described how an interpretative process, that involves communication with the self, is required for individuals to be able to select and transform meanings in light of situations and in order to direct their action in relation to others. This fits with how I view the research process as involving social interaction, mutual role-taking, interpretation and meaning-making – as participant and researcher respond to each other, and attempt to communicate effectively and to understand one another's worlds.

I am influenced by my psychodynamic knowledge about how unconscious processes structure relationships. This is relevant to my understanding of knowledge creation, as I believe that unconscious processes may impact the relationship between myself and the mothers who are my research participants. I also accept that unconscious processes may influence the relationship between myself, the data that I gather and the interpretative process. The idea that the use of theory can be used defensively, and that overvalued ideas can become alluring in the face of psychic uncertainty (Midgley, 2006), is also something that interests me.

Devereux (1967) writes that anxiety in the research process can lead to attempts to remove subjectivity. Therefore, it is important for me to explore and

reflect upon how the conversations and texts affect me and what I bring of myself. This includes the consideration of my unconscious needs and transference and how it might influence the co-constitution of the data (Finlay, 2002). I have been influenced by Rizq (2008), who suggests that the researcher's ability to create "a third space", separately from the "research couple", is fundamental for the research process. I acknowledge that without an awareness of the potential for "narcissistic identification" with the research participant (Caper, 1999, cited by Rizq, 2008) my thinking space may be diminished.

I think that my epistemological position would fit with a moderate version of a social constructionist perspective, as I agree that reality is socially constructed and that meanings are negotiated in particular contexts (Denzin & Lincoln, 1994). "Critical realism" has been named as a "less naïve" version of realism, which has more in common with social constructionism than with empirical scientific "realism", as it recognises subjectivity in knowledge production (Willig, 2002). I relate to this approach as accepting my humanness comes along with the embracing of subjectivity. I do not believe in an unambiguous reality. I believe that there are always multiple interpretations of the same event and that gaining access to these multiple perspectives can enrich our understanding of a phenomenon. This could also be termed as a "contextual constructionist" perspective, which means that I view knowledge as contextual and dependent on standpoint (Willig, 2002).

Schools of thought amongst social constructionist researchers would reject that research methods are able to access thoughts, experiences or feelings, and would argue that in order to access meaning, researchers need to look outwards at discourse, interaction and shared meaning (Edwards & Potter, 1992). In this way, social constructionism can reject a psychological realm beneath people's speech, which conflicts with my relationship with language as data and my usage of IPA. I value Sartre's (1943) phenomenological perspective that a way in which to capture a meaningful appreciation of affective, emotional and imaginative life is to understand it in the manner in which it is lived i.e. through language.

1.2.6. Reflexivity

Reflexivity involves reflecting upon the impact the researcher has on the research process (Yardley, 2000). Reflexivity is considered to be the key defining feature of qualitative research (Banister et al. 1994). It is argued that researchers must consider the ethical implications during the process of analysis, where there is always a risk that the researcher imposing meaning on the participants' experiences can repudiate the voice of the participant (Willig, 2008). The process of reflexivity enables the researcher to acknowledge the impossibility of remaining outside of one's subject matter and encourages them to become more aware of how they contribute to the construction of meaning throughout the research process (Nightingale & Cromby, 1999). According to Finlay (2002), the reflexive process is full of "muddy ambiguity" and involves a complex negotiation of "the swamp of interminable deconstruction, self-analysis and self-disclosure" (Finlay, 2002, P. 209).

In order to enhance my self-awareness during the research process, I kept a research diary and reflected upon each case after interviewing and whilst analysing. This was important to the process of research enquiry as by recording my thoughts, feelings and reactions, this helped me to try to gain some distance and perspective on my own personal process and to take ownership of my own assumptions and beliefs. This follows Gadamer's (1975) recommendations used by hermeneutic phenomenologists and is in keeping with other researchers who have used IPA (Brocki & Wearden, 2006). Clinical supervision and research supervision were vital arenas for enhancing my self-awareness and having my assumptions challenged and held to account. I also kept abreast of current developments and discussion in IPA by following and involving myself in critical debate in the IPA Yahoo Group which is moderated by Jonathan Smith.

1.2.6.1. Personal Reflexivity

As a daughter who has been in therapy, I am aware that my personal experience of therapy and my relationship with my mother have coloured my perspective. By this I mean that I have come to the subject area with preconceptions about the experiences of mothers who have had an adult daughter in therapy. I have reflected that I sometimes felt guilty going to therapy, as I felt that speaking about

my family was a betrayal. As a Trainee Counselling Psychologist, I was able to justify going to therapy to my family as it was a compulsory part of my training. Over time, I have been able to share some of my more personal reasons with my family.

My experience of my mother was that she was supportive, but appeared suspicious about my therapy. She was sometimes defensive in response to what I discussed about it with her. These experiences of therapy as a daughter led me to fantasise that, as with my own mother, my participants would hold deep-seated reservations, fears, jealousy and negativity about their daughters' therapy. Also, as I have experienced my own mother as defensive and struggling to accept her imperfections and humanity as a mother, perhaps I was unconsciously looking for some form of vicarious confessional. In the appendices (see *Appendix 1*) I have recorded a further reflection about my own experience in order to be transparent about my experience of therapy, and what might underlie my assumptions about the process that takes place for others.

As a Trainee Counselling Psychologist, my clinical experience and knowledge of psychological theory and research came to bear on my assumptions about a mother's experience of having an adult daughter in therapy. It was important that I was aware of how these factors influenced my interactions with participants and the co-production of the research data. For example, having worked with children and adults in therapy, I have developed the assumption that parents need to be on board in order for their child to feel that they have permission and acceptance to use therapy freely. Acknowledging my attitudes and opinions, and trying to remain open to the experience of the participants, was an important part of my reflective practice.

As a Trainee Counselling Psychologist, I could not help but bring my therapeutic skills to the relationships with my participants and it was inevitable that I would be biased towards exploring certain avenues. For example, I was particularly interested in how participants coped with their difficult feelings, and I think this is related to my values as a Counselling Psychologist as I try to bring my client's attention to their coping resources. However, the tensions between the role of researcher and Counselling Psychologist, both during the data collection process and during the analysis, were undoubtedly something that I struggled with,

and I will discuss this dilemma further under the next heading and in the discussion.

I have used personal therapy to help me to manage my workload and particularly to be able to explore in greater depth how I might be in relation to others, that might lead me to close down my openness and curiosity. This is of particular relevance to IPA, where the qualities required of an IPA researcher are “open mindedness, flexibility, patience, empathy and the willingness to enter into, and respond to the participant’s world” (Smith et al., 2009, p. 55). For example, if I feel uncertain about what to say or do, I can sometimes feel anxious and vulnerable. From here, I may feel more confident if I take on the position of the expert who “knows”, or who “plays stupid” (Sinason, 1992) and pretends to understand.

1.2.6.2 Epistemological reflexivity

In this section, I just want to reflect briefly on how I negotiated the balance between description and interpretation during the analysis of the data. As discussed earlier, these different aspects of IPA are renowned for causing tension within researchers. It is a challenge to remain faithful to the participants’ accounts, and at the same time, to engage in the hermeneutic sense-making process required for greater depth of understanding (Smith, 2004). Given one’s epistemological position, this dialectic can become more or less strain-inducing.

I would say that my balance was weighted on the side of interpretation over description. Having collected the data, I jumped quite quickly into an interpretivist position whilst analysing my results. I have already reflected on my epistemological position above, and explained my understanding of the co-constructed nature of knowledge creation. Indeed, from the transcribing process, I became acutely aware of the hermeneutic process that took place during the interview, which I recorded in my research diary as *“her words are my words and my words are her words”*. I think this was illustrative of meaning-making in action. My therapeutic experience with the practice of interpretation may also have made this process quite automatic.

Ultimately, in my exuberance I assumed that whatever I analysed would be heavily influenced by me anyway and underestimated the extent to which I needed

to stay with the minutiae in order to access meanings. It was important for my supervisor to point out this jump in my initial coding and to stress the importance of returning to the words of the participants before entering the next stage of interpretation. I believe that language can be a way of capturing meaning, but as it can have multiple meanings, it is crucial to stay as closely to it as possible so as not to lose its essence.

I wonder as well whether my experience shared with that of Fulder-Heyd (2010) in her thesis about women's experience of psychological homelessness. She felt that her participants urged her to help them to make sense of their experience and that this level of interpretation was extended into the write-up stage. I certainly felt encouraged by my participants to offer my ideas about the aetiology of mental health difficulties, and to give an expert formulation of their daughters' difficulties. Staying with uncertainty and not being drawn into reassuring the participants was a tension that I worked with during interviews and perhaps this was a struggle that I continued to battle with during the analysis.

1.2.7. Procedures

I will now describe the practical procedures involved in carrying out the research and the developments that took place during the process.

1.2.7.1. Participants and sampling

The participants consisted of nine women aged between 54 and 61 (mean = 56.5 years, standard deviation: SD = 2.56). Seven participants were employed in a range of different part-time and full-time occupations. Seven participants identified themselves as White British and two identified themselves as White Other. Six participants identified themselves as married, two divorced and one widowed. Six mothers had undertaken personal therapy. One White British woman, aged 63 and married, was recruited for the pilot interview. One of the participants was interviewed twice as the first audio-recording did not work (See *Discussion* for further comment).

The participants' daughters were aged between 19-35 years (mean = 27 years, SD = 4.91). All but one of the daughters lived away from home and four of them were living with their partner. All but one of the mothers had more than one

child. The majority of the participants' daughters (seven out of nine) had been in multiple therapies and the same amount was undertaking therapy at the time of interview. The average number of times in therapy was two (SD = 1.22). All but two of the participants' daughters had been in private therapy and three daughters had experienced private therapy and therapy with the National Health Service (NHS).

The small sample size is characteristic of IPA. Smith et al. (2009) suggest that 4-10 interviews are appropriate for a research study. IPA is committed to detail (Smith & Osborn, 2008) and as analysing each interview thoroughly is a lengthy process, a small sample is necessary and realistic (Hefferson & Gil-Rodriguez, 2011). Morrow (2005) stresses that quality, length and depth of interview data and selecting information-rich data is far more important than sample size in qualitative research methods.

I used the following inclusion/exclusion criteria:

Inclusion criteria:

- The individual is female. As discussed and justified earlier, in order to answer my research question, I was specifically interviewing mothers, not fathers. This relationship was chosen for closer exploration as the mother-daughter relationship has been described as the most intense intergenerational relationship in terms of emotional connection and interdependence (Fischer, 1991).
- The individual has a daughter aged 18. I was investigating the mother's relationship with their adult daughter and 18 is the legal age of adulthood.
- The individual's daughter is or was in personal therapy/counselling/psychotherapy. I did not stipulate the length of time of the daughter's therapy, or a timeframe within which the daughter had been in therapy. I also kept the concept of therapy broad. IPA posits that the most important reality is what people perceive it to be (Willig, 2001). Therefore, the facts of the daughter's therapy were considered to be less important than the mother's experience of therapy and the underlying meanings attached to this.
- The individual was proficient in spoken and written English. This was in order for informed consent to be given and so that a depth of communication could be reached. I am aware of the literature pertaining to power-deferential and

translation within researcher-participant relationships (e.g. Temple & Young, 2004; Willig, 2012). I believe that even within the same language, there is variation within the meanings ascribed to different words, and, hence, the choice of words used by participants and the meanings presumed by researchers. Therefore, in a sense, a process of translation takes place even within the same language. There is also a variation based on the different access that individuals have to vocabulary, which may depend on a number of factors, including education level and family of origin.

I am aware that in deciding upon these criteria, I limited my sample to individuals who communicate via the spoken word. Although I may be attempting to “give voice” to a specific group of women, it could be seen that I am privileging the voices of some and upholding the marginalisation of other oppressed groups of women. This topic has been discussed by Ashby (2011).

Exclusion criteria:

- I chose to exclude individuals currently in personal therapy as I thought this was ethically appropriate. I was concerned that the experience of being interviewed might feel similar to therapy and that this could overwhelm the participant, or influence their personal therapy.

There was a need for a wide range of methods for recruitment as this participant group was not easy to access. The recruitment procedures described below have been recommended by individuals who are involved in caring for their family members who have mental health difficulties (Mental Health Research Network, 2011). This was thought to be a useful endorsement as it was hypothesised that a number of the mothers might be involved in supporting their adult daughters.

Recruitment procedures:

- I developed an advert/leaflet (see Appendix 2), which I handed out in public areas and displayed in a variety of venues across London and Essex and Hertfordshire, including: gyms, shops, cafés, supermarket noticeboards, public toilets, public house toilets and churches.
- I used the internet. I set up a website (www.themothersexperienceofhavinganadultdaughterintherapy.yola.co.uk)

and advertised for participants on internet sites (www.mumsnet.com, www.facebook.com, www.twitter.com).

- I used a snowballing technique, whereby I asked participants to pass on the details about the project to others. Snowballing is a helpful technique for locating specific and often hidden populations (Heckerthorn, 1997). I asked people that I knew in general – including friends, family, course colleagues and work colleagues – to pass the details of the project on to others.

Due to the use of small samples in IPA, it is recommended that researchers try to use purposive, homogenous samples so that convergence and divergence within the sample can be analysed meaningfully, in detail (Smith et al., 2009). In order to limit heterogeneity, I particularly chose to advertise in locations which had a similar socio-demographic to the majority of my contacts. Therefore, a sample with a similar demographic and socio-economic status profile was produced. The sample can be defined as “purposive” as there was a specific pre-defined group: mothers who had experienced having an adult daughter in therapy.

1.2.7.2. Data collection methods

A demographics questionnaire and an interview were used as data collection methods.

The demographics questionnaire

This questionnaire (see *Appendix 3*) was used as part of the early stages of rapport-building with the participant. It was a quick information-collecting method that aimed to provide quantitative, supporting demographic information for the interview data. It was developed by considering what kinds of demographic information would assist me to explain similarity and difference between research participants. Due to the small sample size used in this research, it was not possible or intended for the findings to be statistically generalisable. By collecting significant information about the sample, I hoped for the reader to have sufficient information to be able to think about where possible the findings or relevance of meanings may be applied to other contexts, situations or people (Finlay, 2006; Morrow, 2005). In

developing the questionnaire I looked at demographic questionnaires used in similar studies and discussed what to include with my research supervisor.

Although I had included the employment status on the questionnaire, initially, I did not ask for the occupation to be named. Following reflection after my first five interviews, I thought that this would be important information to collect, particularly as several participants referred to their work during the interviews. Fortunately, I knew the occupation of the five I had interviewed, but I added this new item on to the questionnaire for subsequent interviews.

Whilst compiling the demographic information and coming across different research literature, I reflected that it might also have been useful to have asked the following questions of the participants in the demographics questionnaire:

- *Where does your daughter reside?*
- *What is your daughter's employment status?*
- *What is your daughter's marital status?*

This information seemed relevant for developing a better understanding of the context of the mother-daughter relationship and the daughter's therapy. As this information was readily provided by the participants during the interview, I was able to compile this information. This was also the case for collecting information about whether the daughter's therapy was private or with the NHS. As it was a detail provided by and often elaborated upon by the participants during the interviews, I could easily gather this information.

Semi-structured interview schedule

A semi-structured interview schedule (see *Appendix 4*) was used to collect the data, as this enables a flexible method of phenomenological inquiry required for IPA. Semi-structured interviews are particularly suitable when the research topic is personal, complex and interested in process (Smith et al., 1995). To accumulate rich data, it is important for the participant to be able to share closely in the direction of the interview, so having a schedule that guides and does not dictate the interview is useful (Smith & Osborn, 2008). This is thought to help facilitate empathy and rapport, to enable the researcher to freely probe interesting areas that arise and to allow the participant to provide a fuller picture.

Semi-structured interviews also fit with the phenomenological position which is central to IPA. The researcher has some ideas about the area of interest and some questions pre-planned. However, they have a wish to enter as much as possible into the world of the participant and so need to provide maximum opportunity for the participant to tell his or her story. The limitations of semi-structured interviews, as is relevant to this research project, will be addressed in the discussion.

The semi-structured interview schedule was developed by formulating questions with my research supervisor that would encourage the participant to talk about the topic. We thought of the broad range of perceptual information that would be useful to collect, and the questions that I would need to ask in order to elicit this. The questions were then reviewed for emotional sensitivity and comprehension.

There were 3 main areas: 1) identity, understanding and internal world, 2) process and 3) management of change.

1. I wanted to access different aspects of the mother's experience of having an adult daughter in therapy i.e. personal and shared:
 - *At a personal level.* This included her *understanding* of having an adult daughter in therapy, how her *identity* was influenced i.e. as a mother, a woman and a person, and the different aspects of her *internal experience* i.e. thoughts and feelings.
 - *At a shared level.* This included looking at the impact of her experience on her relationships and her life in general.
2. I wanted to think about the passage of time, and attend to the mother's experiences at key stages in the process. This included the *beginning of therapy, during therapy, end of therapy* and *after therapy*.
3. I wanted to understand how the mother responded to changes that occurred in herself, in her daughter, in her relationship with her daughter and with members of the family or relationships within the family as a result of her daughter being in therapy. I wanted to understand more about what helped her to manage with these changes.

Applying an appropriate sequence was the next step. This meant thinking about the nature of the questions and leaving the most sensitive questions to later on in the interview, once rapport had developed and the participant had become more comfortable with speaking to me (Smith & Dunworth, 2003). To help ease the participant into the research area, I started off the schedule with a general question about what the participant understood about their daughter's therapy. From here, I followed the passage of time in order to explore their experience of their daughter being in therapy. I asked more personal questions about how their experience had affected them in relation to different aspects of their identity later on. I decided to end the interview on how the participant had managed the process, as this sought to contain the participant, by helping them to reflect on what had helped them to cope with the experience. I included prompts at each stage to help to facilitate the participant in providing and elaborating upon their answers and to help me to be more explicit about what information I was looking for.

Developments upon the data collection process:

The interview schedule was necessarily flexible and carried out differently each time as I needed to adapt the questions according to what the participant brought. The pilot study, interview experience and feedback from participants also led to developments in the interview process:

Pilot study

I trialled my interview schedule with an initial research participant. From this trial and discussion with the participant, I was able to assess the usefulness of the interview questions for eliciting rich information and whether the questions were perceived as sensitive to the participant. From the feedback, I uncovered that some of the questions seemed repetitive. This meant that I refined the questions for use in subsequent interviews and made effort to consider the wording of the questions I asked and to bring some variety. For example, if I asked the question:

"Can you tell me about what it was like for you when your daughter first started therapy?"

I worded the next question differently:

“What about after the first few months; how did you feel about your daughter being in therapy at that stage?”

My participant advised that she had felt listened to and understood and did not report any unpleasant reactions from hearing the questions.

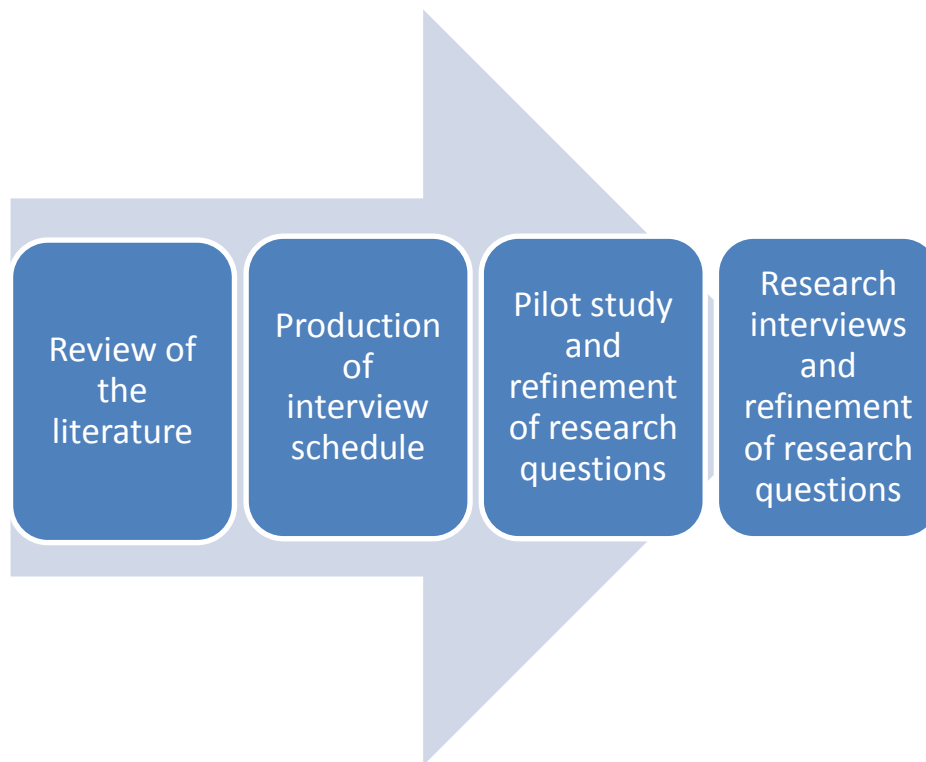
First interview

Following the first interview, I reviewed the interview schedule (see *Appendix 5* for the revised interview schedule) with my supervisor as I was concerned that I had focused too much upon the mother’s experience of her daughter’s mental health problems, rather than on her experience of her daughter being in therapy. With this awareness, I reworded the questions with an emphasis on the mother’s experience of her daughter’s therapy e.g. *“How did you feel about yourself as a mother, having a daughter in therapy?”* This helped in subsequent interviews to refocus my participants back on to their experience of their daughter being in therapy and how they managed this process. I also felt that I had not been able to access enough about the mother’s experience of perceived social stigma or of shame. This was also influenced by the participant’s feedback, as we agreed that I had not enquired about how she felt about other people’s responses to her daughter being in therapy. Therefore, I produced some more questions to help to explore this facet of the mother’s experience if it was not forthcoming. For example, *“Do you ever reflect upon how others might perceive you for having a daughter in therapy?”*

Feedback from other participants

Following a participant’s feedback that she was left unclear about what was being asked of her, due to the open nature of the questions and the lack of a clear structure, I sought to provide some more clarity about the style of interviewing to future participants. Although it was described briefly in the information sheet, I reiterated in the covering letter (see *Appendix 6*) and at the start of the interview that the interview would be semi-structured. I explained that this meant that I had

some questions to guide us, but that I would also be guided by what the participant brought.



Flow diagram 1.2a: Process of semi-structured interview development

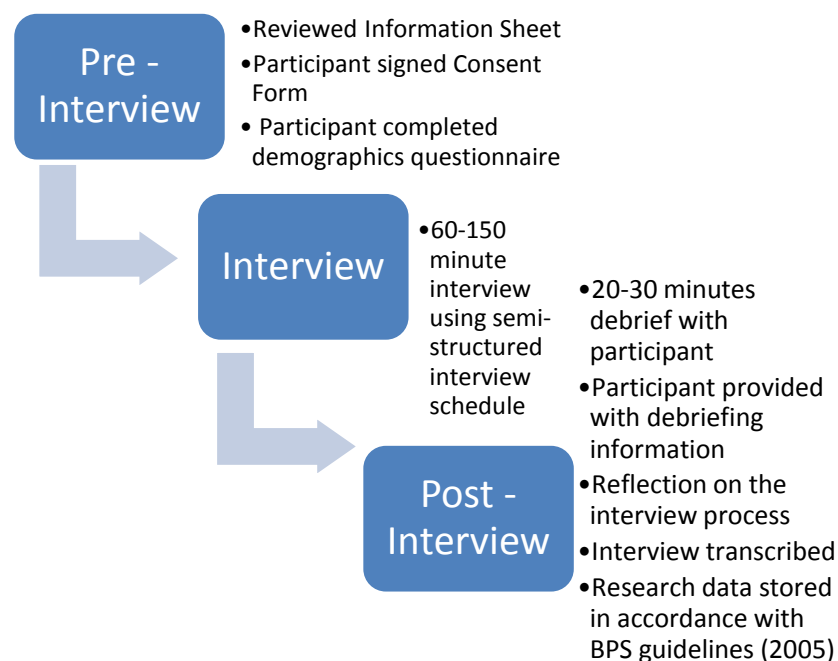
1.2.9. Process of data collection

Once contact was made with potential participants via email or telephone, I provided them with a covering letter and information sheet and answered any arising questions. I then arranged to meet with them in order to go through the information sheet (see *Appendix 7*) and to carry out the interview once their consent was given (see *Appendix 8* for consent form). I asked the participant to suggest a time and location that was convenient for them. However, I needed to stipulate that the location was appropriate for interviewing i.e. private and quiet.

I used introductions and ice-breaker questions initially to help to make the participant feel comfortable in my presence and to build rapport. After a short amount of time, I went through the information sheet and answered any outstanding questions, ensuring that the participant understood the nature and purpose of the research study. Working collaboratively with the participant, consent was sought and the participant responded to the demographics questionnaire. Once this process was complete, the interview commenced. The

interviews were between 60-150 minutes in length. Following the interview, there was a debriefing period in which I asked the participant to share any thoughts, feelings or feedback they had about the interview process. I also provided participants with debriefing information, which included an extensive list of resources for services where they could seek additional support if they found it useful to do so (see *Appendix 9*).

The interviews were audio-recorded and transcribed verbatim. All verbal utterances were recorded, along with non-verbal information e.g. gestures, facial expressions that I recalled. This was so that I could create a text that was as close a representation as possible to the research interview. Please see the appendices for an extract of an annotated transcript (see *Appendix 10*).



Flow Diagram 1.2b: Process of data collection

1.2.9. Ethical considerations

The research was carried out in accordance with the BPS Code of Ethics and Conduct (2009), the Standards of Conduct, Performance and Ethics as set out by the Health and Care Professions Council (HCPC:2012) and it met the ethical approval of City University (see *Appendix 11*). I have described below the steps that

I took in order to do this. Participants were informed of these details on the participant information sheet.

Informed consent was sought from research participants after they had read the information sheet and been given ample opportunity to ask questions and to receive satisfactory answers.

Confidentiality and participant anonymity

1. All identifying information was anonymised in the transcripts.
2. Hard copies of transcripts, demographic information and signed consent forms were stored in separate secure locations. A password-protected USB stick (also stored in a secure location) stored electronic versions of the transcripts and demographic information. I was the only person with access to the data.
3. All data will be stored for 5 years and then destroyed, in accordance with the BPS's Good Practice Guidelines (2005).
4. Participants were recruited from areas where I do not live or work in order to reduce the likelihood that I had had previous contact with them or their family members.
5. Participants were advised that complete confidentiality could not be guaranteed as any disclosures of criminal activity, professional malpractice or risk of harm to self or others would have to be acted upon.

Ownership of data/conclusions: I informed the participants that they had the right to withdraw their consent at any time, without giving reason. Each participant was allocated an ID number and a pseudonym, so should they wish to withdraw their consent, this would make it possible for me to easily identify and destroy their data.

Harm: Due to the nature of the research topic, participants may have reflected upon past events, which they found upsetting. It may also have led to a re-evaluation of their current situation or relationships. In the participant information sheet, it was suggested that if anyone was at all concerned about the effect of taking part in the study, then it was advisable not to participate. I provided

participants with options for how the interview could proceed if they became distressed:

- I would suggest a short break or to stop the interview altogether.
- They could signal that they did not want to answer the question and we could move on.

During the debriefing process that followed the interview, I used my therapeutic skills in order to validate the thoughts and feelings of each participant following the interview. I also gave participants a comprehensive list of services where they could receive additional support. I recognise that there are important differences between the role of researcher and therapist and that managing the boundaries of the role of researcher, particularly in the context of emotionally complex research topics, has been a topic of ethical debate in the literature (e.g. Kvale, 1999; Mitchell & Irvine, 2008). I therefore sought to manage these boundaries appropriately and respectfully for the participants.

I needed to consider my own well-being throughout the project. This was in order to manage my own emotional responses, and to prevent burnout and detachment from the research participants (Dickson-Swift et al., 2006). Before meeting participants I ensured that I took a telephone with me. I told someone where I was going beforehand and arranged a time when I would contact them after the interview so that others were aware of my whereabouts and my safety. If I was not in contact or unreachable after this time, this would signal a cause for concern.

In terms of my psychological well-being, making use of research supervision and personal therapy was important for taking care of myself throughout the process.

Reciprocity: I hoped that taking part in the research provided the participant with the opportunity to tell her story and to have her views taken seriously. Through a process of gentle enquiry, I aimed to encourage the participant to reflect upon her experiences, including her thoughts, feelings and responses. Hatcher and Hatcher (1983) detected that spouses and parents of patients responding to their survey

had an unmet need for someone to talk to about their feelings regarding the therapy process and to fill a perceived gap in intimacy with their loved one in therapy. I hoped, as suggested by Birch and Miller (2000), that the interview may have a therapeutic effect and that new realisations and re-evaluations arising out of the research process may help the participant to make sense of her experiences. However, I also acknowledged that the research interview is not therapy and that offering anything other than a research interview, such as interpretation, could be considered unethical (Kvale, 1999; Rizq, 2008).

By taking part in the research, it was anticipated that participants' personal experiences and contributions might be of benefit to other mothers and daughters and their relationships in the future. It was hoped that the knowledge from the research could be used to develop therapeutic practice and training for working with mothers and daughters.

Arising ethical concerns:

An ethical concern that arose involved approaching potential participants through their daughter i.e. through an email asking whether anybody or their mother would be interested in participating. Due to daughters approaching their mothers about participating in the research project, it was possible that this invited mothers unwittingly to reflect upon how their daughter's therapy was affecting them and their relationship with their daughter, which hitherto they may not have done. This may then have had an influence on the mother-daughter relationship.

During this project, ethical challenges arose around the bounds of confidentiality. One particular incident led me to think further about confidentiality and I was able to bring my concerns to supervision and to bear this experience in mind during subsequent interviews.

1.2.10. Validity and issues of trustworthiness

Quantitative research methods are evaluated according to three main criteria: reliability, validity and generalisability. The applicability of all three for qualitative research methods has been contested (Finlay 2006). It could be argued that the concepts of reliability and validity fit more within a realist, positivist research tradition, where the aim is to achieve an objective truth. These concepts are

perhaps less relevant to the epistemology of most qualitative research methods, which are more exploratory and acknowledge the inevitability of subjectivity in the research process (Yardley, 2000). However, it is important not to place a strict dichotomy between quantitative and qualitative methods in terms of subjectivity, as both acknowledge researcher bias but have different ways of approaching it (Morrow, 2005; Striven, 1997). In relation to generalisability, qualitative researchers do not aim to generalise their findings statistically, but rather show the transferability of their findings or relevance of their meanings if applied to other contexts, situations or people (Finlay, 2006).

There has been concern that by placing strict limitations on the criteria for establishing truth and knowledge in qualitative research, this may restrict knowledge and privilege the perspective of a particular group (Yardley, 2000). However, as well as the desire to enhance quality in qualitative research, concern that confusion about qualitative research methods could lead to fragmentation, rigidity and competitive research groupings has led to an increasing recognition of the need for quality control (e.g. Elliot, Fischer & Rennie, 1999; Morrow, 2005; Yardley, 2000). Researchers (see, for example, Lincoln & Guba, 2000) that have provided “parallel criteria” for benchmarks of rigour in qualitative research based upon criterion in quantitative methods have been criticised (Morrow, 2005). It has been suggested that in their attempt “to make qualitative research more acceptable to conventional audiences” they have created “logical inconsistencies” (Morrow, 2005, p. 252). Importantly, it has been stressed that qualitative researchers should be unapologetic about the differences between qualitative and quantitative approaches e.g. small sample sizes (Morrow, 2005).

Specifically in relation to the development of qualitative approaches to research in counselling psychology, Morrow (2005) recommends that intrinsic standards of trustworthiness emerging from qualitative research should be used. Smith et al. (2009) have also highlighted how IPA, as with other qualitative research methods, should be evaluated in relation to relevant criteria. They particularly focus upon Elliot et al.’s (1999) and Yardley’s (2000) guides to validity and quality which they describe as “sophisticated” and “accessible” (Smith et al., 2009). From my review of the literature, there does not appear to be an overall consensus

amongst qualitative researchers as to the criteria to use. However, Finlay (2006) suggests that when taken as a whole, there is some evidence of agreement and overlap.

Aiming to fit within what she describes as the pluralistic ethos of qualitative methodology, Yardley (2000) provides four open-ended and flexible criteria for assessing the quality of a qualitative study. I have chosen to include the breakdown of these here and to reflect upon how my research has aimed to meet these standards as I feel that Yardley's criterion embraces the complexities and ambiguities involved in qualitative research methods. In some instances, I have referred to Elliot et al. (1999) and Morrow (2005) where there are some helpful overlaps. Yardley (2000) clearly states that these criteria are open to interpretation; therefore, it will be left to the reader's critical evaluation to decide whether I have met them.

1. Sensitivity to context

I have attempted to demonstrate an awareness of the existing literature that is relevant both for my research topic and research methodology and to integrate this into my interpretation of the data and throughout my writing. Throughout the project, I have tried to bear in mind the historical and socio-economic context of my research project, and of each participant within it, so that the sample that I provide is "situated" (Elliot et al., 1999).

I acknowledge the inevitable power-imbalance between researcher and researched and that, ultimately, my interpretation of the data will be heard. I have attempted to make the voices of the participants strongly present by including their language and by illustrating how I have come to my conclusions by grounding them within quotes from the transcripts. I have also made explicit how I think that my beliefs and assumptions have impacted the research process (see the *Reflexivity* section and excerpts from the reflective diary in *Appendix 12*) which is referred to by Elliot et al. (1999) as "owning one's own perspective". By doing so, I hope to encourage the reader to critically evaluate the research and to make an informed judgement about whether they view my interpretations as justifiable.

2. Commitment and rigour

I have attempted to fully immerse myself in the research process, to show commitment to the research topic and determination to develop my understanding of this area. This has involved repeatedly returning to the transcripts, to my notes and analysis, in order to try to gain a deep understanding of what makes up the body of the data and how the different parts interrelate (Morrow, 2005). As an adult daughter who has been in therapy and as a Trainee Counselling Psychologist, I have an investment in this topic as it holds personal relevance to me.

Through lengthy interviews and thorough analysis that involved trying to stay as close as possible to the participants' experiences, I have tried to show rigour in the data collection and analysis process. I have attempted to develop a thorough interpretation of the meaning of the phenomena for each research participant by addressing the variation and complexity that I have observed, providing an empathic involvement in the analysis and "sophisticated theorising" (Yardley, 2000).

3. Transparency and coherence

By detailing every aspect of the data collection and data analysis process, I have tried to make the way I have come to my conclusions explicit and transparent. As previously stated under *Sensitivity to context*, I have presented substantial extracts from the textual data so that readers are able to decide for themselves whether the patterns that I have identified make sense to them – thereby exposing my analysis as much as possible to the critical eye. I have also used what Elliot et al. (1999) refer to as "credibility checks". For example, I have exposed a section of an annotated transcript to a group of fellow IPA researchers in order to receive feedback about whether they could see a goodness of fit between my analysis and the text. I shared my annotated transcripts and generation of themes with my supervisor, who checked to see whether she could understand my analysis and see how my themes fit with what she observed in the text. I also shared my written analysis with my supervisor and two colleagues trained in the use of IPA, to see whether they "agreed" with my analysis. I responded to the feedback I received, and adjusted my analysis accordingly.

As stated before, I have included sections on reflexivity, whereby I have made as transparent as possible my subjectivity as a researcher and an awareness of how I may have influenced the research process. In addition, by including a negative case that contradicts some of the emergent patterns, I have tried to bring to life the contrast and complexity evident in the data. Negative case analysis has been described as a strategy that can increase the credibility of qualitative research (Lincoln & Guba, 1985) and strengthen research findings (Barusch, Gringeri & George, 2011).

4. Impact and importance

I hope I have achieved the last criterion by providing a thorough discussion (see *Discussion* section) of how I believe this research is relevant to the field of counselling psychology and could be used to inform counselling psychology training and practice. I have also attempted to illustrate in the *Introduction* how these research findings could contribute to a gap in the existing research literature, which lacks an in-depth understanding of the experience of the mother who has an adult daughter in personal therapy and how she manages the process.

1.2.11. Analytic strategy

Larkin et al. (2006) suggest that IPA is more of “stance” towards data analysis, rather than a clear analytic method. Indeed, as mentioned earlier, Yardley (2000) suggests the danger inherent in those new to qualitative research in rigidly following “clear-cut” procedures in the hope of guaranteed acceptance. Therefore, the data was analysed using guidance from Willig (2008) and Smith et al. (2009), with the understanding that there is considerable variability and flexibility within the approach. I have tried to record a detailed and transparent explanation of the analytic process so that the procedures I used to help me to arrive at my findings are made as explicit and repeatable as possible (Morrow, 2005).

As I listened to each recording and transcribed them, I noted down some initial arising thoughts in my research diary and tried to detail in the transcripts my memories of gestures, facial expressions and activities other than speech. On a case-by-case basis, I read through each transcript a number of times before starting to make any annotations. Following this stage, I started to make notes,

observations, summaries and descriptive labels alongside the left-hand margin. I worked hard to take what I read at face value, and not to move beyond the level of description of content at this stage (Smith et al. 2009). After this process, using the right-hand side of the page, I started to assign themes or labels, using the participant's words as much as possible, and tried to characterise each section of the transcript. It sometimes involved the use of psychological terminology. I noticed that the labels I used revealed my lexicon and, at times, it was restricting and, at other times, expansive. It was helpful to brainstorm different phraseology and to choose from these what seemed to fit best.

Once this part of the analysis was complete, I opened an Excel worksheet and listed each theme I had written in chronological order and cross-referenced it on the transcript. By scanning the page and familiarising myself with the themes, I started to analyse the relationships between them and to form clusters of themes. Throughout this process, a cyclical activity of checking back took place, to ensure that each theme made sense in relation to the original data (Langridge, 2004). This was also an attempt to create a good balance between the reading and understanding of the part or idiographic and the whole or general (Langridge, 2004; Smith et al., 2009). During the checking process, I sometimes uncovered misunderstandings and personal bias. I tried to counteract this by noting it down for reflection in my research diary and asking myself what this meant for my understanding of the data. A summary table of themes, including cluster labels and illustrative quotes, was used to give structure to the data (Willig, 2008).

This process took place for each participant's transcripts before I attempted to integrate the summary tables into one inclusive list of master themes and subthemes for three of the participants, which reflected this group of participants as a whole. I printed each participant's list of themes out so that I had an overall picture, and looked for relationships between themes across participants, and how clusters could be integrated and condensed. This is akin to Smith et al.'s (2009) process of *abstraction*, whereby themes are grouped according to similarity and a new name called a "superordinate" (or "master") theme is given to the cluster. I then used this summary table to bring together the remaining participants' data and tried to ensure that I maintained an openness and curiosity to newly arising

themes and continued to pay attention to similarities and differences amongst the participants.

Using the final summary table of themes, I wrote post-it notes detailing the individual subordinate themes and stuck them to a contrasting coloured sheet of card attached to the wall. I moved around the master themes to help to bring together a tentative structure or model, to enable the themes to tell a story, and to allow relationships between themes to become more apparent. Using this structure also helped me to reorder the themes in the summary table in a way that seemed to help me to capture the most important aspects of the data (Smith et al., 2009). See the appendices for an example of a summary table for one of the participants with quotes (see *Appendix 13*), a summary table of themes for all of the participants with the location of quotes (see *Appendix 14*) and a summary table for one theme with examples of quotes (see *Appendix 15*).

By starting to write a narrative summary of the shared experience of the participants, this helped me to condense, focus my attention on, and to sift out, the most salient findings from the research. This process is recommended in the literature as a way to gain a sense of the whole picture before moving towards the idiographic level (Smith et al., 2009). From here, I aimed to identify illustrative examples of shared experiences, as well as those that were distinctive or contradictory, from the participants' quotes to use to write up the analysis. I tried to find the quotes that were the richest in metaphor or that seemed to summarise a significant aspect of the participants' experience, in order to make the analysis interesting and convincing. I had developed a quote bank on Excel by creating a worksheet per theme and pasting all relevant quotes and locations on to it. This helped me to locate and discriminate between the examples I could use.

Echoed again in the write up of this section was the slow hermeneutic process of movement between the holistic analysis, my attempt to provide an overall understanding of the data, and the use of particular extracts to illustrate participant experience at the individual level.

1.3. Analysis

1.3.0. Overview

In this chapter, I present the over-arching themes that emerged during the process of IPA. The themes, and my ensuing discussion of them, aim to increase the understanding of how the mothers in this study experienced having an adult daughter in personal therapy and how they managed this process.

During the analytic process, I condensed a number of subthemes within themes due to significant overlap in meaning. Overlaps were also found to exist between superordinate themes. In my efforts to create a coherent and systematic argument, I used a process of meaning-making and personal interpretation in order to structure the presentation of superordinate themes and subthemes. This meant that I needed to be selective with the themes and how I described them as there was no scope to present an exhaustive account of themes.

I have chosen to discuss in depth the themes that seem to relate to my research question as closely as possible, and those that I hope will provide the reader with the insights that I found to be the most novel, interesting and to hold the most implication for this research area. I hope that this presentation of the material aids clarity and readability. However, I stress that I do not wish to reduce the unquestionable complexity of the participants' experiences. Throughout this chapter, I provide the general and shared experiences of the participants in order to present what may be more common to mothers who have adult daughters who have been in therapy. I also present distinctive examples which aim to illustrate the uniqueness and intricacy of the participants' experiences.

I hope that my findings will be able to support, clarify and illuminate other literature in the field. Therefore, where I find it relevant to do so, I draw from existing psychological theory and research in order to enhance the understanding of the information I present and to situate the findings within the existing knowledge base. However, I do this selectively as I want to prioritise the voices of the participants. The reader will find more links with the relevant literature in the discussion section.

Below is an overview of the five emerging themes which I will present. Each of the sub-ordinate themes is divided into two or three subthemes.

The first super-ordinate theme is ***the impact of the daughter's therapy upon the daughter***. This theme seeks to explore the ways in which mothers perceived and made sense of the influence and impact of their daughters' therapy upon their daughter. The experience of the tentative nature of change and the multiple factors perceived as contributing to change is scrutinised.

The second super-ordinate theme is ***the impact of having a daughter in therapy on the mother-daughter relationship***. This theme describes the mothers' experience of changes that they encountered in their relationships with their daughters as a result of their daughters' therapy. These changes related to increases in conflict and closeness and improvement in communication and compromise. The experience of ongoing closeness in the mother-daughter relationship is also explored.

The third super-ordinate theme is ***the impact of having a daughter in therapy on the mother***. This theme aims to illuminate how mothers were affected at an emotional level, a cognitive or sense-making level and at the level of identity. Within this theme, a range of emotional responses experienced during the process of having a daughter in therapy are examined. A number of different sense-making activities used by mothers to help them to make sense of their experience of having a daughter in therapy are addressed. In relation to identity, reflection on the sense of self as a mother, whilst trying to comprehend their daughter being in therapy, is explored.

The fourth super-ordinate theme is ***managing the process of having a daughter in therapy*** where the ways in which mothers appeared to manage their thoughts and feelings during the process of their daughter being in therapy are explored. The experiences that mothers shared about how they attempted to manage the mother-daughter relationship and, reciprocally, how mothers perceived their daughters as managing the mother-daughter relationship during the process of therapy are scrutinised.

The final super-ordinate theme is ***processing the daughter's story and re-evaluation***. This theme explores the different responses that mothers appeared to

have to hearing their daughters' perspectives on life events. The finding that for some of the mothers, their daughters' therapy appeared to have a therapeutic effect upon them is considered. Through discussion with their daughters and reflection upon their stories, this sometimes seemed to lead to a process of re-evaluation for the mothers themselves, and to changes in attitude and self-awareness. In order to integrate the analysis within the data and to ensure transparency, direct illustrative quotes from the transcripts are used during this section (Smith et al., 2009). At all times I use pseudonyms and identifying information is changed or omitted in order to protect confidentiality of participants and their family members. To aid clarity and transparency, the pseudonym and line number in the transcript are indicated in brackets following each quote. The table below depicts what symbols in the quotes mean to enhance readability:

Table 1.3a: Meaning of symbols in quotes

Symbol	Meaning
[...]	Omitted text
.....	Pauses and silences
()	Non-verbal reactions
[]	Words added for readability
<i>Italics</i>	Word stressed by participant
()	My verbal prompts

As much as possible, I have left the text from the transcripts unedited in order to stay as close as possible to the original meanings of the participants. Where I have made changes, this has been when it has been particularly difficult to follow a participant's speech, either due to poor sound quality on the recording, or due to the client's language difficulties. However, I have endeavoured to honour the participants' accounts, including grammatical errors and non-verbal expressions.

I would like to introduce the readers to the mothers who generously shared their experiences with me. I present their pseudonyms below, followed by the pseudonyms of their daughters, and a thumbnail sketch in order to contextualise

the reading of the analysis. Please note that the participants are not presented in any particular order.

- **Jane and Heidi**

Jane is 59 years old and is in full-time work as a healthcare assistant¹. She is divorced and lives alone. She has undertaken private therapy in the past. Jane's only daughter – Heidi – is 29 years old. She lives away from home with her partner and is in employment. Heidi first went into therapy 12 years ago when she was 17. This was private therapy and lasted for 6 months. Heidi recommenced private therapy two years ago for a period of 6 months. She returns intermittently to see the same therapist.

- **Lisa and Stacy**

Lisa is 54 years old and a teaching professional. She is divorced and has remarried. Lisa has undertaken private therapy in the past. She has 3 children: her daughter Stacy (30 years old) and her older son (28 years old) from her first marriage, and her younger son (16 years old) from her current marriage. Stacy lives alone and is in employment. Stacy commenced therapy when she was 19 years old. This was provided by the National Health Service (NHS) and was for a period of six months.

- **Hillary and Alex**

Hillary is a 56-year-old woman, who is currently unemployed outside of the home. She is a science and engineering professional. She has been divorced and remarried. Hillary has undertaken private therapy in the past. Hillary has a son and a daughter from her first marriage aged 28 and 25 years old respectively. Alex is her only daughter from her current marriage. Alex is 19 years old and is a student living away from home. Alex was 16 when she commenced private therapy. She was in therapy for two and half years.

- **Sarah and Anita**

Sarah is a married, 54-year-old woman who works as an information and communication technician. She has two children: her daughter Anita (aged 27 years old) and her son (aged 25 years old). Anita lives at home and is unemployed outside of the home. Anita first commenced therapy when she was 22 for a period

¹ Jobs described by the participants were classified using the International Standard Classification of Occupations – ISCO-08 (ILO, 2007). This was for standardisation and confidentiality purposes.

of 1 month. Three years later she undertook therapy for 6 months. She is currently in therapy and has been for the past two years. All of Anita's therapies have been within the NHS.

- **Celeste and Jenny**

Celeste is a 57-year-old married woman who is unemployed outside of the home. She has undertaken private therapy in the past. She has 3 children: Jenny who is 30 years old and two younger sons, aged 28 and 16 years old respectively. Jenny is a student and lives away from home with her partner. Jenny was in private therapy for a few months when she was 19 years old. She is currently in private therapy and has been for the past year.

- **Mary and Caroline**

Mary is 61 years old. She is married and works as a sales manager. Mary has two children; her daughter Caroline is 35 years old and her son is 32 years old. Caroline is employed and lives alone. Caroline first commenced therapy within the NHS when she was 19 years old. This lasted for three years. Caroline recommenced therapy privately this year and it is ongoing.

- **Meredith and Miria**

Meredith is 54 years old and works as a sales manager. She is divorced and has two children, her son, who is 30 years old, and her daughter Miria, who is 27 years old. Meredith has undertaken private therapy in the past. Miria is self-employed and lives with her partner. When she was 23 years old, Miria undertook different private therapies that were overlapping. One of the therapies lasted for one year, one for 6 months and the other is still ongoing.

- **Teresa and Sandra**

Teresa is 57 years old, not currently in employment outside of the home and married. She has two daughters; her eldest is Sandra, who is 27 years old, and her youngest is 24 years old. Sandra is not employed outside of the home and lives alone with her parents' support. Sandra was five years old when she first commenced therapy within the NHS. This therapy was on and off for 13 years. It involved other family members until Sandra was about 13 years old. Sandra was then seen individually for five years until she became too old for NHS child and adolescent mental health services. Sandra recommenced NHS therapy for two

years when she was 21 years old. Another therapy within the NHS commenced a year later, which is ongoing.

- **Evelyn and Vanessa**

Evelyn did not give her age. She works as a linguist and teaching professional. She has undertaken private therapy in the past. Evelyn is widowed and has three children. Her eldest son is 27 years old and her daughter Vanessa and her twin brother are 21 years old. Vanessa is a student and lives away from home with friends. Vanessa commenced private therapy when she was five years old for two years. Aged 11 years, Vanessa undertook therapy at school for a period of one year. Two years later Vanessa was involved in family therapy with the NHS for two years. Vanessa is currently seeing a private therapist, who she has been seeing for six years, and she has recently been assessed for further therapy within the NHS.

More in-depth case summaries of each participant can be found in the appendices (see *Appendix 16*), along with a table of demographic details (see *Appendix 17: Demographics matrix*).

After careful consideration, I have decided that through the remainder of this chapter I will refer to participants as *mothers* rather than participants, as well as by name. This is in order to respect the significance of being a mother for the woman who chooses to adopt this role in her life (McMahon, 1995; Wagstaff, 2010). Also, by choosing to take part in this research, my participants have unmistakably identified themselves as mothers.

1.3.1. Superordinate Theme 1: The impact of the daughter's therapy on the daughter

Depending on the stage of their daughter's therapy and how often they saw their daughters, the mothers in this study appeared to notice various manifestations of the impact of therapy on their daughters. For mothers whose daughters had completed therapy, it was more common for concrete changes to be reported. For those who had daughters that were still undertaking therapy, changes explored were more hypothetical and tentative. However, in general, mothers seemed to find it hard to articulate the changes that they had noticed in their daughter and to elaborate upon specific changes.

Trying to concretise an impact

A common occurrence in the accounts was the mother's judgment of the impact of therapy upon their daughter. This was more forthcoming than a description of explicit changes. All mothers reported that they had witnessed a **"helpful"** or **"positive"** impact of therapy on their daughters from at least one of their daughters' therapies. For the mothers that were able to recognise changes in their daughters, these were identified as behavioural or mood changes, changes in levels of self-confidence or self-awareness, increased emotional maturity and, what is described in the words of Celeste as the **"opening her up to other sides of her"** (Celeste, 730-731). A broadening of the mind and thinking in new ways are suggested here and also by Jane's presentation of her daughter Heidi: **"opening up her mind and talking about things"** (Jane, 737-740). For some of the mothers, therapy appeared to instigate a questioning process in their daughters, which might also be related to commencing a journey of self-exploration.

"[...] that could be the therapy that's bringing it out, making her really question things (hmm). Maybe making her see things differently. It's a little bit, I mean therapy is a little bit about taking off the shades, you know. It is very much like, you know, we all have these layers" (Celeste, 561-565).

"She found it very helpful (hmm) and it was very difficult for me because she was trying to answer questions for herself, and to do that she was asking me questions" (Meredith, 384-386).

Celeste focused upon how the questioning process might be encouraging her daughter Jenny to look at things in new ways. She appeared to use two different analogies to describe how therapy might take its affect. Firstly, she referred to how therapy was like **"taking off the shades"**, perhaps suggesting that it enabled her daughter to see things in a new light or from a different perspective. Secondly, she referred to how individuals have different layers. By this, Celeste might have been thinking about how therapy could help her daughter to address different layers or aspects of herself.

For Meredith, she seemed to recognise that for her daughter Miria, the questioning process was a helpful one for Miria's personal self-understanding. However, she also conveyed that this process had a difficult impact upon her. This interaction will continue to be explored in a following section (see *The impact of having a daughter in therapy on the mother: Emotional impact*).

Some of the mothers, mainly those whose daughter's therapy had ended, provided concrete evidence of change that they had noticed in their daughter as a result of therapy. For Mary, her daughter Caroline's improved eating pattern was clear evidence of the impact and effectiveness of the therapy.

"But the CBT actually worked for Caroline. She had a set of tools with which to live her life, and it worked. It worked, because she definitely got over the, you know, starving herself" (Mary, 488-491).

Mary repeated that the therapy worked, and by using Caroline's name, she seemed to highlight that it worked specifically for *her*. This perhaps subtly contrasted Caroline with others, for whom therapy might not work, but this emphasised that therapy *actually* can work. By **"getting over"** starving herself with the use of a set of tools, Mary portrayed Caroline as newly equipped to overcome life's hurdles.

The limited nature of change

Several mothers stressed that changes as a result of therapy were limited and that their daughter's difficulties were ongoing after therapy had come to an end. For example, Teresa expressed certainty and a sense of hopelessness about her daughter Sandra's future outlook. Her language suggested that she believed that therapy could only have a limited impact on her daughter's well-being.

"[...] she's better, so much better now than a youngster, but she will never be normal, she'll never have an easy ride" (Teresa, 922-924).

The language that Teresa used also seemed to accentuate the powerlessness that she foresaw Sandra as having in her path in life. Never having **"an easy ride"**,

suggested that rather than being the driver, she perceived Sandra as being driven, and her fate as not in her control.

The tentative nature of the process of change can be identified in several of the mothers' accounts. Some of the mothers spoke about the non-linear **"2 steps forward and 2 steps back"** (Mary, 248-249) process taken by their daughters in their therapy journey. For example, Hillary spoke about the instability of her daughter Alex's recent progress.

"[..]she seemed to be, we thought she'd really pulled herself together, but then Monday [laughs] it was like [big intake of breath] you know, back to how it has been" (Hillary, 251-253).

In this quote, Hillary appeared to re-evaluate Alex's progress in light of recent events, and concluded that Alex had not managed to "pull herself" together, as much as she and her husband had hoped and that they were back to square one. In comparison with **"opening up"**, an experience of their daughter's progress described by some mothers, **"pulling herself together"** seemed to indicate a different kind of progress that Hillary was hoping for which may have been more related to self-control and autonomy. The non-linear nature of progress, experience of relapses and exacerbations – accompanied by feelings of loss and grief – is evident in the literature about parents who experience adult-children with severe mental health difficulties (e.g. Mohr & Regan-Kubinski, 2011; Muhlbauer, 2012).

Other contributing factors to change

Along with therapy being viewed as limited in its impact, most of the mothers indicated other factors which might have contributed to change. These included other intimate relationships, medication, family support and natural maturity.

"So, I think, I find her, you see, I don't know whether it's the relationship with Charles [daughter's partner] [...] I just think that there's so many things going on right now for her (hmm)

that it's a combination maybe of all of them (*hmm*). And possibly the therapy is almost the cherry on top" (Celeste, 7336-7340).

Celeste considered a number of different factors that might have contributed to the changes she had witnessed in her daughter Jenny recently and found the therapeutic impact impossible to isolate amongst all of the other changes going on in Jenny's life. The image of therapy as **"the cherry on top"** suggests a non-essential, but complementary, contribution to the process of change her daughter was experiencing from therapy. Uncertainty about the cause of change, and an unwillingness to pin down one cause, is evident in this account, given the cautious language used.

The majority of mothers had daughters that had been in multiple therapies. These mothers experienced different impacts upon their daughter as a result of different therapies. They often appeared to make sense of these different experiences according to their perception of the goodness of fit between the daughter and the therapist or their judgment of the therapist as being **"good"** or **"right"**.

For Sarah, success in therapy equated with the therapist doing a good job and her daughter being happier.

"Well, I feel when the therapist's doing a good job, when it's working, she's happier? Erm, you know, she can, she was tending to be very morose" (Sarah, 991-993).

Sarah's intonation suggested some hesitancy and uncertainty about identifying and confirming an impact of therapy e.g. **"when it's working, she's happier? Erm, you know"**. This may be another example of the shared finding of mothers' uncertainty about the impact of therapy upon their daughters. The research indicates that there is still a lack of understanding about what parents can expect from services (e.g. Gerkenmeyer et al., 2006) and this is probably also the case for the nature of the therapeutic process.

1.3.2. Superordinate Theme 2: Impact of the daughter's therapy on the mother-daughter relationship

The majority of mothers stressed that there was no detrimental impact of therapy on the mother-daughter relationship and several reported improvements in terms of closeness, communication and compromise. Most mothers had been in therapy themselves and appeared to predict that the mother-daughter relationship would be a topic of conversation in therapy. As this knowledge appeared to be used in order to help the mothers to fantasise about what took place during therapy and to make sense of how this impacted the mother-daughter relationship, it is referred to here. It will continue to be discussed in a following section (see *Impact of daughter's therapy on the mother: Sense-making activity*).

Conflict and closeness

Mothers differed in terms of their perception of the impact of therapy on closeness in the mother-daughter relationship. Some of the mothers recognised an increase in anger and criticism towards them, which they associated with their daughter being in therapy and using it to work through the mother-daughter relationship. For Meredith, her daughter Miria's anger towards her became detrimental to their relationship. She found that the mother-daughter relationship had become comparable with **"an abusive relationship"** as a result of therapy, and that a struggle for control was occurring.

"Of course her therapist was clearly telling her to get her life back she had to have power, she had to be in control. But in her mind I was the one she had to control (*hmm*). With her it's about controlling me. So controlling when she speaks to me, controlling how I interact with her" (Meredith, 575-579).

"It's easier for me now to say I'd rather not have her in my life than have her in an abusive relationship because I think she's abusive to me and the reason I stopped her is because I had to stop her abusing me" (Meredith, 847-849).

For Meredith, it seemed as though the lack of control and abuse that she experienced in her relationship with her daughter was intolerable. The choice to not have her daughter in her life appeared to be her attempt to make her life more bearable and to gain back some control in her life.

In contrast, Hillary, who also felt that her daughter Alex had become more critical towards her, hypothesised that Alex's attention to the mother-daughter relationship in therapy may have improved her maturity and made it possible for her to feel closer to Alex.

“[..]perhaps it's because she's more mature” (Hillary, 816-817).

““So I don't know what she's said about me, I know she's talked about me, and the outcome is that we're very close and actually I wonder whether perhaps we're closer perhaps because she's sorted out some of her anger” (Hillary, 826-829).

Hillary used her knowledge based on her conversations with her daughter to help piece together and to fantasise about what her daughter had discussed in therapy, and to make sense of changes in her daughter and in the mother-daughter relationship. Hillary seemed to theorise that psychological work had taken place as a result of therapy, which had enabled her daughter to be closer to her.

Communication and compromise

An improvement in communication between mother and daughter was observed by a few of the participants and, in particular, an increase in sharing, openness and understanding.

For Mary, rather than going round in circles when communicating with her daughter Caroline, improvements, as a result of therapy, seemed to enable them to come alongside one another, move together in the same direction and to reach *somewhere*.

“We used to have these circular conversations. And, well I call them circular because they'd always end up with her saying the

same thing that she did to start off and you felt that you'd got nowhere. Whereas when she was in the therapy, that was a big improvement. Those conversations were fewer and far between. And so obviously she was getting a lot more from the therapist and from the CBT, um, so that was helping in those conversations" (Mary, 230-237).

Interestingly, Mary separated out **"the therapist"** and **"the CBT"**, rather than referring to the combined effect of therapy. This might indicate the differential impact Mary viewed her daughter's relationship with her therapist having on her daughter's communication skills, alongside the "new set of tools" that she was learning from CBT. Mary's insight into the impact of Caroline's therapeutic relationship on her ability to communicate and relate is mirrored by the studies of change processes in psychotherapy, which indicate how the therapeutic relationship impacts upon an individual's way of being with others (e.g. Boston Change Process Study Group, 2010; Rogers, 1967).

Evelyn also provided evidence of positive changes in the mother-daughter relationship as a result of therapy. Evelyn seemed to feel strongly that the therapist's interventions, which occurred during a joint mother-daughter session, helped to improve the mother-daughter relationship in terms of her daughter Vanessa's ability to compromise.

"And since that word 'compromise', she calmed down (*hmm*) and she tidies up after herself, it's amazing how one word, understanding of it, taking away the stigma of sort of you know, controlling mother" (Evelyn, 598-601).

Evelyn described how the word **"compromise"** taught by the therapist acted almost like a "magic word", transforming Vanessa's thoughts, mood and behaviour and enabling them to live more peacefully together. This suggests that the therapist helped introduce a different perception of the mother-daughter relationship to Vanessa, as one involving two adults who have to compromise. Evelyn perceived that this intervention was instrumental in removing the

stereotypical and stigmatising view of **“controlling mother”** that Vanessa had formed.

Continuity of closeness

A strong theme in the mothers’ stories was the continuity of closeness in the mother-daughter relationship. Several mothers commented that they perceived their relationships with their daughters to be close already and some voiced an absence of change in the mother-daughter relationship as a result of therapy. In the extracts below, these mothers seemed to stress continuity of closeness in the mother-daughter relationship:

“Vanessa says that she is her Pandora’s box (*ok*), because she says, ‘she knows even things that you don’t know about me’, although we are so very close” (Evelyn, 609-611).

“She’s never, she just said that she likes the woman she’s going to (*ok*) she is um, getting on with it, she [...] actually shares a lot with me not specifically about the therapy (*right*) but about her life, and about her relationships, about her relationships with her friends (*hmm*). Um, she’s actually very, very open” (Celeste, 60-64).

Although Evelyn’s daughter Vanessa shared many things with her therapist that she did not with her, this did not seem to call into question the closeness in the mother-daughter relationship (**“we are so very close”**). Evelyn stressed that she understood that Vanessa had a right to privacy. Evelyn’s main concern was that Vanessa received help and that she was told about how she was progressing in therapy. She stressed on several occasions that not being privy to the nature of intimate discussions between Vanessa and the therapist did not cause her to feel angry, for example:

“Because the point is, I’m not furious with what she’s discussing during the sessions (*hmm*), I am interested in help, that she is

gradually getting better (yeah, yeah), but somebody has to let me know” (Evelyn, 1062-1065).

In a similar vein, Celeste appeared keen to emphasise continued closeness and sharing in the mother-daughter relationship and to present her daughter as open. At the same time, Celeste tried to make sense out of why her daughter Jenny had not as yet shared many details about her therapy. Perhaps this process was because it contrasted with her perception of Jenny as being open in their relationship. Celeste appeared to return to this sense-making process at different points in the interview, for example:

“I think there’s a lot going on for her. Maybe she’s using the time in her therapy with her therapist, to analyse some of these things, it could be (*hmm*). So maybe that’s why she’s not talking to me about specifics with the therapist” (Celeste, 679-682).

This may indicate a sense of confusion about why Jenny was not sharing about her therapy; however, at the same time, Celeste showed an understanding that therapy may be a place for her daughter to work on issues separately from her.

1.3.3. Superordinate Theme 3: The impact of having a daughter in therapy on the mother

What seemed key to making sense of the effect that their daughters being in therapy had on mothers was understanding that this experience was inextricably intertwined with their thoughts and feelings related to their daughter’s difficulties. As Mary put it, **“So it’s difficult to differentiate [between my daughter’s difficulties and her therapy] because they go hand in hand” (Mary, 5-10).** The mothers’ experience of having a daughter in therapy sometimes appeared to be quite overwhelming and muddled with feelings about their daughter’s difficulties. Indeed, therapy often appeared to be a background issue, whereas the daughter’s difficulties were foregrounded in the mother’s experience. It seemed that recognising the impact that their daughter being in therapy had on them,

separately from the impact of having a daughter with mental health difficulties, presented a challenging task.

Emotional impact

Mothers reported a range of different emotional feelings that they experienced during the process of their daughters being in therapy. For many mothers, their daughter commencing therapy marked a turning point, where they felt relief, gladness and gratitude that their daughter was receiving help.

Sarah expressed that just knowing that her daughter Anita had started the process of therapy was relieving.

“And urm, I think it’s just knowing that she’s having therapeutic input [...] Erm, knowing that she’s going and attending sessions, because that can be quite tenuous as well. [...] just it’s a relief and it’s just you just think, yes, well we know it’s ongoing, we know it’s slow, there are times when you feel a bit frustrated about it [...] it’s just a relief when you get to that stage” (Sarah, 1103-1114).

Sarah appeared to put across her awareness that Anita’s recovery would be a slow and ongoing one, but that reaching the point where her daughter had started therapy and accepted that she needed help was a significant stage. She also seemed to voice her ambivalence that was also part of her experience of her daughter’s recovery process.

Knowing that the job of caring for their daughters’ well-being was being shared with the therapist – especially when feeling emotionally overwhelmed or out of their depths – seemed to play an important role in providing reassurance for mothers. Indeed, several mothers voiced that their daughter being in therapy was **“like a bit of a respite” (Hillary, 300-301)**. Teresa viewed her daughter Sandra’s therapy to be like a **“safety valve” (Teresa, 847)**, a place for Sandra to **“let out the angst” (Teresa, 848)**.

“She can go off to a stranger, and say terrible things and say she wants to do terrible things [...] and get her release, and then

come back home and she doesn't have to say it to me" (Teresa, 562-72).

By Sandra having this space, this appeared to mean for Teresa that Sandra did not need to let her emotions out with her or other family members, and so the family could be protected from her outbursts.

For some of the mothers, their daughter being in therapy seemed to be emotionally painful and difficult to cope with. These experiences were more commonly voiced by mothers whose daughters had recently started therapy, or were in the middle stages. Worry was a significant theme throughout the mothers' accounts; it was often ongoing and entered more prominently into mothers' experiences at the start and ending of their daughters' therapy. Feeling **"really powerless" (Sarah, 1092)**, useless and unable to help their daughters or to assist them in getting what they needed from therapy sometimes accompanied mothers' anxiety, particularly during the early stages of therapy.

Evelyn voiced feeling angry and **"shut out, cut out by force" (Evelyn, 731)** from her daughter Vanessa's therapy by the NHS process that did not involve her. As the interview progressed, Evelyn also acknowledged her feelings of powerlessness about not being able to be part of the **"remedy"** that helped her daughter.

"They take away the power. It's not that I want power, but I want to be, be part of it (hmm) be able to be part of remedy (hmm). It's strength, it's power, being part of remedy" (Evelyn, 1046-9).

With little exception, reference to self-blame and feelings of guilt were present in the mothers' stories about their daughters being in therapy. Many appeared to feel responsible as a mother for their daughter's well-being, and it was as if they felt sad and guilty for not giving their daughter what she might have needed.

"You kind of feel guilty coz you think, what have I done wrong? Where did I go wrong? Where hasn't she had the support?"

Maybe she needed the support in certain areas that we didn't give her. What is it?" (Mary, 283-286)

Mary appeared to link her feelings of guilt and self-blame with a search for meaning and for explanation. Mary moved between different positions; her individual responsibility as a parent ("**I**"), her shared responsibility as a parenting couple ("**we**") and her shared position as a mother of a daughter with mental health difficulties ("**you**"). This could represent the many different levels underpinning the mothers' experience, and how search for meaning touched upon multiple aspects of the identity (see *Sense-making activity* for further discussion).

However, notions of self-blame and guilt were also challenged by mothers and the extent of self-blame appeared to vary in intensity and impact. For example, through the process of giving voice to her experience of feeling "**bad**" and "**awful**", Meredith appeared to try to make sense of her painful, sorrowful feelings, where self-blame did not seem to quite fit.

"I feel bad that I gave birth to a human being that had to go through that experience. That's what I feel. And I don't blame myself but I just feel so awful" (Meredith, 1196-1198).

Conflicting feelings about the extent of her responsibility as a mother for her daughter's traumatic early experiences were suggested in Meredith's narrative. Meredith repeated "**I don't blame myself**" but at other times appeared to take full responsibility by stating, "**I have failed as a mum**" (Meredith, 1132). This finding mirrored Mohr and Regan-Kubinski's (2001) study, which revealed that the parents of children with chronic mental health difficulties do not fully "buy in" to self-condemnation, yet repeatedly negatively judged their actions in their parenting role.

As described earlier, Meredith's daughter Miria's therapy led her to question her mother about past events. Meredith explained that this process opened up "**Pandora's Box**" (Meredith, 388) which appeared to convey the resurfacing of painful feelings from the past that Meredith did not want to recall.

“Yeah, I didn’t want to open it. (*hmm*). It was just too painful (*hmm*) And you know, when I dealt with my feelings, I thought that it’s gone. And then this comes along, which in a way is worse than my problems. Her problems are far worse” (Meredith, 1368-71).

Although confronting her own feelings and problems was painful, Meredith seemed to suggest that acknowledging her daughter’s pain was even harder due to the severity of her daughter’s problems. These findings resonate with some of the literature about mother-daughter relationships. It is proposed that mothers can struggle to respond authentically to their daughters’ pain as this can challenge their perception of themselves and their relationship with their daughters (Daly, 2005; Miller, 1991; Sayers, 1993; Surrey, 1993).

When their daughters’ therapy came to an end, there were differing responses from mothers. Some mothers viewed their daughter ending therapy as a sign of progress, whilst others seemed to miss the **“safety net” (Jane, 550)** that therapy provided and to resent **“getting it full on” (Hillary, 230)** again from their daughters.

Jane reflected during her interview upon why she felt the need to remind her daughter Heidi that she could always return to therapy again in the future if she wanted to.

“No I think that was for me (laughs) (*oh right*) to make me feel better, that yes she could go back and have that safety net, if she wanted to and then I wouldn’t have to worry, I wouldn’t have to have that anxiety again (laughs).Uhha- (Jane indicates with a raised pointed finger that she’s had a realisation) (*So do you, do you notice feeling, sorry was that like quite an interesting realization for you?*) yes, yes, yes. I hadn’t, I hadn’t realised it was, it was a bit about me in there, that safety net thing (*hmm*). Yes, wanting her to be happy” (Jane, 543-552).

Jane realised that Heidi being in therapy was helpful for *her* in managing *her* own anxieties. Wanting their daughter to be happy was a strong priority for all of the

mothers and for Jane, knowing that Heidi was in therapy seemed to help Jane to feel more secure in the knowledge that the **“safety net of giving her, freedom, to yeah, feel safe to say what she wanted to say, what was on her mind” (Jane 525-526)** would be provided by the therapist.

The experience of daughters returning to therapy as adults, or restarting therapy after a hiatus, seemed to spark ambivalent feelings, including new feelings, such as pleasure about their daughter’s ability to make use of therapy and the reawakening of old feelings such as sadness and confusion (confusion will continue to be explored in the following section – *Sense-making activity*). In addition, having an adult-child, as opposed to a child, in therapy created new concerns for mothers who wanted involvement in their daughter’s therapy. For example, Evelyn conveyed her anxiety about her daughter Vanessa being in therapy as an adult because she **“has legal rights, I cannot do anything to help her” (Evelyn, 527-529)**.

Sense-making activity

Common cognitive activities used by mothers to help to make sense of their experience involved questioning why their daughter needed therapy, struggling to come to terms with the chronicity of their daughters’ difficulties and lots of theorising about the nature and cause of their daughters’ difficulties.

As well as their understanding and experience of their daughter, mothers appeared to draw upon their knowledge acquired through life experience, reading, talking to other mothers, professionals and with their daughter as sources of information to help them to process their experience. Most of the mothers in this study had been in therapy or knew others who had. As previously mentioned, this knowledge was drawn upon in order to help mothers to think about their daughter being in therapy.

Lisa shared her experience of her sister who had been in therapy regularly, but still struggled to manage the emotional sequelae of her early experiences.

“Because my sister [...] has never got over the things that happened to her in her childhood. And she regularly goes back into therapy [...] And as I’ve become to be an adult I’m very understanding this will never leave her. So I look at my daughter

and I think, some things never leave us, you have to be awfully strong to say, this happened and move on. And some people do but they are very strong individuals. And they're the rarity" (Lisa, 406-418).

Lisa appeared to express that over the years, she had begun to accept the enduring impact of her sister's early life experiences. It seemed that this had been influenced by witnessing her sister return to therapy repeatedly over the years and the fact that therapy had been unable to ameliorate her difficulties. By highlighting that those who are able to leave the past behind them are the exception, Lisa seemed to draw upon her life experience to help her to manage her expectations for her daughter Stacy's future wellbeing.

Hillary was aware that the mother-daughter relationship was often a focus of discussion in therapy.

"[..] it's important, it's just one of those things that you just have to let happen, you know, you don't know, you don't necessarily know what's happening, and you will never know, and you guess" (Hillary, 824-826).

However, Hillary acknowledged that she did not *know* and could not know what took place during Alex's therapy. Hillary's excerpt seemed to highlight the difficulty for mothers in accepting the uncertain process of their daughter being in therapy and the part that guessing played in the experience.

"In a way I wonder if perhaps Roy [Hillary's husband] and I are slightly hiding behind this, why are we still being used? Why does Alex need so much therapy? Particularly, I suppose for me, she's my third child and I felt um, by that time I'd done quite a lot of personal therapy, so I felt all sorted out. And I'd practiced on two children (laughs). So in a way the whole what have I done wrong to, for Alex to need so much help? um (*hmm*), so bemused I think is the word, not sort of cross or anxious, but a

bit like, you know, I don't quite understand, why it's like this"
(Hillary, 160-166).

Hillary's quote appeared to exemplify the state of confusion and guilt sometimes masked by frustration that some of the mothers experienced as part of the process of having an adult daughter in personal therapy.

Sense of self as a mother

Reflection upon the mothering role was prevalent in the mothers' stories and it sometimes presented itself in the form of generalised speaking about motherhood. Typically, mothers used the phrase **"you think"**, followed by an explanation of their actions. This seemed to suggest that their ways of responding were common to a shared identity. *Needing to be strong* and *worrying* were two such aspects of mothering defined by some of the mothers.

"[..] she needed me to be a brick, a rock, a wall (hmm). You know, a tower of strength" (Mary, 673-674).

"I think the mother's job often is that she has got to worry. (Hmm). You've gotta worry in case it happens (we both laughed). If you worry it may not happen [...] like if I worry then things will get better" (Sarah, 1125-1131).

Mothers sometimes expressed the need to be strong for their daughters and their families. Mary used a number of different metaphors which seemed to depict the high level of emotional and physical strength and resistance that she felt was necessary for her to possess in order to meet her daughter's needs. Sarah appeared to construct worrying as a fundamental part of being a mother and a way for her to feel more in control of life events.

Mothers seemed to stress their unique understanding of their daughters' needs and, in some cases, mothers compared their knowledge and ability to help their daughter to taking on the role of a therapist.

Evelyn shared her view that mothers are therapists for their children:

“I feel that at the moment [...] I’ve taken the role of the therapist (do you?) yes, oh yes, because (what’s it like being in that role?) not very comfortable because although I’ve been doing it, every mother is a therapist to her own child, but we’re, I’m dealing with a very difficult case” (Evelyn, 1282-1288).

However, Evelyn explained that due to the severity of her daughter Vanessa’s mental health difficulties, her job in the role of therapist was extremely challenging.

Reflecting on the past was a common activity undertaken by mothers when reflecting upon themselves as mothers. In particular, mothers reflected on their family histories, how they had parented their daughter, and their struggle to do so. Struggles to parent included living in a culturally different or new environment, being a single parent, being a working mum, going through a divorce or bereavement, struggling to care for other children and loss of income. This highlighted the socio-cultural contexts in which these women were mothering and drew attention to the multiple factors influencing the mothering role. The impact of the socio-cultural context upon motherhood has been well documented in the research literature (Arrendell, 2000; Elvin-Nowak, 1999; McNab & Kavner, 2001; Nice, 1992; Parker, 2009; Sheppard, 2000; van Mens-Verhulst, 1995).

Lisa shared her experience of analysing the past and reflecting upon her actions as a mother:

“I do see the past very differently now and not because I see the events differently urm..and not because I think I could have gone back and done it differently - because that has often gone through my mind - whether there are things I could have done better or done differently. And looking back, I don’t think so. You know I think I did the best, and I was a cog in a wheel, I was caught up in it all. I suppose I could have been less emotional, you know. There were times when I cried in front of the children because it was upsetting for me and yes it would have been

better if I hadn't, but a large part of that was not having anyone to confide in or talk to" (Lisa, 764-773).

Lisa appeared to frame her reflection upon the past as something that she often returned to when trying to understand what had taken place and when evaluating the role she had played in creating the situation that may have contributed to the development of her daughter Stacy's difficulties. She referred to herself as a **"cog in a wheel"** and as **"caught up in it all"**, which suggested she felt disempowered and unable to stop the wheels in motion. Lisa appeared self-compassionate as she recognised that, without a confidant or social support, she had struggled to manage her emotions and that her children had witnessed this and may have been affected by it. Indeed, self-compassion and accepting their imperfections as mothers was mentioned by several mothers and this seemed to play an important role in helping mothers to manage their feelings of guilt and self-blame.

The importance of being a mother to their sense of identity and self-worth was apparent in the mothers' accounts. For Meredith, her struggles in her mothering role, particularly in her relationship with her daughter Miria, led her to question herself as a mother.

"[...]makes me question myself as a mum, because my relationship with my two children is really the only thing, the most important thing for me (hmm) and it makes me question, you know, why I'm even on this earth"(Meredith, 1078-1081).

Meredith's words seemed to highlight the integral role that being a mother played in her identity and that her children were a significant source of meaning in her life. Struggling to maintain a relationship with Miria and doubting her abilities as a mother appeared to have resulted in significant existential anxiety for Meredith.

1.3.4. Superordinate Theme 4: Managing the process

Throughout the different stages of their daughter's therapy, mothers appeared to be actively involved in managing their experience in many different ways – including the negotiation of their emotional and relational worlds.

Managing thoughts and feelings

Mothers appeared to engage in thinking processes that involved putting things into perspective and increasing access to hopeful or reassuring emotions. For example, several mothers reminded themselves that they were not the only mothers to have an adult daughter with mental health difficulties or to have an adult daughter who had been in therapy (**"I'm not the only one" – Meredith, 1678**). Mothers also compared their situation to negative alternative future scenarios or to those worse off. Another coping strategy involved not engaging with certain thoughts or memories that were found to be painful. For example, mothers sometimes stressed focusing upon their daughter's progress as opposed to watching for signs of deterioration, not dwelling on the past and, in some cases, mothers mentioned the function of forgetting.

Mary appeared to focus on the concept of *luck* and on the positives in her situation.

"No I don't find myself trying to work it out, I accept that everyone is different so, and I actually think that we were very lucky with her, because you see and hear stories about people who never actually get out of, spend their whole lives battling it (hmm). So I think, I think we were very lucky and I think that we were very lucky with the therapist that we found, because it could have been awful" (Mary, 909-915).

In contrast to the questioning and theorising that were predominant in the mothers' stories, including in Mary's (**"Where did I go wrong? Where hasn't she had the support?" - Mary, 284**), Mary denied that she found herself trying to work out what had caused her daughter to go to therapy and instead appeared to emphasise her acceptance of her daughter and of her experience of her daughter being in therapy. This appeared to indicate the fluctuating process of acceptance that mothers experienced regarding their daughters being in therapy.

Sarah's account highlighted the role of forgetting as a form of coping.

"[..] what you want to try and do is go on to what what's coming, and what's a bit more positive (hmm) I think that's,

maybe that's a human coping mechanism (*hmm*) and I sometimes think maybe, maybe that's why I sometimes forget how bad something was" (Sarah, 1215-1226).

Sarah seemed to stress the positive action of focusing on **"what's coming"** and to make sense of the process of forgetting by viewing it as a natural survival mechanism that helped her to move forward.

The majority of mothers had not discussed their daughter being in therapy with others outside of the family and several seemed to suggest that this did not feel necessary or appropriate. The main source of support for mothers that were married was their husband and this was usually described in terms of their husband's physical presence.

Mary's husband's availability and physical contact was an important source of comfort.

"The fact that you've got someone to give you a cuddle at night (*yeah, that comfort*). Yeah, because you know that whatever happens you're going through it together" (Mary, 600-602).

The sense of a shared struggle, of not being alone during the process but being in a couple, also seemed to be suggested by her account.

Without exception, none of the mothers expressed that they felt ashamed of their adult daughter being in therapy. However, several mothers conveyed the lack of understanding from their friends and stigma from the general public about mental health difficulties and about therapy. None of the mothers wished to attend support groups. As mothers appeared to manage what they shared, and with whom, I wondered whether their experience of stigma was more significant than was openly discussed.

Sarah explained her approach to sharing with others and appeared to convey some of her ambivalence about doing so.

"you know sometimes you get so fed up of talking about it, you just want to get on with your life, you don't want to be just someone's mum who's anorexic (laugh), [...] a lot of people ask

me how is she getting on now, and I'll just say, it's a slow process, and you know sometimes a couple of steps back, and then sometimes a couple of steps forward, and this is the way um recovery is for most people, in this particular illness, and that's the way it is and we'll leave it at that [...] sometimes you need to take a step away from it (*hmm*) 'cause [...] if you let it totally encompass you and this goes back to what I was saying about not letting it beat the family" (Sarah, 698-715).

Sarah appeared to feel constrained by the identity of being **"just someone's mum who's anorexic"**. By deciding what and how much she shared, Sarah seemed to be engaged in a process of managing her experience on several different levels. By providing an explanation of the process of recovery, Sarah seemed to try to control social expectations and perhaps her own expectations about Anita's recovery. At the same time, Sarah seemed to manage the extent to which she felt encompassed by the identity of being **"just someone's mum who's anorexic"**. In these ways, perhaps Sarah was also making sense of how she was attempting to take control and not let the family be **"beaten"** by anorexia.

Managing the mother-daughter relationship

A prevalent theme throughout the mothers' accounts was regarding how they managed the boundaries in their relationship with their daughter throughout the process of their daughter being in therapy. The management of intimacy in the mother-daughter relationship and acceptance of their daughters' separate life journeys were significant aspects of this theme.

For the majority of mothers, the idea that mothers and daughters could not be best friends was evident and was used by mothers to help them to think about what was and what was not shared in the mother-daughter relationship. Thinking about what she shared with her daughter was part of the way of managing the boundaries in her relationships with her children that Hillary mentioned:

"So I suppose in a way that's another thing that Alex can get out of therapy (*hmm*), that she can talk to her heart's content about

Remi [Alex's sister](*hmm*) whereas I would be like, *no! I'm not going there*" (Hillary, 536-538).

Therapy appeared to be a way for the boundaries in Hillary's relationship with Alex to be upheld, so as not to jeopardise other relationships in the family. Hillary seemed to recognise that Alex may well need to talk about Remi, but therapy was the appropriate arena, not the mother-daughter relationship. Indeed, the majority of mothers seemed to welcome the input of an impartial therapist and acknowledged that they were too emotionally involved to be the one to help their daughter.

The need for boundaries in the mother-daughter relationship was described by several mothers as being a self-protective device. Therapy appeared to be a place for daughters to be able to discuss things that were beyond mothers' limits in terms of subjects that felt too uncomfortable or upsetting to discuss. Mothers also discussed managing what felt appropriate for sharing within the mother-daughter relationship about their daughters' therapy.

Mary recalled how upsetting it was when she was given an insight into what took place during her daughter Caroline's therapy when Caroline showed her some writing that she had done for her therapist.

"[..]I didn't really want to read it because it was hard. I mean it was about what was going on in the family, which was nothing very much, but you know, I can't remember, to be honest (*hmm*). I remember reading it and feeling very, I don't want to read this (*sure*). I think, I feel like I'm encroaching" (Mary, 709-716).

"[..] like, I would never read her diary (*hmm*), coz that's a way of protecting yourself you see, that you don't. Coz if she's written something bad about you, you don't want to read it" (Mary, 788-789).

As well as feeling as though she was intruding upon Caroline's internal world and perhaps upon something that took place privately between Caroline and the

therapist, Mary appeared to acknowledge that not wanting to know was also a form of self-preservation. She seemed to use the comparison of reading her daughter's diary to reading what her daughter wrote for her therapist to emphasise her fear about the risk of making contact with painful material about herself.

Mothers differed in their perspectives about involvement in their daughters' therapy in terms of whether it was conducive or inappropriate. Lisa and Evelyn were at opposite ends of the spectrum. Lisa described how she did not enquire about her daughter Stacy's therapy as she thought that this **"defeated the purpose"**.

"I don't really know much, I think she went for six months and I have no idea how it was left or what she did because I thought it defeated the purpose if I questioned it. (*I see*) What was the point of me needing feedback if what I said is what she needs is to speak to someone who's independent?" (Lisa, 192-194)

Lisa appeared to describe how Stacy's therapy went on in the background and did not feature in the mother-daughter relationship. Lisa seemed to strongly question the relevance of enquiring about her daughter's therapy and viewed the private nature of Stacy's therapy as integral to its purpose.

Evelyn worried that her daughter Vanessa would not get the full benefit of therapy without her involvement.

"So the therapist, not knowing everything moved on (yeah), and sort of you know, 'where did you go to school?' And if it wasn't for my presence, she wouldn't know [...] Because it's too painful for.. I said Vanessa, I'm sorry, but it's not the whole story. [...] And Vanessa said to me, 'you tell the lady,' because she couldn't bring herself to tell. So how vital it is to have a family as a support, as a source of knowledge for the therapist - that shows you. So I had to tell the therapist" (Evelyn, 1225-1233).

Evelyn feared that without her contribution to Vanessa's therapy, Vanessa's story would not be fully heard as Vanessa struggled to discuss painful subjects with the therapist.

As part of managing the process of having an adult daughter in personal therapy, the majority of mothers reflected upon the fact that their daughter was now an adult and was therefore responsible for her therapy. This acknowledgement was not a straightforward process whereby mothers felt able to easily relinquish their sense of responsibility for their daughter. For example, Sarah conveyed her conflicting feelings about her responsibility as a mother.

"I'm not really my daughter's keeper but I'm her support. So I feel that I just, you know, she's mine, she's my responsibility even though she's an adult (*Hmm*) and I know she's not. Oh it's all conflicting (laughs)" (Sarah, 1371-1379).

It appeared as though Sarah struggled with her role as a mother in Anita's recovery process. At the same time as recognising that she did not have control over Anita's actions, she seemed to feel overwhelmingly responsible for Anita's well-being, which caused internal conflict. Sarah's comments also hinted at her ambiguity in her mothering role. Ambiguity in the caring role has previously been identified in the experiences of parents of adult-children with mental health difficulties receiving professional support (Pejlert, 2001).

The daughter managing the mother-daughter relationship

Evident in some of the mothers' accounts were the ways in which daughters were involved in reciprocally managing their relationships with their mothers during the process of being in therapy. Daughters appeared to differ in the extent to which they managed the levels of intimacy in the mother-daughter relationship and in how much they involved their mothers in their therapy. Some mothers experienced their daughters withdraw from them by limiting their communication in some way and some understood that this was related to their daughters' therapeutic journey. Others were involved in meaningful discussions with their daughters about their therapy.

Sarah recalled how her daughter Anita had tried to manage their relationship by indicating to Sarah when she was overstepping her (Anita's) boundaries.

"[..]sometimes if I probe a bit too deeply myself (Hmm)and try and make sense of it, she'll go, you know when I've done that in the past, she'll go, 'this is not helpful, it's really not helpful' (hmm)um you know. 'You always want it to be what you want it to be'" (Sarah, 748-753).

"And those were the times, sometimes, she'd say, 'Mum you've overstepped it a bit. I can't cope with your upset,' she said, 'it's enough to cope with mine'" (Sarah, 922-924).

Sarah appeared to have grown to understand that her interference sometimes had a detrimental impact upon Anita's well-being. By referring to her actions as taking place in the past, this suggested that Sarah had tried to alter her behaviour. Sarah also seemed to allude to a common struggle for the mothers – accepting their daughters' alternative perspective (See - *Processing the daughter's therapy*).

Several mothers reported that they were advised by their daughters to seek therapy for themselves. This could be viewed as another way in which daughters attempted to manage their relationships with their mothers. Jane shared that her daughter Heidi suggested that she seek therapy:

"She would always encourage me to do it, and if I've got the glums, or I'm miserable about something, or I'm banging on about something over a couple of months, she'll say, 'do you think you need to go.. why don't you go and have another chat, book in for some more'. And I haven't done, but I, I think it's good that we both feel equal enough to say that and comfortable enough to say it to each other" (Jane, 596-603).

Jane described that when Heidi noticed a change in her mood or that something had been bothering her over a prolonged period of time, she advised Jane to seek

therapy. Jane seemed to express positive feelings that she and Heidi felt equally able to advise each other to seek therapy.

The mothers' experiences seemed to be influenced by how their daughters negotiated intimacy in their relationships. In particular, the daughters' input sometimes seemed to impact upon changes in the mothers' ways of being within the mother-daughter relationship.

1.3.5. Superordinate Theme 5: Processing the daughter's story and re-evaluation

Mothers appeared to differ in their responses to hearing and processing their daughters' stories. This seemed to have important implications for the mother's journey as a result of having an adult daughter in therapy.

Processing the daughter's story

The majority of the mothers in the sample discussed their understanding of their daughter's perspective of life events. Mothers seemed to acknowledge a difference between the mother's and the daughter's **"truth"** and sometimes referred to being unsure about whether their daughter's perspective was **"correct"**. Some of the mothers, like Teresa, voiced their concern about how the daughter's version of reality impacted upon her ability to gain benefit from therapy.

"She tells therapists things and if Sandra [daughter] sits and stews on something and daydreams and thinks about it enough then she's not sure if it's real or not" (Teresa, 757-758).

In contrast, the daughter's dissimilar perspective sometimes seemed to provoke further curiosity, reflection and discussion with the daughter.

"I've revisited a couple of things that perhaps she's asked or (hmm) made me think about (and has that, has that been, what's that been like?) it's good, it's good, it's brilliant, yeah (hmm). We don't always agree on stuff. Or she'll say, I think you think this, or I think you did that or said this. And um, we don't always agree on it so (laughs) (How is that when you don't agree on it?) It's fine, yes it's fine, it's fine to talk about it" (Jane, 815-825).

Jane conveyed very enthusiastic feelings about hearing her daughter's alternative perspective and about the reflective process that her daughter had engaged her in. She also indicated her experience that having different versions of life events was acceptable and tolerable within the mother-daughter relationship.

The mother's vicarious therapeutic journey

Several mothers described their daughter's therapy as being *their* therapy. For some mothers, this therapeutic effect seemed to be conditional upon their perception of their daughters' improvement ("**my therapy will be if she gets better**", Sarah, **1719**). For others, discussion with their daughter about her therapy and subsequent reflection led to personal benefit in terms of changes in behaviour, attitude and self-awareness. This process appeared to involve re-evaluation of their perception of their daughter and her life experience, and re-evaluation of relationships within the family.

Jane said that she found the process of discussing her daughter Heidi's therapy eye-opening:

"[...]well it's opened my eyes and made me think, well fancy I thought that she was thinking this or didn't see this happening, you know (laughs). Yeah, it made me feel a bit daft actually. Daft meaning, why would she see it like that, just because I thought that was how I presented it (laughs). They see more than you think (right!) and they take, they absorb more and take more than you think" (Jane, 835-841).

Jane shared how listening to Heidi's perspective had led her to feel embarrassed as she had thought Heidi had been naïve to what was really going in the past when, in fact, she had been aware. Discussion with Heidi ultimately led Jane to change her understanding of past events and her perception of what children are capable of absorbing.

Meredith referred to changes in her attitude towards psychiatry, which had taken place over the process of her daughter Miria's therapy.

“I mean, coming from my background, [...] I believed that everybody could just get over everything, if they talked to people..... But there are, there are, there is a reason for people to be in psychiatry and I’ve seen that in my own life now (*hmm*) And there are people that do need that and I should never have had that judgement” (Meredith, 1161-1170).

This change appeared to be influenced by an increase in Meredith’s awareness and empathy of Miria’s ongoing difficulties and in her knowledge about others with similar difficulties. She expressed regret for her past negative judgement of psychiatry and of those who made use of it.

On reflecting upon their experiences of having an adult daughter in therapy, many of the mothers referred to the therapeutic process that their daughter’s therapy had facilitated within them and within their daughters’ relationships in general.

“[...] by helping her it helps everybody around her (*yes*). You know (*yes*). So it’s a domino effect (*yes*). All the ripples” (Celeste, 1105-1107).

Celeste’s image of the **“domino effect”** seems to powerfully bring to mind the daughter’s therapy as an inevitable and cumulative chain reaction.

1.3.6. Meredith: A negative case analysis

All of the participants illuminated the complexity of the experience of having an adult daughter in therapy and offered unique insights. However, under this heading I will discuss Meredith in further detail (also see *Appendix 16* for case summaries). I have included this as a negative case analysis to highlight an exceptional example, and one whose differences provide additional insight and may contribute significantly to implications for clinical practice.

The first outstanding difference in Meredith’s account was the complexity of her family history, including the cultural background and her daughter Miria’s severe early trauma. Meredith described Miria’s history of childhood sexual abuse and seemed to try to comprehend how these experiences had irreversibly

damaged the mother-daughter relationship. In the process of sense-making, Meredith appeared to apportion out the blame; to the east Asian culture of secrecy (**"because I was in a society where you don't talk, I mean I couldn't talk to anybody" – 64-64**), to her daughter for rejecting her (**"she pushed me away" – 1139-1143**), to herself for not having kept her daughter safe (**"I was a terrible mother" – 1201**) and to those that had abused her daughter.

"And no one can give me back my daughter. But that's what I regret the most, that I never had a daughter. That horrid person, people, they stole my daughter from me" (1205-1208).

By indicating that her daughter had been "stolen" from her, Meredith alluded to the loss of her "real" daughter and the absence of a mother-daughter connection. These strong feelings resonate with the literature, which highlights the overwhelming experience of loss and pain voiced by mothers whose children have been sexually abused (Carvalho et al., 2009; Pretorius et al., 2011). Secondly, Meredith's experiences indicated that the mother-daughter relationship can be adversely affected as a result of the daughter's therapy. When Miria started her therapeutic journey in adulthood and began to question her mother, Meredith felt unable to cope with the opening of **"Pandora's box"** (see also Superordinate Theme 3: The impact of having a daughter in therapy on the mother – Emotional impact).

"And I said to her please give me space (hmm), I cannot deal with that, because if I deal with it I'll implode (tearful). I said, I'd rather you do it, but just don't bring me into it. You know, I accept that you do it (hmm) and she wouldn't accept that so she pushed me and pushed me. Until I said stop it, you know, I'm not interested. Please don't tell me, I'm not interested. And um, then she got angrier, and angrier..." (383-403).

Meredith appeared to justify how she put up her defences in her relationship with Miria and rejected Miria's attempts to explore things with her, in order to prevent her own breakdown. In response to this, Meredith found that Miria became angrier towards her and that this contributed to an increasingly **"abusive"** and strained relationship between them.

"But I've said sorry, I've apologised [....] why doesn't she just get over it? Why can't she? I mean do they ever get over it?" (1209-1210)

Meredith indicated her struggle to reconnect with her daughter and to repair their relationship. She seemed to voice frustration, confusion and uncertainty about whether her daughter would ever forgive her. The suppression of her feelings and memories and the denial of Miria's very existence (**"I have to forget, you pretend that she's dead! – 1073-1075)** seemed to indicate how intolerable her experience of pain and hopelessness was, due to feeling abandoned and rejected by her daughter (**"I can rot in hell as far as she's concerned" – 1040).**

Meredith's experiences conveyed a negative perception of her daughter's therapy. This was more prominent than what I found in the other mothers' accounts and included a suspicion and mistrust of therapists in general. This provided counter-evidence that as a general rule, the mothers were positive and supportive of their daughter's therapy.

"I wouldn't put it past a therapist to put her up to not to speak to me" (1489-1490).

1.4. Discussion

In this final chapter, I have drawn together my findings, in order to present an overview of the analysis which might tentatively convey how superordinate themes come together and mutually inform each other (see *Appendix 18* for a diagrammatic representation). I have attempted to provide an account of the mothers' experiences, in order to elucidate the key findings and to provide a flowing narrative, including both descriptive and interpretative elements. I hope that I convey the plurality of the mothers' experiences, as well as those that were

shared. A review of the limitations and challenges of this research in terms of transferability issues and credibility will follow. In addition, I will continue to make transparent the reflexive process that I engaged in. The contribution of this research to the field of counselling psychology will be explored in relation to existing theory, research and practice. Areas for future research will be suggested and final reflections concluded with.

1.4.1. Overview

When discussing their experiences of their daughters being in therapy, I found that mothers spoke hesitantly and uncertainly about therapeutic change. Whilst their support of their daughters' therapy was strong, it emerged from the analysis that mothers were reluctant to isolate the impact of therapy from other contributing factors to change, and were tentative in identifying specific changes. It appeared as though mothers were involved in managing their expectations about therapy and were trying to draw upon their knowledge of the therapeutic process in order to make sense of their experiences. However, ascribing therapy as the only cause of change in their daughters seemed to personally invalidate the amount of love, care and support these mothers offered their daughters. I sensed a great need in the mothers for them to be able to help their daughters and sometimes a sad awareness that they had to let go and have "*blind faith*" in "*a stranger*".

"Ambivalence" seemed to best describe the mothers' emotional experience – which appeared to fluctuate over the course of their daughters' therapy. Therapy represented hope in some of the mothers' accounts and to mark the start of a new journey in the daughter's life, where the potential for her to heal, mature and grow was more conceivable. At the same time, the mothers' worry about their daughters' well-being and how they would make use of therapy was prevalent. I was struck by how worrying seemed to become "professionalised" or even justified as part of the mother's job description. However, adding another facet to the complex picture of the mother's emotional experience was the juxtaposition of recurrent use of similes associating the daughter's therapy with safety ("*safety valve*" and "*safety net*") and increased feelings of security for the mother.

Alongside the conveyance of coinciding and contrasting emotions, the mothers appeared to strive to find meaning and to identify the causes of their daughters' mental health difficulties. Separating out the experience of their daughters' mental health issues from the intricacies of their daughter being in therapy seemed to be somewhat perplexing. For many, the self-questioning process of "*why?*" and "*what did I do wrong?*" in relation to their daughters' mental health difficulties, and the fact that she was going to therapy, seemed to lead down the same path of interminable inquiry. Paradoxically, the mothers' meaning-making processes also appeared to be linked to the ways in which they sought to manage their painful experiences of self-blame, not-knowing and feeling powerless over the process.

In their efforts to provide explanation and justification for the context of their daughters' therapy, mothers appeared to defend against viewing themselves as "bad mothers" (Wagstaff, 2010) and to highlight their absence of choice over life occurrences. These efforts seemed to reflect a strong desire to be understood and not to be judged by others, including by me, the researcher. This perhaps gave an indication of the internalised cultural discourses of mother-blame (McNab & Kavner, 2001; Sheppard, 2000; van Mens-Verhulst, 1995) that the mothers battled with and defended against, both within their internal dialogues and within their relationships with others.

Diverse meanings were shared about the role of the daughter's therapy and its function within the mother-daughter relationship. Some of the mothers felt privileged and found it fascinating to hear about and share the "private world" of their daughters' therapy. However, therapy often seemed to play a role in enabling the boundaries of intimacy between mothers and daughters to be managed. Moderating the level of sharing and being involved in their daughters' therapy seemed to feel required in order to ensure the therapy was effective. However, therapy also appeared to be a sort of "dumping ground" for the messy and uncomfortable feelings that felt intolerable and unsafe for sharing within the mother-daughter relationship. This suggested that limiting involvement in the daughter's therapy, and knowledge of her private mental life, often felt important

for maintaining the mother's well-being, including her levels of worry, self-esteem and self-blame.

Cognitive coping strategies, and managing disclosures in their relationships with others, were found to play important roles in helping mothers to manage the process of their daughters being in therapy. Forgetting about the past, through the suppression of painful and upsetting memories, was often perceived as integral to coping with their life experiences and to remaining strong and supportive for their daughters. Managing their identities as "good enough" mothers, protecting themselves from experiencing blaming and stigmatising reactions from others (Jackson & Mannix, 2004) and preserving close relationships from their ongoing experiences of emotional distress seemed to be important motivations governing their disclosures within their relationships.

Conversations with their daughters emerged as potentially important catalysts of change for mothers. This seemed to involve a pattern of listening to and processing the daughter's story, followed by personal reflection and re-evaluation of the perception of the daughter, life-events and other relationships. A "dynamic cycle" of further discussion with their daughter and subsequent reflection was sometimes set up, which contributed to a process of internal change for mothers at the level of self-awareness, behaviour and attitude. The very experience of having a daughter in therapy, and the growing understanding and acceptance of the severity of their daughters' mental health issues, appeared to infiltrate the mothers' belief system, altering their perception of mental health issues, use of therapy and psychiatry.

Mothers varied in their responses to hearing their daughters' perspective. Whilst some seemed to accept their daughters' "truth" and to gain benefit from listening to it, others appeared to challenge its validity. I wondered if this revealed that their perception of themselves and of the mother-daughter relationship was threatened by their daughters' alternative version of reality (Miller, 1990).

Cautiously, I suggest that an important factor which seemed to mediate the extent to which mothers perceived benefit from discussions with their daughters was their ability to bear witness to their daughters' version of reality. Mothers that perceived their discussions with their daughter as beneficial, and accepted, if not

agreed with, their daughters' perspective, seemed to experience increased closeness within the mother-daughter relationship. They also seemed to be able to develop new understandings of their daughter and of life events.

Mothers sometimes referred to feeling emotionally overwhelmed or out of their depth with regard to hearing their daughters' stories or when trying to help their daughters with their mental health issues. They often connected this experience with their perception of their coping resources in their present situation. Therefore, I gathered that differences in the mother's perceptions of her daughter's story may also be influenced by the mother's socio-cultural context, including the level of stress she perceived in her environment and the meanings that she used in order to make sense of her experience. Mothers who did not feel overwhelmed by their own emotional pain in response to their daughters' suffering, or by environmental stressors, seemed to report the most value from the dynamic cycle of discussion and reflection.

However, I found that personal growth was not isolated to the mothers that reported having closer relationships with their daughters as a result of her being in therapy. This suggests that the complex mechanism through which having a daughter in therapy resulted in therapeutic impact for mothers could be viewed as diverse in outcome and multi-determined.

In summary, although mothers sometimes recognised increased conflict, in general, the experience of closeness within the mother-daughter relationship was perceived as ongoing regardless of their daughters' therapy. This perhaps suggests that the mothers found ways of remaining very connected to their daughters (McMahon, 1995) and that they respected their daughters' needs for privacy and space separately from them to work on their issues. Ultimately, the ways that mothers made sense of changes occurring within the mother-daughter relationship appeared to directly impact upon the mothers' thoughts, feeling and behaviours.

According to the epistemological stance that I brought to the research process, I acknowledge that the findings that emerged were co-constructed between myself and the mothers who participated (Denzin, 1995; Lewis, 2008). Due to the hermeneutic process of interpretation, I recognise that mothers were often in the process of making sense out of their experience of their daughters

being in therapy for the first time. As the mothers highlighted – their roles as mothers sometimes encompassed the therapist role, and this was my experience of them – as much like psychologists, formulating and reformulating their “client’s” difficulties. My perception of this predominantly cognitive process perhaps highlighted the challenge for mothers to stay with their experience at an emotional level. At the same time, it may also convey how reflection upon this experience was largely a novel one for them, and that the interview helped to facilitate this process.

1.4.2. Quality and transferability

I would now like to bring the reader’s attention to issues to consider when evaluating the quality of this study. The intention of this research was not to try to present an objective truth or to be able to generalise the findings to all mothers who have an adult daughter in therapy. However, it is important that the issues that impact upon the transferability of these findings to other mothers with similar characteristics are considered. To this end, I offer a discussion of the methodological and procedural challenges, a final reflexive account and an analysis of the research process.

As referred to in the methodology, I have aspired to meet Yardley’s (2000) criteria for assessing the quality of a qualitative study. I have also been motivated by my personal and professional ethics to respect the expertise of the mothers who were willing to share their invaluable experiences. In particular, I have tried to make the process that I followed for my analysis transparent in a number of ways. I shared my analysis with other colleagues who are trained in the use of IPA and I asked for their advice and feedback. I responded to this feedback, along with the feedback of my research supervisor. I tried to show my methodology and the evidence on which I have based my findings by using quotations and exposing my analysis to the critical eye of the reader.

By monitoring my influence upon the data analysis and acknowledging my own perceptions and experiences through the use of a reflective diary, research supervision and personal therapy, I have also tried to bracket my experiences and to remain as close as possible to the stories of the mothers.

1.4.3. Methodological challenges

In this section, I will discuss some of the limitations of IPA that have been recognised in the literature and that hold relevance for the assessment of the quality of this research. This will include reflection upon the role of language and cognition in IPA.

a) Role of language

As a research methodology, IPA is reliant upon language via written diaries and interview transcripts as a way of gaining access to the participant's experience (Willig, 2008; Smith et al., 2009). This emphasis on language is influenced by IPA's phenomenological underpinnings which suggest that the only way to understand a phenomenon meaningfully is to understand it in the manner in which it is experienced – through the body and through language (Merleau-Ponty, 1945; Sartre, 1943). Willig (2008) argues that words add meaning to experience, hold different meanings for different people and that individuals do not have the same access to them. She explains that the language one individual uses to construct a version of an experience of a phenomenon may be differently constructed by another individual through the use of other words (Willig, 2008). Furthermore, this individual may have a different experience of the same phenomena precisely because he/she has access to a different vocabulary (Willig, 2008). Willig argues that IPA could therefore be criticised for not addressing the constitutive role of language sufficiently.

As recommended within IPA guidance I have striven to highlight my recognition that there are multiple interpretations of the same text and that meanings arising out of the research encounter are co-constructed (Smith et al., 2008). I have also tried to use other sources of knowledge to add depth to my analysis. For example, I tried to address my embodied experience as a source of knowledge and attend to the embodied experience of my participants through recording my observation of non-verbal information (Finlay, 2009).

IPA is also criticised as it depends upon thick description and in-depth narrative for rich analysis to take place (Brocki & Weardon, 2006; Willig, 2008). As I

have referred to in the methodology, I purposefully limited my sample to individuals able to communicate articulately using the spoken or written word. Therefore, IPA and other qualitative methods dependent on language could be seen to privilege the voices of the articulate, upholding the marginalisation of oppressed groups (e.g. Ashby, 2011). Indeed, within my sample, there were women from a narrow range of educational and occupational backgrounds and the breadth of their vocabulary differed, but not vastly. Their language sometimes represented a challenge, but not a barrier, to my role as researcher in facilitating them to elaborate upon previously unexpressed or unformed thoughts.

The repertoire of IPA is growing, with research taking place with individuals who do not necessarily have a wide vocabulary, such as adults with learning difficulties (e.g. Pestana, 2011) and children (e.g. Back, Gustafsson, Larsson & Bertero, 2011). It could be suggested that the increasing range of IPA participant groups challenges the criticism that the usefulness of IPA is limited to participant groups with extensive vocabularies.

b) Cognition

IPA has been seen to naturally ally itself with social cognition (Smith, 1996). This is because IPA is interested in how participants think and their beliefs about a phenomenon in question. Also, unlike DA, IPA believes that verbal reports can map on to cognition and physical states (Smith, 1996). However, both Langridge (2007) and Willig (2008) argue that IPA could be viewed as incompatible with cognition. Langridge (2007) suggests that linking IPA with cognition is theoretically inconsistent as focusing on “cognition is at odds with phenomenological philosophy and rejection of a mind-body dualism” (p. 108). In other words, cognition can be viewed as fundamentally different to phenomenology as it suggests that meaning resides in mental representations within the mind (Brown, 2000), whereas in phenomenological understandings, meaning is conveyed through dialogue, embedded in the individual’s behaviour (Phillips, 1999). Other principles of phenomenology that are viewed as unsuited to cognition include phenomenology’s attention to pre-cognition as the route to gaining access to individual’s experience in its immediacy (Willig, 2008).

It has been argued that IPA is more concerned with pre-cognition, for example, vague feelings, sensing and hunches, as these aspects of experience are essential to try to access exactly because of their unfocused, inarticulate quality (Willig, 2008). By attending to non-verbal information and using my interviewing skills to help mothers to articulate their experience, particularly when it appeared to be in the process of being realised, I tried to access these phenomenological aspects of the mothers' experience.

1.4.4. Procedural challenges

The main issues to discuss here include recruitment and data collection methods. It could be argued that the mothers that agreed to participate in this research represent a subset of mothers who have particular relationships with their daughters, given that they were self-selecting and were aware of their daughters' therapy. On reflection, mothers in my sample may be representative of a group of mothers who hold non-stigmatising views of therapy. Their daughters felt able to share about their therapy with their mother and mothers felt able to discuss it during a research interview. Indeed, mothers stressed the absence of shame that they felt in relation to their daughter being in therapy and sometimes voiced that they felt motivated to take part because of their positive views about therapy.

Alternatively, it may suggest a level of trust, openness and sharing within the mother-daughter relationships in the sample with perhaps some representation of quite "over-involved" relationships. This may help to explain the mothers' focus upon managing the boundaries in the mother-daughter relationship and their struggles to do so. However, I am also aware that several mothers in the sample were aware of their daughters' therapy because they helped to instigate it due to their significant concerns about their daughters' mental health. It is important for readers to bear the qualities of the mother-daughter relationships in this sample in mind when considering the transferability of the results to other mother-daughter relationships.

Although these mothers represented a homogenous group in terms of age and ethnicity, they represented a diverse group in terms of their experiences of their daughters' therapy. Ultimately, they reported differences in their daughters'

mental health issues (or lack of) and differing amounts of and types of therapy that their daughters had experienced. The variety of experiences in terms of type and amount of therapy may have been partly due to the variety of recruitment methods that I utilised in order to recruit my sample (see *Methodology*). Mothers also differed in terms of the time that had elapsed since their daughter has been in therapy and, for some mothers, their daughters were still in therapy at the time of interview. This could therefore have affected the amount of time mothers would have had in order to reflect upon their experience. In one case, I interviewed a mother – Hillary – twice, due to a fault in the recording equipment during the first interview. As with her first interview, the second interview was very reflective, but some of her ideas had altered as a result of her reflection during and upon the first interview (see *Appendix 12: Excerpts from reflective diary* for further insights).

It could be argued that within this study's epistemological and methodological framework, the credibility of the research is not affected by the impact of retrospective memory, the type of therapy or length of time the daughter was in therapy, as the important reality in IPA is what people perceive it to be (Willig, 2008). From my epistemological position, I also understand that meaning is a product of social interaction and is therefore context-dependent and changeable. Therefore, the specifics of the daughter's therapy were regarded as less important than the meaning of the daughter's therapy to the mother within the research context.

As I have referred to in the methodology, both of the data collection methods that I used (demographics questionnaire and an interview schedule) underwent modification during the research process. This happened as I responded to participant feedback and attempted to gain greater focus upon the mothers' experience of their daughters' therapy as opposed to their daughters' early experiences and mental health difficulties.

As mentioned previously, I sometimes noticed there was a decline in self-justification and searching for blame over the course of the interviews. A greater sense of mothers' feelings of powerlessness, sadness and loss became apparent as I responded in a curious and non-judgemental way to their stories. Further modifications to the interview schedule may have helped me to develop rapport

with the mothers before broaching more personal topic areas. For example, it may have been useful to have facilitated a greater exploration of the mother's thoughts and beliefs about therapy in general before broaching the topic of her daughter's therapy. McNab and Kavner (2001) suggest a movement from the societal to the relational and to the personal as a way to free mothers from the "paralysis of blame".

1.4.5. Personal reflexivity

I understand that interactions that took place during the interviews were influenced by multiple factors, including the significance of the relationships that I formed with each individual mother. As I have already acknowledged, this topic was relevant to me personally, reaching me at different levels of my identity, particularly as a daughter who had been in therapy and as a Trainee Counselling Psychologist who has worked with mothers and daughters individually and dyadically.

I felt admiration towards the mothers and was moved by the compassion and care conveyed regarding their daughters' well-being. I can empathise with McMahon's (1995) finding that women are deeply connected to their children. A part of me even wanted to be mothered by these women, who shared such wisdom and showed such willingness to be helpful and nurturing towards me. I wondered whether I entered into a "mother-daughter transference and counter-transference" (Hollway & Jefferson, 2000, p. 51) with some, if not with all, of the mothers, especially given that I was the same age as many of the daughters. If this was the case, how might this "unconscious intersubjective dynamic" (Hollway & Jefferson, 2000, p. 52) have affected the stories that the mothers were able to tell me? How able were they to honestly convey their more murky and difficult feelings, especially given that the mother struggles to protect her daughter from knowing about the complexities of womanhood (Sayers, 1993).

There were times when I felt emotionally responsible for protecting the mothers from the painful awareness of their feelings. There were also occasions when I felt surprised by how emotionally overwhelmed I felt during and after the interviews. In such cases, I used my research diary, sought supervision or utilised

my personal therapy to reflect. I sometimes detected when mothers felt uncomfortable to talk about certain things and I did not push certain questions. In hindsight, this might have enabled me to gain a greater depth of understanding. I wondered whether I wanted to protect myself from hearing the mothers' full range of experience. Perhaps at some level this related to my guilty feelings or sense that I betrayed my mother when I went to therapy. These concerns were mainly present during earlier interviews. This suggests that as my experience as a researcher and as a therapist increased, as did my ability to stay with uncomfortable feelings of anxiety and to move beyond the superficial to greater depths of understanding. However, it is challenging to work out whether the barriers arose from within me, from the "defended subject" (Hollway & Jefferson, 2000, p. 26), or from the dynamic between us.

During interviews, I was aware of some of my arising thoughts and feelings that influenced my perception of some of the mothers and it was important for me to reflect upon these thoughts and to consider the impact of my judgements on the research process. I wonder whether my concern that I had internalised a mother-blaming discourse led me to be overly cautious in the presentation of the research data in my attempt to convey a non-stigmatising account of mothering. However, in my growing understanding of my epistemological position, as one which acknowledges multiple truths and the contextualisation of these truths, providing a tentative, non-judgemental account felt important to uphold.

1.4.6. Research process and contribution to understanding of IPA methodology

Within IPA methodologies, there is much attention to the relationship between the researcher and researched in terms of the co-creation of knowledge (Smith, 2004; Smith et al., 2009; Willig, 2008, 2012). This research contributes to this body of knowledge as it draws attention to the potential impact of transference influencing the research process. Although the mother-daughter dynamic was something that I reflected upon, I was not prepared for the amount of connection that I experienced with these mothers or how emotionally impacted I would be as a result of hearing their stories. I was also unprepared for how I may be unconsciously drawn into protecting the mothers and myself from exploring the depths of their experiences.

In this research, due to the explicit identification of the mother-daughter relationship as the focus of attention, this enabled a spotlight to be shone on the potential influence of transference. However, it may also play a significant, if more implicit, role in other research relationships, data collection and analysis processes. The nature of transference has already been highlighted and explored by qualitative researchers such as Finlay (2011) and Hollway and Jefferson (2000). However, within IPA literature, there is less attention to this process. This research helps to highlight this aspect of the research process within IPA.

This research also contributes to the literature commenting upon the challenges of managing the boundaries of the researcher's and therapist's role and the impact this challenge has on the research process (Mitchell & Irvine, 2008). Therapeutic skills are useful within research interviews (Finlay, 2011; Kasket, 2012; Lewis, 2008) and I think that mine helped to sensitively manage the intense emotions of the mothers during the interview and to provide an atmosphere of non-judgement and openness. However, as a therapist, I sometimes noticed my tendency to respond to the mothers' self-blame in ways that encouraged them to explore alternative perspectives and that brought their attention to their inner resourcefulness. I was also aware of following the mothers' lead and feeling uncertain about how to manage these moments when the mother appeared to go off topic. These experiences seemed to be in accordance with IPA rapport-building and allowing ambiguity and complexity to unravel (Willig, 2008). However, I felt uncertain about whether I needed to be more agenda-driven at times.

The ambiguity of the data collection process is renowned in IPA and it is acknowledged that there is not one definite method (Larkin et al., 2006). It was certainly something that I needed to tolerate and I had to trust in my intuition in order to help the mothers to tell their stories and to sense when interviews had reached an endpoint. This perhaps draws attention to where the anxiety and uncertainty experienced by the researcher about IPA methodology might influence the data collection process.

It could be argued that my anxiety influenced the mothers, their experience as research participants and the data collection process. Indeed, mothers often commented upon their uncertainty about whether what they had shared would be

helpful to me. This may indicate that they had received some of my unconscious projections, as I feared whether I was doing a good enough job as a researcher. However, at the same time, with mothers voicing their self-blaming attitudes and thoughts about being “*a failure as a mother*”, my anxieties were challenging to separate from those of the mothers. This helps to highlight the “muddy ambiguity” involved in reflexivity (Finlay, 2002) and the considerable experience of uncertainty inherent in the research process in general, and perhaps particularly so for the novice researcher.

1.4.7. Key findings and contribution of research to the field

Being able to contribute novel findings to the field of psychological research is an important criterion for assessing the value of research findings (Yardley, 2000). I believe that this research provides unique insights into the phenomenological experience of having an adult daughter in therapy from the mother’s perspective. The findings also reveal perceptions of the experience of mothers who have adult daughters with mental health difficulties – an experience intricately interlinked with having a daughter in therapy for some mothers within this study. In the following section, I will highlight how the key findings from this research contribute to, complement, contradict or illuminate existing research and theory in order to draw attention to where this research sits within the extant field. I will also recommend how these findings could be used in the field of psychology, and particularly within counselling psychology, in order to enhance therapeutic knowledge, training and practice.

1.4.8. Theory and research

1.4.8.1. The mother’s emotional experience

Mothers are supportive of their adult daughter being in therapy An overarching finding from the research was that mothers positively judged their adult daughter being in therapy, and found it beneficial and useful. This suggests that both the mothers of adult daughters as well as the parents of children in therapy (Nevas & Farber, 2001) experience mainly positive feelings about this experience. It also supports the literature that has found how supportive significant others can be of

their loved ones' therapy (Murray, 2007). However, the current research also sheds light upon the complexity of the mother's emotional responses to their daughter's therapy and the difficult and paradoxical feelings that may co-exist alongside support for therapy.

Mothers worry whilst having an adult daughter in therapy

Worrying seemed to be particularly present for mothers, irrespective of the severity of their daughters' mental health issues. Parents who have adult-children with mental health problems report an ever present sense of responsibility and worry for their children (Johanasson et al., 2010; Mohr & Regan-Kubinski, 2001; Pejler, 2001). Given the diversity in their daughters' mental health issues, the findings of this research seem to reinforce the evidence that the experience of worry is not isolated to mothers who have children with severe mental health issues but is something commonly experienced in parent-adult-child relationships (Hay et al., 2007, 2008).

The current research findings could be seen to add to the substantial body of knowledge which imparts that having a loved one in therapy can be perceived as threatening to the relationship with the loved one. Like in the present study, Hatcher and Hatcher (1983) found that parents of psychotherapy patients were affected by their own fantasies and anxieties about their loved ones' relationship with the therapist. In the child psychotherapy literature, it is suggested that mothers can feel threatened by their child's improvements (McCarthy, 1989) and act in ways that negatively impact the therapy (Daniel & Jenkins, 2010). It is also noted within other adult psychotherapy (Brody & Farber, 1989; Freud, 1913; Hatcher & Hatcher, 1983) and systemic literature (e.g. Glasser, 1963; Jackson, 1957) that individuals can struggle with having a significant other in therapy. In the current study, there was evidence to suggest that the perception of negative changes in the daughter was experienced as threatening to the mother-daughter relationship and to the mother's sense of self as a mother.

However, to some extent, the present study contributes to Hatcher and Hatcher's finding of a temporal change in the experience of parents of psychotherapy patients. As in Hatcher and Hatcher's study, the greatest level of

agitation reported by mothers in the present study appeared to be at the beginning of their daughters' therapy. Therefore, the current study adds weight to the research suggesting that the level of agitation experienced by the parents of those in therapy decreases over time as worries about their adult-child's therapy often go unrealised (Hatcher & Hatcher, 1983).

In the present study, having a daughter in therapy seemed to help the mother to feel reassured, safer in the knowledge that their daughter was being cared for by a professional. This is in keeping with Pejler's (2001) finding that their adult-child's professional mental health care provided a sense of relief for parents who knew that their child was being cared for. However, for some of the mothers in the present study, their anxiety was rekindled when their daughters' therapy ended. This finding suggests that therapy can provide mothers with a sense of "*respite*" from the perception of their never-ending parental responsibility, but one that is temporary and that may be feared to be unsustainable.

Parental involvement has been found to be an important factor in the parents' experience of and parental satisfaction with services (Holmboe et al., 2011; Pejler, 2001). In contrast, different responses were conveyed by mothers in this study about the level of involvement in their daughter's therapy that was felt to be appropriate. For a minority of mothers, not being able to influence the process of their daughter being in therapy, or feel as though they were contributing in some way to help her therapy, was an extremely distressing experience. However, others found not being involved in their daughters' therapy to be a relief and the most appropriate course of action. The current study suggests that different factors affect the level of involvement desired by mothers and that these may include the daughter's age, the severity of the daughter's difficulties, and the mother's individual understandings of the therapeutic process. Along with the mother's personality and life experiences, these factors perhaps play a significant role in determining the level of responsibility that mothers feel about their daughters' well-being and, hence, the level of their involvement that they view to be necessary.

Mothers experience guilt about their adult daughters being in therapy

The findings from the current study contribute to the body of literature that suggests that self-blame and guilt are common experiences for mothers who have children in therapy. The child psychotherapy literature suggests that parents feel hurt and guilty about their child's need for therapy (Furnan, 1995). It is also noted within the adult psychotherapy literature (Brody & Farber, 1989; Freud, 1913; Hatcher & Hatcher, 1983) that individuals can struggle with guilty feelings whilst having a significant other in therapy. The mothers in the present study widely reported experiencing guilt and self-blame about their daughters' need for therapy. Furthermore, the present study indicates that the age of the child in therapy may not affect this response as the experience of having a child and an adult-child in therapy both appeared to provoke feelings of guilt in mothers.

In the literature, it has been suggested that mothers who feel guilty and blamed by others about their daughters' chronic health or mental health problems can become more protective of their daughters (Rassamen et al., 2008) and over-compensate (Daly, 2005). The mothers in the current study sometimes recognised how their behaviour impacted upon their daughters, particularly when they noticed that they "*interfered*" in their daughters' lives. The present research findings perhaps gives an indication of the extent to which feelings of guilt surrounding the daughter's mental health difficulties can impact upon the mother's behaviour and her difficulties with relinquishing responsibility in the mother-daughter relationship. However, in contrast to Rassamen et al., the current study suggests that as a result of being in therapy, daughters may become more able to challenge the mother-daughter "guilt-dynamic", to break the silence and confront their mothers.

Mothers experience sadness and emotional pain

To some extent, the common finding of sadness reported by mothers in relation to their daughter being in therapy could be compared to the literature reporting "chronic sorrow" experienced by parents who have adult-children with mental health difficulties (Eakes et al., 1998; Godress et al., 2005; Johanasson et al., 2010; Mohr & Regan-Kubinski, 2001; Pejler, 2001; Ryan, 1993). Mothers in the present

research study reported diversity in their daughters' mental health issues and those with daughters with the most severe and enduring mental health difficulties appeared to demonstrate the greatest chronicity and impact of sadness in their lives. Therefore, the findings of the current study appear to corroborate the experiences of "chronic sorrow" in mothers with adult-children with chronic and severe mental health problems, due to their significant experience of loss and the impact such difficulties can have upon an individual and their family (Johanasson et al., 2010; Mohr & Regan-Kubinski, 2001; Pejler, 2001; Zauszniewski et al., 2008).

A striking finding in the current research was the sheer pain that was sometimes evoked in mothers whilst they reflected upon the experience of their daughters' therapy. This was particularly the case for the mothers whose daughters had experienced family disruption or sexual abuse in their early lives. Comparable experience of unique pain and loss has been revealed in the stories of mothers of suicidal adolescents (Daly, 2005) and in those of mothers whose children have been sexually abused (Carvalho et al., 2009; Pretorius et al., 2011). The current research contributes to the research knowledge that highlights the challenges for mothers in coping with their own feelings of pain and loss in the context of having a daughter with mental health difficulties or traumatic life experiences. Loss may be apparent in the mother's disappointment related to unmet hopes for her daughter and in the loss of the perception of self as a "good mother" when acknowledging that she had not been able to prevent her daughter's suffering.

However, the findings of the present study also indicate that sadness, loss and pain are experienced regardless of the severity of the daughter's mental health difficulties or life experiences. It could be proposed that in the process of trying to make sense of the experience of having a daughter in therapy, the mother reflects upon her daughter's life and her own perceived wrong-doings. This process may result in the re-awakening of the forgotten past and the opening of "*Pandora's box*".

Self-in-relation theory suggests that the woman's identity and self-worth are organised around maintaining relationships (Miller, 1986) and are heavily invested in the nurturing role (Miller, 1986, 2008; Gilligan, 1982). Contributing to this understanding of femininity, the current research conveys that on hearing the

daughter's subjective experiences of pain or of her need for therapy, mothers experience significant emotional tension. To feel that they have contributed in some way to their daughter's suffering can be seen to painfully impact and conflict with the mother's sense of self and their evaluation of their self-worth. Furthermore, the current research powerfully illuminates the importance of interdependence and connection in relationships for women (Miller, 1986; Jordan, 1991). It suggests that disruption in their connection with their daughter, or the threat of, as a result of her therapy, can result in worry, sadness and even depression for mothers.

1.4.8.2. The impact on the mother-daughter relationship

Therapeutic changes in the daughter impacts on the mother-adult daughter relationship

The findings of the present study support the research which informs that the process of therapeutic change is heterogenous, non-linear and takes place both in and outside of therapy (Hanna & Ritchie, 1995; Krause et al., 2007). This research contributes to the abundant findings that the impact of therapy occurs at both an individual (Bandura, 1977; Bittner, 1981; Du Plock, 2010; Frank, 1982; Hanna & Ritchie, 1995; Howard et al., 1993; Krause, 1992; Krause, 2005; Krause et al., 2007; Kumari, 2011; Lemma, 2007; Martens, 1991; Rogers, 1961; Yalom, 1995) and interpersonal level (BCPCG, 2010; Dallos & Draper, 2005; Duvall, 1977; Haley, 1973; Jackson, 1957; Lemma, 2003; Rogers, 1961). Mothers recognised that their daughters' behaviour, mood, self-awareness and confidence were impacted by therapy. They also referred to the tentative nature of the recovery and rehabilitation process, which is well-documented in the literature related to parents' experiences of having an adult-child with mental health difficulties (e.g. Johannason et al., 2010; Muhlbauer, 2002).

Mothers in the present study recognised changes in closeness and communication in the mother-daughter relationship and that daughters became more active in managing their needs within it. This is concordant with other research which similarly suggests that relationships with a significant other who is in therapy can be perceived to improve over the course of therapy (Bedics et al., 2005; Murray, 2007; Smerud & Rosenfarb, 2011), including improvements in

communication and closeness (Brody & Farber, 1989; Murray, 2007). The current research also illuminates the existing research which demonstrates how the change process that occurs during therapy alters the client's ways of being with others (e.g. BCSG, 2010), including the individual's abilities to separate their needs from those of others, and to communicate these needs (Rogers, 1961). The current research findings appear to confirm that the level of interdependence in the patient-significant other relationship can change as a result of being in therapy (Bedics et al., 2005) as daughters in the present study were perceived to exert more of their power and autonomy within the mother-daughter relationship.

The findings from the present research reinforce the usefulness of systems theory in its application to the understanding of therapeutic change (Dallos & Draper, 2005; Duvall, 1977; Haley, 1973; Jackson, 1957; Watzlawick et al., 1967). The findings indicate that as a result of having a daughter in therapy, a systemic pattern of reciprocal influence can take place via mother-daughter interactions. This can disrupt and alter the existing mother-daughter relationship and lead mothers to re-evaluate their roles and their life experiences.

The finding in the current study that some mothers experienced beneficial changes themselves, as a result of their daughter being in therapy, highlights the literature that propounds that an individual's therapy can facilitate therapeutic changes in their family members (Brody & Farber, 1989; Rogers, 1961).

Ambivalence is ongoing in mother-adult daughter relationships

The present research revealed that the stories of mothers who had adult daughters in therapy seemed to be saturated by their ambivalence about their personal responsibility for their adult daughter and her therapy. These findings lend support to psychoanalytic and developmental understandings of complexity and ambivalence in the mother-daughter relationship, particularly in relation to the process of separation-individuation (Charles et al., 2011; Fenchel, 1998; Firman & Firman, 1989; Freud, 1933; Shrier et al., 2004).

The daughter's therapy could be viewed as part of a separation-individuation process as the daughter could be seen to discover a new, private space or "the third" (Britton, 1989), for her own thinking and identity to develop

separately from her mother. The mothers in the present study conveyed feelings of confusion and ambiguity about their role in their daughters' lives. It was notable that mothers often reflected upon their struggle to accept their daughters' individuality and separate life journey. These responses could be connected with oedipal feelings of competition, envy and inadequacy (Freud, 1933) and be related to the experience of loss of exclusivity in the mother-daughter dyad.

The mother's ability to hear her daughter's unique perspective illuminates the processes of recognition and intersubjectivity in separation-individuation (Benjamin, 1990). The experience of closeness and connection in the mother-daughter relationship, brought about by discussion of the daughter's therapy, appeared to be enhanced through recognition of difference and the development of a shared reality and mutual understanding. The reflective process that some of the mothers engaged in as a result of hearing their daughter's story might relate to the "spacious opening up of the 'the third'" (Benjamin, 2009, p. 442) and, hence, the mother's capacity to hear multiple voices. An understanding of the ongoing tension in separation and connection and that recognition is often unevenly realised in relationships (Benjamin, 1990) helps conceptualise the challenge for some of the mothers, particularly as recognising the daughter's individuality may lead the mother to reflect upon her own limitations and feelings of powerlessness.

As the majority of the daughters were in early adulthood, this might suggest that the current research captured an experience of life-cycle transition in the mother-daughter relationship which might have taken place with or without therapy. The daughter's therapy could even be viewed as augmenting the separation-individuation process within the mother-daughter relationship as it sometimes led to changes within the mother-daughter relationship in terms of new boundary-setting and power-relations. Nonetheless, evidence of re-evaluation, renegotiation and adaptation in the mother-daughter relationship was present in the mothers' accounts in the current study. Therefore, the current research findings complement the body of research which associates these occurrences with the life-cycle transition in the mother-daughter relationship (Bengston & Kuypers, 1971; Fischer, 1991).

Ambivalence and role ambiguity seemed to be most commonly experienced by mothers in the current study who were their daughters' main source of emotional support and who felt discomfort with being in this role, given their daughters' adult status. This corroborates the research which has highlighted that the extent of ambivalence experienced in parent-adult-child relationships is influenced by the adult-child's level of independence (Birditt et al., 2009; Elvin-Nowak, 1999; Pillemer & Suitor, 2002).

The socio-cultural context impacts upon mothers' experiences of the mother-daughter relationship

The present research suggests that there are differences in the ways that mothers perceive the validity of their daughters' version of reality. It also indicates that there may be differences in the mother's ability to hear her daughter's story and that this could be associated with their emotional resources. The heterogeneous dynamics found within the mother-daughter relationships in the current research study corresponds with those found by Charles et al. (2001). Charles et al. differentiated between mothers that were "enabling" or "constraining" of their daughter's perspective. Charles et al. also identified a group of mothers who were "enabling" but "situationally-stressed" and less emotionally available. This study could be seen to reinforce the understanding that the mother's emotional resources can impact upon her ability to hear her daughter's perspective, which may result in less acceptance of the daughter's story and greater negative evaluation of the daughter.

It could be argued that the present research contributes to the extant literature by imparting that the impact of socio-cultural experiences of motherhood upon the mother-daughter relationship influences the mother's ability to hear her daughter's perspective (Daly, 2005; Gilligan, 1982; Johansson et al., 2010; McNab & Kavner, 2001; Miller, 1990, 1991; Sayers, 1993; Suleiman, 1988; van Mens-Verhulst, 1995). Self-in-relation theory suggests that much of the mother's identity is invested in her relationship with her daughter (van Mens-Verhulst, 1995) and in the nurturing role in general (Miller, 2008), so it is perhaps no wonder that on hearing the daughter's subjective experiences of pain or her need for therapy, that mothers might experience tension. Furthermore, the dominant culture that

prioritises separation and individuation, as opposed to interdependence and mutuality, can be seen to restrict the relational context in which mothers and daughters can develop mutual connection and understanding (Gilligan, 1982; Miller, 2008; Sayers, 1993).

The current research appears to illuminate the extant literature as it emphasises how mothers may manage the mother-daughter relationship in order to limit contact with emotive material that might threaten their self-perception and self-confidence as a mother and as a person. In addition, it indicates that the constraints in mothers' or daughters' lives may influence the physical and emotional availability in the mother-daughter relationship and limit opportunities for the daughter's therapy to be experienced or translated into benefits for the mother.

This research supports the sizable body of knowledge that emphasises the importance of recognising the socio-cultural contexts of mothering (e.g. McNab & Kavner, 2001; Sheppard, 2000; van Mens-Verhulst, 1995). Perhaps in line with Fischer (1986), the findings of the current research indicate that mothers attempt and struggle to both "hold on and let go" within their relationships with their adult-daughters, in what seems to be a complex and dynamic negotiation of interdependence and mutuality. Psychological discourses that pathologise the mother for desiring closeness in the mother-daughter relationship have been used to help explain loss of intimacy in mother-daughter relationships (e.g. Surrey, 1993; van Mens-Verhulst, 1995). Therefore, it could be suggested that these discourses, and the resultant internalised mother-blame, contribute to the pain and self-doubt experienced by mothers whilst struggling to find synthesis between these opposing poles in their relationships with their adult daughters.

1.4.8.3. The mother's management of the process

Mothers manage their thoughts and feelings

The coping strategies used by mothers, as they attempted to cope with feelings of unbearable pain and to avoid contact with thoughts and memories related to their daughters' experience, are similar to some of the coping-strategies identified in the extant literature (e.g. Daly, 2005; Miller, 1990; Johansson et al., 2010; Sayers, 1993). Trying to stay grounded in the present moment was identified as a helpful

strategy for parents coping with the experience of having an adult-child with mental health problems (Johanasson et al., 2010). The comparable finding in the present study that mothers tried to put things into perspective and to focus on improvements in their daughters' well-being rather than for signs of deterioration suggest that these attention-focusing strategies may be common coping mechanisms amongst parents with adult-children with mental health difficulties.

Forgetting was also commonly reported as a way of coping in the present study but is a coping-strategy less present in the literature. Whilst playing a function in helping mothers to cope, it also appeared to fuel friction and to shut down routes to mutuality within mother-daughter relationships. This suggests that a mother's forgetting may have significant implications for communication within mother-daughter relationships.

Mothers use “courtesy stigma management strategies”

As found by Wagstaff (2012) in her study of depressed mothers, the mothers in the present study appeared to be invested in preserving their image as a “good enough” mother, and in justifying their actions as mothers with reference to their socio-cultural contexts. The present research highlights that mothers recognise the public stigma about mental health issues and therapy. The findings suggest that mothers may try to preserve their self-esteem and to protect themselves from feelings of guilt or shame in relation to their daughter's need for therapy through selective disclosures to others. This evidence contributes to the research which indicates that mothers of children with mental health difficulties may employ “courtesy stigma management strategies” in order to control social perceptions and to reduce contact with stigmatising responses from others (Koro-Ljungberg & Bussing, 2009).

It was unclear to what extent the mothers in the present study experienced stigma as a result of the responses of others or the internalisation of mother-blaming attitudes. This is a phenomenon well-discussed in the literature (Corrigan & Miller, 2004; Jackson & Mannix, 2004; Sheppard, 2000). The current research seems to highlight the complexity of separating out the mother's experience of stigma from her social relationships. This could be seen to provide tentative

support for Fox's (2012) explanation of intersubjectivity theory in relation to the co-constructed experience of stigma.

The results of the present research contrast with the positive findings in the literature related to the benefits of social support and support groups (Johansson et al., 2010; Peijert, 2000). The mothers voiced mixed feelings about sharing their experiences with others and negative feelings about attending support groups. The aforementioned research studies took place in Sweden. Different availability of social support, or support groups, or cultural meanings attached to attending support groups in Sweden, may account for the disparity of the current research findings.

However, the findings of the current research may indicate a high level of sensitivity to perceived criticism in this group of mothers and/or the need to dis-identify with other mothers who have children with mental health difficulties in order to maintain self-esteem. This may suggest that the current research findings provide insights into the significant extent to which mothers may experience painful stigmatising responses from others (or the self), and feel the need to self-protect in order to avoid these experiences.

Meaning-making processes influence the mother's experience

The prevalent questioning and theorising activities expressed by the mothers in the current sample are perhaps comparable to the experience of the "limit situation" (where current systems of meaning are limited and provide no relief) – a concept used by Lindgren et al. (2010) to describe a significant part of the parents' experience of their adult-child's professional care. The current research findings appear to provide further evidence of the phenomenological experience of the "limit situation" and to suggest that this experience can arise in response to having an adult-daughter in therapy.

Thornhill (2011) describes how individuals experiencing a "limit situation" attempt to find access to new meanings via a process of "existential communication" – a particularly intense form of communication with others. It could be suggested that for some of the mothers, discussions with their daughter, in particular, provided a comparable form of existential communication. Mothers in

the current study often felt enriched by their discussions with their daughters, and experienced increased closeness in the relationship as a result. This supports the existing research findings that post-therapy discussions with significant others who are in therapy can deepen the patient-significant other relationship and the level of communication with the loved one who is in therapy (Brody & Farber, 1989; Murray, 2007).

The dynamic cycle of discussion and reflection, which appeared to significantly impact upon the mothers' experiences of personal change within the present study, corroborates with the important role of meaning-making in determining the experience of personal growth in parents of adult-children with mental health difficulties (Aschbrenner et al., 2010; Johansson, 2010; Muhlbauer, 2002; Schwartz & Gidron, 2002). The meanings mothers used in order to make sense of their experiences, along with the resources that they perceived to be available in order to help them to cope, seemed to have an important impact. This appears to support the utility of Lazarus and Folkman's transactional theory of stress and coping (Lazarus, 2000).

In addition, the new meanings and understandings that sometimes arose for mothers as a result of the dynamic cycle of discussion and reflection appears to highlight the intersubjective nature of the mothers' meaning-making processes. The findings of the current research study appear to contribute to an intersubjective theoretical approach to the understanding of meaning-making processes as activities inevitably embedded within relational experiences. This provides further weight to the strength of intersubjectivity theories, such as Fox's (2012), in explaining how individual subjectivities can mutually influence and co-construct each other's personal meanings.

Finally, the current research indicates how the development of meaning and new understandings may be fundamental to the well-being of mothers who have had an adult daughter in therapy. It suggests how public and self-stigma may interact synergistically to stifle opportunities to access new meanings via in-depth communication with others. This may restrict the potential for the mother's personal growth and lead to the persistence of "the limit situation" without relief.

1.4.9. Therapeutic practice

For Counselling Psychologists and other psychological therapists, the following suggestions are included that could be used to inform teaching, training and practice.

Along with the awareness that one's understanding of an individual cannot be separated from an understanding of the context (Mearns & Cooper, 2005; Sugarman, 2010), it is important that one recognises that the therapy arena is also contextual and it is likely that it will be impacted by and impact upon its context (Lemma, 2003). Having sensitivity to the context of therapy may provide a helpful inroad to exploring the impact of the context, and any factors contributing to client ambivalence, such as their family's beliefs and responses to the individual being in therapy.

Understanding the socio-cultural contexts in which mothering occurs may help to challenge and breakdown the prevailing cultural discourses of mother-blaming and prevent us as Counselling Psychologists from passively accepting that mother-blaming fits the client's reality, thereby perpetuating beliefs about mother-blame. An understanding of the heterogeneity and complexity of mothering, highlighted in this research, may enable Counselling Psychologists to be mindful of and to challenge mother-blaming discourses within their practice. These findings could be used to help trainees to explore the different contextual aspects of their own and each other's family histories, and the impact of these factors on their family relationships. This may help to build understanding, empathy and curiosity towards mothers who we work with directly or indirectly.

For Counselling Psychologists working with mothers of adult-daughters who are in therapy, it is hoped that the findings can be used to help inform the process of therapy, particularly as it draws attention to some of the areas that are commonly identified by mothers as challenging and painful to manage. These findings may also be of use to Counselling Psychologists working with mothers of adult-daughters in general with or without severe mental health difficulties.

When working with such mothers, it may be helpful to encourage them to explore their own experience of being mothered and the socio-cultural contexts of their mothering. McNab and Kavner (2006) recognise a tension between helping

mothers to accept responsibility without causing them to feel frozen by mother-blame and the role of therapist empathy in helping to bring forth feelings of shame. Gaining a greater insight into the mother's life struggles and an understanding of the impact of any life challenges on their relationships with their children within a non-judgemental and empathic therapeutic arena may help to establish a climate of acceptance and non-blame. As a result, this may foster greater self-validation and self-compassion within mothers and, in turn, greater potential for empathy and connection in the mother-daughter relationship.

Beliefs about mothering, such as *the need to be strong* and *to worry*, may be useful to challenge as such beliefs may serve to maintain unhelpful introspection, rumination and isolation. In turn, this may further reinforce feelings of guilt, anxiety, powerlessness and helplessness. Focusing on the present and being in the moment was found to be a useful strategy for mothers. This is reminiscent of "mindfulness", which is described as "paying attention in a particular way: on purpose, in the present moment, and non-judgementally" (Kabat-Zinn, 1994, p. 4). Mindfulness skills may be taught to mothers as it has been found to be an effective way of coping with a range of difficulties, including depression (Segal, Williams & Teasdale, 2002), anxiety (Kabat-Zinn, Massion, Kristeller & Peterson, 1992) and overwhelming emotional distress (Linehan, 1993a).

Alternative understandings of mothering may be offered to highlight the complexity of an individual's early development. For example, Aldwin's (2007) ideas about "*transformational coping*" i.e. that individuals develop resilience and agency through the experience of stress – might be used to challenge the notion of perfect parenting. Combating such unhelpful beliefs may help to reduce the likelihood of "undoing" or, in other words, help mothers to relinquish some responsibility for their adult daughter.

It may be useful for Counselling Psychologists to facilitate mothers to explore their understanding of their daughter's perspective, her therapy and to reflect upon how this impacts upon their own perception of life events and their identity as a mother. Mothers may be guided to explore their perception of events and the differences between and similarities that they may share with their daughter's perspective.

Alternative meanings regarding their daughter's perspective may be helpful to share with mothers who struggle to come to terms with their daughter's version of events without judgement or blame. Acceptance of differences and new meanings made about these differences may be useful directions for therapy that help mothers to find more balanced ways of understanding past events and personal growth for themselves. For example, as well as validating the mother's experience, it may be useful to provide a phenomenological perspective, *that there may be different versions of reality, and that each one may be equally valid*.

Acceptance is used as an approach to managing emotional distress within mindfulness-based approaches, including Acceptance and Commitment Therapy (ACT; Hayes, Strosahl & Wilson, 1999). This approach may be helpful for mothers for accepting their daughter's version of reality, accepting their emotional experiences and for decreasing engagement in avoidant coping-strategies (e.g. distraction, denial, cognitive distortion, suppression, repression, self-harm) which are associated with worse psychological and health outcomes (Gross, 2002; Salovey, Rothman, Detweiler & Steward, 2002; Segerstrom, Stanton, Alden & Shortridge, 2003).

For mothers, such as Meredith, who seem to struggle to stay with their painful feelings, they could be taught acceptance skills following Linehan's (1993) skills training to help them to accept rather than to fight feelings, memories and thoughts that they experience. Over time, they will hopefully find that their experience of intense pain will subside or transform (Hayes & Feldman, 2004). This may then help mothers to tolerate their experience of pain and loss that arises when acknowledging their daughter's experience. However, in learning from Meredith's experience, it may also be important for the therapist to accept the extent of the mother's ambivalence within the mother-daughter relationship and to appreciate how the mother's current life difficulties and emotional resources may contribute to their willingness and readiness to reconnect with their daughters.

Counselling Psychologists working with daughters in therapy may aid their client to acknowledge the complexities of their mother's experience and the socio-cultural contexts of their mothering to help them to develop a more enriched

understanding of the mother-daughter relationship. Drawing a genogram (see Bowen, 1978), a common practice within systemic therapy, may be a useful aid for helping daughters to gain some perspective upon their life story and to recognise intergenerational patterns.

Being able to acknowledge multiple perspectives, i.e. plurality and complexity, is a core part of counselling psychology (Cooper & Mcleod, 2011; Kasket, 2012; Rafalin, 2010). When working with mothers or daughters it is useful to be flexible and hold joint sessions or to recognise when individuals may benefit more from working individually). In either case, it is paramount for the therapist to hold onto the mother's and daughter's subjectivities and their socio-cultural contexts.

The research findings may be used as information provided to mothers of daughters in therapy. For example, daughters in therapy could be provided with optional information for their mothers which gives an explanation of the therapy process, what they can expect and where they can receive additional information and support (see *Appendix 19* for an example of an information booklet).

1.4.10. Future directions

In this section, I include some of the future directions for research inquiry, inspired by the findings of my research. As this research was carried out with a relatively homogenous sample, future research may explore the experience of mothers from other ethnic groups and then compare the findings with the current research, giving greater attention to the role of cultural factors. This may help to shed light on different cultural practices, including alternative coping strategies, which may facilitate the therapeutic journey for mothers. A longitudinal approach to the data collection process may provide more opportunities for developing rapport, capturing meaning and in-depth understandings of the experience of having an adult daughter in therapy over time. Asking participants to complete diary entries may also provide additional information to enrich the data (Willig, 2008).

Hearing from daughters about how their experience of being in therapy impacted upon their relationship with their mothers – and the choices underlying daughters sharing or not sharing about their therapy with their mothers – may help

to unpick any similarities and differences in mother-daughter relationships. In particular, it would be interesting to explore how the mother's responses to their daughter being in therapy affected her therapy. Hearing from the fathers or the siblings of daughters may also provide additional insights into the ways in which a daughter's therapy impacts upon the family and is impacted by the family.

This research drew attention to the impact of transference on the IPA process. A greater awareness of transference processes within IPA research may enable researchers to prepare more effectively for its impact, through the practice of reflexivity, and to be able to use this information as data. The use of mindfulness has been identified as helpful for managing challenges arising within the therapeutic relationship (Bruce, Manber, Shapiro & Constantino, 2010; Katzow & Safran, 2007). A future direction for research may be to interview researchers who practice mindfulness in order to ascertain its utility as a research tool, particularly in the management of transference within the research relationship. In the spirit of IPA, it would be important to find ways of exploring the phenomenon of mindfulness and transference without precluding other ways of understanding them (Midgley, 2010).

1.4.11. Conclusion

Within this chapter, I have acknowledged the potential limitations of the research study and reflected upon the challenges experienced whilst conducting the research. I hope that I have provided a convincing explanation of the utility of this research for Counselling Psychologists working with mothers who have adult daughters in personal therapy, by highlighting the mother's emotional, sense-making and reflective journey, how she manages her emotional and relational world and how her daughter's therapy can lead to the experience of personal growth.

The research encounter appeared to provide mothers with a therapeutic and empathic space where they undertook a process of self-exploration. Through this process, they seemed to give voice to previously unformed and unexpressed thoughts and to acknowledge a range of different emotional experiences, some of which seemed unprocessed, painful and surprising. As the researcher – a daughter

who has been in therapy and a Trainee Counselling Psychologist – I have explored how my relationships with the mothers impacted upon what was shared. I have highlighted the complexity of managing this experience as a researcher and suggested how the utility of mindfulness as a research tool may be explored.

Mothers conveyed their struggles to manage closeness in their relationships with their daughters and provided insights into the heterogeneity of the experience of mothers, contextualised within their socio-cultural experiences. It is hoped that the findings of this research helps to hone the awareness of the socio-cultural contexts in which women are mothering. Furthermore, through acknowledging the contexts in which daughters are in therapy and how the context may both impact upon and be impacted by the daughter being in therapy this research hopes to reinforce the Counselling Psychologists' attention to the context of therapy and the plurality of experiences within that context.

1.4.12. References

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1.6. Appendices

Appendix 1: A reflexive piece about my experience as a daughter in therapy

I have experienced four pieces of therapy between 2008-2012. A large incentive for undertaking therapy was in order to enhance my self-awareness to prepare myself for commencing the Counselling Psychology Doctoral Programme. I was curious about the process of therapy and thought that undertaking therapy as a client would help me to understand the experience of the client role so that I could empathise with my future clients. There were also areas in my way of being with others that I wanted to address for both my professional and personal life. For example, I held quite a strong identification with my mother and was concerned that I would unconsciously repeat certain inter-generational patterns. When I started the Doctorate, it was a course requirement to undertake therapy with a Counselling Psychologist. I was also motivated to go to therapy to manage my levels of stress whilst completing the training.

I had not contemplated to what extent my relationship with my mother would play a part in my therapy. I was aware of strong feelings of closeness, love and affection towards her, which also included a sense of loyalty and obligation. When therapy commenced and I started to speak about my mother, and my family in general, I felt full of emotion and surprised by how raw and emotionally painful it was to reflect upon my early life experiences and family relationships. I was aware of feelings of betrayal and guilt about what I was disclosing during therapy. Especially coming from a family where I had been encouraged not to share family secrets, exploring these secrets with a stranger felt scary but also liberating. The experience of warmth and non-judgement that I received from my therapist was incredibly satisfying and validating.

I had periods of being in therapy whilst living at home and when living away and different experiences of both. When I lived at home, facing my family members after therapy with tearstained cheeks was anxiety-provoking. I think the first break that I took from therapy was influenced by living at home and how painful it was to be reflecting upon the same family dynamics whilst trying to tolerate living with them. Over time, I felt able to gain benefit from therapy even when I was living at

home. However, having periods of time in therapy when I was living away from home was especially beneficial and helped me to cope when I returned to live at home intermittently.

Having received such reassurance and compassion from my therapist, I felt encouraged to take more risks with openness in my close relationships, including in my relationship with my mother. Often, my discoveries during therapy provoked my thinking and I had questions for my mother about her early life experiences and about my childhood. I also wanted to share some of the impact that my early life experiences had had upon me and wanted to be heard by my mother. My mother did enquire about my therapy, but cautiously. She also seemed to seek reassurance that the only reason I was going to therapy was because of my training. In order to save her feelings, and my own discomfort, I was willing to reassure her. It took several years before I felt brave enough to suggest that perhaps starting the training, and having the requirement of undertaking therapy as part of the training, was an “acceptable” avenue for me to pursue in order to work on my interpersonal issues.

My mother wanted to know whether I was discussing the family and made it clear that she did not believe that parents could be solely blamed for their child’s problems. She seemed concerned that therapy was a breeding ground for blame and negativity towards parents and appeared to defend herself against experiencing any blame or judgement. Perhaps she felt ambivalent about knowing what I was talking about as she would ask but then not seem to want to listen. Again, over time, I became braver about explaining the process of therapy. I found that my own attitude towards blaming my parents and the level of anger that I felt towards them had changed and that I felt more understanding and accepting towards them. Being able to reassure my parents that *they had done the best they could but that no parent can get it right all the time, nor should they*, felt like a balanced perspective, as it enabled me to self-validate as well as experience and convey compassion for my parents.

From her comments and the questions she asked me, it appeared as though the fact that I was in therapy provoked a questioning process in my mother, even to the extent where she spoke to me about her reflections upon her experience of

being parented and the impact this had had. However, perhaps as it felt too painful to acknowledge any suffering that she may have caused me, she denied any suffering that her parents may have caused her – and seemed to present her parents in an idealised light. Over the time that I was in therapy, my mother seemed to become more interested in the benefits of therapy and she has commented on changes she has noticed in me. For example, she has shared that she considers me to have become more tolerant of her, my father and of their relationship. She has also seemed to jokingly consider the benefits she might gain herself from going to therapy, although these considerations seem to have remained at a superficial level.

The closeness in my relationship with my mother has fluctuated. At times, my willingness to be more open with my mother seems to have enabled a greater depth of communication, where we have both been able to share more of our vulnerabilities. However, at other times, my mother appears to be unwilling to reflect upon things at the same level of intimacy and depth. At these times, it appears as though she may be being self-protective and avoiding contact with uncomfortable feelings as it is perhaps painful to acknowledge my difficult experiences and her own.

This piece is an amalgamation of my reflections upon my experiences of being an adult daughter in therapy over the research process. Therefore, it has been influenced by the research process and research findings. I have developed a greater compassion for my mother over the course of this research project as I feel that I have gained more insight into the ways in which my therapy may have impacted her thinking, feeling and being.

Appendix 2: Flyer



Are you a mother?

Do you have a daughter?

Is she 18 or over?

Has she ever been or is she currently
in personal therapy/counselling?

*Would you be willing to share your experiences
as a mother, of having a daughter in therapy?*

I want your story to be heard.

My name is Deborah Kemp and I am a Trainee Counselling Psychologist at City University, London. For my Doctoral Research Project I want to develop a greater understanding of mothers' experiences of their daughters being in therapy. I hope that the findings of the research will aid therapeutic practice and counselling psychology training.

If you would be willing to share your experiences in confidence I would like to hear from you. Please contact me or my research supervisor using the contact details below if you are interested in helping with this research project, or would like more information.

Researcher: Deborah Kemp
Email: deborah.kemp.1@city.ac.uk
Tel: 07729462964

Research Supervisor:
Dr Deborah Rafalin
Email: d.rafalin@city.ac.uk Tel: 020 7040 4592

Appendix 3: Demographics Questionnaire



Demographics Questionnaire

ID Number:

Date:

I would like to start by asking you some background information. These questions will help me to gather information about the characteristics of the women taking part in the study. Please be assured that the answers you give will be kept confidential.

What is your age?

How would you describe your ethnic group?

White: British ☐	White: Irish ☐
White: Other ☐	Mixed: White and Black Caribbean ☐
Mixed: White and Black African ☐	Mixed: White and Asian ☐
Mixed: Other Mixed ☐	Asian or Asian British: Indian ☐
Asian or Asian British: Pakistani ☐	Asian or Asian British: Bangladeshi ☐
Asian or Asian British: Other Asian ☐	Black or Black British: Caribbean ☐
Black or Black British: African ☐	Black or Black British: Other Black ☐
Chinese ☐	Other Ethnic Group ☐

Do you have any long-term illness, health problem or disability which limits your daily activities or work you can do? Yes ☐ No ☐

What qualifications do you have?

GCSEs or equivalent ☐	Diplomas ☐	Professional Degree ☐
A-levels or equivalent ☐	Advanced Diplomas ☐	Doctoral Level ☐
Bachelor's Degree ☐	Secretarial ☐	Other ☐
Master's Degree ☐	Technical/Vocational ☐	

What is your current employment status?

Looking after home/family ☐ Retired ☐ Student ☐
Unemployed ☐ Part time ☐ Full time ☐

How would you describe your occupation?.....

What is your relationship status?

Married ☐ Single ☐ In relationship, living apart ☐
Widowed ☐ Divorced ☐ Civil partnership ☐
Separated ☐ Co-habiting ☐ Other ☐

How many children have you looked after in your parenting role?

Please provide details of the children you have looked after in your parenting role, including their age, gender and your relationship to them (e.g. step mother, aunt, biological mother). If you need additional space, please indicate and continue on the back of the page:

Child 1: Gender...M/F...Age.....Relationship.....

Child 2: Gender...M/F...Age.....Relationship.....

Child 3: Gender...M/F...Age.....Relationship.....

Child 4: Gender...M/F...Age.....Relationship.....

Child 5: Gender...M/F...Age.....Relationship.....

Child 6: Gender...M/F...Age.....Relationship.....

.....

.....

.....

Please provide as many details as you can about the nature of your daughter's therapy, including when this was (month, year) and the length of the therapy (e.g. 1 year, 12 sessions). Please record the most recent first. If it is current, please state that the therapy is ongoing.

Therapy 1: Commenced.....Length.....

Therapy 2: Commenced.....Length.....

Therapy 3: Commenced.....Length.....

Therapy 4: Commenced.....Length.....

Therapy 5: Commenced.....Length.....

Therapy 6: Commenced.....Length.....

.....

.....

.....

Have you ever been in personal therapy? Yes ☐ No ☐

Please can you provide the first 2 letters of your postcode. For example, if your
postcode is NW12 HRC, please record NW in this space:.....

Thank you for taking the time to complete this questionnaire.

Appendix 4: Semi-structured interview schedule for participant

I am interested in hearing about your experience of your daughter being in therapy. Can you tell me a bit about your daughter's therapy?

Prompts

- What did you understand about it?
- How did you feel about it?

I'd like to hear about your experiences over the time that your daughter was in therapy.

- Can you tell me about what it was like for you when your daughter first started therapy?
- Can you tell me what it was like for you whilst your daughter was going to therapy?
- Can you tell me what it was like for you when your daughter ended therapy?
- Can you tell me what it has been like for you since your daughter has stopped going to therapy?

Prompts

- How did you feel about it?
- How did you feel about your relationship with your daughter?
- How did you feel about yourself as a mother?
- How did you feel about yourself as a woman?
- How did you feel about yourself in general?

Some people say that when someone goes into therapy, this then has an impact on those around them. Other people don't think this way. What do you think?

- In what ways, if any, do you think your daughter being in therapy impacted upon you and those around you?

Prompts

- How did it impact your relationship with your daughter?
- How did it impact other relationships?
- How has it impacted you in general?
- How has it impacted your life?
- How did you manage any changes that occurred?

I don't have any more questions, is there anything else you would like to say before we finish?

Appendix 5: Revised interview schedule

I am interested in hearing about your experience of your daughter being in therapy. For most of the time it would be useful to focus on your experiences, but maybe we could take some time to begin with for you to tell me a bit about what you understand about your daughter's therapy.

Prompts

- What did you understand about it?
- How did you feel about it?

I'd like to hear about your experiences over the time that your daughter was in therapy.

- Can you tell me about what it was like for you when your daughter first started therapy?
- Can you tell me what it was like for you whilst your daughter was going to therapy?
- Can you tell me what it was like for you when your daughter ended therapy?
- Can you tell me what it has been like for you since your daughter has stopped going to therapy?

Prompts

- How did you feel about your daughter being in therapy at this time?
 - The fact that your daughter was in therapy - how did you feel about your relationship with your daughter?
 - How did other people respond to your daughter being in therapy?
- The fact that your daughter was in therapy - How did you feel about yourself as a mother?
- The fact that your daughter was in therapy - How did you feel about yourself as a woman?
 - The fact that your daughter was in therapy - How did you feel about yourself in general?

Some people say that when someone goes into therapy, this then has an impact on those around them. Other people don't think this way. What do you think?

- In what ways, if any, do you think your daughter being in therapy impacted upon you and those around you?

Prompts

- In what ways did your daughter being in therapy impact your relationship with your daughter?

- In what ways did your daughter being in therapy impact other relationships?
- In what ways did your daughter being in therapy impact you in general?
- In what ways did your daughter being in therapy impact your life?
- How did you manage any changes that occurred as a result of your daughter being in therapy?

- ***I don't have any more questions, is there anything else you would like to say before we finish?***

- ***How has it felt to take part in this interview?***
- ***Do you have any questions?***
- ***Do you have any feedback?***

Appendix 6: Participant Covering Letter

Hi!

Thank you very much for expressing an interest in participating in my Doctoral Research Project titled: *What is a mother's experience of her adult daughter being in therapy and how does she manage this process?* This project has been granted ethical approval by City University, London.

Please find attached to this email a copy of the participant information sheet. I would really appreciate it if you could spend some time reading through this and let me know if you have any questions or concerns.

Brief explanation of process:

- If you decide that you would like to participate, please contact me on the details below and we can then discuss a convenient time and location for us to meet for the interview.
- Before the interview I will ask for you to sign a consent form and to complete a short questionnaire about some of your personal details. The interview is semi-structured, which means that I will have some questions to ask you but that I will also be guided by what you bring.
- The interview will be followed by a short debrief where you will be given the opportunity to ask questions and to provide feedback. I will also provide you with debriefing information, including a list of resources. In total, this meeting will last up to 2.5 hours.

I look forward to hearing from you.

Best Wishes,

Deborah Kemp
Trainee Counselling Psychologist

Email: deborah.kemp.1@city.ac.uk
Telephone: 07729462964

Appendix 7: Participant Information Sheet

Name of Researcher: Deborah Kemp, City University, London

Research Supervisor: Dr Deborah Rafalin, City University, London

Research Title: *What is a mother's experience of her adult daughter being in therapy and how does she manage this process?*

PARTICIPANT INFORMATION SHEET

You are being invited to take part in a research study. Before you decide to participate it is important that you understand why the research is being done and what it will involve for you. Please take the time to read this information and to ask any questions.

What is the purpose of this study?

To gain an in-depth understanding of the experience of mothers who have had adult daughters in therapy. The research is interested in giving a voice to the participants, in order that their perspective be heard and understood. It is hoped that the results of the research will be used to develop therapeutic practice and training. For example, it will help to educate therapists working with daughters who want to explore their relationship with their mothers. Therapists may be able to help their clients to explore how their relationships with their mothers have been impacted by their therapy and how their mother's thoughts, feelings and behaviour may have been affected as a result. It may also help therapists working with mothers who have adult daughters in therapy, to explore their thoughts, feelings and reactions. Potentially, the themes generated in the study may assist them to develop greater insight into their experiences.

What are the potential disadvantages of taking part?

Some people may find the personal nature of the questions distressing. The researcher will attempt to minimise this distress in the following ways:

- By advising a short break or stopping the interview altogether.
- You do not have to answer any questions you do not want to and have the right to ask to stop talking.
- By debriefing you following the interview (see section **How will I be debriefed?**)

What are the potential benefits of taking part?

As someone who has experienced a daughter being in personal therapy, you may benefit from the opportunity to talk about your experiences and to have your perspective heard and taken seriously. It may offer you the chance to think about how this experience has affected you and your relationship with your daughter in different ways and how you have dealt with any changes that have occurred. As an 'expert' – someone who has experienced

a daughter being in therapy, the knowledge that you can share may help to benefit other mothers and daughters and their relationships in the future.

How will the data be gathered?

A minimum of 8 participants will be separately interviewed by the researcher at their chosen venue. Each will be given a demographic questionnaire and then asked to participate in a semi-structured interview. This will entail a verbal discussion prompted by some pre-prepared questions. The interview will be approximately one to two hours long and it will be audio-recorded. The interviews will then be converted into written words (transcript) which will help the researcher to spend time reflecting on what you were saying and ensure no details are missed out. The researcher may employ the help of another person to assist with transcribing. This person will receive the audio-recording without access to demographic or identifying information. Any identifying information will be anonymised.

The researcher has chosen to use the method of Interpretative Phenomenological Analysis (IPA), which enables the researcher to identify themes arising out of the transcripts. The researcher will then collect the themes arising out of the interviews with all of the participants and see if there are any similarities or differences. Overall themes will be assigned and explored in more detail. The research supervisor will assist in this process. Here, the intention is to create greater insight for others, whilst being responsible for preserving the experiences and voice of the participants.

Participants will be assigned an ID number and a pseudonym and are entitled to withdraw part of or their entire transcript from the study. If you would like to choose your own pseudonym, please inform the researcher, otherwise one will be chosen for you. Your signed consent is necessary before any of your information can be used in the research.

How will confidentiality be maintained?

The researcher and research supervisor are bound by professional duty to follow ethical and legal practice as set out by the British Psychological Society's Code of Ethics and Conduct (BPS, 2009), the Standards of Conduct, Performance and Ethics as set out by the Health Professions Council (HPC, 2007) and City University. Therefore:

1. All identifying information will be anonymised in the transcripts.
2. Research data (including recordings, transcripts, demographic information and signed forms) will be stored in separate secure locations, or on a password-protected computer, only accessible by the researcher and research supervisor, until the study is complete.
3. All data will be stored for 5 years and then destroyed, in accordance with the British Psychological Society's Good Practice Guidelines (BPS, 2005).

What are the limits of the confidentiality agreement?

Complete confidentiality cannot be guaranteed as any disclosures of criminal activity, professional malpractice, or risk of harm to self or others would have to be acted upon.

What happens to the results of the research study?

The results of the study will be available to you by request via the researcher. The results will also be found in the completed dissertation of the researcher, held by City University. Here, it will be accessible by students, researchers, teaching staff and examiners. The results may also be published in a condensed format in a research journal or magazine available to the general public.

How will I be debriefed?

Following the interview, the researcher will provide you with a list of resources for support, which you can use if you experience any distress as a result of taking part in the research study. The researcher will also offer you time to discuss any issues you may have.

What if you change your mind?

Your participation is voluntary and you have the right to withdraw at any stage of the process without giving reason. You are not obliged to complete the demographic questionnaire or the interview if you feel uncomfortable for any reason. If you wish to withdraw from the research, your data will be identifiable by its allocated ID number and pseudonym and destroyed.

Participation in this research may lead you to reflect on past events, which may be upsetting. It may also lead to a re-evaluation of your current situation or relationships. If you are concerned about the effect of taking part in this study, please be advised not to participate.

Who has approved this research?

This research has been approved by City University, who have ensured that the safety, rights, well-being and dignity of research participants is protected.

If you would like to participate in this research study or have any questions, please contact the researcher or research supervisor using the contact details below:

Researcher: Deborah Kemp
Email: deborah.kemp.1@city.ac.uk
Telephone: 07729462964

Research Supervisor: Dr Deborah Rafalin
Email: d.rafalin@city.ac.uk
Telephone: 020 7040 4592

Thank you for taking the time to read this information sheet.

Appendix 8: Consent Form

Name of Researcher: Deborah Kemp, City University, London
Research Supervisor: Dr Deborah Rafalin, City University, London

ID number:

Research Title: *What is a mother's experience of her adult daughter being in therapy and how does she manage this process?*

CONSENT FORM

Please tick box

- | | | |
|----|---|--------------------------|
| 1. | I confirm that I have read and understood the information sheet for the above research study. I have had the opportunity to consider the information, to ask questions and to have these questions answered satisfactorily. | ☐ |
| 2. | I understand that my participation is voluntary and that I am free to withdraw my consent at any time, without giving a reason. | ☐ |
| 3. | I consent to the interview being audio-recorded. | ☐ |
| 4. | I understand that all information will be anonymous unless the researcher judges there to be a risk to self or to others. | ☐ |
| 5. | I am aware that following the study I will be debriefed by the researcher and a list of resources for support will be given to me. | ☐ |
| 6. | I agree to take part in the above research study | ☐ |

Name of participant.....DateSignature.....

On behalf of those involved in the research project, I agree to uphold the confidentiality of participants unless there is deemed to be risk to self or others. I agree to abide by the Standards of Conduct, Performance and Ethics as set out by the Health professions Council (2007), the Code of Ethics established by the British Psychological Society (2009) and City University, London.

Name of researcherDate.....Signature.....

Researcher: Deborah Kemp Email: deborah.kemp.1@city.ac.uk Telephone: 07729462964

Research Supervisor: Dr Deborah Rafalin Email: d.rafalin@city.ac.uk Telephone: 020 7040 4592

Appendix 9: Debriefing information



Name of Researcher: Deborah Kemp, City University, London

Temporary Research Supervisor: Dr Deborah Rafalin, City University, London

Participant ID Number:.....

Research Title: *What is a mother's experience of her adult daughter being in therapy and how does she manage this process?*

Debriefing Information

Thank you for participating in this research.

After discussing personal issues such as those addressed in this research study, it is understandable for participants to experience some level of emotional distress. The researcher would like to offer you some time to discuss any issues with them now that may have come up for you.

If you feel that you require additional help and support following your participation in this research, please refer to the list of resources below. Also, if in the future you would like to discuss any of these issues in more depth, these resources may come in useful.

Samaritans: www.samaritans.org.uk or Tel: 08457 90 90 90

Samaritans provides confidential non-judgemental emotional support, 24 hours a day. They offer their service by telephone, email, letter and face to face in most of their branches. There are over 200 branches across Ireland and the UK.

BPS Directory of Chartered Psychologists: www.bps.org.uk/e-services/find-a-psychologist/directory.cfm

This is a free search facility, which allows you to locate a chartered psychologist, registered with the British Psychological Society, in your area. It enables you to specify the area of expertise you are looking for and provides you with contact details. You can use these contact details to enquire about fees. There are over 1200 psychologists in the directory.

BACP Directory of Counsellors and Psychotherapists: www.bacp.co.uk/seeking_therapist

This tool allows you to find a private therapist based on criteria of your choice. Please note that this tool will enable you to freely select a therapist, and provides contact details. However, the majority of therapists listed will charge for therapy sessions. Some therapists may offer fee concessions.

Directory of Qualified Counsellors and Psychotherapists: www.counselling-directory.org.uk

This search tool allows you to locate a counsellor or psychotherapist based on criteria of your choice. Please note that this tool will enable you to freely select a therapist, and provides contact details. However, the majority of therapists listed will charge for therapy sessions. Some therapists may offer fee concessions.

Psychologists based in London:www.londonpsychologists.com

This group of Chartered Psychologists work from different locations in London. They offer psychological intervention for a wide range of emotional and behavioural difficulties based on a variety of perspectives. They base their therapeutic interventions on the nature of the difficulties and the needs of the individual. Therapist contact details are available on the website and enquiries regarding fees can be made via this avenue.

Women's Counselling Services in London:

Women's Therapy Centre: <http://www.womenstherapycentre.co.uk/referrals.html> or Tel: 020 7263 7860

The Women's Therapy Centre can refer you to a qualified psychotherapist's private psychotherapy practice. An initial consultation takes place with an experienced psychotherapist at the Women's Therapy Centre in Islington. Appointments are usually offered within a fortnight and evening times are usually available. Preferences of time and location can be taken into account when arranging the referral. The set fee for a consultation is £60.

West London Women's Therapy: www.westlondonwomenstherapy.co.uk or Tel: 07791 782 822

This is a psychotherapy and counselling practice based near Holland Park and Shepherd's Bush in London (W11). It offers one to one, person-centred counselling exclusively for women. Low-cost sessions are available.

South Norwood Women's Counselling Practice:

www.womencounsellingpractice.counselling.co.uk or Tel: 020 8768 1366

This service specialises in short- and long-term Humanistic Counselling/Psychotherapy for young women and adults. Fees for all their services are based on a sliding scale system depending on your income. Selhurst on the Southern Railway Line and Norwood Junction train station on the Southern Railway Line are the nearest transport links.

The Maya Centre: www.mayacentre.org.uk or Tel: 020 7281 2728

This centre provides free psychodynamic counselling to women on low incomes in the North London community. Clients can choose between individual and group counselling. Finsbury Park tube station is the nearest transport link.

Women and Health: www.womenandhealth.org.uk or Tel: 020 7482 2786

This counselling and psychotherapy service provides long- and short-term low-cost individual counselling and psychotherapy and a range of groups for women who live in the London Borough of Camden. Camden Town tube station and Camden Road rail station are the nearest transport links.

Counselling services in Essex:

Forest Therapeutic Counselling Agency : <http://www.forestcounselling.co.uk/> or Tel: 020 8502 4674

This is an independent group of qualified professional counsellors and psychotherapists, who offer a range of therapies for both individuals and couples. The main counselling practice is situated in South Woodford, London E18, but they *also* have satellite practices in Ilford, Docklands and Walthamstow. These are amply serviced by the tube and buses.

If you have additional concerns about your participation in this research, please raise these with the researcher or research supervisor using the contact details below:

Researcher: Deborah Kemp
Email: deborah.kemp.1@city.ac.uk
Telephone: 07729462964

Research Supervisor: Dr Deborah Rafalin
Email: d.rafalin@city.ac.uk
Telephone: 020 7040 4592

Thank you for taking the time to read this debriefing information.

Appendix 10: Extract from Jane's annotated transcript

ID 7 Pseudonym for mum: Jane, for daughter: Heidi, for ex-husband: Darren
 498 J: yes, that's right. Yes, Well she shares a lot now. I mean she always did, we
 499 were always very close, (hmm) prob, well I was going to say possibly too
 500 close, but I don't think you can have that. Um. But she's very open about her
 501 life and her feelings and her thoughts on her relationships with her friends
 502 and her dad, and her bloke at the moment. Um. Yeah, we we talk about stuff,
 503 a lot of stuff like that (hmm) and we sit here and analyse things, you know
 504 (laughs) (yeah), it's great. And I think, I think, yeah I do, looking back, I think
 505 it's because she had a taste of therapy when she was that young and perhaps
 506 just ready for something like that, for someone to open, help her open up
 507 and explore her thoughts. (hmm) and not be afraid of saying stuff, um to
 508 total strangers, because that's what a therapist is, isn't it? It's a total stranger
 509 (absolutely).
 510 D: ok. And she, what about when she came to end that piece of therapy,
 511 what was that like for you?
 512 J: Um, Again I felt that little bit of worry that the safety net was gone. Um, I
 513 think the therapist kind of suggested to her that, you know, perhaps just
 514 another couple of sessions and she would be ready to stop. And I remember
 515 thinking exactly the same that oh, her safety net will be going then and
 516 feeling worried about that.
 517 D: say more about what you feel the safety net provides, was providing for
 518 Heidi
 519 J: um..the space and the safety to talk and say how she feels without
 520 someone saying: well you shouldn't be, you shouldn't think that or you
 521 shouldn't say that, or you shouldn't do this to that person. The safety of
 522 saying stuff. Because I think if you hear yourself say things, er, I've lost what I
 523 was going to say now...if you hear yourself say things, or you see what you've
 524 written down (hmm), it becomes a bit more real and I think it's the truth and
 525 you can deal with it (hmm). So that safety net of giving her, freedom, to yeah,
 526 feel safe to say what she wanted to say, what was on her mind and (hmm). Is
 527 that a load of jumble?

what impact
has it had on
her mind?

57 thinking about
what's going on
58 sharing in
and rel

59 always
close to her
60 sharing in
about her
feelings
61 taking in
everything
62 about her
63 her is a
total
stranger

what's sense of
discovery

64 feel
important to
open up
in time

65 ready
to go
66 it is a
total
stranger

67 worried again
when I
ended

68 some exp. of
horry
about loss of
safety net

69 the safety
net was
lost

70 I remember
saying
thinking
in report

71 it was
a bit of
a jumble

72 safety net
5 years to
talk
been able to
talk

73 self validation
talking about =

ID 7 Pseudonym for mum: Jane, for daughter: Heidi, for ex-husband: Darren

528 D: I, no those are kind of things that I (oh good), that kind of, that are quite
529 important to me as well (yeah), seeing things written down er, hearing it out
530 aloud, I think there's a lot of importance.

531 J: So I felt that perhaps that would go and she would, wouldn't have that
532 safety

533 D: so how did you deal with those fears for yourself? Did you speak to
534 anyone about it? Did you write them down, write things down for yourself? (J
535 laughs and shakes her head) No. Did you er?

536 J: I think I probably said to her, if you don't feel that that was enough and you
537 want to go back, make sure that you do, just feel free that you do, because
538 although your therapist said she thinks it was time perhaps to wind things up,
539 that she if she felt that she needed to go back, and again I think that was
540 probably for me, wasn't it? (laughs) But the sound of it what I'm saying

541 D: is that how it feels? Or is there anything that your daughter may have also
542 benefited from in hearing you say that?

543 J: No I think that was for me (laughs)

544 D: oh right

545 J: to make me feel better, that yes she could go back and have that safety
546 net, if she wanted to and then I wouldn't have to worry, I wouldn't have to
547 have that anxiety again (laughs). (uhha- J indicates that she's had a
548 realization)

549 D: So do you, do you notice feeling, sorry was that like quite an interesting
550 realization for you?

551 J: yes, yes, yes. I hadn't, I hadn't realized it was, it was a bit about me in
552 there, that safety net thing (hmm). Yes, wanting her to be happy

553 D: and do you, are you aware of those feelings when she's out of therapy, the
554 kind of, the more of the worry that she doesn't have a safety net or who does

Managing am
anxieties
spoke to d
cuc. d he return
to ① if she
feels its not
enough - despite
Dad's - Mar
Awareness that
etc. d to go back
if she wants to
was to allay
own anxieties

wasn't have to
worry if d in
① - she has
the safety net
in ① = no
worry about d.

Now
realisation
that
safety net
is for m
wanting d to
be happy -

(A) managing
places -
advised/
encouraged
d to feel
free to
return to ①
(75) Awareness
of managing
am
anxieties

(26) reasoning d =
reasoning
for self

(27) don't have
to worry
when d in
①

(28) Awareness
that
safety net
is way for
mum to
manage
anx.

555 she talk to (um) or is it only when she's in therapy and she's coming out that
556 you become more conscious of it?

557 J: um no I think I'm conscious of it all the time now you've said that. Um.

558 Yeah, I don't think you ever stop worrying about your children (hmm) and

559 how they're going to get on through life (hmm)

560 D: what helps you to manage those those worries?

561 J: talking to her about it, how she is and how we are (hmm) and we go over a

562 lot of things and sometimes we don't we just go out and have fun or..yes I

563 think talking to her (ok) makes things clearer (hmm)

564 D: so having a good understanding of where she's at (hmm) and how she is

565 and keeping that kind of open dialogue (yes), which I guess is what was very

566 different in the earlier days before she started therapy when she kind of

567 closed down (yeah) and you didn't know quite what was going on for her

568 J: that's right yeah, yeah, I made an assumption. But not I don't I don't not

569 have to make assumptions, I don't mean that, I don't find myself making

570 assumptions, I don't even think about it now, I know I can talk to her and she

571 can talk to me (hmm). Yes

572 D: that's great (yeah). Um do you have any feelings about the therapists that
573 she sees?

574 J: um, well I guess that first one she saw when she was younger, from what

575 she used to come back and tell me, I can't remember specifics, but I

576 remember feeling a little bit cross that she hadn't got the response that gave

577 her comfort or helped her (hmm). Um I don't know why I felt cross....(laughs),

578 but the recent one, um, do I have any feelings? I just think she's probably

579 brilliant, because she, they clicked very well and I get brilliant vibes from

580 Heidi about her therapist, confident vibes (hmm). I hope she never leaves the

581 country (laughs). Yes.

conscious of
worry all
the time
part of role of
parenthood
is to worry
about child's
survival
managing worry
speaks had
about how she
feels at the
time and
talking with
makes things
clearer
it's ok to have
made
assumptions
but doesn't really
knows she can
talk about it!

assesses current
D is brilliant
because have
clicked well
has good vibes
from d.
confident vibes
Hopes therapist never
leaves country (worry)

79 worry is
ever present
80 Worrying is
part of
parenthood
81 managing
worry - talking to
daughter
82 going to
have fun
with d
83 makes
things
clearer
84 talk
rather
than
make
assumptions
85 positive
response
of therapist
d & therapist
clicked
86 Brilliant/
Confident
vibes from
d.
making
sure of
therapy
D therapist as
safety net

582 D: So you have, it sounds like you have, yeah, positive feelings about her and
583 you trust her

584 J: yes, I do that's a good one, yes. Yes. And I trust her skills that she knows
585 Heidi well enough to continue possibly in later life or later, later years

586 D: hmm, And you mentioned that she sometimes goes back and sees her
587 (yeah), what's that like for you?

588 J: again, I'm glad that she's Heidi feels free enough, confident enough to do
589 it, and that um, that she goes back to the same lady (hmm), I think that's
590 good for her, yeah, very pleased (laughs)

591 D: and what about for yourself, coz I know that you've experienced some
592 some counseling or therapy yourself (yes). How does that experience um,
593 kind of influence the way you feel about your daughter's therapy, (um) at all?

594 J: I think she felt glad that I was going to go and have some therapy, in the
595 same way as I felt glad that she was going to have some therapy. Actually, we
596 haven't discussed that sort of thing, um, but she would always encourage me
597 to do it, and if I've got the glums, or I'm miserable about something, or I'm
598 banging on about something over a couple of months, she'll say do you think
599 you need to go.. why don't you go and have another chat, book in for some
600 more and I haven't done, but I, I think it's good that we both feel equal
601 enough to say that and comfortable enough to say it to each other. I don't
602 know if that's the answer to the question, I've forgotten what the question
603 was now

604 D: well that's, that's still very useful (ok, yes), but you mentioned something
605 that was interesting, that it's not something you've discussed. I wondered
606 what parts of it you haven't discussed. Was it your therapy you haven't
607 discussed or the influence of your therapy or?

608 J: um, we haven't discussed the influence, never thought about that. And I
609 probably haven't discussed all that I was talking about in my therapy with
610 her. Because obviously it was kind of related to the relationship with dad and

trusts
therapist's
skills
therapist knows
d & can help
her in the
phone
Mum d feels
free/confident
to go back to
same lady -
(gender/person
not only a
therapist)

Positive that
both m & d support
each other's
Hannah discussed
d's feelings
about her
d and m want to
go to ① if has
me going
miserable/
going on about
my
positive that both
m & d can
support ① as
each other

Haven't
discussed
all of ① with
her

① Trusts
① therapist
① knows
① phone
① d
① is
① confident
① free/comfortable
① to use
① Mum d goes
① back to
① same
① therapist
① d is
① supportive
① her
① d and
① m go to
① ①
① both equal &
① comfortable
① enough to
① advise ①
① to encourage
① each other
① positive
① about
① mutual
① support ①

what is
① not
① shared
① about ①
① 100

ID 7 Pseudonym for mum: Jane, for daughter: Heidi, for ex-husband: Darren

611 relationship I was having at the time, so, I didn't want to give her any, any
612 feedback on that. Hmm. Not sure why (laughs)

613 D: you're not sure why you wouldn't want to share certain things?

614 J: I think I think I still, although we're still very good friends, I'm still, I'm still
615 definitely her mother, and that's my main role (hmm). And I think, for me,
616 that's healthy and that's how it should be. Although she says you're my best
617 friends, um, she's not my best friend. I'm her mum, she's my daughter and I
618 think that's, there's a bit of a gap there, that's my opinion anyway

619 D: hmm, has that been your learning that that's that kind of need for a gap
620 or, how did you come to that decision?

621 J: (talking over), I think a mother should always be a mother, you can be very
622 good friends, but she's also, your children have also got good friends, that
623 they can use for different things. Is that a muddle? (laughs)

624 D: that sounds, that sounds great, that sounds very, there's like a different
625 role, there's a certain role (yes it's roles exactly) that mum's have and yeah,
626 and certain things that you talk about, and certain things then that you think
627 your daughter shares with you and doesn't share with you?

628 J: um, I would think there are certain things that she doesn't share with me,
629 yes, I'm, again I would assume there is, yeah

630 D: and how do you feel about that?

631 J: hmm, that's fine, I think that's right, I think that's healthy really (ok) yeah.

632 D: right, um, what about I think I did say early, have you spoken about your
633 daughter being in therapy with other people, but I wondered how, what
634 other people responded or, if you have mentioned your daughter's been in
635 therapy?

636 J: what, to friends and relatives (hmm) or something, to people I know? um

637 D: or your perception of how they responded?

Key: m = mother, d = daughter, [T] = therapy, Number in circle e.g. (5) = Cross-referenced theme, Ax = Anxiety

Appendix 11: Ethics Form

Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc M.Phil M.Sc D.Psych X n/a

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

What is a mother's experience of her daughter being in therapy and how does she manage this process?

2. Name of student researcher (please include contact address and telephone number)

Deborah Kemp

3. Name of research supervisor

Dr Deborah Radalin

4. Is a research proposal appended to this ethics release form? **Yes** **No**

5. Does the research involve the use of human subjects/participants? **Yes** **No**

If yes,

8

a. Approximately how many are planned to be involved?

b. How will you recruit them?

- Through advertising using posters and leaflets at doctor's surgeries, gyms, weight loss clubs, shops, supermarket notice boards, internet sites, public toilets, public house toilets.
- A snowballing technique – I will ask participants to try to recruit other participants

c. What are your recruitment criteria?

(Please append your recruitment material/advertisement/flyer)

The inclusion criteria for participants:

- Female
- Has daughter aged 18 or over who is in therapy or has been in therapy
- Is proficient in both spoken and written English

Exclusion criteria for participants:

- Is currently in personal therapy.

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent? **Yes** **No**

d1. If yes, will signed parental/carers consent be obtained? **Yes** **No**

d2. If yes, has a CRB check been obtained? **Yes** **No**

(Please append a copy of your CRB check)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? (If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).

Once contact is made by participant via telephone or email, the participant will be asked to identify a convenient and appropriate location to meet. At the meeting, each participant will be asked to read an information sheet about the research and what is required of them and given ample opportunity to ask questions and have these answered satisfactorily. Each will be then given a demographic questionnaire to answer before the researcher commences a semi-structured interview with the participant. This will entail a verbal discussion prompted by some

pre-prepared questions. The interview will be approximately one to two hours long and it will be audio-recorded. Following the interview, participants will be given some debriefing information to read and the opportunity to ask any questions.

7. Is there any risk of physical or psychological harm to the subjects/participants?

Yes

No

If yes,

a. Please detail the possible harm?

Due to the nature of the research topic, participants may reflect upon past events, which they may find upsetting. It may also lead to a re-evaluation of their current situation or relationships.

b. How can this be justified?

Taking part in the research will provide the participant with the opportunity to tell her story and to have her views taken seriously. In a way, the interview may have a therapeutic effect and provide new realisations and re-evaluations that help the participant to make sense of her experiences.

The participant will also be able to contribute her personal experiences in a way that can benefit other mothers and daughters and their relationships in the future. It is hoped that the knowledge from the research may be used to develop therapeutic practice and training for those working with mothers and daughters.

c. What precautions are you taking to address the risks posed?

- Prior to interviews taking place, participants will be advised that if they are concerned about the effect of taking part in the study then they should choose not to participate.
- The interview schedule was developed by formulating questions that are sensitively worded so that they encourage the participant to talk about the topic without feeling judged.
- If during the interview participants become distressed, then I will advise a short break or stopping altogether.
- I will debrief participants following their interview and will be able to use my therapeutic skills in order to support them. A resource list of avenues for further help and support will be provided for future reference.
- Participants will be informed that they have a right to withdraw at any stage of the process without giving reason.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes No

(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

Yes No

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes No

If no, please justify

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

Audio recordings, transcripts, demographic information and signed consent forms .

12. What provision will there be for the safe-keeping of these records?

All records will be stored in separate secure locations, or on a password protected computer, only accessible by the researcher and research supervisor.

13. What will happen to the records at the end of the project?

All data will be stored for 5 years and then destroyed, in accordance with British Psychological Society's Good Practice Guidelines(2005)

Signature of student researcher

Date

31/5/1

CHECKLIST: the following forms should be appended unless justified otherwise

14. How will you protect the anonymity of the subjects/participants?

- Each participant will be allocated an ID number and a pseudonym and any identifying information in her transcript will be anonymised.
- Her consent form will be kept separate from recordings, transcripts and demographic information
- Participants will be recruited from areas where I do not live or work in order to reduce the likelihood that I will have had previous contact with them or their family members.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

- I will debrief participants following their interview and will be able to use my therapeutic skills in order to support them.
- A resource list of avenues for further help and support will be provided for future reference.
- My contact details and those of my research supervisor will be provided so that participants can raise any additional concerns about their participation in the research

(Please append any de-brief information sheets or resource lists detailing possible support options)

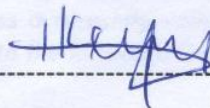
If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

What provisions are to be taken to address the risks posed?

- The researcher is in personal therapy and will have research supervision to support her in the process.
- The researcher will take a 24-hour telephone number and will arrange to speak with them after work or at the weekend.

Section C: To be completed by the research supervisor

Signature of student researcher



Date

31/3/11

CHECKLIST: the following forms should be appended unless justified otherwise

Research Proposal
Recruitment Material
Information Sheet
Consent Form
De-brief Information

Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself? Yes No
If yes,

a. Please detail possible harm?

- As the researcher will meeting an unknown person and seeing them in a private area, there are potential risks of physical or emotional harm, hostage taking or theft by the participant.
- It is possible that the researcher may become distressed by the issues that are being discussed with the participant.

b. How can this be justified?

- It is important that the interview takes place in a private space that is convenient so that the participant feels comfortable to talk about confidential and personal information.
- It is important that the space is quiet so that the quality of the audio recording is good and so that the researcher can concentrate.
- It is hoped that the knowledge from the research may be used to develop therapeutic practice and training for working with mothers and daughters.

c. What precautions are to be taken to address the risks posed?

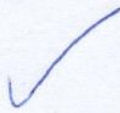
- The researcher is in personal therapy and will use research supervision to support her in the process.
- The researcher will take a mobile telephone with her and tell someone where she is going beforehand and arrange to speak with them afterwards at an agreed upon time.

Section C: To be completed by the research supervisor

(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)

Please mark the appropriate box below:

Ethical approval granted



Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee

Signature

Date

01/05/11

Section D: To be completed by the 2nd Departmental staff member

*(Please read this ethics release form fully and pay particular attention to any answers on the form where **underlined bold** items have been circled and any relevant appendices.)*

I agree with the decision of the research supervisor as indicated above

Signature

Date

11 May 11

Appendix 12: Excerpts from Reflective Diary

10.07.11 I have potential interviewees but feel scared to get started. In particular, following my pilot interview where I felt very protective of the participant when I was asking questions, and felt responsible and fearful about upsetting her, I am concerned that I will feel protective with the actual participants. I wonder whether I have detected how painful it is for my own mother to talk about her experience of me being in therapy, and so I am searching for questions elsewhere. I feel better knowing that I have warned them that the interviews may be emotionally evocative, so by choosing to take part I must remember that they are taking responsibility for their own emotional process.

15.07.11 I met with my temporary supervisor today and discussed how I needed to explore in my personal therapy about my mother's relationship with my personal therapy. Also discussed importance of managing my feelings and taking care of myself after interviews, reflecting on the process using my reflective diary and thinking about what may have affected the data.

12.08.11 Being in researcher role felt very different to being a therapist. A lot of the parts of being a therapist, such as noticing counter-transference and working on the relationship, although important to note as influencing factors upon the data creation process – cannot be attended to as explicitly during the interview. This freed me up to focus upon enabling Sarah's narrative to unravel and I felt able to sit back and let her do the talking. However, I detected her anxieties and that she seemed to be trying to say the right thing. I wonder how this defensiveness may influence the richness of the data.

Sarah was keen to enquire about my thoughts about her experience of her daughter's mental health problems and I was able to refocus her attention away from me as the expert, but I was unsure how much disclosures as the researcher, in contrast to disclosures as the therapist, influence the research process. I need to explore this in supervision. I also felt frustrated that I did not find a way to explore Sarah's experience of shame more fully. This is also something to explore in supervision – how to enquire about feelings of shame or social stigma.

19.09.11 Had discussion about the ordering of questions and refocusing participants on to the topic of their experience of their adult daughter being in therapy with Deborah (Supervisor). This seemed to make a difference for me during Meredith's interview today as I felt less anxious about time when hearing the chronology of her daughter's life experiences. I felt that this provided a useful overview and context in which to gain an in-depth understanding of Meredith's experiences. I have noticed that some of the questions close conversation down, or seem particularly hard for mothers to make sense of. Mothers have, so far, not seemed to find it relevant or stimulating to think about how their daughter being in therapy affects them as a woman. Is this due to the phrasing of the question? Or is it due to the fact that mothers do not view their identities as women as separate from their identity as a mother or as relevant to their experience of having a daughter in therapy?

I have been left feeling overwhelmed by Meredith's interview and curious to know what help is currently on offer for mothers who have daughters who have been sexually abused/have severe mental health issues/who are in therapy.

28.10.11 I think I have found a number of the participants that I have met to be full of wisdom and hope. I have also found that several participants have felt quite controlling during the interviews and I have found it hard to interject. However, I think that this may be due to participants feeling anxious and unsure about what to expect and whether they are 'doing it right', or have given me 'enough' or any of what I want – as conveyed by Celeste today.

I have felt very moved by the love and care of the mothers for their daughters and for Meredith in particular, a great sense of deprivation and loss – for the relationship that never was and how damaging and painful that is. Mothers have come away from interviews telling me I will make a great therapist, caring for me and nourishing me, like they might their own daughter.

I came away from the interview with Celeste feeling a bit guilty – like I was rushing out of the door, and that the debrief was too rushed. This was coupled by the fear that I was taking up too much of her time. I wonder if this speaks of the ambivalence within mother-daughter relationships and the transference feelings of protectiveness and guilt that I have felt towards my mother. Or perhaps this is the

therapist part of me that feels responsible for ending sessions in a containing way and this highlights the renowned challenge of managing endings.

05.11.11 Recruitment struggles – brainstorming ideas for advertising. I feel doubtful about who will respond/take seriously advertisements put in supermarkets/newsagents/shop windows. I am feeling very negative, tired and low about the research process. I do not feel like explaining to others about what I am doing with my research and do not think that they will understand. I've been advised to just get the interviews done and not to procrastinate, but I am finding it difficult to ask others for help. There are still lots of avenues I have not explored, but my pride or low self-confidence seems to be getting in the way of getting out there and recruiting.

26.11.11 I think that my assumption that mothers feel threatened by their daughters being in therapy prevents me at times from trusting in the positive attitudes towards therapy expressed by the mothers. I also feel judgmental and critical towards some of the mothers, particularly when they appear to justify their behaviour or are blaming towards their daughter for her actions when she was a child. I am aware at times of my discomfort when I think that a participant has not acknowledged the role of environmental factors that may have contributed to their daughter's difficulties. I notice how I want for them to accept some responsibility in whatever shape or form.

22.01.12 I am aware whilst I am transcribing interviews how automatic it is to interpret, particularly using psychoanalytic concepts – in order to try to make sense of the mother's experiences. For example, I thought about how Celeste may be working on her own issues with her daughter i.e. having the very close relationship with her daughter that she had not have with her own mother – and how her daughter may be making use of the therapist as part of a 'triangle' due to her absent father. It's so important for me to bracket these interpretations and theoretical assumptions in order for me to stay as close as possible to the mother's experience. However, just listening back to the interviews has been helpful for immersing myself in the data, for allowing my thought processes to be stimulated and for becoming aware of my existing frames of reference for making sense of the information.

28.01.12 I went out recruiting on the high street today by handing out flyers to women who looked over 50. The best approach I found was to smile and ask *can I give you a leaflet?* And then show the flyer which has the question *are you a mother?* For those women who were with their adult daughters/husbands/grandchildren, this felt harder for me to approach them as I was concerned that it might cause friction, particularly between mothers and daughters. I was worried that the mother would then ask their daughter and that this would then place the daughter in the position of lying or admitting to it in a way that felt premature for her. This felt messy as these questions may then be responsible for breaking a silence, intruding upon a daughter's privacy or creating conflict which may impact upon the relationship. Alternatively, it may create an opportunity for openness and intimacy. Any way that mothers may hear about my research might create a stimulus for conversation with their daughters, so my concerns may have been overly cautious.

2.03.12 After finishing my interview with Hillary I discovered that the interview was deleted from my recorder. I need to be more prepared about these things and use two recorders. I will ask Hillary to repeat the interview but will totally understand if she declines. It feels hard to feel guilty or annoyed with myself as I don't understand what happened with the recorder and sometimes bad things can't be avoided. I think a lot of the mothers have helped me to see this through their self-compassion.

09.03.12 Re-interviewing Hillary – there were aspects that Hillary did and did not repeat from her first interview, and aspects that she brought to the second interview that seemed to have been stimulated by the initial one. Re-interviewing seemed to be very useful as I developed more of a rapport with Hillary and had an understanding of the background of her daughter's life experiences and so did not need to go over this ground. This meant that I could really focus my questions to target the areas I had developed less of an understanding about. This made the interview feel richer in data and more focused.

26.04.12 I am concerned that several of my participants' daughters have been under 18 when they commenced therapy and about how this will influence the data. There also seems to be a bias towards mothers with daughters under 30. I wonder whether this is because therapy is becoming more socially acceptable – although it still carries a stigma. Therefore, perhaps women are telling their mothers more or mothers of this generation are more willing to talk about it.

Reflecting upon my interview with Jane I wonder if I responded to her anxieties about “opening up a can of worms” by focusing on her strengths – *what about you/your relationship with your daughter enabled you to help you to help your daughter?* This didn't seem to help facilitate reflection during the interview – although these questions are left for her to reflect upon after the interview.

I feel concerned about my research and how the mothers who have contributed will feel about what I write. I feel a loyalty to them and I feel that I have also shared myself with them. Having six interviews to draw experience from has really helped me to formulate my questions.

31.05.12 Discussed in supervision why I may not have richness of data and how I can best make use of the data that I have collected. It will be important to reflect upon how I have struggled with the researcher-therapist relationship – e.g. containing and managing the research interview in a different way to a therapy session. The areas that seem to evoke the most emotions in mothers were feelings of guilt. Perhaps because of how painful these feelings were to share in with the mothers, I may have struggled to stay with these feelings and instead used questions that have veered them in the direction of thinking about their strengths and ways of coping. Perhaps the mothers have also struggled to stay with these feelings and have changed topic in order to protect themselves. Being able to recognise when this process is occurring and help to contain and support mothers to continue to remain with these feelings is helpful for the research process and is also essential for therapeutic practice as well.

I feel a bit deflated about the limitations of my data and the flaws in my analysis so far. However, I feel more confident about how to proceed with the guidance Deborah has given me. I also feel more prepared for future interviews and how to focus the

interview and spend less time on paraphrasing and summarising and have ideas of ways to close down tangents respectfully.

14.06.12 Reflections following interview with Evelyn – meeting each of the mothers seems to involve a big risk on my part. I do not know what to expect from the encounter and each mother has their own unique story, many, such as this one, involving loss, tragedy and trauma. I am sometimes left feeling really overwhelmed and exhausted by the experience. I cannot predict or control the stories the mother's narrate, and I sometimes feel subjected to and trapped by the stories, knowing that I need the data for my research, but feeling the urge to leave rather than bear witness to the mother's pain.

I am noticing the same themes reoccurring repeatedly now, suggesting to me that the process of data collection is coming to a natural conclusion. I feel relieved. Evelyn invigorated me to think about the potential influence of the research and how it could help to improve services provided for individuals and families. As I am feeling tired with the research process, this helped to remind me of my initial motivations.

5.07.12 Reflections upon analysis – I am finding it very frustrating analysing interviews for mothers who had daughters who were in therapy as an adolescent and as an adult. During the interviews, I ended up asking the same questions twice – related to their experience of having a child in therapy and having an adult-child in therapy. Sometimes, it seemed as though more time was spent on thinking about the impact of having a child in therapy than an adult. This may reflect the mother's process – that having a child in therapy, or the first experience of their child being in therapy, was more impactful. But I also think that this was a flaw in my interviewing technique which has also made it harder to analyse the data. It is challenging to try and separate out and to compare and contrast the experience of having a child and having an adult-daughter in therapy. However, in a way, their experience of having a daughter as a child in therapy has directly influenced their experience of their daughter as an adult being in therapy, so I could not have excluded this data from their experience.

20.09.12 My subject matter can be emotionally draining as researching into the impact of an adult-daughter's therapy on the mother prompts me to reflect upon my own life experiences and relationships with my parents. I am aware from my reading that my subject matter (mother-daughter relationship) holds fascination for women who are driven by a desire for self-understanding (Walters, 1992) and to achieve selfhood within a relational context (Miller-Day, 2004). Although it seems so obviously personally related, I still did not envisage how personally involving this might be. However, I think that this personal investment has helped to keep my subject endlessly fascinating for me.

References

Miller-Day, M. A. (2004). *Communication among grandmothers, mothers, and adult daughters: A qualitative study of maternal relationships*. Mahwah, NJ: Laurence Erlbaum.

Walters, S. (1992). *Lives together/worlds apart: Mothers and daughters in popular culture*. Berkeley, CA, US: University of California Press.

Appendix 13: An example of a summary table for one participant

Table 1.6a: Summary table of themes and evidence for Jane

<u>Overarching Theme</u>	<u>Sub-themes</u>	<u>Quotes and location</u>
<u>Impact of therapy on daughter</u>		
	Trying to concretise an impact	362 it was good, I was very glad 737-740 with receiving counselling, and yeah, and opening up her mind and talking about things, she observes things in other people and is very helpful as a friend, or seems to be very helpful as a friend. So , that's another thing that's been very useful about it 828-832 I think since she went into the first bit of therapy, she's felt free to tell me how she saw things at the time, and I never thought she saw them like that, that's really beneficial that she can, she's said, that she can say them to me, safely, I believe (laughs) and I go, <i>WHAT! I didn't know you thought that!</i>
<u>Impact of therapy mother-daughter relationship</u>		
	Communication and compromise	498 Well she shares a lot now
	Continuity of closeness	498-502 Well she shares a lot now. I mean she always did, we were always very close, (hmm) prob, well I was going to say possibly too close, but I don't think you can have that. Um. But she's very open about her life and her feelings and her thoughts on her relationships with her friends and her dad, and her bloke at the moment.
<u>Impact of having a daughter in therapy on the mother</u>		
	Emotional impact	392-4 yeah, I just feel sad that she would have to keep doing that (hmm) and feel responsible as a mother, or a parent, that, I think it was down to that 748-50 I am very proud and I am very glad that she's got that sensitivity and awareness to be able to have that in life. Because I think that does her, that helps, it's good for her as well and her friends around her 512-516 Again I felt that little bit of worry that the safety net was gone. Um, I think the therapist kind of suggested to her that, you know, perhaps just another couple of sessions and she would be ready to stop. And I remember thinking exactly the same that oh, her safety net will be going then and feeling worried about that.
	Sense-making activity	10-11 I assume it was to do with the break up of her family home and what she was missing and that. 30-34 And I actually also thought it was to do with school, I wasn't sure if it was to do with A-level work, because she was doing A-levels which can be quite stressful, and not getting on with friends at the time, you know, rather than

		perhaps looking a little bit deeper, I thought it was perhaps school or friends or something 664-665 I decided to become, at work, do a volunteering for the Samaritans, and that opened my mind to a lot of things
	Being a mother	165-8 And I think I kept it all zipped up because I thought I need to stand nice and strong and firm for her (<i>oh right</i>), not firm, that sounds like a bossy mother doesn't it? But strong and there for her should she, you know, need me in that section 433-436 I think as a woman, you take on a lot of stuff, you're right and then you go into motherhood and there's another huge bit of stuff you take on (<i>hmm</i>) and you shouldn't beat yourself up if in some areas of it you're not 100% spot on (laughs). (<i>yeah</i>). Shouldn't, really should you really? (<i>Absolutely</i>). You can't be perfect 558-559 I don't think you ever stop worrying about your children (<i>hmm</i>) and how they're going to get on through life
<u>Managing the process</u>		
	Managing thoughts and feelings	80-2 I probably dealt with a lot of things myself rather than use friends or family (ok) to have support or to have advice or opinion from. Bit of a DIY sort of person 561-563 talking to her about it, how she is and how we are (<i>hmm</i>) and we go over a lot of things and sometimes we don't we just go out and have fun or..yes I think talking to her (<i>ok</i>) makes things clearer (<i>hmm</i>) 502-4 Yeah, we we talk about stuff, a lot of stuff like that (<i>hmm</i>) and we sit here and analyse things, you know (laughs) (<i>yeah</i>), it's great.
	Managing the mother-daughter relationship	498-500 Well she shares a lot now. I mean she always did, we were always very close, (<i>hmm</i>) prob, well I was going to say possibly too close, but I don't think you can have that. 621-23 I think a mother should always be a mother, you can be very good friends, but she's also, your children have also got good friends, that they can use for different things.
	Daughter managing the mother-daughter relationship	596-600 she would always encourage me to do it, and if I've got the glums, or I'm miserable about something, or I'm banging on about something over a couple of months, she'll say do you think you need to go.. why don't you go and have another chat, book in for some more
<u>Processing the daughter's story and re-evaluation</u>		
	Processing the daughter's story	828-832 I think since she went into the first bit of therapy, she's felt free to tell me how she saw things at the time, and I never thought she saw them like that, that's really beneficial that she can, she's said, that she can say them to me,

		safely, I believe (laughs) and I go, WHAT! I didn't know you thought that! 502-4 Yeah, we we talk about stuff, a lot of stuff like that (hmm) and we sit here and analyse things, you know (laughs) (yeah), it's great.
	The mother's vicarious therapeutic journey	475-477 she came back and told me a description that her counsellor had given her about friends - this is just an example. And I used it myself (wow) and it gave me a great deal of comfort 835-841 well it's opened my eyes and made me think, well fancy I thought that she was thinking this or didn't see that happening, or didn't see this happening, you know (laughs). Yeah, it made me feel a bit daft actually. Daft meaning, why would she see it like that, just because I thought that was how I presented it (laughs). They see more than you think (right!) and they take, they absorb more and take more than you think, or more than I thought anyway 816-25 I think we've revisited and I think it's happened and I've gone back and said you know, remember the other day when we were talking about so and so, I think that's what's happened I've revisited a couple of things that perhaps she's asked or (hmm) made me think about (and has that, has that been, what's that been like?) it's good, it's good, it's brilliant, yeah (hmm). We don't always agree on stuff. Or she'll say I think you think this, or I think you did that or said this and um, we don't always agree on it so

Appendix 14: The summary table of all themes and quote locations

Table 1.6b: All themes with quote locations from all participants

<u>Overarching Theme</u>	<u>Sub-themes</u>	<u>Quote locations</u>
<u>Impact of therapy on daughter</u>		
	Trying to concretise an impact	1. 790-796, 1. 991-993, 2.715,2. 383-403, 2. 447-452, 2. 1543-1548, 2. 1573, 3. 189-191, 3. 279, 4. 561-565, 4. 673, 4. 730-14. 777-780, 4. 1095-99, 4. 1104-1107, 5. 866-867, 6. 816-17, 7. 362, 7. 498-502, 8. 875-881, 7. 828-832, 9. 416-419, 9. 230-237, 4. 737-9, 4. 1095-99, 6. 396-399, 6. 399-401, 7. 737-740, 7.737-740, 9. 192-196, 9. 237-241, 9. 416-419, 9. 467-468, 9. 495-497, 9. 488-491, 9. 933-937, 1. 991-993, 6. 816-17
	The limited nature of change/limitations of therapy	9. 245-250, 3. 584-587, 3. 206-208, 4. 777-780, 3. 934-939, 4. 1089-91, 4. 758-62, 6. 251-3, 5. 922-924, 3.206-208
	Other contributing factors	3. 911-914, 8. 925-926, 4. 736-7340
<u>Impact of therapy mother-daughter relationship</u>		
	Closeness and conflict	2.383-403, 2. 1380-3, 2. 1222-1224, 2. 575-583, 2. 1037-1040, 6. 826-829, 6. 836-7, 7.498-502,
	Communication and compromise	4. 765-769, 8. 598-601, 9. 230-237, 1. 874-882
	Continuity of closeness	4. 60-64, 1. 110-17, 1. 993-996, 2. 1474-1475, 7. 498-502, 8. 609-611
<u>Impact of therapy upon the mother</u>		
	Emotional impact	1. 264-268, 1. 306-307, 1.926-927, 1.1103-1114, 1.1091-2, 1. 1859-60, 2. 383-389, 2. 1078-1081, 2. 1132-1133, 2. 1368-71, 2.1198-1201, 2. 1379-80, 2. 1203-1205, 2. 1196-1198, 2.1374-76, 4. 415-421, 4. 1038-1043, 5. 756-772, 5. 1001-1006, 6. 163-4, 6. 155-159, 6. 160-166, 6. 293, 6.283-286, 6. 300-1, 6. 770-2, 6. 657-658, 6.160-166, 6. 321-323, 7. 582-83, 7. 362-369, 5. 847-849, 5. 851-862, 6. 160-166, 7.382-384, 7. 392-4, 7.748-50, 7. 512-516, 7. 536-547, 8. 513-519, 8. 527-36, 8. 731, 8. 875-881, 8. 1045-1049, 8. 1262-1267, 9. 125-126, 9. 283-292, 9. 511-513, 9. 618-620, 9. 709-716,
	Sense-making activity	1. 586-92, 1. 594-5, 1. 562-76, 1. 584-588, 1. 665-675, 1. 1180-82, 1. 1765-68, 2. 237-243, 2. 1453-1455, 2. 1525-1530, 2.1678-1681, 2. 1209-1210, 3. 21-27, 3. 40-47, 3. 51-54, 3.214-216, 3. 425-430, 3. 406-418, 3. 420-423, 3. 540-542, 3. 889-891, 3. 1047-1056, 3. 1272-1273, 4. 172-175, 4. 267-70, 4. 303-308, 4. 388-92, 4. 539-542, 4. 835-839, 6. 169-179,

		6. 583-7, 6. 817-21, 6. 823-829, 7.10-11, 7.30-34, 7.664-665
	Being a mother	1.1122-6, 1. 1129-30, 1.1139-1143, 1. 1122-23, 1. 1369-70, 1. 1587-90, 2. 2-5, 2. 139-140, 2. 237-243, 2. 383-403, 2. 1026-1032, 3.86-87, 3.425-430, 3. 452-454, 3.573-581, 3. 252-255, 3. 764-773, 3.869.872, 3. 1022-1026, 3. 1059-1067, 4.473, 6. 538-416. 856-9, 6. 930-4, 6. 940-3, 6. 694-7, 7.165-8, 7. 323-336, 7. 498-500, 7. 558-559, 8. 1282-88, 8. 1302-5, 9. 673-84,
<u>Managing the process</u>		
	Managing thoughts and feelings	1. 549-551, 1.586-92, 1. 874-882, 1.1125-6, 1.1129-30, 1.1681-4, 1. 1218-1233, 2. 383-403, 2. 1073-1075, 2. 1152-1161, 3. 563-568, 3.752-754, 3. 756-757, 3. 785-88, 3. 909-15, 3. 1059-1067, 4. 927-933, 5. 980-982, 5.1001-1006, 6. 250-5, 6. 1009-1013, 7.80-2, 7. 131-3, 7. 157-8, 7. 502-4, 7. 561-563, 8. 1087-1089, 9. 297-304, 9. 600-602, 9. 618-620, 9. 624-626,
	Managing the mother-daughter relationship	1. 742-59, 2. 1461-1464, 2. 383-403, 2. 1152-1161, 2. 1251-1253, 3. 540-542, 3. 192-194, 3. 530-531, 4. 135-6, 4. 184-85, 6. 384-390, 8, 306-19, 3. 1222-1224, 6. 215-217, 6. 244-9, 6.296-9, 6. 800-805, 9. 281, 2. 1064-1070, 2. 634-635, 3. 1059-1067, 3.563-568, 4. 120-122, 3. 985, 6. 752-9, 6. 420-424, 6. 536-8, 7. 621-23, 8. 611-614, 8. 1057-1062, 8. 1104-1110, 8. 1225-1233, 9. 338-339, 9. 279-286, 9. 538-552, 9. 709-716, 9. 716-725,
	Daughter managing the mother-daughter relationship	9.391-397, 1. 922-924, 9. 518-520, 7. 596-600
<u>Processing the daughter's story and re-evaluation</u>		
	Processing the daughter's story	2. 888-890, 7. 828-832, 6. 215-217, 6. 420-424, 9. 279-286, 3. 1258-1263, 7. 502-4, 7. 816-825, 5. 889-890, 5. 893-4, 5. 820-822, 5. 824, 6. 377-379, 8. 1236-1239, 2. 447-452
	The mother's vicarious therapeutic journey	1. 742-59, 1. 1722-31, 1. 1719-20, 2. 1161-1174, 4. 1104-1107, 7. 239- 242, 7. 475-477, 1. 473-83, 1. 341-348, 1. 485-93, 2.1167-70, 6.836-41, 7.816-24, 7. 835-841, 8. 1001-1004, 9.315-22

Appendix 15: Example of one super-ordinate theme and evidence

Table 1.6c: Summary table of quotes for Superordinate Theme 5: Processing the daughter's story and re-evaluation

Theme	Quote locations	Example quotes
Processing the daughter's story	2. 447-452, 2. 888-890, 3. 1258-1263, 5. 889-890, 5. 893-4, 5. 824, 6. 377-379, 7. 828-832, 6. 215-217, 6. 420-424, 7. 502-4, 7. 816-825, 5. 820-822, 8. 1236-1239, 9. 279-286,	3. 1258-1263 I am under no illusions that Stacy sat down and told you about her father and if she was to tell you the unadulterated truth, that you would hear a very different story. I am quite certain. But I am not totally sure what that story is, I'll be honest. I don't know. I've told the truth as I see it. 5. 889-890 so Sandra's like a, well she calls herself, in the family we call her a nut- nut. Well she says that, she says I'm in nut nut mode 6.836-41 I mean although she has said that, but she (...) reprimanded me that Remi's my favourite, then she is and then Mark, well in a way I have had to accept what she said on that a bit, coz in way that's what we've been taught (<i>hmm</i>), but, I'm not sure, I don't know if she's actually correct about it, I mean perhaps I ought to discuss that with her because I'm not you know, in a way she told me that, but I'm not sure if that's true. 8. 1236-1239 people coming for mental, for the therapy, they are not functioning 100% normally, so to speak, so therefore, they are, they they're information bank, or they, they're relating of the affairs, not necessarily might be correct
The mother's vicarious therapeutic journey	1. 341-348, 1. 485-93, 1. 473-83, 1. 742-59, 1. 1722-31, 1. 1719-20, 2.1167-70, 2. 1161-1174, 4. 1104-1107, 4. 1104-1107, 6.836-41, 7.816-24, 7. 475-477, 7. 835-841, 8. 1001-1004, 9.315-22.	1. 485-93 But it's getting her to , but I what we will both , what I realise was, that I couldn't counsel her round, I thought I could help her myself at the beginning. (<i>Yes</i>) I'm gonna help you, I'm gonna, I'm here for you and I'm you're gonna get over this but but what I came to realise was that that's the last thing you can really do (<i>I see</i>) You can't, you cannot counsel your own child 1.1719-20 my therapy will be if she gets better (laughs). If she gets better, then I will be better. 2.1167-70 there is a reason for people to be in psychiatry and I've seen that in my own life now (<i>hmm</i>) And there are people that do need that and I should never have had that judgement. 4. 1104-1107 No, I think it's amazing and it doesn't bother me, it doesn't make me feel anything uncomfortable or, I think it can only help her, and by helping her it helps everybody around her (yes). You know (yes). So it's a domino effect (yes). All the ripples (yes). 7.816-24 I think we've revisited and I think it's happened and I've gone back and said you know, remember the other day when we were talking about so and so, I think that's what's happened I've revisited a couple of things that perhaps she's asked or (<i>hmm</i>) made me think about (<i>and has that, has that been, what's that been like?</i>) it's good, it's good, it's brilliant, yeah (<i>hmm</i>). We don't always agree on stuff. Or she'll say I think you think this, or I think you did that or said this and um, we don't always agree on it so (laughs) (<i>How is that when you don't agree on it?</i>) It's fine, yes it's fine, it's fine to talk about it. 8. 1001-1004 but also, it works, I suppose, it works also, it sort of occurred to me, as a part of therapy for me as well. Because being involved in the healing process of my child means I'm participating in the healing process full stop which is healing me as well.

Appendix 16: Participant Case Summaries

Jane

Jane was 59 years old and in full-time work as a healthcare assistant. Her daughter Heidi was 29 years old, lived with her partner, was employed and was intermittently in therapy. Jane came across as someone who was very keen to help me in a motherly and caring way. She appeared very reflective and would sometimes pause to collect her thoughts and voiced her enjoyment over the thinking process. Jane had experienced her own therapy and was a real advocate of therapy. She was able to articulate a clear sense of what therapy meant for her, including the usefulness of hearing your own words aloud.

Jane recounted how she had encouraged her daughter Heidi to go to therapy as Heidi had become depressed. Quite early on in the interview, Jane became tearful and surprised as she recounted how she had been scared that her relationship with Heidi would deteriorate when Heidi first went into therapy as an adolescent. As Heidi's therapy progressed and she found that Heidi was coming out of her depression, her fears gave way to relief, gratitude and happiness. She expressed very positive feelings about Heidi's therapy. In particular, she highlighted how Heidi was now very perceptive about other people's mental health issues. When Heidi returned to therapy, Jane had mixed feelings of fear and sadness. Jane felt embarrassed that she felt guilty and sad about Heidi needing therapy – in a way conveying some self-criticism about her struggle to accept her feelings. However, Jane also appeared self-compassionate and highlighted that women take a lot on and cannot blame themselves for not being perfect.

Jane felt very close to her daughter and presented with some mixed feelings about whether mothers and daughters could be too close. Of all of the mothers, Jane appeared to have experienced the most benefit in terms of personal growth via Heidi's therapy. She conveyed how much she and Heidi enjoyed discussing therapy together and that she learned so much from these discussions – about Heidi, about the past, about herself and about the therapeutic process. Jane appeared to gain therapeutic benefit from taking part in the interview and said she was looking forward to thinking more about what we had discussed and the new realisations that she had had.

Lisa

Lisa was 54 years old, divorced and remarried and a teaching professional. Her daughter Stacy was 30 years old, employed and living on her own. Lisa was unsure of how much she would be able to help me as her daughter Stacy's therapy ended several years ago and she did not know how much she would be able to remember. A lot of the interview was spent recounting the difficulties in Stacy's early life due to Lisa and her ex-husband's divorce, his remarriage and Lisa's separation from Stacy, who went to live with her father. Retelling this story and establishing a clear context for Lisa's mothering of Stacy and her struggles to do so seemed very important to be heard.

Lisa had had her own therapy. She seemed cynical about how much the therapist's role had played in the benefits that she received from what seemed to be the cathartic process of ventilating her thoughts and emotions. What was most beneficial for Lisa had been the humanity that the therapist had shown her as she had acknowledged, as a mother herself, Lisa's hardship caused by being separated from her child. Of all of the mothers, Lisa seemed the most adamant that not being involved in her daughter's therapy was the right thing to do. From what she understood about therapy, Stacy needed to feel able to say whatever she needed and not to feel guilty about it, so asking her about it would have been counter-productive.

Lisa appeared to use her knowledge of child development to make sense of the impact that Stacy's early life experiences had had upon her and voiced her certainty that this impact was likely to be enduring. She also seemed to use her knowledge of others who had been in therapy and not managed to entirely overcome their pasts to manage her expectations about Stacy's future. Lisa seemed to take up the expert role of her daughter's needs and voiced her certainty that the living, financial and career support that she was currently giving Stacy was what she needed to stay well. In the future if she was not able to support Stacy, Lisa thought that Stacy may return to therapy, but that right now she did not think that therapy, unless it was practical, structured and short term – like Cognitive-Behavioural Therapy (CBT) – would be helpful.

Hillary

Hillary was a 56-year-old woman, who was currently unemployed outside of the home but a qualified science and engineering professional. Her daughter Alex was 19 years old and was a student living away from home who had recently terminated her long-term therapy. Hillary's daughter was the youngest daughter of the mothers in the sample. Her ambivalence about closeness with her daughter seemed partially to do with Alex's age and her transition into adulthood. However, it also seemed to be due to Alex's mood swings and dependence on Hillary for emotional containment, which Hillary seemed to find tiring and uncomfortable.

Hillary came across as highly reflective, self-aware and self-critical. Of all of the mothers, she seemed to make the most associations between her life experiences and the way that she understood Alex and the influences Alex had received in her life. She also identified and empathised with Alex and was reflective about their relationship. She recognised that openness and trust had developed in their relationship over the course of Alex's therapy. She seemed to be appreciative of Alex's point of view and to take it into consideration when reflecting upon her own behaviour and the family dynamics.

In particular, Hillary voiced her confusion and her guilt about Alex being in therapy and conveyed her struggle to make sense of why Alex needed therapy. As she had financially facilitated Alex's therapy, she also conveyed her disappointment that the therapy had not been as effective as she had hoped, considering the amount of time and money spent on it. However, of all of the mothers, Hillary seemed to express the most appreciation for therapy. In a humorous way, Hillary associated her personal connection with therapy to a religion and shared that therapy was very important to her and her family and this connection had motivated her participation in the research.

Sarah

Sarah was a married, 54-year-old woman who worked as an information and communication technician. Her daughter Anita was 27 years old, lived at home and was currently unemployed outside of the home. Anita was in long-term therapy with the NHS at the time of the interview. Sarah appeared to be at quite a different stage in the process of her daughter's therapy to the other mothers perhaps as Anita was in the early stages of therapy and still struggling to manage her eating disorder. Sarah appeared to be in a state of hyper-vigilance as she had been so disturbed by Anita's recent life-threatening behaviour. She explained that she had experienced panic attacks and health problems as a result of worrying. Sarah's narrative seemed to be dominated by her understanding of Anita's eating disorder and the course of recovery. I could also hear technical language in her account, which made me wonder whether she was using her conversations with professionals as a resource for managing her expectations about the process of change. Sarah seemed keen to hear my opinions about eating disorders and their treatment, which perhaps highlighted how prevalent this subject was in her thoughts.

Sarah's emotional experiences about Anita being in therapy were very much intertwined with her feelings about Anita's mental health difficulties and her struggle to cope with them. Sarah was very open about her difficulties with managing her own behaviour in response to Anita. Of all of the mothers, Sarah conveyed how her daughter's therapy had influenced her (Sarah's) behaviour. Through a process of discussion with her daughter and learning that what she was doing was not working, Sarah accepted that she needed to listen more and not to tell Anita what to do.

Sarah shared her experiences of support groups and talking with others about Anita's eating disorder and about her therapy. She conveyed her ambivalence about talking, the lack of benefit she had received from doing so and her preference for not talking sometimes. She shared her discomfort with talking about herself and reflecting on things too much and related this to her feelings about the interview experience, which felt quite unnatural and one-sided to her.

Celeste

Celeste was 57 years old, married and unemployed. Her daughter Jenny was 30 years old, a student and living with her partner. Celeste presented as very willing to help, but unconfident about what she could contribute, especially given that Jenny had only recently commenced therapy. She appeared to give her answers a lot of thought and reflection, to ponder on alternative perspectives and to hypothesise and fantasise about her daughter being in therapy. She seemed to show her understanding of her daughter in a balanced way, recognising her strengths but also her vulnerabilities. She felt positive that her daughter was opening up and questioning things from being in therapy and predicted further improvements e.g. in her daughter's ability to think about things from different perspectives and feeling more confident in herself. At the same time, Celeste emphasised that a number of different factors contribute to change, including new relationships.

Celeste had been a stay-at-home mother and described being virtually a single parent as her husband had travelled a lot with work. Being a mother seemed to be central to Celeste's identity and as her children were growing up and "leaving the nest", she was aware that she was undergoing an important life transition involving significant loss. Celeste described feeling strongly connected with women and valuing the intuitive wisdom that women have. She felt very close to Jenny and related this to her own life experiences and absence of closeness that she had experienced with her mother. She seemed to be unsure and bemused that Jenny was not sharing more about her therapy with her, given the openness that they had in their relationship.

Celeste appeared to have some mixed feelings about therapy. Based upon her personal experiences of being in personal and couples' therapy, she was very positive, especially as she had witnessed significant change in her husband as a result. However, based on other people's experiences, she had her doubts about the benefits of long-term therapy.

Mary

Mary was 61 years old, married and working as a sales manager. Mary's daughter Caroline was 35 years old, employed and living alone. Caroline was in ongoing therapy which started recently, although she had previously been in therapy for the treatment of an eating disorder. Mary was unsure about how she could help me with the research as she had not been directly involved in therapy and she repeated this at several points during the interview. She initially seemed a bit more reluctant to elaborate upon her answers than the other mothers, and provided quite short answers to questions.

Mary was very positive about Caroline's therapy and seemed to think really hard about what she knew based on what Caroline had told her. In particular, she drew upon her experience of Caroline showing her CBT thought records and how this gave her an unwanted insight into what Caroline was discussing in therapy. Mary explained that she found this painful as she did not want to think that Caroline had been affected by anything that had taken place in the home. She linked not wanting to know about what went on in Caroline's therapy with being self-protective.

Of all of the mothers, Mary was very open about her ambivalence about intimacy with Caroline and how she did not feel comfortable with or think it was appropriate for Caroline to share her intimate thoughts and feelings with her. Mary was also open about how she valued the time that she spent with Caroline but that not having to see Caroline or to be confronted by Caroline's problems on a daily basis was easier to cope with.

Mary's narrative included quite a lot of theorising about the origins of Caroline's mental health difficulties and Mary was able to share her feelings of guilt that accompanied the theorising and questioning processes. She was certain that Caroline's difficulties were most likely genetic and did not have an environmental influence as she felt that she and her husband had provided a loving and supportive home. She seemed to want some reassurance that this was the case and expressed how upsetting it was that people blamed the home environment.

Meredith

Meredith was 54 years old, divorced and worked as a sales manager. Her daughter Miria was 27 years old, self-employed and in long-term therapy. It seemed important to Meredith for me to hear the cultural context in which she mothered Miria. Meredith had been very socially isolated as a mother within a secretive culture where she felt she had no choice but to fulfill the role of “trophy wife”. Meredith shared how she had struggled to develop a relationship with Miria and felt rejected by Miria when Miria was very young.

Meredith openly described the horrific details of Miria’s sexual abuse that had occurred in the household. She voiced that at some level she intuitively knew that something had happened to Miria, but initially denied its occurrence when it was revealed to her. Meredith’s personal life struggles, including divorce and financial hardship, were also part of her experience of mothering. She acknowledged that other concerns consumed her attention and that she had not worried about Miria, who appeared to be achieving well. However, when Miria eventually broke down, Meredith assisted her to access therapy.

Meredith conveyed her support of therapy in general and shared her personal identification with therapy and how therapist roles were held within her family. She had experienced positive and negative effects of her daughter being in therapy and blamed Miria’s current therapy for the difficulties in her relationship with Miria. She felt that she was being controlled by Miria and that in order to protect herself from being abused by Miria, she needed to distance herself from the relationship and to pretend that Miria was dead. She justified her response as she said that she had never really had a relationship with Miria. Meredith shared her conflicting feelings about her relationship with Miria as she voiced a strong desire to have a relationship with her. However, it was apparent that her awareness of her daughter’s suffering was unbearably painful for her and that she felt unable to bear her daughter’s pain, given the stress that she was currently experiencing in her life.

Teresa

Teresa was 57 years old, unemployed and married. Her daughter Sandra was 27 years old and her latest therapy had been ongoing for one year. Teresa shared the story of Sandra's involvement with child and adolescent mental health services, psychiatry, inpatient care and group and individual therapy. Throughout her story, Teresa conveyed her unwavering efforts as a mother to follow professional advice and to help to support Sandra the best she could.

She shared her struggle to mother Sandra and her sadness, shame, fear and guilt which arose as a result of Sandra needing to have therapy when she was a child. She described the excruciating fears that she had experienced about the prospect of Sandra being taken away from her and being labeled an "incapable mother". She worried about Sandra's distorted thinking ("Sandra's world") and how Sandra's powerful personality enabled her to manipulate situations and people in order to achieve what she thought she wanted. Teresa shared her attempts to help Sandra to access the therapy she needed and the experience of rejection by services.

Coping with her daughter's mental health problems, life-threatening and aggressive behaviours and the process of Sandra's therapy had taken Teresa to the depths of despair – where she had even contemplated joint-suicide with Sandra. Her faith in God, prayer support and the needs of other family members had enabled her to keep going. Although she continued to support Sandra, she expressed relief that Sandra was now living away from home as the family no longer had to live in fear of what Sandra might do. She also identified that "forgetting" about the past was a survival mechanism and she shared that it had been surprisingly painful during the interview to remember about some of her experiences.

Evelyn

Evelyn did not give her age. She was a linguist and a teaching professional and she was widowed. Her daughter Vanessa was 21 years old and a student who lived away from home with friends. Evelyn was keen to take part in the research and to share her experiences of NHS psychological services as a family member. She felt very angry about being excluded from her daughter's therapy. She felt passionately about the need for it to be possible for family members (not only mothers) to be involved in an individual's therapy.

Evelyn shared her understanding of Vanessa's mental health difficulties and grounded them in Vanessa's early environment. The context in which Vanessa was mothered was complicated by Evelyn caring for Vanessa's twin who had severe physical and mental disability and the death of her husband when Vanessa was still a child. Evelyn was clear that she felt very ill-equipped for mothering a disabled child and that her energies were exhausted. She had been virtually a single parent before her husband's death as he had travelled a lot with work. Evelyn stressed that choosing to have a bright and positive outlook helped her to tolerate the trauma she had experienced.

Evelyn was extremely positive about therapy and welcomed any help that was on offer for Vanessa and the family. She had experienced stigma about Vanessa being in therapy and compared this to her experience of coping with the stigma of having a disabled child.

Evelyn shared a range of different experiences of Vanessa's therapies and that her main priority was that Vanessa found it helpful. Evelyn appreciated the level of involvement that she had been able to have with private therapy, which included telephone contact with the therapist and joint sessions. Post-therapy discussions with Vanessa were helpful for managing her worries about Vanessa.

Not being able to be involved in the NHS therapy left Evelyn feeling powerless as she was unable to ensure that Vanessa shared all of the relevant historical and risk information that she thought would assist the therapy process. Being part of Vanessa's therapy felt therapeutic for Evelyn as it was so meaningful to her to be part of the "remedy" that helped her daughter.

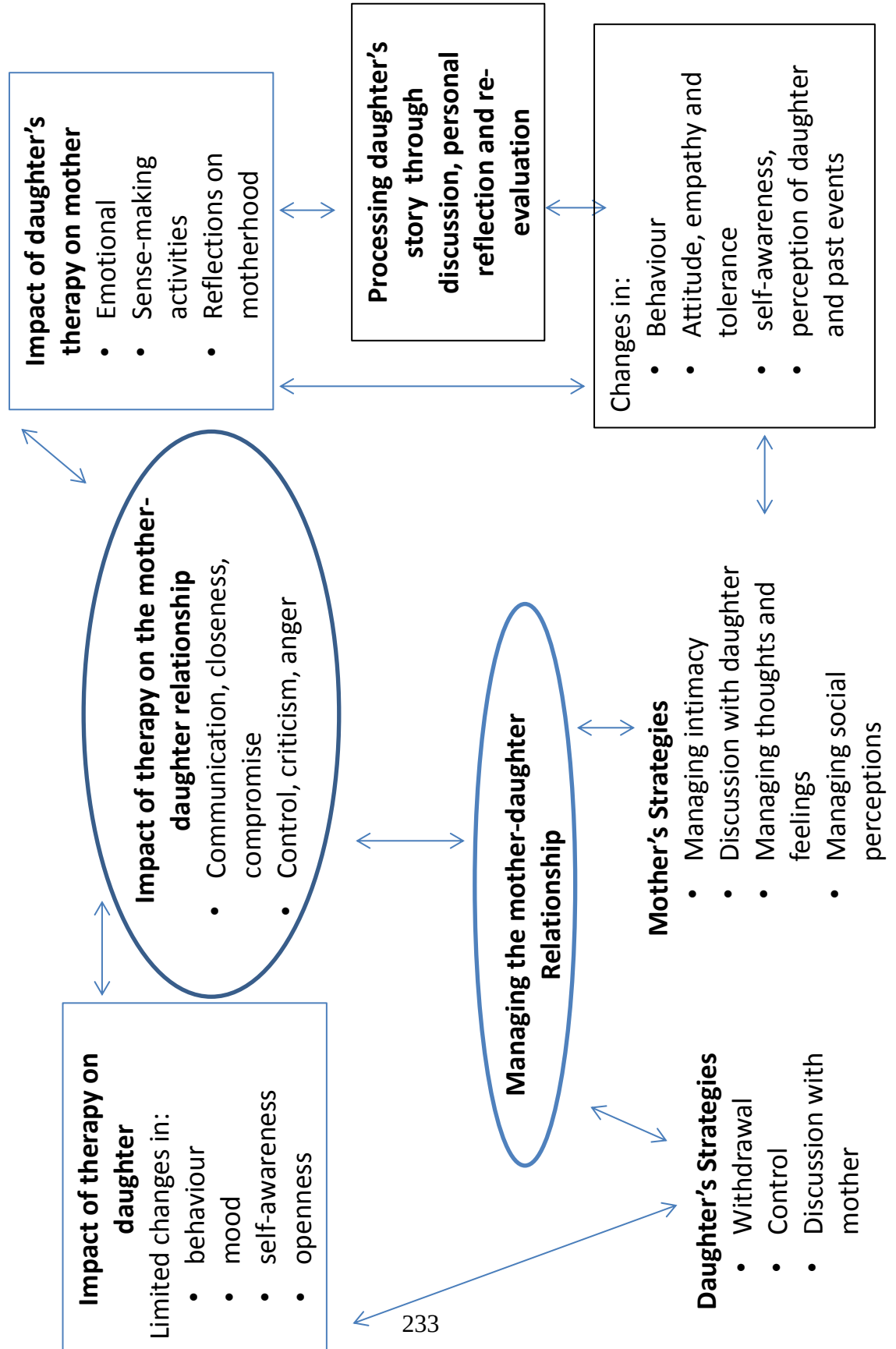
Appendix 17/ Table 1.6d: Demographics Matrix

<u>Mother (M) Daughter (D)</u>	<u>Age</u>	<u>Ethnicity</u>	<u>Relationship Status</u>	<u>Education</u>	<u>Employment</u>	<u>Children</u>	<u>Daughter's therapy</u>	<u>Personal Therapy?</u>	<u>Post code</u>
Jane (M) Heidi (D)	59	White British	Divorced	GCSEs or equivalent	Health care assistant	Daughter aged 29	<u>Therapy 1</u> – Commenced 2001 – 6 months <u>Therapy 2</u> – commenced 2010 – 6 months (returns intermittently)	Yes	AL
Lisa (M) Stacy (D)	54	White other	Married	GCSEs or equivalent, A levels or equivalent, Secretarial, Bachelor's degree, Master's degree	Teaching professional	Daughter aged 30, Son aged 28, Son aged 16	<u>Therapy 1</u> – commenced 2001 for 6 months	Yes	IG
Hilary (M) Alex (D)	56	White British	Married and divorced	GCSEs, A-levels, bachelor's, master's, diplomas, professional degree	Home-maker and engineering professional	Son aged 28, Daughter aged 25, Daughter aged 19	<u>Therapy 1</u> – commenced 2008 – 2.5 years	Yes	N6
Sarah (M) Anita (D)	54	White British	Married	GCSEs or equivalent, Diplomas, Secretarial	Information and communication technician	Daughter aged 27, Son aged 25	<u>Therapy 1</u> – commenced 2006 for 1 month <u>Therapy 2</u> – Commenced 2009 for 6	No	IG

							months <u>Therapy 3</u> – Commenced 2010 ongoing		
Celeste (M) Jenny (M)	57	White British	Married	A levels or equivalent, Secretarial	Home- maker	Daughter aged 31, Son aged 29, Son aged 19	<u>Therapy 1</u> – commenced 2001 for a few months <u>Therapy 2</u> – Commenced 2011 – ongoing	Yes	NW
Mary (M) Caroline (D)	61	White British	married	GCSES, diplomas	Sales manag er	Daughter aged 35, son aged 32	<u>Therapy 1</u> – Commenced 1996 – 3 years <u>Therapy 2</u> – commenced 2012 – ongoing	No	IG
Meredith (M) Miria (D)	54	White British	Divorce d	A levels or equivalent	Sales Manag er	Son aged 30, Daughter aged 27	<u>Therapy 1</u> – commenced 2008 for 1 year <u>Therapy 2</u> – Commenced 2008 for 6 months <u>Therapy 3</u> – Commenced 2008 ongoing	Yes	SW
Teresa (M) Sandra (D)	57	White British	Married	GCSEs or equivalent	Home- maker	Daughter aged 27, Daughter aged 24	<u>Therapy 1</u> – commenced 1989 on and off for 13 years	No	E4

							<u>Therapy 2</u> – Commenced 2006 for 2 years <u>Therapy 3</u> – Commenced 2002 ongoing <u>Therapy 4</u> – Commenced 2009 ongoing		
Evelyn (M) Vanessa (D)	??	White other	Widowe d	Master's degree	Linguis t and teachi ng profes sional	Son aged 27, Daughter aged 21, son aged 21	<u>Therapy 1</u> – Commenced 1996 – 2 years <u>Therapy 2</u> – commenced 1999 – 1 year <u>Therapy 3</u> – Commenced 2001– 2 years <u>Therapy 4</u> – commenced 2006 – ongoing	Yes	KT

Appendix 18/Diagram 1.4a: Model of the data analysis



LOOKING FOR IDEAS?

TRY TO STAY FOCUSED ON THE PRESENT
AND A GOOD LISTENER AND SHARE YOUR
THOUGHTS WITH THEM
FIND OUT MORE INFORMATION ABOUT THE
PROCESS OF THERAPY
TRY TO APPRECIATE YOURSELF AS A
WOMAN AND AS A MOTHER
TRY TO ACCEPT YOUR DAUGHTER'S
INDIVIDUAL LIFE JOURNEY AND TO DO
ENJOYABLE THINGS TOGETHER



deborah.kemp.1@city.ac.uk
City University London

ARE YOU A MOTHER WHO HAS AN ADULT DAUGHTER IN THERAPY?



Appendix 19: Example Information Booklet



DO YOU EVER WORRY ABOUT YOUR DAUGHTER'S THERAPY?

Have you noticed any changes in your daughter while she's been in therapy?

When individuals go to therapy they can become more emotional. This can be because they might be exploring their thinking, feeling and experiencing in more depth.

Sometimes individuals who go to therapy prefer not to discuss what takes place. This might be because it feels private. It might be because it feels scary to talk about certain things outside of therapy in case others respond angrily or are hurt by what is said.

BEING AVAILABLE TO LISTEN TO YOUR DAUGHTER WHO IS IN THERAPY, CAN BE VERY HELPFUL TO HER AND HER THERAPY

Some people find that listening to someone who has been in therapy, and learning from their experiences can be beneficial for them as well.

It has been found that having a family member in therapy and listening to their experiences can be life-enhancing for the listener. In some cases, such discussions can bring family members closer together.

TAKING TIME TO LISTEN



Do you ever worry about what your daughter talks about in therapy?

Do you ever worry about your daughter getting the help she needs?

Having a daughter in therapy may sometimes feel unsettling, even if you support her therapy. It may feel like there are lots of unanswered or unanswerable questions about what takes place in therapy with your daughter.

Chapter 2: Publishable Paper

A qualitative study of the mother's experience of having an adult daughter in therapy and how she manages the process

2.1. Author Guidelines for Journal of Family Therapy

Papers submitted for publication should be original work not previously published in English and not currently submitted elsewhere for consideration. If accepted for publication, a paper cannot be published elsewhere in any language without the consent of both Editor and publisher. It is a condition of acceptance that the Association for Family Therapy and Systemic Practice automatically acquires the copyright throughout the world. Manuscripts should be submitted to the following website: <http://mc.manuscriptcentral.com/jft>. Full submission instructions can be found on this website.

A cover letter should be submitted with your manuscript and must include a statement that the data have not been published, and is not under consideration for publication elsewhere. It will be presumed that all listed authors of a manuscript have agreed to the listing and have seen and approved the manuscript.

Format for Manuscripts

1. Manuscripts should allow for 'blind/anonymised' refereeing and **must** not contain author names or any identifiable data.
2. Manuscripts **must** be typed in double spacing throughout, including quotation, notes and references in the following order:

Title Page: to contain the title of the paper, word count, suggested running head (short title for your paper) and key words.

- Abstract: on a separate sheet, the title to be repeated followed by a summary of not more than 150 words. The suggested running head should also be present.
- Organisation of the text: see copy of Journal for the format currently in use.
- References (in text)

these should be indicated by the name and date e.g. 'Carr (2009)'. If more than two authors are listed, cite the reference as 'McHugh *et al.* (2010)'. Quotations should

include page numbers. Web sites should also be cited in this way, with a full reference appearing in the References section (see below).

- Figures, tables, etc.: All figures and tables should be numbered with consecutive arabic numerals, have descriptive captions and be mentioned in the text. They should be kept separate from the text but an approximate position for them should be indicated. These will need to be uploaded separately. Please supply figures in the format in which they were created, if possible.

- References

should be listed at the end of the paper in alphabetical order according to the first author and be complete in all details, again following the Journal's existing format.

Articles: Lerner, G Intergrating Family Therapy in adolescent depression: an ethical stance. *Journal of Family Therapy*, 31: 213-232.

Chapters: Woodcock, J. (2009) Love and hate and the oedipal myth: the perfect bridge between the systemic and psychoanalytic. In Flaskas, C. And Pocock, D. (Eds) *Systems and psychoanalysis: contemporary integrations in family therapy*. London: Karnac. Pp 129-146

Books: Rivett, M. and Street, E. (2009) Family therapy: 100 key points and techniques. London: Routledge.

Web sites: Alzheimer's Society (2009) *Counting the cost: caring for people with dementia on hospital wards*, retrieved 11 January 2012 from http://alzheimers.org.uk/site/scripts/documents_info.php?documentID=1199.

3. The word limit, excluding abstract and references will vary depending on the type of paper you are submitting. Please refer to the 'Advice to Authors' section below.

4. Style: Whilst Journal style is generally formal, originality in presentation does not necessarily preclude publication if clarity and readability is thereby enhanced. Sexist language forms are unacceptable.

Your manuscript will be returned to you if you fail to conform to these requirements.

Pre-submission English-language editing

Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. A list of independent suppliers of editing services can be found at http://authorservices.wiley.com/bauthor/english_language.asp. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

Evaluation of Manuscripts

The Editorial office will acknowledge receipt of manuscripts. The Editor will arrange for evaluation by at least two assessors. Following receipt of the assessors comments the Editor will advise the authors about the decision concerning the manuscript. This will be done as rapidly as possible with the aim being 12 weeks.

Exclusive License Form

Authors will be required to sign an Exclusive Licence Form (ELF) for all papers accepted for publication. Signature of the ELF is a condition of publication and papers will not be passed to the publisher for production unless a signed form has been received. Please note that signature of the Exclusive Licence Form does not affect ownership of copyright in the material. (Government employees need to complete the Author Warranty sections, although copyright in such cases does not need to be assigned). After submission authors will retain the right to publish their paper in various media/circumstances (please see the form for further details).

Copy Editing

Following acceptance for publication an article is copy edited for conformity to the style of publication, clarity of presentation, punctuation, standard usage of terms, etc.

Proofs

First-named authors will receive proofs for correction which must be returned within 48 hours of receipt. The corresponding author will receive an email alert

containing a link to a web site. A working e-mail address must therefore be provided for the corresponding author. Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following web site: <http://www.adobe.com/products/acrobat/readstep2.html>. Further instructions will be sent with the proof.

ADVICE TO AUTHORS

Writing is a very enjoyable and satisfying way of being involved in the world of family therapy. The exchange of ideas and experience is important both for the development of our chosen field and for the development of the individual practitioner. We intellectually sustain ourselves by creating a healthy and vibrant literature. Family therapy needs to develop authors and *The Journal of Family Therapy* wants to hear from you.

Research Presentation (3,000-6,000 words)

A research paper should include:

- An introduction to the principal concepts and theoretical issues relevant to the study.
- Previous work.
- Brief description of methodology including participants.
- Results.
- Discussion of results, including implications for future research and practice.

PAPERS EXCEEDING 6,000 WORDS (including references) WILL BE RETURNED TO THE AUTHOR

PREPARING THESIS MATERIAL FOR PUBLICATION

From the outset, it needs to be appreciated that the audience for a thesis is very different to the readership of a Journal. A thesis is prepared to demonstrate candidates' knowledge of an area, their understanding of how theoretical matters link and their ability to use a wide range of sources to develop arguments. In

presenting research material, the thesis will provide explanations about the process of deciding on a methodology, the utilisation of that methodology and a critique of its application. A Journal article by contrast seeks to make one or two points clearly and to link these with the current understandings and conceptions in such a way that there is the development of ideas. The Journal reader assumes that the author has a wide range of knowledge of the area and is looking for the author to make a few points well by building on what is already known.

The key to overcoming the difficulties of moving from a thesis to a Journal article is to be aware that one uses the thesis as a source rather than using it as an earlier version of the article. In preparing a Journal article you begin with a blank sheet of paper, a lot of knowledge and previous written material. What is available has the potential of being an article but further work will be necessary.

A thesis and a Journal article are very different pieces of writing and the process of preparing one for the other is more than just re-wording the title page!

Many Journal reviewers can easily identify thesis based material by the following common problems that appear:-

1. The introduction is over long and covers too broad an area.

Histories of where family therapy came from and descriptions of core elements of systemic practice are not necessary in Journal articles. Only the theoretical point germane to the article's principle aims need to be outlined.

2. Long explanations as to why particular methodologies are used.

For a Journal article there is no need to enter into discussions of this nature or to compare different methodologies. The decision was made to undertake the research on one particular methodology and this is what should be present.

3. Too many quotes from other authors.

There is a need in a thesis to seek validation from a wide range of sources, but in a Journal article the author's own arguments should be enough with a few selected quotes to emphasise points.

4. The attempt to write the journal article by following the same structure of the thesis.

In many cases this is not necessary as the article will demand a different type of structure.

5. Over long self-critique of the work.

Although self-criticism is a necessary part of any public presentation of one's work, it needs to be pertinent to the material presented. There is no need for a full descriptive account of the self-reflective process.

6. De-emphasising the main findings of any research study in an attempt to fit it in with the fuller perspective of the thesis.

In an article the main findings of the research study need to be emphasised and examined and then linked to broader themes relevant to the issues discussed.

In short, writers of papers prepared from theses often attempt to include as much of their thinking that went into the thesis in the paper. There is a need to overcome the reluctance to cut out elements of the thesis in the preparation of an article to keep the writing solely relevant to the ideas being present.

Good Marks and Articles

Because the consumers of theses and papers are different, the potential author needs to be aware that if a thesis is praised it does not necessarily mean it is readily translatable into an article. It simply means a good mark towards the degree. Similarly, even if a thesis or extended essay just scrapes past the pass mark, it may contain some very useful material that can be worked with for future submissions as an article to a Journal.

The Question of Authorship

In many academic departments there is a tradition that material which is offered for publication which is based on a thesis should be seen as a joint endeavour between the student and the supervisor. The student is seen as being the senior author with the supervisor in a supporting role. Courses and supervisors are quite likely to have different views on this. There are no set rules. However in some

situations it may be that by using the thesis material as a source a good quality article could be developed by the student and supervisor working on it jointly. This is a point that should be borne in mind by both students and staff of family therapy courses.

These guidelines were copied word for word from the following reference:

Journal of Family Therapy (1999–2013). *Author Guidelines*. Wiley Online Library: John Wiley & Sons, Inc. Retrieved January 22, 2013 from [http://onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)1467-6427/homepage/ForAuthors.html](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1467-6427/homepage/ForAuthors.html)

2.2. Letter to Editors

Department of Psychology
School of Arts and Social Science
City University
Northampton Square
London
EC1V OHB

Journal of Family Therapy

14th March 2013

Dear Editors at the Journal of Family Therapy,

Please consider this research paper for publication in the Journal of Family Therapy. It is an original piece of work, the data has not been previously published, and it is not under consideration for publication elsewhere. All listed authors of this manuscript have agreed to the listing and have seen and approved the manuscript.

Yours Sincerely,

Deborah Kemp
Trainee Counselling Psychologist
Department of Psychology
School of Arts and Social Science
City University London

And

Dr Deborah Rafalin
Registered Psychologist and Senior Lecturer
Department of Psychology
School of Arts and Social Science
City University London

2.3. Title Page

A qualitative study of the mother's experience of having an adult daughter in therapy and how she manages the process

***Key Words:** Mother-daughter relationship, interpretative phenomenological analysis, qualitative, therapy, mother, daughter*

Abstract: 150 words

Research Paper: 59986 (including references and headings)

2.4. Abstract and titles

A qualitative study of the mother's experience of having an adult daughter in therapy and how she manages the process

The mother's vicarious therapeutic journey

Abstract

Nine participants were recruited in south-east England to investigate how mothers manage the process of having an adult daughter in therapy. Data was collected using semi-structured interviews and analysed using Interpretative Phenomenological Analysis (IPA) (Willig, 2008; Smith et al., 2009). Theorising and questioning activities, underpinned by feelings of relief, guilt, powerlessness and confusion, were commonly engaged in whilst making sense of the cause of their daughter's difficulties and her need for therapy. Mothers managed the process by forgetting, accepting, focusing on progress and managing intimacy. Discussions with daughters sometimes facilitated personal growth for mothers. A greater awareness of the mother's perspective may enable mothers and daughters to be better supported. Transferability issues must be considered when applying the findings of this research.

2.5. Introduction

Systems theory (Dallos & Draper, 2005; Duvall, 1977; Haley, 1973; Jackson, 1957; Watzlawick et al., 1967) has been critical in understanding the reciprocal impact of context on the therapeutic process and the interdependence of actions in relationships. Current research confirms that an individual being in therapy can have important implications for significant others (e.g. Bedics et al., 2005; Murray, 2007) and that the therapeutic process is impacted by significant others (e.g. Murray, 2007; Pereira et al., 2006; Smerud & Rosenfarb, 2011). For therapists, it is important to realistically assess social support available for clients and how lack of it may collude with ambivalence about therapy (Lemma, 2003).

Mothers provide a significant source of support for daughters across the lifespan (Bojczyk et al., 2011), especially if social contacts decline in connection with their mental health difficulties (Johansson et al., 2010). However, there is an absence in the literature informing about how mothers might manage the process of their adult daughter being in therapy. Furthermore, the majority of the literature focuses on the experience of having family members with chronic mental health problems (Johansson et al., 2010; Schwartz & Gidron, 2002). This corresponds with the tendency within psychological research to focus on the “pathological” at the expense of the “normal” (Smith, 1999; Shrier et al., 2004).

2.5.1. Managing the mother-daughter relationship

Mother-daughter relationships have historically been defined by complexity and ambivalence, particularly in relation to the process of “separation-individuation” (Charles et al., 2001; Freud, 1933; Shrier et al., 2004). It is described as the most

intense intergenerational relationship in terms of emotional connection and interdependence (Fischer, 1991).

Mothers can find it immensely painful to live with the idea of not having prevented their daughters' suffering and can experience multiple losses, ongoing guilt and "unhealable" emotional pain imbedded in the myth of "perfect mother" (Carvalho et al., 2009; Pretorius et al., 2011). In order to protect themselves from their daughters' accusations and their own self-blame, mothers can emotionally distance themselves from their daughters' emotional distress (Daly, 2005), try to change feelings rather than empower their daughters (Surrey, 1993) and struggle to acknowledge their daughters' perspective (Johansson et al., 2010; Miller, 1990; Sayers, 1993). Furthermore, it has been found that mothers of adult daughters with diabetes (Rassamen et al., 2008) and mothers of suicidal adolescent daughters (Daly, 2005) can become more protective of their daughters and "overcompensate" as a result of self-blame.

2.5.2. Managing the process of having an adult daughter in therapy

Although being in therapy is not synonymous with having diagnosable mental health difficulties, for a significant number of mothers who have had an adult daughter in therapy, it is likely that managing the experience of their daughters' mental health difficulties is intertwined with this process. The following section addresses some of the common coping responses and feelings highlighted in the research regarding the parents' experience of having an adult-child with mental health difficulties and/or who has been in therapy.

Social support and support groups are frequently cited as coping resources for mothers who have adult-children with mental health difficulties (e.g. Johansson et al., 2010; Pejler, 2001). Johansson et al. (2010) found that, for mothers able to

talk freely, openness was viewed as a survival strategy from which strength and validation of shared experiences could be gained. However, mothers of children with mental health problems report feeling negatively judged as mothers and made to feel guilty by others, including mental health professionals (e.g. Daly, 2005; Jackson & Mannix, 2004; Johansson et al., 2010; Lindgren et al., 2010; Pejler, 2001). This has been found to impact upon their engagement with services (Fox, 2012) and lead them to resist seeking social support (Jackson & Mannix, 2004).

Those who associate with members of a stigmatised group can experience “courtesy stigma” (Goffman, 1963). “Courtesy stigma” has been reported by parents of children with mental health problems, and described as an internal sense of shame and discrimination and rejection and avoidance by others (Corrigan & Miller, 2004). For example, parents of adolescents with Attention Deficit Hyperactivity Disorder (ADHD) were found to employ “courtesy stigma management-strategies” such as avoidance or activities aimed at enhancing the social perceptions of others (Koro-Ljungberg & Bussing, 2009). Given the stigma towards those who seek help from professionals (Ben-Porath, 2002; Jorm & Wright, 2008; Vogel & Wade, 2009), mothers of adult daughters in therapy may also experience “courtesy stigma” and employ such coping strategies.

Trying to stay grounded in the present moment and focusing on the factual situation are examples of coping-strategies which help mothers to cope with the experience of ongoing worry about their adult-child with chronic mental health difficulties (Johansson et al., 2010). A moderate degree of worry is commonly experienced in parent-adult-child relationships (Hay et al., 2007, 2008) and is ever-present in the experiences of parents of adult-children with mental health difficulties (Johansson et al., 2010; Mohr & Regan-Kubinski, 2001; Pejler, 2001). Hatcher and

Hatcher (1983) found that parents of psychotherapy patients were affected by their anxieties and fantasies about their adult-child's therapy.

Parents of adult-children with mental health difficulties can feel “shut out”, ambiguous in their role (Pejlert, 2001) and find significant problems communicating with care providers (Muhlbauer, 2002). Lindgren et al. (2010) described how parents felt accused, broken, invisible, confused, excluded, isolated and alienated in their experiences of their adult daughters' professional care. They compared parents' experiences to a “limit situation”. This phrase, coined by Jaspers (1932), refers to moments, usually accompanied by dread, guilt or acute anxiety, where the human mind confronts an inescapable situation, from which it must seek to create meaning (Thornhill, 2011). Jaspers defined “existential communication” as an intense process of communication through which the limits of consciousness can be overcome and new meanings discovered (Thornhill, 2011).

Meaning-making has been found to play a significant role in determining the subjective experience of having an adult-child with mental health problems (Schwartz & Gidron, 2002). For example, Johansson et al (2010) found that mothers reported a sense of security in their mothering roles and trust in their ability to manage situations once they had developed insight into their child's difficulties. In addition, there is an increasing body of research (e.g. Aschbrenner et al., 2010; Schwartz & Gidron, 2002) attending to the potential for life enrichment that can arise from the experience of having an adult-child with mental health problems. Findings include a deepening sense of self-awareness and inner strength (Aschbrenner et al., 2010; Marsh et al., 1996; Schwartz & Gidron, 2002), and a greater empathy and tolerance towards others (Muhlbauer, 2002). This indicates how the development of meaning and new understandings may be fundamental to the well-being of mothers who have had an adult daughter in therapy.

2.5.3. The aims and rationale of the present study

This study explored the experiences of mothers who have adult daughters in therapy and how they manage this process. By acknowledging the complexity in mothers' lives and in their relationships with their daughters, it was hoped that the research findings would enable a more in-depth understanding of the mother's experience and inform therapeutic practice with mothers and daughters.

2.6. Methods

2.6.1. Choosing method informed by epistemological position

Interpretative Phenomenological Analysis (IPA) is a descriptive and interpretative qualitative research method (see Smith, 1996, 2004). It was chosen as, like IPA, this research was concerned with complexity, process and novelty (Smith & Osborn, 2008) and elucidating the experiences of the "experts" (Reid et al., 2005). Like IPA, it was appreciated that the research process is co-constructed and that, in order to gain access to meaning, the researchers must engage in a process of interpretation with the data (Smith et al., 2008). The practice of reflexivity was carried out throughout the research process in order to enhance the awareness of the researcher's contribution to the development of meaning-making (Nightingale & Cromby, 1999).

As IPA uses small sample sizes and views findings as context-dependent, statistical generalisability is not intended. Instead, information about the sample, collected using a demographics questionnaire, aimed to help readers to think about where the findings may be applied to other contexts, situations or people (Morrow, 2005).

2.6.2. Participants

The participants were nine women aged 54-61 (mean=56.5 years, Standard Deviation=2.56) recruited using a range of methods (snowballing, flyering, local and internet advertising). Seven participants identified themselves as White British and two White Other. Six participants identified themselves as married, two divorced and one widowed. Six mothers had undertaken personal therapy themselves. None were currently in therapy. All but one participant had more than one child.

The participants' daughters were aged 19-35 (mean=27 years, SD=4.91). All but one of the daughters lived away from home and four lived with a partner. The majority of participants' daughters (seven out of nine) had been in multiple therapies and the same number was undertaking therapy at the time of interview. The average number of times in therapy was two (SD=1.22). All but two of the participants' daughters had been in private therapy and three had experienced private and public-sector therapy.

2.6.3. Process of data collection and analysis

Once contact was made with potential participants via email or telephone, a meeting was arranged in order to go through the information sheet and carry out the interview. A semi-structured interview schedule was used in order to encourage the participants to talk about the topic.

Interview transcripts were analysed using guidance on carrying out IPA (Willig, 2008; Smith et al., 2009). On a case-by-case basis, each transcript was read a number of times. Summaries and descriptive labels were made along the margin trying to use the participants' words, before moving on to assign themes or labels. Relationships between themes were analysed and clusters of themes formed. A cyclical activity of checking back took place to ensure that each theme made sense

in relation to the original data. A summary table of themes, including cluster labels and illustrative quotes, was used to give structure to the data. Summary tables for each participant were integrated by looking for relationships between themes, and seeing how clusters could be condensed. A narrative summary based on overarching themes helped to sift out the most salient findings from the research. From here, illustrative examples of shared experiences were identified from the participants' quotes along with those that were distinctive or contradictory.

2.7. Findings

This section presents two emergent, over-arching themes, which aim to shed light on the mother's experience of having an adult daughter in therapy and how she manages the process. The first theme, *managing the process*, describes the sense-making activities and coping-strategies that mothers appeared to engage in when responding to their emotional and relational experiences. The second theme, *the mother's vicarious therapeutic journey*, explores the mothers' experience of the daughter negotiating the mother-daughter relationship, the mothers' responses to their daughters' stories and the therapeutic change process sometimes instigated for mothers.

By presenting the research data in this way, it is hoped to aid clarity and readability but not to reduce the complexity of the mothers' experiences. For the remainder of the paper, participants are referred to as mothers, as well as by name. This is in order to respect the significance of being a mother for the women who choose to adopt this role in their lives (McMahon, 1995; Wagstaff, 2010).

2.7.1. Managing the process

Sense-making activity

Common cognitive activities used by mothers – whilst making sense of their experience of having an adult daughter in therapy – appeared to involve questioning why their daughter needed therapy, and theorising about the cause of their daughter's difficulties.

“So in a way the whole *what have I done wrong for Alex to need so much help?* um (*hmm*), so bemused I think is the word, not sort of cross or anxious, but a bit like, you know, *I don't quite understand, why it's like this*” (Hillary).

Hillary's quote appeared to exemplify the emotional state of powerlessness, confusion and guilt that mothers experienced during their sense-making processes.

Mothers used their “expert” understanding of their daughter, and knowledge acquired through life experience, their own and others' personal therapy, reading, talking to other mothers and to professionals, as sources of information to help them to process their experience. Reflecting on the past, including upon family histories, how they had parented their daughter and their struggles to do so (e.g. being a single parent/working mum, divorce, bereavement, caring for other children, loss of income) was prevalent.

Lisa shared her experience of reflecting upon her actions as a mother:

“I was a cog in a wheel, I was caught up in it all. I suppose I could have been less emotional, you know. There were times when I cried in front of the children because it was upsetting for me and yes it would have been better if I hadn't but a large

part of that was not having anyone to confide in or talk to”
(Lisa).

Lisa referred to herself as a **“cog in a wheel”** and as **“caught up in it all”**, which suggested she felt disempowered and unable to stop the wheels in motion. Lisa appeared self-compassionate as she recognised that without a confidant she had struggled with her emotions and that her children may have been affected.

Although self-blame was often referred to in the mothers’ accounts, accepting their imperfections appeared to play an important role in helping mothers to manage their emotions.

Managing thoughts and feelings

Managing the process of their daughter being in therapy often involved cognitive processes that seemed to increase hopeful or reassuring emotions. This included putting things into perspective, looking on the bright side or comparing their situation to negative alternative scenarios. Not engaging with certain painful thoughts or memories was also mentioned by mothers and several referred to forgetting as a **“coping mechanism”**.

Mothers appeared to show caution with what and with whom they shared as part of managing their experiences. They also seemed to discount support groups. Mothers emphasised that they did not feel ashamed of their daughter being in therapy and, at the same time, stressed the lack of understanding from others and public stigma.

“You know sometimes you get so fed up of talking about it, you just want to get on with your life, you don’t want to be just someone’s mum who’s anorexic (laughs), [...] a lot of people

ask me how is she getting on now, and I'll just say, it's a slow process, and you know sometimes a couple of steps back, and then sometimes a couple of steps forward, and this is the way um recovery is for most people, in this particular illness" (Sarah).

Sarah appeared to convey some of her ambivalence about sharing with others about the details of her daughter Anita's therapy. By providing an explanation of the process of recovery, Sarah seemed to manage social perceptions and perhaps her own expectations about Anita's recovery. She also seemed to try to control the extent to which she felt encompassed by the identity of being **"just someone's mum who's anorexic"**.

Managing the mother-daughter relationship

The management of intimacy in the mother-daughter relationship and acceptance of their daughters' separate life journeys were significant aspects of this theme. The need for boundaries in the mother-daughter relationship was often described as a "self-protective" device. This sometimes included what was felt to be appropriate for sharing within the mother-daughter relationship about the daughter's therapy.

Mothers differed in their perspectives about involvement in their daughters' therapy in terms of whether it was conducive or inappropriate. Lisa and Evelyn were at opposite ends of the spectrum.

"I think she went for six months and I have no idea how it was left or what she did because I thought it defeated the purpose if I questioned it" (Lisa).

“And Vanessa said to me, you tell the lady because she couldn’t bring herself to tell. So how vital it is to have a family as a support, as a source of knowledge for the therapist” (Evelyn).

Lisa viewed the private nature of her daughter Stacy’s therapy as integral to its purpose, whilst Evelyn felt **“shut out by force”** by the NHS psychological service that did not include her in her daughter Vanessa’s therapy. Evelyn recalled her previous experience of involvement and conveyed her worry that Vanessa would not get the full benefit of therapy without her help.

Their daughter’s therapy often appeared to offer respite to mothers and to be a place for daughters to be able to discuss things that were beyond mothers’ limits in terms of subjects that felt too uncomfortable or upsetting.

“[..]like I would never read her diary (hmm), coz that’s a way of protecting yourself you see, that you don’t. Coz if she’s written something bad about you, you don’t want to read it” (Mary, 788).

Mary used the comparison of reading her daughter’s diary to knowing what her daughter shared with her therapist. Mary appeared to acknowledge that not wanting to know was a form of self-preservation as being privy to such knowledge created the possibility of contacting painful material about herself.

2.7.2. The mother’s vicarious therapeutic journey

Experience of the daughter managing the mother-daughter relationship

The mothers’ experience appeared to be impacted by how the daughter negotiated intimacy in the mother-daughter relationship. This included how much they

involved their mothers in their therapy. Some mothers experienced their daughters withdraw from them by limiting their communication, whilst others partook in meaningful discussions with their daughter about her therapy.

Sarah recalled how her daughter Anita tried to manage their relationship by indicating to Sarah when she was overstepping the boundaries.

“[..]sometimes if I probe a bit too deeply myself (*Hmm*) and try and make sense of it, she’ll go, you know when I’ve done that in the past, she’ll go, ‘*this is not helpful, it’s really not helpful*’ (*hmm*) um you know. ‘*You always want it to be what you want it to be*’” (Sarah).

Sarah understood that her interference sometimes had a detrimental impact upon Anita’s well-being and, by referring to her actions as taking place in the past, indicated that she had started to alter her behaviour. Sarah also seemed to allude to a common struggle for the mothers – accepting their daughters’ alternative perspective.

Processing the daughter’s story and re-evaluation

The experience of having an adult daughter in therapy appeared to lead mothers to reflect upon their understanding of their daughter’s perspective. The difference between mothers’ and daughters’ versions of life events was often acknowledged. Some mothers, such as Teresa, voiced concern about the accuracy of their daughters’ version of reality and how this impacted upon her therapy.

“She tells therapists things and if Sandra [daughter] sits and stews on something and daydreams and thinks about it enough then she’s not sure if it’s real or not” (Teresa).

In contrast, some of the mothers referred to how their daughter's dissimilar perspective provoked further curiosity, reflection and discussion with their daughter. Such discussions and subsequent re-evaluation sometimes seemed to lead to personal benefit for mothers in terms of changes in self-awareness, tolerance and behaviour. For example, Jane said that she found the process of discussing her daughter Heidi's therapy eye-opening and described how it changed her understanding of past events and her perception of what children are capable of absorbing:

"[...]well it's opened my eyes and made me think, well fancy I thought that she was thinking this or didn't see this happening, you know (laughs). [...] they absorb more and take in more than you think" (Jane).

On reflecting upon their experiences of having an adult-daughter in therapy, many of the mothers referred to the therapeutic process that their daughter's therapy had facilitated within them and within their daughters' relationships in general.

"[...] by helping her it helps everybody around her. You know (yes). So it's a domino effect. All the ripples" (Celeste).

2.8. Discussion

The present research provides novel insights from mothers of adult daughters with a range of issues about their experiences of their daughter being in therapy. The bias towards purely hearing from mothers who have "positive" relationships with their daughters has been eliminated by not requiring mother and daughter to participate. Future research may include cross-cultural or longitudinal approaches to data collection.

2.8.1 Reflexivity

I understand that the interviews were influenced by multiple factors which impacted on the co-construction of data. I wonder whether I entered into a “mother-daughter transference and counter-transference” (Hollway & Jefferson, 2000, p. 51.) with some mothers, especially as I was the same age as many of the daughters. If so, how might this “unconscious intersubjective dynamic” (Hollway & Jefferson, 2000, p. 52.) have affected the stories that the mothers were able to tell me? Furthermore, my concern that I had internalised a mother-blaming discourse may have led me to be overly cautious in the presentation of the research data in my attempt to convey a non-stigmatising account of mothering.

2.8.2. Contribution to theory and research

Managing the mother-daughter relationship

The mothers’ stories seemed to be saturated by ambivalence about personal responsibility for their adult daughter and her therapy. This lends support to the understanding of complexity and ambivalence in the mother-daughter relationship (Charles et al., 2001; Freud, 1933; Shrier et al., 2004). The relationship between the management of intimacy and self-protectionism in the mother-daughter relationship appears to connect with the findings that mothers adopt self-protective strategies in their relationships with their daughters (Daly, 2005; Johansson et al., 2010).

Different responses were conveyed by mothers about appropriate involvement in their daughter’s therapy. For some mothers, not being able to influence or contribute to helping their daughter was found to be very distressing. Research suggests parental involvement can have an important impact on the parents’ experience of services (Pejlert, 2001). Different factors affecting the level

of involvement desired by mothers could include the daughter's age, the severity of their daughter's difficulties or individual understandings of therapy.

Mothers sometimes reported that, as a result of being in therapy, daughters tried to establish new boundaries with them, particularly when mothers were interfering. Research suggests that in response to their daughter's difficulties, mothers can feel guilty and become overprotective (Daly, 2005; Rassamen et al., 2008). This research indicates that the mother's guilt feelings related to her daughter being in therapy might also impact upon her behaviour in the mother-daughter relationship.

Managing the process of having an adult daughter in therapy

The mothers' sense-making processes could be linked to the ways in which mothers managed not-knowing and feeling powerless over the process of their daughters' therapy. These findings support the existing research that parents of psychotherapy patients are affected by their own fantasies and anxieties about their adult-child in therapy (Hatcher & Hatcher, 1983) and highlights the experience of ongoing worry in the lives of parents who have adult-children with mental health problems (Johansson et al., 2010; Mohr & Regan-Kubinski, 2001; Pejler, 2001) and in parent-adult-child relationships in general (Hay et al., 2007, 2008). Like the parents in Lindgren et al.'s (2010) study, managing the experience of having an adult-daughter in therapy appeared to involve a process of desperately searching for meaning. Discussion with their daughters seemed to provide a particular form of existential communication (Jaspers, 1932) for some mothers.

Mothers' use of cognitive coping strategies, such as putting things into perspective and focusing on the present, were similar to coping strategies reported by parents of adult-children with mental health difficulties (Johansson et al., 2010).

The finding that mothers managed what they shared about their daughter being in therapy and voiced an awareness of stigmatising views of therapy and mental health difficulties suggests that they may have employed “courtesy stigma management-strategies” (Koro-Ljungberg & Bussing, 2009). The results contrast with the positive findings in the literature related to the benefits of social support and support groups (Johansson et al., 2010; Peijert, 2000). Different availability of social support or support groups or cultural meanings attached to attending groups in Sweden, where the aforementioned studies took place, may account for this disparity.

The mother’s vicarious therapeutic journey

Personal reflection and re-evaluation was part of the process that seemed to lead to changes in the mothers’ self-awareness, tolerance and behaviour. These findings add to the budding literature base highlighting that an individual being in therapy has positive implications for significant others (e.g. Murray, 2007). It also highlights the role of meaning-making in determining the experience of personal growth (Aschbrenner et al., 2010; Johansson et al., 2010; Muhlbauer, 2002; Schwartz & Gidron, 2002).

Differences in the ways that mothers processed their daughters’ stories seemed to mediate the therapeutic effect of their daughter’s therapy upon mothers. Those who accepted their daughter’s version of reality – even if they did not share it – seemed to gain most personal benefit. The finding of heterogeneity in this respect corresponds with Charles et al.’s (2001) research, which found differing mother-daughter relationships in terms of mothers being “enabling” or “constraining” of their daughter’s perspective. The findings support existing research that mothers sometimes struggle to hear their daughter’s version of reality due to self-

preservation (Daly, 2005; McNab & Kavner, 2001; Miller, 1991; Sayers, 1993; Surrey, 1993; van Mens-Verhulst, 1995).

Mothers in this research drew attention to the socio-cultural contexts of their mothering and how this impacted upon their ability to hear their daughters. Indeed, this research indicates that the constraints in mothers' or daughters' lives may influence the physical and emotional availability in the mother-daughter relationship, and limit opportunities for the daughter's therapy to be translated into benefits for the mother and into relational gains in the mother-daughter relationship.

2.8.3. Implications for practice

In training programmes this knowledge may be incorporated to enable trainees to challenge mother-blaming within their practice. Sharing the socio-cultural contexts in which they were mothered may assist trainees to build understanding, empathy and curiosity towards mothers who they work with directly or indirectly.

When working with mothers who have adult-daughters in therapy or with mental health difficulties, it may be helpful to:

- Encourage exploration of their experiences of being mothered, the socio-cultural contexts in which they mother and their experience of stigma. A greater insight into the impact of their life struggles on the mother-daughter relationship may foster greater self-compassion within mothers and greater empathy and connection in the mother-daughter relationship.
- Facilitate exploration of the daughter's perspective and understanding of difference and similarity. Acceptance of difference and new meanings made about any differences could help mothers to find personal growth.
- Teach mindfulness skills (see Linehan, 1993) to help mothers to accept painful stimuli, hear their daughter's version of reality and decrease

engagement in avoidant coping-strategies (e.g. forgetting, distraction) which are associated with worse psychological and health outcomes (Gross, 2002; Salovey et al., 2002; Segerstrom et al., 2003).

When working with adult daughters:

- It may be useful to assist daughters to explore the complexities of the socio-cultural context of their mothering in order to develop a greater understanding of any struggles within the mother-daughter relationship. Drawing a genogram (see Bowen, 1978) may be a useful aid for helping daughters to gain new perspectives on their life story and recognise intergenerational patterns.

As is well known within systemic practice, it is useful to be flexible about holding individual and joint sessions with mothers and daughters (McNab & Kavner, 2001). This research highlights the importance for therapists to hold onto the mother's and daughter's differing subjectivities and socio-cultural contexts.

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