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LOYOLA UNIVERSITY CHICAGO

CONNECTION, CARETAKING, AND CONFLICT:
THE RECALLED LIVED EXPERIENCE OF ADULT DAUGHTERS
OF
BIPOLAR MOTHERS

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

SCHOOL OF SOCIAL WORK

BY
LOUISE RIBEIRO PRESLEY

CHICAGO, IL

AUGUST 2009

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I applied to Loyola's School of Social Work to learn how to research, write, and share my ideas by publishing them. The faculty of the School has allowed me to fulfill my intentions and still encourages me. There are too many to thank individually, but Dr. Marcia Spira has always helped me with issues about mothers and daughters. She became member of my committee. Dr James Marley has guided my early efforts at research and also became a committee member. Dr. Randolph Lucente saw me into the School as the Director of the Doctoral Program and saw me out as my committee chairperson. When the size of my project overwhelmed me he pointed the way. He has been positive, creative, and encouraging from the very beginning of my student career at Loyola University Chicago.

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My participants persisted through multiple, then long interviews. I hope they see parts of this dissertation in print some day soon.

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For my family, Laurie Kerlin and James Presley.

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ABSTRACT

At present in the United States approximately four million people (one and six tenths percent) suffer from Bipolar I and Bipolar II disorders. Twenty percent of bipolar persons are not helped by medication. Each bipolar person has two parents, and may have siblings, friends, spouses, and children. All of these people are affected by the feelings and behavior of the bipolar person. The children are particularly vulnerable to behavior disorders, depression and anxiety, even if protective factors mitigate the family situation.

This qualitative research addresses the events recalled by adult daughters whose mothers are bipolar: what they recalled of what they thought, felt, and did in response. Events from early childhood to the time of the interview were explored. Seidman's phenomenological interview series was the model for the interview, both in the pilot study and later when it was modified into one long interview as suggested by McCracken. This study was not retrospective. It focused on the daughters' recollections and how these affected their development, their relationships, and their work or careers.

The transcripts from the two pilot study participants interviewed in two-thousand-two were included as archival material and analyzed with the transcripts from the two thousand-five interviews with the dissertation participants. The pilot study participants were recruited from a clinical setting. One dissertation participant heard about the study by word of mouth. The others responded to a newspaper advertisement. Two were twenty

five, two were in their early fifties, and the rest were between thirty four and thirty nine. Two were African American, one was biracial. The remaining seven came from a wide variety of ethnic backgrounds.

The data was analyzed using N’Vivo. It enabled comparison of themes from each life stage addressed in the interviews. These themes were recorded in forty-one tables. The most populated and enduring were role reversal, beginning in early childhood, and conflict, beginning in the high school years. Each theme persisted in the presence of the other until the time of the interviews, profoundly interfering with development, trust, intimacy, and work. These conclusions suggested both needed services and further research.

CHAPTER ONE:

INTRODUCTION

Topic

This paper first explores the current knowledge about the experience of daughters of bipolar mothers, and then reports qualitative research on the topic. Historically, social workers have recorded little involvement with families in which a parent has bipolar disease. My focus on this population grew from an interest in the contribution of early life experience to anxiety. I chose it because of several personal and professional encounters with women who grew up with bipolar mothers. They struggled with anxiety, depression and shamed silence until I knew them really well, whether they were clients or friends. I chose girls because the literature indicates they fare worse in these families, and because increased knowledge of their specific difficulties may help clinicians assist them in their parenting tasks.

Daughters of bipolar mothers may present in therapy as earnest, high functioning, anxious, depressed, guilty, and overcommitted to home, family, work, and community. They may be exhausted but view any lapse as evidence that they are like their mothers. Those who have become aware their mother is bipolar are often slow to come to therapy because they fear, realistically, that they have inherited their mother's illness. Whether or not they know their mother is bipolar they have often

internalized the content and the pattern of their interactions with her. Their distrust of their own perceptions and their distrust of others' reactions make therapeutic engagement and other relationships difficult.

The literature on families with bipolar parents is sparse and obscure. Therapists may be unaware of these women as a population and have little information that would help to normalize their clients' experiences. They may not be aware of theories that apply to the relational and other experiences the client may have had. They may have trouble assisting the client to differentiate the past from the present, especially if the daughter continues in a caretaking role toward the mother. Clinicians may lack background to help adult daughters of bipolar mothers acknowledge the positive as well as the negative parts of their relationship to their mothers and recognize legacies from both. When the adult daughter's body language contradicts her narrative, clinicians may misattribute this to abuse or psychosis. Clinicians may find it difficult to generate the information needed to help the adult daughter of a bipolar mother differentiate herself from her mother. They may not realize the extent to which the client is caretaking her mother or other family members, or the difficulty of abandoning this task. Clients may discount the therapist's knowledge of their situation, restricting the therapist's ability to be helpful and authoritative.

A literature review follows: it presents, first, epidemiological information, including the incidence of bipolar disorder and of mental health problems in the

children of parents who have it. Second, it discusses research, clinical impressions and theory pertaining to families in which one parent is bipolar. In this section I introduce three frameworks for understanding these families; the psychodynamic view, the family systems view, and the family support view.

The chapter discusses the research regarding children in families with a bipolar mother, including what is known about the experiences of daughters. To this material I add relational theories of psychological development in childhood, adolescence, and young adulthood, and the neurobiology that supports them. Because females in European-American society are acculturated to value their relationships highly, relational theories are especially applicable to girls.

I discuss pertinent issues revealed in longitudinal studies on resilience in children. I also review issues regarding memory, recall of past events, and development.

From these sources of knowledge about girls growing up in relationship with bipolar mothers, I developed research questions that were explored and clarified with research using a qualitative method based on the recalled narratives of the research participants. This is not the same as exploring what really happened, an absolute truth value, but its significance is even greater because the recalled narrative is the way adult individuals put their experience in order and make meaning of it. Meaning leads to emotion, cognition and action, to a personal way of being in the world.

I describe a rationale for using a qualitative method and a strategy for the research, define variables and other key concepts, outline their implications for data collection, and discuss the design of the instruments, the method of data collection, the population, the sampling plan, the method of recruitment and the validity and reliability of the design and the research. Finally, I address the ethical considerations and the method of data analysis. I analyze the data in the Findings chapter and let the participants speak for themselves in the Discussion chapter (V) Appendices supply copies of the survey instrument, interview guide, and other materials used in the study.

Purpose

The purpose is to introduce a qualitative study of the recalled life experience of daughters of bipolar mothers, their biopsychosocial development, functioning, and identity. Such a study has a potential to be significant for theory and practice. It may become significant for program design and mental health policy.

The existing research on bipolar families falls into several categories. Small cohorts of families with bipolar parents are included in epidemiological studies of families where there is an affectively disordered parent. The children's problems are identified and counted. These studies have an underlying assumption there are biopsychosocial causes of psychopathology that include family interaction, but the interaction itself is not addressed specifically (Kendler, Neale, Kessler, Heath & Eaves, L. (1993 a, b, c).

There are longitudinal studies of the effects on children's development of having an affectively disordered parent, with attention to the differences between the children of unipolar parents and the children of bipolar parents. These studies identify the ups and downs of children's mental health at different developmental stages and identify adverse conditions that may be associated with their difficulties.

There are studies of the interactions between parents with affective disorders and their children, including families where the parent with the affective disorder has a bipolar disorder. These studies attend to interactions in a laboratory setting. The parents and children, no matter how familiar with the researchers they might be, are still aware of being observed. There are a few studies that address specific issues like sleep problems and early childhood parenting practices.

There are two psychodynamic clinical studies of bipolar families. One focuses on the marriages of bipolar persons, the other on the family interactions. The clinical material is more contextual than the epidemiological, longitudinal, or interactive studies. Several studies found girls to be more negatively affected by having a bipolar mother than are boys.

There are a few references in the literature on resilient children to those from families in which a parent had bipolar illness. These studies have a broader attention to context and help to explain why children from families in which a parent is bipolar may have fewer difficulties overall than those in which a parent has unipolar depression.

Specific areas not addressed in the research literature are, first, the family interactions that might affect the child but do not directly involve him or her. Second, the observed interactions are unlikely to be as intense as those that occur in these families at home when unobserved. The third neglected area is the child's subjective experience of her or his parent's bipolar illness. The fourth is the adult's perception of the meaning of the recalled childhood experience to his or her daily life, identity, and his or her mental health. These issues usually only emerge in the clinical hour, and are very difficult to study by observing them when they occur. I believe a qualitative study based on participant's recall of events, responses, and the resultant meaning may assist in filling in these gaps.

New theoretical material may emerge from the participants' narratives. This will certainly be of use to the clinical social work practitioner. It may be used as well to create or endorse community mental health policies and private foundation efforts that support optimal development of children in bipolar families, specifically girls. It may be useful to other daughters of bipolar mothers, helping them evaluate and normalize their own experiences.

Rationale for this Paper in Light of the Social Work Knowledge Base

Social Work as a profession focuses on the person in her or his environment. The most important environmental factor for the development for the individual child is the family. For girls, the mother or mothering person provides the most developmentally important relationship. This relationship not only is instrumental in

determining the daughter's mental health in childhood, but affects her mental health as an adult, her motivation to mother, and shapes the style of her mothering.

The information already available from research and theoretical literature and any information that may emerge from further research should be helpful to the clinician. Both will provide a framework for intervention with families in which a parent has been diagnosed with bipolar illness. It will help the clinician to develop empathy for the adult daughter of a bipolar mother, and patience in her treatment. It will guide interpretations. It will assist the clinician in his or her efforts to work with the client about managing her relationship with her mother.

Shared with the client, it will normalize her experience and work against her internalization of her mother's difficulties, relieving guilt, shame, frustration and anger. It may place in perspective her fears of mental illness for herself and her children as well as her family's fears for her mental health. In both family and individual treatment, it will assist social workers in helping the adult daughter of a bipolar mother with the almost inevitable difficulties with parenting. It will thus work toward prevention of dysfunctional child-raising patterns in the next generation.

Pilot Study

I did a pilot study of this research in Detroit under the auspices of the Wayne State University Behavioral Investigations Committee. I taught part time at Wayne State, and took a directed study in qualitative research there. The pilot is closed but

the two participants' interview transcripts will be included in the dissertation as archival material, and analyzed with the dissertation transcripts.

CHAPTER TWO:

REVIEW OF THE LITERATURE

Demographics / Epidemiology

This section will discuss the incidence and course of bipolar disorders, difficulties in treatment, and the impact of the disorder on the patient and the patient's family. It will identify the percentages of children in these families who experience psychiatric and behavioral difficulties.

Bipolar disorders include bipolar I and II disorders, hypomanic disorder, and cyclothymia. All these states are characterized by manic and hypomanic episodes. They often include depressive episodes (APA, 1994). Bipolar I disorder affects approximately 1.1% of the adult population. It affects men and women fairly equally. Bipolar II disorder affects about 0.6%. It is more common in women (Surgeon General, n.d.). Together they affect over four million people and their families.

Onset is usually in late adolescence or early adulthood. The mean age is twenty-one. Symptoms most often start between fifteen and nineteen, and slightly less often between ages 20 to 24. Five or more years may pass between the first and second episode. Subsequent episodes occur at shorter and shorter intervals (Rapid Cycling). Diagnosis and treatment are often delayed five to ten years. Untreated patients may have more than ten total episodes of mania and depression (APA Online,

2000). Bipolar parents report 2.8 to 12.6 lifetime episodes of disorder (Hammen, Burge, Burney, & Adrian, 1990)

There is evidence that the families of bipolar patients, and the patients themselves are of higher socioeconomic status, achievement and creativity than patients with schizophrenia (Coryell, Endicott, Keller, Andreason, Grove, Hirschfield, & Scheftner, 1989). There is even stronger evidence that bipolar disorders take a striking psychosocial toll. Patients lose ground progressively in occupation, education and income. They are one half as likely to have ever been married and twice as likely to have been divorced or separated as comparison subjects. Those who are married, however, rate their relationships similarly to comparison subjects (This may be an effect of their coping style: See next section.) Those bipolar patients who had sustained recoveries during a two year research period fared no better than those who had repeated episodes (Coryell, Scheftner, Keller, Endicott, Maser, & Klerman, 1993). Among bipolar persons who are treated, approximately 20% do not respond to drug therapy. Others continue to have mild or moderate cycles of moods while on medication (Davenport, Zahn-Waxler, Adland, & Mayfield, 1984).

The children of bipolar parents experience psychiatric disorder at rates from 23% (LaRoche, Cheifetz, Lester, Schibuk, DiTommaso, & Englesmann, 1985, cited in Radke-Yarrow et al., 1992) to 92% (Hammen, Gordon, Burge, Adrian, Jaenecke & Hiroto, 1987, Cited in Radke-Yarrow, et al., 1992). The disorders represented in

these percentages are less severe than those reported for the children of parents with unipolar disorder (Hammen, Burge, Burney, & Adrian, 1990).

Even theorists and researchers who are committed to a genetic and biological explanation for affective disorders acknowledge that family environment is important in their development (Goldsmith, Gottesmon, & Lemery, 1997; Kendler, Neale, Kessler, Heath, & Eaves, 1993a, b, c). A diagnosis of bipolar disorder in a young person is shattering to the patient's family of origin. It changes interaction, emotional tone, and effectively prevents the ordinary conduct of life (Berger & Berger, 1992). Such a diagnosis is much more destructive to family life when the other family members are spouses and children who are depending on the person with bipolar disorder to fill spousal and parental roles.

Psychodynamic Views of Families with a Bipolar Parent

This section reviews three papers written by staff at the Clinical Psychology Branch of the National Institute of Mental Health in Bethesda, Maryland between 1975 and 1984. Two of these papers are based on clinical impressions (Ablon, Davenport, Gershon, & Adland, 1975; Davenport, Adland, Gold, & Goodwin, 1979). The most recent is a research study. These studies comprise the most experience-near research that I was able to locate on the functioning of families with a bipolar parent.

Ablon, Davenport, Gershon & Adland, (1975) observed couples' group treatment that began in the convalescent period after a manic episode. The most important theme that emerged was that of the recurrence of mania. Spouses viewed

mania as an expression of the patient's true feelings, under his or her control. The patients saw it as an overwhelming event, and expected the spouse to provide control. Each experienced the mania as the other's responsibility, and its return as imminent.

There was conflict between the spouses. The patient often initiated distance. Both experienced this distance with a sense of abandonment and hurt. This was not expressed openly because of fears of loss of control and abandonment. Both partners denied losses and problems. There were no attempts to communicate about feelings. This blocked the resolution of even small problems. Partners had no faith in each other, and both over-focused on the children. The triadic relationships of parenting were never formed.

There were patterns of loss in the generational families of both patients and spouses. Many patients and some spouses had lost their father before age sixteen. Less than half as many had lost the mother.

Out of a sample of forty-eight bipolar patients, twenty-one of whom were male, a higher percentage of the males remained married (86%) than the females (59%). This means that 41% of the bipolar women were divorced. If there were children, chances were reduced that there was another adult to provide care and nurturance when the mother was in episode.

The authors attributed this pattern of female spouses remaining with a bipolar man to a compulsion to repeat the difficult relationships they had with their fathers. The female spouses saw themselves as keeping the family together and correcting the

pattern of loss. Bipolar men were seen as repeating a family pattern of choosing dominant, spouses, as their fathers had done.

Davenport, Adland, Gold, & Goodwin (1979) described the bipolar family based on observations of six multigenerational families in which bipolar illness was present in two or more generations. The study was conducted at the Clinical Psychobiology Branch of NIMH. The authors believe that the malignant quality of bipolar illness is minimized compared to unipolar illness because there are periods of euthymia. (Author's note: The true scope of the difficulties suffered by members of these families may be hidden from clinicians and researchers by the family's denial, shame, and intelligence.)

Existing research presents the family with a bipolar parent as more benign than one with a parent who has unipolar depression. Despite this, the growth and development of all family members is impeded. Families of bipolar patients often adhere, but inconsistently, to rigid rules (Cohen, et al., 1954; Fromm-Reichmann, 1949; & Gibson, 1958) (All cited in Davenport et al., 1979). Smith (1960) (Cited in Davenport et al., 1979) saw a covert emotional withdrawal by mothers during the bipolar patient's infancy. Overtly the bipolar patient's family overemphasized conventionality. Finley and Wilson (1951) (Cited in Davenport et al., 1979) noted that the dominant member of the family constructed a "walled in existence" that prevented individuation and frustrated the family members. Consequently there was a high incidence of covert hostility and guilt in the family.

Families of bipolar patients avoid affect and use denial to manage family anxiety and hostility. They have unrealistic standards of conformity and performance and difficulty initiating and sustaining intimacy outside the family. The parents displace their low self-esteem on to the children. All family members worry about whether the children will inherit bipolar illness. These patterns reduce open conflict, while maintaining the cohesiveness of the family and the disturbed relationships in it (Ablon, et al., 1975). The family problems remain unresolved from generation to generation. These families seem unaware of their own needs and do not have methods to resolve conflict and solve problems.

Perhaps as a part of this pattern, they rarely frustrate their children by saying “no.” Adolescents adopt exaggerated behaviors and the maturational process is prolonged or incomplete. An expectation of perfection functions to combat the parents’ fear that the child will be bipolar. Members of these families have difficulty expressing anxiety or sadness. They may use psychosomatic complaints as an acceptable outlet for negative feelings.

Children whose parents were in the couples’ group often said they wanted their parents to continue in it. In group the families could talk about sensitive issues that were not discussed in the less structured milieu at home. Through group discussion these families attempted to avoid marital separation, breakdown of the family, and the possible triggering of another manic or depressive episode.

Davenport, Zahn-Waxler, Adland, & Mayfield (1984) conducted a study at NIMH to provide information about early child caring practices. Seven index bipolar-I patients, four men and three women, became parents of boys within four months of each other. Seven control infants were matched with the “proband” infants.

The researchers observed mothers and infants from the index and control families separately when the infants were twelve, fifteen, and eighteen months of age. They used the Ainsworth strange situation paradigm, the Block Q Sort, and home visits by staff from the Laboratory of Child Development. Staff again visited the families when the participant children were four years old, rating the global functioning of the families and doing two-hour structured interviews to assess primary problems.

The bipolar mothers were evaluated as though they were part of the same group as the female spouses. Mothers from bipolar families differed somewhat from the control mothers along the following dimensions. They were more likely to want their children to perform for others, they were more overprotective, and they were more likely to report negative feelings toward their children. They were less active in interaction with their children, less likely to attend to their children’s health needs, and less likely to encourage openness to experience. When observed they were more disorganized, unhappy, tense, inconsistent, and ineffective. According to the global functioning scores they were most organized about work. The mental status score was

somewhat abnormal, due to moderate mood cycling. The lowest scores were in family interaction and social adjustment.

These articles describe families with an anxious, non-communicative atmosphere, fearful of loss, avoidant of conflict, without good problem-solving skills, and isolated from the community. The researchers saw parents as over-focused on performance and conventionality and overprotective of the children. Communication that challenged these defensive characteristics, whether it was from spouses or children, was rejected and denied. This has a profound effect on the children's social and personal development.

Family Systems Views of Families with Bipolar Parents

The Family Support Framework Applied to Bipolar Families

Miklowitz and Goldstein (1997) adapted the family support program developed by Anderson, Hogarty and Reiss (1986) for use with families of schizophrenics, to the needs of the families of bipolar patients. The authors' research showed that face-to-face communication in bipolar families was characterized by emotionally charged interchanges. Family members' speech often became unclear when they engaged in problem solving. Negative affective relationships between patient and relatives predict a poorer course of illness and poorer social functioning for the patient. Stress precedes manic and depressive episodes.

The authors have devised an approach that allows for the development of a treatment relationship and an individual assessment of each family member. They then teach the family about bipolar illness, train family members in communication skills and finally, train them in problem-solving skills. This intervention reduces the stress in the family and thereby the number of mood cycles. It addresses directly and without blame several of the problems found in the families of the bipolar patients studied at the outpatient clinic at NIMH.

When families learn these skills, communication is clearer in the home and problem solving becomes more possible. This improves the lives of the children in the family, but their needs are not addressed directly nor are parenting issues addressed unless the family raises them.

Mainstream Integrated Family Systems View

I have formulated this description from my clinical experiences with adult daughters of bipolar mothers, the bipolar mother herself and from two published autobiographies (Lyden, 1997; Steinem, 1983).

When an adult in a family is bipolar, the family structure is altered dramatically whenever the bipolar parent enters or exits an episode. When the bipolar parent is not in episode, the family members exist in expectation of the next manic or depressive mood swing, in hope that the next episode will never come, and in denial that it will come. This complex mix of feelings and attitudes blocks family decision-making and creates important roadblocks to needed changes in family roles.

Structurally (Minuchin & Fishman, 1981), the executive function of the spousal holon is placed in limbo. The spouse who is not bipolar may attempt to involve the bipolar spouse in decision-making when he or she is going into, or is in, episode. The opposite may occur. When stabilized the bipolar spouse may be ignored or her or his judgment discounted. The non-bipolar spouse may become overwhelmed and passive or passive aggressive. Each of these distortions causes stress and risks the well being of the family and its members. Relatives and friends who may have agendas of their own, or at the least will not have to live with the decisions in which they participate, may be co-opted into the spousal subsystem.

The structure of the family is further influenced by such changes through the adult holon's management of the parenting function. The children may learn to ignore the bipolar parent or take advantage of changes in his or her mental status and behavior. The bipolar parent at times may function as a member of the sibling subsystem, playful and permissive. At other times she or he may become a harsh, rageful, resentful disciplinarian. The non-bipolar parent may attempt cooperative discipline and a structured home life for the children. This may be successful when the bipolar parent is out of episode, but inconsistency occurs whenever he or she is in episode. Therefore, the parenting is inconsistent over time. Stress may increase the chances that one parent or parent figure might become physically abusive. Divorce does not solve these problems as the absent parent continues to have an influence and remains part of the parental subsystem.

The sibling subsystem also suffers. Its members may be co-opted as members of the spousal subsystem, becoming decision initiators, or confidantes of a parent. A parent, the lover of a single parent, or a stepparent may sexualize the parent-child relationship, either emotionally or physically.

A sibling may also have to or choose to become the source of structure in the household, thus becoming a part of the parental subsystem. Those who are overwhelmed by the task of trying to parent may become verbally or physically abusive to their siblings. The cohesiveness of the sibling subsystem is subverted. This may lead to lifelong conflicts among its members over issues that would be better resolved by working together.

Subsystem boundaries are overly permeable. The family members do not know from week to week whether the bipolar person can be trusted to function as spouse or parent. The external boundary of the family is in question. Is the bipolar person a member of the family at all times, or just when not in episode? Is she or he to be ignored when in episode? Should there be an actual divorce?

Boss (1999, 1991) addresses these issues, terming them “ambiguous loss.” Her insights are developed from the analysis of family and individual narratives. Ambiguous loss occurs when a person is physically absent but psychologically present, as in the case of a missing person. It also occurs in situations where the person is physically present but psychologically absent, as in chronic life-threatening illness, coma, dementia, and other mental illness. She sees ambiguous loss as the

most stressful type. She states that the more uncertainty exists regarding whether the loss is real and permanent; the more difficult it is to come to terms with it. Unresolved ambiguous losses result in denial, depression, anxiety, somatic symptoms, and family conflict. Family members feel helpless and cannot plan wisely for the role flexibility needed to cope with the changes brought about by the ambiguous loss.

A spirituality that frames change not as catastrophic but as a normal part of life facilitates this role flexibility. So does treatment that emphasizes the ambiguity of the loss, not the family members' behavior, as the cause of the problems the family is having.

Persons who experience ambiguous loss experience conflicting thoughts and feelings. These conflicts result in personal and family tension that freezes the capacity to make decisions, act in a situation, or let go of attempts to control it. This ambivalence is less an internal conflict between two ways of feeling than it is a conflict between cognition and emotion. It results from not knowing who is inside the family. This cognitive difficulty leads to internal emotional conflicts and interpersonal conflicts as family members anticipate future losses from further episodes of mania or depression. It is as if the conflict will buffer the anticipated loss. However such conflict leads to guilt and blame when the bipolar parent does decompensate. Family members may differ as to whether the bipolar person is in or out of the family, and this may lead to increased conflict in the extended family. This

diminishes the family members' ability to support each other in adapting to change and may alienate the children. At the very least it teaches them a negative style of coping.

The clinical social worker, when treating the family of the bipolar person, the adult child raised in such a situation, or even a child, will find many of Boss's suggestions useful for treatment. Most important is communicating to the client(s) that the loss is indeed ambiguous and that ambiguous losses are more stressful than those that are clear-cut. Feelings should be explored, verbalized, and clarified, and this process should be carried into multigenerational family meetings.

The clinician should be prepared to provide a setting and structure for these meetings so that family members have an opportunity to hear each other's views of the problem and the meaning each makes of it. If the clinician is not trained for this task, he or she should try to find someone who is and refer the family to them. These meetings will help the family work through denial and their fear of conflict and loss. It will allow them to verbalize and clarify their feelings even if the feelings are mixed.

The clinical social worker should provide knowledge of the problem causing the ambiguous loss. In a family with a bipolar member, that would include knowledge about the disease, its treatment and the variations in its probable course. The clinician should also provide help in locating resources for information, support, and other assistance, if available.

The meetings should also address the family identity, its cultural, generational and individual sources of meaning. Sharing individual perceptions of this meaning and identity will assist the family in deepening and changing itself. Meanings may include ideas and feelings about blame and responsibility, need for mastery, response to the unexpected, spirituality, and sense of community or isolation. The existing family rules and roles should be clarified and grounded in the sources of family identity.

In preparing the family to begin changing roles and relationships, the clinician needs to communicate his or her understanding that there is no perfect solution. She or he should model and process the need to “temper our hunger for mastery (1999, p 107).” He or she should encourage the family’s appreciation of the elements of humor that are inherent in the ambiguous loss situation.

It is part of the clinician’s role to provide support to the family as they begin to change roles and relationships. The clinical social worker needs to help the family find ways in which the bipolar person can continue to participate in family life. The clinician should encourage the reconstruction and observance of family rituals and celebrations, once the meaning of the loss as it affects the celebration is understood. Once the family sees that it is possible to change its behavior without losing the bipolar person, the clinician should encourage redefinition and sharing of care giving and necessary family roles.

Above all a clinical social worker treating such a family should be very aware and accepting that change might be too difficult. As a result all or part of the family may exclude the patient.

Research on Problems of Children in Bipolar Families

In this section I discuss six research studies that focus on the children in the family with a bipolar parent. These studies cover a variety of areas that do not display much cohesiveness.

Zahn-Waxler, Mayfield, Radke-Yarrow, McKnew, Cytryn, & Davenport (1988) studied seven male babies who were born at approximately the same time to families in the NIMH clinical research project that generated the articles reviewed in the previous section. These children were studied in their first two years of life, at five, and again at six. Three had bipolar fathers. Four had bipolar mothers. Five of the spouses were diagnosed with unipolar depression; one had “war neurosis” and was a substance abuser. Behavior patterns that were evident when the children were toddlers were present four years later.

The children had difficulties with empathy, role-taking and conflict resolution. At six, the children had depressive symptoms and antisocial orientations that resembled the behavior of the bipolar parent. Some children showed different problems across the two time periods: others’ problems remained the same.

The researchers attempted to identify the stressful life events that occurred in the children's homes. They identified "disorganization, bizarre events, unpredictability and alienation (p. 508)." This study attempts, among other purposes, to elaborate on these problems and their specific consequences

Stoleru, Nottelman, Belmont, & Ronsaville, (1997) studied children in a sample that included families with bipolar mothers. Children from families with mothers who had lifetime diagnoses of bipolar disorder had more sleep problems than children in a control group, but fewer than those whose mothers had unipolar depressions. Children of bipolar mothers had slightly more sleep problems if the current, rather than the lifetime diagnosis was used as the variable defining the groups. Older children had more sleep problems than younger ones.

In families where one child had sleep problems, siblings did too. The sleep problems were not concurrent with a psychiatric disorder except in older children with behavior disorders, and they were not predictive of a later diagnosis.

Hamilton, Hamilton, Hammen, Minasian, & Jones (1993) found that mothers with bipolar affective disorder were less likely to have a negative affective style than mothers with unipolar depression. A negative affective style predicted both relapse and lowered social functioning at follow up. Coping style is a response to affective style and may be benign, characterized by autonomy and neutrality, or negative, characterized by criticism of self and others and self denigration.

The child's communication is linked both to the mother's affective style and to his or her own depression. Child depression is related to the child's critical coping style. The mother's negative affective style is linked to the child's criticism of her. The researchers interpreted this as suggesting that a child's negative coping style produces poor interpersonal relationships with a mother who has an affective disorder. These poor relationships tend to maintain the child's affective disorder. There was no comment as to the origin of the child's coping style.

Inoff-Germain, Nottelman, and Radke-Yarrow (1997) examined family, dyadic, and individual functioning in families in which the mother had a history of affective disorder. The mothers in ten of these families had a diagnosis of bipolar disorder. Both bipolar and unipolar mothers functioned significantly worse in the previous year than the control mothers.

The bipolar mothers in the group were the angriest.

Bipolar mothers of sons, especially younger sons, were the most chaotic. In the study bipolar mothers were strong in expression of feelings and involvement with both older and younger children.

Younger children of bipolar mothers had the highest rates of problems during family interaction. Older children of bipolar mothers had high rates of clinical problems, but low rates of interaction problems. This suggests that younger children externalize, and older ones internalize.

One third of the bipolar mothers had extensive symptoms, but the remainder functioned quite well in family interactions. The authors concluded that the problems in mood and behavior that are part of a history of parental affective illness do limit the effectiveness of family functioning, but many, especially bipolar mothers, seemed to function competently in family interactions.

Tarullo, DeMulder, Martinez, and Radke-Yarrow (1994) looked at affective communication patterns in families where there was one sibling in the age group eight to eleven years old and one in the age group twelve to sixteen years old. The mothers had unipolar or bipolar illness or were well controls. Mother and child behavior in interaction were clearly linked to maternal diagnostic status and child problem status.

With younger children bipolar mothers tended to be less engaged in interaction than well mothers. Preadolescents were more comfortable and happy with well mothers than with affectively ill mothers. Children with both externalizing and internalizing problems demonstrated more difficulties in interaction with their mothers. Affectively ill mothers were more likely to focus on psychological issues regardless of their children's psychiatric status.

Among adolescent offspring, those with bipolar mothers were less comfortable and happy than those with unipolar mothers, especially the children who had no problems in the past year. The reverse was true with younger children.

Both bipolar and unipolar mothers were less engaged with their daughters than with their sons. Among mothers and daughters, there was a higher incidence of critical or irritable behavior when there had been a recent maternal episode of affective disorder. The authors concluded that the affectively ill mother had boundary problems and could not tolerate her adolescent daughter's need to have her own identity, self-esteem, and autonomy.

Radke-Yarrow, Nottelman, Belmont and Welsh (1993) observed and coded the affect of unipolar depressed mothers, bipolar mothers, and nondepressed mothers and their children twice for two and a half hours each at an interval of two weeks. Unipolar mothers expressed the most negative affect and bipolar mothers expressed somewhat less, but both expressed more negative affect than nondepressed control mothers.

Depressed mothers of sons displayed a degree of negative affect comparable to the control mothers. Depressed mothers of daughters displayed more negative (sad, anxious, downcast) affect than depressed mothers of sons.

Children displayed twice the negative affect that mothers did. Boys were significantly more angry and irritable, girls more anxious and sad. The differences did not correlate with maternal diagnosis. Depressed mothers' children's affect was more stable across the two observation periods than that of the children of bipolar mothers. The gender differences were thought to be associated with inputs from both mother and child.

From these studies it is clear that children who grow up in families with a bipolar parent have difficulties that last at least until adolescence. If the bipolar parent is the mother, a daughter is more at risk than is a son. I was unable to find any research that followed children in bipolar families into adulthood.

A Relational View of Development

This section addresses the relational quality of human development, focusing on women. I will apply the developmental theories created by feminist scholars at the Stone Center and elsewhere over the last thirty years to the situation of children in a bipolar family, specifically daughters. I will support these theoretical insights primarily with Siegel's (1999) integration of neurobiology, developmental research and child psychiatry, and to a lesser extent with the work of other researchers. This discussion will clarify to a degree the impact of maternal manic and depressive episodes on the development of their children, especially daughters.

Feminist theorists have questioned existing models of development, especially their applicability to the development of females. Miller (1984) (Cited in Jordan, 1997a) states that the received view of the "self does not seem to fit women's experience." Gilligan (1982) (Cited in Jordan, 1997a) argues that this failure of fit may indicate a problem with the representation of self, because it omits the ethic of interpersonal care so important in the lives of women. Chodorow (1978) (Cited in Jordan, 1997a) points to the importance of the early and long lasting bond in the mother-daughter dyad because it creates a different experience for boys and girls. In the development

literature she finds that infants of both sexes who develop a strong attachment to the mother are more likely to respond to other important people in their lives, including their fathers. When girls' ties to their mothers are conflictual, Stiver (1991) hypothesizes that this is because husbands and fathers often devalue women. The girl does not want to be denigrated, so she constructs herself in opposition to her mother.

At the Stone Center at Wellesley College, feminists Jordan and Surrey (1986, 1997a), Surrey (1985), Jordan (1984, 1985, 1987), Miller (1984), Kaplan (1984), and Stiver (1984, 1991) continued over time to develop a relational perspective for development, especially women's development. In this perspective, relating, collaborative initiative, and responsiveness are the central dynamics in women's lives, and perhaps those of men (Jordan, 1989). This means that the primary feature of the developing personality is an increasing empathic responsiveness that poses a challenge to the inner sense of an inviolate self. Boundaries are altered; "subject" and "object" become indistinguishable. Siegel (1999) in The developing mind, his integration of neuroscience, developmental science and psychiatry, supports the Stone center theories, in a parallel pathway.

At the extremely early age of one to two days, infants resonate to each other's distress by crying along with another distressed infant. Female infants are more likely to do this than male infants (Sagi & Hoffman, 1976, Simmer, 1971) (Cited in Jordan, 1997a). Women's identities are constructed in relationship to important others (Gilligan, 1982) (Cited in Jordan, 1997a)" and consist of dynamic interactional

interplays of attending and responding to others. This relational self is present in infants of both sexes but cultural beliefs about girls and boys cause girls to augment the relational self and boys to systematically diverge from it (Miller, 1991).

Siegel (1999), states that an “inborn system in the brain...evolves in ways that influence and organize motivational, emotional and memory processes with respect to significant care giving figures (Bowlby, 1969, cited in Siegel, 1999, p.67; Stern, 1986)” to enable the infant to survive. The infant does this by interactionally using the mature functions of the parent’s brain to organize its own processes. Parents’ emotionally sensitive responses, repeated, help the infant to establish patterns of amplifying positive emotional states and soothing negative ones. Through this “attachment system (Siegel, 1999, p. 68)” the infant seeks proximity to the parent whenever it senses danger. As the child increases in abilities, possibilities, and new understandings she remains within the primary attachment system, rather than becoming autonomous as Erikson and others have suggested (Stern, 1986). The developing child, especially the girl, needs relatively consistent responses within the attachment relationship. A mother’s bipolar-disordered behavior presents the child with a wider than optimum variation in response.

Miller and Stiver (1997) define relationship as a “set of interactions that occur over a length of time (p. 26).” A relationship may be composed of connections or of disconnections or more usually, both. A connection is an “interaction between two or more people that is mutually empathic and mutually empowering (p. 26).” A

disconnection is an “encounter that works against mutual empathy and mutual empowerment (p. 26).” In this theory the basic processes of growth in relationship are mutual empathy and mutual empowerment.

In relationship connections both parties more fully recognize their own feelings and thoughts and the feelings and thoughts of the other. This validating and growth-producing experience enhances energy and enables action inside and outside the relationship. It contributes to self-knowledge and knowledge of others, and increases the participants’ sense of self worth. The individuals feel more connected and want to be even more connected. This empowerment process inherent in mutuality leads to personal growth. Both parties have to be able to engage with each other in empathy for this process to take place (Miller & Stiver, 1997, Siegel, 1999).

Siegel (1999) states that when the parties to empathic connection are parent and child, repeated mutually empathic or “attuned” interactions create patterns of brain function, developing the child’s ability to self-regulate.

There are many minor disconnections all through life. The key factor that facilitates growth when there is a threat of disconnection is that the child or adult can take action to reconnect or re-attune. She can represent her experience and the others in the relationship can respond to this action in such a way that it leads back toward a reconnection (Miller, 1988).

If a child’s mental model of attachment prevents a reconnection, the development of behaviors like exploration, play and wider social interactions will be

impaired. Children may have different mental models of attachment for each parent. Interactions with parents directly shape the neurobiology of the infant's brain in ways that reduce distress, control his or her behavior and organize the self. Neural pathways are enhanced by repetition of similar interactions (Siegel, 1999). These enhancements may shape either a model of positive interactions or a model of negative ones. Language provides an increasingly accurate way of representing experience (Nelson, 1986). When the bipolar mother is in episode there will be times when the child's attempt at reconnection will fail.

If one person in a relationship has more power than the other, it is more difficult for the less powerful person to bring about a mutual engagement. The most difficulty occurs when there seems to be no possibility of engaging with the immediate feelings and thoughts within the relationship. The more mutually engaged interactions we have, the more chances we have to develop a strong base of psychological resources. The fewer we have the more likely we are to feel ineffective and undesirable (Miller & Stiver, 1997). Parents have more power than children. Children who try to reconnect with their parent and are rebuffed develop a sense of their ineffectiveness and unworthiness. They are unable to expand and clarify their thoughts linguistically, stifling development of communication skills (Miller & Stiver, 1997). The bipolar mother, when in episode, is much less likely to be able to allow for a reconnection. She may be too depressed to attend, or in a manic phase, grandiose, angry and threatened by the child's attempts to reconnect, insisting on her

own version of reality. Since infants are equipped to relate to others from the earliest hours of life (Stern, 1986; Siegel, 1999) the bipolar mother in episode may perceive the infant's attempts to relate as threatening and may ignore, or worse, rebuff them.

Jordan (1997b) sees the need for emotional connection as a primary need. If it is met it leads to growth: "Initiative, creativity and responsiveness; clarity of perception and desire, the capacity to act with intentionality, and the capacity to effect change (P. 143).

If the need for emotional connection is not met, the need to feel special is substituted. Narcissistic people do not let others have an impact on them, and they do not take joy in the growth of others. They try to become invulnerable and strictly limit their responsiveness to the reality of other people. When they are injured in an interpersonal relationship they become enraged. This is a process that Zahn-Waxler, Mayfield, Radke-Yarrow, McKnew, Cytryn, & Davenport (1988) documented in the children of depressed and bipolar mothers.

Persons who are not narcissistic and for whom much of the primary relational need has been met, as they mature, tend to take responsibility for relationship failure, as Inoff-Germain, Nottleman, and Radke-Yarrow (1997) noted of the older children of bipolar mothers. They feel ashamed, "a felt sense of unworthiness to be in connection (Jordan, 1997b, p.147)." They experience a lack of empathy in others, a feeling of exposure, defectiveness, and isolation. They feel more involved and more vulnerable

than their relationship partner. Jordan (1997b) views Western culture as preoccupied with control. Feelings of shame result from a perceived loss of control.

A person who is ashamed is immobilized to some extent in all his or her relationships, and there is a greatly reduced chance of reparative interaction. This increases the sense of helplessness, and along with it, the sense of shame. Euro American cultures use male standards of maturity and functioning to devalue and marginalize women's reality. Women care deeply about their relationships; therefore they are very vulnerable to shame when they feel they have let others down. A social function of shaming is to silence, a powerful method of oppression because it invalidates a person's trust in his or her own perceptions. If a person has had enough of her or his relational needs met in a primary relationship in childhood, she or he might be able to understand both persons involved in the relationship well enough to define the characteristics of both that led to the breach in the relationship. For such a person, the experience of shame might increase his or her ability to empathize (Jordan, 1997b).

However, if relationship failures occur too frequently in childhood, a lifelong sense of shame and a pattern of isolation may develop (Jordan, 1997b). Attachment relationships are the crucial environmental factors that create a child's unique patterns of synaptic connections as the brain develops. The behavior of caregivers directly shapes these patterns (Siegel, 1999).

Mothers who suffer from varying degrees of bipolar disorder differ in their ability to provide complete engagement in an attachment relationship. Their success in doing so depends on the character, intensity and frequency of their mood swings, and their ability to acknowledge their illness and seek treatment. It also depends on their response to medication, and the support provided by other adults in their environment.

Chodorow (1978) identifies two ways in which a family may contribute to shame and disempowerment. The first may occur when the girl is three to five years old. The mother may model behavior that shows women should focus their energy on the growth and development of men. This may cause conflict between mother and daughter, interrupting the mutuality of their attachment. She also suggests that if the father's behavior denigrates the mother, the girl will not identify with her, thus again interrupting the mutuality of their attachment. The first of these patterns occurs when a bipolar mother puts the needs of her partner ahead of the needs of the children. The second occurs when the father or male partner of the mother is verbally or physically abusive to her (Lyden, 1987).

Miller (1988) identifies three family patterns that emerge from and perpetuate non-mutual family relationships. The first is the sort of secrecy that denies an unacceptable reality. The second is inaccessibility of the parents. The third is parentification of the children. These three patterns restrict connection, and underlie

many psychological problems. All of them may be present in the family with a bipolar parent (Lyden, 1987; Steinem, 1983).

Even in late adolescence, girls attempt to engage parents in conflict without disturbing the essential relationship qualities of care and commitment. If they are able to do this, girls move toward being able to do the same in their adult relationships. Young women tend to want to move into any relationship to confront differences, rather than maintaining distance through indifference, withdrawal, diffidence, or false compliance. The relational process between parents and daughter becomes a model in the daughter's relational self. This attachment pattern builds on earlier ones (Siegel, 1999). Daughters work toward finding ways to fulfill their own aspirations without damaging the ties to their families (Kaplan & Klein, 1991). This becomes exceptionally difficult when the daughter's primary parent is a bipolar mother whose response to her daughter's anger may be based on poor reality testing and be out of proportion to the event that occasioned it.

In this paper I argue that when a girl's mother has bipolar illness, there will be disruptions in the relationship between mother and daughter. These disruptions will be difficult to repair because of the discontinuity between the bipolar mother's mood states. The daughter will be liable to dysfunction as she struggles with feelings of loss of control, shame, inferiority, and distrust of her own perceptions. If she has other people who are able to engage in collaborative, consistent, empathic communication, especially adult women, in her intimate circle, this may ameliorate her difficulties.

She may “earn” security and autonomy by careful relationship choices including therapy during adulthood (Jordan, 1997b, Siegel, 1999). However, she is often prevented from doing this by shame at her inability to reconnect reliably, or by a realistic fear that she has inherited her mother’s bipolar disorder.

Resilience

Werner and Smith (1992) define resilience as the opposite of vulnerability, as an ability to resist stress, due to environmental and constitutional factors. Development is not adversely affected even when there are important disturbances and failures in the environment. Environments may facilitate or impede development. They may include specific learning opportunities. They may connect the child to the social system and culture. The degree of environmental facilitation may vary among developmental domains. Protective factors are specific conditions that reduce the effects of environmental stress on the person. They have no observable effect when risk is low. This section will address the vulnerability of children from homes where there is parental psychopathology, family dysfunction, and poverty. It will also address the factors that tend to work against these impinging stressors. The first two negative factors apply to families in which the mother has bipolar disease and the third frequently applies.

Werner and Smith (1992) studied, over a period of thirty-two years, a cohort of five hundred five children born in nineteen fifty-five on the Hawaiian island of Kauai. The goal of the study was to document historically the course of all

pregnancies in the community and the individuals' development until adulthood.

The study participants varied ethnically, including those of Japanese, Philippine, and Hawaiian descent. The majority of the participant infants were not "high risk." Their homes were supportive, their lives were not unusually stressful and they had no serious learning, mental health, or legal problems.

The high risk segment of the population, about one third, or one hundred sixty-eight, had perinatal stress, grew up in poverty, had parents with little formal education, and/or lived in disorganized family environments marred by discord, desertion, divorce, parental alcoholism or mental illness (Some of these families had a parent who suffered from bipolar illness). Two thirds of the one hundred sixty-eight encountered four or more of these factors prior to age two. These were the children who developed serious learning or behavior problems before age ten, or had a record of delinquency, mental illness, or pregnancy by age eighteen. These figures differ slightly from the earlier account, published in 1986. In that report, only one-quarter were doing well.

The remaining third developed into competent, confident adults. When the high-risk children elicited predominantly positive responses from their environment, they resisted stress. When the responses were negative, they were vulnerable.

Werner (1986) identifies four categories of postnatal psychosocial risk. These are family dysfunction, illiteracy, parental psychopathology, and poverty. Researchers agree that risk is a comparative and relative term. It describes the possibility of a

current or future developmental hazard or handicap that at present is uncertain (Ramey & Trohanis, 1982) (Cited in Werner, 1986). These authors agree that to pinpoint this developmental risk, they must relate the child's strengths and weaknesses to the environment's support of the child's development toward social norms (Sameroff & Seifer, 1983) (Cited in Werner, 1986). They agree that the probability of negative outcomes is not constant from one individual to another. This probability varies according to the transactions between risk factors and various environmental circumstances that the child experiences (Pollitt, 1984) (Cited in Werner, 1986). There are several transactional models that may be used to describe and evaluate these factors. In all these transactional models, the family characteristics emerge as decisive. However, the family's competence situates within holding systems at various levels that also demonstrate important effects. Included are local phenomena related to the family or community, to local, state, or national government, and multinational political or natural catastrophes. All of these entities are contained within impinging cultures that may impose stressors of their own. Werner and Smith (1992) observe that as the amount of stress accumulates in a child's life, the need for protective factors in the children's care-giving environment increases if positive development is to be ensured.

For women the researchers found that no single stressful life event in infancy contributed much to poor adaptation at age thirty-two. The exception was below-average psychological status at age two. Between ages two and ten, the most

damaging factors were the death of the mother, the prolonged absence of the father, and chronic conflict between the parents. In adolescence financial problems, teenage pregnancy, teenage marriage, and conflict with peers created the most damage. Girls were more resilient than boys overall. They were, however, at their most vulnerable in their second decade of life.

The most significant protective factors for both sexes were characteristics of the individual that elicited positive responses. Infants who were highly active, sociable, and free from distressing habits, toddlers who were autonomous and socially competent, school age children who were academically competent, all fared better. Indicators of resilience changed through the individual's development. At age ten the absence of serious behavior problems was important. At age eighteen, high self esteem, internal focus of control, and realistic educational and vocational goals indicated resilience. By age thirty-one or thirty-two a low level of distress and emotionality was the key indicator (Werner & Smith, 1992).

In this longitudinal study both biological and psychosocial risk factors were studied. Among those children who experienced four or more risk factors before the age of two, three-quarters developed serious learning or behavior problems by age ten. These same children at age eighteen had delinquency records or serious mental health problems. The remaining one-fourth of the children developed into stable, mature, and competent young adults (Werner, 1986). As noted above, these numbers differ slightly from those in the 1992 account.

Parental competence, especially in the opposite sex parent, and a variety of sources of support in the family, neighborhood, school, and community mitigated stress. Spirituality was an effective buffer. Individuals' dispositions led to the construction of environments that supported and rewarded the individual's strengths.

The family with a bipolar mother experiences at least two of Werner's (1986) categories of risk, psychopathology in a parent and family dysfunction as a result. When the bipolar parent is the mother, such a family, according to the demographic literature cited above, has a good chance of experiencing poverty as well (Coryell, Scheftner, Keller, Endicott, Maser, & Klerman, 1993).

Kaufman, Grunebaum, Cohler and Gamer (1979) studied children of schizophrenic mothers identified four years earlier for a study of home nursing aftercare. They found that the lowest-functioning mothers had the lowest functioning children, but the highest-functioning mothers had some strikingly competent children. These competent children had warm relationships with their mothers and extensive contact with an adult outside the family. These findings are congruent with the findings reported in the 1992 Werner and Smith study.

Daughters of bipolar mothers will be likely to demonstrate resilience factors similar to those of other high-risk populations. If the mother at times has better reality testing and engages with her daughter in a positive way, a higher degree of resilience may be present.

Memory: Recall of Childhood Stressors (Not exclusively trauma)

This section will address the issues attendant on using adult narratives of childhood and earlier adult events as research data. Siegel (1999) defines memory as “the way past events affect future function (p.24).” The brain is composed of web-like neural networks that are capable of firing in an infinite number of patterns. The more the network fires in a similar pattern, the more probable it becomes that it will do so again. The specific pattern of firing is “information.” Retrieval activates the original network in a similar, **but not identical** pattern to the activation from the original experience. Thus, the narratives generated in this study are not evaluated as an accurate representation of the participant’s past, but as similar to it.

Parkin (1999) reports that research now shows that there are two basic kinds of memory. *Short-term store* (STS) is the type of memory that allows us to remember the beginning of a sentence while completing it. Other types of memory can be gathered under the rubric of *long-term store* (LTS). The process of transferring memory from STS to LTS is known as *consolidation*. This process is not well understood but researchers think that the formation of new memories in LTS involves permanent alterations in synaptic connections between *neurons*, or nerve cells, as noted in Siegel. Acetylcholine is the chemical agent of this process of connection. Scopolamine, alcohol, benzodiazapines, marijuana, and sudden shocks or interruptions, as in traumatic events, can disrupt the consolidation process.

Long-term store is often presented as having three components. These are procedural memory, semantic memory and episodic memory. Procedural memory or implicit memory refers to the process of retaining a skill or pattern of events. It uses parts of the brain that do not need conscious processing to encode or retrieve a memory (Parkin, 1999; Siegel, 1999). The distinction between semantic memory and episodic memory is unclear. Semantic memory appears to refer to material learned through the medium of language. Episodic memory appears to relate to material learned experientially. However, since experience contains language, the issue is complex. If we are asked a personal question we might answer in terms of our general knowledge about ourselves (semantic), or based on recall of a specific experience (episodic). In order to deal with this problem these two categories of memory can be subsumed under the term declarative memory or explicit memory (Parkin, 1999; Siegel, 1999). Narratives generated in response to the interview guide in this study may contain material related to all three kinds of memory. In describing how she has related to her mother and others, the participant describes a procedure that may or may not be conscious.

Memory is not a passive process where every moment is faithfully recorded. Instead it is selective in order to be efficient. Everything we experience may initially be in STS, but it is never consolidated.

The more we process the meaning of what we experience, the more we are likely to be able to remember it. Conversely, if we are having difficulty understanding

something we will have difficulty in remembering it. This is the reason we often have less trouble remembering negative events than positive ones. In order to classify an event as negative, we must understand it. Its negative qualities stand out in our mind, and we remember it (Parkin, 1999; Siegel, 1999). Due to this process, the narratives generated in response to the interview schedule may include a preponderance of negative events. A metastudy of thirty-nine studies of retrospective recall of adverse events, from 1980 to 2001, concluded that retrospective reports of serious conflict, abuse, or neglect are valid enough to be usable, but only if they can be operationalized. Details separate from the narrative of the event were not nearly as valid (Hardt & Rutter, 2004).

Retrieval of memories is a reconstructive process. The act of remembering is begun with some type of cue. These cues are often organized in *schemata* or *scripts*.

A *schema* is a mental model of the world based on past experience. The process of creating schemata begins in the first days of life, at least in implicit memory. Explicit memory is what we usually experience as remembering. Schemata are used as a framework within which we retrieve specific information. The purpose of these schemata is to enable us to anticipate what will happen in the future. (Parkin, 1999; Siegel, 1999).

Schemata are one way in which distortions are introduced into memories. Individuals use their own views of the world when trying to make mental models or organize facts they are trying to remember. They may forget what does not fit into

their worldview, rationalize regarding things they may either not understand or believe, and fill in gaps (Parkin, 1999; Siegel, 1999; Nelson, 1986). Nevertheless, schemata guide all our behavior, since as Siegel (1999) comments above, memory is the way the past shapes function our present and future functioning.

The two forms of remembering germane to this study are recall and cued recall. In recall a person tries to retrieve a memory unassisted by any cues. In cued recall the person is given specific cues to help with recall. Recollection is a variant of cued recall in which context is the part of the process of reclaiming a target memory (Parkin, 1999). The interview guide frames questions in terms of life stages that act as cues to context. The narrative cue refers to “something that happened.” In the pilot study this pattern of inquiry has reliably resulted in an autobiographical narrative, although the participants varied in how easily they recalled the material. This might be because autobiographical narratives are more easily recalled if they have been processed repeatedly with primary caregivers (Siegel, 1999). Adult daughters of bipolar mothers may or may not be able to talk with their mother about specific incidents. In the pilot study they were more likely to have talked with siblings or adult relatives such as their father or aunts, uncles, family friends or professionals.

People who learn or experience while in a mood state, will remember better the parts of the material or experience that are congruent with that mood (Parkin, 1999). Each participant interview generates a mood that stimulates further recollection.

Memory can be implicit or explicit. In implicit memory, past experience influences memory even though the person is not aware of it. In explicit memory a person consciously recognizes or recalls material or experience (Parkin, 1999). The former operates in shaping the relationship with the mother, past and present. Participants are more likely to respond to interview guide questions with explicit memories. However, the final interview draws more on implicit memories that shape relationship.

Memories are easily and frequently lost or altered. About half of the information learned or experienced is forgotten within twenty minutes, and eighty percent within a month (Ebbinghaus, 1885) (Cited in Parkin, 1999.). Material may be inaccessible due to a change in context or mood. Information may not be “meaningfully encoded (Parkin, 1999, p 35).” Storage failure may occur because of consolidation failure due to intoxication or shock (both physical and from extreme terror). There may disruption to the memory once it has been transferred to long-term store. Old memories may disrupt new ones, or vice versa. Material apparently lost through interference may be spontaneously recovered later. Emotion and participation usually make memories easier to retrieve, and vice versa (Parkin, 1999, Siegel, 1999).

Not only may material be forgotten, it may be remembered incorrectly. Although using a variety of retrieval strategies may increase the accuracy of memories, information provided after an event may “over-write” the first and more accurate memory. Memories also may be influenced by the input of those in authority

and other relationally important persons (Parkin, 1999). Inaccurate memories feel the same as accurate ones to the person experiencing them (Siegel, 1999). If a bipolar mother cannot process and confirm her children's memories, the children may adopt the version she favors.

Even though most people cannot explicitly remember their childhood prior to the development of episodic memory between age two and three, characteristics of the child's relationship with a primary caregiver will be encoded into implicit memory in a generalized way. When faced with an interpersonal situation that resembles the parent-child relationship, the infant will base behavior on the implicit schema (Siegel, 1999).

The adult daughter of a bipolar mother will organize her early implicit and later explicit memories in a way that is characteristic of the meaning she assigns to those memories. These meanings are the driving force behind adult personality organization and behavior. They are more important than the events themselves.

An adult narrative of childhood episodes, then, is not an accurate depiction of the childhood of the narrator. Instead it provides information that has been recalled (reconstructed from LTS) within the framework of meaning of the narrator. It is a record not of events but of the meaning of the events to the person who experienced them. It is reflective of the meaning derived in the current moment. It also reflects the continuity of mental models developed over the individual's lifetime (Parkin 1999;

Siegel, 1999). This meaning illuminates statistics on depression, anxiety, and resilience with the “real” of those who have lived with bipolar parents.

CHAPTER THREE:

RESEARCH PLAN

Potential Significance

Specific lacunae exist in the research literature. First is attention to the family interactions that might affect the child but do not involve the child directly. Second, researchers' observations of family interactions are unlikely to be as intense as those that occur in these families at home when unobserved. The third area that has not been addressed is the child's subjective experience of the parent's bipolar illness. The fourth is the adult's perception of the meaning of the recalled childhood experience to his or her daily life and identity, including his or her mental health. These issues usually only emerge in the clinical hour, and are very difficult to study by observation or contemporaneously. I believe that a qualitative, phenomenological study of participants, memories of past events may provide a heuristic for a long-term look at how growing up with a bipolar mother affects a woman (Heineman Pieper, 1989).

Rationale for a Qualitative Method

Quantitative studies have provided only glimpses of the experience of children in the home of a mother with bipolar disorder and summaries of the results of that experience in terms of emotional distress and behavior problems. Often the results of

this research do not differentiate children of bipolar parents from the children of depressed parents. The global understanding of what happens as a result of growing up with a bipolar mother is of some use to social planners. It is not helpful to a clinician who is working with the adult daughter of a bipolar mother or to a family in which the mother is bipolar.

There are five persuasive reasons to study this problem and population using qualitative methods. The first is the retention of contextual material. The second is the opportunity to elaborate the subjective content presented by the participant. The third is the accessibility of the meaning of the participant's subjective experience. The fourth is the manner in which qualitative methods capture not only pattern, but also variation. The fifth is the congruence of social work values and qualitative methods.

Qualitative research allows information to emerge in context (Mischler, 1979). Witkin (1993/1995) states that context influences understanding by helping the researcher to interpret the meaning of a communication and by providing guidelines for discriminating among categories. Actions and context form a relationship that determines meaning.

Contextualization of participants' responses allows exploration of the possible pathways to, through and around depression and anxiety within the experience of growing up female in the family with a bipolar mother. It provides an opportunity to understand what positive qualities prevent this experience from being as damaging as growing up with a depressed parent. It may allow understanding of what factors are

particularly protective, and which are most problematic. Contextualization reduces the power of researcher biases (Witkin, 1993/1995).

Qualitative methods enable the researcher to elaborate her understanding of the respondents' subjective experience. This is of importance in evaluating its impact. The participant may introduce new material that has not emerged in previous research, rather than just supporting or contradicting existing knowledge. The researcher, rather than interpreting the participant's words and actions, is free to ask the participant to interpret them herself. This is another process of contextualization.

Both depression and anxiety distort thinking, thinking that occurs in the subjective realm (Burns, 1980, 1981). How does growing up with a bipolar mother enhance or distort the daughter's ability to deal with the reality of herself and her surroundings after she leaves home? Qualitative methods allow the participant to express this in the cognitive manner in which it occurs, an event representation (Nelson, 1986) and to discuss with the researcher the meaning of her words.

Qualitative methods allow exploration of the meaning of the participant's subjective experience. The end result of the research process is the participant's understanding of the meaning of her relationship with her mother as it is communicated in words and action in her life. Although adult daughters of bipolar mothers may report many similar experiences, these experiences may be invested with different meanings. New meaning may manifest itself in the dialogue with the researcher, as it does in the therapeutic dialogue (Saari, 1991). Qualitative methods

allow variations in experience, and the meaning attached to them, to show more clearly than quantitative methods do, because the voice of the individual is preserved in textual analysis (Heineman Pieper, 1989).

Primary values in the value-driven social work profession are the dignity and worth of each person, and the importance of human relationships (NASW, 1997). Because qualitative research preserves a focus on the respondent's subjective experience, in all its individuality, it is congruent with social work values. The qualitative method's retention of context preserves the value of human interdependence.

New theoretical material may emerge from participants' narratives. This will certainly be of use to the clinical social work practitioner. It may be used as well to create or endorse community mental health policies and programs that support optimal development of children in bipolar families, specifically the girls who are the mothers of the next generation.

Strategy

Because I am a family and individual therapist my basic interest and appreciation is of narrative and meaning. I am naturally interested in this aspect of any topic. This study grew out of an interest in the family circumstances implicated in anxiety. I have two friends and two clients who are daughters of bipolar mothers. Our many conversations about their experiences and the meaning each invested in them led me to want to look more at the issue of how such a history might affect women.

My skills are clinical and so is the information that is meaningful to me in my therapeutic work. I could easily see how more understanding of the patterns and variations of meaning emanating from life with a bipolar mother might be helpful to clinicians and to the daughters of bipolar mothers themselves.

This suggested a qualitative strategy. I am more at home with the kind of knowledge generated by this method than I am with knowledge of broad shared characteristics. The existing literature is at this point is largely quantitative and epidemiological, so there appears to be room for qualitative knowledge.

In studying qualitative methods, I was first drawn toward the word “narrative,” the method which persons in all cultures (Polkinghorne, 1988) use to derive meaning from events. This led me toward a phenomenological method.

My natural point of view seems to locate itself within philosophical hermeneutics. Understanding (Gadamer, 1970) is a basic structure of our experience of life. It is embedded in our socio-historically inherited bias, which we as qualitative researchers cannot and do not try to get rid of or manage. *Our* tradition enters into all our understandings. Understanding requires the engagement of our biases. Only in an open dialogue with the unfamiliar do we risk and test preconceptions. Understanding is dialogic (Rorty, 1991).

Social constructionism argues that we do not uncover knowledge; we make it through dialectic utterance. We see, make sense of and know everything through interpretation, thus the “real” is constituted through interpretation. Therefore it is

possible that no interpretation is inherently more correct than any other (Schwandt, 2000). Rather than valuing one interpretation over another, I view interpretations as “habits of action for coping with reality (Rorty, 1991, p. 1).”

Hermeneutics, constructivism, and Rorty’s pragmatism all see dialogue as the route to a “real” that has meaning for all participants. To achieve such a “real” the dialogue between the researcher and the participant must be as equal as possible, so that meaning is co-constructed (Janesick, 2000). Greenwood and Levin (2000), action researchers, also support the inclusion of the participant as an equal partner in research.

Strickland (1994) suggests using an autobiographical interviewing approach in psychosocial assessment. The autobiographical interview is a concept adopted by Strickland from Bruner (1990) (Cited in Strickland, 1994). Instead of eliciting a narrative structured by the concerns, organization, and categorizations of the clinician, the clinician invites the client to tell a story about him or herself.

As the client tells the story, the client supplies the meaning. Strickland suggests that the clinician make only minimal responses during the telling of the story. Strickland suggests that in order to bring out the meaning of the narrative the clinician apply plot analysis (Gergen, 1988) (Cited in Strickland, 1994), analysis of the narrative structure of episodes (Labov & Waletzky, 1967) (Cited in Strickland, 1994), and scrutiny of the role of the interviewer in the narrative structure (Spence, 1982) (Cited in Strickland, 1994). Nelson’s (1986) research on the importance of

event knowledge in early cognitive development demonstrated that stories are of primary importance in the child's growing generalized knowledge about the world. It also demonstrated that children begin to tell stories about their experiences at a very early age. By age three, children are not only able to tell stories about unique experiences, but they have developed "scripts," or generalized event representations for typical events in their lives. Further, they are able to discriminate between event representations and generalized event representations (scripts).

Marshall and Rossman (1999) define phenomenological interviewing as a type of in-depth interviewing based on phenomenology. This is the study of lived experience and how human beings come to understand their experiences and develop a worldview. There is a structure and essence to life experiences that can be narrated. It describes shared meaning, shared with the culture, within a locality, and in intimate relationships.

The authors present Seidman's (1998) phenomenological model. In this model, prior to any respondent interviews, the researcher writes a full description of her own experience, thereby clarifying its differences from the experience of the respondent. This is called an *epoche*. [This Greek word was used in Academic Skepticism by the philosopher Arcesilaus to mean the suspension of judgment on the question of truth (Internet Encyclopedia of Philosophy, 2001)]. The writer and researcher then better understands the biases she or he brings to the research process

by writing his or her own version of the truth. In a sense, this paper does partial service as an epoche.

The Seidman model then uses three interviews to develop the respondent's narrative and its meaning. The first focuses on past experience, the second on the present. The last interview is used to interpersonally construct an essential understanding of themes present in the two previous interviews.

The next phase is phenomenological reduction. The researcher, by analyzing the text of the interview identifies the essence of the phenomenon and its meaning in the respondent's life.

The strength of this method is that it permits an explicit focus on the researcher's personal experiences and those of the respondents. Its most salient weakness is its length and complexity. Such disclosures and reflections also fit into one long interview (McCracken, 1988). Each method has advantages.

Variables and Implications of Key Definitions for Data Collection

The research on the experience of the child living with a bipolar parent has been filtered through the sieve of mental health survey instruments to produce epidemiological understanding of the impact of life with one or more affectively disordered parents. It is couched in the language of the mental health field and often ignores how the child experiences his or her family and wider cultural environment. This experience is interpreted through the subculture of others (mental health professionals, governmental planners) who are interested in end results. Their interest

is valid but the techniques associated with it distract us from the events that produce the end results and their meaning to the child and later the adult. This meaning is essential in the co-construction of change in the therapeutic relationship (Saari, 1991).

Information about events within the family with a bipolar parent and their meaning to a child is quite inaccessible. Young children rarely are able to give verbal reports about their families or their feelings to strangers. Adolescents are more able to verbalize their experiences and feelings but a complex of forces, feelings of loyalty, love, guilt, shame, and fear, usually keeps them from doing so outside the context of a trusting relationship.

Researchers have devalued historical reports of an individual's life as a child because of the reconstructive nature of memory and the tendency of individuals to narrate experience, investing it with plot and meaning. I do not agree with this devaluation. It is exactly the plot and meaning of the experienced life as reconstructed in memory that shapes emotion, cognition, and behavior (Siegel, 1999). These elements combine with biological and social factors to create the mental health or mental illness of the adult as experienced by researchers and professionals.

This study will look at each research participant's own reconstruction of the critical events, emotions, cognitions and behavior experienced in interaction with her mother at various stages of development. It will explore the current experiences, emotions, cognitions, and behavior of the participants in interaction with their

mothers, their partners, their children, their family and their work. Finally it will explore and clarify the meaning of these past and current experiences to the participants.

All of the participants are adult biological daughters of bipolar mothers. This research focuses on the impact and meaning of experience, not the biological dimension except as experienced by the individual.

Recall of *events* is the participant's reconstructed remembrance of occurrences from early childhood to the present.

Emotions are psychobiological processes that accompany events and are accompanied by cognition and or behavior, other psychobiological processes. These three elements are inextricably entwined.

Cognitions are also recalled, what the participant reconstructs of her thinking about an event in the past or present, or what she thinks of it now (depending on the phase of the interviewing).

Meaning is the narrative reflection of the self on itself, its and its relationship to other elements that may include events, emotions, cognitions, behavior, and other elements.

Narrative is the vehicle by which we humans relate our experience in the cultural context established by language, and infuse it with meaning (Rorty, 1979, cited in Bruner, 1979). Narrative portrays human intention and behavior, in their ups

and downs, and their consequences (Bruner, 1979). It is an “organizational scheme expressed in story form (Polkinghorne, 1988, p.13).”

In the participants’ narratives of events I heard about the whole range of emotion, including but not limited to tenderness, affection, guilt, shame, anxiety, specific fears, depression, and anger.

I heard about cognitions both concrete and evaluative. Concrete cognitions include thoughts that accompany events and events as recalled. Evaluative cognitions include positive and negative aspects of the mother-daughter relationship through time.

I heard about behavior including underfunctioning and overfunctioning, in relationships, in the community, and at work, parenting behaviors and the participants’ actions used to manage emotionally laden issues, especially ambiguous loss (Boss, 1991, 1999; Davenport, et al., 1976). I heard about support from others. I also heard about meaning.

The omission of concepts from clinical theory is deliberate. The Gergens (1986) view clinical theory as a type of narrative framework. If this research were grounded in clinical theories, the plot of the clinical narrative form would guide the shape of the participant’s narrative. However, it may be that the use of even narrative metatheory in constructing the interview guide influenced the participants’ recollection of events, emotions, cognitions and behavior. Without the expectation of

a narrative form the participant might have presented a less connected or storied way of making meaning.

Problem Formulation

This qualitative study explores and seeks to clarify the answers to the following questions.

- What are the recalled critical events in the life of the daughter of a bipolar mother, at every developmental stage and in the present?
- What are the emotions, thoughts, and actions recalled in association with these events?
- How does the relationship with the mother influence the participant's self-identity and her identity as expressed in feeling, thought and action?

Thematic questions that emerged in the interviews are also addressed in this research.

Research Design

I used a qualitative, phenomenological research design originated by Seidman (1991) inside a long interview structure (McCracken, 1988). It led the participant through past and present issues in her relationship with her mother, and produced a narrative that led to the deep meaning of the phenomenon under study; the participant's recalled lived experience as the adult daughter of a bipolar mother.

Donald Polkinghorne (1988) and Kenneth and Mary Gergen (1986) provide the theoretical base for using a qualitative design and narrative data. Polkinghorne (1988) divides human existence into organized, stratified realms; the material, the organic, and the mental realm. In his view human beings have emerged from “life in general” to reflective consciousness and language is a threshold change that has brought about a unique level of reality (p. 2).” This level of reality Polkinghorne terms the “order of meaning (p. 2).” The levels of human existence are related to one another hierarchically. The unique human capacities of consciousness and language have produced a “special stratum of the environment that is---culture and meaning—in which we exist (p. 3).” One salient feature of the mental realm is the knowledge of the self. The mental realm examines not only the material realm and the organic realm, but itself. The realm of meaning is an activity that produces names of elements and the connections between them. Narrative meaning is created when a human being notices that something is part of a larger whole and that something causes something else. The meaning of each event depends on the part it plays in the whole narrative episode. “The realm of meaning is best captured through the qualitative nuances of its expression in ordinary language (p. 10).” Narrative is the method human beings use to give meaning to their temporal experiences and behavior.

The Gergens (1986) point out that theoretical language acts to predetermine what phenomena are to be understood as the “real.” Theoretical accounts have at their foundation metaphors that guide what behavioral and other scientists “find” in nature.

The theory itself is a narrative that structures events so that they cohere, so that they have an endpoint or goal, and so that events are arranged so that the goal is probable.

Narratives, including theoretical narratives, are structured so that each event explains the next in the context of the culture in which the narrative is situated. Narratives have “plots.” These plots may progress toward a goal. They may also regress from the goal-state. They may remain stable. They may combine two or three of these plots as the narrative account moves through time. The slope of each ascent or decline may be more or less precipitous, creating a greater or lesser degree of dramatic engagement in the listener. By using narrative theory in the construction of my interview guide, I open the way for the participant to make plot choices of her own, rather than being bound by the narrative implied by a clinical theory.

Instrumentation

In this research I adopted a variation of the method of in-depth phenomenological interviewing proposed by Seidman (1991). Seidman’s model is particularly attractive to me. It takes into account the need for a researcher-participant relationship. It mimics my therapeutic style, which relies greatly on open-ended questions and exploration, and only rarely uses Socratic questions or classical interpretations.

Seidman’s (1991) research design consists of four face-to-face interviews totaling seven hours over a four-to-five-week period. The lengthy interview time is

intended to allow the formation of a trusting researcher-participant working relationship, to facilitate disclosure and allow time for incubation between interviews in order to increase the depth of the data.

In the pilot study I followed this format. Neither of the participants seemed to be held back from participation due to the length of the process, but with each participant the interviews took over five weeks to complete because of prior commitments and family or personal illnesses. Both participants expressed mixed feelings at the end of the interview series and hopes that their participation would benefit others like themselves.

As a result of this experience I decided to combine Seidman's (1991) focus on past, present, and meaning with the overall format proposed by McCracken (1988). This is an interview process designed to substitute for ethnographic participant observation when the researcher is working within her or his own culture. It is offered as a pragmatic option to be carried out within the sort of constraints of time and budget that affect this research. The actual length of the long interview is not discussed, although in the appendices one hour and three hours are mentioned. McCracken discusses its suitability even with physically fragile populations. He states that there is a stimulating quality about such an interview so that the participant's enthusiasm builds as the time goes on. Cannell and Axelrod (1956) and Caplow (1956) (Both cited in McCracken, 1988) note that qualitative interviews supply an opportunity absent in ordinary social intercourse, with a conversational

partner who gives up his or her turn to speak and listens intensively to almost anything the participant might say (Stebbins, 1972) (Cited in McCracken, 1988). I noticed the growth of this enthusiasm in the participants in my pilot interviews. By the end of each one to two hour interview, the participant was offering additional material. The effect dissipated somewhat between interviews, but in each successive interview reached a higher level. A long interview proved very effective in generating responses. In order to minimize fatigue and stress there were breaks, and refreshments were offered suitable to the time of day. The participants were asked to choose their own refreshments, and I took a break and had something, too. They had a choice about having a break from me, but none chose that. They continued talking about themselves, with one exception. She asked for a hot lunch, not take-out, but at the little restaurant where I got food for anyone whose interview crossed a mealtime.

Within this external structure, I addressed the categories suggested by Seidman (1991). The initial part of the long interview focused on getting to know the participant, going over the appropriate informed consent and other materials, obtaining needed information and signatures, and answering the participant's concerns and questions. The second part was concerned with the participant's past relationship with her mother up to the age of thirty (Or the present if she is between twenty-five and thirty). The third segment looked at her present relationship with her mother. The fourth explored the cumulative meaning of this important relationship to the participant's identity in various contexts.

Seidman's model utilized a total of four interviews, as noted above. I used a long interview with four parts. This design allows time for "housekeeping" issues, then for focus on the contributions of the past, the current situation, and the deep meaning of the material.

It allowed the growth of a researcher-participant relationship. Families with a bipolar member tend to use denial and isolation to manage the feelings associated with the bipolar member's symptoms. Both make it difficult for family members to share personal information with outsiders. Even though the participants knew that they were supposed to share information about their families it was a bit difficult for a few to do so.

The get-acquainted segment allowed participants to take the measure of the researcher before deciding whether or not to participate. The second segment focused on the past. This is more remote and is likely to have been subjected to some processing in the course of daily life, as well as in therapy. I thought the third segment, focusing on the present, was more of a challenge, but there were no negative responses. The growing familiarity with the researcher seems to have had an effect of sustaining the participant through the possible stress of this segment.

The fourth segment, focusing on deep meaning, was expected to be the most stressful. The participant by then had more of a sense of how the researcher would respond. This, again, seemed to help to sustain her through her interpretation of the meaning of her relationship with her mother.

Segment One

This segment could take up to one hour, but did not. Its purpose was threefold; to help the participant understand what will be required of her, to begin building a participant-researcher relationship, and to begin a process of screening for vulnerability that continued throughout the interview. The first section provided the participant an opportunity to understand the requirements of participation through review of the informed consent. If any had declined to participate, the interview would have ended at that point. When participants signed the informed consent, they were paid the \$75.00 cash stipend. The second section of the first segment focused on obtaining information through a survey instrument while building a beginning relationship. The informed consent contains a release of emergency information to a designated emergency contact. If I had seen signs of problems with reality testing or emotional lability, I would have screened the participant out at any point during this segment or at any time during the interview. If I had screened anyone out, the tapes and other records of her participation would have been destroyed. If she had signed the informed consent, she would have kept the cash stipend.

I advised the participant of the breaks and refreshments to be offered between the second and third sections of the second segment and the longer break and refreshments between the second and third segments. I also told each participant she could have a break at any time she asked for one.

Segment Two

This segment explored the effects of the mother's bipolar disorder on the daughter's development from her first memory of her mother through age twenty-nine. I allowed up to two hours for this segment, with a short break between sections and additional breaks if requested by the participant. A non-alcoholic beverage of the participant's choice was served between the second and third sections of this segment. The longer break with substantial refreshments occurred between section two and section three. In each section of the segment, the participant was prompted to tell about two incidents.

The first section explored a first memory and then a memory from when the participant was "really little." Questions in this section and the sections that follow addressed the variables of critical event, emotion, cognition, and behavior: what happened, what the participant felt, thought and did. One question was devoted to exploring the participant's age at the time of the incident. A further question explored whether anyone besides the mother tried to help the child at that stage of development.

The second section explored the same variables as they related to the participant's experience during the grade school years, using the same pattern of questions. A break occurred between the second and third sections. The third section used the same pattern of questions to explore the participant's adolescent experience of her mother, while she was in high school. The fourth addressed the late teens and

early twenties, again using the same pattern of questions. In this segment, as in those that follow, the researcher was alert throughout to the level of the participant's stress and reactivity as she processed the questions. If the participant's stress level had appeared to increase, the researcher would have stopped and processed with her what she was experiencing and would have been ready to help her seek treatment or terminate her from the research if it appeared to be in her best interest. At the end of this segment I served a substantial snack or light meal of the participant's choice, depending on the time of day.

Segment Three

This segment explored the participant's current relationship with her mother "now, just recently," and how it affects her relationship with herself, her partner, her children, other family members, and her career or job. This segment was divided into five sections, and could take up to two hours. One section was devoted to each of these topics. During each section I prompted the participant to tell about two incidents. In each of these sections the same pattern of questions was used to explore first an incident, then the emotions, cognitions, and the behavior of the participant in connection with it. At the end of this segment there was a short break. A non-alcoholic beverage and a light snack were offered and left out during the final segment.

I remained watchful for signs of stress and processed them with the participants, but I never had to intervene either to help the participant obtain treatment or terminate from the study.

Segment Four

This segment built on the second and third segments. Its structure allowed the participant to reflect upon and state how her relationship with her mother influenced her identity as an individual, a partner, a mother, a family member, and a worker. As before, questions addressed feelings, cognitions, and behavior in each of these areas.

The fourth segment, the last, was divided into five sections. The first dealt with how the participant's relationship with her mother affects how she sees herself as a person. Questions were directed to how this relationship influences feelings and thoughts about the self, and how it influenced her behavior.

The second section focused on how the participant's relationship with her mother influenced her relationship with her partner. The first question addressed this issue broadly "how you are with your partner." The next questions dealt with feelings, thoughts and behavior. The third section addressed how the participant's relationship with her mother has influenced her relationship with her children. The first question is broadly stated as are the first questions in the previous sections of this interview. The second through fourth questions inquire about feelings, thoughts and behavior.

The third section addressed how the participant's relationship with her mother influenced her relationships in her family. This was addressed first broadly, then with attention to feelings, cognitions and behavior.

The same pattern was repeated in the fifth section with respect to the participant's job or career. A final question asked for "anything else about the meaning" of her relationship to her mother in her life.

The researcher continued to be watchful for signs of stress and intervened to process the participant's distress. None of the participants needed help to obtain treatment, or terminate from the study.

Site or Population Selection

In accord with the phenomenological nature of this study, the sampling plan was purposive, constructed so as to allow a wide and representative variation in the possible responses within the inclusion/exclusion criteria (Marshall and Rossman, 1999).

A purposive sample is most fruitful when the goal is to find respondents who are atypical in a way that makes them useful for the particular study (Anastas & MacDonald, 1994). Miles & Huberman, 1994, (p. 28) present a "maximum variation" sample as best for documenting differences and identifying common patterns as I have done in this research.

The two basic issues in constructing this type of sample are defining selection and inclusion criteria and gaining access to respondents who meet the criteria. If the

inclusion/exclusion criteria are too tight, it becomes harder to find individuals who meet them (Anastas & MacDonald, 1994).

In constructing the sample I used several strategies to obtain volunteers with different backgrounds. In the pilot, only a clinical sample was sought, to give the two participants as much support as possible. Neither participant in the pilot study decompensated in any way. Each was enthusiastic and both verbalized a wish to help others in similar situations through their participation. This did not mean that no participant would ever decompensate. If one had done so, I have eight years of pre-masters experience in child protective service and an additional twenty-three years of post-masters clinical social work experience in child welfare and mental health. I was sensitive to participant stress during the interviews and collected the information required for management of an emergency with the demographics at the beginning of each interview. None of the participants decompensated.

I tried very hard to develop other sources of volunteers. I had letters of support from a family agency, from a psychologist, and from a psychiatrist who were in private practices. I was granted approval by the IRB at a hospital and medical center, resulting in access to two inpatient settings and a chain of outpatient clinics including the one where I worked. In the inpatient settings, adult daughters who visited their bipolar mothers were the target population. In the outpatient clinics, current clients were targeted. I had a letter of support from the Depression and Bipolar Support Alliance permitting me to approach family members' groups in my

home city and Chicago. I used a “snowball” component so that participants and others who knew about this research could refer possible participants to me. None of these approaches yielded any volunteers. I finally used a newspaper advertisement (*See AppendixD*), run twice in the city’s free paper where medical and behavioral research notices usually appeared. This advertisement yielded the eight volunteers I needed.

Participants who responded to a newspaper advertisement were interested in talking about their relationships with their mothers. After orientation to the study, during the first segment, any participant could refuse further participation if the study seemed to her to be threatening. Likewise, the researcher, an experienced clinician, (*See Appendix VIII*) screened for vulnerability and stress reactions beginning at the screening and continuing until the interview was successfully completed. Participants could refuse to answer any question or drop out at any time. If the interviews proved very upsetting to a participant I would have terminated her from the study and referred her to an appropriate resource.

The sites for recruitment of the pilot research sample were at four clinics, part of the hospital system discussed above. Both participants came from the clinic where I worked, from therapists who knew me and were excited about my study. Additional sites did not yield any participants. A clinical sample alone does not provide the variety recommended by Marshall and Rossman (1999), Anastas and McDonald (1994), and Miles and Huberman (1994), but it was sufficient for the pilot study.

The pilot and the dissertation samples did not include involuntary clients.

Both excluded my own clients, anyone whose relatives I have had as clients, and anyone with whom I had a personal relationship.

The goal of this purposive sample was to introduce as much variety as possible into the study while keeping the number of participants as small as possible. I was looking for women from different cultures and subcultures, of different ages, different economic and living situations, and differing levels of functioning. I did not interview everyone who presented for the study. I chose only those who added to the variety, even though only newspaper advertisements yielded volunteers.

A telephone protocol was used to screen for double relationships, voluntariness, and the credibility of the volunteer's belief that her mother was bipolar. It screened for economic status, ethnic-racial status, and whether the volunteer herself was bipolar. If the volunteer was or had been my client, if she was a relative of a past or current client, or if she was an involuntary client she would have been thanked for her interest and advised at the screening call that she could not participate for ethical reasons established for her protection. The remaining volunteers were ranked in order of the credibility of their belief that their mothers were bipolar. The most credible were screened for diversity. A diverse group of the most credible was selected on a first-come, first-served basis. Those who were not selected received a letter thanking them for volunteering.

The two participants from the pilot were identified by the pseudonyms Alice and Bridget. They were interviewed in fall 2001 and winter 2002. They were referred by clinicians and were not screen as the dissertation participants were.

The Participants

Alice

Alice came in for the first of three interviews on October 5, 2001 at two pm. She was a slender, pale skinned, thirty-six year old Caucasian woman with Appalachian heritage. She had a long face and high cheekbones, and long light brown hair that was not cut or styled. She wore a navy sateen workplace logo windbreaker, a tee shirt, and jeans. She had a good vocabulary, was quiet-spoken, and had only a few questions. I encouraged her over and over to ask them. She talked about how she thought that talking so much about her relationship with her mother might help her in her therapy. She chose to come early on Friday mornings for the interviews and, since she worked nights, picked donuts and cappuccino for her snack. When the interviews started, she read each question on the interview guide, and sometimes answered before I could ask it.

Bridget

Bridget was referred by her therapist in November, 2001, but was reluctant to schedule until February second, two-thousand-two. I was unsure whether she would come in, but she did. There was some question about whether her mother was bipolar although the mother had been on Lithium for 15 years. Bridget was a very slender

thirty-eight year old woman whose fair, freckled face was long and delicate, with high cheekbones. Her eyes were bright blue. Her windblown brownish hair was tinted auburn. She wore an aqua anorak over a hounds-tooth check riding-style jacket, khakis, a turtleneck, and loafers. She did not spend much time reading the materials, appearing to skim them. She signed the informed consent and ignored the fifty dollars I put beside her while she filled out the questionnaire. She asked for veggies and diet coke for her snacks.

I asked her how she might feel if she went through the interviews and I turned out to think her mother was not bipolar and couldn't use them. She said that would be ok. She started to talk in some detail about herself and her mother. By the time we parted, I was pretty sure her mother was bipolar.

There were eight participants recruited for the dissertation, seven using the newspaper advertisement. Their pseudonyms were Caroline, Danielle, Ellen, Frances, Gayle, Holly, Ilene, and Justine. Caroline was the partner of a clinic client but not a client herself

Caroline

Caroline was interviewed on May 14, 2005. She was referred by a clinician who was seeing her female partner. She was a stunningly beautiful, thirty-seven year old biracial woman with long auburn hair of an African-American texture, slim, and close to six feet in height. She wore jeans and a plaid shirt. She came in the late morning, sweeping in a little bit late, so I offered her a lunch at the break. She picked

a deli sandwich and only ate half of it, wrapping the remainder carefully to take home.

She has two children, one of whom has bipolar disorder. She has her own business taking care of “details” for others. She lives in a relatively stable relationship with a woman.

Danielle

Danielle was interviewed on June 17, 2005. She was 36 years old, about five feet tall, and appeared to be morbidly obese. Her shining black hair fell to her waist and was neatly cut. She wore a sleeveless black knit top and leggings. Her visible skin, except for that on her face and hands, was decorated with black tattoos. The designs were in the “tribal” style. Her ears were multiply pierced. Her interview was in the afternoon, and she did not request a snack. She did have a diet cola at the break.

She had worked at a number of jobs and was creative in art and writing. She completed high school but never went further.

Her mother’s side of the family was Greek-American and her father’s name was Italian. She lives alone and has contact with her mother almost every day.

Ellen

Ellen was interviewed on 6-18-05, and was one of the two youngest interviewed, at age 25. She was slim and attractive, had short blond hair and came to the interview in a pale blue nylon windbreaker, white tee shirt, and jeans. She worked as a medical assistant but had a pattern of quitting when there was tension or conflict.

She lived with her second husband and infant daughter, and sees her mother whenever the mother wants.

She reported a number of behavior patterns consistent with bipolar disease. A doctor has told her she has it but she believes the behaviors are learned. Either could be true. She was raised in an apocalyptic, evangelical religion. She completed high school at 17, and trained as a medical assistant.

Frances

Frances was interviewed on 6-19-05. She was 39, single, with dark hair put up. She was wearing a flower print, tie-back dress and shawl. She had lunch with friends and come straight to this Sunday afternoon interview. She is some what plain in appearance, and somewhere between overweight and obese. She lives with her uncle. Her mother and grandmother lived there prior to their deaths a few months apart in 1995. Her ethnicity is mixed, Latin and Italian on her mother's side and Irish, Welsh, French and Aztec on her father's side. She has an intonation in her voice that makes her sound older than her years.

Gayle

Gayle was interviewed on 7-2-05. She is 51, with mid length blonde hair, slim and pretty in an age-appropriate way. She was wearing a gauzy, draped pastel, multicolored dress appropriate to the summer weather but not to the air conditioned, empty clinic. She was very appreciative of a throw I lent her and the food I provided

at her request. During over half of the interview she talked as though she was born in 1970, when in fact she was born in 1953.

She is the oldest of six children. She lives alone, in a gentrified suburb, and her mother lives in another city. She reports the family culture as being German and traditional, although there is some Irish ancestry. She identified her socioeconomic status as “comfortable” She states she is not bipolar, but she relates she is a recovering alcoholic, with many relapses. She displays a lot of knowledge about recovery.

Holly

Holly was interviewed on 7-8-05. She, like Ellen, was 25. She had short, dark blonde hair and regular features. She was casually dressed in jeans, a T-shirt and a hooded sweatshirt, and was comfortable in the air conditioning. She identified herself as working class, and assigned her ethnicity as Caucasian/American, although her surname may indicate some French or Latin ancestry. This was a noon interview and she asked for coffee, fruit, and bagels. She lives in a working-class suburb that is just beginning to gentrify, with her male partner and her son by another man.

Ilene

Ilene was interviewed on 8-26-05. She was 53, the oldest participant, a medium-dark skinned Black woman with regular features and neatly arranged graying hair. She dressed for the interview in a good, navy, dress with a lace collar. She lived in a pleasant residential neighborhood in the city, with her adolescent son. She said

she was “not well off”, that she was not functioning well, and that she feels that she herself is bipolar. She has not been diagnosed. She reports her mother’s behavior to be consistent with bipolar II, but she has never been hospitalized, and although her mother sees a psychiatrist, the participant has never been told of her mother’s diagnosis.

Ilene came in on a weekday at 9:30 and asked for a hot lunch, to which I agreed. She wanted to eat at the little restaurant where I had gotten food for the other participants. I agreed to this after processing the possibility of a breach in privacy. She made no effort to avoid notice at the restaurant. She praised the food and service there and left a generous tip.

Ilene tried to get feedback from me at the restaurant. She remained disappointed that I could not give her feedback until the interview was over.

Justine

Justine was seen on 8-28-05. She was a plump, light-skinned Black woman, aged 35. She had light, streaked short hair and was dressed in a yellow and orange floral print summer shift. She lived in a pleasant residential part of the city. She had a master’s in accounting and had had a job as a controller. She sees her mother three times a week and sometimes talks to her on the ‘phone, but only since the birth of her baby at the beginning of the summer. She had had a solid marriage for 6 years

The participant had a back injury, and as a result, her mother had the role of helping her. Prior to the baby’s birth, for two years, Justine had had no contact with

her mother. Her mother did not come to the baby showers, but did come to the participant's graduation from her master's program, just before her baby was born.

The table below records demographics of the 10 participants.

Table 1
Demographics

| | Age | Ethnicity Self Assignment | Mental Health Self Assignment | Race Self Assignment | Socio-Economic Self Assignment |
|----------|-----|---------------------------|-------------------------------|----------------------|--------------------------------|
| Alice | 36 | Hillbilly | Not Bipolar | Caucasian | Working Class |
| Bridget | 38 | Irish-American | Depressed | Caucasian | Working Class |
| Caroline | 36 | | Not Bipolar | Biracial | Working Class |
| Danielle | 36 | Italian/ Greek | Unsure | Caucasian | Poor |
| Ellen | 25 | | Unsure/ Depressed | Caucasian | Middle Class |
| Frances | 39 | Latin/Italian Welsh | Depressed | Caucasian | Middle Class |
| Gayle | 51 | German/Irish | Not Bipolar | Caucasian | Comfortable |
| Holly | 25 | American | Not Bipolar | Caucasian | Working Class |
| Ilene | 53 | African American | Unsure | African - American | Not Well Off |
| Justine | 34 | | Not Bipolar | African - American | Middle Class |

I asked each question on the interview guide only twice. If the participant went on to supply another narrative, I let her, however. Often the later narratives in response to each question seemed more meaningful.

The first interview in the pilot study and the first segment in the dissertation research were not taped. Both began in a very businesslike fashion as paperwork was completed, and questions were asked and answered. I began to change my manner after the participant signed the informed consent and completed other paperwork.

My manner became less brisk and businesslike and more gentle and reassuring. I looked for the participant's characteristic voice tones and phrases and began to imitate them, in order to build a good rapport. Rapport served the purposes of the research but it also assisted in sustaining the participant through any anxiety she felt. I watched for signs of stress in her responses to the survey. I talked with her about what might be difficult for her to discuss and how she wanted to handle that in the interview. I advised her of the scheduled breaks and refreshments, and told her she was free to ask for a break at any time.

I asked her not to use her own name, the names of others or the names of locations during the interviews, but reassured her that if she did I could correct it. I again asked if she had any questions before going on to the second segment.

I invited the participant to do what she needed to do to make herself comfortable. I then turned on the tape recorder. I then went over what was going to happen in this segment and asked if she had any questions. After answering them I began the segment. During this part of the session I adjusted my speech tempo to hers, gentling my voice tones, and dropping into any idiosyncratic speech patterns I had noticed. I made short, encouraging comments to help participants begin their answers. If the participant seemed to be having trouble answering the basic questions, I processed this with her. If she cried, I waited for her to finish and processed what had brought her tears. I often expressed the importance of participants' input. These rapport-building behaviors were continued throughout the remaining parts of the

interview, as was my vigilance for signs of stress or apprehension. These were processed as they occurred. There was no need for further intervention.

Breaks were offered approximately as scheduled in the interview guide, but the participant and I often agreed on another time. During the pilot study, I began to individualize the refreshments, and at the end of the last interview it seemed natural to give the participant a chance to ask questions that the interviews had brought to mind. The participants were pleased to have the food they wanted. From the first participant I learned of the need for information and resources. I continued to offer debriefing and information at the end of each interview with the dissertation participants.

Trustworthiness

Getting situated

An initial issue in determining whether an account of a phenomenon depicts the subject to be studied is how it is situated with respect to place, time, and informant (Kirk & Miller, 1986). This study took place in mental health clinics, among their clients, and among motivated women from the community who read the advertisement. This study is situated in terms of the other available research on the lives of children in families where a parent is bipolar (Cheek, 2000).

Process validity

The participants were interviewed in depth and were encouraged to tell their stories, including events, feelings, thoughts and behavior, thus increasing the plausibility of the narrative (Smith & Deemer, 2000) by increasing the depiction of “experienced, embodied, emotive qualities” of human life (Lincoln & Guba, 2000, p.179). The long interview allows the participant to demonstrate connection between the parts of her narrative and consistency over time (Seidman, 1991). The transcripts and quotations from participants provide a factually accurate account of the interactions with them (Smith & Deemer, 2000), and one in which the voices of the participants, the most important stakeholders, may be heard (Lincoln & Guba, 2000).

Analytic validity

N’Vivo 8 was used to manage the 425 pages of transcripts. Prior to entering them into *N’Vivo 8*, I had audited each one of them, making substantial changes and corrections. I acquired an uneven, but comprehensive, sense of the content of each. When coding of events, meanings, and helpers was completed, I used the software to examine the transcripts for themes that had emerged during the audit and the coding to date. My codes were evaluated by a Loyola University graduate familiar with qualitative research who used my code book to code an excerpt from a transcript.

Ethical and Political Considerations

Marshall and Rossman (1999) identify seven ethical considerations that are pertinent to this project. These are voluntary participation, informed consent, reciprocity, deception, right to privacy, advocacy and intervention, and power.

Voluntary Participation

Prospective participants could decline to be referred when given information by therapists, hospital social workers, by me, or by others who knew of the study. No one needed to answer a newspaper advertisement. Participants could decline to sign the informed consent. Having signed it, and received the honorarium, they could decline to answer any individual question, or refuse to participate further at any time, while keeping the \$75.00 (\$50.00 in the pilot study). No one was accepted as a participant who was an involuntary client of an outpatient or inpatient facility. No one who was or had been my client, or was related to a person who was or had been my client was recruited or accepted for this study.

Informed Consent-

The prospective participants received written information regarding the nature, extent, duration of participation, and the risks and benefits that might accrue (NASW, 1999) from participation in this research. I explained who I was and the purpose of this study. I described participation in concrete terms. I would have used two informed consents, one a packet required by St. John Health IRB, had any prospective participants been recruited at their facilities. I did use the other,

constructed according to the rules of the IRB for the Lake Shore Campuses of Loyola University Chicago (See Design, Method, Appendix G, Appendix H, Informed Consent and Appendix L, Interview Guide) for all the dissertation participants who volunteered.

Participants could revoke their consents at any time. There was no pressure to continue to participate.

Reciprocity

I was respectful of the participants' time. I paid them for their participation at the time the informed consent was signed. Depending on the time of the interview, I provided them with their personal choices for snacks or a meal. At the end of the interview I answered any questions they had if I was able to do so. If participants were interested in information or resources like books or contact information for support organizations I provided them to the best of my ability.

Deception

There were no lies or deceptive omissions in the written materials given to participants or in my interactions with them. If I had omitted something accidentally I would have acknowledged it and apologized. The written report was truthful, de-identifying the participants, the clinic and the community.

Right to privacy

Since I was not able to claim privilege regarding the research interviews, I made every effort to protect privacy and create anonymity. I interviewed so as

not to record names or locations. Any names or locations that were inadvertently recorded, I erased them before giving the tapes to the transcriber, or omit them from any transcripts I make myself.

I assigned numbers to each participant. I kept the materials with both names and numbers locked and secured in one location with the informed consent. I have kept the data, including a copy of the second page of the participant questionnaire without any identifying information besides the participant number, audiotapes, transcripts, and coding materials locked and secured in another location. Only a number identifies the participant who is the source of the data. I used pseudonyms when writing about the participants. They were assigned in alphabetical order according to the numbers originally used. The names had no relation to the real names of the participants

I held interviews in a professional office at a clinic. I hired a transcriber who typed the audiotapes of the interviews. I audited the tapes against the transcripts and made corrections if needed and if I could do so. The audiotapes and any identifying information were destroyed once data analysis was completed.

Advocacy/ Intervention

I obtained names, ages, and the name of an emergency contact at the first interview. As a part of the informed consent, the participants gave permission for communication with the emergency contact in case of a medical or psychiatric emergency. I could call the emergency contact in the case of a serious adverse

reaction to the interview questions, where hospitalization might be required, or if the participant were to have had a medical emergency during the interview.

Fortunately there were no emergencies, psychiatric or medical.

If a participant were to have become upset I would have worked with her to determine what support would make her comfortable, and would have assisted her in obtaining it if she wished. In the event any participant had decompensated and threatened to harm herself or someone else, or showed florid psychotic symptoms, I would have called her emergency contact and worked with him or her toward psychiatric evaluation and evaluation of the need for hospitalization. I supplied a list of emergency resources with the informed consent. If there had been any medical emergencies associated with an interview, I would have called the emergency contact and /or an ambulance. Fortunately there were no adverse events of any kind and none of the protective measures described were needed.

Power

Kimmel (1988) identifies problems caused by the loss of equality in the research relationship. I took six measures to equalize the power in this research relationship. I paid the participant just after she signed the consent. I informed referring persons and the participants that they could withdraw at any time up to the end of the final interview, and could decline to answer any question. None of my clients were recruited, nor were their relatives. In the clinical segment of the sample only voluntary clients were asked to participate. I gave the participants a reasonable

choice of foods for snacks and meals. At the end of the last interview I answered any questions they had to the best of my ability. If they wanted information about resources, I provided it as well as I could.

Unanticipated outcomes

There were no unanticipated outcomes.

Data Analysis

All the transcripts were entered into N'Vivo 8. I coded them in tandem, creating codes for events, meanings, and helpers at each stage of recalled events.

In N'Vivo coded material was gathered into categories, called nodes, facilitating comparisons of likeness and difference across participants. Each of these categorical nodes was examined and likeness and differences were analyzed and reported in the findings chapter of this paper. N'Vivo facilitates the coding of themes, both individual and overarching. I “queried” the data for themes that had emerged when I audited the tapes, and when I coded events and meanings at different ages. The results of my thematic analyses are reported in the findings chapter.

The coding was validated by an expert on mother-daughter relationships and bipolar families who used the researcher's code book and unmarked copies of part of a transcript. The validating expert was Margaret Arnd-Caddigan, a graduate of Loyola University Chicago School of Social Work, a qualitative researcher and Assistant Professor at East Carolina State University.

The data was analyzed using the relevant features of N'Vivo8, as described in the section will be examined using two theoretical narratives (Gergen & Gergen, 1986). I have used concepts from psychodynamic theory, the Stone Center theorists and the family systems approach exemplified by the work of Monica McGoldrick and Froma Walsh.

Limitations

This study is neither observational nor contemporaneous. It cannot tell us what “really” happened, only what the participant recalls as having happened and how she experiences its influence on her at the time of the study. It has only ten participants. This last limitation is offset to a degree by the length and depth of the interviews.

Since I am the designer of the research, have conducted all the interviews, and analyzed the data, the results are bound to reflect my conscious bias toward family and relationship as the most important influences on personal growth. This is an orientation typical of women. The study may reflect yet undiscovered biases from my own experience in a family where one parent was alcoholic. It may reflect unconscious biases from other experiences including my personal and clinical experience with adult daughters of bipolar mothers and bipolar women themselves.

CHAPTER FOUR:

FINDINGS

This chapter uses tables to identify from four hundred twenty five pages of interview transcript data, information about recalled events, meanings, and sources of help experienced by the ten study participants. The tables explicate material about participants' relationships with their mothers and how these relationships affect other aspects of their lives. The chapter addresses material from childhood before first grade to recent adulthood. For two participants recent events occurred in the period from age eighteen to twenty-five. For six others, they occurred in their mid to late thirties. For two, they happened in their early fifties. There is a great variation in their experiences, but several themes are clearly more common.

Childhood before First Grade

Living Situations and Events

All ten participants recalled events before first grade. Their living situations tended to be influential in their memories.

Table 2
Living Situations before First Grade

| | Mother | Parents | Mother & Grand- mother | Grand- mother | Relatives | Mother sometimes Present |
|----------|--------|---------|------------------------------|------------------|-----------|--------------------------------|
| Alice | X | | | | X | |
| Bridget | | X | | | X | X |
| Caroline | X | | | | | |
| Danielle | | | | X | | X |
| Ellen | | X | | | | |
| Frances | | | | X | | X |
| Gayle | | X | | | | |
| Ilene | | | X | | | |
| Justine | | X | | | | |

Two, Ellen and Justine, reported pleasant childhoods. Alice has a memory of a specific positive incident but was later told by family members that it occurred between the mother's hospitalizations.

For participants who stayed with grandmothers and other relatives, there was excitement, fear, confusion and irritation when the mothers were present. Ilene's situation was consistent. Her grandmother was hostile and her mother was distant. Caroline lived with her mother and was consistently and seriously neglected to the point of role reversal, subjected to inappropriate expectations, and abused. Even in the intact families Gayle remembers fear when she had to start kindergarten. Bridget was ignored and molested. Her mother blamed her for the molestation.

Helpers before First Grade

In this age group, helpers were either family or friends of the family. Paternal and maternal grandparents assisted in the children's care, as shown in Table 1. Other

relatives provided short-term care and experiences that buffered the negative ones between the participants and their mothers. A boyfriend of Caroline's mother was protective.

Meaning before First Grade

Five participants assigned contemporaneous meaning to their experience. Bridget reported confusion. She also felt that she would never do right after being blamed by her mother. Caroline and Frances were aware that there was something wrong with their mothers. Danielle never knew where her mother was and feared being taken by her. Ilene idolized her mother and disliked her grandmother.

The Grade School Years

Recalled Events from Grade School Years

Participants reported a wide variety of negative experiences during the grade school years, and a few positive ones. Role reversals were by far the most frequent negative event. Seven out of ten participants reported them. Four participants reported sexual exposures, four reported chronic rejection. All of the participants who were subjected to sexual exposures were subjected to role reversals. The participants who were in role reversal situations were vulnerable to other negative events, usually involving the bipolar mother. Five participants reported good times. Of these, three involved a bit of role reversal, the children being allowed to do something that was not necessarily in their best interest.

Table 3
Recalled Events in the Grade School Years

| | Mother's first Episode | Relapse | Role Re-versals | Sexual Exposures | Molest-ation | Chronic Rejection | Physical Abuse |
|----------|------------------------|---------|-----------------|------------------|--------------|-------------------|----------------|
| Alice | | | X | | | | |
| Bridget | | | X | | | | |
| Caroline | | | X | X | X | | |
| Danielle | | | | | | | |
| Ellen | X | | X | X | | X | |
| Frances | | X | X | X | X | X | X |
| Gayle | | | X | | | | |
| Holly | | | X | X | | X | X |
| Ilene | | | | | | | |
| Justine | X | | | | | | |

Table 3 Continued

| | Severe Physical Discipline | Target of mother's Rage | Place-ment | Run-away | Absent Mother | Secrets | Two Feel-ings |
|----------|----------------------------|-------------------------|------------|----------|---------------|---------|---------------|
| Alice | | | | | | | |
| Bridget | | | | | | | |
| Caroline | | | | | | | |
| Danielle | | | | | X | | X |
| Ellen | | X | | | | | |
| Frances | | | X | | | | |
| Gayle | X | | | | | X | |
| Holly | | | | X | | | X |
| Ilene | X | X | | | | | |
| Justine | | | | | | X | |

Table 3 Continued

| | Communication Breakdown | Good Times |
|----------|-------------------------|------------|
| Alice | | X |
| Bridget | | |
| Caroline | | |
| Danielle | | |
| Ellen | | X |
| Frances | | X |
| Gayle | | X |
| Holly | | |
| Ilene | | X |
| Justine | X | |

One participant reported there was little support for school attendance in her home. Another who had misbehaved did not welcome it when the mother went to the school. Two who needed advocacy were ambivalent, because of the mother's varying behaviors. Another did well in school and comforted herself with that when her mother verbally abused her.

Feelings were prominent in reports about events in grade school years. They are less common in the teens. This may be due to the relative helplessness of grade school age children to act on their situations. During grade school, none of the participants were closely enough connected to their mothers to communicate their feelings and have them validated. Even Frances, who was close to her grandmother, seems not to have gotten much validation, considering her fear and dread.

Table 4
Negative Feelings in the Grade School Years

| | Anger | Fear and Dread | Humilia- tion Embarrass- ment and Confusion | Confus- ion | Hurt | Sadness | Anxiety | Disgust |
|----------|-------|----------------------|---|----------------|------|---------|---------|---------|
| Alice | | | X | | | X | | |
| Bridget | X | | | | X | | X | |
| Caroline | X | X | | | | | | X |
| Danielle | X | X | | | | | | |
| Ellen | X | X | | X | | | | |
| Frances | | X | | | | | | |
| Gayle | X | | | | X | X | | |
| Holly | | X | | | | | | |
| Ilene | | | | | | | | |
| Justine | | | | | | | | |

Table 4 Continued

| | Guilt | Betrayal |
|----------|-------|----------|
| Alice | | |
| Bridget | | |
| Caroline | X | X |
| Danielle | | |
| Ellen | | |
| Frances | | |
| Gayle | | |
| Holly | | |
| Ilene | | X |
| Justine | | |

Table 5
Positive feelings in the Grade School Years

| | Self Worth | Love and Courage | Happiness | Excitement | Joy |
|----------|---------------|---------------------|-----------|------------|-----|
| Alice | | | | | |
| Bridget | | | | | |
| Caroline | X | | | | |
| Danielle | | | | | |
| Ellen | | | X | | |
| Frances | | X | X | | |
| Gayle | | | | | X |
| Holly | | | | X | |
| Ilene | | | | | |
| Justine | | | | | |

The positive feelings from grade school years are sparse and quite individual.

Ellen and Frances spent time with their mothers shopping and going to the movies,

Participants saw fathers as passive, absent, absent and ignored, or very much missed.

Helpers in Grade School Years

Participants identified a wide variety of helpers during the grade school years.

One identified her siblings, an aunt and her father. Two named grandmothers, one named her grandfather, and two named family friends. One mentioned many family members who didn't help, and another a professional person who was not helpful.

Three did not address this issue.

Meaning in Grade School Years

Four participants assigned positive meanings to experiences with the mother.

The same four, plus five others gave negative meanings to their experience. One did not give any meanings.

The High School Years

Recalled Events in the High School Years

For almost all the participants, events were increasingly negative, and there were few positive ones. Role reversals declined, to be replaced by conflict and other active behavior. By the age of 18, four participants had left home. Two mothers had left. This left participants with little guidance or support. Bridget and Frances reported problems with self-image. Ellen and Frances continued to have good times with their mothers. Both African-American participants continued to try to get their mothers' approval despite conflict and in Justine's situation great distance.

Table 6
Recalled events in the High School Years

| | Changes in Mother's Behavior | Conflict | Unrewarded Role Reversals | Seeking Approval | Money Problems | Sibling Relation- ships |
|----------|------------------------------------|----------|---------------------------------|---------------------|-------------------|-------------------------------|
| Alice | X | X | X | | | X |
| Bridget | X | X | | | | |
| Caroline | X | X | X | | | |
| Danielle | | X | | | | |
| Ellen | X | X | | | | |
| Frances | X | | X | | | |
| Gayle | | | | | | |
| Holly | | X | | | X | |
| Ilene | X | X | | X | | |
| Justine | | X | | X | | X |

Table 6 Continued

| | Placement | Leaving | Mother Leaves | Distant Relationship | Kicked Out | Self Image | Good Times | Helpful Legacies |
|----------|-----------|---------|---------------|----------------------|------------|------------|------------|------------------|
| Alice | | | | | | | | X |
| Bridget | | | | | | X | | |
| Caroline | | X | | | | | | |
| Danielle | | X | | | | | | |
| Ellen | | | X | | | | X | |
| Frances | | | | | | X | X | |
| Gayle | | | X | | | | | |
| Holly | X | | | | X | | | |
| Ilene | | | | | | | | |
| Justine | | X | | X | | | | |

In addition to these events, Ellen got married just before her mother left, at age 17.

Helpers in High School Years

There was a great variation in the number and type of helpers during the high school years. Only seven reported help, but they reported eleven sources. Justine had the most helpers, four. This degree of help may have had some influence on her good marriage in her late twenties, her completion of college, and her master's degree.

Table 7
Helpers during High School Years

| | Sisters | Friends Mothers | Partner's Mother | Stepfather | Mother | Co-Workers | Father |
|----------|---------|-----------------|------------------|------------|--------|------------|--------|
| Alice | X | X | | | | | |
| Bridget | | | X | | | | |
| Caroline | | | | X | | | |
| Danielle | | | | | | | |
| Ellen | | | | | X | X | |
| Frances | | | | | | | |
| Gayle | | | | | | | X |
| Ilene | | | | | | | |
| Justine | | X | | | | | |

Table 7 Continued

| | Stepmother | Grandparents | Peers | Teachers |
|----------|------------|--------------|-------|----------|
| Alice | | | | |
| Bridget | | | | |
| Caroline | | | | |
| Danielle | | | | |
| Ellen | | | | |
| Frances | | | | |
| Gayle | | | | |
| Ilene | | | | X |
| Justine | X | X | X | |

As she had in grade school at age 11, Frances had an encounter when she was 17 with a professional who was not helpful. She had no other helpers, the only one in that situation, and did not report her grandmother as one. While she is productive as an adult, she takes few risks.

Meaning in the High School Years

Meanings constructed by the participants in the high school years were complex and individualized. I have classified them as either references to a changing reality or interpretations of it. Alice, Bridget, and Danielle make references to changes in their situations. All but Bridget have started to try to develop theories about themselves, their mothers' behavior, their relationships to their mothers, their family dynamics, and their relationships outside the family.

Table 8:
Meaning in the High School Years-References

| | Mother's Illness | Relationship with Mother | Own Needs | Own Behavior |
|----------|---------------------|-----------------------------|-----------|--------------|
| Alice | | X | X | |
| Bridget | X | | | |
| Caroline | | | | |
| Danielle | | | | X |
| Ellen | | | | |
| Frances | | | | |
| Gayle | | | | |
| Holly | | | | |
| Ilene | | | | |
| Justine | | | | |

Table 9
Meaning in High School Years-Interpretations

| | Mother's Behavior | Participant's Behavior | Relationship with Mother | Parental Dynamics | Social- Contextual Reactions |
|----------|----------------------|---------------------------|-----------------------------|----------------------|------------------------------------|
| Alice | X | | | | |
| Bridget | | | | | |
| Caroline | X | X | | | |
| Danielle | X | | | | |
| Ellen | | | | X | |
| Frances | X | X | X | | |
| Gayle | | | | | |
| Holly | X | X | | | X |
| Ilene | X | | X | | |
| Justine | | | | | |

The Late Teens and Twenties

Recalled Events from the Late Teens and Twenties

As the daughters became more independent, their roles in events became more active. Events were much more complex, often including several themes. Daughters experienced significant life changes.

Table 10
Significant Life Changes

| | College Graduation | Marriage | Birth of Children | Deaths |
|----------|--------------------|----------|-------------------|--------|
| Alice | | X | X | X |
| Bridget | | X | | |
| Caroline | X | X | | |
| Danielle | | | | |
| Ellen | | X | X | |
| Frances | | | | X |
| Gayle | | | | |
| Holly | | | X | |
| Ilene | | | X | |
| Justine | X | X | | |

Gayle and Danielle concentrated on work.

In the late teens and twenties the role reversals continued, but they split into two types. Five participants were involved in helping and caring for their mothers in some way. Caroline and Ellen listened to their mothers and helped in some specific situations. All but Frances got some help in return.

Table 11
Role Reversals

| | Caretaking Role Reversals | Role reversals |
|----------|---------------------------|----------------|
| Alice | X | |
| Bridget | X | |
| Caroline | | X |
| Danielle | X | |
| Ellen | | X |
| Frances | X | X |
| Gayle | | |
| Holly | | |
| Ilene | X | |
| Justine | | |

Seven of the mothers had intensified symptoms during their daughters' twenties. Two were hospitalized, and two started pack ratting. Caroline's mother, whose symptoms had started before she was born, kept the same high intensity of symptoms. The relationships between the mothers and daughters became more complex and difficult. The daughters were adults, but still needed emotional support, information, and validation.

Table 12
Change in Mother's Behavior

| | Symptoms Worsen | Hospitalizations | Pack Ratting |
|----------|-----------------|------------------|--------------|
| Alice | | X | |
| Bridget | X | X | |
| Caroline | | | |
| Danielle | X | | X |
| Ellen | X | | |
| Frances | X | X | |
| Gayle | X | | |
| Holly | | | |
| Ilene | X | | |
| Justine | | | X |

Table 13
Relationship Connections and Disconnections

| | Daughter Attempts Connection | Mother Attempts Connection | Daughter Disconnects | Mother Disconnects | Partial Disconnection |
|----------|------------------------------|----------------------------|----------------------|--------------------|-----------------------|
| Alice | X | | | | |
| Bridget | X | | | | X. |
| Caroline | X | | X | | X |
| Danielle | X | | | | |
| Ellen | X | | | | |
| Frances | | | | | |
| Gayle | X | X | | | |
| Holly | | | | | X |
| Ilene | X | | | | X |
| Justine | X | | | X | X |

Table 13 Continued

| | Temporary Disconnection | Conflictual Connections | Intrusive Connections | Financial Connections | Family Pressure to Connect |
|----------|----------------------------|----------------------------|--------------------------|--------------------------|----------------------------------|
| Alice | | | | | |
| Bridget | | X | | | |
| Caroline | | X | | | X |
| Danielle | | X | | X | |
| Ellen | X | X | | | |
| Frances | | | | | |
| Gayle | | | | | |
| Holly | | X | | | |
| Ilene | | X | X | | |
| Justine | | | | | |

The connections represent the ability to interact and receive validation. In the twenties this process needs to be flexible as daughters develop increased independence. The mothers need to tolerate the loss of the more dependent relationship while continuing to be connected. Bipolar mothers have great difficulty with the change, but so do the daughters, who have gotten so little emotional and cognitive validation. The mother-daughter relationships fluctuate wildly.

Table 14
Projections and Internalizations

| | Mother Projects on Daughter | Daughter Internalizes Projection | Daughter Questions Projection/ Internalization Process |
|----------|-----------------------------|----------------------------------|---|
| Alice | | | |
| Bridget | X | X | |
| Caroline | | | |
| Danielle | | | |
| Ellen | | | |
| Frances | | | |
| Gayle | X | X | |
| Holly | | | |
| Ilene | X | X | |
| Justine | X | X | X |

The mother's reality testing is inadequate and she projects her own thoughts and feelings on her daughter and others. Daughters, whose identities are tied to those of their mothers, internalize these projections. Self esteem suffers. The daughters' energies are trapped in the struggle for validation from their mothers and are not free for their own growth.

Table 15
Emotional and Financial Support between Mother and Daughter

| | Mother supports Daughter Emotionally | Daughter Supports Mother Emotionally | Mother Provides Financial Support | Daughter Provides Financial Support |
|----------|--------------------------------------|--------------------------------------|-----------------------------------|-------------------------------------|
| Alice | | X | X | |
| Bridget | | X | | |
| Caroline | | | | |
| Danielle | | X | X | X |
| Ellen | X | X | X | |
| Frances | | X | | |
| Gayle | | | | |
| Holly | | | | |
| Ilene | | | | X |
| Justine | | | | |

Table 15 Continued

| | Mother does not Support Daughter Emotionally | Daughter does not Support Mother Emotionally | Mother Provides Occasional Financial Support |
|----------|--|--|--|
| Alice | | | |
| Bridget | X | | |
| Caroline | X | X | X |
| Danielle | | | X |
| Ellen s | | | |
| Frances | | | |
| Gayle | | | X |
| Holly | X | X | |
| Ilene | X | X | |
| Justine | X | X | |

The mother's struggle to avoid loss and the daughter's struggle for connection and validation are enacted in terms of emotional and financial support.

Table 16
Maternal Betrayals

| | Denies Daughter's Reality | Lies | Siding against Daughter in Family Disputes | Emotional | Financial |
|----------|---------------------------------|------|--|-----------|-----------|
| Alice | | | | | |
| Bridget | | | | | |
| Caroline | | X | | | |
| Danielle | | | X | | X |
| Ellen | X | X | | X | |
| Frances | | | | | |
| Gayle | | | | | |
| Holly | X | | | | |
| Ilene | | | | X | |
| Justine | | | | | |

The daughter is apt to perceive betrayal in when the validating connection between her and her mother is lost.

Table 17
Reported Chemical Abuse and Chemical Dependency

| | Participant | Mother | Both Parents |
|----------|-------------|--------|--------------|
| Alice | | X | |
| Bridget | | | |
| Caroline | X | X | |
| Danielle | | | |
| Ellen | | | |
| Frances | | | |
| Gayle | X | | X |
| Holly | | X | |
| Ilene | | | |
| Justine | | | |

Daughters tend to imitate parents in use of drugs and alcohol. Use on the part of both generations complicates the already difficult relationships. Caroline has been sober since her early twenties, but not early enough to affect adolescent conflict with

her mother. Gayle has a distant relationship but her mother does not understand the ramifications of her recovery.

Helpers in the Late Teens and Twenties

Table 18
Helpers in Late Teens and Twenties

| | Father | Maternal Grand-mother | Paternal Grandparent | Child's Paternal Grand-parents | Step-mother | Step-father |
|----------|--------|-----------------------|----------------------|--------------------------------|-------------|-------------|
| Alice | | | | | | |
| Bridget | | | | | | |
| Caroline | | | X | | | X |
| Danielle | | | | | | |
| Ellen | X | | | | | |
| Frances | | X | | | | |
| Gayle | | | | | | |
| Holly | | X | | X | | |
| Ilene | | | | | | |
| Justine | | | | | X | |

Table 18 Continued

| | Father in Law | Sister in Law | Co-Workers | Acquaintances | Therapists |
|----------|---------------|---------------|------------|---------------|------------|
| Alice | X | X | | | |
| Bridget | | | | | |
| Caroline | | | | | X |
| Danielle | | | | | |
| Ellen | | | X | | |
| Frances | | | | | |
| Gayle | | | | | |
| Holly | | | | | |
| Ilene | | | | X | |
| Justine | | | | | |

The amount of help available has declined in the late teens and twenties.

Only Alice, Caroline, and Holly have more than one source. Bridget, Danielle, and Gayle have none.

Meaning in Late Teens and Twenties

Table 19
Meanings in Daughter's Relationship with Mother

| | Love | Sees Mother in Self | Guilt | Resentment | Delayed Adolescence | Finally a Positive Relationship | Relieved at Mother's shame |
|----------|------|---------------------|-------|------------|---------------------|---------------------------------|----------------------------|
| Alice | | | | | | | |
| Bridget | | | | | | | |
| Caroline | | | | | | | |
| Danielle | X | | X | | | | |
| Ellen | | X | | | | | |
| Frances | | X | | X | X | | |
| Gayle | | | | | | X | X |
| Holly | | | | | | | |
| Ilene | | | | | | | |
| Justine | | | | | | | |

Table 19 Continued

| | Ashamed | Despair when Alone | Fear of Mothering Like Mother | Being a Better Mother | No Love for Mother | Yearning for Approval | Distant Strained relationship |
|----------|---------|--------------------|-------------------------------|-----------------------|--------------------|-----------------------|-------------------------------|
| Alice | | | | | | | |
| Bridget | | | | | | | |
| Caroline | | | | | | | |
| Danielle | | | | | | | |
| Ellen | | | | | | | |
| Frances | | | | | | | |
| Gayle | X | | | | | | |
| Holly | | X | X | X | X | | |
| Ilene | | | | | | X | |
| Justine | | | | | | | X |

Although Danielle feels love for her mother it is tempered by guilt. Even though Gayle is happy to have a positive, somewhat validating relationship, there is a negative twist to it: her mother is ashamed of her illness, and Gayle is relieved by that. She herself is ashamed of her mother. (At this time Gayle was already an alcoholic, although she did not know it.)

Recalled Recent Events

Recalled Recent Events with Mother

In this section Ellen and Holly do not speak. They have already told their recent events from the first half of their twenties. Alice, Bridget, Caroline, Danielle, Frances, and Justine are in their thirties. Gayle and Ilene are in their early fifties. Frances' mother and grandmother have been dead for ten years. The living mothers are older. In some cases they have had to stop taking lithium due to the side effects and are on less effective medications. None of the daughters understand the reasons for the change. In all of the situations, the bipolar behavior has intensified. Their stories report the following content:

Table 20
Mother's Negative Behavior

| | Manic Behavior | Attempts to Provoke Reactions | Wanders | Refuses Medical Care | Increased Pack Ratting | Lies | Brings Trash as Gift |
|----------|----------------|-------------------------------|---------|----------------------|------------------------|------|----------------------|
| Alice | | X | X | | X | | |
| Bridget | | | | | | | |
| Caroline | | | | | | | |
| Danielle | X | | | X | | | |
| Ellen | | | | | | | |
| Frances | | | | | | | |
| Gayle | | | | | | | |
| Holly | | | | | | | |
| Ilene | | | | | | X | |
| Justine | | | | | X | | |

Table 20 Continued

| | Mother Enraged & Manipulative | Mother Very Anxious | Hostile to Daughter's Friends | Unrealistic Expectations | Unable to Live Together | Daughter Considering Placement |
|----------|-------------------------------|---------------------|-------------------------------|--------------------------|-------------------------|--------------------------------|
| Alice | | | | | X | X |
| Bridget | | X | | | | |
| Caroline | X | | | | | |
| Danielle | | | | | | |
| Ellen | | | | | | |
| Frances | | | | | | |
| Gayle | | | | X | | |
| Holly | | | | | | |
| Ilene | | | X | | | |
| Justine | | | | | | |

Alice tried to make a home for her mother after she was released from the hospital, but her mother's late hours and phone calls kept Alice and her daughters from sleeping. The mother wanted to go back to her dirty, junk-filled house. Reluctantly Alice let her go. Now Alice wonders whether she would be better off in a

group home, but her siblings won't help her make the decision. As their mothers' symptoms worsen, and their ability to manage their mothers decreases, the caretaking daughters will need to face their feelings and make similar decisions.

Table 21
Mother's Positive Behavior

| | Restored Sense of Purpose | Accepts Physical Affection | Supplied Family History | Asks Daughter's Advice | Positive Legacies |
|----------|---------------------------------|----------------------------------|-------------------------------|------------------------------|----------------------|
| Alice | | | | | |
| Bridget | | X | | | |
| Caroline | | | | | X |
| Danielle | | | X | | |
| Ellen | | | | | |
| Frances | | | | | |
| Gayle | | | | | X |
| Holly | | | | | |
| Ilene | | | | X | |
| Justine | X | | | X | |

Not all the behaviors were negative. There were positive responses to grandchildren, more respect for some daughters as they got older and better responses to daughters who demanded little from them.

Table 22
Quality of Relationship

| | Connected | Partially Disconnected | Disconnected | Restored Connection due to Birth of Grandchild | Conflicted Connection |
|----------|-----------|---------------------------|--------------|---|--------------------------|
| Alice | X | | | | X |
| Bridget | X | | | | X |
| Caroline | | | X | | X |
| Danielle | X | | | | |
| Ellen | X | | | X | X |
| Frances | | | | | |
| Gayle | | X | | | |
| Holly | | | X | | X |
| Ilene | X | | | | X |
| Justine | | | | X | |

Table 22 Continued

| | Mother not Support -ive | Daughter not Support- ive | Mother Ignores Daughter's Caring | Daughter Aware She Cannot Control Mother's Illness | Role Reversal | Financial Betrayal |
|----------|----------------------------------|------------------------------------|--|---|------------------|-----------------------|
| Alice | | | X | X | | |
| Bridget | | | X | | | |
| Caroline | X | X | | | | |
| Danielle | | | | | | X |
| Ellen | | | | | | |
| Frances | | | | | | |
| Gayle | X | | | | X | |
| Holly | | | | | | |
| Ilene | | | | | | |
| Justine | | | | | | |

Only two daughters who were connected to their mothers reported no conflict.

The two daughters who reported being disconnected still do some things for their mothers. Caroline still has a half-hidden hope for change in her mother's attitude. In the context of these connections other types of interactions take place.

Table 23
Daughters' Feelings

| | Guilt | Anger | Sadness | Fear | Worried about Mother | Daughter Worried she Might be Bipolar | Happy |
|----------|-------|-------|---------|------|----------------------|---------------------------------------|-------|
| Alice | X | X | X | | X | | |
| Bridget | | | | | X | | |
| Caroline | | | | | | | |
| Danielle | | | | X | X | | |
| Ellen | | | | | | | |
| Frances | | | | | | | |
| Gayle | | | | | | X | |
| Holly | | | | | | | |
| Ilene | | | | | | | |
| Justine | | | | | | | X |

All the feelings are negative except Justine's. She is happy for the restored partial connection she has with her mother due to her daughter's birth.

Recalled Recent Events with Mother that Involved Partners

Table 24
Recalled Recent Events with Mother that Involved Partners

| | Mother has + Relationship with Partner | Mother Blames Participant for Problems | Mutual Financial Assistance | Good Holidays | Transferences from maternal relationship to marital relationship |
|----------|--|--|-----------------------------------|------------------|---|
| Alice | X | X | X | X | |
| Bridget | | | | | X |
| Caroline | | | | | |
| Danielle | | | | | |
| Ellen | | | | | |
| Frances | | | | | |
| Gayle | | | | | |
| Holly | | | | | |
| Ilene | | | | | |
| Justine | X | | | | |

Table 24 Continued

| | Low Trust in Marriage | Mother has negative relationship with Partner | Mother Uses Partner vs. Daughter | Disconnection in Mother-Daughter Relationship |
|----------|--------------------------|--|--|---|
| Alice | | | | |
| Bridget | X | | | |
| Caroline | | X | X | X |
| Danielle | | | | |
| Ellen | | | | |
| Frances | | | | |
| Gayle | | | | |
| Holly | | | | |
| Ilene | | | | |
| Justine | | X | | |

Five participants reported both negative and positive interactions that involved their mother and their partner.

Recalled Recent Events with Mother that Involved Children

Table 25
Recalled Recent Events with Mother that Involved Children

| | Mother has Positive Relationship with Grandchildren | Mother Participates in Grandchildren's Lives | Mother Affectionate with Grandchildren | Mother Firmer Disciplinarian than Daughter | Mother Defers to Daughter's Discipline |
|----------|---|--|--|--|--|
| Alice | X | X | | | |
| Bridget | | | X | X | X |
| Caroline | | | | | |
| Danielle | | | | | |
| Ellen | | | | | |
| Frances | | | | | |
| Gayle | | | | | |
| Holly | | | | | |
| Ilene | | | | | |
| Justine | X | X | | | |

Table 25 Continued

| | Mother Has Mixed Relationship with Grandchildren | Mother Starts Arguments in Front of Children | Daughter Does not Trust Mother's Judgment | Mother Unable to Put Children First | Mother has Unrealistic Expectations of Grandchildren | Mother Uses Grandchildren against Daughter |
|----------|--|--|---|-------------------------------------|--|--|
| Alice | | | X | X | | |
| Bridget | X | X | | X | X | |
| Caroline | | X | | | | X |
| Danielle | | | | | | |
| Ellen | | | | | | |
| Frances | | | | | | |
| Gayle | | | | | | |
| Holly | | | | | | |
| Ilene | | | | | | X |
| Justine | | | X | | | |

Table 25 Continued

| | Mother Unable to care for Grand- children Alone | Daughter Allows No Contact between Mother and Grandchildren | Ambivalent Hopes to have Children | More Positive Mother- Daughter Relationship |
|----------|--|--|--|---|
| Alice | X | | | |
| Bridget | | | | |
| Caroline | | X | | |
| Danielle | | | | |
| Ellen | | | | |
| Frances | | | X | |
| Gayle | | | X | |
| Holly | | | | |
| Ilene | | | | |
| Justine | X | | | X |

Of the six participants that reported, three identified both positive and negative events with their mother that included their children. Frances and Gayle hoped for children despite their ages.

Danielle had no children but she did have cats and kittens. Her mother took an interest in the animals and would visit, in a way similar to the grandmothers visiting their grandchildren. At those times she interacted with Danielle in a positive way.

Recalled Recent Events with Mother that Involved Family Members

Table 26
Recalled Recent Events with Mother that Involved Family Members: Positive
Events

| | Daughter Avoids Conflict | Daughter Just Listens to Mother's View of Family Conflict | Mother Increases Respect for Daughter | Siblings work Together in Emergencies |
|----------|--------------------------------|--|---|--|
| Alice | | | | X |
| Bridget | | | | X |
| Caroline | | | | |
| Danielle | X | | | |
| Ellen | | | | |
| Frances | | | | |
| Gayle | | | | X |
| Holly | | | | |
| Ilene | | | X | |
| Justine | | X | | |

Only one of these events involves positive change in the mother's behavior.

Two involve positive changes in the behavior of the daughters. Gayle's sibship always may have worked together in emergencies.

Table 27
Recalled Recent Events with Mother that Involved Family Members:

Negative Events

| | Mother's Symptoms Worsen | Family Members Worried &/or Confused | Sibship Distant & in Conflict | General Family Conflict | Family members in Conflict with Mother | Daughter has Negative Feelings About Her Own Role |
|----------|--------------------------------|--|-------------------------------------|-------------------------------|--|--|
| Alice | X | | X | | X | X |
| Bridget | X | X | | X | | |
| Caroline | | | | | | |
| Danielle | X | X | | | X | |
| Ellen | | | | | | |
| Frances | | | | | | |
| Gayle | X | X | X | | X | X |
| Holly | | | | | | |
| Ilene | | | | | | |
| Justine | | | | | | |

As the mother's symptoms worsen, there is family conflict in the families of the four reporters. Alice, a caretaking daughter, needs help. Like adolescence, this change requires family changes.

Recalled Recent Events with Mother that Involved Work or Career

Table 28
Recalled Recent Events with Mother that Involved Work or Career

| | No Support for Success | No Support for Career | No Support for Career Development | Girls' Work Is House-work | No Understanding of Job | Mother Verbally Abusive About Work | Mother Wants to Interfere at Job |
|----------|------------------------|-----------------------|-----------------------------------|---------------------------|-------------------------|------------------------------------|----------------------------------|
| Alice | | | | | | | X |
| Bridget | X | X | | X | | | |
| Caroline | | | | | | | |
| Danielle | | | X | | | | X |
| Ellen | | | | | | | |
| Frances | | | | | | | |
| Gayle | | | | | | | |
| Holly | | | | | | | |
| Ilene | | | | | | X | |
| Justine | | | | | X | | |

Table 28 Continued

| | Mother Undermined Business | Caught Between Mother & Work | Mother Comes First | Illness a Secret | Lies to Cover Absences | Work Supports Family & Mother | Work Helps Daughter Cope |
|----------|----------------------------|------------------------------|--------------------|------------------|------------------------|-------------------------------|--------------------------|
| Alice | | X | X | X | X | | X |
| Bridget | | | | | | | |
| Caroline | X | | | | | | |
| Danielle | | | | | | X | |
| Ellen | | | | | | | |
| Frances | | | | | | | |
| Gayle | | | | | | | |
| Holly | | | | | | | |
| Ilene | | | | | | | |
| Justine | | | | | | | |

Daughters report the same lack of support and problematic behavior that impeded their careers when they were younger. Alice and Danielle continue their care

of their mothers. Alice's behavior is an extension of a role reversal that started in childhood.

Meaning of Maternal Relationship

Meaning of Maternal Relationship to Identity

Table 29
Meaning of Maternal Relationship to Identity

| | Similar to Mother's Behavior | Opposite from Mother's Behavior | Mixed | Other Positive | Other Negative |
|----------|------------------------------|---------------------------------|-------|----------------|----------------|
| Alice | | | X | X | |
| Bridget | | | X | X | X |
| Caroline | | X | | | |
| Danielle | | X | | X | X |
| Ellen | X | | | | |
| Frances | | | X | X | |
| Gayle | X | | | X | X |
| Holly | | | | | X |
| Ilene | | | | X | X |
| Justine | | | | X | X |

All of the participants saw themselves as taking some part of their identity from their relationship to their mothers. The "other" categories refer to behaviors that are neither like nor unlike their mother's behavior.

Meaning of Maternal Relationship to Partner Relationship

Table 30
Meaning of Maternal Relationship to Partner Relationship

| | Relationship Similar to that with Mother | Relationship Dissimilar to that with Mother | Both Similar and Dissimilar to that with Mother | Positive Other | Negative Other |
|----------|---|--|---|----------------|----------------|
| Alice | | | X | | |
| Bridget | X | | | X | X |
| Caroline | | | X | X | |
| Danielle | | | | | |
| Ellen | | | X | X | |
| Frances | | | X | | X |
| Gayle | | X | X | | X |
| Holly | X | | | | X |
| Ilene | X | | | | |
| Justine | | X | | X | |

Partner relationships inevitably included some meaning from the maternal relationship.

Meaning of Maternal Relationship to Parental Relationship

This was also true of the daughters' relationships with their children. None thought they parented like their mothers, but Alice and Ilene could see some similarities.

Table 31
Meaning of Maternal Relationship to Parental Relationship

| | Maternal Relationship Similar to Parental Relationship | Maternal Relationship Dissimilar to Parental Relationship | Mixed | Positive Other | Negative Other | No Children |
|----------|--|---|-------|----------------|----------------|-------------|
| Alice | | | X | | X | |
| Bridget | | X | | | X | |
| Caroline | | X | | | X | |
| Danielle | | | | | | X |
| Ellen | | X | | | X | |
| Frances | | | | | | X |
| Gayle | | | | | | X |
| Holly | | X | | | | |
| Ilene | | | X | X | | |
| Justine | | X | | | | |

Meaning of Maternal Relationship to Relationships with Family Members

Table 32
Daughter's Understanding of how Extended Family Sees Her

| | Mother's Caregiver | Scapegoat | Mother's Support | Local Executive of Family Events | Distant from Family Members | Caregiver in Multiple Relationships |
|----------|--------------------|-----------|------------------|----------------------------------|-----------------------------|-------------------------------------|
| Alice | X | | X | | X | |
| Bridget | X | | X | | | |
| Caroline | | | | | | |
| Danielle | | | | | X | |
| Ellen | | | | | X | |
| Frances | | | | | | X |
| Gayle | | | | | | X |
| Holly | | X | | | | |
| Ilene | | X | | | | |
| Justine | X | | | X | X | |

It seemed the only way to depict the quality of family relationships was to record the dichotomies as seen by the participant, since other family members are not available for this research.

Table 33
Daughter's View of Extended Family

| | Extended Family Members Avoid Mother & Situation | Extended Family will Help Daughter if Mother Doesn't know | Extended Family is Distant but can be Cooperative & Flexible | Daughter is Grateful for any Family Contact | Extended Family Provides No Support |
|----------|--|---|--|---|-------------------------------------|
| Alice | X | | | | X |
| Bridget | X | | X | | |
| Caroline | | | | | |
| Danielle | X | | | | X |
| Ellen | | | | | X |
| Frances | | | | | |
| Gayle | | | X | | |
| Holly | X | X | | X | |
| Ilene | | | | | X |
| Justine | X | | | | |

The Meaning of the Maternal Relationship to Work or Career

Table 34
The Meaning of the Maternal Relationship to Work or Career

| | No Support for Education | No Support for Career Development | No Support for Creativity | Repeats Mother's Negative Work Patterns & Values | Improves Mother's Negative Work Patterns | Repeats Mother's Positive Work Patterns & Values | Repeats & Corrects Maternal Relationship in Work Setting |
|----------|--------------------------|-----------------------------------|---------------------------|--|--|--|--|
| Alice | X | X | | | | | |
| Bridget | X | X | X | | | | |
| Caroline | X | X | | | | | X |
| Danielle | | | | | | | |
| Ellen | X | X | | X | X | | |
| Frances | X | X | | | | | |
| Gayle | X | | | | | | |
| Holly | | | X | X | X | | |
| Ilene | | | | | | X | |
| Justine | | | | | | X | |

Table 34 Continued

| | Feels Negative about Self in Work | No Patience with Workplace Politics | Resists Supervision | Not realistic about Work & Opportunities | Enjoys Staying Home With Son | Negative Transition to Management |
|----------|-----------------------------------|-------------------------------------|---------------------|--|------------------------------|-----------------------------------|
| Alice | | | | | | |
| Bridget | | | | | | X |
| Caroline | | | | | | |
| Danielle | | X | | | | |
| Ellen | | | | | | |
| Frances | | | | | | |
| Gayle | X | | X | X | | |
| Holly | | | | | X | |
| Ilene | | | | | | |
| Justine | | | | | | |

Six of the ten participants felt their mother had given no support for education.

Five felt that they got no support from their mother for career development. Ilene and

Justine imitated their mothers' positive work patterns and values. Caroline reworked her relationship with her mother in the context of her own small service business.

Anything Else about the Meaning of your Relationship with your Mother?

Table 35
Love and Compassion

| | Love of Mother | Compassion for Mother | More Compassionate |
|----------|----------------|-----------------------|--------------------|
| Alice | X | X | |
| Bridget | X | X | |
| Caroline | | | X |
| Danielle | X | X | |
| Ellen | | | |
| Frances | X | | |
| Gayle | | X | |
| Holly | | | |
| Ilene | | | |
| Justine | X | | |

Table 36
Closeness and Distance

| | Close to Mother | Distant from Mother | Disconnected from Mother |
|----------|-----------------|---------------------|--------------------------|
| Alice | X | | |
| Bridget | | X | |
| Caroline | | | X |
| Danielle | X | | |
| Ellen | X | | |
| Frances | | | |
| Gayle | | X | |
| Holly | | | X |
| Ilene | X | | |
| Justine | | X | |

Table 37
Conflict and Reconciliation

| | Conflict | Partial Reconciliation | Reconciliation | Hopes for Reconciliation |
|----------|----------|------------------------|----------------|--------------------------|
| Alice | | | X | |
| Bridget | X | | | X |
| Caroline | X | | | |
| Danielle | | | X | |
| Ellen | | X | | |
| Frances | | | | |
| Gayle | | | | X |
| Holly | X | | | |
| Ilene | X | | | |
| Justine | | X | | |

Table 38
Anger and Acceptance

| | Accepts Mother's Anger | Accepts Own Anger | Does not Accept Mother's Anger | Does not Accept Own Anger |
|----------|------------------------------|----------------------|-----------------------------------|---------------------------------|
| Alice | X | X | | |
| Bridget | | | X | X |
| Caroline | | | X | X |
| Danielle | X | | | X |
| Ellen | X | | | X |
| Frances | | X | | |
| Gayle | | | | X |
| Holly | | X | X | |
| Ilene | | X | | |
| Justine | | | | X |

Table 39
Control Issues

| | Feels in Control of Self | Feels Out of Control of Self | Wants to Control Disease | Accepts Inability to Control Disease | Does not Understand disease |
|----------|--------------------------|------------------------------|--------------------------|--------------------------------------|-----------------------------|
| Alice | X | | | X | X |
| Bridget | | X | X | | X |
| Caroline | | X | | | |
| Danielle | | X | X | X | |
| Ellen | | X | | X | |
| Frances | | X | | | |
| Gayle | | X | X | | |
| Holly | | | | | X |
| Ilene | | | | | |
| Justine | X | | | X | |

Table 40
Positive Outcomes

| | Good Relationship | More Compassionate | Knowledge | Strength |
|----------|-------------------|--------------------|-----------|----------|
| Alice | X | | | |
| Bridget | | | | |
| Caroline | | X | | |
| Danielle | X | | | |
| Ellen | | | | |
| Frances | | | X | X |
| Gayle | | | | |
| Holly | | | | |
| Ilene | | | | |
| Justine | X | | X | X |

Table 41
Negative Outcomes

| | Resentment | Mistrust | Socially Backward | Intense Anxiety | Depression | Anger | Fear of Emotion |
|----------|------------|----------|----------------------|--------------------|------------|-------|--------------------|
| Alice | X | | | | | | |
| Bridget | | X | | X | | X | X |
| Caroline | | | X | X | X | X | X |
| Danielle | | | | | | | X |
| Ellen | | | | | | | |
| Frances | | X | | | | | |
| Gayle | | | | X | | | |
| Holly | | | | | | X | |
| Ilene | X | X | | | | | |
| Justine | | | | | | | X |

Table 41 Continued

| | Drawn to Difficult & Abusive People | Automatic Caregiving Roles | Chronic Substance Dependence |
|----------|---|----------------------------------|------------------------------------|
| Alice | | | |
| Bridget | | X | |
| Caroline | | | |
| Danielle | | | |
| Ellen | | | |
| Frances | X | X | |
| Gayle | | | X |
| Holly | | | |
| Ilene | | | |
| Justine | | | |

Table 42
The Future

| | Fears about Mother's Death | Hopes for Continued Stability | Continued Improvement in Daughter's Life | Hopes for Relationship with Mother | Focusing on Self & or Children | Hopes Current Relationship Continues |
|----------|----------------------------------|-------------------------------------|--|--|---|---|
| Alice | | | | | | |
| Bridget | X | | | X | | |
| Caroline | | | | | X | |
| Danielle | | | | | | |
| Ellen | | X | | | | |
| Frances | | | X | | | |
| Gayle | | | | X | | |
| Holly | | | | | | |
| Ilene | | | | | X | |
| Justine | | | | | | X |

CHAPTER FIVE:

DISCUSSION OF FINDINGS

Introduction

The three research questions are briefly answered in the tables in the findings chapter. The following narratives answer them in a more detailed way.

This chapter discusses and exemplifies the two longest lasting and most populated themes identified in the tables of the findings chapter. The first is role reversal, the second is conflict. Both themes are intertwined with the variations in the connections in the mother-daughter relationship.

Role Reversals

By far the most prominent and enduring of these is role reversal. The participants tell their own stories because each is different.

Caroline tells how she was taking care of herself at age five.

I was five... and a...footie pajamas and...she was gone. And I remember that I couldn't reach the refrigerator and I couldn't reach the blinds and there was no adult there and I just...I just remember being angry... Um...great, I'm in charge ... damn! [sigh]... I just remember trying to get...a...furniture to reach the cabinets, so that I could eat, and getting really pissed off that there were no adult that...it's like hello, you know, I'm five. It's like where is an adult? How am I here by myself? And I remember the wall phone, not being able to reach the phone, the cabinets, the refrigerator

It is very clear that she is assuming the role of her own caregiver under duress, that she's not very good at it, and she is very angry to be put in that position.

During the grade school years seven out of ten participants reported role reversals. Each role reversal was sharply different.

Alice remembers:

I do remember there were times when my mom did housework, she slept a lot. She would get up and make dinner. I remember coming home from school and watching TV and she would be sleeping on the couch. She slept quite a bit... I didn't really think about it because I didn't know differently. As far as I can remember, she always slept a lot and cooked. The housework me and my siblings did most of the time.

The presence of Alice's siblings seems to normalize activities that otherwise might be more burdensome. They shared the work so it was not that hard, and they kept each other company even though they did not get along at other times.

Bridget began to take emotional responsibility for her brothers before seventh grade.

I already knew that mom wasn't in control, so I was going to have to be in control, so... I used to really, worry about my brothers walking home from school 'cause she would freak out about that. Somebody was going to kidnap 'em, somebody is going to take 'em, y'know. And I remember one time really having a huge amount of anxiety because one of my little brothers wasn't home from school yet. And I was not in the 8th grade. I must have been younger, and just feeling like if he didn't then it was me, I should have ...I already, I already was starting to feel like I had to take control of that. I was ...very upset that he wasn't home. And I thought something was horrible was going to happen to him. But looking at it...She was acting that way and pacing and... acting weird.

Caroline was still taking care of herself, even when her mother was semi-available.

...so during one of these, it's real hard to get a-hold of a homeless heroin junkie but I'm still going to school and ...I get violently ill and I shit myself ... And I have no clothes at this school, and I'm with the nurse and they keep calling her and ...they can't get a-hold of her. But I know she's on campus because everybody in the family went to State ... and I'm trying to call her and find out what class she's in. ...the age I was, how the hell did I know to tell them to call State? I've been sitting in my own shit for three hours and she walks in and I slap her. ...And her reaction was so all about her. It turned into, she suddenly, after I slapped her, turned into the perfect parent for the nurse... She took me, she took me home and ...in this ...all real sing songie, like it was a commercial – “Baby, I'm so sorry that happened.” And I'm like, “Dude, how about getting me into some clean clothes,” “No, they called me and I came right “I know where you were. In relationship to where I'm at, you could have gotten me something.” And, it was just...but it turned into getting me home and it being about let's play checkers, since we both have the day off,”

Ellen 's mother did not expect Ellen to take care of herself as Caroline's did, but there was role reversal all the same in her relationships with her daughter's friends.

And I think that's part of the bipolar. ...She was more of like my friend... tried to be, because there was some times when she'd act like... when she would say certain things to me, and I'd be like, “You're my mother.” ... And she's be like, “Well, I can be your friend too, and stuff.” And I just remember being like, “No.” [laughs] ...“No, that...that's...” ...She was always really good friends with my friends too, which really bothered me.

Frances was very protective of her mother, and tried to rescue her when she was being raped.

Well, that was when I was, I guess, when she ended up hospitalized when I was, uh, 10...that...when I was 11...that was that summer. This guy that was this supposed reverend, he lured her to his... uh, home, and he...I was with my girlfriends...my friends...And I followed down there, and I guess she could hear me banging on the door with my friends, trying to get her out of there. And what he did was he gave her drugs and... raped her... and then that landed her in the hos...then she came and said, “Oh, I have to call the hospital. I've got drugs in me”. ...I'm 11 years old. If I had my uncle's

shotgun, I'd blow the door knob off, and I might kill him for hurting my mother, you know [laughs]. I hate to say it.

Frances seems to have had this energy because she had considerable protection and nurturing from her grandmother.

Gayle took on, on her own, many tasks that kept her home and yard in order so she would not be ashamed in front of friends.

I'm also the oldest of six children, so... as I became older, so my relationship in my household and with my mother was ...just to be her helper... to take care of...all of the children when she was gone... with my dad. A lot of [chores], ...I took upon myself, because I wanted our house to be a certain way... really clean... ... I thought this was just what you did. I thought, if you were older, you took care of the kids. I didn't realize that that wasn't my responsibility at the time. But I didn't know. That's what I was asked to do ...How I found out was because of her maternity clothes hanging up in the bathroom again, and I thought, I was...I sank...my heart sank, like another child. I felt like so disturbed, and sad, and doom...you know, another child coming into this family. We had a three bedroom house and there's six kids.

Until quite far into the interview with Gayle, she spoke as though she was much younger than she actually was. She was unclear about her age until we clarified it later in the interview. I was able to calculate her age as eleven when her brother was born.

Holly had a very different kind of experience.

Oh, well, when I was in middle school; that got bad because the abuse was very extreme. I, um, was babysitting then. From the minute I started working, she took my money... that caused a lot of fights, because ...I would work a lot to save that money, to buy myself things, to...to do whenever I needed to... go out with my friends...or save up for something special, or what have you. And she would take it constantly because she drank so often. She did drugs. She would go to the bar, and just take my money, and spend it all. She would wear my clothes to go out. ...my grandmother, um, didn't show affection physically. She showed affection by buying me things. ...So she would buy

me these nice clothes ...because it was her way of telling me. And I would feel special in my nice clothes. And my mother would take them and wear them, and she'd go to the bar, and she'd get so drunk, and she'd throw up all over them so... much, or she'd rip them because she didn't quite fit into them, um, or...she was very promiscuous. She would, I mean, go home with guys, bring them home while I was there...that started in middle school too.

For Holly, conflict started earlier than in high school.

In high school only three of the ten participants reported role reversals, Alice, Caroline, and Frances. Conflict accompanied caretaking for Alice and Caroline and replaced it for Bridget, Ellen, and Holly. Alice says:

I remember feeling bad for her. Because she didn't do a lot of housework. I lost the joy in doing dishes and cleaning house. I still did it because nobody else would do it. My oldest sister had already left: she got married and left the house very young. She was 15 or 16 and pregnant. So a lot of the stuff that she did shifted to me. ...None of us finished high school.

Caroline felt she had to rescue her drunken mother.

Another high school one... I don't have a car, she's on...she's now gone back to school, again, this time for a law degree. She calls me from some bar on campus so fucking drunk, and Tom, my step dad, bless his heart, was probably working one of his three jobs. He's not home. And she's like, "You have to come get me, you have to come get me." I have to call a friend; a male friend who I knew had a crush on me, whom I could get out of bed at this time of night. I don't have a car so again here I am, you know, not sleeping with him to get this favor but, using my feminine wiles to get this man out of bed. Well, he's a child like me, let's be real, he's just barely older because he has a car, drives me down to the campus to get my drunk mother [pause] and this crazy bitch actually has the audacity to try to convince me to drive her car home ...I haven't been to driver's ed at this point!

Frances had to commit her mother.

...and then later on, when was 17, and I had to commit her because my grandmother just couldn't do it, and I had to fill all the paper work out, then this woman said, "If you ever need to talk about anything, you know, we're

here. You can call me.” And I said, “Oh, forget that. I don’t need anybody’s help. And I’ll take care of it on my own.”

Role reversals increased in the late teens and early twenties. Five participants functioned as caregivers for their mothers or assumed part of their mothers’ roles.

Alice was her mother’s advocate

I remember going to the doctor with her a couple of times because I really wanted to try to understand, to try to help her. I think that a lot during my twenties that I thought that I was her savior, that somehow [laughs], some way that I was going to find a cure for her problems [laughs. ...I never did. ...I listened, I read different things, and I still couldn’t figure out how to keep her taking her medicine, um, or... what kind of medicine that she needed to stay on to keep her balance for a long period of time. So, when she was younger, I think she took tranquilizers and they, um, started affecting her organs, so they had to be careful of what they put her on after awhile.

Bridget was an empathic hands-on caregiver, trying to soothe her mother’s distress.

I think she went in the hospital. So I don’t remember. It’s all getting all mixed up now. My twenties were like ...the worst years of my life was that time, because I think ... very codependent, very in tune to everything she was going through. And it was ...it was hell. She would be lying in bed, she’d be crying, she’d call me up at work crying. So I think it’s like she couldn’t call my dad so she’d call me.

Danielle struggled with her mother’s pack-ratting.

I tried to keep as much of her stuff as I thought I could, you know, that was sentimental to her, things that I knew, you know, she’d had for a really long time and that she really liked. And I packed all that stuff up and I put it away safely and got rid of everything else... three couches, a dining room table stacked on top of another one, one that was like half broken and meant to fix it at some point...so we just got rid of it ...she had a fit [laughs].

Frances actually had to supervise her mother until she died at sixty-seven, when Frances was 29. She expresses love and resentment about the relationship, but there was no conflict.

Well, I felt like I was the mother and she was the child then, and having to take over the role, even though I felt like I was a mother when I was littler. But then, it was even more pronounced. I'm having to lead her around and be like the mother to her... and she hasn't really, you know, been my mother." There was resentment...and then, maybe I didn't understand everything back then, that she couldn't help it... rebelled against responsibility all through life, but had it thrust upon me [laughs].

Ilene tried to improve her mother's life, but she was also trying to prove her worth to her mother and gain her approval.

... I wanted to show her how productive I was. I would buy things for the house. Washing machines, I bought the dryer, we had never had a dryer... being incredibly poor... that buying a dryer seemed like a luxury to most black people. ...So of course as soon as I had started working, the first thing I did is I would accumulate my money, save it, and buy these items which I felt were so important. And my mother never appreciated it. She would always tell me, "That's a waste of money; I don't know what you bought that for."

Ilene's analysis of her own motivation may apply, at least in part to the motivations of other daughters, a way of reaching for approval and closeness.

Not all the role reversals in the twenties were care giving, nor were they initiated by the daughters. Caroline, Ellen and Frances were thrust into situations they just had to handle. Caroline's concerned the birth of her second child.

Second child...I was married, um, and I asked her to watch the oldest. Went into a rage. I...my water's broken, I'm having contractions in the front yard. I mean, you know, I can feel his head. She's screaming because I won't let her come to the hospital! I'm like, "Your other grandchild's in the house, probably awake now because you're screaming! You need to go in the house and be with him. "

Ellen needed emotional support, due to a bad relationship and instead was asked to support her mother emotionally because of her mother's bad relationship.

... "You are so dumb." I go, "You shouldn't let him take your money."
 ... "You shouldn't let him take anything." ...he pawns all her jewelry. That's how weird this guy was. And I was like, "Mom, why'd you let him do that?"
 ...And it feels like sometimes I have to be the mother... I have to be the adult one, because I had to be the one to tell her, "Look, you're being stupid."...and it hurts...it makes me angry because I feel I shouldn't have to do that. That's not my job.

After her mother's death Frances had to handle her grandmother's last illness, death, and arrangements because her uncle couldn't face it.

...She was in the hospital... They... took her to the hospital and put her on the machines... I called... and... there was so much damage. And then I realized...I said, "Well, we don't want her on the life support." But I had to go to the doctor and request that. ...And then I got blamed, "Oh, you... you let 'em take grandma to the hospital when your mother died. That helped shorten her life." ...I'm being told, "You should have got them to the hospital,"...and then, "Oh, you shouldn't have taken them to the hospital." What should you do? And I have to do everything. And my uncle couldn't deal with it when my grandmother died.

Of the ten participants, three continued caretaking behaviors after the twenties, but it would be hard to define them as role reversals at that point.

The participants invested a great amount of energy in taking care of themselves when the mother was incompetent, and in taking care of their mothers, seeking closeness and approval. The energy needed for their own development was used to deal with their day-to-day problems and process the pain of their relationships with their mothers. All of these women are to some extent hampered in their development.

Conflict

In early childhood and in the grade school years the participants were essentially acted upon by the mother and her environment. Their responses ranged from becoming the parent in the mother-daughter relationship, taking care of themselves as best they could, trying to talk to their mothers, to crying. They had many feelings that were rarely shared. Adolescence brought dramatic changes.

In the high school years, the mother's behavior changed for the worse in six out of the ten situations, making it the second most prominent type of event. It created profound consequences in most of the families. Alice says:

The only memory I have of my mom is she slept a lot. I started to be defiant and didn't listen to her. Maybe I was trying to get her to discipline me.... I dropped out of school when I was 14 or 15. I had to walk to school and the high school was probably around 4 or 5 miles away. We lived in the city and it was really bad. I attempted to go to school for the first few months, but then I stopped because I was having trouble with kids at school and I was afraid to go back. My mom didn't have a car to drive me, and I didn't want to walk... None of us finished high school. My oldest brother left the house when he was 15 or 16.

Bridget notices a change in her mother.

Um, one thing that really sticks out in my mind was I was a cheerleader my freshman year and neither one of my parents came to any of my games, and that really hurt me. But there would always be some casual conversation and I would say, "Aw, that's all right ... when I'm thinking back to feelings and stuff like that, I'm really picking up on something was starting to become majorly wrong with my mom. Because it wasn't just a matter of being not there, and I don't mean physically because she was most of the time, but she was ... starting to become very sad and very depressed and I guess maybe I was at an intellectual level to pick up on it.

Caroline noticed a change too, when she changed physically.

... But...in this apartment, where my step dad still lives to this day, it was...he and I were walking around and I realize now...that she had already had some of the first breaks...she was breaking down and being nonsensical in front of us. Whoa, we're talking about this and it was just...oh, it was just the strangest thing. And I remember feeling...this is never going to change, this, this weirdness... I remember I finally got the "balls" during a three-way family argument to scream, "Doesn't anyone else notice that she acts like a nut!" this can't be normal. ...this is insane. ...am I the only one seeing this?

Ellen was angry at her mother but couldn't confront her.

...I'm thinking in my head, at this point, "Then why are you doing this other stuff? [Cutting] This is just as hurtful. ...I wanted to tell her that, but when I was that age ... I didn't know how to tell her some of the stuff that I tell her now, or well, we don't talk about these things now, me and her, because she gets really upset, because she doesn't remember it the way it really happened.

Holly, finally, at the age of 16, was placed with her grandmother by children's protective services.

When I was 16, I was taken out of the house. ... I had threatened her a bunch of times, "I will tell people. I will tell them, social services, what you do. I have bruises. I...I can tell someone." ... she'd say to me, "Why, so they can put you in foster care? ...All foster care is, is a bunch of dirty old men who like to molest little girls. You'd rather have that than live with me?" And eventually, I just took the risk ... I ended up being placed with my grandmother at the time, who did not know that any of this was going on. She didn't...we didn't tell her....I don't think she totally believed me, but I had to file a police report... and...she knew that there was no way I could be making that up

Ilene said she had a physical fight with her mother.

... But I had started rebelling though against my mother a lot because I was tired of her. Like I was really felt...I think me and my mother got into a big fight, a physical fight one time because I was tired of her whupping me about...I think I was about fifteen... Well, I...I'm trying to remember and I can't really remember it right now... Let me see. ...I'm trying to remember what happened. I don't know, all of a sudden I...I'm trying to remember what had led up to all that, you know. And... I can't...um, I don't know, all of a

sudden it's like out of my mind. I don't know. I don't know, all of a sudden...I've gone blank, I don't know why but I....

Justine was in conflict with her mother over her desire for increasing freedom, commensurate with that of her friends.

I guess once I started reaching puberty and when I started developing a little bit you know, started to break out and mature, my mother kind of resented me because in the past our relationship, I would rely on her for, um, taking us to the movies, taking us skating, taking us to the mall, different things like that. And she was like our chauffeur mom. And in high school I got a car when I was 16 and I was able to take myself places. And I think...she saw that I had interests outside the home now and she started to...I don't know, she just started resenting me. She would always make references to my friends...So, it became a problem. You know, just everything was just so negative towards my friends and I mean they...we were typical teenagers...

Between fourteen and eighteen seven of the daughters' negative feelings coalesced into anger and were more openly expressed in words and action. This process continued in the period between eighteen and thirty. Alice was not in conflict with her mother, but Bridget definitely was.

... I had plans with a friend of mine to go out... she had come upstairs and I had a bunch of clothes, some were dirty, some were clean, but they were just all piled in my room...And she was very angry...when are you going to clean up this room. And I said, "I will..." "Well, right now I'm going with my friend, and I was in the bathroom trying to... get ready, and she came in there and said "What kind of a mother do you think you're gonna be?" And she was yelling at me... "What kind of a mother do you think that you're gonna be?" ...I remember saying back to her, not one like you... But it just, it just, crushed me, y'know what I mean, it just crushed me. So shortly, I think, after that, (crying)...I don't know if it was before, right before that or musta been after that, is when she went into the hospital for the second time.

Caroline's conflict with her mother did not abate in her twenties.

{Boyfriend}'s the first that, um, you do this, you rake at your face whenever we're around your mother. ... "No I don't, you don't know me." So she pulls

up and I immediately start raking at my face and I'm like, "Okay, okay." Then that's... okay. You're right; I do...so it started off innocently enough with the drinking before I would see her because I seemed to not rake at my face quite so much. And it got to the point where... early twenties, it ... was almost, like, psht...Appalachia Mountains we would go at it [laughs] You know, we're like, barefoot screaming at each other in the front yard whenever we saw each other. ...it got bad because we were both buzzed. But then, for my twenty-first birthday, I checked myself into treatment...from nineteen to twenty-one I went from drinking like a fish to smoking, to trying cocaine. ...And I was still high, the fifth time I did cocaine, when I called, uh...my boyfriend at the time "You need to get a hold of T_____ and get me into treatment, I want...but I need to go now before I come down from this because cocaine is... I can't walk away from this stuff"...My mother...what is it, a writ of habeas corpus, corpus, _____went insane. She tried to... get me sprung from the treatment center, um, because she thought they were brain washing me...What are they going to say about me? I'm a lawyer now, what are they going to say about me? And ironically I went to an all Black treatment center... the first time she came to visit me and they saw that she was white, anything that happened at this treatment center after that ... "Well, you're obviously rich, your mother's a lawyer." And so... in treatment...in the confines of getting this treatment and all this coming out;... it's about her and her law degree.

Danielle did not live with her mother as a teen, and the conflicts with her mother came out of her attempts to help her. They were relatively mild compared to some of the others, but sometimes she got really angry.

... I went over there... we were living in a far suburb so we weren't coming down here a whole lot and um, we were paying the house payments because... we owed her money. ... so it wasn't bad, and you know, the deal was as long as she paid for all the utilities and stuff like that, we were going to have to have to pay the house payments anyway if it was empty, you know....I went over there and it was on its way to becoming a hellhole... I freaked out. I freaked out.

Ellen's conflicts with her mother in her late teens and early twenties often concerned her mother's failure to guide her out of negative situations.

... And I said, you let me get married because you wanted to leave. And she says, "No, no," why she would never do that. She would never let me get married to someone...she would never let me be unhappy because she...because of what she wanted or because she wanted to leave. "Bull crap...she says, "You were an adult... You can take care of yourself... it's not all my fault. You should have done it yourself. If you were having any doubts, you should have, you know, listened to yourself." I'm like, "You were my mother. [Ellen] got married at seventeen.)... if it's convenient for her, than she'll do anything for me... she does love me...I can't talk about these things with her any more, because it just turns into like... crying. It turns into her denying everything, and me getting upset because she's denying it.

Holly had fierce arguments, when her mother did not accept what Holly confronted her about.

... She just, um, I told her what happened and...with those two sitters. And she had found out about the teenager doing it, and she had ...yelled at his mother ...But the other one, she said I was lying. She just told me he would never do something like that. "You're wrong, and clearly you didn't screen my babysitters very well... she just didn't believe me... she got so mad at me. She...and that ended up being a fight where I didn't speak to her for a month...And this was a couple years ago...I wasn't surprised at all...I had no expectations left of her, but it still made me mad.

Ilene's mother became more aggressive in the twenties, but Ilene didn't leave until age thirty-two.

Because eventually that's why I eventually left and ... I probably never would have lived on my own...I'm not that adventurous and I really didn't want to live on my own, I just wanted peace and quiet from her, constantly ranting and raving. I felt like as I got older she would try to blame me...I think I really should have left earlier... I was that imprisoned in this situation, do you hear me? ...I really felt devoted to her...and to her craziness... And I think she had absolute control over me.

By the end of the twenties Ellen, Holly and Ilene were making attempts to be more realistic about their mother's capacities. For Ellen, only twenty-five, this involved lessening nonproductive confrontation and responses. Holly, also twenty-

five, saw her mother only when she visited her grandson. Ilene left at thirty two.

Now fifty three, she recognizes the hold her mother has over her. She is still involved in proving herself to her mother.

Care and Conflict in Recent Events

Recent Events with Mother

At the time of the interviews Alice was thirty –six, Bridget was thirty-eight, Caroline was thirty-seven, and Justine was 35. For them, recent events reflected a gap of five to nine years from the events of the twenties. Ellen and Holly were both twenty-five and those experiences were recent events. Gayle was fifty-one and Ilene, fifty-three. More than twenty years had passed since the events of the twenties. Frances' mother died when she was twenty-nine, and her recent events included only the memory of her mother and its effects on her. I will continue to follow the two themes of caring for the mother and conflict in the mother-daughter relationship.

Alice expresses both love and anger over her mother's behavior, but there is little you could call conflict.

...it makes me feel bad to see her house like that, me and my sisters used to go and clean it for her... she was never able to do the housework after we all left. ...lets people in the house... sometimes ...my mom will say ...“My kids don't care,” or “Nobody ever calls me.” And I say to her, “But, mom, I'm on the phone [laughs] with you right now. Am I nobody?” [laughs]. So that makes me feel mad ...She'll laugh about it and she'll say she did it just to get a reaction ...like she enjoys ...trying to upset us. And that makes me angry because I wonder why she would get ...enjoyment out of trying to see how upset we can get... she'll go out walking, day or night... and she, she says really bad words, like the “n” word... there's a lot of Afro-American people who live around her, and she might say that to the wrong person ...I guess

that's my worst fear, is that something really bad is going to happen, and, um, I have no control over it...

Bridget, too, is worried about her mother. She does not understand the problems with her mother's medication

...I overheard her say to my dad today, and my dad had talked to my one brother and she said, did he sound mad? ...Just very paranoid..., nobody gives her credit, everybody is, not out to get her, but that everyone's going to get the feeling that she's bothering them. And the only thing that's bothering us is that ...we really see there's such a change going on...and we feel it's medication-related. Because, because, she, this didn't happen when she was on the Prozac and the Lithium. And the reason they... felt that she had been on it for like fifteen years. And she was still fine, I mean she was still doing fine, not happy, but ... [coughs], she was shaking, an uncontrollable shake. And the doctor felt that it was a, uh, from the medication. [continues to cough and sniff].

Caroline is in the process of completely disconnecting from her mother.

When I got educated about the disease, it got mean... almost all of our interactions... her threatening to get my bipolar son taken away from me because of me medicating him, of arguments about the dis— whether it happens in children...always came back to my childhood. ...And no matter what I said, the whole, “You did the best you could where you were, with what you had ...and I forgive you my childhood, so let's let it go.” Nothing. I have had no contact except the letters that she sends me or the notes that she sends the kids. ...and I'm supposed to move ...I'm... thinking about... putting the real estate in the name of a trust so that when you run it, [whispers] doesn't look like I live anywhere... I'm thinking about taking my partner's last name legally so that when you run my married name and my maiden name they don't come... and it's not connected....I mean, while that is the last contact we've had and, you know, I feel some guilt. I'm hoping it really is the...the last. ...I praise her for what she gave me...she's a beautiful, beautiful woman. Physically and her mind, and...I'm grateful for what she gave me but, pffew...from over there.

Danielle is connected to her mother and does not report much conflict even though her mother has been manic and is acting out a great deal.

... And so my ex and I had just broken up and my nana has just died, and that was really bad, really... it's not even two years yet. ...we had to get a joint bank account ...my mom went to get a membership at a Fitness U.S.A. ...it was like a grand or something. She had made it [the check] on the ...joint account ...And ...she asked them not to cash it and they did it anyway... And she talked to the bank and the bank said that they were going to be responsible for every overdraft that had occurred on that bank account. And so my mom took the debit card and went and made like two grand worth of charges on it...she had used the one with my name on it, the debit card with my name, because conceivably I could have not known about any of that and gone out and bought a whole bunch of stuff. Which I suppose was true, except it just really ticked me off... She did... a sixteen-day water fast a couple months ago ...for Greek Easter... she was all right up 'til close to the end, when she started passing blood in her urine and blood clots. I still wanted her to talk to a doctor at that time and she wouldn't. ... just a few days ago she started bleeding again like that, I freaked out. I was like, "You've got to go to the doctor ... I have to go over there when I'm done here... to check on her ...so when I get there...frustrated because there isn't anything I can do, worried that it's something... really bad and that... she's just not going to do anything about it.

Ilene is still in frequent contact with her mother and still in conflict with her.

...just more arguments. Like I say, even today when I was getting ready to come the day before, she was concerned what I was doing with my friend, Cheryl. Because she...she doesn't like me having any friends...She tries to make comments about them. Anything I tell her about that person she tries to twist it around.

Justine is currently better connected with her mother because of the birth of her baby, but she has set very firm limits.

...prior to having my daughter...I had not talked to my mother in two years. We did not talk or anything until my daughter was two months old and...Maybe just the... relationship of having a granddaughter has changed her... she's excited, ah, with my daughter. ...I don't want her to spend the night with her because...I'm not comfortable as far as her mental status...I am not comfortable with her living environment... she will come over about 3 or 4 times a week and spend time with my daughter. So, we're really doing well. ...she knows, um, that I'll go on years without speaking to her but I don't think she wants to jeopardize her relationship...with her granddaughter...

Recent Events with Mother that Involved Partner

Alice reported good and bad experiences.

... Well, a lot of times he would go and rescue her... when I felt like, ... she was unsafe, he would go and pick her up from wherever she was and take her home or take her food or cigarettes, whatever she ...needed. ...she wouldn't get upset with him like she does with her own children... she made me feel really bad when he died because he committed suicide and she was sick probably long not afterward and she told me that it was my fault and that really hurt. ...I had left him a few weeks before that because we were having trouble...I didn't talk to her for a few weeks.

Bridget talks about issues that come from her relationship with her mother.

...He feels I carry...all this into our relationship, which I probably do...I don't trust my mom with my feelings... therefore I don't trust my husband with my feelings... I try, but ...I am very guarded. ...We've been in... counseling. ...he was, as a child, he was sexually molested...and had that, he has hard times trusting, ...so, you got these two people... with these huge things coming together and trying to make a life together and yet we still have these ...not hang-ups but...

Caroline's partner is very disturbed by her mother's behavior, and has helped her disconnect.

...Um, right around that same time she actually, uh, took to trying to get me into trouble with tattling on me, to...to my partner. ...I would say...I would do something and I got sick and... I couldn't do it, I was literally in bed. ...just threw "hissyfits." And pissed my partner off to the point where...it's like, dealing...living in a mental institution. And my partner's like, "How the hell do... you do this...we can't interact....this woman would call forty times in a day and hang up...and it got to the point where my partner actually had to...tell her not to call the house.

Justine's mother disliked her husband when they first married, but has come to respect and accept him.

... Well, I could tell you something that my mother she respects my husband for stepping up and caring for me. Because, you know, I have medical

problems...Because, at one point, my husband and take care of my...me and my daughter...So, I know that she respects him, which is important for me.

...initially my mother...she would...I think it was more resentment, more of the ___ pulling away from me more, when we first got married. Um, she made up all these stories that he had all these kids outside of marriage and just, you know, started all these rumors in the family. They were untrue... It was hurtful but, I mean, knowing her history, it was expected.

Recalled Recent Events with Mother that Involved Children

Alice's children love her mother even though they recognize her unusual behavior.

... last Christmas she bought my, ... baby daughter a stove set...that made my mom feel good to be able to... get her something that she really wanted. And my older two daughters are really fond of my mom. They don't really seem to mind that she has a sickness... when she comes over and they spend time with her and talk... If she says something weird they'll laugh, ...and I don't think they know how to...take her mood swings...I tell them it's not really funny... you shouldn't laugh. I know sometimes you just can't help... it sort of makes me sad because she's the only grandparent my children have...When my older two were little, I let my oldest daughter spend the night with her ... and I didn't realize she was sick ...when I went to pick my daughter up, they were gone. ... she took her walking around to Burger King...my daughter was safe, but that really made me worry, because when she is like that I don't know if she hangs around with people that she shouldn't.

Bridget struggles with some of the events that occur when her mother has contact with her children, especially those that escalate into conflict.

... when my children come to her, she waits for them to acknowledge her. And if they don't... I can tell she gets... hurt... she'll come in and if they don't... stop what they're doing... she kinda put her arms down and said "Hello-o, your grandmother's here"...real sarcastically. I quickly said... "Say hi to grandma."...Because I'm feeling the tension, already... They're only, they're 6 and ...4 and no they don't have the best manners...they don't mean to ignore you...Sometimes my mom is good at getting respect and I'm not [laughs]. ...when she handles my children sometimes in a disciplinary way ... she doesn't try to do it for me... she'll say "You'll have to talk to mom about that", or "Go talk to your mom about that." ...I do feel that she handles the

discipline end of it much better than me [laughs]... to get results... me and the children have to engage first before ...I decide that it is going to be OK for me to punish them or discipline them... Unsure...it leaves me always feeling unsure that I'm doing the right thing.... it's just so important to me, but yet I don't seem to get the results [laughs] that I want. ...I care so much, and I feel so deeply, but I have that unsure ...Because my mom's support... is unsure.

Caroline's mother tries to manipulate her using her two children, especially the oldest, who is bipolar

...anything I say now is pretty much why I stopped seeing her entirely but one of them involved, um, my oldest. Both boys have dreadlocks, um, which are intense to take care of." Uh, so she isolates my son, my oldest who is a.d.d.n.o.s. and bipolar and tells him that his hair is nasty and dirty and I should be ashamed of myself for letting him out of the house ...So I have to confront her and I try to do it diplomatically...she tells him, "Your mother is crazy and she should be on medication." So I have to confront her and I ask her not to undermine me anymore with the children." At which point, she threatens me using the grandparents law ...my husband's Black, I'm on her front porch screaming at her to open the door and talk to me... because if you're going to threaten to take my kids from me at least do it to my face. She calls the police on me and they immediately...not a lot of Black folks in that part of the suburb she lives in, they immediately pull my husband and I off the porch... then after she gets her diagnosis and...My oldest son gets his and I start him on the meds and the trials and tribulations of the Prozac and, you know, and what that does and, I send him over to stay the night at her house... I'm not going to spend time with a person I ...should have known that I shouldn't send my kids into the same situation but it took me awhile to get there and until a therapist told me, "If you keep sending your children with people you wouldn't go with, that's abuse."

Danielle has no children. Her mother's relationship to her cats resembles the relationship between other mothers and their grandchildren.

The cats are my babies [laughs]. They're her grandbabies. Um, when she's really, really depressed I can't get her to leave the house at all. So I try to use the kitties to bring her, "Oh, little Figgy hasn't seen his grandma in so long, you have to come and see Figgy,"... stuff like that. ...eventually it does wear her... she's really gotta feel like going out though, I mean, she's really gotta...but I...we've gotten her to come over.

Ilene's mother uses her son against her in the way she uses other family members.

...one thing is that she wants to talk about my son and how, um, nasty he is. And he is very nasty acting. Now my son who is a teenager and is self-centered and selfish and all he thinks about is money...now for the last six years I don't make hardly anything. So he wanted money to get the car fixed...So he, to show me up, called my mother and asked for the money that was needed to get it repaired... but she went ahead and gave him the three hundred-fifty dollars. And he is not doing what he needs to do in life to deserve that type of money... And my mother seems to be playing the devil's advocate with this...

Justine and her mother have reconnected enough to be civil because of the birth of Justine's daughter.

...she and I... prior to having my daughter, I had... not talked to my mother in two years. We did not talk or anything until my daughter was two months old and, she's excited... with my daughter. ...I don't want her to spend the night with her because... I'm not comfortable as far as her mental status. But she will come over about 3 or 4 times a week and spend time with my daughter. So, we're really doing well.

Ellen and Holly discussed recent events in the section on the late teens and early twenties. Frances and Gayle did not have children---or cats that their mother relates to.

Recalled Recent Events with Mother that Involved Family Members

Alice tries to keep her family together

It bothers me, because I'm the only one that talks to everybody. The other ones have problems with each other...I've never had to petition my mom, and, uh, [my older sister] has. And I would imagine it's a pretty hard thing to do. So she said she had to step out of it for a while... I was always able to kind of talk my mom into going in the hospital on her own, and, um, there was a long stretch where she hadn't got sick in maybe seven, eight years, and, uh, so sometimes I get angry at my sister because I think it's just...an excuse... I get

angry at them all because sometimes I'm the only one that talks to my mom on a daily basis. And sometimes I feel like I'm alone...they, uh, sort of push all the responsibility of my mom on me. And, um, I think it would be a helpful, if everybody took some sort of part, or role in it. And that might help her to stay more stable

Bridget is trying to have a relationship with her mother that is less conflicted, but finds it virtually impossible.

If you don't stop by then you don't care about her. If you do stop by, you are wanting something, y'know, it... ..then, then the very next day, um, it was Thursday, and she baby-sits my daughter while I go to my counseling appointment, and then I went and but my other children had a ½ day of school and I went and picked them up. And she said, um, asked...what is my sister-in law...doing for Easter and I said "I don't know. ...she told me she had a ham." ... she was standing at the kitchen sink and she just said, "You told me that you didn't have any plans so I went and I bought a ham" and...I could tell she was angry. ...this was in front of my children...This is so unlike her...to the facial movements, ...she's not going to end this, I need to end this. I just said, "You're right mom, I said, that is the w..." Well, by this point my oldest daughter is in tears because she sees mom and grandma, two grown people having an argument, And I just tried to say that, y'know that I still love her and, and, y'know. I gathered our things, not in a huff, but tried to do it in a kind of quick manner.

Danielle avoids conflict with her mother, sister, and grandmother, because she knows she is not going to change them, and they are not going to change each other.

...And the thing is, is when my mom gets pissed off she gets very, very snotty and just really verbally abusive... it's not always stuff that she makes up. There's enough of it based on reality to really hurt your feelings [laughs] ...And they got in a fight and my mom was really mean and...I totally stayed out of it. ...I'm really surprised because normally that's really tough to do. I was busy... working on their computers...it was kind of easy, to pretend like I was real busy with what I was doing. ...it died out a lot faster than if we'd all have gotten into it, ...because that would have just been like, ahh! ...My yaya, my mom's mom. ...we have to deal with her every now and then ...I think we all sort of don't really like her. ...but we all try to understand... where she came from and her background and what made her the way she is and...We also all know that there's no point in trying to change her because she's

ninety-five and she doesn't want to change. So we just sort of try and be nice...

Gayle has a long history of alcoholism. She wants to help her mother and her family with her mother but her recovery is fragile and she is afraid that too much involvement might cause her to relapse.

...I'm the oldest, and when my...when I'm...when things are functioning right for me, I can be that...that kind of pillar for us all. And, um, you know, trying to be supportive of...of where everyone was at. ...And...I felt helpful, and I felt good about myself for doing such....and so, when my mom going in the hospital, which she eventually agreed to, we all just thought she's going to get better, and she hasn't gotten better. There's no medication that they can seem to find to do, except to take care, and to take care of myself in my kind of vulnerable...place...

Ilene continues to wrestle with her mother's pattern of putting extended family members first.

...that's a big theme. My mother and my cousins...because ...she's always compared me to my cousins and ...everybody has....I feel like I've been a victim to that all my life...and one of the things she keeps trying to talk to me about and...I'm very nasty with her about it is my cousin...wants my mother to give her eighty thousand dollars to buy a house ...and yes my mother does have eighty thousand dollars in the bank And in dealing with my cousin, my mother whittled one bank account down to about five thousand dollars when it was almost half a million dollars... I...was always trying to avoid asking for money because I always wanted to stand on my own... And my mother keeps trying to talk to me as if she doesn't know what the answer or the solution to this problem is, and the solution to this problem is to tell this cousin, "Hell no, I'm not giving you that money"...I take a great deal of satisfaction, and she knows I do because I'm finally winning, okay. Because the point is giving this woman that type of money, buying that house for her means nothing because she's going to lose it.

Justine has learned that she can't influence her mother's relationship to other family members. She just listens. There is less conflict but not much actual connection

...there is controversy at my mother's house as far as my brother and his circumstances being there. ...my mother's always very protective of my brother. My brother is forty years old and he's still in the house. He doesn't work. It's... his girlfriend and her two children and my mother is trying...she would like to retire. Can't really afford to retire taking care of four adults...five adults. So, I just know, I...I just listen...I used to be angry....I'm so numb by it now...my feeling are, if she wants them, she...obviously, she wants them there because they are there. You know, she has to deal [laugh] with whatever comes along with it.

Recalled Recent Events that Involved Work or Career

Alice is uncomfortable with anyone at her work knowing about her mother's condition, but she puts her mother first and is willing to take some chances.

...there's been times where I've had to call into work because I've either had to...try to keep her calm [clears throat]. Or sometimes worry that she's going to call my job because she's threatened to do that if I have a problem at work and I complain to her. Then she says ...I'm going to call them, and she starts cussing and saying, I'll tell them not to do this and that to you. And I'm like, mom, please, I can handle it [laughing]. So in the back of my mind, I'm thinking she's going to call and embarrass me. Who knows what she might say? Um, I've never told anybody at work that...my mom has this problem. When I call in sick because of what she's going through I always make up some other kind of excuse ... just afraid they just wouldn't understand and they wouldn't be good about it... and they wouldn't be understanding about it...Luckily I haven't ever had to miss a lot of time... I feel bad because I don't want to put them in a spot... I know I have to take care of my mom first...I feel like...if I really had to, I would tell them...I wouldn't know how to tell them or how to explain it...Because they might say, you've been here ten years and you've never brang the issue up, before...I've always been able to take my mind off of things by throwing myself into...work...

At the time of the interview Bridget was not working outside the home.

She said:

...I do remember my father telling me that, one time when I was upset... someday you'll get married and you'll have children of your own and then, and then, then you'll feel fulfilled...even when my one, even when one of my brothers had that attitude, you don't really have to do or become anything because your husband will support you [laughs]... it's not really funny. But first of all, when we got married I bought our house [laughs]. I was working...I was very...I'll show you [laughs]... My mother...really pushed the cleaning and stuff like that on me like that was girls work...Consequently my husband is not very helpful when it comes to that and I guess I chose that too [laughing]. And it bothers me so much [continues laughing]. You better believe my son is going to do all those things. I feel like my husband takes me for granted domest., with the domestic things.

Caroline's mother tried to sabotage her business.

Unfortunately she knew, um, one of my clients and, um...this client was sc— wanted to give away this gorgeous loveseat, sofa bed....and knows that my mother needs a love seat and we load the thing up and I'm assuming...because she's my client, I'm only servicing her as an assistant...it's not my job to tell her, "Did you call my mother in advance." Which is what I would do if I was being a daughter so...we go over there with this gorgeous couch... and my mother wasn't expecting us and, see, being the child of a crazy person, I knew by the look on her face. Oh my God, what have you gotten us into... she...badmouthed me to this group of people that this...my client was a member of this group...in the circle of friends rather. And, so I had to deal with this at work now because my mother is feeding this woman information, like on a sabotage level...she's calling me at the office. In... a self-employed way, she tried to undermine me...why would you jeopardize your adult-child's source of income? The person that takes care of your grandkids? But she just...it's like she couldn't help herself... I wouldn't have taken it but I took it...that would have been...that was about a year and a half before I stopped seeing her

Danielle's mother gave no support for career development and wants to interfere in her work even though she contributes to her mother's support.

I just worked at the same place for seven years up 'til 2001 and they went out of business... I have not had a good job in five years. ...I have fifteen years experience as administrative assistant customer service sales. I'm a whiz at doing graphics and at IT work. And I had a couple of really good positions. ...Just that, she...she really does help; ...when I need it. ...I know she doesn't have it either...it's a hardship on everyone when I'm out of work, because normally I'm bringing in money for everybody else too [laughs].

Ellen's mother interfered at her job.

... One time she called me at work, got me out of a room, because I was in with a patient, just to tell me something so stupid. And I said, "I'm at work." ..."do not call me at work to tell me something this dumb." That's not what a parent does. You should realize that your daughter's at work, and she works in the medical profession, so she's with patients...it's not like I'm a secretary anymore where I can just answer the phone and I'm right there.

Ilene's mother is verbally abusive about her work.

...one of the things my mother is doing to me which she's delighted and is harassing me with is the fact that I lost my job six years ago with the count... Then I have been going on working these little jobs, I was working with the post office. ...the post office offered me another temporary job...driving a mail truck. ...I wasn't able to do it which ...she took a delight in the fact that I failed, Oh, I never worked jobs like that. I just stayed on one job all my life...Maybe I'm not in a job, maybe I have been terminated but I am trying to work and I continue to try to work, and I'm trying to come up with a...job that I can continue to work in...and support myself."...I think I'm coping with her better...she talked against everything that I tried to do and it tears me down...for the better part of my life I never admitted to it. ...I've gotten to be fifty and I admit to it...and it's a freedom...I feel like I've been a prisoner so long. And mind you, it's the prison that I...I erected in and I stayed in...I mean, it was always a door that I could have gone out of and I didn't.

Justine's mother is helping her since the baby was born because Justine has a back injury and can't work at present. The conflicts that caused Justine to disconnect from her have essentially disappeared.

...my mother has been a great assist to me...as far as me not being able to work because of my back injury...which is a surprising.... She will do

that...and I'm grateful for her because...I just totally didn't expect it. ...I can thank her for that. ...I think my mother has a need to nurture and the need to feel wanted...prior to the baby, prior to my injury, I don't think...I needed her to help...It's...she has to come by...for a purpose...Before the baby came, my mother...we will go years without talking. So, [groaning sound] it...we didn't have relationship. My mother probably doesn't even know what I do...She knows I work...where I work, but she couldn't tell you what I did....I attribute it to her illness...I can't really be angry about it.

Meaning of Maternal Relationship

Meaning of Maternal Relationship to Identity

Alice feels that her negative and positive traits have a lot to do with her relationship with her mother.

I don't think that I stick up for myself as much as I should... when somebody says something to me that might hurt me or I might not agree with. I don't argue with them or...tell them ...my real feelings...I cover up a lot... and just sort of go along...I'm a shy quiet kind of person. I don't know if that has anything to do [laughs] with ...my mother and my relationship or how I was raised... I feel pretty good about myself... I do get embarrassed and I don't like to admit to other people that my mom has problems because I feel that they don't understand or they won't understand or they might look at me differently...I hold a lot in because... I'm kind of afraid to share my feelings. I think I'm afraid of... the other people, their reactions, or... their thoughts, their feelings toward me or my mom.

Bridget has internalized her mother's criticism and now she internalizes her husband's. It is part of her identity.

I don't have good self esteem. And intellectually I know different, but if it was just feeling...like the feelings about myself, they're usually not good. ...My mom...has always been a person who really does think about other people, um, thoughtfully, whether they're ill or [coughs] in need...Uh, and I've noticed that. She took care of her mother who lived with us, who had cancer, when we were growing up. ...I seemed to...see needs around me and help... and that my mom did... but when I'm feeling defeated or bad about myself, when I have a conflict with my husband or with my mom, I have this feeling that I want to disappear, whether it is physically getting out of the room,

whether it is taking all of my belongings and getting rid of them ...and I took everything, I took everything off the dresser, I took everything that was me away and I put it in boxes and put it away...therefore nobody will be able to hurt me...I guess the whole bottom line is I really feel that I'm not so bad and the people of my life that are suppose to love me the most...have hurt me the most and they don't see the good things in me....I really don't want to hear any more comments...let's say from my husband. I'll sacrifice sleep to get something done. So I would say that is ...not healthy. ...I realize that. I feel that I'm supposed to be able to do this. Other people do it. My husband has made that comment, other people do it...

Caroline is very close to the events she lived through, and she feels she has to reverse her mother's behavior. She relives the conflicts with her mother. She is anxious and panicky.

Compassion. I mean I think I'm much more compassionate. ...I think that I am...backwards. I mean socially I'm backward...I often avoid social situations where I'm afraid if I can't read somebody... I'm overly protective...of my...feelings...the reality checks I have to give myself, the "are you crazy" checks, the... whole, having to tell one hundred percent of the truth because ...I'm terrified someone's gonna re-write history. I'm terrified to have emotions that seem too big or too inappropriate...and ...I end up under expressing myself...because I haven't read a situation and I don't have the guts to ask for clarification ...It's a depressing place to be...alone. I mean I'm isolated. Just...up until the last couple of years just enraged. I'm so terrified to let her get back into my head that ...I would push these feeling away at whatever the cost because I just didn't want to... feel that vulnerable... you change friends a lot because you don't want people to know that...that there's craziness...I think that's why I've stayed in my house so long. The feeling of being in one place... the compul—...her spending, that's one where...that totally impacted me. Oh, how insecure. How unsafe I felt. ...we're barely getting by sometimes. ...but you best believe I've got an emergency fund.

Danielle does not have much support, and she is sorry she did not stay at home and get a better education. She doesn't blame it on her mother, though.

...I think that [clears throat] because of a lot of different factors in my life, I've had to be very... self confident. ...just because nobody else was interested in backing me up ever...I wish that I had done a few things

differently. I wish I hadn't left home when I did. I wish I had finished school and like gone to college or something, but there wasn't any money for it and I was working.... I really didn't think ahead. I had kind of a plan about what I wanted to do and I did end up doing it, it just didn't work out the way I thought it was going to...my mom really wasn't there. ...she was a little bit supportive but too unstable to count on in any way...and my dad's side...I saw him on the holidays and stuff but that was about it... I need a lot of down time; I need as much down time as I can possibly get [laughs]. ...I can manage to work and deal with my family and deal with my home... Once in a blue moon I'll do something social. I do wish that I had gotten to go to college. I might have ended up with a better job, I might not have...I have a very low tolerance for stuff, mostly because I have to put up with so much from my mom... it just seems to me that if she's crazy and she can make the effort, these non crazy people should be doing about ten times this good [laughs], and it kind of disgusts me when people don't.

Ellen feels she is like her mother in many ways, including how she handles anger.

Well, a lot of her examples have influenced me because a lot of things that she did, or the way she acted, sometimes I'll find myself acting that way. Like I mentioned before, when it comes to money, um, she was very frivolous with money, because of the bipolar. ...I was also taught by her, in a way, you know, taught by example, um, that you grow up and you marry somebody who is going to take care of you, and you don't have to worry about...all this stuff. ...because...she raised me to be a homemaker...because that was what she did, so by example...But like, once in awhile she would try to encourage me to go to college... I feel like I'm not good enough. ...I don't know why that is, because my mom's always...praised me on doing a good job... in school and stuff...I feel like I have to be the adult, and I don't want to be. I want her to be my mom ...She should be a mom to me. I shouldn't have ...to deal with the things I've had to deal with... I could've been happier as a child, even if I had to deal with the bipolar. ...I think that if she wouldn't have allowed this religion to control her I think I would have had more friends and been happier, been more of a normal teenager, you know...Now after I'm raised in this strict...not allowed to do anything, not allowed to have fun, she turns around and changes... I feel like I don't have a chance now...I am happy in my marriage, but I feel that part of me wanted to settle down and get married and have a family because of my mom ...sometimes I act irrational [laughs]. Sometimes I get mad over really dumb stuff just like, you know, she used to... I say hurtful things, things that I know

are going to hurt somebody and it's a reaction because I'm hurt so much inside by what happened... in the situation. It was to get attention for her...it wasn't because it was going to hurt me. I guess I say things to hurt people... I know how I feel, so I want to make other people feel that way when I get angry, or when I get hurt ...another way I act out, I guess, because I've actually, you know, taken knives and you know, said I'm going to cut myself kind of thing and...just to get attention...or just to get him [husband] to stop. ...I'm trying to reason. I'm trying to talk it out, but it's not working. ...And I get that from my mom, definitely... It's because...I've had to do things a certain way for so long, that I just stopped doing it...it all came crashing down ...at one time So out of all the things that I dealt with, with the therapist...That was one good thing that I learned that I was being a perfectionist and that I didn't have to be.

Frances has thought about what her mother has meant to her personhood and has been integrating it. She has begun to think in a forward direction, about love, and about work.

Gayle sees her mother's influence in her identity as both positive and negative.

I think...it's two-fold. I think that...because ...in her heart, she's a good person. She raised me to be an honest, decent, dignified human being. ...I strayed from that in my... more in my disease... so those are...qualities that I have that I'm really thankful, that came from my mom. She's pretty...I'm pretty physically. ... and she's sweet... and really bright. So those are all good qualities...the negative side is... the lack of nurturing, the lack of parenting, the lack of emotional development, the lack of ...having a mom.... any kind of thing about a relationship, or about a boy, or I started my period...all that girl, woman stuff. I...I didn't have that. I had it a little bit with my aunt. ...part of it is too, this strict, German upbringing...my parents were both German, same religion, same...it's a...stereotypically, it's a very kind of cold...it can be a cold, non-feeling, you know. ...and the fact that she wasn't well, and then the fact that I'm an alcoholic... I haven't blamed my mother for a long time. If that conversation comes up with siblings, I don't go there. ...I really attempt to take responsibility for my life...There's all this good stuff, which I certainly am grateful for. Then there's all the extreme in the negativity... a lot of fear, like my mother...she had six children. She didn't work. So for me, working is like, you know, I'm not good enough to have a successful career.

And I've kind of proven it to myself, because I've switched to a lot of different things. Although, I'm being too hard on myself too... for a long time, certainly I... let... affect me, and didn't seek responsibility to create that for myself. ...probably even in a subconscious level. ...that I don't have any of my own children, that I'm not...that somehow all my relationships haven't worked out...for a long time, I would feel like badly about myself, but these days, I really feel... good about myself for what...where I'm at...I've done the best with what I had to do with.

Holly is having problems developing a stable identity.

...when we talk. Um...how do I feel when I'm alone? Ah, it really...like I feel when I'm having an anxiety attack but without being anxious. Like that despairing, hopelessness, to some degree, always, when I'm alone. Until somebody comes back. So...and that was, I picked up the habit of living with my boyfriends when I was 20, 21... Because somebody always comes home. But even that gets to a point where if they're not home enough, oh, it's so hard. So hard for me to deal with. And I don't know...I don't know why, but I really do feel like that has to do with her. Yeah, I think that has to do with some other members of my family too, but I think mostly it has to do with her.

Ilene still struggles with the negative view of her own dark skin color she learned from her mother, because it represents her mother's rejection.

One of the problems I always feel I have with my mother is I look like the my father's family and my mother looks like her father's family, and I'm dark. And, um, black people love you to be light and my mother, I think, has always resented...because my...her sister... was light...the white lady hired her (mother) and said even though you're dark I'm going to still hire you. ...it's always been an impact on my mother and I think she's always held it against me, because I was dark... it's resentment of people not accepting you for what you are.....even if I had felt bad about it at one point, I stopped feeling bad...I feel more resentful and hate and...why can't you accept me for me? It's not right and it's not fair and it's not taking my side...My mother is the same way, even though she was dark...she felt dark people are bad because she was trained to feel that way...I think why I never believed it is because I sat there with those old men all that time and I listened to them. And I never have heard voices other than theirs ...when I get around people and they don't say what I want to hear, I tune them out. The only person...I didn't learn to do it with was my mother...maybe I should have tuned in more and just coped more with other people.

Justine damped down her emotional responses in order to deal with her mother's abandonment. She seems to be saying she is counterdependent

...the impact from my mother's behavior towards me has made me such...before my daughter...it made me such a rigid person...That's the most hurt a person go through is to be rejected by your mother...it's just the absolute worst. If your mother rejects you, and if you deal and get through that, well a lot of things really just don't compare to it...Not to say they don't hurt me and not to say I'm not affected by it, but I don't have that outpouring response like everybody would think I would have...So, I really hoped that, through marriage and through me having kids, that I could...develop those types of emotions again or...initially have. And I do. I kiss my little baby all the time ... [crying] I really felt abandoned... as a teenager as a young adult. When I needed my mother the most, my mother provide...she gave us things. And that's what invoked the tears so with my daughter because I'm...it's such a painful emotion. I never want her to feel that way...she'll [mother] avoid...any type of... emotional... feedback or exchange...I don't know if she just cannot deal with it...through it, it has made me what I am and who I am. I'm very tenacious. I'm very...strong willed. ...I'm very depen...independent. ...through it all, it has made me a very strong determined person because I had to be.

Meaning of Maternal Relationship to Partner Relationship

Alice's husband, who accepted her mother, committed suicide. She idealizes him and is very uncomfortable about beginning to date again.

...I think that would probably play into both my mother and father because I never had a father figure around, so I was always sort of, 'take charge.' I didn't really want my partner to discipline the kids. I would try and take over or interfere or that kind of thing... my mom...sometimes seemed to choose her partners over us. I think I have a hard time because I have only had one partner for 17 years ...I think that's sort of made me want to try... to make it work no matter what. I see my mom date different men and she sort of put them before us and I never wanted that for my children...I really don't think it affected my relationship with him...I am still new at the dating game so [laughs] it's hard to tell right now how it might in the future affect me.

Bridget feels that there are unresolved issues in both her relationship with her mother and her husband that interfere with trust and physical affection.

...I don't trust him the way I should and the way I want to. ...it is very connected to my mom. ...there's a lot of correlation with... different comments that they make. I don't feel that we're as intimate as I would like ... it's where we are almost ten years later and ...I wouldn't make the same decision that I made ten years ago...Presently I don't... really have anyone that I...[almost crying] I don't have like intimate support from anyone, whether that's a friend ...or my counselor is probably the closest person...you're probably closer to me right now because of ...than my husband or ...my mom. But I feel like I am coming to a point in my life where ...I want to depend on someone. I would like that to be my spouse and it just doesn't seem to be happening. Whether that's because I won't let it, y'know, I don't know...I can't talk to...either one of them. When I try to respond to something that happens...like I did a little bit that other day, what came back at me was, it's you, you're overreacting...and there's no validation. Then I feel like why bother saying anything and I don't say anything and I shut up. I do the same thing with my husband...I'm uncomfortable with physical, y'know, where...other people. Obviously I'm not completely uncomfortable, I have three children, [laughing]... I'm human, but to have that and feel good to give it and receive it and like, hey that's OK... I think with me, I don't know...because I didn't have ...that affection goes into,... is connected with ...sexuality... I have no problem hugging [my children] and kissing them and but with my husband, yes. Because I think there's unresolved...because I think what happens is there's so much unresolved...how can you hug me and kiss me and tell me everything's alright when it is not, it's not alright...so when my mom even to this day when she goes to give me a hug or kiss or whatever... it's like it doesn't feel alright.

Caroline is very anxious, panicky, angry, and depressed. She has rages and episodes of crying. She has had an episode of anorexia. She feels her female partner is amazingly patient with her.

Anybody that can be with, you know, a child of a bipolar parent...there...it's "saint hood." They deserve "saint hood" because I'm not...I mean, who wants to argue with a person ...whose grasp of reality is so based in fear that, I can tell you what you wearing when we had the argument, where you were standing, and exactly what you said, verbatim. You can't... have a normal

relationship in that because I'm not normal. I am so altered by this upbringing that... that my partner has to have an incredible amount of patience...I don't think I could date me. I don't think I could marry me; it alters that intimate relationship because, you know, my role model...emasculated how she treated... my dad...I won't nag. I don't nag. I don't, I won't remind people. I say something to you once; if you don't remember it, fuck you. And I get nasty...so how do you live with... My partner's got ADD. I won't remind, so...it affects that relationship to the point where they had to do an intervention with me. My step-dad and my partner had to say, "If you don't start nagging, us we won't know how to help you," because who the hell remember everything someone says.

Ellen struggles with her temper, with her husband's fear that she will have her mother's behaviors, and with the perfectionism and consequent procrastination learned when she was a child, trying to please her implacable mother.

I don't really think it does influence my feelings about him because...because I know the way he is, and I know the way I am, and I know sometimes that by what I'm doing, is acting like my mom...Sometimes he'll say that, and I get really upset. ...sometimes he says things that are really mean about my mom, and it really, really hurts me...I said something about how his parents annoyed me... And he said..."Well, at least my mom doesn't carve herself up like a turkey or something." And I just flipped out...And he realized...and he was really sorry for what he said... it's like things like that, that I have to deal with because of my mom's problems, and because of some of her actions...I can't even tell you how many times when I was pregnant...how many times he would bring up stuff and be like, "You better not ever do that to her."...You know, so he uses that stuff against me, and he thinks that I'm going to be like her, and that bothers me really bad because number one, I don't want to be like her, and number two, he shouldn't base what she did on me....he's thinking that I'm going to be like that...He knows the way that she is. he's thinking that, "Okay, if I do this one day, or if something's not done one day, then automatically, I'm going to be like this forever, and just lay down and sleep all day and do nothing."

Frances reflects on her work on her relationships with men.

...I was standoffish, but ...I'm human. I need companionship. ...some of them may have been similar to my mother, different aspects of them... I got that out of my life, going toward people that just want to criticize and...And break you down to build themselves up. Of course I don't say that she did that, but I don't know. She...maybe she did a little with my self-esteem eroded away a little, not wanting to...Well, I couldn't get close to them [men] for a long time. But I always did have male friends though... even the...the guy that I mentioned, that ended up having another girlfriend,...and he never told me that...That happened right after my mother and grandmother died. I feel like I imprinted on him [laughs] immediately, you know. ...But we're...still friends. He has some tragedies in his life...and tried to help him through that... he'd help me if he could in any way... he'd be there for me. He always has, to talk to.

Gayle has had relationships that were not marriages. She sees herself as too dependent.

...I depend on men too much for..., I've had different relationships where I depended on a man financially, depended on a man emotionally, depended on a man spiritually. I de—had too much dependency on men, because that's what I learned from my mother. My mother's very dependent on my father. Of course, that was a generation that was more dependent on a man. Um, so that dep—and this generation, a woman's dependency on a man doesn't work...when I was born in the early 50's too, where...it was right on the edge of a woman being, you know, getting married and taking care of a man, or a woman taking care of herself...I feel like I'm a lot like my mother...as far as relationships, t...I have not had the...truly the proper skills,...haven't had the proper emotional skills...and other things about myself, to be able to bring a whole other person to a relationship...I've had long term relationships, that never ended in a marriage, and I guess that's good and bad. I'd have been divorced probably a couple of times now. ...there are really good qualities I can bring to a relationship that came from my mother too. ...I don't weigh one over the other.

Holly is very aware of her abandonment fear and of the element of repetition in her current relationship.

I don't know for sure if it's...in living with her, there's fuzzy kind of understanding of what, you know, loving is or...there was no trust, there was no love, there was no any of that. So I get very controlling. I feel like I have to

control them if I love them [laughs]. Otherwise, they leave. If I'm not controlling, it's because I don't care anymore...if it's something special to me, I'm terrified that it's going to go away, or that their feelings are going to change... the person I'm with currently, ...is similar to my mother. So it has affected my current relationship very much...Part of my staying with him as long as I have, part of my draw being to him is that when he does the things that she used to do, he apologizes. I get from him what I couldn't get from her...At the same time it's familiar, you know, that kind of dysfunction or...or fighting or whatever. So if I'm with someone who's too normal. who's too good or too, um...successful in their career or anything that's just standard, I get really uncomfortable and really nervous, because they won't understand me...and I'll back out of like a relationship before it even starts...But with my boyfriend that I'm with now, I don't have to worry about that...I know that he'll understand when I get like that, Because he gets like that too.

Ilene is aware of her mistrust and its origin in her relationship with her mother. She relates to it also her need for absolute devotedness in a partner. She is also aware of her verbal combativeness.

I don't trust people; I don't feel as that people will be devoted to me like I want them to be... I never found myself to be totally in love with anybody because I don't feel that that person is totally in love with me...I have a dear friend now...And I really feel that over the years maybe I've misjudged him,...have reservations about him because of my mother...And then it gets to what would total devotion be? ...I really don't know. I think I've idealized it to the point that I didn't really know and never did...I think I have missed out on a lot of really good relations because of the fact that I haven't felt that that person was devoted. Again, on my side, I ...have always felt that I needed somebody one hundred percent ...another thing too that bothers me a lot about men...is I don't like men where they think you're stupid. And I found that a lot of times men think women are stupid. And I'm very...and I think it's because of my adversary relationship; I keep up one with the men... I always want to prove myself and when I'm...with a person who won't accept my level of intelligence being equal to them, I resent them. And when they do it, it's going to make you so marvelously angry at them...I think a lot of women don't have that...and I think it comes from being in a con—a conflict constantly.

Justine is trying to learn to be more emotionally open and vulnerable in the context of her family of procreation.

... as...as far as...having emotions he, you know, he says I am the iceberg. [Laugh]...is good in some sense and it's good in other my husband... he wears his heart on his sleeve...My daughter was born, I didn't think he was going to make it through the delivery because he just, boohoo-ed ...he's just so emo—he just feel emotion and I'm not. So... I'm getting there...as far as, um, just having those feelings with my daughter. I'm getting there

The Meaning of the Maternal Relationship to the Parental Relationship

Alice talks about “over mothering” her children and having a hard time disciplining them. Because of the way she was raised she is uncertain what to do.

... with my children, I think I over mother them... maybe because I was parented very little, I go overboard. And sometimes that causes problems because they're a little bit too spoiled... they're not as self-sufficient as they should be at the ages that they are...when they were little, I took them to church pretty regularly. Now we probably don't go as much as we should...But I try to ...teach them the same values and morals and... to believe in God and... that sort of thing. I think that they're lucky [clears throat] to have been able to... grow up slowly...rather than fastly like I had to. ... I never put chores on them ...real early, 'cause I felt bad because I thought... when I was a child I thought I was a little young to be doing some of the things that I had to do. So in some ways it helped and in some ways, I think that maybe I should have instilled some of it but I wasn't sure what age to... start... having them do chores and different things...Usually tell them could you please clean your room. I've been asking you for how many days and it's still not clean [laughing]...I usually have to get upset and say you're cleaning your room or you're not going anywhere, you're not doing anything [laughing].

Bridget worries about her children and her mothering. She tries to parent differently than her mother, reflecting the conflict they have had

... my counselor says that I... have trouble disciplining because I am too enmeshed with them emotionally because they are the only ones that I feel love me unconditionally. And it makes being a parent very difficult ... when

you're close, but at the same time I am very thankful that they're able to talk to me about anything. And we've had some really enlightening things come home that they've heard about at school. And I figured if I didn't have that line of communication with my kids, they would have never told me, because I didn't tell my parents anything ...I worry. I think ... a lot of that comes from my mom worried about us. I worry about the kids. I don't feel safe; don't feel secure with the schools sometimes. ... I am having a difficult time with discipline, and, and order, and structure. It's because ... I identify that with isolation and putting that into my life is really hard... that's something that I struggle with pretty much on a daily basis. ...It's the worst of all. Because there's this ... little person inside of me saying you're no good. You're not going to be a good mom. Because that's what my mom told me, she told me I wasn't going to be a good mom...I didn't believe her then, but it planted something in my head, I was always wanting that love, wanting that connection... and she told me that I would basically grow up and fail...I don't think it is true. ...I think I have more tools than she had... I don't think that, um, having a messy bedroom equates calling somebody not capable of being a good parent someday...even though now today, she'll say you're a better parent than I am... 'cause we had already had such a bad relationship and then to put that into a mother role and here she was my mom, it's just like a doubt...being a parent. I felt that that was a very important thing to be someday... I feel... I think, ...it's affected me and...I don't want it to anymore... I'm just involved in their lives. I read to them, I do arts and crafts.

Caroline feels her experience with her mother affects every aspect of her parenting.

It's everything. ...It impacts everything about my children, how I interact with them. All of it...And these people got my bird stoned and it was dead the next morning. I now have two dogs and three cats that get better health care than I do...I don't know how I'm gonna finally talk about sex with them because I was so warped by...seeing my mother do things...I don't think if I hadn't had a bipolar mother...I don't think I would be willing to sacrifice these...my strongest earning years, to home school my child... the more you cycle ...what it does to you, you know, you don't come back. So the whole goal is to keep him from cycling as much... admitting when I'm wrong...before I got the diagnosis I thought he was possessed by the devil, I mean, the way it came up in him. And I was so brutal. I beat him; ...I would say it in front of him. ...so he would go, "Okay. It's okay if I talk about it 'cause she's gonna talk about it."...If my son comes to me and says, "Did you really do those things," because I'm having a hard time remembering them at this point, "Absolutely.

I sure did, and I'm still sorry."... You know, the whole notion of giving what you didn't get... I have to read constantly about these things I didn't get... oh, her spending, that's one... that totally impacted me. Oh, how insecure. How unsafe I felt... we're barely getting by sometimes... but you best believe I've got an emergency fund. I've got cash under the mattress. I own stocks, bonds...

Danielle explains why she has no children.

I: Mmm, you don't have kids.

R: She's the reason I don't have any, absolutely. For one, I'm afraid of ending up being like her and I certainly am not going to pass that along to anybody else. I know that I don't have the patience for it. I know... she didn't want me, you know, she definitely didn't want me. And it was just the thing to do at the time and so she had me and I'm never going to do that to a kid, so... no way, I don't even like them that much [laughs]. I mean they can be cute but... [Whispers] mostly they're smelly and in the way.

Ellen was a mother only a short time when she was interviewed, and her early childhood was good, so she is thinking ahead to her own conflicts with her mother

Well, she's only two months old, so I really don't have much to go on there, but she... one thing I'm not going to do for sure, is I'm not going to make her feel bad when she's doing normal teenage stuff. When she's 15 years old, I'm not going to make her feel bad if she doesn't want to be with her mom... And I'll try and be more understanding about stuff like that because my mom... I mean I know it probably bothers you when your kids grow up... I know it's going to be... kind of upsetting, but I'm not going to take it out on her. And that's what my mom did, and I'm not going to do that ... I pretty much am able to separate things.... I feel differently about her... *than* I do about my mom, definitely... it's two totally separate issues. ... just hope that I don't be like my mom with her... I'm not worried that she's going to be like my mom... I guess I do worry that she's going to have bipolar.... because it's a hereditary problem... I do worry she's going to have depression ... because I do have that... I hope that she doesn't...

Frances is fairly sure she won't have children, but there is some ambivalence.

...those old feelings of being rejected by your mother. But she didn't totally reject me, but ... in ways, because of ... not getting the affection, or feeling criticized.... I didn't want to have any children anyway. A long time ago, I was

afraid that they might have this illness...And what kind of a mother would I have been...kids like me...I like kids...you don't want the children to be rowdy and totally out of control. I know kids will be kids...Children need discipline...to know they're loved." And I got disciplined from my grandmother, so that balanced out. I don't feel that I'm stable enough...I would want them to have a decent father...And I've gotten older, and I don't know that I ever would...I think I'm fairly stable though. If I had a stable person that...I don't know...I'm 39 now, so... maybe my children are like children of the mind...like poems, or paintings, or creative endeavors...I never felt the need to have a child like some people...

Gayle is fifty three and has no children. She thinks through why she has not.

I don't even know if it's just that was a conscious thing, because I really wanted to have children, and it just seems like the years have so gone by me, and then, being in, you know, in this alcoholic thing...I've lost years... trying to sort that out, not ...because I was drinking, but just kind of thinking, "Well, you know, my recovery," and then I would have a relapse in my recovery... So, um, probably on a subconscious level, it's like I'm not worthy, or I can't handle it, or...or maybe it's more the bigger influence, like maybe I just didn't have the children, because ... I would have lost them...I don't say "I don't have children, because I had a bad upbringing, because I didn't have...a nurturing mother." I don't believe that, but I'm maybe, you know, on a sub— of more of a subconscious level maybe that's why. Can I say something else about my mother too, is that, um; to be...she's owed to get what she wants. She's owed to get her own way, you know, she's owed that. And I had that attitude a lot...I'm owed a certain amount of...behavior from a man, because...and that comes from my mother. And that is just so not reality. I'm not owed anything from anyone.

Holly is very aware of how her actions might affect her child.

I...know that... my feelings about him, I make sure that I...I let him know when I'm appreciating him. I try to just value my time with him more, appreciate him as much as I can. I think that her being so bad makes me really actively value him...the thing that's so common is that it makes me feel negatively towards her more so...it doesn't change my feelings about him, it maybe enhances them, but it does consistently make me think ...How could she do that? Through any emotion, through any mood swing, through any whatever, how could she?...it makes me constantly think about...how my actions will affect him... But I am...ridiculous about how will this affect him...what he sees in me, how will this affect him...what can he understand,

what can't he understand?...And not that I'm not myself...I don't let my son see me if I have an anxiety attack, I don't let him see me when...I'm in extreme emotion...things that I don't think he'll understand about me, I just don't let him see yet. And the older he gets, I explain what I think he can grasp.

Ilene was, in some ways, parenting like her mother did. The one thing she did differently was let her son talk.

... Well, I think I act unfortunately a lot like my mother. I was a yeller, screamer, yeller, screamer...And, um, it got to the point where he would tell me when he was like twelve or thirteen, he'd say, "You're always yelling and screaming." And I realized I was and I didn't want to be like that. I was just doing it... because I don't know how to talk to people...I didn't know how to talk any other way...Remember I was telling you about your voice and your mannerisms, you know. I...I don't think I showed that enough, I really do. I think I...I have been a bad parent because I have a bad...I was taught bad parenting skills, very much...I think I've tried to modify some...although I've got a problem with my son now. One thing, my son is truly spoiled because I did give him a lot of things...I think at first I didn't realize I was being her...And then when you do realize it, it's almost too late. Because he actually told me, because I told you he's very smart...he's also been given an option; I was never given the option of being able to speak up as a child. I never could speak up or say anything...

Justine wants her daughter to grow up feeling loved and secure. There is a little uncertainty about still needing that in the present.

... I always want her to know [crying]...Just always want her to know [crying] I'll never leave her. Um, I just want her to know. [sniffles] I want her to feel totally secure and...I don't ever want her to know or feel like she cannot come to me for anything .. I don't want her to ever know...what it feels like to not have a mother. ... that is so important to me... I never had that sense of security... I never felt that I have a person to go through it totally alone...And feel as though it's somebody that's going to help me. I guess it's my ideal of a mother... that's what I envision a mother's role to be. A mother to me is the one who always has the answer.... that's just what... my thoughts of what a mother would be...I don't feel like...I had that. I had it through other sources but not through my mother. And as far as my daughter, I don't ever want her to feel that she has to go through this channel, this channel, this channel. I

want her to always have a beeline to me. ...It was the feeling of a—I really felt abandoned...as a teenager as a young adult. I need nurturing, a mother's love. ...I don't need...material things. I need emotional ...support ...from my mother. I cannot say my mother. I have it through a stepmother...a husband, different other avenues but not through my mother, which is so hurtful to me. And that's what invoked the tears so with my daughter because...it's such a painful emotion. I never want her to feel that way.

All of the participants are trying to give their children what they did not get.

Those who do not have children were trying to spare them the pain they had experienced.

The Meaning of the Maternal Relationship to Relationships with Family Members

Alice is more willing to interact with her mother than the other siblings and she gets angry with them.

That's hard because... everybody doesn't help out ...And I speak to her daily. And that bothers her a lot, that she doesn't hear from them, and I get the guilt of it all...I feel bad for that but...I can't force them to... call. I mention that to them every time I speak to them, and it's their choice after that ...Sometimes I get mad at them because ... if they helped by maybe talking to her maybe not as much as I do every day, but at least once or twice a week, uh, or even a few times every couple of weeks...It might fulfill, um, something that she's lacking or missing, the attention she needs just to be felt like she is loved and cared for. .. and sometimes I feel like it's all on my shoulders, like they don't really care

Sometimes I could kick myself for being so caring. [Still laughing] ... I seem to feel guilty more... than they do. ... maybe it's my birthplace...I'm the youngest...Sometimes... if I get upset with them... I might not talk to them for a while or I might call them up and say... "This is ridiculous, why can't you just call her or talk to her?" I used to do that quite a bit for a while and now I just don't mention it when they bring up my mom...I hold that in too. I should probably tell them how I feel and just let it out, but I ended up just holding it in so I don't cause... friction between us.

Bridget and her youngest brother, a psychologist, are the siblings who try to help and care for their mother.

Sometimes I get mad at him because I feel that he... was 18 ...when he left home. ... the big problems ... didn't even start until then...But...he just blows her off ... Sometimes I wish he was a little bit more concerned...I think maybe that came from, ... I was the... only girl and I was the next in line, and so then all of it just [laughs] would... came to me. But I love him, I'm proud of him. He's a very... well educated person, a doctor ...It's different for ... my ... brother ... younger than me...we are the closest in age and experienced I think a lot of the... most difficulty with my mom...just recently, I found out that he...has gone through depression and it started when he was in his 20's... he's been on medication now for ... the last two years. And he's just doing really good...actually some, um, medication for...obsessive compulsiveness..... and he's the closest to me and my children... the next brother down from that...he also has been diagnosed with clinical depression, and he's been on medication since the fall. ...he... says it is just like a miracle for him...Oh, I think the sense of concern and worry is just, um, it's my role. It's because I was more like the mom...and then my youngest brother...he has degrees in psychology... so ... he handles things well. And he handles my... mom well...I just kind of feel like he's ok...He's the best adjusted. He might have been too young for a lot of things... at the time...we shared a bedroom ...it was great... we'd say our prayers and sing together...Oh, my mom, ... always stressed that family was important...I feel that way, too. ...I'm able to stop that...and she can go overboard on it, controlling. But...I do think that you should make an effort...to attend things if you can...I'm starting to get better at it...sometimes I don't want to go and [laughing] there's been times that I've actually gotten the guts to say no...

Caroline's mother controlled her relationships with extended family using lies, an aspect of their conflict.

She used to tell me that my step-dad, his family would never really accept me. Never really love me, please, honey, you're ...Black so let's be real. You're ...the black sheep. ...not that joking...but... I need some space from you." She's like, "Well, what're you going to do, go be with his family..." isolating me from people that obviously love me. That I've only now recently... because of what she told me they were saying about me behind my back...I just found out that he's giving me all of his possessions when he dies. I'm like, well, that makes sense, bookcases and what not...people I now see all the

time who, now that she's not involved, love me dearly, deeply. When my partner, said, "Well, honey, you know you're going to get the cottage and you'll get "granny's" house because she'll give it to your dad and then you'll get it." And I go, "Please, you don't know what you're talking about. Of course he'll want to keep it in the family." So my partner tells my dad this and he bursts into tears. And he says, "Well, what the hell are you?" And I'm like, "What do you mean." And goes, "You're my family...My partner and I ... and my two kids. So there's times out there [at the cottage] when there's... four generations... this is huge and I'm thinking that it's...my dad's gonna give it to my niece and...or no, my cousins they'd be, because they're his sister's children and I'm like, like he's gonna skip over me, like I'm invisible because she rewrote that history for me.

Danielle's extended family is distant except for an aunt and a cousin. Her paternal grandmother is helpful but her father is very contentious and tries to control his family.

I don't really have anything to do with a lot of my family because they've managed to remove themselves because of it. ... my grandmother has like seven or eight brothers and sisters... I have no contact with most of them. My cousin...we're the closest. ...she's my mom's cousin ...and she knows...she's really nice. ... and her daughter is just a little bit younger than me, she's got a kid... who's probably got to be thirteen now. ...they know how difficult it is and stuff and they've been really nice. Um, the rest of the family though on that side just doesn't want to know, my aunt is nice too, my grandmother's sister ...I have not really talked to my dad in four going on five years. When... my work closed ... I didn't get my final paycheck. ... I called my grandmother, my dad's mom...to ask her to borrow money. And I have never in my life asked her for anything...So I had a heart attack...so after I asked my grandmother to borrow the money she loaned it to me... She told me I didn't even have to pay it back...my dad found out about it and he called me that night and he had a shit attack over the phone at me. ... he lost his mind and like started screaming that I was a worthless cunt just like mother and that I was crazy and that... the problem started because he never paid child support... it was just a huge war and he already didn't like my mom...They really don't get it, it's not her choice. When she does stupid fucked up shit, she does it because she's crazy, not because she has a choice. My dad has a choice.

Ellen is isolated from her extended family because her parents isolated themselves in an apocalyptic, fundamentalist religious group.

...I really don't have much family, except for ... my husband and my daughter....I don't really have cousins that live around me. ... I just never really had any...had anybody but my mom, which makes it so difficult because I was so sheltered in that religion that ...it just... made it impossible for me to have close ties with people... other than in that religion. And then when I left the religion, there... I don't have those friends anymore...the combination of the two is just terrible...because it's almost like you need something normal in your life when you're dealing with a bipolar... the people even in it don't even help you, just... my relationship with my mom right now, it's fine basically because I just don't let it be a problem...I just I just take it as it comes...My husband knows how my mom is [laughs]...first-hand on some things. So he can understand...

Frances has only her uncle. Her grandmother took care of him and to an extent she does that now.

...And what family I have left is just my uncle...And, then, she took care of him when he was little too. She...if he got bullied, he...I mean, she'd take care of the bully. She was protective of him. I protected him too in the hospital. ...my grandmother would protect him. And I don't know how that...maybe...what would you say, extended family of friends? That's what I would have now. But I'm kind of somewhat still the caregiver...I mean, counselor...and listening to their problems. But...they get mad when I have a little bit of a temper, and I might go off on them, like a mother chastising her child. But maybe they need it [laughs].

Gayle feels that her relationship with her family fluctuates like her mother's disease does.

...it's almost like my mother's disease. Like if I pull a disease, where there's...there's both extremes, where I have...on one hand, I have this wonderful relationship with my siblings, at times, you know, when I'm really in a good place, and where I can be like the big sister who's helpful, and who...has the wisdom, and who's been there before.....I've helped many of my siblings, through different things. And on the other hand, I can be, you know, when I've not been ... I'm like the kid that they're trying to help. I

think...with my mother's disease, I've been a voice of reason with our family, more than everyone else, a voice of compassion. ... what's frustrating, is I think I don't get listened to because I could be helpful in other ways, and so...I just... call when you...the retreat, um, which my other family members for the habit that I might have...caused in our family with my disease...for a chunk of time, now, that I'm not contributing to being of any kind of help, in any way. My sister lives right in the same town, and she is very helpful, and bathing my mother, and you know, all of those hands on tasks that I...

Holly's relatives will only help or interact with her if her mother doesn't know

... she and they affect our relationship, because she affects them... She scares them. So as long as I... keep them a secret from her, they're willing to be active as family members for me...But my feelings about what happens with her weren't really something that I was supposed to talk about in the family. They don't... like to hear about it. They like to pretend that she just never was. ... they can find a little bit of humor in the things that I tell them, like I said earlier, but not really...So I'm not allowed to bring up my feelings. My feelings about that are that I don't really mind, because I'm kind of grateful to have any family....it makes me angry often at my grandmother, because she has a great deal of money, there could have been much more that she did to help me. There's no helping my mother. I understand that. I feel bad for her[grandmother]; because I know that she blames herself for a lot of it. She doesn't understand because she doesn't believe in too much mental illness, you know. But I...I do, I feel angry with her sometimes that she didn't do more. ...they're just people... She does what she can. She's only capable of doing so much, and I know that she loves me...And she still does more than any of my other family members do... if I do anything irresponsible at all, the first thing my grandmother says is, "You're just like your mother." And she doesn't mean it completely. She does it just to push my buttons. ... she knows I'm not just like my mother; otherwise she wouldn't talk to me either. But that gets me so angry, and that gives us our confrontation.

Ilene feels she has been scapegoated by her family because she does not help them without raising questions.

...I don't fool with other family members because of the fact that I don't act like my mother...I am I think at times more friendly with strangers, because I know just how far I'm going to go with them, than I am with family because I feel like my mother has always let family impose on her. My mother is a person who...she will yell and scream at me for nothing, but when it comes

time to stand up to and speak up to some person for a substance abuse, she will say nothing. She will act as if it doesn't exist. She will not let those words cross her lips and I have told her that that is crazy. ... "that's how Ilene is." Which is supposed to mean I'm a bad person...and make me feel like I'm a bad person. But as far as I'm concerned, I'm not a bad person. ...gradually people are beginning to learn that I'm not a bad person,

Justine:

... my family knows my mother struggles with this. And...my mother struggles with her mental status. ... they'll have me and receive from different things that my mother...should do. Like, we have family reunions. They'll contact me 'cause my family is....spread throughout the United States. ... to support the in state end of it...and my brother he's not going to do it. So, I have to always come to the forefront and represent pretty much the family here in this state... before I started really observing... my brother....I could never understand how could you not speak to your sibling, except on holidays...I know they have their other families and their other lives...my brother and... how he acts. And he and I we don't have a relationship...We're trying to resolve some things. But it's... hard [sigh]when you have my mother... as their... head of the household...It's just... is difficult to maintain relationships, where she has so much influence... I guess the guys because they just automatically will call me and say, "Well, okay, can you get your mother together." And then, you know, get your brothers or whatever. And all her brothers and sisters, they're all out of town...She has nobody to support her here, as far as family. And she doesn't have any friends...acquaintances, but not a friend...There's nobody here in the state.

The Meaning of the Maternal Relationship to Work or Career

Alice's relationship with her mother led her to drop out in the ninth grade, even though she had never failed any grades. It causes her to keep her mother's illness a secret at work.

... sometimes I think if life had been different for me, maybe I would be doing a job that pays more money... where I would be at a job that I felt more better about myself. I have a good job, but sometimes I think I work really hard for the money I make [laughing] and I think if my life had been different then maybe I would have finished school, went to college and done something a lot different...at the time I lived in a bad neighborhood and my security was

probably the biggest thing. I probably wouldn't have quit if I would've had a, a ride to school. It was probably four miles away from our house, the high school. I had to walk or... take the city bus with friends and... some people were hassling us so that's when I made the decision to quit school...and then not only that, I had to get myself up for school and I just didn't feel like there was anybody... rooting me on to go or... telling me I have to go to school and I'll find a way for you to go to school no matter what.

... nobody at work knows anything about her illness. ... there have been times where I have had to take time off work and I've never discussed why because...I'm not sure how people might react or what they might talk about. And she's my mom, so ... probably... it'd infuriate me and I'd probably [laughing] end up funk into trouble.

Bridget has had problems creating structure for herself and subordinates when she is promoted into management. This is similar to the problems she has at home.

... I was always in a position, I just took on more and more and more and more responsibility, never knowing when to say, hey I'm not going to do that. I'm not getting paid for that...afraid to say no...And you get into, well, getting promoted into management...then there's no lines drawn...it's all your responsibility, all the time, no hours...there's no lines, no structure, and I would always run into difficulty with that. Feeling completely overwhelmed. Completely like I can't do this anymore, um, too much for me, uh...had to work really hard for sticking up for myself...Like to have enough of my own being where I can just not care about what they think or say to me...want it to just be who I am, and it isn't...[sighs] ... the difficult part is, I believe...and this is just honoring God...I have a creative side to me in drawing and painting... That is not structure and it doesn't come from things in order. In fact, the more out of order they are, the better, because then you have to, then you form it your own way...So structure sometimes is good in one way and it's not good in another way. Because I don't always know where everything's at...nothing really, really important ever like goes, slips...But sometimes I feel like if I knew where everything was, it would make my life a little easier...Sometimes I have anxiety attacks...I think when the stress gets to a certain point. ...if it starts like maybe four or five things in a row, start happening all at one time, then ... I feel it physically.

Caroline has recreated a positive mother-daughter relationship in her work.

...I have a entrepreneurial spirit, you know, but the craziness there, I think it pushed me to, um,...to define my, my own time differently, to not want to be... beholden to someone else... while my clients write my checks... I can...I can take six months off; I can take a year off. If they, if you find somebody else, fine...it's not how it works... in this instance you know where the body's buried. ...I've got clients that, when they go my kids get fifty grand. ... these people...they trust you. I find it odd that I usually only work for women that are about my mother's age...doing very daughterly-like things for someone that could be my parent, that's my parent's age, that this person might actually have a child that's similar in age to me. And I end up in this situation, no exaggeration, where I have felt with my clients, that I've not only recreated this situation intentionally, but that, their children end up hating me because I get to be the good daughter. So it's like, ..., it has impacted me...she can't drive my life forever... but it worked out okay in terms of ...the work, but...with relationships at this group... this circle of family friends...the shit stinks but it's warm. These people don't really...dismiss me because she's my mother and everything but I didn't leave this circle of friends 'till after I had kids because it was...it was comfortable. They knew her, they knew where I came from and ...I needed people that knew how crazy it was so that while I was teaching myself to be an adult, as an adult, that they didn't judge me for it. So here I am, this circle of friends that... my partner even said, "Hey, do you find it a little odd that you don't have any friends your own age?" And I'm like, "Oh...wow."...So that's kind of a recent one where I didn't realize that it had impacted me.

Danielle feels that her toleration for office politics is very low.

...I don't think it really even influences my work at all. Although...I don't have any tolerance for bullshit, like office politics and ...those little petty high school games that these adults continue to play with you. It makes me sick. I can't stand that stuff; I can't stand being involved in it. It takes energy that I just don't have...I think it's made me very... intolerant of bullshit, really. ... I just can't stand it. And it's not just work either, it's with friends too, like any relationships. And I'm very quick, and ...I don't think I'm judgmental...I'm extremely open minded, I'm really nice to people but I have no tolerance for assholes. I don't feel really bad about it either [laughs]. It's really cut a lot of baggage out of my life. And the people that I do associate with are much...I have a better time with them...my free time is... I just don't have much of it [laughs].

Ellen is like her mother in not being very committed to work, so when there are problems, she quits. She doesn't bring her work home like her mother did, though.

... because of my mom, um, I'm able to recognize a lot more when people are not stable [laughs], and it makes it difficult to work with people that are unstable, especially when you know they are, and...you know... because you've been through therapy, or you know because you've seen it that they're acting...because...I know what's wrong with them. ...I know if they were just on Prozac, they would be a lot better [laughs]. So that's part of it... another part of it is that...I am able to keep things [work]...generally separated I would complain a lot, and my husband just had to listen to what I said. I wouldn't yell at him, or blame him. I would just tell him what happened.... during my day...My dad was...able to just leave it at work... come home and...be...at home. I think I have a tendency to do [not leave it at work] that sometimes, but I try not to...my mom, ...I know she doesn't like to work, and I know that she doesn't feel like she has to work...I'd say, because of her, I have a more lazy attitude about work, and when there's a problem, I tend to just quit...I think that's what she's done...I mean maybe not just with work, but it relates to work because when there's a problem in a relationship with my dad, she just quit...So when there's something wrong, I just quit, but not in my relationships...I know in my head that's not normal. And I know in my head that you just have to put up with it [work], sometimes, bad days ...

Frances works in a family business, but her real job over the years has been a caregiver. She works in her family's businesses, and is using them to move toward more creative, self-structured work.

...In my work? Well, I've been like a caregiver....most of my life. I really haven't had jobs, outside of working in my family's businesses. And right now...I'm working on...we...my uncle and I have property...and I'm trying to repair that, and rent it... but he put that on me because he wants me to...that's not really something I ... wanted to do. But it is a pretty good way to... have some income coming in...he'll holler at me for not moving quick enough on things, but you don't see him trying to go out and find anybody [laughs]...I helped him in...a store, ...and we had a little candy store ...when I was a teenager. Then, my uncle ...had a business where I was like the secretary ...just working on their businesses, and not really having my own direction.

...maybe I was resentful of it, but ...I don't even know ...what am I going to do with my life?" ...I would have liked to have had a career in something...a real career, not this care giving career. ...I'm expanding my horizons toward people that are doing something, not people that are stagnated...or that need caregivers.

Gayle feels she is not worthy to do well, even though she sees herself as very capable. She attributes that to lack of guidance and support from her parents.

... not good enough... I do a lot of sabotage. I'm not worthy of...of financial success. I'm not worthy of having a better position. I'm not capable. In fact, I'm very capable. I'm very bright. ... I think the laziness is more...more comes out of fear, or depression... I guess ...I never felt like I was ...because my mother wasn't capable of guiding me into what I want to be when I grow up. I think it was assumed I'd be the housewife mom, like she was which never happened ... So I was never...given any guidance... I was very, probably angry about that for a long time that ...I wasn't directed more as a young woman to go to college, or get a grant, or get a scholarship, or work harder, what do you want to do, or...some help from,... your main support system, your mother and father. We were just left to figure it out all by ourselves. And I didn't figure out anything. So at times, I think I'd be further along down the road...I'd be in a better financial position...I have a tendency to get ahead of myself... I don't realize... you need to like st—stay doing this work, because you have more debt to pay off, not because you're paying your bills on a monthly basis, and paying the minimum balance. ...I need to see a broader picture...I need to be...more realistic.

Holly is usually in conflict with her mother, but not really about working

...On that...that is one of those things too that I'm not sure I understand. But, um, my mother never held down a job, not ever ...And she's been everything from, you know, a shoe salesperson to vice president of a major mergers and acquisitions company... in a span of like a two-year process... she just goes and does whatever... for a while she wanted to be in advertising... every job related to advertising. She's ...Freakishly smart. When I was in high school for a while, she had, through the computer system at work...she's brilliant on the computer, like a hacker. She had hacked into the Federal Reserve and gotten social security numbers and identities of dead people and changed their status...So that she could get credit cards for them and then buy herself presents with them...she never... got caught. ...she would have moments... that's how she got to be a vice president of that company... she would apply

herself. And then she wouldn't, because she would feel like drinking for a while ...or she would go from a job like that to a job where she was like just a secretary. ...And for me, I have no problem holding down a job if I choose to, and that's been my biggest issue, is that... the longest I've ever held a job for ... was like four years. That's a standard of two years where I stay at a job. And I'm young... and I don't have a career specifically. So I don't think that's too abnormal ...if I really love a place, that's when I'll stay for longer than two years. ...I've been working since I was fourteen, legally, and then I was babysitting before that... The jobs that I find that I'm liking, it doesn't necessarily have to do with the job, it has to do more with the environment, the people, or...or the amount of work that I'm doing ...I think that has to do with her. I'm not particularly unhappy with the way that I work...I wish I could find something that I was so in love with it that I stuck with it ...The things that I did love, the rest of my family wouldn't let me do, because they're not things that you can make a lot of money on. Like I can paint, and I can write... it's difficult to make money like that...one of those things I could do until I die every day. Oh, I have to plan this around work today. I have to organi—sometimes I can't stand it. When I can't stand it anymore, I quit and I find something else to do. ...For the entire time that I was a stay-at-home mom, I very much enjoyed not working and ...taking care of my family be my job... that was the most important job in the world, because my mother seemed to not like being a mother so much ... and one thing she taught me that I have used is how to get out of working... and how to lie... as far as that goes, that's pretty much all been up to me, my work ethic. I think if I choose to work hard and stay at the job, there isn't anything where she has. And I tried to be conscious about my behavior enough so that I don't get fired like she has.

Ilene modeled herself as a worker on her mother, but no longer feels that it is such a good path.

...I think for the longest of time I devoted myself to a job as opposed to my life and I let people bother me at the job...I associated my self-esteem... with the job because my mother associated her self-esteem with the fact that she had a job, and I think that she taught me to think that way. And I don't think you should think that way... I think it's taught me to work hard. I have always valued work. She always saw her going to work as the most positive thing I think ...about her is that she would regularly get up... dressing up in her nurse's uniform ...so meticulously. ...when I work I have always had people tell me I'm so meticulous. ...that's one of the things that bothers me, is that I feel I'm more meticulous about work than I am about my personal... Even

now... when [I] talk to her, she tries to make a comment about, "I never lost a job. I kept my job all my life,"... But I don't think she liked her job so what difference did it make? You should've...it would've been better off if you'd lost a job. If you didn't like it...

Justine feels she got a good work ethic from her mother.

... Now, my mother...um, is a hard worker. She's...this is thirty-four years at the plant. Go to work every day. My mother doesn't miss. She'll go to work. She...sick, illness, cold, but she is at work....my mother...has always shown me throughout my life, I will have to work hard. Nobody is ever going to give you anything. If you want anything, you got to work hard for it. And you have to be responsible. So she's always told me that and she's always modeled that. And I have... those same characteristics at work. ... work hard... and do the best I can and try to...be independent. And, that is something also that she's also shown me and taught me throughout my life, is that... you have to be independent. You have to... stand on your own two feet... And, that's funny, because I don't how I got that message and my brother didn't.

Is There Anything Else You Want to Say about the Meaning of your Relationship with Your Mother?

Alice expresses love and compassion for her mother. She feels close and reconciled to her. She accepts her mother's anger and her own, feels a sense of control of herself despite acknowledgement of her inability to control her mother's disease and her lack of understanding of it and her resentment toward her siblings.

...I love her a great deal. I feel really sorry for her. ... I think about everything that I go through but for her it must be a bit worse because she feels really bad when she comes down from the high, about some of the things that she does or says. So sometimes I feel really just bad for her and don't understand why she has it so rough. ...She has had a very hard life from the time she was little up until now. And sometimes...I wonder why God put so much on one person.

... I think we have a pretty good relationship. ...when she's sick she likes to argue, and sometimes I get really mad and then... sometimes I'm able to just overlook it. But I think the anger is more of ... why do we have to go through this and anger is because I worry about her and scared for her.

Bridget wants to be closer to her mother. She is very distressed about a change in her mother's medication and the decline in her condition that she does not understand. She is afraid her mother will die and her children will have to grieve as she did when her grandmother died. She seems to be talking about her own grief.

...I don't want to die feeling the way that I feel about her, and that we're not close... That's like one of my biggest fears, that I'm not going to be able to work this out and she's going to die ...and what that would... mean to me, and what that might mean to her... I feel like there's a solution. [laughs] ...that's the hope thing. ... like these things happened the last few days, I just feel ... so far away from her. ... I don't want something to happen ... I think that I ... walk through my days carrying resentment and ... I have been hurt...so deeply. I'm not God, and ...I want that. I guess that could be like a prayer, it's almost like a deliverance ... To see somebody awesomely, both ways. ... I look at her conditionally because of... experiences and I know vice-versa that's where she's at.... I would like to see it... just an unconditional love, truce, [laughs] something without... all this baggage. Just this... mistrust... I'm not sure what you are going to say to me, and that's a hard... very difficult... I want it [relationship with mother] Even on the way over here... I just really sensed that... she had something very different was going to go on, and that she needs somebody to take care of her... And I felt like I gotta take... but it was a loving thing, not so much a co-dependent thing... I do love her and I don't want to see her suffer like that. But there is nothing I can do. I mean she's just, her doctors, I talked to my dad... what are they doing about her medication? ... they're decreasing something... he should be talking to the doctor or doing something for her.... I don't know what you do, but it's obvious something needs to be done.

I want it [relationship with mother] to not have so much effect on me that I am able to look and act and make decisions for myself and my family not based on how she is going to think, feel or react to them.

...I'm afraid they're not going to be able to make her better... So that she can have a life, that she doesn't have to feel this way, that everyone's against her... ... she raised five kids the best she could. They don't really have a whole lot... she deserves a little bit of happiness. [crying]. And I'm also anticipating a bigger problem Maybe I feel a little scared... [still crying]. That she might say something or do something that's just so off... I, it's ...painful for me. I was there when she got sick before... it's painful to think it might happen again... she would have to go into the hospital ... [continues crying] ...I believe it is very real. Her problems are very... what I mean by not normal

is...that she could feel, that she could experience the kids, the grandchildren like other people do...I got upset... if something happens... the kids... that they would have to experience what I...where did grandma... I just don't want her to get sick again... I want to be prepared...

Bridget seems to be in a process of growth that may lead to genuine acceptance of her mother as she is and therefore an understanding that she need not internalize her encounters with her mother's angry words

Caroline is trying to figure out if the disconnection with her mother is worth it. One of her considerations is the fear of having no financial backup.

...I guess I'm trying to figure out if what it cost me is...is worth it... it's like, you know not to go back to the abusive spouse... books and movies ...tell 'ya, your friends tell you, your family tells you. But when you try to stay away from the bipolar parent...is it worth it, the cost I'm paying....it's like I can't make it right... ... these kids, I've taken their grandmother away... It's hard to know if you're doing it right because you don't have the instincts in the first place, 'cause you didn't get 'em. ...here I am trying to use them... to determine whether or not I made the right choice about severing this relationship. ...It might even be part of why I'm here, to hear myself say it out loud and to help myself decide whether I've made the right decision...kids go through...looking like they need therapy. Sometimes needing therapy,...I don't want them to...that relationship...being totally self-employed for fourteen years ...not knowing sometimes if you can pay the bills, let's be real. ... God forbid you need a new transmission. ... people think...I'm together and I'm...and yet, whether or not to walk away from a completely abusive person...hmm [laughs]. You know, it's like, that catches me...they teach you how to fall in love. They teach you how to... you get the good half of everything but nobody teaches you how to break up with a significant other, let alone a parent. ...I try to read on everything and this one...haven't been able to find the book yet ...

Danielle has put aside most of what others call a life to care for her mother.

...I'd like to see more people have... a sympathetic view of people who are mentally ill and really try to understand it better... it's not a choice and that's...that's been the toughest I think for me with my friends is... just...[tape

skips] anybody who didn't understand it isn't really anybody that I have anything to do with anymore, so...but it's not [laughs].

I: ... I gave um this participant a little feedback because I usually offer to. .. I said that...it seemed to me that your life is just streamlined around her mother's needs. And then you said... it is, I mean it is all the time... Just 'cause that's how it has to be. ...I'm afraid if I get too emotional about stuff I'm not going to be able to shut that off...

She has devoted her adult life to her mother and accepts her, but seems to be grieving for the potential she has not been able to use. She is half Greek and her care of her mother is part of that culture.

Ellen is trying to let go of her anger about the past conflicts so she can have a good relationship with her mother in the present.

...I think that ...we have a pretty decent relationship now... because I've just let all this stuff go... I remember it because I can't help but remember it. But I just let it go because there's nothing I can do about it, and ...I don't want it to influence my life now....I want to be done with it ... not my mom, but be done with the way she acted and the way she...things she's done mistakes ...That's the only way I can get through it is if I just put it out of my head... for the time being. Sometimes I'll just be... in the shower, and something will just hit me and I'll just get really mad, and start talking to my husband about how, "I can't believe my mom did this, and I can't believe my mom did that."... And I can tell her, you know, and ask her, or ask her about it. So I'm just hoping that things stay pretty stable and normal like they are now... there's really not much else I can do...just have to deal with it... That stuff's all over with. ... go ahead. There's...that's stuff's all over.

Frances is trying to come to terms with her past so she can move forward. Her mother has been dead for ten years, as has her grandmother.

... I don't know... maybe I wouldn't have had so many hang-ups, but then I...maybe I wouldn't have known as much either, you know. Maybe I wouldn't have known...seem to know men as well, because...I kind of know them quite well. I don't...maybe mistrust of men and women even, you know, women too, because... I mean, she was a woman... just...a lot of things with a male-female issues.

... I love my mother...I loved her even though she did... so many seemingly terrible things ...they were kind of terrible, some of them...maybe that caused me to love people that are abusive... I have a lot of difficult people...have had difficult people in my life, difficult to love... and that's what kind of I seem to have attracted into my life. But...but I'm trying not to now...not too many anyway... my hang-ups with men were a combination of my mother and my uncle being so...so Catholic."... I was lucky... mainly have a good grandmother to teach me things and try to help me understand my mother and who she was ill, and she didn't mean to do... what she did. ...It's a sickness... And I know it's...it's influenced me for the good, and for the worse...

Gayle is processing the issue that she has not been very close with her mother.

I feel positive about myself, and my... the rest of my life. I feel really positive and really hopeful about the rest of my...that it'll be better than the first half of my life... And I also feel that, in due time, that I'll do the right thing as far as visiting my mother, and anyway that I can help, based on my ability, and be okay with it all too. ...I don't know that I feel like I did because I...because my relationship with my mother wasn't maybe so much hands-on...but on the other hand, in my life experience, is a product of all of that.

Ilene has an insight about how Black families might have a more difficult experience with a bipolar mother because of the respect and compliance that is culturally appropriate. She feels strongly the importance of focusing on her son and herself instead of extended family.

...it's a family problem. I think in the Black family, I think especially you should start talking to more Black people because Black woman are more of matriarchs in their family, because most Black people, their fathers don't live, they're not there, or they don't take an active role, they let the wives take a more controlling role...And I think so many people have a problem with their mothers still trying to run their lives and tell them what to do. And that's what I have a problem with, and it's not just that she's bipolar ... I don't worry about cousins before I worry about my son and I don't worry about... cousins who think they're like my nieces and nephews 'cause they're my first cousins...kids.... And I'm not gonna worry about them before I worry about my family or me, and my mother did a lot of that in my young life.

The amount of time and energy spent by the participants in attempting to connect with their mothers, attempting to avoid painful disconnections, caretaking their mothers, and being in conflict with them, uses energy that otherwise could have been invested in development. The meaning sections detail their perceptions of some of their developmental losses. These losses lead in adulthood to impairment of trust in the self and in others.

All of the participants discussed their deficiencies in social relationships with both men and women. Of the ten participants, Alice married a man who committed suicide. Bridget married a man who became alcoholic. Caroline had numerous relationships, including marriage to an abuser, before settling in a lesbian partnership. Ellen, only 25, is in her second marriage with a man who does not trust her not to be like her mother. Justine seems to have found a good marriage that began at twenty-nine. Frances, Gayle, Holly, and Ilene have never had really long-term relationships. All of these women seem to have repeated some aspect of the relationship with their mother in their partnerships. All of the participants reported emotional distress and isolation.

Productivity and creativity were diminished for all of the participants. Alice and Danielle did not finish high school. Both had to settle for jobs that were less secure and well paid than those they could have gotten if they had finished. Bridget, Ellen, Frances, and Gayle finished high school. Bridget and Gayle advanced beyond their initial low-level jobs, but both had difficulties at the higher levels. Ilene had

some college. Caroline, Holly, and Justine completed college with help from relatives and Justine had her master's. Only Justine seemed to be working up to the potential indicated by her degree. Justine had money from her mother for her education and her stepmother was encouraging.

Conclusion

Summary

This paper began with an introduction to the difficulties of adult daughters of bipolar mothers. The literature review addressed epidemiology, research and clinical impressions of families with a bipolar parent from three theoretical frameworks. These were the psychodynamic, the family systems, and the family support views. It discussed the research on children in bipolar families, including the experience of daughters of bipolar mothers. It addressed a relational view of development, resilience, and memory.

The research plan proposed a rationale for a qualitative method and a strategy for the study. It defined terms used in the research and outlined implications for data collection. It described the population, the sampling plan, the method of recruitment and the sample. It discussed the validity of the design and research, ethical considerations and limitations.

This study addressed three questions:

What are the recalled critical events in the life of the daughter of a bipolar mother, at every developmental stage and in the present?

What are the emotions, thoughts, and actions recalled in association with these events?

How does the relationship with the mother influence the participant's self-identity and her identity as expressed in feeling, thought and action?

Answers to these questions have been identified in the findings chapter and illustrated in the discussion chapter. The data was analyzed using tables. The discussion of the themes of caretaking and conflict was illustrated by material from the participant interviews.

The two most populated, enduring, and interrelated themes in the findings chapter have been exemplified and further analyzed in the discussion chapter. It is impossible to discuss either without using the concept of connection, found in the definitions. Connection appears in the lives of these women as a part of both role reversal and conflict, although it is not analyzed separately.

Further research

Parts of this data might be used to construct survey research that has a larger participant group, and possibly a control group. Two possible goals of such research might be to determine if the sample for this study is typical and to identify the supports that might be instituted for daughters of bipolar mothers at various ages.

A study of the barriers that keep family members from discussing their mother's situation with the professionals that work with her might yield helpful information.

Using the learning from this study, the experiences of other dyads in bipolar families, including mother-son, father-daughter, and father-son might be explored to determine their needs, compare them, and derive a more complete picture of families with bipolar parents.

Finally, a study might be done to clarify the differences between daughters of Caucasian and African-American bipolar mothers. This might be repeated with other dyads.

Services

This study indicates that the daughters of bipolar mothers need information and mutual support to normalize their experience and ameliorate its effects. The Depression and Bipolar Support Alliance and the National Alliance on Mental Illness provide general information and patient support groups. NAMI has didactic groups that teach the family support framework and provide a time limited (twelve week) venue for mutual support (DBSA website, 2009; NAMI website, n.d.) Additional long-term groups are needed for all family members. The resilience literature indicates children are most vulnerable in the second decade of life,

Understanding of the mother's specific difficulties and needs can only come from the mother's treating professionals. For the ten participants a dialogue with their mother's psychiatrists was not effective, if it occurred. Many questions were left unanswered, even if the daughter attended appointments with her mother. It appears that the family members may need to work through any feelings that blunt their

ability to understand information provided and bring up questions that are pertinent. Having one family member go to appointments does not necessarily assist the other family members to help and support each other. It is not clear how professionals who treat bipolar patients view family involvement. Clinicians need to take the role of helping family members in therapy and connecting them with treating psychiatrists and other resources.

I have not been able to locate any support groups that focus on the needs of family members. This research described nuclear and extended families that might have done better for the patient and the children if efforts were made to unify and mobilize them. It tends to indicate that children of bipolar parents from school age to adulthood may benefit from support groups as well as information geared to their age level.

It is less clear what services might be helpful in the preschool period. Federally funded services for young children like the Early Intervention Program in Illinois and Early On in Michigan may already supply specific information about resources for bipolar parents and help the family come to terms with the impact of bipolar cycling. If they do not yet do this they would be ideal providers of this information and help.

The children of bipolar parents have different needs from the children of depressed or schizophrenic parents. Bipolar families often have trouble coming to terms with the other problems occasioned by the illness. The children's needs may be

denied and, as is shown in this study, they may not get much help from their non-bipolar parents or their extended families.

Several participants expressed a desire, by participating in this research, to spare others in similar situations their pain and uncertainty. I hope that this study will assist other daughters of bipolar mothers through an increase in professional knowledge, an increase in personal knowledge, and increased programming specific to their needs.

APPENDIX A:
APPROVAL DOCUMENTS
&
LETTERS OF SUPPORT
IN DATE ORDER



114 Orchard Lake Road
 Pontiac, Michigan 48341-2244
 (248) 858-7766 • Fax (248) 858-8227

September 16, 2003

Louise Kerlin, MSW, CSW, ACSW, BCD
 1015 West Hazelhurst
 Ferndale, MI 48220-1632

Dear Louise,

We have received your request for permission to recruit appropriate Oakland Family Services' clients as participants for your dissertation research on The Recalled Lived Experience of Adult Daughters of Bipolar Mothers: Implications for Clinical Social Work. It is understood that participation in the study is entirely voluntary. We have reviewed your dissertation proposal and agree to offer you that opportunity.

Sincerely,

Michael S. Earl
 President/CEO



Patrick K. Ryan PhD ABPN

233 Southbound Gratiot Avenue
Mt. Clemens, Michigan 48043
Telephone 586-465-7790 Facsimile 586-464-7900
pkikryan@aol.com

09-17-2003

The Chair, IRB, c/o Research Services
Loyola University of Chicago
6525 Sheridan Rd.
Skyscraper, Suite 307
Chicago, Illinois 60626

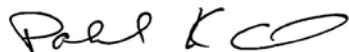
Dear Sir or Madam,

Louise R. Kerlin, MSW, CSW, ACSW, BCD has provided me with information about her dissertation research, The recalled lived experience of daughters of bipolar mothers: Implications for clinical social work. I have a Neuropsychology and substance abuse practice at 233 Southbound Gratiot Ave, Mt Clemens, Mi 48043.

I am writing to affirm that I will assist in her project by referring potential participants for her research. I will give appropriate voluntary clients the Participant Brochure. If you need more information, please feel free to contact me at 586-465-7790.

Thank you for your attention.

Sincerely,



Patrick K. Ryan PhD ABPN ICADC
Licensed Psychologist/Neuropsychologist
Certified Substance Abuse Counselor



Depression and Bipolar
Support Alliance

October 9, 2003

Louise R. Kerlin, MSW, CSW, ACSW, BCD
1015 Hazelhurst
Ferndale, MI 48220-1632

Dear Ms. Kerlin:

Thank you for communicating with the Depression and Bipolar Support Alliance (DBSA) regarding your dissertation research on the experiences of adult daughters of bipolar mothers. As the leading patient-directed national organization focusing on depression and bipolar disorder – the most prevalent mental illnesses – DBSA seeks to foster an environment of understanding about the impact and management of these life-threatening illnesses.

We understand that you may be contacting DBSA chapters in both Detroit and Chicago to make their members aware of your study, and to offer individual members an opportunity to voluntarily participate.

I hope that communicating with these chapters will be helpful to you as you pursue your research. We look forward to hearing from you in the future concerning your results.

Best wishes,

Lisa C. Goodale, ACSW, LSW
Constituency Relations Director

We've been there. We can help.
730 N. Franklin Street, Suite 501 Chicago, IL USA 60610-7224
(312) 642-0049 Toll Free (800) 826-3632 Fax (312) 642-7243 www.DBSAAlliance.org



22101 Moross Road
Detroit MI 48236-2172

February 26, 2004

Louise R. Kerlin, MSW, CSW, ACSW, BCD
Eastwood Clinics
20811 Kelly Road, Suite 103
Eastpointe, MI 48021

Dear Ms. Kerlin,

This letter is to inform you that on February 26, 2004, via Expedited Review, the Institutional Review Board of St. John Hospital and Medical Center reviewed and approved the Informed Consent Revision (stamped approved 02/16/04) for the protocol entitled:

SJ 0903-01 The Recalled Lived Experiences of Adult Daughters of Bipolar Mothers: Implications for Clinical Social Work

The Authorization for the Use and Disclosure of PHI approved by Legal Services 2/9/04 must be used together with the Consent.

As part of the Institutional Review Board's requirements, which are mandated by the FDA, during the upcoming year, you are required to report back to the IRB in the event of any of the following:

1. Significant adverse reactions
2. Changes to the study protocol
3. Termination of the study

In addition, the IRB and FDA require, at least, an annual review of all studies. As the principal investigator, you are responsible for reporting on the progress of each study. A final report is required at the conclusion of the study.

If you have any questions regarding the above requirements, please contact the Medical Education Department (343-8314).

Sincerely,

Jan Pinchak, R.Ph., M.S., CIP
IRB Coordinator for
Peter A. Nickles, M.D., Chairman
Institutional Review Board





6525 North Sheridan Road
Chicago, Illinois 60626

October 29, 2004

Louise R. Kerlin, MSW, BCD
1015 West Hazelhurst St.
Ferndale, MI 48220-1632

Dear Ms. Kerlin,

Thank you for submitting the research project entitled: **The Recalled Experience of Adult Daughters of Bipolar Mothers: Implications for Clinical Social Work**, for review by the Institutional Review Board for the Protection of Human Subjects. After careful examination of the materials you submitted, we have **approved** this project as described for a period of one year.

Approximately eleven months from your initial review date, you will receive a renewal notice stating that approval of your project is about to expire. This notice will give you detailed instructions for submitting a renewal application. If you do not submit a renewal application prior to **October 18, 2005**, your approval will automatically lapse and your project will be suspended. **When a project is suspended, no more research or writing regarding human subjects may be done until the project is reevaluated and re-approved.** I recommend that you respond to these annual renewals in a complete and timely fashion.

This review procedure, administered by the IRB, in no way absolves you, the researcher, from the obligation to immediately inform the IRB in writing if you would like to change aspects of your approved project (please consult our website for specific instructions). You, the researcher, are respectfully reminded that the University's ability to support its researchers in litigation is dependent upon conformity with continuing approval for their work. Should you have questions regarding this letter or general procedures, please contact Dana Vitullo, Compliance Manager, at (773) 508-2689. Kindly quote File #73135 if this project is specifically involved.

With best wishes for the success of your work,

Patricia Rupert

Dr. Patricia Rupert
Chair, Institutional Review Board

cc: Dr. Randolph Lucente

APPENDIX B:
MEMO TO THERAPISTS

Loyola University Chicago School of Social Work

820 North Michigan Avenue
Chicago, IL 60611
312-915-7005

Dissertation Research

**The recalled lived experience of adult daughters of bipolar mothers:
Implications for clinical social work**

Principal Investigator: Louise R. Kerlin, MSW, CSW, ACSW, BCD
586-445-2210

Date:

To: Clinical Staff

From: Louise R. Kerlin, MSW, CSW, ACSW, BCD, Principal Investigator

I am a clinical social worker and a doctoral candidate at Loyola University Chicago School of social work. In my dissertation research I am examining the recalled lived experiences of adult daughters of bipolar mothers using a qualitative design. I have permission from Loyola University Chicago's Institutional Review Board to conduct this research and I have permission from name of clinic to recruit participants from among the clinic's clients.

I am looking for women aged twenty-five and older who know their mothers were bipolar. For purposes of the study, the mother may be a birth mother, adoptive mother, stepmother, or foster mother with whom the participant has lived since birth.

The research involves one long interview of about four to six hours. It will focus on the relationship with the mother as it has affected the participant's development and as it affects current relationships with self, others, and work. The final portion will focus on the meaning of the relationship now. I have provided your management with copies of the informed consent and the interview guide. I am attaching copies of the flyer that you would be giving to appropriate clients. I will be selecting, from those referred, a small number of individuals with varied characteristics to complete the interview. Areas of variation will include socioeconomic status, age, ethnicity, role in the family of origin, and whether or not the participant is herself bipolar.

Your client must never have been my client, and, to your knowledge, she must not have relatives who are or have been my clients. She must not be an involuntary client.

I am asking you to take about five minutes, perhaps at the end of a session, to inform appropriate clients of the study. You will say to them "There is a research

study going on that you might be interested in. Here is some information about it.” If they start to ask questions, please refer them to me. There is information on the flyer about how to contact me for answers to questions.

You do not have to refer anyone to this study even if you have appropriate clients. Your clients do not have to participate if you refer them. If they decide to participate, they can refuse to answer any question, and they can drop out of the research at any time up to the completion of the interview.

If you are willing to refer and have someone who fits into this research please give her the information about it. If you have questions please feel free to call me at any time at 586-445-2210, extension 306.

Thank you.

APPENDIX C:
LETTER TO HOSPITAL SOCIAL WORKERS
&
DISCHARGE PLANNERS

Loyola University Chicago School of Social Work

820 North Michigan Avenue

Chicago, IL 60611

312-915-7005

Dissertation Research

The recalled lived experience of adult daughters of bipolar mothers:

Implications for clinical social work

Principal Investigator: Louise R. Kerlin, MSW, CSW, ACSW, BCD

586-445-2210

Date

Name of hospital social worker or discharge planner

Name of Hospital

Street Address

Dear (Name):

I am a clinical social worker and a doctoral candidate at Loyola University Chicago School of social work. In my dissertation research I am examining the recalled lived experiences of adult daughters of bipolar mothers using a qualitative design. I have permission from Loyola University Chicago's Institutional Review Board to conduct this research and I have permission from name of hospital to recruit participants from among the adult daughters of female patients diagnosed with bipolar disorder.

I am looking for women aged twenty-five and older who know their mothers are or were diagnosed bipolar. For purposes of the study, the mother may be a birth mother, adoptive mother, stepmother, or foster mother with whom the participant lived since birth.

The research involves one long interview of about four to six hours. It will focus on the relationship with the mother as it has affected the participant's development and as it affects current relationships with self, others, and work. The final portion will focus on the meaning of the relationship now. I have provided you with copies of the informed consent and the interview guide. I am attaching copies of the flyer that you would be giving to appropriate clients. I will be selecting, from those referred, a small number of individuals with varied characteristics to complete the interview. Areas of variation will include socioeconomic status, age, ethnicity, role in the family of origin, and whether or not the participant is herself bipolar.

The patient's daughter must never have been my client, and, to your knowledge, she must not have relatives who are or have been my clients.

I am asking you to take about five minutes, when you are with such an adult daughter to say to her "There is a research study going on that you might be interested in. Here is some information about it." If she starts to ask questions, please refer them to me. There is information on the flyer about how to contact me for answers to questions. If they would rather I called them, as the participants in my pilot study did, there is a tear-off part of the flyer that gives permission to give me their name and telephone number. You can call me with this information, or mail it to me, whichever is easiest for you.

You do not have to refer anyone to this study even if you have contact with appropriate family members. Those who are referred do not have to participate if you refer them. If they decide to participate, they can refuse to answer any question, and they can drop out of the research at any time up to the completion of the interview.

If you are willing to refer and have someone who fits into this research please give her the information about it. If you have questions please feel free to call me at any time at 586-445-2210, extension 306.

Thank you for your attention.

Sincerely,

Louise R. Kerlin, MSW, CSW, ACSW, BCD
Principal Investigator

APPENDIX D:
NEWSPAPER ADVERTISEMENT

Is your mother bipolar (manic-depressive)? Are you over 25?

You may be appropriate for a Loyola University Chicago dissertation research study of your experiences with your mother.

Call 586-445-2210, ext. 306 for more information.

APPENDIX E:
PARTICIPANT BROCHURE

Loyola University Chicago School of Social Work

820 North Michigan Avenue
Chicago, IL 60611
312-915-7005

Dissertation Research

**The recalled lived experience of adult daughters of bipolar mothers:
Implications for clinical social work**

Principal Investigator: Louise R. Kerlin, MSW, CSW, ACSW, BCD

- If you are reading this, you believe that your mother suffers or suffered from bipolar illness. You are twenty-five years old or older. Neither you nor any other family member is a therapy client of the researcher. If you are in therapy it is not because a court or an agency will penalize you if you do not receive treatment.
- I am a clinical social worker and a doctoral candidate at Loyola University Chicago School of social work. In my dissertation research I am examining the recalled lived experiences of adult daughters of bipolar mothers. I have authorization from Loyola University Chicago's Institutional Review Board to conduct this research and I have authorization from name of hospital, clinic, or support group to recruit participants from among its clients.
- Bipolar illness is also called manic-depressive illness or disorder. Persons with this problem alternate between bouts of depression and bouts of high energy, impulsiveness, anger, and risk-taking. Some do not get as deeply depressed as others, and some do not get very "manic," but their moods do alternate. Some live relatively normal lives, others are frequently hospitalized, may have unrealistic ideas (delusions) and/or see and hear things that are not real (hallucinations).
- The purpose of the research is to help clinical social workers and other therapists better understand the experience of women who have grown up in the home of a bipolar mother, so they can provide better treatment. It will also help other women whose mothers had bipolar illness to understand their own stresses and to feel less alone. This study is designed to explore how adult women remember their relationship with their bipolar mother in the past and how they relate to their mother in the present. It is also designed to clarify what this important relationship means to them now.
- If you are selected as a participant and you agree to take part in this study, you will be asked to participate in one four to six hour interview. Compensation will consist of \$75.00, paid in cash at the interview, when you sign the informed consent. Refreshments will be supplied appropriate to the time of the interview. At the end I will answer any questions raised by the interview process to the best of my ability.
- Once you are selected, the choice to participate in this study is entirely up to you. No one will try to persuade you to take part. If you decide to participate, you may refuse to answer any question. In addition you may withdraw from the study at any time up to the completion of the interview process.

Questions? Interested?

Please call Louise Kerlin, MSW, CSW, ACSW, BCD

586-445-2210, Extension 306

I will be glad to talk with you about anything related to the study.

APPENDIX F:
TELEPHONE SCREENING TOOL

Loyola University Chicago School of Social Work

820 North Michigan Avenue
Chicago, IL 60611
312-915-7005

Dissertation Research

**The recalled lived experience of adult daughters of bipolar mothers:
Implications for clinical social work**

Principal Investigator: Louise R. Kerlin, MSW, CSW, ACSW, BCD
586-445-2210

Telephone Screening Tool for Prospective Participants

Researcher asks: How do you know your mother is/ was bipolar (manic-depressive)?
Researcher then checks all that apply and/or makes notes on narrative.

____ Social worker on inpatient unit where mother was hospitalized referred prospective participant

____ Mother's psychiatrist or therapist told the prospective participant.

____ Mother's primary care physician told the prospective participant.

____ Mother disclosed her diagnosis to the prospective participant.

____ Mother's psychiatrist or therapist told the father and then he told prospective participant.

____ Mother's primary care physician told the prospective participant's father who then told the prospective participant.

____ Mother's psychiatrist, therapist or primary care physician told another adult of the parents' generation who then told the prospective participant.

____ Sibling of prospective participant spoke to mother's psychiatrist or primary care physician, mother, or father and then told her.

____ Mother has taken lithium for more than ten years.

____ Mother is depressed enough to be in bed much of the time and isolates herself, but occasionally becomes energetic and social for a few weeks.

Other credible narrative: _____

Prospective Participant Name_____

Contact Information_____

APPENDIX G:
LETTER TO VOLUNTEERS
NOT SELECTED
FOR
PARTICIPATION

Loyola University Chicago School of Social Work

820 North Michigan Avenue
Chicago, IL 60611
312-915-7005

Dissertation Research

**The recalled lived experience of adult daughters of bipolar mothers:
Implications for clinical social work**

Principal Investigator: Louise R. Kerlin, MSW, CSW, ACSW, BCD
586-445-2210

Date

Applicant's Name
Street Address
City, State, Zip Code

Dear Ms. (Applicant's Name)

Thank you for volunteering for this research. I am sorry that I cannot include you. I regret having to make this decision but the study design calls for no more than eight participants, and a large number applied.

I appreciate your interest. It means that this study is important to women in your situation. I hope that you will have other opportunities in the future to take part in research on this topic. Thank you again.

Sincerely,

Louise R. Kerlin, MSW, CSW, ACSW, BCD
Principal Investigator

Appendix H:
Researcher's Clinical Qualifications

**CURRICULUM VITAE (Abridged): Louise Ribeiro Kerlin, MSW, CSW,
BCD**

1015 West Hazelhurst, Ferndale, Michigan 48220-1632/Telephone: 248.546.8577

CAREER SUMMARY:

Thirty-three years of creative professional experience, in masters-level social work education, field instruction, public welfare, public and private child welfare and mental health agencies. In direct service I have provided crisis assessment, individual, family and group therapy, and didactic groups to children, adolescents and adults, individual and group chemical dependency services. As a manager I have done consultation, administrative supervision, contract management, public relations, clinical sections of grant proposals, program planning and implementation, long range strategic planning, design and implementation of quality assurance systems, special programming for students, and in-service instruction.

AREAS OF SPECIALIZATION:

Teaching, consultation, program planning and implementation, quality assurance systems
Family, group, insight or supportive individual therapy, cognitive-behavioral therapy
Family violence, family dysfunction, sequelae of trauma, grief, loss, and separation

EDUCATION:

Candidate, Ph.D. Program, Loyola University Chicago School of Social Work, Chicago, Illinois
(Expected completion August, 2009)

Master of Social Work, 1981, Wayne State University, Detroit, Michigan

Bachelor of Arts, 1968, Rutgers University, New Brunswick, New Jersey

ACADEMIC HONORS

Haggerty Scholarship: Loyola University Chicago, 9/1997 to 12-1997, 1/1999 to 5/2000

Graduate-Professional Scholarship: Wayne State University, 9/80-5/81

New Jersey State Scholarship: 9/64-5/68

Douglass College Scholarship: 9/64-5/65

CERTIFICATIONS:

Board Certified Diplomate

Academy of Certified Social Workers

Certified Social Worker, State of Michigan

PUBLICATIONS AND PRESENTATIONS:

See Attachment.

PROFESSIONAL DEVELOPMENT:

See Attachment.

CLINICAL EXPERIENCE:

8/2000-Present: Contractual Therapist, Counseling Associates, 26699 West 12 Mile Road, Southfield, Michigan.

In multidisciplinary setting, credentialed for and serving adults, adolescents and children in individual, family, group and marital therapy. Approximately five hours per week.

9/1991-Present: Contractual Therapist, Eastwood Clinics, 20811 Kelly Road, Eastpointe.

In multidisciplinary setting, credentialed for and serving adults, adolescents and children in individual, family, group and marital therapy, credentialed for clinical supervision. Approximately twenty-four hours per week.

1986-2003: Oakland Family Services, 114 Orchard Lake Road, Pontiac, Michigan 48341

5/97-9/2003: Therapist, approximately one hour per week.

6/92-5/98: Program plan and implementation of student unit to serve families who cannot afford sliding scale fee. Training and consultation to support high quality of service.

10/86-6/92: Clinical and administrative supervision and contract management of Children's Protective Service Counseling, Sexual Abuse, and Parent Education contracts.
1981-1986: Social Worker, Children's Aid Society, 7700 Second Avenue, Detroit, Michigan 48202

1984-1986: Intake Social Worker: Timely assessment of crisis and chronic family situations involving sexual abuse or assault, marginal parenting, and children's or adolescents' acting out behavior
1981-1984: Foster Care Social Worker: Case management, treatment of the foster child with her natural and substitute families as an integrated system,

1984-1986: **Private Practice, Direct and Contractual**

Direct: Family, group, individual therapy with clients presenting for problems associated with a child's behavior, incest, sexual abuse and assault, grief, separation and loss. Forensic reports.

Contractual: Oakland Family Services, 114 Orchard Lake Road, Pontiac, Michigan 48341.
Parent Education/Support groups for parents referred by Department of Social Services.

PRACTICUM/FIELD WORK PLACEMENTS:

1999-July 2000: **Counseling Associates**, 26699 West Twelve Mile Road, Southfield, Michigan 48234

1980-1981: **Region Five School Social Work**, 10001 Puritan, Detroit, Michigan 48238.

1979-1980: **Detroit East Community Mental Health Center**, 9141 East Jefferson, Detroit, Michigan 48214

PRE-MASTERS EXPERIENCE:

1970-1978: Welfare Social Worker 09, State of Michigan, Department of Social Services

1977-1978: Child Neglect Treatment Worker

1975-1977: Child Abuse Treatment Worker

1973-1975: Child Protective Service Worker

1972-1973: Basic Family Service Worker

1970-1972: General Assistance Worker

PROFESSIONAL MEMBERSHIPS:

American Association of Marriage and Family Therapy

National Association of Social Workers, Metropolitan Detroit Chapter

National Membership Committee on Psychoanalysis in Clinical Social Work

PROFESSIONAL DEVELOPMENT (Abridged)

Louise Ribeiro Kerlin, MSW, CSW, BCD

RELEVANT FORMAL EDUCATION:

Ph. D. Program in clinical social work: Loyola University Chicago, Chicago Illinois.

Clinical Seminar and Practicum: 11 Credit Hours

Nature of Clinical knowledge: 3 Credit Hours

Social Work and Law: 3 Credit Hours

Approaches to an Understanding of Meaning: 3 Credit Hours

Independent Study: Adult Daughters of Bipolar Mothers. 3 Credit hours

ONGOING CONSULTATIVE PROCESSES:

Eastwood Clinics Case Conference: Currently every six weeks with Gary Faulstich, M.D.

Weekly January 1992 to April, 1996, July, 1997 to August, 2001. Weekly with

Cheryl Mazzara, M. D. May 1996 to June, 1997.

Loyola Doctoral Program Practicum with Sidney Grossberg, Ph.D. Weekly from

January, 1999 to July, 2000.

Gayle Stroh, A. C. S. W. Consultation Group. Focus on Dissociative Disorders.

Monthly, September, 1996 to July, 1997.

William Harshman, M. A., L. L. P. Consultation Group. Focus on Chemical Use

Disorders. Monthly, June, 1995 to July, 1997.

Donald Wismer, A. C. S. W. Consultation Group. Focus on Dissociative Disorders. Monthly, 1990 to June, 1996.

Bernadette Beyer, MA, LLP, RPTS Individual supervision. Focus on shift to mental health practice, chemical dependency, and play therapy. Monthly, October to December, 1992, biweekly, January to July, 1993

RELEVANT WORKSHOPS:

Universal First Aid. Margaret E. Poupard. February 14, 2003, St. John Health Corporate Office, Warren, Michigan.

Assessment of Chemical Dependency and Treatment Planning. Macomb County Office of Substance Abuse. 3.5 hours. July 31, 1995, Mt. Clemens, MI.

Dual Diagnosis: Assessment and Treatment. Bert Pepper, M.D. 7.0 hours. April 20, 1995, Macomb County Office of Substance Abuse, Mt. Clemens, MI.

Practicing Safe Social Work in Michigan. N.A.S.W. 7.0 hours. April 7, 1995, Ann Arbor, MI.

Assessment of Violence Potential. H. Reid Meloy, Ph.D., A.B.P.P. 7.0 hours. April 3, 1995, Dearborn, MI.

DSM-IV Diagnoses. Jaswant Bagga, M.D. & Steve Fabick, Ed.D., 4.5 hours. March 12, 19, & 26, 1993. Oakland Family Services, Pontiac, MI

Suicide Assessment. Brian Enright, L.L.P. 1 hour. June 25, 1992, Eastwood Clinics, Eastpointe, MI.

Suicide and Lethality. Common Ground Staff. 1.5 hours April 5, 1991, Oakland Family Services, Pontiac, MI

Discovering Normal. Children of Alcoholics Foundation. 7.5 hours. April 20, 1990, New York, NY.

Family Intervention. Donald Pipes, A.C.S.W. 12 hours. October 28, 30, 1987, Oakland Family Services, Pontiac, MI

Intimacy, Shame, and Alcoholic Family Recovery. Sondra Smalley, M.A., C.C.D.P. 14 hours. November 9, 10, 1984. Sponsored by Fairlane Health Services, Mercy Center, Farmington Hills, MI.

Child Sexual Assault. Kathleen Faller, Ph.D. University of Michigan Spring-Summer Symposium. 21 hours. June, 1983, Ann Arbor, MI.

RELEVANT PUBLICATIONS AND PRESENTATIONS

Louise Ribeiro Kerlin, MSW, CSW, BCD

RELEVANT PUBLICATIONS:

Kerlin, L. & Brandell, J. (1997). Family Violence and Clinical Practice. In Brandell, J., Ed. (1997). Theory and Practice in Clinical Social Work. The Free Press: New York, NY.

Kerlin, L. & Brandell, J. (1996). Violence in intimacy. Proceedings: Thirty Fifth Annual Meeting and Conference for the Advancement of the Private Practice of Clinical Social Work. Hamilton, Bermuda.

RELEVANT PRESENTATIONS

Society's Silent Victims: Treating the physical, emotional, and sexual abuse of our children. Eastwood Clinics/St. John Health System, Madison Heights, Michigan. May 7, 1999

Family Therapy: Basic Theory and Techniques. Eastwood Clinics/St. John Health System, Madison Heights, Michigan. May 23, 1997.

Anxiety Disorders. Agoraphobics in Motion, Warren, Michigan. October 8, 1996.

Violence in Intimacy. International Conference for the Advancement of Private Practice in Clinical Social Work, Hamilton, Bermuda. July 14, 1996.

Recognizing, Documenting, and Reporting Emotional, Physical, and Sexual Abuse and Neglect. Oakland Steiner School, Bloomfield Hills, Michigan. February 29, 1996.

Chemical Dependency and Depression. Eastwood Clinics, Eastpointe, Michigan. October 20, 1995.

Metaphors in Client Work: An Experiential Workshop. Ferndale, Michigan. June 3, 1995.

Sexually Abused Clients. Inservice at Oakland Family Services, Pontiac, Michigan, February 26, 1993.

Child Abuse and Neglect. T. V. Orient, Detroit, Michigan. May 28, 1992.

Adult Survivors of Sexual Abuse. W. Channel 2, Detroit, Michigan. October, 1991.

Impact of Childhood Abuse. W. D. I. V. Channel 4, Detroit, Michigan. February 18, 1991.

Violence Against Children. FOX Channel 50, Detroit, Michigan. February 6, 1991.

Sexual Abuse. Reproductive Health Institute, Detroit, Michigan. February 20, 1986.

APPENDIX I:
BEHAVIORAL RESEARCH INFORMED CONSENT

Loyola University Chicago School of Social Work

820 North Michigan Avenue

Chicago, IL 60611

312-915-7005

Dissertation Research

The recalled lived experience of adult daughters of bipolar mothers:

Implications for clinical social work

Principal Investigator: Louise R. Kerlin, MSW, CSW, ACSW, BCD

586-445-2210

Behavioral Research Informed Consent

Introduction and Purpose:

Louise R. Kerlin, the principal investigator, is a Doctoral Candidate in the School of Social Work at Loyola University Chicago. This research fulfills requirements of that program. She is conducting this study under the auspices of Loyola University Chicago and St John Hospital and Medical Center. It is about the experience of women who grew up in the home of a mother who had or has bipolar illness. Bipolar illness is also called manic-depressive illness or disorder. Persons with this problem alternate between bouts of depression and bouts of high energy, impulsiveness, anger, and risk-taking. Some do not get as deeply depressed as others, and some do not get very “manic,” but their moods do alternate. Some live relatively normal lives, others are frequently hospitalized, may have unrealistic ideas (delusions) and/or see and hear things that are not real (hallucinations).

Approximately eight to ten women will be interviewed for this study.

This research is designed to clarify similarities and differences in lifetime patterns of thoughts, feelings, and behavior that women experience in relationship with a bipolar mother. It also clarifies what this important relationship means to them now.

This study may help clinical social workers and other mental health professionals better understand women who have grown up with a bipolar mother and be able to provide better treatment.

It may be helpful to other women who have grown up with a bipolar mother who read it.

- You are being asked to take part in this research study because there is good reason to believe that your mother suffers or suffered from bipolar illness.
- You are over twenty-five years old.

- Neither you nor any members of your family member are clients of the researcher.
- If you are in therapy and your therapist gave you information about this study, you are in therapy of your own free will, not because a court or agency will penalize you if you do not get treatment

Procedure:

If you take part in this study, you will be asked to participate in one interview, between four and six hours long. The first segment lets you get acquainted with the researcher and learn more about the study. During it you will read this consent form and the interview guide. You will decide whether to participate. If you do decide to participate, you will fill out an information form so that if you become physically ill or extremely upset in the interview the researcher may notify your designated emergency contact. You will be given numbers for local crisis services. The researcher will give you a copy of the interview guide.

There will be three additional segments. The interview will focus on your relationship with your mother from early childhood through your twenties. Next it will concentrate on your current relationship with your mother. It will ask how this relationship affects your other important relationships and your job or career. Finally it will clarify what your relationship with your mother means to you now.

Once this consent and the personal information form and survey are completed, the remainder of the interview, except for breaks, will be audiotaped. Any names or locations that are accidentally recorded will be erased by the researcher. Then the tape will be transcribed. You will be assigned a number so that your name will never appear on the audiotape or the transcript. Materials with both names and numbers, including the informed consent and the original of the participant information sheet will be stored in a locked box in one area at 20811 Kelly Road, Eastpointe, MI 48021. A copy of the participant information sheet from which the identifying information has been deleted, will be kept along with the tapes and transcripts in a locked cabinet in a different room at the same address. Once the analysis of the transcripts is completed, the tapes, and the participant information sheet will be destroyed.

If you bring with you with any other kind of information, like journals, diaries, letters, pictures, tape or video recordings, this material will be discussed and the process will be recorded. If written material is too lengthy to approach in this way, the researcher will take it with her, reading it as soon as possible, keeping it in a locked box, and keeping a record of her impressions in her qualitative research journal. In the journal, you will be identified only by number. This information will be returned to you at the earliest possible opportunity.

If you withdraw from the study, none of your information will be used. The researcher will destroy any recorded or written materials that relate to you, including relevant material in the qualitative research journal.

Benefits:

The possible benefits to you for taking part in this study are that you may find that these interviews help you better understand yourself and your relationship to your mother.

There may be no direct benefit to you; however, information from this study may benefit other daughters of bipolar mothers in the future, when the information from this study becomes known.

Risks:

In this interview you will be talking about one of the longest and closest relationships in your life. You may find yourself describing events you have never talked about before even with your family members or a therapist. You may find these events and the feelings, thoughts and reactions connected to them to be difficult, even painful to discuss. You may become upset.

If during or after this interview you need to obtain psychiatric care, the researcher will call your emergency contact to help you arrange it.

If during the interviews you tell the researcher about current child abuse or neglect, or abuse or neglect of elderly persons, you understand that the researcher is required by law to report these situations to Child or Adult Protective Services.

If the researcher learns that you are in danger, or that you are about to cause an immediate threat to someone else she will have to do everything she can to prevent you or others from being hurt. This could include disclosure of the danger to your designated emergency contact, or in some cases, the police. In this situation you might be hospitalized.

If you become seriously physically ill during the interview, the researcher will have to call emergency personnel and disclose your identity to them. She may also call your emergency contact and disclose facts about your illness and whereabouts to her or him.

There may also be risks involved in taking part in this study which are not known at this time.

Alternatives:

The only alternative to participation in this study is not to participate.

Voluntary Participation and Withdrawal:

Taking part in this study is voluntary. You may choose not to take part in this study, or if you decide to take part, you can later change your mind and withdraw from the study at any time without penalty.

Your decision will not change the present or future health care or other services that you receive. In addition, if you are asked a question during the interview that you do not want to answer, you do not have to answer it.

If the researcher believes that you should not continue with the interviews because they are causing you too much stress, she will terminate you from the study and help you arrange for support if you so desire.

Costs:

If you participate in the study you may have costs for child care or transportation. These costs are your responsibility.

Compensation:

For taking part in this study you will receive \$75.00. This money will be given to you as soon as you sign the informed consent, so you are under no obligation to continue. During the interview you will be provided with refreshments of your choice appropriate to the time when it is being conducted. At the end of the interview the researcher will answer any questions raised by it, to the best of her ability.

In the event that you are injured as a result of taking part in this study, you will be given information about where to receive medical care; but you or your insurance company will be responsible for the costs. No reimbursement, compensation or free medical care is offered by Loyola University Chicago, St. John Health,

Eastwood Clinics or any organization in which the research interview has taken place.

Confidentiality:

All information collected about you during the course of this study will be kept confidential to the extent permitted by law. The research records will be locked and secured at 20811 Kelly Road, Eastpointe, MI 48021. You will be identified in the research records by a code number. Information which identifies you personally will not be released without your written permission. However, your records may be reviewed by Loyola University Chicago's Institutional Review Board for the Protection of Human Subjects and appropriate federal agencies. Information from this study may be published, but your identity will be kept confidential in any publications.

If you decide to participate in the study, the researcher, the professors on her committee and others who work with the study will see your transcript. This Informed Consent governs how your study transcript is disclosed and used. To participate in the study you will need to sign the Informed Consent.

EMERGENCY CONTACT CONSENT

_____ Yes, the researcher may contact the following person in an emergency.

Signature

Questions:

This study has been explained to you and all of your questions have been answered. If you have any questions in the future or in the case of a research related injury or illness, you may contact Louise R. Kerlin, MSW, CSW, ACSW, BCD, at 586-445-2210, Extension 306, or Professor Randolph Lucente, faculty advisor for this project, at 312-915-7031. If you have any questions about your rights as a research participant, you should call the Loyola University Chicago's Research Compliance Manager at 773-508-2689.

Consent to Participate in a Research Trial:

To voluntarily agree to take part in this study, you must sign on the line below. If you choose to take part in this study, you may withdraw at any time up to the completion of the interview. You are not giving up any of your legal rights by signing this form. Your signature below indicates that you have read, or had read to you, this entire consent form, including the risks and benefits, and have had all your questions answered. You will be given a copy of this consent form.

Signature of Study Participant

Date

Printed Name of Study Participant

Date

Signature of Witness (Researcher)

Date

Local Crisis Services

Macomb County Crisis Line: 586-573-2200

Oakland County: Common Ground; 1-800-231-1127

Wayne County Crisis Line: 313-224-7000

In Chicago, go to nearest emergency room.



APPENDIX J:
LOYOLA UNIVERSITY CHICAGO
&
ST JOHN HOSPITAL AND MEDICAL CENTER
BEHAVIORAL RESEARCH INFORMED CONSENT

Loyola University Chicago School of Social Work/St John Hospital & Medical Center

820 North Michigan Avenue
Chicago, IL 60611
312-915-7005

22101 Moross Road
Detroit, MI 48236-2172
313-343-7000

Dissertation Research

The recalled lived experience of adult daughters of bipolar mothers: Implications for clinical social work

Principal Investigator: Louise R. Kerlin, MSW, CSW, ACSW, BCD
586-445-2210

Behavioral Research Informed Consent

Introduction and Purpose:

Louise R. Kerlin, the principal investigator, is a Doctoral Candidate in the School of Social Work at Loyola University Chicago. This research fulfills requirements of that program. She is conducting this study under the auspices of Loyola University Chicago and St John Hospital and Medical Center. It is about the experience of women who grew up in the home of a mother who had or has bipolar illness. Bipolar illness is also called manic-depressive illness or disorder. Persons with this problem alternate between bouts of depression and bouts of high energy, impulsiveness, anger, and risk-taking. Some do not get as deeply depressed as others, and some do not get very “manic,” but their moods do alternate. Some live relatively normal lives, others are frequently hospitalized, may have unrealistic ideas (delusions) and/or see and hear things that are not real (hallucinations).

Approximately eight to ten women will be interviewed for this study.

This research is designed to clarify similarities and differences in lifetime patterns of thoughts, feelings, and behavior that women experience in relationship with a bipolar mother. It also clarifies what this important relationship means to them now.

This study may help clinical social workers and other mental health professionals better understand women who have grown up with a bipolar mother and be able to provide better treatment.

It may be helpful to other women who have grown up with a bipolar mother who read it.

- You are being asked to take part in this research study because there is good reason to believe that your mother suffers or suffered from bipolar illness.
- You are over twenty-five years old.
- Neither you nor any members of your family member are clients of the researcher.
- If you are in therapy and your therapist gave you information about this study, you are in therapy of your own free will, not because a court or agency will penalize you if you do not get treatment

Procedure:

If you take part in this study, you will be asked to participate in one interview, between four and six hours long. The first segment lets you get acquainted with the researcher and learn more about the study. During it you will read this consent form and the interview guide. You will decide whether to participate. If you do decide to participate, you will fill out an information form so that if you become physically ill or extremely upset in the interview the researcher may notify your designated emergency contact. You will be given numbers for local crisis services. The researcher will give you a copy of the interview guide.

There will be three additional segments. The interview will focus on your relationship with your mother from early childhood through your twenties. Next it will concentrate on your current relationship with your mother. It will ask how this relationship affects your other important relationships and your job or career. Finally it will clarify what your relationship with your mother means to you now.

Once this consent and the personal information form and survey are completed, the remainder of the interview, except for breaks, will be audiotaped. Any names or locations that are accidentally recorded will be erased by the researcher. Then the tape will be transcribed. You will be assigned a number so that your name will never appear on the audiotape or the transcript. Materials with both names and numbers, including the informed consent and the original of the participant information sheet will be stored in a locked box in one area at 20811 Kelly Road, Eastpointe, MI 48021. A copy of the participant information sheet from which the identifying information has been deleted, will be kept along with the tapes and transcripts in a locked cabinet in a different room at the same address. Once the analysis of the transcripts is completed, the tapes and the participant information sheet will be destroyed.

If you bring with you with any other kind of information, like journals, diaries, letters, pictures, tape or video recordings, this material will be discussed and the process will be recorded. If written material is too lengthy to approach in this way, the researcher will take it with her, reading it as soon as possible, keeping it

in a locked box, and keeping a record of her impressions in her qualitative research journal. In the journal, you will be identified only by number. This information will be returned to you at the earliest possible opportunity.

If you withdraw from the study, none of your information will be used. The researcher will destroy any recorded or written materials that relate to you, including relevant material in the qualitative research journal.

Benefits:

The possible benefits to you for taking part in this study are that you may find that these interviews help you better understand yourself and your relationship to your mother.

There may be no direct benefit to you; however, information from this study may benefit other daughters of bipolar mothers in the future, when the information from this study becomes known.

Risks:

In this interview you will be talking about one of the longest and closest relationships in your life. You may find yourself describing events you have never talked about before even with your family members or a therapist. You may find these events and the feelings, thoughts and reactions connected to them to be difficult, even painful to discuss. You may become upset.

If during or after this interview you need to obtain psychiatric care, the researcher will call your emergency contact to help you arrange it.

If during the interviews you tell the researcher about current child abuse or neglect, or abuse or neglect of elderly persons, you understand that the researcher is required by law to report these situations to Child or Adult Protective Services.

If the researcher learns that you are in danger, or that you are about to cause an immediate threat to someone else she will have to do everything she can to prevent you or others from being hurt. This could include disclosure of the danger to your designated emergency contact, or in some cases, the police. In this situation you might be hospitalized.

If you become seriously physically ill during the interview, the researcher will have to call emergency personnel and disclose your identity to them. She may also call your emergency contact and disclose facts about your illness and whereabouts to her or him.

There may also be risks involved in taking part in this study which are not known at this time.

Alternatives:

The only alternative to participation in this study is not to participate.

Voluntary Participation and Withdrawal:

Taking part in this study is voluntary. You may choose not to take part in this study, or if you decide to take part, you can later change your mind and withdraw from the study at any time without penalty.

Your decision will not change the present or future health care or other services that you receive. In addition, if you are asked a question during the interview that you do not want to answer, you do not have to answer it.

If the researcher believes that you should not continue with the interviews because they are causing you too much stress, she will terminate you from the study and help me arrange for support if you so desire.

Costs:

If you participate in the study you may have costs for child care or transportation. These costs are your responsibility

Compensation:

For taking part in this study you will receive \$75.00. This money will be given to you as soon as you sign the informed consent, so you are under no obligation to continue. During the interview you will be provided with refreshments of your choice appropriate to the time when it is being conducted. At the end of the interview the researcher will answer any questions raised by it, to the best of her ability.

In the event that you are injured as a result of taking part in this study, you will be given information about where to receive medical care; but you or your insurance company will be responsible for the costs. No reimbursement, compensation or free medical care is offered by Loyola University Chicago, St. John Health, Eastwood Clinics or any organization in which the research interview has taken place.

Confidentiality:

All information collected about you during the course of this study will be kept confidential to the extent permitted by law. The research records will be locked and secured at 20811 Kelly Road, Eastpointe, MI 48021. You will be identified in the research records by a code number. Information which identifies you personally will not be released without your written permission. However, your records may be reviewed by the Loyola University Chicago's Institutional Review Board for the Protection of Human Subjects, The St. John Hospital Institutional Review Board and appropriate federal agencies. Information from this study may be published, but your identity will be kept confidential in any publications.

If you decide to participate in the study, the researcher, the professors on her committee and others who work with the study will see your transcript. This Informed Consent governs how your study transcript is disclosed and used. To participate in the study you will need to sign the Informed Consent.

EMERGENCY CONTACT CONSENT

_____ Yes, the researcher may contact the following person in an emergency.

Questions:

This study has been explained to you and all of your questions have been answered. If you have any questions in the future or in the case of a research related injury or illness, you may contact Louise R. Kerlin, MSW, CSW, ACSW, BCD, at 586-445-2210, Extension 306, or Professor Randolph Lucente, the faculty advisor for the project, at 312-915-7031. If you have any questions about your rights as a research participant, you should call the Loyola University Chicago's Research Compliance Manager at 773-508-2689 or the Coordinator of the St. John Hospital and Medical Center Institutional Review Board, at 313-343-3814.

Consent to Participate in a Research Trial:

To voluntarily agree to take part in this study, you must sign on the line below. If you choose to take part in this study, you may withdraw at any time up to the completion of the interview. You are not giving up any of your legal rights by

signing this form. Your signature below indicates that you have read, or had read to you, this entire consent form, including the risks and benefits, and have had all your questions answered. You will be given a copy of this consent form.

Signature of Study Participant

Date

Printed Name of Study Participant

Date

Signature of Witness (Researcher)

Date

Local Crisis Services

Macomb County Crisis Line: 586-573-2200

Oakland County: Common Ground; 1-800-231-1127

Wayne County Crisis Line: 313-224-7000



APPENDIX K:
PARTICIPANT INFORMATION SHEET AND QUESTIONNAIRE

Loyola University Chicago School of Social Work

820 North Michigan Avenue
Chicago, IL 60611
312-915-7005

Dissertation Research

**The recalled lived experience of adult daughters of bipolar mothers:
Implications for clinical social work**

Principal Investigator: Louise R. Kerlin, MSW, CSW, ACSW, BCD
586-445-2210

Participant information sheet & questionnaire

Name: _____ Birth date: _____ Participant #: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Telephone Number: _____ Work: _____

Pager number: _____ Cell phone: _____

Fax: _____

Best times/ places to call me: _____

Do not call me: _____

Family emergency contact:

_____ Telephone _____

Best times for interview:

Participant number _____

How did you find out your mother was bipolar?

When? _____

How old is your mother? _____ Deceased? _____

Year? _____

Where does your mother live now (Town, State)? _____

Does she live by herself? _____ With a partner? _____ With you? _____ With another family member? _____ Who? _____ In a supervised living situation? _____

How often do you see her? Once a day _____ Once a week _____ Once a month? _____

Once a year? _____ Not since _____

How often do you talk with her? Once a day _____ Once a week _____ Once a month? _____

Once a year? _____ Not since _____

How is her physical health? Circle one.

Excellent Good Fair Poor

How is her psychological health? Circle one.

Excellent Good Fair Poor

If she has been hospitalized for her mental illness, when was her last hospitalization?

How many times do you remember her being hospitalized, total? _____

**APPENDIX L:
INTERVIEW GUIDE**

Loyola University Chicago School of Social Work

820 North Michigan Avenue

Chicago, IL 60611

312-915-7005

Dissertation Research

The recalled lived experience of adult daughters of bipolar mothers:

Implications for clinical social work

Principal Investigator: Louise R. Kerlin, MSW, CSW, ACSW, BCD

586-445-2210

Interview Guide

Get acquainted segment.

This initial segment will begin with a very small amount of social chat to set the

participant at her ease. I will introduce myself and ask if she has any

questions before we begin. I will then explain the rest of the interview to her

as follows:

“First we’re going to go over the informed consent together and I will answer any

questions you have about it and about the interviews. You may have a copy

of the interview guide if you want to. Then I will ask you whether you want

to participate in the study. If you are undecided, you may take the consent

materials home with you. If you decide later to participate, you can call me so

we can arrange for you to sign the consent, mail it back, and make an

appointment for the interview. If you are sure you do not want to participate,

we will end this interview at that point. If you decide you do want to

participate, you will sign the informed consent and I will witness your

signature and give you a copy. We’ll talk about what might be hard for you to

discuss, and how you might want to handle that. There will be two breaks in the interview, but you can ask for a break at any time.

Then I'll give you the participant information sheet and questionnaire and you'll fill them out. I'll look them over to make sure I understand everything. Then we'll go on to the research interview.

Ok. This is the informed consent.

Have you read it?

Do you want to read it (again) or should I read it to you?

(After each section if I am reading, otherwise when the prospective participant looks up or stops.)

Do you have any questions?

Do you want to participate?

If she is unsure I will remind her that she can call me with questions, or if she decides to participate. I will also ask her what I can do to respond to her concerns, including showing her the interview schedule.

If she decides against participation, the interview will end at that point and I will say good-bye.

If she decides to participate, I will obtain and witness her signature. I will pay her the \$75.00 compensation

I will then bring out the participant information sheet and ask her to complete it. I will be available in the room for questions and go over it with her to make

sure I understand it. I will tell her that I'll be asking her not to use names or locations when we're taping but if she makes a mistake, I will go through the transcript and erase the name. I'll ask her what she thinks might be stressful for her to talk about and if there's anything I can do to make it easier for her. I will offer her a copy of this interview guide. At the end I will ask her how she is feeling and make an assessment whether she should go on to the next segment. If not I will tell her I need to terminate her participation because her stress level is too high.

If she is calm and relatively comfortable, I will then go on with the second segment.

Second segment:

Ask her if there's anything she needs to do so she's comfortable and let her do what she needs to do.

Now we'll be talking about your relationship with your mother from the time you were little (or "started living with her") up to now. We're going to start with what you remember, and go on to what you felt, thought and did. Don't worry about remembering that. I'll remind you. Do you have any questions before we get started? What do you think will be hard for you? How can I help? I will reiterate that she can decline to answer any question. I will remind her to try not to use names or locations in the interview, but not to worry if she makes a mistake.

If the participant cries during the interview, I will wait respectfully for her to stop.

I will then ask her what brought her tears.

Section I: 30 min

Tell me about your first memory of your mother. What was happening?

How did you feel?

What did you think?

What did you do?

How old do you think you might have been then?

Do you remember anything else about you and your mother from when you were
really little? What was happening?

How did you feel?

What did you think?

What did you do?

How old do you think you might have been then?

Did anyone really try to help you when you were that age?

Section II:

Tell me about something you remember about you and your mother after you started
grade school. What was happening?

How did you feel?

What did you think?

What did you do?

How old do you think you might have been then?

Do you remember anything else about you and your mother from when you were in
grade school? What was happening?

How did you feel?

What did you think?

What did you do?

How old do you think you might have been then?

Did anyone really try to help you when you were that age?

**Break: at this point I will offer the participant a non alcoholic beverage of her
choice, and allow time for her to drink it and do anything else she feels
she needs to do. Then we will proceed with Section III**

Section III:

Tell me about something you remember about you and your mother after you started
high school. What was happening?

How did you feel?

What did you think?

What did you do?

How old do you think you might have been then?

Do you remember anything else about you and your mother from when you were in
high school? What was happening?

How did you feel?

What did you think?

What did you do?

How old do you think you might have been then?

Did anyone really try to help you when you were that age?

Section IV:

Tell me about something you remember about you and your mother after you were in
your twenties. What was happening?

How did you feel?

What did you think?

What did you do?

How old were you then?

Do you remember anything else about you and your mother from when you were in
your twenties? What was happening?

How did you feel?

What did you think?

What did you do?

How old were you then?

Was anyone particularly helpful during your twenties?

Okay. Your memories are really helpful. I really appreciate your participation. How
are you feeling?

At this point I will supply a light meal or substantial snack of the participant's choice, depending on the time of day, and allow time for the participant to do whatever she might need to do to make herself comfortable. I will leave some food available during the remaining segments.

Third segment:

Is there anything you need to do to be comfortable while we talk? Okay, we'll be talking about how things are between you and your mother now, just recently. I'm still going to be asking about things that happen, how you feel, what you think, and what you did. You don't have to remember that. I'll ask like I did last time. Any questions? Try not to use names or locations, but don't worry if you do, I'll erase them.

Section I:

Tell me about something that happened between just you and your mother recently.

What happened?

How did you feel?

What did you think?

What did you do?

Tell me about something else that happened between just you and your mother recently. What happened?

How did you feel?

What did you think?

What did you do?

Section II:

Tell me about something that happened just recently between you and your mother

and either involved your partner or had something to do with your partner?

What happened?

How did you feel?

What did you think?

What did you do?

Tell me about something else that happened just recently between you and your

mother and either involved your partner or had something to do with your partner? What happened?

How did you feel?

What did you think?

What did you do?

Section III:

Tell me about something that happened just recently between you and your mother

and either involved your children or had something to do with your children?

What happened?

How did you feel?

What did you think?

What did you do?

Tell me about something else that happened just recently between you and your mother and either involved your children or had something to do with your children? What happened?

How did you feel?

What did you think?

What did you do?

Section IV:

Tell me about something that happened just recently between you and your mother and either involved other family members or had something to do with them?

What happened?

How did you feel?

What did you think?

What did you do?

Section V:

Tell me about something that happened just recently between you and your mother and either involved your work/career or had something to do with it? What happened?

How did you feel?

What did you think?

What did you do?

Tell me about something else that happened just recently between you and your

mother and either involved your work/career or had something to do with it?

What happened?

How did you feel?

What did you think?

What did you do?

What else is there about right now?

Okay. This has been really important material. I appreciate your help. How are you feeling?

Fourth segment:

How are you doing? Is there anything you need to do to be comfortable while we go on? Do you need a break? Allow time for break if needed. Okay, this is the fourth segment and we'll be talking about what your relationship with your mother means to you now, how it has affected your feelings, thoughts and your behavior. You don't have to remember that. I'll ask like I have been doing. Is there a part of that that seems like it might be hard for you to talk about? Is there anything I can do to help? Remember, you don't have to answer any question that you don't want to. This is the last segment. How do you feel about that? Any questions? Try not to use names or locations, but don't worry if you do, I'll erase them.

Section I:

Okay, I'd like you to talk about how your relationship with your mother throughout your life influences how you are as a person.

How does it influence your feelings about yourself?

How does it influence your thoughts about yourself?

In what way does it influence how you act?

Section II:

Okay, I'd like you to talk about how your relationship with your mother throughout your life influences how you are with your partner(s)?

How does it influence your feelings about him/her/ them?

How does it influence your thoughts about him/her/ them?

In what way does it influence how you act with him/her/ them?

Section III:

Okay, I'd like you to talk about how your relationship with your mother throughout your life influences how you are with your children?

How does it influence your feelings about him/her/ them?

How does it influence your thoughts about him/her/ them?

In what way does it influence how you behave with him/her/ them?

Section IV:

Okay, I'd like you to talk about how your relationship with your mother throughout your life influences how you are with your family?

How does it influence your feelings about them?

How does it influence your thoughts about them?

In what way does it influence how you act with them?

Section V:

Okay, I'd like you to talk about how your relationship with your mother throughout
your life influences how you are in your work?

How does it influence your feelings about it?

How does it influence your thoughts about it?

In what way does it influence how you behave at work?

Is there anything else about the meaning of your relationship with your mother in
your life?

Okay. This has been really important material. I appreciate your help. How are you
feeling? This was the last part. We're done now. Any questions? Your work
has been very important to the study. I appreciate your participation. Do you
have any questions?

I will answer her questions and provide her with contact information for resources.

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