TO KEEP CLOSE: MOTHERING AMIDST SERIOUS

MENTAL ILLNESS AND SUFFERING

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A Thesis
Submitted to the School of Graduate Studies
in Partial Fulfilment of the Requirements
for the Degree in Clinical Health Sciences - Nursing

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MOTHERING AMIDST SERIOUS MENTAL ILLNESS

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ABSTRACT

The desire to mother in women with serious mental illness (SMI) is increasingly recognized by health care professionals. For women with SMI, mothering is often framed as a pathological problem needing a professional response. However, no research could be found concerning the subjective meaning of mothering for women with SMI.

This grounded theory study sought to explore how a group of 20 mothers with SMI managed mothering. *To Keep Close*, a theoretical model, emerged to describe the mothers' efforts to have meaningful relationships with their children in the context of SMI and suffering. To keep close to their children equated to being "normal", "secure" and "responsible" for them. To keep close, they chose strategies that would imitate ideal representations of mother. These strategies included masking, censoring speech and doing motherwork, each intended to make illness invisible. Mothers made choices concerning how they presented self-as-mother and the extent to which they revealed their true identity. However, mothering in illness and suffering became a vortex of contradictions, resulting in their "hitting bottom". They typically sought help from professionals as the last possibility for reconciliation. With such professional guidance, they hoped to return to their valued place as mother.

In illness and suffering their agency was undermined. These mothers shifted ways of understanding suffering to include their loss of agency in relation to their children.

This study's findings demonstrate that the context of mothering is beyond signs and symptoms of mental illness. These mothers emphasized that the biomedical entity did little to represent their mothering realities. To help them reconcile self-as-mother, nurses must acknowledge their difference and the importance of their strategies of invisibility in order to create mothering possibilities sensitive to their situation. It is important to repeat this study with other mothers in difference for theoretical modification.

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CHAPTER 1

INTRODUCTION

The mother's need to be heard, cared for, understood is certainly as important as that of the child. Most children cannot be helped if mothers are not helped and supported as well. (Swigart, 1991, p.2)

Historically, the mental health care system has not recognized the needs of women with serious mental illness (SMI). As persons with mental illness were largely considered a gender-less, homogeneous group with uniform needs, programs were not designed to address gender-related needs. Failure to acknowledge gender differentials has hindered both service planning and quality of care for women (Bachrach & Nadelson, 1988; Test & Berlin, 1981; Mowbray, Oyserman, Saunders & Rueda-Riedle, 1998). During the past two decades, neurobiologic, neuroendocrine, and genetic theories have been tentatively postulated to explain such gender differences. Literature suggests that, in comparison to men, women with schizophrenia have better premorbid function, a later age of onset, and fewer negative but more affective symptoms, resulting in a unique pattern of service use. Women have a higher mean age of first hospitalization and fewer hospitalizations; they respond differently to neuroleptics, remain in the community longer between hospitalizations, and receive more outpatient than inpatient treatment (Bachrach & Nadelson, 1988; Castle, Abel, Takel & Murray, 1995; Kulkarni, 1997; Seeman, 1982,

Seeman & Cohen, 1998; Test, Burke & Wallisch, 1990). As service providers, we continue to struggle to understand how to help women suffering in illness.

In women, particularly, the effects of illness further contribute to their health risks and pose barriers to health care (Bachrach & Nadelson, 1988). Defining women with SMI strictly in terms of cause, course and treatment of illness overshadows the diversity of their roles as daughters, sisters, partners, mother, grandmothers or workers. Being connected to others through these roles is central to their determining self-identity and recognition (Cogan, 1998; Schrieber, 2001). The desire to mother in women with SMI, regardless of martial status, is increasingly recognized by health care professionals (Apfel & Handel, 1993). The prevalence rate of women with SMI who are also mothers is unknown. Yet, fertility rates of women with SMI are no different from the general population of women. Further, Nicholson and Biebel (2002) state that women are just as likely to be mothers even though they meet the criteria of a psychiatric disorder. For women with SMI, attending to the needs of their children is meaningful (Miller & Finnerty, 1996; Mowbray, Oyserman, Saunders et al, 1998; Nicholson & Biebel).

Mothers with SMI have concerns for their children that are similar to those of mothers in general. Despite the inherent challenges of motherhood, mothers with SMI must often contend as well with stigma, poverty, lack of support, inadequate living accommodations, symptomatology, medication side effects and constant fear of their children's apprehension by Children's Protection Services (Blanch, Nicholson & Purcell, 1994; Cogan. 1998; Miller, 1996, 1997, Mowbray, Schwartz, Bybee et al., 2000; Ritsher,

Coursey & Farrell, 1997; Seeman & Cohen, 1998; White, Nicholson, Fisher & Geller, 1995). It seems plausible that mothering within such difficulties makes their place as mother all the more valued by them. Being within a valued place can lend a sense of belonging that contributes to self-worth (Cox & Holmes, 2000).

A review of the literature shows that little published research exists on the subjective experiences of mothers with SMI (Oyserman, Mowbray, Meares, & Firminger, 2000). In addition, little is known, about the perspectives of SMI women and how they mother in illness. The majority of studies involving mothers with SMI are quantitative and descriptive in nature. Reliance on such an approach of inquiry limits the subjective knowledge of SMI motherhood. Often, these studies reinforce mothers as "pathological"; consequently, their children are seen as in need of protection (Phoenix & Woollett, 1993; Stott et al., 1984), and their motherhood realities are not appreciated. Further, these studies present a narrow view of these women as "unfit" mothers because the label of mental illness is objectifying. Viewed as lacking mothering abilities, they are not recognized as *mother*. Such a construction of mother highlights the subject position of the child. Simultaneously, it also risks the children's vulnerability.

In Western society, motherhood is an area requiring more study. Jackson (1992) has reported that motherhood, "is an explored frontier of thought and emotion that we've tried to tame with rules, myth, and knowledge. But the geography remains unmapped" (p. 13). Unfortunately, this gap in knowledge has been replaced by the idealization of motherhood. This ideal image, in turn, has been recently criticized in the feminist

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literature for its monolithic representation of mothers: what is created is a binarism of good/bad mother. According to O'Reilly (1998), what society views as desirable about mothers equates with its concept of the good mother. In contrast, what society fears or dislikes about mothers falls into the latter category. It is not uncommon for mothers of difference to be categorized as "bad" mothers. Their circumstances, one of which may be mental illness, marginalize them. An investigation of how these women construct mothering in difference thus seems necessary.

The Purpose

This research is an attempt to understand, from the perspective of mothers with SMI, their mothering experiences, in particular how the mothers managed the inherent challenges of mothering in light of their illness situation. I am interested in the subjective experiences of mothers with SMI, since very little published research could be located. The goal of this inquiry is to go beyond a description of the mothers and their risk factors, since these areas are already summarized in review articles (Mowbray, Schwartz, Bybee et al., 2000; Miller, 1997; Miller & Finnerty, 1996). Instead, I intend to explain conceptually the underlying processes of what is happening in their realm of mothering. By discovering their mothering strategies, I hope to raise both an awareness of and sensitivity to their situations. Knowing what influences mothers to make certain health care choices will allow psychiatric nurses to focus their interventions within a broader understanding.

Research Questions

The original research questions were:

1. What are the goals and expectations of mothers with SMI?

2. What do mothers with SMI value about mothering?

3. What strategies do mothers with SMI engage in to nurture their child(ren)?

4. How are their mothering abilities influenced in relation to illness/treatment?

Such questions served to structure the initial interviews. With the collection and analysis of data, the questions changed to reflect the emerging theoretical patterns. The questions that came to guide the later interviews were:

1. What is "to keep close" for mothers with SMI?

2. How do mothers keep close to their children?

3. What happens when mothers are unable to keep close?

Organization of the Thesis

This project has been guided by two sets of assumptions. The first set arises from my clinical practice. To understand women's health, the nurse must respect and have an awareness of women's subjectivity; this becomes a means of understanding how women construct and conduct themselves, and how they achieve health (Blanch, Nicholson, & Purcell, 1994; Thorne, 1993). Many women I have met through my nursing practice continue to persevere amidst the daily challenges of living with SMI. Often, as their trust

in me increases, women share stories of their illness. They are insightful in that many know that they have been marginalized because of their illness situation; despite this, however, they struggle to maintain their dignity. For mothers with SMI, especially, this struggle becomes more complicated when they attempt to do what they consider 'best for' their children. In their context of difference, at times their mothering efforts were beyond my comprehension; yet, for them, what they did made sense in light of their contexts. Chapter 2 highlights how our current ways of understanding mothers with SMI contributes to their *othered* position. Oliver (2001) was used to frame the literature review as she recognizes that there can be subjectivity in the othered position.

The second set of assumptions relates to the research process of grounded theory. Although this will be discussed in detail in chapter 3, it is important to highlight that grounded theory is recognized for its contributions to the body of knowledge about women. This method reveals strategies and social processes that help professionals understand women's experiences and their abilities to cope with adversity (Benoliel, 2001). As discussed in chapter 3, grounded theory is not a static method of inquiry. Instead, its nature has and will continue to evolve, in part because of the area of inquiry. The theoretical sampling, data gathering techniques and analysis applied in this study are consistent with Glaser's grounded theory approach. The study setting, participants and ethical considerations are also described in chapter 3.

Chapter 4 discusses the findings in detail. The theoretical model entitled, *To Keep Close*, explained what was happening for this group of mothers. The analysis illustrates

how sustaining meaningful connections with their children was a struggle in the context of illness and suffering. To keep close constituted being normal, being secure and being responsible for their children. The mothers thus chose strategies that would at best imitate ideal representations of 'mother'. These strategies - masking, censoring speech and doing motherwork - were intended to hide illness for the sake of protecting their role and their children. Unfortunately, such pretences resulted in the mother's "hitting bottom", the realization that they could not keep close. To return to their valued place as mother, they sought treatment, hoping to learn how to be with their children authentically. Treatment, unfortunately, often focussed on the management of symptoms with medication. This emphasis overshadowed the need to understand and guide the mothers on how to mother in difference. Reconciliation was not always possible as the biomedical focus did not respond to their needs as mothers suffering with SMI.

In chapter 5, the findings of this study are discussed in light of existing literature. In particular, the findings indicate how illness and suffering undermine these women's agency. These narratives are powerful examples of the possibilities of expanding our conception of mothering in difference. Implications for practice and future research are addressed. I outline the need for health care professions to shift their perceptual lens from a biomedical understanding of mothers toward an appreciation of their agency in difference. The findings of this study are limited to mothers receiving treatment.

CHAPTER 2

LITERATURE REVIEW

This chapter examines the traditional construction of subjectivity regarding mothers with serious mental illness (SMI). For women with SMI, mothering is invariably framed as a pathological problem needing a professional response. Much of the professional discourse portrays these mothers as incompetent to mother their children, who also become at risk (Apfel & Handel, 1993; Mowbray, Schwartz, Bybee, et al., 2000; Ritscher, Coursey, & Farrell, 1997). Also because of their illness, mothers with SMI have thus been removed from the romantic ideology of motherhood in Western society. Hence, the focus of mental health care treatment remains on symptom reduction. These mothers are marginalized or *othered* by illness and by being different as mothers. Oliver (2001) offers a novel perspective of subjectivity from the othered or object position. The essence of this chapter is to reconsider the SMI mothering literature from Oliver's orientation. Such a reframing reveals how mental health care professionals perceive and act toward this group of mothers.

The phenomenon of motherhood is of interest to a broad variety of disciplines, including women's studies, psychology and sociology. For the purpose of this chapter, psychiatric and nursing literature focussing on the mothering experiences of women with SMI has been reviewed. Studies of women with postpartum mental illness have been

excluded, as these new mothers did not necessarily suffer from long-term mental illness. As well, the literature discussing the dynamics of the mother-child interaction or child development has not been reviewed entirely.

Oliver (2001) is a professor of philosophy and women's studies. She questions the Hegelian notion of recognition that perpetuates hostile relations and contributes to dichotomizing subject and object. The relative position of the object against the privileged subject implies that the object can never be subject. The subject is active; the object is passive. The othered is a 'thing' that exists for the subject. In her book, *Witnessing: Beyond Recognition,* Oliver rejects the subject/object binary. Instead, she suggests a creative view of subjectivity of the othered based on bearing witness as reconstruction from the object position. Oliver differentiates between eyewitness and bearing witness. As an eyewitness, the othered has 'firsthand knowledge' of experiences that attempt to objectify her sense of self as agent. In addition to seeing with one's own eyes, the othered also bears witness to what cannot be seen, what words can capture, what is beyond recognition.

What we see is more than words can say. Oliver's (2001) combined view of witnessing constitutes subjectivity. Testifying to what can be seen and to what is beyond recognition denotes ontological status. In the literature reviewed, what has been captured is mothers with SMI providing eyewitness testimony, information or *facts* describing their characteristics, stressors and needs. This frames them in illness, a position of othered. Little is known, however, about their experience as mothers (Oyserman et al., 2000).

Literature that attempts to consider more than that which is visible, or repeatedly

documented, reaches that which is beyond recognition. Being receptive to an alternative

way of thinking about mothering may expand upon how we understand their subjectivity

from this othered position. Through bearing witness and by supporting agency, there can

be perhaps a provision of services that supports their day-to-day living in a more

meaningful way.

Oliver's (2001) break from contemporary theorists is characterized by her belief that

marginalization, oppression or trauma undermines the possibility of subjectivity by its

interference with bearing witness. Trauma varies in degrees, from torture to everyday

child rearing (Oliver, p. 88). Regardless of degree, it erodes the possibility of subjectivity

by limiting one's address- and response-ability. Address-ability refers to the manner in

which one approaches self and other. It necessitates respect for difference and appreciates

that there can be subjectivity in the othered position. This guides response-ability to what

is beyond recognition. Address and response constitute the ethical obligation towards the

othered. As Oliver asserts, "we are responsible for the other's ability to respond" (p. 19).

To attend to those deemed othered, defined by difference, mental health care providers

need to provide opportunities for mothers with SMI to bear witness to what is beyond

recognition as a means towards strengthening their subjectivity. By affirming the

mothers' subjectivity, the possibilities within challenging situations can be nurtured.

Mothers with SMI as Othered

Prior to the 1950s, social values, erroneous assumptions about mental illness and institutionalization negated women as gendered persons (Bachrach & Nadelson, 1988; Carmen, Russo, & Baker, 1981; Chesler, 1997; Geller, 1985; Miller 1997; Test & Berlin, 1981). Sadly, women in mental institutions were often sexual victims. Under the guise of asylum, Chesler notes that women were not protected "from rape, prostitution, pregnancy, and the blame for all three" (p. 77). The custodians of care, in the position of subject, judged the women's agency. Women who suffered from chronic mental illness were "faceless" and defined only in terms of their illness and patienthood (Test & Berlin, 1981). Illness stereotypes exemplify antagonistic relationships that dictotomize the object from the privileged subject. To conceive of the othered as object or to limit their ability to act characterized the dehumanization inherent in domination (Oliver, 2001) - an aspect of treatment well-documented in the institutionalization literature.

Furthering their position in relation to the subject is the health care professionals' assumption that persons with SMI are asexual beings (Apfel & Hendel, 1993; McEvoy, Hatcher, Appelbaum, & Abernethy, 1983; Test & Berlin, 1981). Such a notion, however, is not supported by Miller's (1997) literature review of studies of sexual attitudes and practices among women with schizophrenia. Miller suggests that illness in and of itself does not influence sexual desire. By way of support, Test, Burke and Wallisch (1990) investigated gender-specific issues of 122 persons with schizophrenia and schizophrenic-related disorders enrolled in two types of community treatment programs. Compared to

men, women (n = 40) were significantly more likely to parent and have a sexual partner.

In Miller and Finnerty's (1996) study of sexuality, pregnancy and child rearing, 44

women with schizophrenia-related disorders were compared to a control group of women

without mental illness. In comparison, women with SMI had a significantly greater

number of sexual partners, sexual assaults, unplanned pregnancies and loss of custody.

Such findings are similar to those of Cogan (1998), who conducted structured interviews

with 25 women with SMI. The authors of all the aforementioned studies recommend

moving beyond the myths of SMI women's sexuality toward the provision of sensitive

programs focussing on safe sexual practices and mothering needs.

Offering family planning, however, may be problematic, especially if only what is

familiar to the privileged subject is recognized (Lewis & Scott, 1997; Oliver, 2001;

Waldo, Roath, Levine, & Freedman, 1987). Oliver explains that

> contact with difference or otherness becomes impossible because recognition
> requires the assimilation of difference into something familiar. When recognition
> repeats the … subject-object hierarchy, then it is also bound to assimilate difference
> back into sameness. The subject recognizes the other only when he can see
> something familiar in that other, for example, when can see that the other is a
> person too. (p. 9)

Clinicians' difficulty in responding to difference may help explain the discrepancy

between awareness and action in Coverdale and Aruffo's (1992) survey of 82 clinicians.

Despite the importance of providing family planning information to all patients, they

reported discussing the issue with only 25% of their patients; in fact, only 10% of their

female patients confirmed that this had been done. For women with SMI in Cogan's

(1998) study, assistance with accessing information about pregnancy, birth control and sexually transmitted diseases was usually available. What women identified as lacking was support to create and sustain their femininity as expressed through loving relationships. Emphasis on the biological functioning in family planning programs is not congruent with their realities to participate in and experience loving relationships. Consequently, women with mental illness experience estrangement, delimiting their possibility of wholeness. Thus, as well, their testimony remains beyond recognition.

Davis (1992) suggests that the denial of a woman's sexuality undermines her subjectivity. For women, expression of femaleness affirms self as *natural* or normal, especially through heterosexual practices. Women with SMI voice expectations and hopes of leading lives like those of their non-mentally ill peers (Apfel & Handel, 1993; Miller, 1992; Ritsher et al., 1997). This includes achieving the typical milestones of coupling, reproducing and mothering. Being a mother may be the only legitimate social role women with SMI have in society (Cogan, 1998). Despite not knowing the prevalence of women with SMI who are also mothers, it is estimated that their fertility rate is no lower than that of the general population (Miller, 1992). In a survey of mental health state departments in the United States, Nicholson, Geller, Fisher and Dion (1993) found that data on the parenting status of women with SMI was not routinely collected. Not knowing whom we are looking for prohibits address-ability for the intention of dialogue, and without address-ability there is no subjectivity.

Some mothers with SMI measure their mothering success against mainstream values and maturity. Clinicians and family members, on the other hand, may conceive of the mother's behaviour as defiant or problematic. Existing state hospital policies focussed primarily on medical management and competency to consent to abortion (Nicholson et al., 1993). Oliver (2001) discusses the implications of drawing strict boundaries between subject and object as well as increasing surveillance over the othered. Perceiving threat, such measures by professionals serve to maintain an antagonistic subject-object relation. For Oliver, identity rooted in hostility negates the possibility of addressing and responding to what is beyond recognition, which could otherwise support mothers' subjectivity. When Nicholson and associates (1998) conducted focus groups to explore the parenting experiences of mothers with SMI, these women identified day-to-day issues common to most mothers. The stigma of mental illness was stressful as they were under surveillance. Being watched serves to remind mothers of their tenuous position as mothers. Illness as their defining feature highlights the narrow conception of their identity and thereby the adequacy and availability of treatment (Bachrach, 1985; Blanch, Nicholson, & Purcell, 1998; Hearle & McGrath, 2000; Mowbray, Oyserman, Saunders et al., 1998).

Mothers with SMI have been accused of infecting the genetic pool and negatively influencing future generations (Apfel & Handel, 1993; Stott et al., 1984 & Musick, 1984). Research concurs that having a parent with mental illness increases the child's genetic vulnerability to psychiatric illness and behaviours (Gross, 1995; Sacker, Done, & Crow,

1996). Besides genetic vulnerability, much of the literature on parenting and severe mental illness has focussed on parenting difficulties and the impact of mental illness on the child's developmental and health status. Often, the unidimensional representation of mother as mad (Apfel & Handel, 1993), bad (Swigart, 1991), or toxic (Oates, 1997) negates the relevant life circumstances of mothering. Oliver (2001) suggests that derogatory terms amplify differences that serve to remove them further from the possibility of agency. Such labels also distract clinicians from witnessing the lived experience of mothering and highlight the undesirability of their mothering. Clinicians' comments about pregnant women with SMI – "She shouldn't be a mother", and "At least let's save the baby" – (Apfel & Handel), imply that the child becomes subject through lack of recognition of the birth mother who is marked by illness.

Being framed as *bad mothers* shifts social responsibility and ethical duty away from a recognition of such mothers' agency. The mother is an immediate suspect as she is viewed as the "wrong" woman giving birth in the "wrong" circumstances, rather than acknowledged for her mothering abilities or needs (Phoenix & Woollet, 1991). Conformation to the 'good/ideal' mother are expected and enforced even though this serves to undermine mothers' subjectivity. Further, programs geared to saving the child from the expected demise of the othered seem "benevolent and indeed essential" (Phoenix & Woollet, p. 20). Yet, these authors caution, such services may be a trap for allowing easy surveillance of mother and children. When Sneddon, Kerry and Brant

(1981) attempt to help new mothers with psychiatric conditions towards recovery in a

home-like unit, this "haven", ironically, becomes a subversive tactic of surveillance:

> Although at first she may be unfit to look after her child, she will be able to see and
> touch him and, as she begins to recover, to care for him under the unobtrusive but
> careful observation of the nursing staff. She is more likely to agree to being
> admitted if she can bring her baby, particularly when no alternative arrangements
> may be possible for his care. (p. 1295)

Zemencuk, Rogosch and Mowbray (1995) conducted a descriptive study to explore

how mothers with SMI (n = 48) functioned in the parenting role. The majority of mothers

were found to manage adequately, as assessed by low levels of perceived difficulties in

the children. Although there were many situational challenges, the mothers were satisfied

with their role. Many of the participants gave suitable responses with regard to scenario

parenting situations. The researchers suggested, however, that such mothers may never be

able to achieve unequivocal success because of difficult past and current circumstances:

"It appears likely that other aspects of the women's personal histories and/or social

circumstances may contribute to parenting problems at a later time" (Zemencuk et al., p.

90). To these researchers' credit, they acknowledged the mothers' abilities and the value

of support to sustain their mothering role. Mothers' ability to mother, however, seem to

be underpinned by the preconception of mothers as a homogenous group requiring long-

term monitoring. Being blind to the uniqueness of each mother's sociohistorical situation

may perpetuate further blindness to her reality of difference. For Oliver (2001), "the

struggle for recognition is really the struggle to be accepted as normal or natural rather

than different and abnormal" (p. 154).

Mothers with SMI as Eyewitnesses

As mentioned at the beginning of this chapter, witnessing for Oliver (2001) has two meanings. First, eyewitness testimony refers to "first-hand knowledge". Second, bearing witness is testifying to something that is beyond recognition, that is, loss of subjectivity from trauma. Out of an awareness that these processes coexist and for the sake of simplicity, each is discussed separately as it applies to the literature reviewed.

The literature reviewed mainly reflects mothers as eyewitnesses as opposed to mothers who bear witness. As eyewitnesses, mothers with SMI can provide testimonial *facts* based on what they "see with their own eyes" (Oliver 2001). As a clinical group, mothers with SMI are described as being at increased risk for unplanned and unwanted pregnancies, prenatal complications, postpartum psychosis and further psychiatric decompensation (Joseph, Joshi, Lewin, & Abrams, 1999; Miller, 1996, 1997; Miller & Finnerty, 1996; Miller, Resnick, Williams, & Bloom, 1990; Mowbray, Oyserman, Zemencuk, & Ross, 1995). The eyewitness position is uniquely influenced by the mother's context, since what a person attends to is affected by personal, social, political and historical backdrops (Oliver, 2001). Complicating the inherent responsibilities of mothering are confounding issues of substance use; sexual and violent abuse; raising the child alone; minimal support; homelessness; poverty; loss of custody of their children; and lack of supportive parenting services (Cogan, 1998; Harris, 1994; Miller, 1992, 1997; Miller et al., 1990; Mowbray et al., 1998; Nicholson et al., 1998; Ritscher et al., 1997; Rudolph, Larson, Sweeny, Hough, & Arorian, 1990). Such circumstances can undermine

the possibility of subjectivity by impairing witnessing to what is beyond recognition

(Oliver). In other words, illness and overwhelming circumstances have the potential to

limit a mother's sense of herself, her choices and her abilities.

Oliver (2001) emphasizes that it is not just what is said but how and why it is said

that is critical. Listening for "the silences and the blindness inherent in the event" (Oliver,

p. 86) makes going beyond the facts possible. To illustrate, a comprehensive literature

review was done on the pregnancy, birth and postpartum literature of mothers with SMI

(Mowbray, Oyserman, Zemencuk et al., 1995). These researchers summarized the

numerous and diverse stressors in each of these phases of motherhood, but many of the

studies used small, biased samples and inadequate methods. The researchers' reliance on

quantitative measurements of symptomatology, problematic maternal attitudes, and

parental competency overlooked the meaning of mothering from the perspectives of

mothers with SMI. Sole attention to the facts for the purpose of statistical validation fails

to capture the essence of agency (Oliver). In a later review of SMI maternal parenting of

young and adolescent children, Oyserman et al. (2000), also found that the mother with

SMI as a person with agency is obscured by research that narrowly focuses on the

mother's diagnostic category, or risk factors that may adversely influence the child.

In another study, Mowbray and colleagues (2000) also criticized the fact that the

repeated collection of such "cursory" research information does not adequately address

the context in which mothering occurs. As a result, they conducted structured interviews

with 379 mothers with SMI, inquiring about maternal stressors and resources. Sixty

percent of the sample was African-American and lived in poverty. The most frequent

(57%) and highest rated stressor was a psychiatric crisis within the past year. Next were

financial stressors (51%) and loss of significant others (50%). Contending with fatigue

(81%) and poor health (68%) on a daily basis were the highest-rated daily struggles. In

the discussion section of their study, mothers were discussed holistically and as being

capable to nurture their children with support and assistance. In a limited manner, the

researchers recognized another way of visioning these mothers, an expanded vision that

considered circumstances that made mothering difficult. Attempting to see beyond the

facts helps clinicians to conceive of these mothers in meaningful ways in relation to their

realities.

Mothers with SMI as Bearing Witness

This section offers insight on how the literature bears witness to mothers with SMI

testimony. Oliver (2001) stresses that it is not the "accuracy" of the testimony that is in

question, but rather the meaning. Even more important is listening for the meaning within

the narrative, including so-called "inaccuracies" or distortions. For example, mothers

asking how to mother in difference does not necessarily indicate that they are

incompetent.In a small sample of chronically institutionalized women, their responses to

questions about contraception, pregnancy and child rearing were described as "bizarre"

and "inaccurate" (McEvoy et al., 1983). Other responses of the mothers, however,

suggested the significance of motherhood – womanhood, acceptance and affirmation.

Long-term illness in and of itself may not be a condition that promotes self-despair. Instead, for women with SMI, it may be loss of one's essence or sense of agency. For instance, it is the day-to-day responsibilities of taking care of others that give meaning to their lives; this is agency (Miller & Finnerty, 1996; Ritsher et al., 1997). In comparison to a matched control group of women without children, White and associates (1995) found that women with SMI who cared for young children scored significantly higher on such items as social support, productivity, self-care skills and emotional adjustment. In another study, Mowbray, Oyserman and Ross (1995) interviewed 24 mothers with SMI to explore both their parenting abilities and the meaning of motherhood for them. To measure parenting behaviours, several types of questionnaires were used. Data concerning the meaning of motherhood was gathered by structured open-ended questions. Despite difficult social and economic situations, mothers demonstrated adequate competencies in parenting. Key topics to emerge from the open-ended questions included happiness; personal growth and development; and the stresses inherent in mothering. As examples, these studies go beyond what is traditionally recognized. The significance of such a shift highlights the value of mothering for women with SMI.

For mothers with SMI to bear witness, to speak of their mothering, requires that another listens for what is beyond recognition. Nicholson et al.'s (1998) focus groups opened up the possibility for mothers to speak as othered. Such an approach promotes the sharing of experiences, and many mothers also appreciated the opportunity to talk with other mothers. Mothers spoke to their challenges of coping with stigma, illness, and daily

parenting. Their greatest fear, potential loss of contact or custody of their child, was equated with loss of self-value and purpose as well as increased risk of illness. The researchers responded that mothers should be invited to participate actively in care planning as they "related subtle aspects of their experiences that were previously unrecognized by researchers and clinicians" (Nicholson et al., p. 642). Such a recommendation opens the possibility of encountering one another as unique individuals with unique socio-historical contexts.

Bearing witness is required for subjectivity and includes the two necessary components of address-ability and response-ability. Through the process of bearing witness, mothers with SMI can begin to restore that subjectivity. According to Oliver (2001),

> ...those othered can begin to repair damaged subjectivity by taking up the position of speaking subject. What we learn from beginning with the subject position of those othered is that the speaking subject is a subject by virtue of address-ability and response-ability. (p. 9)

To identify and intervene (aspects of address and response) with respect to service delivery impediments, parents with SMI were invited to provide "testimony" at public hearings (Blanch et al., 1998). Issues such as unavailable and inaccessible services; stereotypical and prejudicial policies; and lack of coordination among services were identified. In response, the task force proposed respective action stressing the value of ongoing dialogue between service providers and consumers at all levels. Bearing witness to the experience of being viewed as patients rather than parents by service providers may

have prompted the task force recommendation to shift to a family-centered system of mental health services. Oliver stresses that bearing witness is not done for the sake of recognition, but for agency recognition.

Not only does one bear witness to another's testimony; one also bears witness to her own telling. Sensing this, mothers may censor their sharing of meaning. Further, what is beyond recognition may still be inarticulate for the mothers. Hence, it is difficult to fully appreciate the nuances of the narratives when reproduced. It is noteworthy that for parents with SMI to bear witness at such hearings involved a degree of risk to reaffirm their othered position. During the testimony process,

> ...it was implied or even stated that people diagnosed with severe mental illness should not marry or have children, because they are too fragile psychologically, carry a genetic predisposition toward mental illness, or are incapable of providing a stable family treatment. Similarly, many people with psychiatric diagnoses were reluctant to publicly acknowledge their histories for fear that either they or their child would experience discrimination. (Blanch et al., 1998, p. 212)

In addition to fear, other feelings such as shame, embarrassment, and guilt (Hearle & McGrath, 2000; Miller, 1997) may be barriers to bearing witness, with an overall effect of silencing mothers. Despite the reason for such feelings, Oliver (2001) proposes that they emanate from becoming an object. Hence, clinicians have an ethical responsibility to open up possibilities for responding without threat of harm. This may require an expanded notion of ethical obligation for the purpose of agency as opposed to duty.

Despite mothers' requests for "addressibility", only a few programs have attempted to bridge the gap between subject and object (Mohit, 1996; Mowbray, Oyserman &Ross,

1995; Nicholson et al., 1993; Seeman & Cohen, 1998). The Seeman and Cohen program for women with schizophrenia does appear to open up the possibility of respectful relationships between women and clinicians. The program integrates a variety of clinically relevant topics for the treatment of women with schizophrenia. Further, the program is sensitive to unique differences among mothers with schizophrenia. The program's conception of mothers with SMI as persons facilitates establishing and maintaining relationships across difference.

In general, the agency of mothers with SMI has not been traditionally recognized by clinicians. Subjectification is generally invisible, as it underpins the structure of service delivery. When mothers with SMI are viewed as othered, clinicians became caught in the subject-object relationship, and may offer services not appropriate to the mothers' realities. From a place of *Otherness*, mothers with SMI have witnessed their objectification: illness, negative labels, difficult mothering circumstances, and inadequate or inaccessible programs undermine their subjectivity. Several authors recognize the need to address and respond to the meaning of mothering within the mothers' lived context. To listen to testimony that is beyond recognition is an aim of my research.

CHAPTER 3

METHODOLOGY AND METHOD

This study is based on a grounded theory approach, one well suited to discovering a

common problem and how it is managed within a particular area of interest. In simpler

terms, Glaser (1992) states that grounded theory allows for the discovery of what is going

on with regard to a particular issue and how it is handled. Grounded theory is based on an

assumption that a group of persons sharing similar circumstances (such as mothers with

SMI) experience common socio-psychological problems and processes. Revealing and

conceptualizing these is central to understanding mothering behaviours. Mothering

behaviours are actions arising from their interpretation of a complex interplay of

numerous variables such as perceived circumstances, desires and the anticipated actions

of others.

This chapter begins with an overview of the origins and underpinnings of the

grounded theory methodology. Because of the debate between grounded theory's

originators concerning the true essence of grounded theory, I focus on the present-day

methodology espoused by Glaser. Throughout the methodology discussion, I introduce

the application of Glaser's conceptualization to this project. Then, participant

characteristics and specific method processes used in this study are described, followed

by a discussion of the scientific rigor of the grounded theory method and how rigor was addressed in this project.

Grounded Theory

Evolution in the Use of the Methodology

In their seminal book, *The Discovery of Grounded Theory*, Glaser and Strauss (1967) introduce the systematic generation of theory from social data. They argue that many of the existing theories have little relevance to the reality of a situation, and hence limited utility in predicting behavioural variation in a group. In contrast to applying or verifying theory, hypotheses and concepts are "grounded" in empirical data. As sociologists interested in naturalistic inquiry, Glaser and Strauss assert "that grounded theory will be more successful than theories logically deduced from priori assumptions" (p. 6). Grounded theory uses an inductive (from-the-ground-up) approach to uncover theoretical explanations of everyday behaviours. This inherently eliminates the need to force-fit a theoretical conceptualization to human phenomena (Glaser, 1992; Lowenberg, 1993; Sandelowski, 1993).

Glaser and Strauss (1967) reject the binarism of either/or logic regarding quantitative or qualitative approaches. In fact, the original grounded theory combined the complementary quantitative and qualitative educational backgrounds of Glaser and Strauss. As a graduate of Columbia University in the late 1950s, Glaser's quantitative research training contributed to the method's systematic conceptual analysis that "respects and reveals the perspectives of the subjects" (Glaser, 1992, p. 17). Strauss, on

the other hand, was educated at the University of Chicago, historically known for its tradition in qualitative research. Strauss' methodological contributions were naturalistic inquiry; the active role of persons in shaping their worlds; an emphasis on continual change and processes in view of the complexity of life; and the interrelationship between a person's meaning and action (Glaser, 1992). Their combined research efforts were revolutionary, as the method challenged the arbitrary division between a person's symbolic meaning and empirical inquiry (Charmaz, 2000). Further, their research was praised as a mode of inquiry that is more faithful and representative of reality than results from the use of either method alone (Glaser & Strauss, 1967; Glaser, 1992; Stern, Allen, & Moxley, 1984).

In the years after the publication of *Discovery*, Glaser and Strauss taught their method to doctoral nursing students at the University of California. Nurse graduates published their work using grounded theory methodology on a variety of phenomena. For example, in an early study of stepfather families, Stern (1980) discovered that the main problem in the integration of a stepfather into an existing mother-child dyad was the disciplining of children. This problem was addressed through a basic social process of affiliating actions that served to bring the stepfather and child closer together. Grounded theory became such a prominent means of researching human behaviour and interaction for the basis of nursing action that it has become almost synonymous with qualitative research (Chenitz & Swanson, 1986; Stern, Allen, & Moxley, 1984; Lowenberg, 1993; Wuest, 1995).

Grounded theory has been "adopted and adapted" (Glaser, 1998) by a variety of disciplines and its originators. To assume that research labelled "grounded theory" represents a unified approach is misleading; instead, there are several versions of grounded theory with varying ontological and epistemological orientations as well as procedures for data analysis. Fuelling the debate on what constitutes the true essence of grounded theory are Glaser and Strauss themselves. Throughout the book, *Basics of Grounded Theory Analysis*, Glaser (1992) strongly criticizes Strauss, accusing him of developing another method as explained in *Basics of Qualitative Research* (Strauss & Corbin, 1990). Glaser refers to this other method as "full conceptual description", which disregards the original tenets of grounded theory. To illustrate, Glaser (1992) claims,

> If you torture the data enough, it will give up! This is the underlying approach in the focussing preconceptions of full conceptual description. This data is not allowed to speak for itself, as in grounded theory, and to be heard from infrequently it has to scream. Forcing by preconception constantly derails it from relevance. ...In grounded theory we try to tap and do theory for what the participants are interested in; that is, how they process their main concern. (p. 123)

The central difference between what has become known as the "Glaserian" and "Straussian" grounded theory approaches lies in the researcher's lens (Glaser 1992; Stern, 1994). In contrast to a Straussian, a Glaserian looks to the data for the concept instead of looking for evidence to support questions or preconceived statements of relationship. When examining the data, a Glaserian is asking, "What is going on?" From a Straussian orientation, the question asked of the data is "What if?" (Glaser, 1998). A Glaserian orientation focuses on discovery of the common problem from the point of view of the

participants and how they process it. On the other hand, the Straussian perspective

emphasizes identifying data to support preconceived questions.

The adaptability of grounded theory is consistent with its methodology. Both

originators (Glaser & Strauss, 1967; Glaser, 1992,1998; Strauss & Corbin, 1999)

described grounded theory as a "general" methodology, acknowledging that it is one of

several approaches creating and elaborating on theory. As a general method, it is only one

way to discover meaning; it does not contain it (Blumer, 1969). Through simultaneous

data collection and analysis, often referred to as the procedure of constant comparative

analysis, theory emerges. Glaser (1998) opposes a prescriptive, rigid research process to

limit the evolution of the theory from the data. Grounded theory's inclusion of general

guidelines and, over time, more specific procedures as a result of the research experience

of its users, has allowed latitude for creativity (Glaser, 1978, 1992; Strauss & Corbin,

1999). The "modifiability" of this generative theory approach enhances its suitability *in*

research:

> The methodology processes out the emergent problem and all data of whatever type
> is grist for the mill of constant comparison to develop categories and properties. The
> emergent research problem will core out and be delimited by diverse conditions
> such as the researcher's training, the locale of the subjects, funding etc. Boundaries
> to the problem will emerge and the one criteria of grounded theory, modifiability,
> says that a good grounded theory should be readily modifiable to new conditions,
> new subjects, and perspectives on the same problem, provided that the same
> problem is relevant in the new area. (Glaser, 1992, p. 24)

Unfortunately, this methodology runs the risk of being misunderstood. In particular

to nursing, Benoliel (1996) reviewed published health-related literature claiming to use

grounded theory. She found, however, that much of the research demonstrated a lack of

understanding of its methodology and method. Most often the research failed to

conceptually explain the phenomena under study or employed only one aspect of

grounded theory analysis such as the constant comparative method. Benoliel (1996), as

well as several other nurse scholars (Baker, Wuest, & Stern, 1992; Becker, 1993;

Cutcliffe, 2000; Melia, 1996; Stern, 1994), stresses the importance of attending to the

underlying assumptions of grounded theory. Another aspect of the risk is confusing

grounded theory with other qualitative approaches (Melia, 1996; Wilson & Hutchinson,

1991). For instance, Baker et al., (1992) define "method slurring" as the negation of the

respective orientations of grounded theory and phenomenology. To complicate matters

further, grounded theory is embodied in philosophical shifts of the qualitative paradigm in

which it is situated. In fact, researchers' misuse of qualitative terminology is indicative of

nursing's progressive understanding of the nature of knowledge and knowledge

acquisition (Bailey, 1997; Lowenberg, 1993; Thorne, 1991). Like other qualitative

approaches, grounded theory is a type of interpretative inquiry; thus it includes "what the

participants say and mean" (Glaser, 1992 p. 44):

> Meaning emerges just as categories and properties do. It is automatic if the analyst
> constantly compares and does not impose his own experiential meaning from what
> source on the data. (Glaser, 1992, p. 56)

To differentiate grounded theory from other qualitative methodologies, Stern (1994)

outlines its features (Table 1).

Table 1: Features of Grounded Theory Methodology

Grounded theorist
• Generates the conceptual framework from the data;
• Explains rather than describes the dominant processes in the social scene;
• Compares all data with all other data;
• Modifies data collection according to emerging theory; and
• Examines data as they arrive, and begins to code, categorize, conceptualize, and write the first few memos.

Epistemology

The major difference between grounded theory methodology and qualitative types

of research is the former's emphasis on theory development. Grounded theories may be

formal or substantive. According to Glaser (1994), formal theories are developed from a

more encompassing and conceptual level of sociological inquiry, using phenomena such

as stigma; status passage or authority; and power. Substantive theories are developed

from a specific empirical area of inquiry (mental health, patient care, dying patients) and

are thus at a different degree of abstraction. Glaser (1994) emphasizes that substantive

theories (also called middle-range theories) can become the building blocks for

generating formal theory.

Ontology

In developing the original methodology, Glaser and Strauss were influenced by the

philosophical orientation of symbolic interactionism as espoused by G. Mead and

expanded by H. Blumer, both of whom were social psychologists (Chenitz & Swanson,

1986; Glaser & Strauss, 1967; Glaser, 1992). Blumer (1969) suggests that human beings

act and interact based on their interpretation of the meaning of language or symbols. His

three basic assumptions are:

1. People act toward things (such as motherhood, mothering images, mental illness) on
    the basis of the meanings that things have for them.
2. These meanings arise from social interactions.
3. In dealing with a situation, a person's interpretive process assigns and modifies
    meanings.

In terms of this project and in accordance with Blumer's (1969) perspective, a

mother with SMI is not merely responding to her situation. Instead, she endeavours to

determine the meaning of a given situation in order to guide her action. As a "line of

action", mothering is purposeful and is a result of mothers' interpretive processing of

symbols. As explained by Blumer (1969),

> [S]He has to cope with the situation in which [s]he is called on to act, ascertaining
> the meaning of the actions of others and mapping out [her] own line of action in the
> light of such interpretation. [S]He has to construct and guide [her] action instead of
> merely realizing it in response to factors playing on [her] or operating through [her].
> (p. 15)

Any person does, in fact, order and make sense of his/her reality even though it may

appear chaotic to the onlooker (Hutchinson, 1986). Understanding how a mother with

SMI acts, requires attending to her interpretative process (Blumer, 1969). Action is

created through the interpretation of a complex interplay of social psychological factors,

such as desires; self-image, perceived expectations of others, anticipated actions of

others. and the risks/possibilities of the situation, to name only a few. To this end,

> This means seeing the situation as it is seen by the actor, observing what the actor
> takes into account, observing how [s]he interprets what is taken into account, noting
> the alternative kinds of acts that are mapped out in advance, and seeking to follow
> the interpretation that lead to the selection and execution of one of these prefigured
> acts. (Blumer, 1969, p. 56)

Based on these underpinnings, the intent of grounded theory research is to

understand how a group of people sharing common circumstances define patterns of

action which shape their realities though social interactions (Glaser, 1992). Glaser (1978,

1992, 1994) identifies the research participant as an expert knower about her experience.

What a mother with SMI is *doing* and why she is *doing it* is known by engaging the

person with that subjective experience. Through mothers' sharing their experiences,

theory is inductively created, a creation analogous to a painting "that draws from,

reassembles, and renders subjects' lives" (Charmaz, 2000).

Grounded Theory and Nursing

Since its inception, grounded theory has been of interest to nursing because of its

accessibility and promise to generate knowledge. Grounded theory has served both to

generate new knowledge and to clarify existing theory for the purpose of guiding and

improving patient care (Chenitz & Swanson, 1986; Glaser & Strauss, 1967; Benoliel,

1996, 2001; Stern, 1980). Its relevance to nursing is summarized by Hutchinson (1986):

Nurses, because they are typically enmeshed in real life dramas, need the freedom offered by grounded theory to intelligently and imaginatively explore issues and concerns with social psychological consequences. ... Grounded theory offers systematic, legitimate methods to study the richness and diversity of human experience and to generate relevant, plausible theory that can be used to understand the complex reality of behaviour. ... Thus, grounded theory can help nurses better understand their own world – people in changing, complex social situations. (p. 129)

Over time, nurse researchers studying a wide variety of phenomena have increasingly used grounded theory procedures. The major areas of nursing knowledge generated have included family, individual, and nurse processes, as well as contextual features of health behaviours (Benoliel, 1996, 2001). According to Benoliel (2001), grounded theory has been particularly valuable in its contribution to understanding women's abilities to cope in adversity.

Expanded use and differing conceptualizations of grounded theory by recognized nurse scholars (Annels, 1996; Chenitz & Swanson, 1986, Hutchinson,1986; Keedy, Sims, & Stern, 1996; Stern, 1980, 1991, 1994, 1996; Stern et al., 1984; Wuest, 1995) are not inconsistent with a Glaserian perspective: "Generating theory and doing social research are two parts of the same process" (Glaser, 1978). The emerging theory guides the unfolding of both processes; as a result, grounded theory's use is directly influenced by the nature of the topic under study. Because of its versatility, grounded theory is relevant to the evolution of nursing science (Hutchinson & Wilson, 2001; Morse & Johnson, 1991).

Understanding Mothering in Difference

Since I am interested in mothers' with SMI subjective experiences of "what is going on", I have used the Glaserian approach (Glaser, 1978, 1992) of grounded theory. Committing to one orientation decreases the risk of methodological misunderstanding (Stern, 1994). My aim is to explain conceptually the essence of a group of mothers' complex social processes. As a researcher, I am also engaged in Blumer's (1969) process of interpretive interaction, and this involves my interpretation of their stories at a point in time. Grounded theory procedures such as constant comparison, theoretical sampling and saturation assisted me in remaining focussed on in vivo concepts and, ultimately, in questioning my own interpretations at each step of the research process.

Study Setting

The study was conducted in a Northeastern Ontario community of 160,000. Two institutions were selected because they provided a variety of psychiatric services to persons with serious mental illness. One setting was an inpatient unit within a general hospital. The other setting provided both acute care and outpatient services. Depending on the mental health needs, service availability and accessibility, a mother with serious mental illness might have been utilizing a service from one of these settings or a combination thereof. As she might have been in a hospital or community care setting, both institutions were accessed for recruitment. Neither institution specifically addressed the parenting needs of mothers.

Description of Participants

A theoretical sample of twenty one mothers living in a Northeastern Ontario community agreed to participate in this study. One mother who was concerned that she might be identified by her family requested that her story be excluded. Hence, data analysis involved 20 mothers (see Table 2). The mothers ranged in age from their early twenties to their late thirties. Fourteen mothers were living with the biological fathers of the children, and the nature of such relationships ranged from abusive to supportive. Of the remaining six, three had previously been in committed relationships with the biological father, and three mothers had always been single parents.

Sixteen mothers were living with their children. Of the four mothers not living with their children, all had ongoing contact with them. In two situations, the children resided with their father following the marital separation. In theother two situations, Children's Protection Services had placed their children with extended family members. Only two of the women were not living with a partner or children.

This group of women parented a total of 39 children ranging in age from two to fifteen years. There were nine adolescents, 23 school-aged and seven pre-school-aged children. Mothers parented from one to four children. The majority of pregnancies were

Table 2: Summary of the Mothers who Participated in the Study

Mother	Parenting Status	Number of Children	Age of Oldest Child	Self-reported Diagnosis
Irene	Father in home	2	Ad**	Depression
Hailey	Father in home	2	Ad	Unsure
Kathleen	Father in home	1	Ad	Bipolar
Melanie	Single	2	Ad	Depression
Mary*	Partner in home	1	Ad	Many
Sally*	Single	2	Ad	Schizophrenia
Brooke	Father in home	2	SA***	Depression
Kate	Father in home	3	SA	Crazy Thoughts
Peggy	Father in home	1	SA	Depression
Betty	Father in home	4	SA	Depression
Gloria	Father in home	3	SA	So sick in past
Nancy	Father in home	2	SA	Depression
Rachel	Father in home	4	SA	Depression
Heather	Father in home	2	SA	Depression
Janice	Single	1	SA	Bipolar
Paula*	Single	2	SA	Schizophrenia
Tracy*	Father in home	1	SA	Depression
Alice	Father in home	2	PS****	Depression
Joan	Single	1	PS	Bipolar
Connie	Father in home	1	PS	Schizophrenia

* = Child/Children not living with mother, ** = Adolescent, *** = School age, **** = Pre-School age

unplanned, but wanted. Five mothers shared information that their children had physical and/or psycho social health problems.

Seven women were employed full- or part-time outside their homes. Four were unable to work because of illness, and three stated that despite illness they had to work to sustain their family. Two other mothers were hoping to enter the work force in the future. Five women relied on disability insurance for their source of income; one other was investigating the possibility; and another refused to rely on such a source of income and preferred general social assistance.

All of the mothers had been identified as having serious mental illnesses by their psychiatrists. As indicated for the purpose of this research, SMI was defined according to Bachrach's (1985) conception of diagnosis, disability and duration. This includes women who have a diagnosis of a major mental illness of at least a two-year duration and a disability that has a negative impact on their daily living abilities. Three women identified their diagnosis as schizophrenia, four had bipolar, nine had major depression, and four did not specify their diagnosis. Several of the mothers had received a variety of diagnoses over time. The unfolding and stage of illness varied among the sample of mothers. Diversity in diagnoses and illness ensures extensive data covering a range of behaviour, which is essential in grounded theory (Hutchinson & Wilson, 2001). The length of time this group of mothers had lived with illness varied from three to twenty years, with many believing that they had been ill for many years prior to seeking psychiatric services. Several mothers identified the onset of their mental health issues as having begun prior to

having children. Others became "unexpectedly" ill after the birth of children. Also,

several mothers spontaneously disclosed the influence of their history of childhood abuse

and its impact on their mothering.

Sample Selection

Data was collected over a one-year period beginning in September 2000. I was in

regular contact with the nurse manager from each of the inpatient settings and a

psychiatrist who agreed to identify participants eligible for the study. Study inclusion

criteria were that each participant be English-speaking; 20 years of age or older; mentally

competent; under a psychiatrist's care for a major mental illness; and self-identification as

the mother of at least one child between the ages of two and sixteen years. The child(ren)

may or may not have been residing with the mother. When the participant's health was

stable, the psychiatrist or designate would ask their permission for me to approach her. If

she was willing, I met with her to provide a further explanation of the study (Appendix

A). Of those identified, seven declined to meet with me.

The purpose of the study was explained to each study participant using a standard

study explanation (Appendix A). Of the thirty-one mothers who agreed to be contacted by

me, two mothers did not meet the study criteria; two mothers could not be located; and

six mothers declined enrolment. Of these six, one inquired if I worked with Children's

Protection Services. If the participant agreed to participate in the study, she was asked to

sign the informed consent (Appendix A); participants were given of a copy of this along

with a written explanation of the study. A time and place were arranged for an interview. Twelve were interviewed in an inpatient setting prior to discharge and the remaining in a place convenient to them. In only one interview did I see mother-child interaction. Only twenty interviews were used in data analysis.

The concept of theoretical sampling guided the selection of participants. Theoretical sampling is a process of selecting participants on theoretical rather than statistical grounds (Glaser, 1978, 1998). The concepts emerging from the data direct the researcher to purposefully select participants to advance the theory. In grounded theory, a theoretical sample is in no way representative of a study population. Instead, it involves an ongoing search for the validity of findings through constant comparative analysis and results in an "ideational sample" (Glaser, 1998). Such a sample represents a substantive area of interest to the researcher. To clarify,

> The researcher must always bear in mind that groups are, from a theoretical viewpoint, clusters of variables, which are not all readily apparent, and many of which are to be discovered by comparison. Thus to compare on one or two initial variables easily brings into relief other properties of the group that find their way into the emerging theory. (Glaser, 1978, p. 42)

My initial decisions for theoretical sampling were based on a substantive unit of interest, mothers with SMI. This interest came about as the result of an informal discussion I had with a group of mothers in an inpatient psychiatric unit. Their stories were unknown to me, as I had no preconceived framework of their parenting methods. Thus, it seemed reasonable to begin sampling in an inpatient setting. With the assistance of the psychiatrist and nurse manager, eight mothers who met the study criteria were

identified. Interviews with them were completed and immediately analysed prior to approaching participants for theoretical sampling. When I reviewed my theoretical memos, the seeking of affirmation as a mother was a variable at this stage in data analysis. Using this as a theoretical lead, I reentered the field to interview more mothers who had undergone similar experiences. Consequently, with more data, the original lead was modified.

In my role as psychiatric nurse, three of the mothers in the initial sample were known to be clients because of their frequent hospitalizations. As a researcher, I purposefully invited each of them to participate in the study. Each of them met Field and Morse's (1985) criteria of a "good informant": willing to participate, giving of their time, articulate and knowledgeable about the topic. Glaser (1978) supports such a strategy. Participants who are good informants assist the researcher in deciding where and how to look for more data.

I did, however, experience a few "false starts" (Glaser, 1978) at the beginning of the study. My theoretical interpretation of the data was flawed because my initial data analysis was unit- rather than process-focussed. I came to realize that researching mothering was not about the mother as an individual. Rather, it involved understanding that the process involved in mothering ultimately transcends her as a unique individual. Therefore, to capture a range of mothering experiences, a sub-group of four mothers who did not live with their children were also interviewed later in the project. Such a sub-group was not selected for the purpose of comparison in the traditional sense. Instead,

mothers living with and without their children gave the researcher access to other

"situations in which those processes would be more visible" (Finch & Mason, 1999, p.

299). Theoretical sampling's flexibility allows the researcher to look elsewhere for the

process at a later stage if her initial sampling decisions are not theoretically grounded.

Openness to correction and change in theoretical sampling is characteristic of grounded

theory's modifiability (Glaser, 1978). Saturation was reached when the data became

redundant.

Ethical Considerations

Written ethical approval was obtained from McMaster University and Sudbury

Regional Hospital (Appendix A). Sudbury Algoma Hospital gave me verbal consent

following a meeting in October 2000. Further, the Chief of Psychiatry wrote a letter of

support (Appendix B). Informed consent to participate was obtained from all study

participants. Privacy was ensured by approaching potential participants in a secluded area.

In the explanation of the study, each prospective participant was informed that there

would be no risk to her, and that she could withdraw from the study at any time or refuse

to answer any questions. It was also explained that the information she shared would not

be communicated to staff members unless she shared information that indicated that she

was at imminent risk of harming herself or others. Early in the study, one participant

indicated that there were abuses in the home towards a child. As she declined to contact

Children's Services herself, I was professionally obligated to contact them as well as her

treating psychiatrist. This was difficult for both the participant and for me. My dilemma

involved the unexpected navigation between researcher and a nurse guided by standards

of practice.

Prior to meeting with another potential participant, I reconsidered my approach

vis-a-vis the consent process in light of addressing mothers' autonomy within vulnerable

positions. In hindsight, despite the consent's comprehensiveness, it needed to be

complemented by open dialogue about what constitutes a secret and what would be

necessary to divulge to others. The difference of approach focussed on helping the

participants to place me within the context of the research question and interview process

(Finch, 1999). This may also explain why I was often asked personal questions rather

than questions about the study. For example, participants often inquired if I had children.

In the explanation of the study, participants were told that they would not

personally benefit from participating in the study, although the sharing of their

experiences may have been considered by the participants to be beneficial per se. Several

mothers expressed gratitude at being able to tell their stories because they were rarely

asked. This is supported by Finch's (1999) findings that women frequently describe the

research interview as a welcome experience since they lack opportunities to talk about

themselves. Many of the women in her studies did not have opportunities to engage in

supportive dialogue with other women.

Even if only one interview was required, the consent included provision for a later

one. When asking each participant's permission to record the interview, I told her that I

would be the only person listening to the tapes, and that the tapes would be destroyed

upon the conclusion of the study. Strict anonymity was maintained. For example, names

and other identifying information were changed in the transcript of each interview. With

regard to the report of the findings, I mentioned to each participant that she might be

quoted without any identifying details. Many, when asked, requested a copy of the

findings. Data were stored in a locked cabinet accessible only to the researcher.

Data Gathering

The main data gathering strategies in this study were consistent with natural

inquiry, field notes and interviews.

Field Notes

As guided by Lofland and Lofland (1999), field notes were kept by the researcher,

written immediately after each interview as a chronicle of my observations and

preliminary insights. My intent was to record information as correctly and honestly as

possible to assist with my memory recall. Initially, I used a standard form (Appendix C)

as a structure to freely document my description of an encounter with a participant. The

form did not specifically identify the demographic variables of each participant, as such

information is "only relevant when they earn their way into the theory by fit, relevance

and work" (Glaser, 1998, p. 84). The information I have about such variables as age or

illness demonstrates what they were comfortable telling me, as I did not review any

medical documentation. An example of a field note at the beginning of the study is

illustrated in Figure 1.

Figure 1. Example of an earlier field note

> **Field note – Sally**
>
> *What happened?*
> Sally was identified as a potential participant by a nurse manager. She had been an inpatient for several weeks. Before I could finish explaining the study to her she began sharing her experience as a mother. "It is so hard because I wish I could mother more to my kids". She talked about "the bond" and "not being labelled disabled", all before signing the consent form. Once she had signed it, she invited me to return later so "she could help me". When I returned, she informed me that she has just rested as her medications make her so tired. Her fatigue became evident toward the end of the 50-minute interview.
>
> Her speech was thick and she often took small drinks during the interview. She requires time to verbalize her thoughts. Early in the interview I sensed that the *guiding* questions did not allow for comfortable dialogue. The question and answer format was too mechanical. Our interaction seemed to change as I moved away from such a structure toward a conversational interaction. Using her language, inviting her to share examples and seeking clarification were skills that encouraged her to talk more spontaneously and extensively about her experiences. I do not believe Glaser specifies a research relational approach! Adjusting the interview process to make it comfortable for both parties involves a balance between skills of attending and information gathering.
>
> I believe Sally is in her early 30s. She is the mother of two adolescent children. They reside with their father whom she separated from several years ago. When she sees them "is not up to me"; such decisions are made either by the father or her children. The youngest visits on a regular basis while her oldest has just began visiting Sally after a six-year absence. Sally stated she doesn't know why her oldest child wouldn't visit her. In fact, "no one knows and I even asked". When she spoke of her children, her tone changed. Concern for them is evident – tone of voice, tearfulness when she spoke about her eldest child not visiting.
>
> She has the walk of a person receiving anti-psychotics. During the interview, she informed me that she has been given numerous psychiatric diagnoses, the most recent one being schizophrenia. Over time, illness has resulted in numerous losses

for her – working, living with her children, being beautiful, and having a home. Now her life consists of living in a small, rented apartment, being taken advantage of by others, using other people's furniture, receiving a disability pension that is too restrictive and not wanting "to hang around sick people".

What were the main themes or issues for this mother?

Mothering involves a "disciplined self" in order to create a "bond" with the children that is "so strong" it is unbreakable by others or circumstances such as illness and limited resources. The "bond" is a symbol of motherhood. Accepts children as "individuals". As a mother she "grew". Gradually "ill, ill, ill." Over time became increasingly stuck in illness. Meanwhile, children grew up and moved on to own interests. She describes how her time with them has changed. She speaks to her role as educator, sharing her knowledge of illness so that they will not "end up here", in hospital. She is attempting to "open their eyes so they don't have a small view of the world". Told by her family and health care workers that she is not a mother. In my opinion, this is cruel. She states that she is not aware of what her children do day-to-day. Over time, she has become increasingly removed from her family and many of her current efforts are directed to "creating a space" to mother. She is trying to "stay close as much as I can".

"Restraints" on circumstances to mother. Others don't understand her or living with illness. The magnitude of loss illness evokes.

How does such data build on other?

As mentioned by another mother, her children are "all she has". In illness, the children may be a reminder of so-called normalcy because illness is unpredictable and chronic in nature. Committed to and values motherhood. Guilt is an emotion previously expressed. Sally is not comfortable discussing "things I am not proud of". Yet, she adds that she has to answer only to God for her parenting mistakes. Sally's guilt did not seem to be as immobilizing for her as for other mothers. Possibly, this may be related to Sally's acceptance of her situation even though she doesn't like it. Sally's often stated, "that's the way it is". Wanting to be appreciated and acknowledged by others as a mother. Illness and circumstances have removed her. As illness becomes more severe, it imposes a greater distance between mother and child. Illness becomes the filter from which others gaze in to evaluate her ability to mother. Sadly, such a filter from the mother's experience may not be under her control. Further, the system can help "only to a point".

What new hunches arise from this data?

Despite disappointments and heartaches, Sally continues to create opportunities to be with her children. For example, make-up, movies. Being with children is a safe place – place where not judged, have dreams.

As the research progressed, however, I found this form somewhat restrictive. The content shifted from a descriptive report to a record of my theoretical impressions as I became increasingly sensitive to the mothers' patterns. The field notes seemed to evolve into an illustration of a category just as Glaser (1998) had predicted. Becoming immersed in the data also became a tool to deal with my confusion, a common state of mind in the implementation of grounded theory methods (Glaser, 1998). An example of a field note completed later in the study is given in Figure 2.

Figure 2. Example of a later field note

Field note – Nancy

This is my shortest interview to date, less than 20 minutes. Although this mother was considered stable and receptive to being involved in the study, early in the interview she became tearful and anxious. She addressed the "pain" of illness and treatment; desire yet inability to be present for her children; fear and uncertainty in the "unknown", and "blue haze" illness, and the daily exhaustion. I wonder if putting her experiences into words brings the pain into the open. She has two school-age children.

The "haze" characteristic infers the unreal, uncontrollable, unbelievable, unpredictable, and unbearable suffering of her illness situation. To preserve her identity as a mother she withdraws her presence by using substances; considering suicide; making excuses to spend less time in the home; pretending; and keeping secrets. Her use of the term "battle" is fitting in that, for her, defensive manoeuver is necessary to endure everyday. She must continually balance her responsibilities as a mother and her need to remove self to control suffering as well as to protect her family. Over time, unfortunately, her suffering and turmoil increase. She moves (consciously and unconsciously) deeper into the 'haze". The further she travels in, the less transparent (hence its shade of blue) it becomes. In other words, she becomes lost, unaware of how to get back to her children, and thus, her position as mother becomes increasingly vulnerable. Being lost on the "other side" of the haze compounds her exhaustion and guilt. Being so far from center is so distressing that she seeks help, only to discover it is just as difficult. To talk about her situation is wounding. With medication, a clearing in the haze is made possible by the masking

---

> of symptoms.
>
> She wishes for a life without illness, a life where she is available to her family. Tragically, keeping secrets (the unstated) strengthens the backlash. Suffering in silence lessens the risk of exposure. If she speaks of her pain, she has to speak of loss, of lack, of failure. In this sense, guardedness in turmoil is an important distinction for treatment as just beneath the outer skin is current and anticipated turmoil. Medications, alone, fail to provide a map (or words?) – assuming there is such - to assist her in navigating through the haze in one whole piece.

Interviews

Each of the twenty participants had one audiotaped interview. The interviews were all under one hour and were transcribed by the researcher within a day of the recording. The nature of the participant's illness and my work role brought me into unplanned contact with some of the participants during the data collection period. They asked me questions about the research that, in turn, opened further dialogue in an informal manner (Chenitz, 1986). Some mothers were not surprised that my project was an understudied topic. By perceiving themselves as the *experts,* some mothers spontaneously shared recommendations for change in nursing care approach. Their views were captured in field notes, if I was given verbal permission by the participant.

For the purposes of this research, Swanson's (1986) perspective of an unstructured formal interview in grounded theory was followed. She and others (May, 1991) emphasize that "unstructured" remains within the intention of the area of interest, but is uncluttered by rigid or predetermined processes. The aim of the unstructured interview is to elicit rich information in the participant's own words. To this end, asking

guiding questions or making statements for the purposes of listening, clarifying, or stimulating a participant to tell her story were acceptable. Even then, guiding questions had to be rooted in "what the interview is about empirically" (Glaser, 1992, p. 25) in order to minimize forcing data.

Although there is no predetermined or "typical" interview in grounded theory (Wimpenny & Gass, 2000), my interviews were characterized by a common approach. Often, I invited a participant to begin her story at a place where she was most comfortable. Some participants were at ease with such an approach, while others requested I begin with specific questions. In such instances, I would begin with a general probe, such as, "How long have you been a mother?" At other times, I would continue to pursue the topic of conversation prior to turning on the recorder: her inpatient experience, her illness, or the return home to her children. As an interview progressed, my typical involvement consisted of seeking clarification, inviting her to tell me more, or asking reflective and feeling questions as defined by Charmaz (1990). To illustrate, "How did you know it was time to seek help?" "In view of what you told me about [an identified issue], how do you manage?" "How have your expectations of yourself as a mother changed over time?" This gave the participant an opportunity to narrate her story as desired and to focus on issues that were important to her, yet remained in keeping with the research focus. The end of the interview was signalled by the participants' cues of apparent exhaustion, or by their voicing that they had nothing further to add. Closure most often consisted of thanking each participant for her time and willingness to share.

My interview style integrated May's (1991) precursors of comparability; namely, flexibility and consistency. Flexibility refers to having some freedom in topic selection and questioning in order to make space for the participant to narrate. Facilitating the story, flexibility in interview approach was required for some participants who did not converse in a conventional manner. For example, those whose thoughts were difficult to understand or whose thoughts seemed incoherent because of the illness required gentle redirection to the topic of mothering. As well, this needed to be balanced with my increasing awareness that the story might challenge any preconceived notions that I had unconsciously brought to the interview. Being a "good listener" was difficult to balance with being a "good grounded theorist researcher" as it was difficult to interpret *on the spot* what was pertinent to the topic of motherhood.

The attribute of consistency is not about asking every participant the same questions (May, 1991). Rather, it involves attending to the types of questions asked in order to generate hunches so that subsequent interviews are informed. Data collection and analysis (as outlined in the analysis protocol) occur simultaneously in grounded theory. Gathering information with enough consistency early in the study assisted me in making decisions regarding theoretical sampling and the focus of the interview. In later interviews, questions tended to become more specific, more directed by the emerging analysis. To illustrate, a type of question used as the study progressed was, "Other mothers spoke about [an emergent issue]. You have spoken about [a similar or different aspect of the issue]. Can you explain this to me?" The questions' context was drawn from

previous participants' stories in order to facilitate further exploration and clarification of a theoretical concept.

Data Analysis

To generate a set of conceptual hypotheses that account for much of the behaviour in a substantive area, grounded theory methods are recursive as compared to linear in nature. Grounded theory processes of substantive coding, constant comparing, theoretical coding, theoretical sampling, and memoing are interdependent and reciprocal in nature. According to Glaser (1998) such cycling processes happen "sequentially, subsequently, simultaneously, serendipitously and scheduled" (p. 1). My Glaserian analytic process is illustrated in Figure 3, which represents a systematic unfolding of several processes that occurred in the data analysis. I detail the steps of my analysis in a linear pattern for the purpose of demonstrating the generation of a theoretical explanation of "what is happening" with this group of mothers. In this study, auditability, in accordance with Sandelowski (1993), is defined by systematic, detailed and accurately transcribed interviews, memos and field notes. The model and the text expose what I did with the data.

Transcribing

Some authors (Easton, McComish, & Greenberg, 2000; Poland, 1999; Silverman, 1993) have suggested that the process of transcribing audiotapes into a textual account of the research interview is critical to the success and quality of data analysis. In contrast,

Transcribing   Constant Comparing   Memoing

```
┌──────────────┐      ┌──────────────┐          ┌──────────────┐
│ Field Notes  │ ◄──► │ Coding Line  │  ◄─────► │              │
│     and      │      │     by       │          │   Memoing    │
│  Interviews  │      │    Line      │          │              │
└──────────────┘      └──────────────┘          └──────────────┘
```

Level I

```
                      ┌──────────────┐
                      │ Examining    │
                      │ pieces of    │  ◄───────────┐
                      │  stories     │              │
                      └──────────────┘              │
```

Level II

```
                      ┌──────────────┐
                      │ Looking for  │
                      │ patterns or  │  ◄───────────┐
                      │ categories   │              │
                      └──────────────┘              │
```

```
┌──────────────┐      ┌──────────────┐
│              │      │ Asking the   │
│  Interview   │ ◄──► │ "meaning" of │  ◄───────────┐
│    Guide     │      │    data      │              │
└──────────────┘      └──────────────┘              │
```

```
                      ┌──────────────┐
                      │ Examining    │
                      │Relationships │
                      │Among         │
                      │Categories    │
                      └──────────────┘
```

Level III

```
                      ┌──────────────┐      ┌──────────────┐
                      │Re-constructing│ ◄──►│ Yeilding a   │
                      │a theoretical  │     │ theoretical  │
                      │  picture      │     │   model      │
                      └──────────────┘      └──────────────┘
```
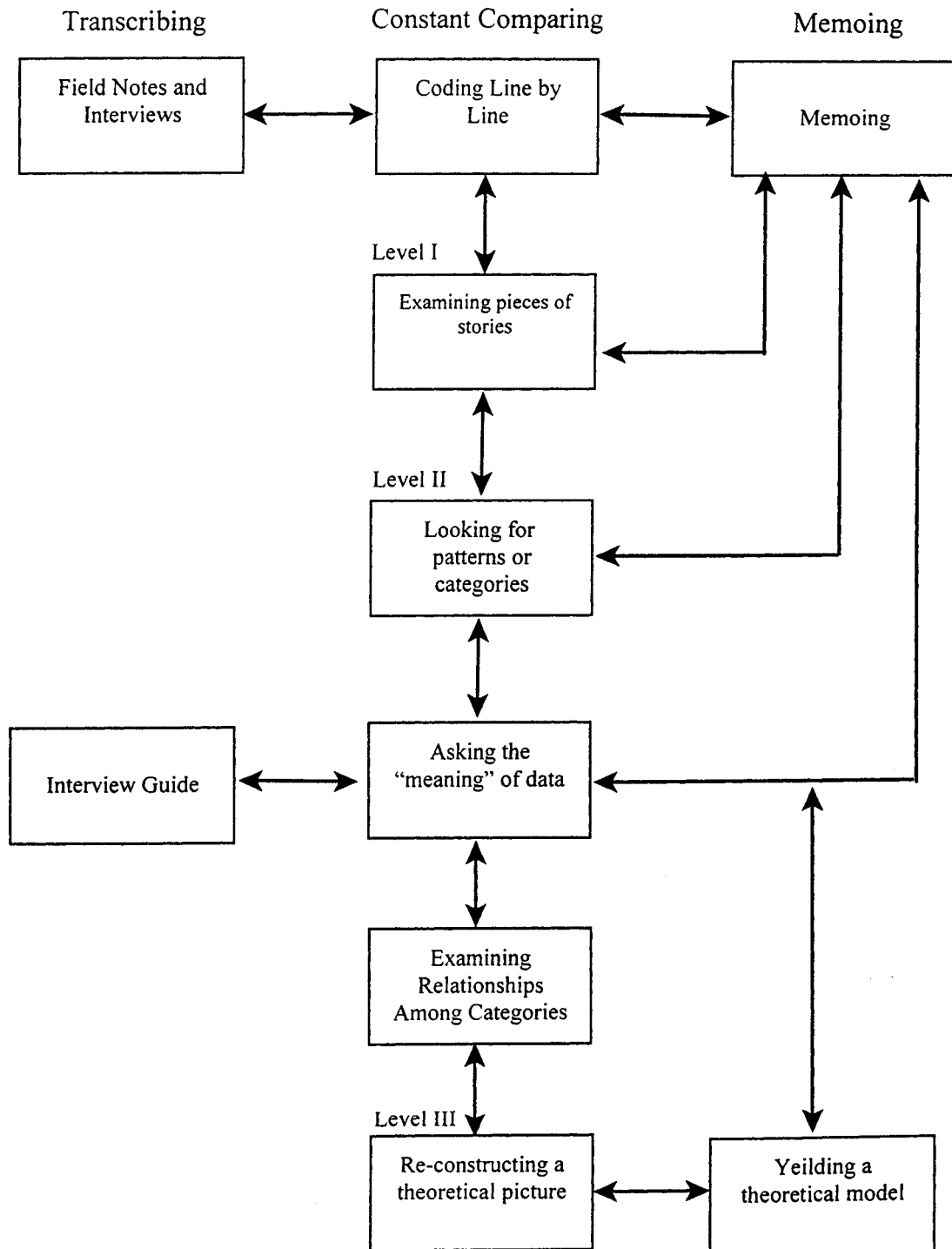
Figure 3: Method of Analysis

Glaser (1998) does not recommend transcribing because it slows down data collection, overwhelms the researcher with too much unnecessary data, and limits creativity. Glaser (1998) asserting that the "mind is a sponge" (p.110), argues that field notes alone are sufficient. Since my confidence in the quality of the data being analysed required more assurance, I chose to transcribe each interview in its entirety. This gave me reassurance that each participant's story was read within its unique context. Listening to the recording demonstrated clearly that I did not always hear the communicated message. The transcript also afforded me the opportunity to return repeatedly to an account. Thus, the risk of personal preconceptions or analytical biases was decreased (Silverman, 1993).

Respecting that transcription is an interpretive activity, I integrated Poland's (1999) suggestions to ensure audiotape quality. For example square brackets were used when I added text for clarity and underlining indicated the participants' emphasis. I also included some recommended standardized syntax notations in selected passages of an entire transcript in order to ensure that the textual representation of the original speech act was as accurate as possible (Figure 4). Since the level of syntax is dependent on the study's methodology, the chosen selections corresponded to themes pertinent to the emerging theory (Poland, 1999). Indeed, this option addressed Glaser's (1998) warning of being overwhelmed by data. Transcripts, general reproductions with selective detailed accounts, as well as field notes, provided illustrations to begin the first part of the analysis process. Frequent reviews of tapes, transcripts and field notes increased my level of theoretical sensitivity that in turn assisted me in determining "what was happening". The

identification of concepts and patterns guided the direction and questions of subsequent

interviews.

Figure 4: Exemplar from a transcript

> **Participant – Connie**
>
> Phyllis: Is this a recent diagnosis? [attempts to clarify as responses difficult to follow]
> Connie: That was done um, just a month ago [pause] not very long ago two months
> ago. I went into the hospital and they started giving me stel, stelazine for
> schizophrenic and they were giving me z-z- um [interject with the word zyprexa]
> something new because I was hallucinating [then a jump in time and idea] so it was
> very hard taking care of [her child] as a baby ah because I was hallucinating and I, I,
> I because I was hallucinating and going through postpartum depression and I was very
> careful with her [quieter tone and takes a pause] and like I was extra careful except
> my own health deteriorated and I became suicidal because I couldn't cope with the
> voices in my head and the visual hallucinations and I was suicidal [no change in tone]
> and I didn't know anybody who could help me except for my physician yeah.

Constant Comparing

The constant comparison method of analysis occurs throughout coding. The aim

of Glaser's (1978, 1998) constant comparative method is the systematic generation of

theoretical constructs that form an integrated theory. Comparing incident with incident;

incident with category; and thirdly, category with category "teases out" the emerging

category/construct (Hutchinson & Wilson, 2001). This process allows for the examination

of each piece of data. After considering its relevance to emergent categories, it is

compared to other pieces of data that have been similarly categorized. Thus, the scope

and variation of a category are delineated, and patterns in relation to other categories are

identified. A clearer picture of how concepts relate to each other is established through this process.

Beginning with the comparison of incident to incident, a category is generated. For example, in this research the in vivo code "hitting bottom" involved mothers choosing between two extremes, to live or to die. With more coding and analysis, basic properties of a category are gradually delineated. Further examination of the evolving concept of "hitting bottom" yielded a denser category. As a consequence of overwhelming circumstances and the realization of how far removed from their children mothers had unwittingly become, many mothers were confronted with the choice to live or die. This choice was made in view of their sense of responsibility for their children. Eventually, the concept, "hitting bottom" was compared with the literature.

Coding

Grounded theory analysis involves several steps, each of which moves the data toward a higher level of abstraction. In this study, the conceptualization of data was based on Glaser's (1978, 1992, 1998) techniques as well as on those outlined by Stern (1980, 1994), who is recognized in the nursing literature for her efforts to clarify the Glaserian stages of grounded theory analysis. What follows is a description and an application of each of my coding steps as depicted in Figure 3.

First, as transcribed data were received, line-by-line coding was done. The data were read carefully, and then code words or phases, often the exact words of the participants, were placed in the right-hand margin. Such codes are referred to as

substantive codes or Level I codes and are a result of open coding: coding each line of

data into as many codes as possible to ensure "full theoretical coverage" (Glaser, 1978, p.

56). Examples of early substantive codes were "masking" "spinning" and "mothering

involves self-discipline", all of which were pieces of data. Early in the study, as Glaser

(1978, 1998) had predicted, codes were abundant. It soon became difficult for me to

organize and access my hand-written code labels quickly. To this end, NUDIST, a

qualitative software package was introduced to store the data as well as keep track of the

code labels. In addition to substantive open coding, memoing (to be discussed later) was

initiated, a process facilitated by ongoing dialogue with and questioning of the data.

Second, similarly coded data were clustered into groups representing a pattern.

Level II codes or categories are concepts formed when initial codes are compared to each

other in terms of their congruencies/incongruencies. Comparing incidents to each builds a

category or concept and its properties (Glaser, 1978). A category, then, is a higher level of

abstraction than a substantive code. It is structured by the "meaning" of a concept as

opposed to conceptual description (Glaser, 1978). Data not "earning" their way into a

category or seeming irrelevant, are placed aside for later determination of fit and

relevance to a category. In achieving the goal of parsimony of concepts and theory, Glaser

(1978) states:

> The more the analyst finds indicators that work the same regarding the meaning
> for the concept, the more the analyst saturates the distinctions and properties for
> the concept for the emerging theory. (p. 64)

Again, dialogue with the data, questioning, constant comparative analysis, and memoing, each with its own definition and properties, facilitated the delineation of distinct categories. For example, types of questions asked to determine categories were: "What is actually happening in the data? What does such data tell me about being a mother? "How is this category similar/different to that category?" This helped me in thinking about the meaning of categories. Gradually, the information of the categories was then used to guide interviews with subsequent participants.

To determine relationships among each unique category involved a conceptual level of analysis known as theoretical coding or Level III coding. Theoretical codes "weave the fractured story back together" (Glaser, 1978, p. 72), assisting the researcher to consider the data in theoretical rather than descriptive terms. To conceptually organize the data, Glaser (1978, 1998) described several families of theoretical codes that might emerge from the data. In this study, to promote my viewing the data in a theoretical light, questions I asked concerning "hitting bottom" were: "What are the consequences of hitting bottom? "Is hitting bottom a staged process?" "What constitutes bottom?" Such questions further delineated the properties of a concept. No existing literature was used during the analysis process to limit preconception of the data. Following ongoing review of the data and theoretical notations, a core problem and process were identified. In other words, a substantive model was generated.

Memoing

As guided by Glaser (1978, 1998), I began writing memos after the first interview

and continued throughout the grounded theory process. These were records of my

substantial and theoretical ideas in relation to data. Written spontaneously without

concern for style in a journal, they helped me to keep track of my thoughts concerning

emerging codes, categories, connections, and concepts. In comparison to field notes, the

content of memos was generally more theoretical. Some memos, for example, identified

aspects of the participants' in vivo term "hitting bottom." In other memos, I dealt with my

thoughts concerning an emerging category, labelled "Invisible". Figure 5 illustrates two

examples of memos clustered under Invisible. It is noteworthy that, with the

accumulation of memos concerning a particular theme, the concepts became increasingly

developed, saturated and interwoven with each other. This was facilitated by questioning

and comparing during memoing.

Figure 5: Memos

June 12 2002 – Hiding

Gloria truncated illness from her identity. [Data lines 69-77] Since illness was yesterday news and now, partner still with her, children in home, time to pursue some of her interests, and money coming in no concerns as a mother. [27, 22-24, 31-40] She no longer perceives self as ill and suicidal act of hanging is put aside, removed from image of self/self as mother. She HIDES from it. The traumatic crisis is in the past and so, leave it there. A wound that may not have yet healed. Re-balances by return to mothering and management of symptoms. [100-108, 112-116]

Longed to be a mother since a young age [46-52, 54] and can't mother when ill. [46]. To be hospitalized unexpectedly posed risk of children being removed [46, 90]. When in hospital, thinking is focussed on protecting children as home situation tenuous.

> Even when acutely ill own needs placed aside for kids' protection. [86-98]
>
> **July 5 2002** – Hiding/Being Seen Simultaneously (Collapsed into category In/visible)
> The value of Hiding/Being Seen at same time be it via "masking", "camouflaging", "hiding", "pretending", "using substances" and so on is for the sake of keeping connected with their children as this is 'what is best' and also for sake of self as a person. The self is fractured by illness circumstances so must remove self so that children protected. Yet, hiding to remain hidden becomes problematic ... a consequence of ... become isolated, alone in illness and suffering. Understanding by others including children becomes all that more difficult as must have to "seek" mom out. In relation to 'hitting bottom' mom is alone and again speaks to how far moved away from children since even they knew something 'wrong' with mom.
> In hiding, there is an interplay of two processes at same time - hiding something while highlighting something else. Hide ill self at cost of not being present as mother – a paradox. Hide self, highlight mechanical mother. Hide self, highlight mask. I wonder if motherhood for these moms just involves a piece of self? When illness out of control, their self is exposed.

Sorting memos, my theoretical interpretation of data, is the final step in generating theory. It is another means of organizing, consolidating and eliminating concepts (Stern et al., 1984), entailing putting the fractured story back together and not unlike doing a puzzle. A memo, like a puzzle piece, is examined next to another memo to determine its "fit". Again, asking questions, comparing data and theoretical sampling facilitated putting together memos to represent the researcher's interpretation of what happened. If the memo didn't "work", it was placed aside and its relevancy to the emerging theory was determined later. Eventually, pieces of the coded data were integrated, thereby, providing a structure for writing a theoretical explanation as supported by the data (Glaser, 1992, 1998).

Rigor

In recent years numerous authors have debated the question of rigor in qualitative

research (Clarke, 1995; Koch & Harrington, 1998; Lincoln & Guba, 1985; LeCompte &

Goetz, 1982; Smith, 1990; Sandelowski, 1993). These authors concur that the

conventional notions of validity and reliability, as defined by the positivist perspective,

are inadequate when applied to qualitative research and must be reconceptualized. Terms

such as credibility, transferability, and dependability have respectively replaced internal

validity, external validity, and reliability (Lincoln & Guba, 1985). Other descriptive

criteria arising from the paradigm of the research (Hall & Callery, 2001; Koch &

Harrington, 1998; Marshall, 1990) have made it increasingly difficult, if not impossible,

to devise standardized criteria for judging the "goodness" of qualitative research

(Schwandt, 1996, as cited in Koch & Harrington, 1998). Indeed, Glaser (1998) considers

such efforts as "the baggage of everyday research critique and requirements" (p. 16)

which ultimately distracts from the doing and valuing of grounded theory. He states:

> Answering questions of properness beforehand often just results in "words for
> words", which might not quite be either understood or believed and certainly
> cannot be believed by true believers of another methodology. It is best to let others
> answer their own questioned reservations ... Erudite discussion of the method
> often is of no use to the researcher and indeed, may block his research with
> discouraging criticism. (Glaser, 1998, p. 18)

Viewing evaluation criteria as a structure to guide systematic inquiry in this study,

I decided to use Sandelowski's (1986) frequently-cited and accepted criteria of credibility,

fittingness, auditability and confirmability. First, the criterion credibility refers to a

faithful and recognizable representation of an experience by both respondent and professional. It is potentiated by the use of the systematic process of constant comparison method (Clarke, 1995). Second, to demonstrate fittingness, the findings must "fit" into a context outside the study situation. Glaser (1998) himself stresses that grounded theory is a study of a conceptual problem and process (after its emergence), as compared to an aggregate. Third, auditability, as mentioned earlier, requires researchers to expose their inquiry processes to the reader. Finally, confirmability - the meaningfulness of findings - is congruent with Glaser's (1998) position that generated theory "speaks for itself" (p. 17) and offers the possibility of a new perspective in a substantive area.

In addition to Sandelowski's external criteria, Glaser (1998) specifically details four additional grounded theory criteria. First, fit is achieved if the theoretical conceptualization adequately represents the pattern in the data. The link between the data and the concepts is facilitated by using the constant comparative method. Thus the researcher's interpretive thinking is all "rigorously induced from data" (Glaser, 1998, p. 12). Second, a quality theory possesses relevance if it has meaning to the participant and practice group. Third, workability refers to the theory's explanation of the core problem and process as identified by the participant in a substantive area. The fourth criterion, modifiability, means that theory can be changed as new data emerges. If the emerging hunches accounting for the social actions are not working, simultaneous collecting, coding and analysing modify data until they do. Since social processes are not static, a theory must be able to capture their fluctuating nature (Backman & Kyngas, 1999;

Hutchinson, 1986). Even if the theory is used in another research endeavour, it may

require further modification so that it fits, works and is relevant to the uniqueness of the

situation.

CHAPTER 4

FINDINGS

The findings reflect the mothers' wish to have meaningful relationships with their children in the contexts of serious mental illness (SMI) and suffering. To keep close and connected to their children equated to being 'normal', secure and responsible for their children. To keep close, the mothers chose strategies that would imitate ideal representations of 'mother'. These strategies included masking, censoring speech and doing. Each of these manoeuvers was intended to hide illness, make it invisible. Depending on the nature of their illness and suffering, mothers were able to mask, voice or do in relation to what they perceived as happening around them. Mothers made choices concerning how they presented self-as-mother and the extent to which they revealed their true identities. However, mothering in illness and suffering became a vortex of contradictions resulting in their "hitting bottom". At the bottom, it became visible to them how far removed they had unwittingly become from their children. At this point, the mothers typically sought help from health care professionals as the last possibility for reconciliation. With professional guidance, they hoped to return to their valued places as mothers. Mothers sought help on how to be with their children more fully while meeting their own mental health needs. In this chapter I will begin by providing a summary of the participant's demographics. All names are fictional. In the data, the term "child" was

substituted when mothers made reference to their children. I will then present my

conceptual model *To Keep Close* (Figure 6). Each category of the model will then be

described with supporting data.

The Participants

Demographic data about the 20 mothers was presented in chapter 3, Table 2.

Table 3 presents an overview of the mothers' primary mothering concerns. Each mother's

concern appeared as a recurring theme in her story. Although mothers shared some

common worries, these themes also illustrate the diversity of mothering in this small

group of women. More descriptive information about each mother is presented in

Appendix D.

To Keep Close

The core problem for mothers suffering with SMI was to keep close to their

children. "Keep close" was a phrase used by some mothers to represent their purpose. The

model, *To Keep Close*, is illustrated in Figure 6. Mothers wanted a "bond so strong that it

can't be broken". To keep close was "the way it was supposed to be" no matter what had

happened, or might happen in illness. To keep close included a sense of being normal,

secure and responsible. How they kept close was dependent on mothers' watchfulness,

their interpretation of what they saw. These four categories form the centre of the model.

With the exception of the continuous line representing being responsible, being normal

Table 3: Main Mothering Concerns

Mother	Main Mothering Concern
Irene	- Protecting children from others
Hailey	- Doing motherwork in adversity
Kathleen	- Realizing child has removed self
Melanie	- Persevering as mother
Mary	- Guiding child away from illness
Sally	- Creating an unbreakable bond
Brooke	- Mothering without pretences
Kate	- Being valued as mother
Peggy	- Protecting child from illness
Betty	- Fighting to keep her children
Gloria	- Keeping her status as mother
Nancy	- Questioning her presence as mother
Rachel	- Protecting children from illness
Heather	- Harming children inadvertently
Janice	- Keeping child at center of her world
Paula	- Re-connecting with her children
Tracy	- Being recognized as mother
Alice	- Appearing in control as mother
Joan	- Helping child to value difference
Connie	- Keeping child safe

Being Normal
Being Secure
Being Responsible

In/visibility

Masking

Censoring Speech

Doing

Watchfulness

In/Visibility

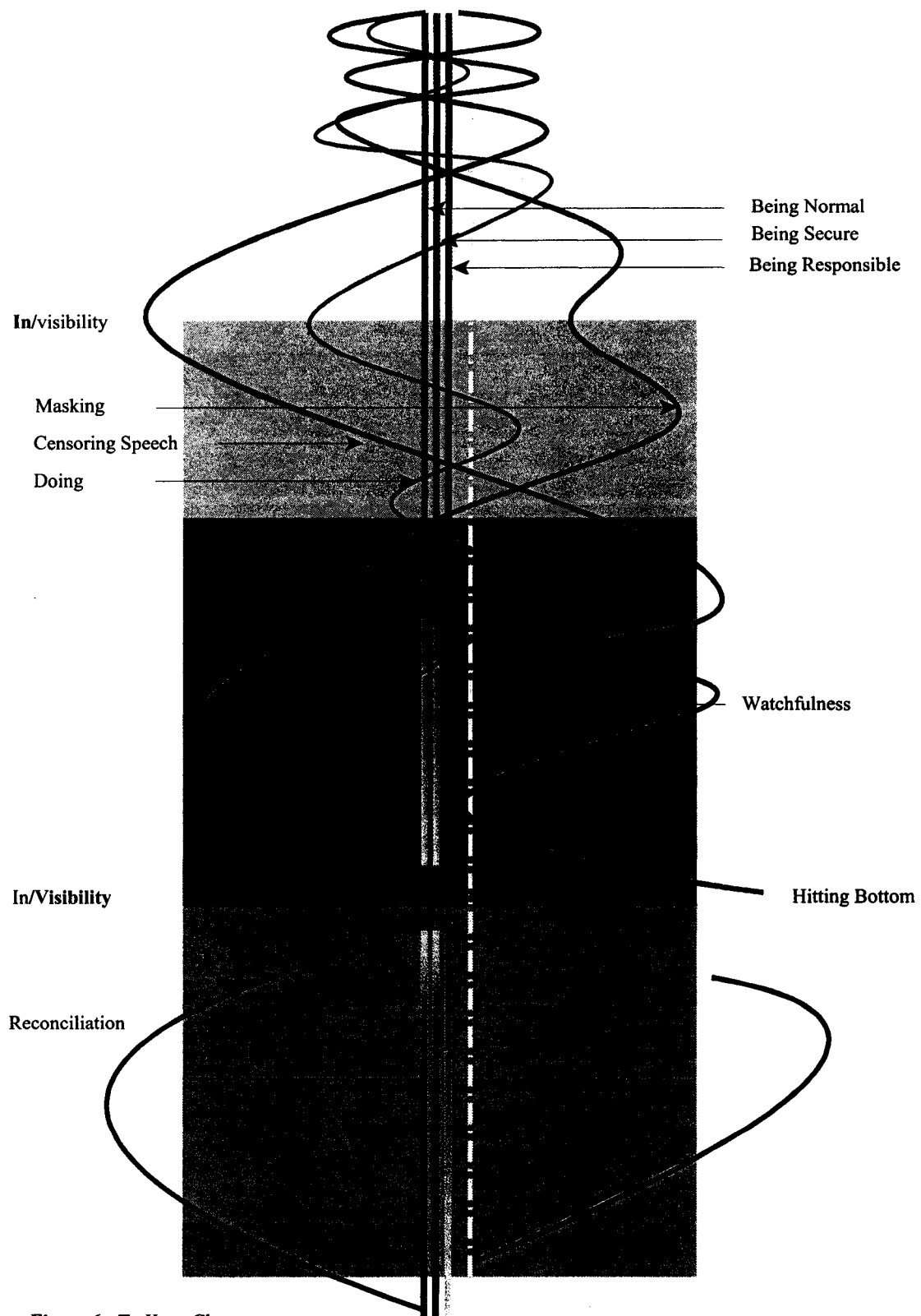Hitting Bottom

Reconciliation

Figure 6 : To Keep Close
* Shading represents increased intensity of suffering. Suffering involves alienation and uncertainty

and secure break at a point in the process. Watchfulness, a necessary condition to keeping

close, is represented by a dashed line alongside the three red center lines. The colouring

of these lines varies in intensity to indicate the mothers' perception of closeness to their

children. For example, as illness undermines their efforts to appear normal, the colour

fades. The colour brightens once the symptoms are treated with medication.

Being Normal

To the mothers, to keep close required that they embody values of the romantic

image of motherhood, as popularized in Western culture. This image, as a virtuous

representation, was considered pure, and thus negated their difference in illness. Mothers

derived notions of what was expected of them based on their interpretations of the ideal.

For example, Alice, a mother of two children, longed to be a "perfect" mother. Instead of

sleeping at night she would read parenting magazines that reinforced her mothering

performance. Alice elaborated:

> ...comparing you know like "My God, I didn't do this. I'm not a good mother!" You
> know and then trying to do it all type of thing ... I always wanted to learn and do,
> do the best I can for my children and it's like, "Oh I didn't do this, oh, I didn't do
> that". ... My husband brought me one [of the magazines] because "You got this in
> the mail". ... I just, you know, look at what others are doing type of thing and want
> to be like [not finishing her thought].

Ideal qualities and attributes of being 'mother' guided them in the determining of

how to keep close. Melanie, a separated mother of two children, felt compelled to

maintain the "ideal image" especially after the father's unanticipated decision to leave the

home. Meeting her children's needs and wants was elevated to the center of her life. She was convinced that portraying the status quo made her more valuable in the eyes of others:

> When their father left it was like you know I felt like I had to overcompensate for his departure. It was like "I'd be damned if those children are going to suffer because you choose to do what you did". I'd be damned you know so I, I put them in a good school and I bought a house with a big mortgage, the most the bank would give me to make sure the kids associated with the best families you know and I always made sure I had a good vehicle in the yard and then the next thing you know it was like, "Ok Mom". Then the ski trips came. Ok, ski trips skip trips [rate of speech increasing] and then designer clothes. Ok, they are getting bigger and bigger and then running shoes were $140.00 and jeans were like $90.00 and it was getting to be like [gestures herself choking].

To be able to claim an identity as a 'good' mother rested on the moral attributes of altruism and relentless commitment to their children. Subverting their own needs, despite limited resources, was a way to keep close with their children. Such a position was congruent with their notion of being "child-centered". Placing the children's needs and interests ahead of their own affirmed them as mothers, while also affording them opportunity to role model being normal for the sake of their children. In this regard, mothers hoped that their children would be accepted by others. For example, Sally, who lives in poverty, spoke of her mothering sacrifices:

> And I send them money in the mail. I send them money with money orders. I, I deprive myself and I give them money because they're at the age when they need a bit of money. ... You know they want to go out on Friday and they need a bit of make-up and or they want to go out for pizza or you know. Usually I give them ten dollars and I give them a certain amount on their birthdays and I give them some on Christmas.

However, in the "chaos" of illness the ideal ironically served to become their undoing, thereby compounding their suffering. The desired image highlighted the fact that their mothering practices were "never good enough", intensifying their efforts to act normal. Hence, the mothers became caught in a constricting downward spiral of either/or dichotomies - good/bad, well/ill, natural/unnatural, strong/weak, productive/unproductive, patience/intolerance, happy/sad, talking/yelling, right/wrong, control/no control, and mother/witch. The illness undermined their efforts to appear normal, resulting in confusion about how to keep close. One of Betty's children had serious dental health problems. The child refused to brush or have her teeth brushed by Betty because it was "too painful". During a visit to Betty's family dentist, he accused Betty of "neglecting" her child, threatening to "report her" to Children's Protection Services.

> You're standing there and you're saying, "Well, am I neglecting my kid … If I'm neglecting them why are they in at the dentist." You sit there and you think, "Ok now what. What way do you go?" And you just sit there and think. "Am I bad for not doing this?"

Being Secure

Despite the inherent struggles of mothering it was an experience that provided them with a sense of security. Being secure meant belonging; that is, being recognized in the valued position of mother. Their children offered value, giving meaning and purpose to their lives. Words such as "an angel," "a good child", "very nurturing," "my number one," "innocent," "pleasant," "beautiful," "healthy and happy," "perfect," and

"wonderful" reflected their significance as mothers. How they perceived their children

equated with their success as mothers. Further, such descriptors demonstrated their

"commitment" to their children. The mother's sense of her children's reciprocity of love

resulted in "happiness", "fulfilment" and "strength". Gloria:

> Having three beautiful children that love you and umm, I don't know, it felt good to
> be responsible for them, to take care of them. I've always wanted to have children
> and umm I think kids are a blessing.

The connection anchored them in their struggle to endure illness. In this regard,

their bond with their children secured place that became overshadowed by illness.

Melanie articulated the value of the bond in illness:

> Through my depressions I've looked like hell. Oh, God. If the door bell rang, I
> never answered it. I rarely answered the telephone. The house was upside down you
> know what I mean. I've always cooked a good meal. It took a lot of effort to wash
> the dishes though. I hugged my kids to death. Those kids never got more hugs than
> when I was depressed, and when I was depressed and they were young the three of
> us would sleep in bed, on either side [gestures with her hands the physical
> closeness]. And like huddled like a team, we stick together. I kept them very close
> to me through my depressions and, ah, emotionally I needed them because, umm,
> they were my reason for wanting to live because I felt so bad. They were the only
> reason I wanted to live.

Being secure required some mothers removing themselves from their own traumatic

past experiences. Those wounded by family members when they were children vowed to

prevent the legacy of abuse. They felt an obligation to ensure that their children could

have a chance at a "nice life". Irene mentioned that she had no parenting role models in

her home-of-origin. She felt compelled to devote herself to her children for their own

protection. Her struggle was a testament to keep close to ensure their security:

I vowed before I had them that they would never go though something like I did. Not in a million years, not to my [children]. My husband was very passive and kind of let me take charge which was good because I needed to take charge ... It was well worth it ... I didn't want the cycle to repeat itself. I had to be very careful and I could never, never harm my kids ... You know they turned out fine, they're healthy, they're umm interact beautifully with other people, they're social, they have the skills [of keeping safe].

Unfortunately, their security as 'mother' became vulnerable to the assaults of illness, and they, as well as others, questioned the value of their mothering practices. Further, the mothers worried that illness was affecting their children. The security within the valued connection was threatened. Joan:

Well, I think it is the reality of hurting her that totally undoes whatever, like the disability that I think I have. Like just the fact that she is changing, she is moody whatever that means it's affecting her and trying so hard for it not to affect her you know. ... I, to a point, think I can do it but you can't hide everything. Obviously not - because she wouldn't be reacting to it.

Being Responsible

Being responsible entailed endless "discipline" and "commitment". This was an orientation that framed their being mothers. Their sense of responsibility helped them to persevere as mother; hence, the continuous nature of this line in the model (see Figure 6). Attending to the day-to-day needs of their children validated their abilities and the worthiness of being with their children. Being valued and appreciated by their children and family was "most important". Without their children, the mothers' lives would be "devastated". Irene mentioned that

because [her youngest child] was very sick as a baby and [the child] spent most of the first year in hospital, I've always just been more protective of him. And it has

only been within the last six months that [her psychiatrist] has convinced me that it is time to let [the child] go. That is not easy, but I am doing it – gritting my teeth but I'm doing it because it is what's best for him not for me and that is what I have to remember.

Even though many of the pregnancies were unplanned, becoming mothers permitted them to "grow" as individuals. Responsibility for another gave their lives "purpose". For some, the urge to be a mother was so strong that even the presence of illness could not undermine it. This stemmed from a desire to achieve a "normal" milestone drawn from their association with children. Tracy, who has had a long history of bipolar illness, explained:

> Well I wanted to be a mother because I wanted to experience the pregnancy and the whole thing aa. I wanted to be a mother to a baby. I wanted to know how it felt, the whole thing. ... But I wanted to know how it felt to be a woman, to go through the pregnancy and aa, aa have the baby and take care and the baby and see how it really was in life. I'd heard about it all my life and I wanted to experience it.

Others' accounts did not indicate such a lifelong desire for motherhood. Nevertheless, they emphasized that they loved their children, accepting maternal responsibility as a matter of course. Janice had an unplanned pregnancy within a short-term relationship she "knew wouldn't work". Her pregnancy was shameful to her family, resulting in pain for Janice. To sustain the support of her family, she had to demonstrate she could attend to her child's need:

> because I was pregnant she [her sister] didn't want me in her bridal party. That hurt me very much. Umm, I had the baby ... I would like to have a father figure for my [child] ... And [my child] is a sweetheart since the beginning like ... I had to take care of [my child], I had to teach [the child] everything, I had to send [the child] to school, I had to do this, I had to do that, like everything I had to do.

Being responsible involved providing information to their children concerning the reality

of illness. Mothers wanted their children to be more "street wise"; that is, spared the pain

associated with SMI. Their efforts to guide their children away from illness depended on

achieving a delicate balance between their ill behaviours and at the same time, provision

of "the means to live differently". Through a gentle sharing of experiences, mothers

hoped their children in retrospect would understand or appreciate them. To keep close

saved their children in the future as well as saving themselves because their children

would recognize them as people. Sally:

> She [her child] said she was sorry [tearful, pause] and I said I forgave her [pause].
> We are starting to build a relationship together but it is difficult ... I talk to my, to
> [my child] and I tell them they have to help each other later on. Life is very hard and
> we have to be there for each other and ah, I still have to say that to them some more.

With time, to keep close became more difficult. Peggy's struggle to "never give up"

for the sake of her child was painful in the context of worsening illness and frequent

hospitalizations. Peggy was frequently told by others

> ...how to raise my [child] you know and "You're setting a poor example for [the
> child]" and "Don't you think I don't know that" ... as my [child] gets older, of
> course, [the child] has more questions and [the child] can think on own now ...
> [The child] is a person with own distinct personality. Boy, does [the child] ever and
> ah, [the child] is into questioning me, "Mommy why are you sick?" And my [child]
> is more demanding than when [the child] was little that's because I've been away
> [though numerous hospitalizations] for so long. [The child] is very insecure. I think
> my [child] thinks I'm going back to the hospital any day now and so [the child]
> literally just grabs on to me [demonstrates by pulling at her gown]. ... I'm worried
> [the child] will pick up on my ill habits. I've got literature. I've gotten a couple of
> books. ... Part of me wants to be there to help [the child] along and the other part of
> me just ah, "It's a rotten life and good luck to you" and [not complete sentence]. I
> thought of writing [the child] a nice long letter explaining, you know, that I love her

and that I've always loved [the child] ... I've tried to tell [the child] it is not because I didn't want [the child] that I didn't hang around. It was just too painful ...

Obviously, protecting the children from the effects of SMI was the mothers' primary responsibility. Many mothers espoused the attitude that if they "did not measure up" it was judged to be their "own fault". Often mothers used the term 'hard' to describe just how difficult it was to determine how best to proceed in the midst of illness in order to protect their children. Paula provided an example of her ambivalence:

> The park was not far from my house and I thought the children were more independent and I allowed them to go to the park ... and I was on my way to go and get the [children] and then when I was on my way I heard the scream at the park so I rushed to go at the park to see ... and I didn't first have the choice cause what happens if I leave the house and what happens if they come to the house and I'm not here. I had two options, so what should I do.

Mothers believed that if their children saw the illness they would be "traumatized", "frightened" or "scared of" them. Hence, for security of both mother and children, they chose strategies that would imitate those of "good" mothers. The prerequisite for such pretences was fragmentation of the self-as-mother. Being responsible in illness involved mothers' reducing their genuine presence to that of a shadow self. This, in turn, required them to "balance" hiding their illness and highlighting their status. Sadly, the pathos of such manoeuver was that the inauthentic presence was visible to both the mother and child. Further, such pretences served to exacerbate their struggles to keep close in illness. Brooke had:

> ...concerns and there is no way as much – as resilient as children can be there is no way this [illness circumstances] has not affected them because there is no way. Umm, you know as much a mask as I can wear, they're [children] able to feel and

they know. [Pauses] At the same time I have this fear and it is a very concrete one, I'm also looking forward to giving them tools of showing them that there are tools available out there, and to steer them in that area so that they're not caught or they're not, you know, able to help themselves.

Watchfulness

To keep close mothers had to be watchful of others' responses towards them. Mothers' watchfulness was a means of ensuring they could maintain the valued place of being a mother. Their watchfulness allowed them to "survive" or to sustain their connections with their children. Mothers knew that significant others and, in some cases, professionals were watching their mothering practices. They thus had to be constantly aware of others' reactions toward them or their children. Hence, to keep watch was exhausting because "illness doesn't always let you see" clearly.

Significant others judged the mother against their own perceptions of the ideal. Onlookers questioned why a mother "wasn't normal" especially with treatment and with time. Mothers perceived that others' watchfulness was for the purpose of surveillance. When watched by another who was perceived as hostile, their status as mother was highly threatened. Sally acknowledged that the father of her children was vigilant over her mothering. Hospitalizations, however, interfered with Sally's watchfulness:

> I had a small house and a car. I was on mother's allowance and ah, but my ex-husband was angry because of the separation. He would always give me lots of trouble. He would call Children's Aid. They came and checked the house to see if it was ah, appropriate for the kids. They checked the cupboards if there was any food for the kids and ah then I got sick and he went to court. While I was in the hospital … he went to court and got custody of the kids. And then I had applied for disability pension because of my illness.

Surveillance by others was threatening because it connoted risk of removal and ultimately dismissal as valued mother. Hence, much energy was spent conforming to the expectations of others. As the illness situation became more chaotic, however, mothers perceived the threat of removal as imminent, especially when they were unable to achieve others' expectations. By making themselves less visible, mothers hoped they could shield self and child. Paradoxically, such a response invited the eyes of others since their mothering practices became increasingly marked by illness. What the onlooker (including their children) saw was very confusing. Betty:

> ...wasn't expecting CAS. I had to sign a contract. They say they would be involved for six months but I have no clue. They can change their mind. ...It is bad enough you are dealing with everything and making sure everything is going OK with the kids. You do this, you do that right. You double think yourself in the first place, well now, you triple think yourself. And if you do the wrong thing, somebody finds out about it, and they say, "Oh that's bad!" And they find out about it and they're back on you for that ... I don't want to feel comfortable with someone coming into my home two or three times a week. ... [The worker would ask] "How did you do this? How did you do that? How can you be a normal mother?"

To keep close was most at risk when mothers could not discern the meaning of what they saw. As stated by Heather, "Your mind takes over and it's cruel". Mothers' need to keep close necessitated caution, especially as their sense of control was tenuous. To reveal the ill self-as-mother risked a separation between mother and child. In other words, either mother or children could be removed. Thus, instead, they mirrored what others expected of them as mothers. Joan, attentive to what others said about her and her illness, stated:

....the mask is on when the door is open. When you shut the door and you're in the room by yourself and you're alone to deal with it. ... Comments and just um, just looks can even be enough. Like, "Oh you got bipolar and they let you keep your child." Like what is that about like you think I've become a total – well I don't want to use the word – but retard because of the way that I think. No I'm not but others think [so].

As their situations became beyond their own control, to keep close demanded that these mothers be even more watchful. Yet, the "haze" of illness "blurred" their vision. In other words, their ability to discern what they observed became all the more difficult. Unsure of how to act, some "did nothing". Others interpreted such a lack of mothering practices as "bad" or "not loving." Heightened watchfulness served only to consume more of their limited energy. This may also explain their inability to act in the moment. In retrospect, Mary regrets her inability to be watchful over her connection with her child. In retrospect, if she had been more watchful, Mary would "really be a good mother":

> Whereas other people in their lives who have a more stable outlook - they don't have problems realize ... "I'm going to hug and kiss that kid as soon as he's born." They see that picture where it takes others like me longer to see that picture. When I look back I had no idea why I couldn't get off medication and really I couldn't get off medication because I do have a problem - my life was so unhappy...

The mothers' ability even to see their children possibly remained their final recognition of self as mother. Even when children lived with others, to physically see their children was affirming. Mary had "to get a court order to see" her son. As another example, Tracy, dismissed by others as mother, remained watchful for the sake of knowing that her child's needs were met. Tracy would:

> ...never deny that I'm a mother. I know how it feels to be a mother and to be denied seeing my own flesh and blood. I know how that feels. I like to see [my child] more

often and maybe [my child] will understand easier – more easily. But I've been dying to tell [my child] for so long, you know, and I know [my child] will understand. I know [my child] has to know and like I say in [the child's] little mind there is some kind of idea you know that [the child] has a place there at our home. [The child] has a place.

Some mothers sought help from particular others. They invited the external eyes of others to alleviate their worry and exhaustion over losing sight or connection with their children. These selected others were to assist mothers in meeting their children's needs or to help them understand their situations. Such an offer was extended only to trustworthy others, those who validated the mothers' abilities on the mothers' own terms. Often, mothers had known them over an extended period of time. A constant fear for Connie was that her child would be removed or abducted. As a result, Connie hesitated to go outside her home unless accompanied by others who could also watch over her child. Connie described herself as:

...still protective. I still get panic attacks and anxiety if I bring her [child] to the lake. You know, you might turn around and someone might take your child from you. [Her child] is still young so that's the main concern to bring [the child] to public places and keeping an eye on [the child]. I feel safer when there's two people involved in the child care. ... You have to really protect them and you have to keep them close to you. But [her child] is really good with me. [Her child] stays close to Mommy you know. Doesn't wander off too much ... but now I worry. It is a constant worry. A constant stress. You know, make sure your child's safe. Make – like now [the child] is going to start school.

In/visibility

For these mothers, it became an overwhelming task to keep close while simultaneously keeping illness away from their children. Serious mental illness required

mothers to strategize in order to keep close. As depicted in the model (Figure 6), illness is represented by the area extending from the core to the boundaries of each of the three encircling coloured lines. Illness disrupted the fluidity of their mothering patterns. Mothers described illness as unexpected, overwhelming, a living hell, unreal, cruel, frightening, isolating, never ending, unbelievable, hurtful, overpowering, unforgettable, failure, loss, worsening with time, and unpredictable. As opposed to being static, mental illness was dynamic. That is, it was up/down, high/low, in/out, peaked/dipped and pulled/pushed. The boundaries of these dialectical positions shifted with the nature of the illness experience. Oscillation between such extremes was "constant". The motion was described as spinning, riding a roller coaster, vicious circling, and/or downward spiralling. Constituting the spiral dimensions were the severity of symptoms within diverse mothering contexts. Besides illness, mothers lived with such issues as abuse, poverty, lack of resources, child health problems, a partner with health problems and "not knowing" how to maintain loving relationships with their children as expected by society. The interrelationship between such variables served to intensify the turmoil of illness, further de-"stabilizing" their ability to mother.

During spiralling, the cause or effect of this "chaos" became difficult to recognize. The nature of illness circumstances overshadowed their desired mothering behaviour. Shifting the focus away from being with children, the motion subverted their energy to illness. Alice stated:

...like at night you know I'd finish the dishes and that, and spending time to sit with the kids like to make a puzzle or color or you know but I couldn't sit for long. As soon as we're done like I'm up. I would tell myself I should be able to sit in the kitchen and that's where we have some quality time, no TV or nothing, but it was hard to sit. And then I would reproach myself because its' like, "These are your children. You love them." Like you know, they been at the sitters or whatever, this is my time with them and it shouldn't be like a chore. It shouldn't be like that.

At every turn, metaphorically speaking, mothers were confronted by 'what was' and 'what ought to be'. Attempting to find "balance" in downward spiralling was illusory. Support, medications and hospitalizations provided only snapshots of balance. Connie stated that receiving a diagnosis of schizophrenia after twelve years of turmoil was a relief:

I lived with my mom and dad and I separated from my husband for a while because we were not getting along ... but my mom and dad helped me quite a bit with the child care and my mom was very good [pause]. She feed her [child] when I was sick. ... It was just this terrible, terrible, terrible depression that I never felt before. I didn't have the will. I didn't have the energy. I didn't have – then I was hallucinating so it was family that helped me out. Well actually I went into the hospital ... and then once I got out I was still sick. I was still depressed and ah, ah, unfortunately I had suicide attempt and I drank. ... Now, being diagnosed is actually a relief. You know why? Because I've gone through twelve years of being scared and frightened and hiding and then know - knowing now that yes you do have this disorder and it could be helped with medical care. The only thing I'm frustrated about is there is not a lot out there that you can go to for help. ...Take it day by day. You hope for the best.

Their mothering practices became coloured by the "blue haze", "fog" or "opaque[ness]" of illness. The haze blurred what they saw and what they thought in their struggle to mother. Some mothers relied on others, such as their children, to help them keep close. In this way, children served as beacons in the fog by highlighting their difficulty in mothering. Janice says of her child:

My [child] knows that I take pills you know and sometimes [the child] will even [not complete thought]. [The child] is seven [pause]. [The child] will give me exactly what I need you know like, "Oh well, thank you." ... Ah, [the child] says "I'm silly". If my [child] says "I'm crazy" well you know [laughing].

For others, the haze was so engulfing that they missed the cues of their children. The illness situation reinforced their doubts as mother and gradually, they lost awareness of mothering. For Betty:

It is just so hard to explain how it is like. If I'm sitting with the oldest [child] and the [child] is doing work like reading the book and I'm already in one of those really low moods and when [the child] is – reading and just goofing off, and I know goofing off which gets me even going, "You can't do this" and you go lower. ... Or the youngest one, my brainiac [pause] - can get very frustrating but then will help with different little things. You don't.even notice until it's actually there, right in front of your face. Even to have that happen again [pause, change in tone] sometimes it's like you wish you [pause]. So, I don't know it is still hard to explain.

In/visibility

To be recognized as a mother meant to keep close to their children. In the context of illness, however, mothers' struggles to accommodate resulted in practices that cost them their integrity. Mothers subverted their authentic identities behind acts of "camouflage" or invisibility. Strategies of *in*/visibility were employed to make illness separate from their connection with their children. The presence of illness influenced how the mothers wove the strategies. Hence, for each mother, the appearance of the lines of in/visibility in the model (Figure 6) would be unique. When the lines of in/visibility crossed over the core, mothers experienced a connection with their children. Illness, however, interfered with the fluidity and purposefulness of invisibility. The greater the risk of removal, the more

mothers found it necessary to narrow their focus to keep close. To navigate in the chaos of illness eventually caused the strategies of invisibility to unravel. Their "points" of connection with their children became less frequent as illustrated in the model.

The "/", or slash in the term in/visibility, denotes the dialectic, the impossible position of being at once hidden for protection and vulnerability to loss of self-as-mother or children. By portraying symbolic representations of the ideal mother, mothers believed they were protecting their children. In addition, they were immunizing themselves against the effects of illness. The in/visibility strategies of masking, censoring speech and doing cloaked the undesirable sick status. Thereby, mothers were able to sustain closeness, but only to a point. Tragically, for some, such actions were life threatening and became the signifier, the moment of visibility. When most ill and in suffering, they questioned the value of remaining as mother. They risked losing the connection even, in desperation, contemplating of suicide. It was wounding to them to realize that their efforts of in/visibility were meaningless in circumstances of chaos; that their illness was out of control; and, most importantly, that they had inadvertently harmed their children. This typically necessitated help through the mental health care system. The following discussion addresses each of the three strategies of in/visibility. The mothers' crafting of strategies depended on the unfolding of their situations' illness and suffering.

Masking in Illness

Mothers wore "masks" to portray an image that censored illness to keep close to their children. This was achieved through such means as pretending and physically removing self from their children. Since they wanted to hide their illness experiences, the mask created the illusion of what mothers believed others expected of them. Some mothers viewed masking as a moral obligation to their family. Serving to mitigate the effects of illness, masking was "always, always, always" critical "for the sake of the kids". Masking in illness allowed mothers to appear well or to project the image of "strength" and "wisdom". At the same time, they were aware that masking was "a lie", "a pretence", a "foolery" – a misrepresentation of their authentic being. In fact, it was painful for mothers not to know how to connect with their children in illness. Irene hid her illness by

> [j]ust putting on a happy face and pretending everything is fine so nobody worries or gets upset. Everything is fine. I didn't know how supportive my husband would be and I never relied on anyone but myself. So all that keeping it hidden, keeping it from him was not letting myself be vulnerable enough to be hurt.

Their expertise in masking was deemed a performance, an art that could be mastered. To determine the degree of masking required to remain in/visible, mothers had to depend on their judgment of others' perceptions. Adopting a mask that would pass for "normal" was perceived as worthwhile only if "it kept illness way from" their children. Further, the mask protected their vulnerable self through this distraction. Their children and others had to believe in their charade for fear of losing the ability to keep close, while

the mothers viewed masking as a means to function as mother. Masking, then, helped them mimic the ideal of being productive and valued. For Brooke, such masking meant

> [k]nowing you must attend, but you are not mentally, emotionally there ... [pause] you want everyone to mix with your own expectations. You want everyone to see that everything is OK at any cost. That is what they [her children] saw because the kids, as far as the kids are concerned they're very nurturing children, they're very well-balanced. They are normal children to the extent that normal can be right now ... so when, whenever someone looks at the children they are doing well in school right now ... And of course I am the master of masks so you can't see really well unless you are right inside.

Depending on their audience, the mask served to protect others from the mothers' illness. Many of the mothers found over time that others were neither "interested", "willing" or "allowed" to go beyond "the superficial stuff" or the mask. In light of such circumstances, mothers perceived their status as secure. At times, mothers welcomed others' efforts to reinforce their inauthentic presentation. Kathleen:

> ...depressions then only lasted three to four months, you know three months I lose the 30 pounds you know what I mean and my husband would, would cover for me you know even when my family calls. I'm used to hiding it you know ... because it's a weakness [change in tone] you know - it was a weakness that I didn't want to admit.

As illness and time unfolded, masking persisted, giving the appearance that mothers were able to meet preconceived standards. Increasing symptoms, however, made it more difficult to perform masking. They could no longer hide their difficulties behind a façade as their illness became more apparent. Masking for the mother became confining and detrimental for self-as-mother. As one mother said, "I could see myself losing touch with a lot of stuff." They became lost among their inauthentic pretences. Hence, some mothers,

like Joan, amplified their masking technique only to find themselves caught in this vicious circle:

> I, to a point, think I can do it but you can't hide everything. Obviously not - because she wouldn't be reacting to it. ... I tried to pull away from any situations that make me angry when I know that I'm manic or depressed because anger comes from depression too. I just try to pull away. I try to remind myself that [my child] is four so you got to work with [the child] because [the child] doesn't understand everything you do or lack of – whatever. I don't know any other way. I don't know. ... yet you are expected to function, societal conventions say you know I'm suppose to have an educated child with nice clothes on my [child's] back and my child's support to be really happy, healthy whatever ...

Masking, in itself, was an exhausting task. It required "determination", "strength" and mothers' watchfulness to remain in/visible. With energy focussed on maintaining the illusion, inner turmoil became out of control. Ironically, relying on the mask mirrored what they were attempting to hide – their illness. The mask became transparent, revealing the broken self-as-mother. As one mother put it, it was "I no more". According to the mothers, others became confused with the masks, the illness, and the discrepancy between what the mothers said and what they did. The heightened vigilance of others increased mothers' sense of imminent risk to their status. Mothers recognized that even their children "knew I wasn't myself. Or that their mother was "not the true self". Alice, who was overwhelmed by her illness situation, explained:

> But I even sense that my [child] was like pulling away from me. I don't blame her. I'm always angry. My husband said like, "You should see the look on your face" you know. You're suppose to protect them not not scare them. [Pause] "God, you scare them." But my husband was very supportive, like I'm not [moves to another idea]. You know he was trying to make sense of the whole thing and all that and ah ... he said go to work and we will talk after. We will see what we can do and in the meantime he called [for help].

One mother stated her masks were "slipping" when illness overcame her. When

unable to mask any more, some mothers resorted to physically removing themselves from

their children for varying lengths of time. By withdrawing self, they could be alone with

their pain, that is, authentic. Sadly, this only served to yield further "hardship" for self-as-

mother and guilt. Melanie:

> ...if people knew how much time I've spent crying in bathrooms you know I've just spent so much time crying in bathrooms just out of sheer unhappiness. ... Sit in the bathroom and you cry and you cry and you cry. And you stay up night after night, sleepless because with depression comes sleeplessness and you lose weight and you lose weight and you lose weight and you know, "You been on a diet. You look great." "Gees thanks." The least of my problems. Meanwhile you look like crap ... you have a hard time focussing, you are not doing your job...

For others, work, for example, was a "refuge" as they could express their authentic self.

Work provided a physical, emotional and cognitive release from the turmoil of mothering

in illness. For example, Rachel said:

> My kids would see me crying, "Why are you crying Mommy?" "What's wrong?" Too much stress. I love the children but I just couldn't do it no more. I go to work and people would have no idea of what I was dealing with at home. At work I'm a different person. I'm a totally different person at work. I can function. It was just a relief. It was like a weight was off my shoulders. I'm me at work. I'm just me. I go home and I'm different, someone I don't want to be [tearful].

The unwitting tragedy of masking is that the mothers' illness overtook them despite

all efforts to appear ideal. As much as the mask hid the authentic suffering, it highlighted

their inauthentic presence with their children. Such realization was the deepest point of

their suffering as the reality was, for some, that their children were also masking. Irene:

> They [the children] came first and for a long time I was totally stunned that my [oldest child] umm, needed to be [admitted to a program providing children

psychiatric services] and needed the help. I had thought that we always had a very open relationship, umm, but she didn't tell me. She hid it, she hid it well but I guess she learned from the best.

In essence, their desired relationship mirrored the shallow representations for both the mother and the child.

Doing in Illness

In illness mothering was reduced to "doing": a "mechanical" or "automatic" mode of being present in order to meet the children's basic, daily needs. Doing was the act of being mother in-relation-to their children. As a routine, mothers did not expend energy beyond what they could in order to provide for their children. By focussing on daily tasks, they attended to their mothering duties as "zombies". Hence, their ill self-as-mother remained in/visible. By distancing self from her own body, a mother could give the illusion of control. The choice of routine focussed on what keeps the child central and, therefore, close to mother. Hailey provided an illustration of such routine:

> On Saturday ... don't ask me to make a sandwich for a kid because I won't get up to make a sandwich because it is my day off and then on Sunday is my day to clean the house and then Monday I go back to work and do it all over again, every week. It is a routine. You have to do it if you're a mother. ... By the time I finish the 8 [hour shift] at work, I go home and do my shift at home after and by the time when my [youngest] goes to bed at nine and my [oldest] goes to bed at 10, I'd usually watch TV by myself for an hour, for an hour and a half and then I go to bed. And then I wake up at 5:30 again - and two, three times with my [youngest] during the night. I'm sleep walking by now. It's a routine I probably do it in my sleep without even realizing that I'm getting up doing it.

Despite their illness, mothers continued *to do* because they could not afford not *to do*. Mothers believed that doing signified their ability to mother; "doing it" at least affirmed their value. It had the advantage of highlighting *do-ability* while hiding their illness. To step out of the ritual would cause great anxiety, could make them responsible for the loss of their children. The doing, tragically, was a trap, as mothering became a "chore" in its task-focus. As Alice put it, she became caught between doing and undoing:

> I didn't know where to turn. I, I just [pause] umm, like umm, I was on automatic type of thing. Looking back I don't know how. Of course the cleaning became more and more obsessive. Like I get up during the night to go to the bathroom and then go check on the kids and straighten out a few things - like there is toothpaste in the sink I'd wash this and I wash all the cabinets making sure everything in the house was [not complete sentence]. Then I go back to bed. ... and wake up in the morning like I haven't slept.

As the mothers know "no other way" in their illness situations, doing constituted "caring for" children. If Janice didn't 'do it', it became more apparent how ill she was:

> You don't have the drive to do it ... You don't have a life. You are tired and you just go to work, oh gee. And you just do it, take care of your child because you have to. You have to. You have to in the situation, like I'm a single mom. If I don't go to work I don't get any money. ... I almost lost my place if it wasn't for my sister and uncle helping me out talking to the girl there who owns the place. I'd almost lost. ... Financial was the last thing on my mind. My [child] comes first. But now I'm organized like so much is going into an account...

Even in illness, mothers did not seem to question their duty of doing. The unwavering attitude that "you have to" was rooted in the image of "good mother". Such security, albeit false, would minimize the risk of being separated from their children. Inevitably, mothers realized that the "doing" of motherwork was becoming meaningless. Mary explained:

I had a kid to look after so it was important to know how. You would do the best
you can. I would push myself in determination I would do it. It's just you do it, but
it would have been much easier if I would have had information. The "Nike" thing –
you just do it. You keep pushing and pushing. Like I said I wish I would have spent
more time interacting with my [child] really be a good mother …

To an outsider, their doing met the standard obligation of parenting. In this regard,

the outsider would have little reason to be concerned about the mother's ability. When the

outsider noted gaps in parenting or when the mother could no longer persist, then help to

do was either requested or imposed. In some situations, family members highlighted to

mothers their inabilities to meet the expectations of mothering. Others wanted to protect

the children from their mothers. When Paula was most ill, her dismissal as mother was

described in terms of pain and trauma:

My mom didn't want me to live [in same city as her] because she had the children
and we were fighting at this time. And we had an argument and I felt like she wasn't
even there for me at this time but I think she was protecting, protecting the boys
somehow.

Regardless of who requested help, the effect was to remove the mother farther away from

the children. In other words, contact between mother and child was less frequent. Sally

lost custody of her children when she was "ill, ill, ill". She

...wish[ed] I could have grown up with them and taken care of them. I wish I could
have been healthy and ah, I'm not that healthy. … When my oldest [child] wasn't
seeing me he [a health care professional] told me to write to [the child]. So I did. I
wrote. I sent out postcards in the mail.

When possible, mothers would allow others to do the routine. Others were typically

family members – partners, grandparents, extended relatives. Family served as the first

line of assistance to help them maintain and fulfill the day-to-day demands of parenting.

Mothers did not necessarily want to relinquish their role to family members; yet they

needed them when they were most ill. In some situations, for the sake of ensuring their

children's safety, mothers would invite family into the home or let their children reside

"temporarily" with another only after negotiating some "ground rules." As Kathleen's

symptoms worsened:

> I wasn't with it you know to talk with [my child] any more or to be there. I was like
> a zombie. You know I would go on a frenzy cleaning throwing things away and it
> just got so terrible and that thought [of self-harm] entered my mind. You know that
> thought would never enter my mind before ever. You know if he [husband] left
> town and I was home alone with [the child] and that's when I got someone I know
> to make sure I didn't do anything stupid like.

Regardless of how helpful family members were, mothers definitively asserted that others

could never replace them as mothers. Heather matter-of-factly stated, "children will

always need their mother." Mothers were acutely sensitive in not wanting to be replaced

by the routine parenting actions of others towards their children.

To keep their children close, some mothers had to put aside their feelings of anger

toward their family members. Through mothers' inherent connections with their family-

of-origins, they would be connected to their children by default. They were unwilling to

risk either their children being totally removed from family or their status as mother.

Despite not being able 'to do', mothers remained watchful of other 'routine-providers' as

an ongoing measure of contact. Rachel perceived her husband as "controlling" towards

her. Yet, when she could not longer attend to the day-to-day responsibilities of child-care,

she relied on him. She told of this routine:

> ...getting them up, dressed, breakfast, driving two to school, coming home and
> entertaining two, putting the baby down for a nap, entertaining one, lunch,
> entertaining some more until picking up the other two from school, doing
> homework, making supper, then my husband comes home then I have time with
> him, and then bath, bed, time for myself, bed. ... I'd gave up. He [her husband] took
> them over completely. He runs the house. I didn't want to do. ... I bring in the
> bigger salary, I pay for the house, I pay the bills. I take care of that. I'm more than
> capable. I've tried to take care of the kids but the past year I've gave up. I've gave
> up. ... Let's face it, he – he's done a good job with the kids.

As a consequence of 'doing', reciprocity was limited. Mothers were unable to do

"with" their children because of their "limited tolerance" and increasing exhaustion.

Mothers found it difficult to attend to the changing needs of their children. They were

reluctant to let go of the doing since that would mean that they would lose the esteem of

those they valued, their children. Hailey's routine had difficulty accommodating to her

youngest child's needs; those needs kept

> [b]luilding up, building up, building up...Like with me [my youngest] is still a baby
> like a year old but with the babysitter [the child] is a grown up. [The child] does
> everything by himself -gets dressed, brushes, eats. [The child] does everything by
> himself with the babysitter, with daddy too, but with me I get "mommy, I need help,
> can you do it for me". What does mommy do? She does it.

Although doing offered a context of security and responsibility for mothers, it

nevertheless posed problems to keep close. Their efforts to identify "the specific source of

the problem" in turmoil became increasingly difficult if not impossible. Therefore, they

were unable to draw on resources to assist them with problem solving. Their children,

meanwhile, began to "move away" toward other family members to get their needs met.

Betty provided an illustration:

> I'd be sitting here and I'd say. "Ok, it's been a bad day. I don't feel like doing nothing." Kids come home and you just want them to go do what they want to do. But as a mother you know you can't do that. You got to make sure they get their homework done, got to make sure they do this and you got to make sure this is done. So you just [pause] the kids all come to where ever I am if I am having a bad day, they sort of know. Then they will say, "I got this, this." [Betty asks] "Did you do this?" [In response] "No." [Betty then inquires] "Why didn't you do this?" [The child replies] "I don't know." "Go do this [instructs Betty]" It's <u>very very frustrating</u> when you're trying to deal with the kids. ... Sometimes, depending on the situation, if they're really getting to the point where they're not doing nothing and they're just getting frustrated, then that's when it's everyone in their corner instead of pushing the buttons.

Censoring Speech in Illness

To keep close, mothers were very cautious regarding with whom, what and how they spoke. By censoring their speech, mothers believed they could conceal the severity of their illness from those who were watching. This strategy of invisibility offered a relative veneer of safety from others' scrutiny. From experience, mothers knew that expression of genuine thoughts, feelings, beliefs or experiences risked being discounted. Realizing that their words were overshadowed by illness, they hid their authentic presence behind partial disclosures or empty words. Their attempts to portray the desired ideal through censorship served to highlight their illness eventually to themselves and others. Heather kept secrets so as not to appear lacking or removed from "normals":

> I knew there was something wrong because when my child – regardless of how I loved my [child] – I had thoughts of hurting her, so I have to put her down and I couldn't understand why I had these thoughts and that when I knew. I kept that a

secret because I was ashamed … Umm, I'm not a murderer. I love my children. I wouldn't do anything to hurt them but I had those feelings and I knew they were normal and people don't understand. I was, I was scared to tell someone. They would have told me that I was crazy first off and which I probably was to a certain extent and umm, I was scared of losing my children because I had those thoughts.

The purpose of such censorship was to keep close with their children. With their children, mothers spoke cautiously so as not to frighten or overwhelm them. Depending on who was listening, but more particularly for their children, mothers spoke as if to mimic acceptable others, spoke in code or were silent. All forms of silence serve to dampen their authentic self. Joan:

> My biggest fear is when [her child] finds out that I'm bipolar that, you know, if [the child] finds out young, "Why is mom's brain not working right" or whatever like. I don't know how to explain it to a child … Like the one night [her child] was talking to me on the phone and was singing to me, like keep signing to mom [pause] "I'm done mom is your headache better?" [asked her child]. And I thought more of a headache than you will ever know. I didn't know what to say. Poor thing. [The child] is left in the dark.

Like Joan, other mothers struggled to find the words to help their children understand their situation. Mothers hoped that the heard voice could then be identified as belonging to a mother in control. Spoken words or silences would inevitably reveal their struggles. Kathleen would:

> …tell her [child] I didn't feel well, my period or something like that but now I can't fool around with that no more because [the child] is too smart, you know… like [the child] kind of wonders sometimes you know why you know "Mommy want to come to the park with me?" "Oh, mommy doesn't feel well." "Mommy's sick all the time" [the child's response].

Sadly, however, the mothers identified that the children 'heard' their ill body, such as through crying and yelling from frustration, and informed their mother of how "silly" they sounded.

There were chosen others with whom they shared pieces of their story; however, they would not disclose the 'whole' story. Their openness was delimited by the experiences of suffering in illness. Connie believed that

> ...sometimes people just don't want to hear. They don't want to be bothered by it. I don't think they want to know. They just rather have the surface ... I think over a period of time you keep too much in and then you relapse ...

Sensitive to others' reactions toward them, mothers learnt the necessity of suppressing their own speaking. Rather than losing contact with significant others, mothers would fragment their experiences by giving others only "what they wanted to hear" to avoid misinterpretation. In essence, they became fragments, and the fragments could not represent their self-as-mother. In addition to illness and social expectations, maternal voices were constrained by such factors as their history, valuing "private is private", especially if they were survivors of abuse. The words were trapped in empty stories as the mothers juggled between maintaining privacy and guarding their information. Kate mentioned that to speak "is embarrassing for me."

In/Visibility

Retrospectively, the mothers realized that there came a point in time when they could not keep close. This point was metaphorically characterized as "hitting bottom" and

was always unexpected and fleeting. This is represented by a broken horizontal line in the

model (Figure 6). From the place of bottom, mothers recognized how far removed they

had unwittingly become. The bottom was considered a shameful place, and the descent to

and the hitting of bottom signified suffering. They sensed distancing from others,

including their children. They became uncertain how to provide and protect their children

as their situations developed beyond their comprehension. The discrepancy between their

mothering and its meaning exposed them. Mothers could no longer keep close because

they were enveloped by suffering. The shadow of self became profoundly visible.

Mothers were confronted with how at odds they were with whom they longed to be. For

example, Melanie:

> ...when you are caught in illness for me, this time this was a big one for me – what
> got me here [admitted to hospital] ... I looked around me and like, "Look where you
> are" you know. And that is when I realized how far, how far I had gone

Suffering is represented in the model by the grey shaded areas, with the degree of

shading illustrating the intensity of suffering. There were two conditions inherent in

mothering in illness that trapped them in suffering – alienation and uncertainty. These

conditions undermined their connections with their children, that is, their place of

meaningfulness. Alienation and uncertainty cultivated shame at the bottom. The

revelation that self-as-mother held no meaning was shaming. "Being ashamed" and

"guilt" were terms used by mothers to express their remorse concerning their mothering,

retrospectively. As a point of clarification, mothers did not distinguish between illness

and suffering. For them, illness transformed into suffering as their situation became out of

control. The meaningfulness of their in/*visible* strategies became obscure, and in chaos, the boundaries between illness and suffering blurred. The realness of their situations was beyond their comprehension. This made it difficult for them to categorize or find words to explain it. As Rachel stated, "It's crazy. It's absolutely – there is no other word for it – crazy." As illness circumstances "invaded" their self-as-mother, they became caught in suffering.

Being trapped in suffering constricted their ability to mother. With increasing turmoil, mothers were unable to discern how to continue being a mother and mothering. Their mothering pretences were incapable of sustaining them in an authentic relationship. Paradoxically, in/visibility strategies did not free mothers to represent their ideal images; rather, the strategies complicated their chaos. Exacerbating their situations, mothers realized what others had known all along, that they could not keep close. The realness of their circumstances was beyond their comprehension, making it difficult for them to categorize or find words to explain it. Some of them displaced their pain to their private spaces. Mary recollected that when she was very ill, she recognized herself

> ...sinking and I was terrified to be left alone with him [her child]. I would tell my husband at that time, "Don't leave me alone with [the child]. I'm afraid something might happen. Don't leave me alone. Don't leave me alone." And he'd say, "Well, there's nothing wrong with you. You got to get use to [the child]." Like he didn't understand. "Don't leave me alone. I'm afraid of what I might do." ... If you're so overwhelmed [tearful], you do things you shouldn't be doing like trying to slice your wrists. ... slitting your wrists or doing anything because you have so much pain you don't know where it goes so you turn it inward on yourself.

Being trapped in suffering also fuelled the spiral to the bottom. Some mothers were not necessarily aware of becoming entrapped due to their situated chaos; others were just too exhausted to act. The "nightmare" of Melanie's circumstances "landed" her at the "bottom" because she "ran out of masks" and "was exhausted on all fronts." Melanie elaborated on how her situation

> ... spirals out of control ... Like for myself, umm, [pause] depression is one issue. If you then tag it on to poor choices that you make in life or problems that you are having even in relationships, work related issues and you compound, you put that together with problems with depression ... it was like there was a mountain coming towards me and I didn't know if I would ever get over it and I made a couple of really, really poor choi – relationship choices in my life that I never thought.

Although some women had 'hit bottom' previously, each subsequent 'hit' was more despairing. Kathleen explained:

> And it hit me hard, hard. Nothing like this. This is the worst. The worst I've ever had. ... It's like you are not there I find. You know it's like you're there but you're not. You're not really in the world. Like ah, you're there but you're not.

The suffering was so deep that they wanted never to experience anything like it again. The depths of despair were poignantly illustrated by a mother's statement: "Oh my God, what have I done". The ability to keep close, weakened by the distortions of strategies in illness, severed the "bond so strong" with their children. The pretences they had once relied upon were now realized for the façades they really were. Many recognized that fracturing themselves did not protect their children from witnessing illness. Several mothers, as well, realized that their children also became trapped within in/visibility.

Indeed, the children may not have comprehended the meaning or significance of the situation, but they were aware of the turmoil. Kathleen knew her child was

> ...different, different from other kids but umm, maybe [the child] seeing this [in reference to illness] is good but it is not good yet. ... like it's too bad I couldn't just stay home and spend more time with [the child] like I used to. ... [The child] would like a home life like we used to have you know.

In brief, being visible in suffering reinforced their meaninglessness, and being trapped in suffering served to weaken the ties with their children. This further revealed their mothering struggles in illness. Alienation and uncertainty embodied suffering, pulling them to the bottom and keeping them there. They felt powerless at the bottom, with many regrets, along with the perception that their remaining choice was at the cost of self-as-mother.

Alienation

These mothers suffered in part because of alienation. Increasing isolation left them doubting the value of their responsibility to their children. Diminishing recognition of them as mothers by family, including their children and others, was also alienating. Often, the label of mental illness became the main characteristic of the mothers, who became identified through the symptoms of their illness. They were no longer considered mothers in their own right. Some had difficulty being discerned as mothers in the midst of illness. Joan explained how it was for her when her parents could no longer see beyond her illness:

It's just like handling something with – like walking on egg shells – that is like how I felt he [Joan's father] felt like it's umm [not complete idea]. They [Joan's parents] understand to a certain degree but they don't. Like, "Why is this affecting our grand[child]? Why is this?" You know. "She's got enough to deal with, don't give her that." As so it could be taken away like you can't. Like this is where I am, who I am. No, now let me change that. It is not who I am, it is what I've got. They [her parents] don't differentiate between my personality and my disorder. That's a hard one. They have done that countless times [tone became much softer].

In this text, Joan spoke of her alienation, reinforced by others who unwittingly blamed her for her child's troubles. Alienation made it difficult for her to speak about the reality of her mothering circumstances. Thus, Joan was trapped between tending to her child, meeting her own needs, and acting according to the expectations of others.

Joan echoed what many mothers perceived: family members had only limited understanding of the turmoil in their suffering. It is important to note that mothers revealed that some family members were also dealing with their own personal issues. Family members' personal issues were compounded by their confusion in relation to the unfolding circumstances surrounding the mothers' illness. As mentioned earlier, family were asked to assist with the day-to-day parenting, but, family's limited understanding of illness may have prevented their helping the mothers to navigate in the turmoil of illness. To share suffering, even with those they trusted, was to acknowledge their "incompten[cies]" as mothers. The mothers knew the topic was taboo, underpinned by the shameful theme of mothering in illness. They could persevere only by shouldering this burden, which eroded their own sense of security. This was the painful daily struggle that

contributed to their exhaustion. Brooke did not share with her husband her inner disharmony:

> ...in my heart they [family] were aware [of suffering] because – himself probably at a subconscious level to start off. He really didn't voice it you know, he didn't say, "I'm worried about you".

Others' silence or lack of recognition of mothers' attempts to keep close in

suffering, intensified the mothers' sense of alienation. Both being a mother and keeping

close were difficult in such isolation. Melanie was unsure if her parents realized the

depths of her suffering:

> Even though I've always had my parents – my parents have always been there – they always been very, very good but they've never known the extent or have chosen to ignore it. They have seen my depression. They know I suffer from depression but they have never wanted to acknowledge the extent of which. For them, it's like, "Oh, come on, pull up your boot straps". You know what I mean. "You got kids." I know that, and I'm doing my best. I'm doing what I can.

With reminders to behave "as a mother should", these women felt they could not

explain or argue against these constricting expectations. They continued to put aside their

needs for the sake of the children. Failure to attend to their illness made the symptoms

more difficult to hide and illness, in turn, constrained their mothering abilities. Then the

visibility of illness contributed to their dismissal as a valued parent. Several mothers had

only their families to rely on. Exposing their suffering to others outside the family would

reinforce their shortcomings as mothers. Betty knew that exposing her suffering to others

risked loss of her children:

> ...I have to say the school has to understand that this is an illness suffering more than like cancer or diabetes, and they just can't jump down on your back every two seconds that's one thing. That's definitely one thing and two, society in itself has

come down very hard, very, very hard and you're unable to be a fit mom when in reality I can if you stop, if harassing and second guessing us.

When some mothers sought parenting assistance, others often reacted to the presentation of illness, instead of the request for support. As such, the mothers felt increasingly vulnerable in visibility. As they no longer knew what to do to keep close, they remained silent and immobile. As an example, Paula discussed the trauma experienced by her and her children as others intervened 'on her behalf':

> I feel like they [child protective service]...I was seeking support and they were really rude, and they said, "You're not getting that." I asked, "Give me any support somehow", like they just took the kids away and I felt like they just kind of raped me. Like my, I asked to go for a support group and they said, "No". Like I felt I was discriminated. My health wasn't good.

When mothers' attempts to secure help were refused, this reinforced their own devaluation of self-as-mother. They had to mechanically 'do' mothering, as they otherwise were completely enveloped by the suffering, and their sense of alienation made the suffering "unbearable". Nevertheless, the mothers would persist in their mothering, albeit in self-blame and isolation. They could no longer plan for their children, as their situation was unpredictable, and they felt helpless. Melanie hoped for some tolerance and respite by

> ...sitting down with my kids and say, "You guys, Mom needs a break. Mom has had it." And there is a lot of guilt... There is guilt with my depression. There is guilt toward my children... But you know what, if there is something I'm going to do it is to stop feeling guilty because if there is anything worse than being depressed it's being guilty.

Ironically, these mothers could not release the sense of guilt of their perceived transgressions of mothering in suffering. Believing they belonged nowhere, they were humiliated with their own despair and intensified dislike for what they had done. Despite the loss of her own sense of self-as-mother, Peggy still regarded her child above her own existential angst:

> I want to do what's best [pause], I don't care about myself, I don't give two shits about myself, but I care about [my child] and I want to do what's best for [my child] but I, I just can't, ah...one day I'm sui, sui....well, I'm suicidal pretty well every day, but ah, one day I got a plan and I'm going to follow through and then the next day, ah [sigh] I keep plugging away and [sigh]... I just hate what I am doing to [my child]. I just feel like I'm ruining [the child's] life.

In this situation, the mothers lost any self-respect they had had, and worried that they might have caused harm to their children. Undermining their mothering standards was "heart breaking". They became aware that the relationship they desired with their children could not be attained through strategies of in/visibility. Some mothers spoke about how their children were now "frightened" by them. Kathleen talked about how she, as a mother, harmed her child. Unfortunately, this realization came at the cost of losing the bond with the child. Kathleen:

> ...actually you know the turning point was if I was doing damage to my [child] and I noticed [the child] getting damaged. I noticed [the child] getting confused... and saying, "Oh, my God, what have I done?" See I remember basically everything, where some people don't, I do, you know what I mean. I wish I didn't, you know. I really wish I didn't you know. I really wish I didn't because the guilt you know is like [not finished sentence].

At the bottom, the mothers perceived that they "failed" as mothers and that their presence made things "worse" for the child. Hitting bottom was the moment that the

mothers were confronted with their anguish, that they lost their place as mothers. Tracy's situation demonstrates how removed a mother could become. By losing her value of mother, she was pushed to the periphery:

> My [child] knows [he/she] has a place here, but [the child] doesn't understand quite totally yet, you know, that we're the real parents. It is hard sometimes. It is depressing a little bit but I have to say to myself, "Well, [the child] is well taken care of." Like my mother says, [the child] is in the family. [The child] is still in the family, you know, and it could be a complete stranger who has [the child], you know. So, at least, you know, where [the child] is [and] you can contact [the child] and even if they [legal guardians] don't bring [the child] every time you like [the child] to come, at least you know where [the child] is [pause]. So, I have to calm myself with those thoughts because it can be a bit depressing, distressing, you know, "What goes on in that house? Do they give [the child] the attention [he/she] needs and everything?"

There were external signs that their place as mothers was no longer recognized – the children were removed either voluntarily or involuntarily. The mothers suffered increasing turmoil and were at the brunt of the hostility from others, blamed for having caused this situation. That they felt ashamed was irrelevant to others, according to the mothers. Internal signs of distress included questioning if they should "ever have been a parent". For some, this questioning resulted in not wanting to continue to parent for the sake of the children's well-being. Their inability carry out their responsibilities for their children was shaming. Susan explains that at the bottom, there is "no more to give" whereby mothers are unable to "even consider anybody". They are at odds psychologically, morally and existentially with their desire to keep close to their children.

Uncertainty

Uncertainty, the second constituent of suffering, entailed mothers' awareness of

their naivety or lack of 'know-how' about mothering in illness and suffering. They often

used the phrase that they did "not know" how to mother in light of their illness

circumstances. This not knowing was complicated by the way the illness had transformed

who they knew themselves to be. Since being persistently ill was foreign to these

mothers, and being a mother in illness was unknown, this situation further jeopardized

their attempts to mother as desired in illness. Even in retrospect, the children remained

the focus of their stories, for mothering was predominant. For instance, Heather offered:

> My kids knew I wasn't myself. Yeah, my moods changed dramatically and umm,
> I've put them through hell because of the moods and not realizing those moods. It's
> almost I'm embarrassed that I, I didn't realize what I was doing cause I think my
> children have been hurt by that and I think they will need counselling because of
> that. I feel guilt very much.

The persistent and unpredictable motion of "spiralling" made it difficult for mothers

even to "get a handle on it". Making certain of or "knowing" their circumstances, so as to

negotiate mothering acts that were "best for" their children, was extremely challenging, if

not impossible. Downward spiralling limited their ability to take stock of their situation.

The falling drained them of energy, necessitating their continuous efforts to keep close,

just for the sake of their children. Tragically, these attempts to keep close in such chaos

made no sense to the mothers. To persevere for the sake of the children was their sense of

responsibility, and meant remaining a mother even if it were only just a label.

Further, downward spiralling made it difficult to maintain any constant way of knowing. The constant flux required flexible ways of remaining connected with the children. Such fluidity was absent as the illness and other situational problems consumed much of their energy. Hence, their blueprints of concrete strategies for the purpose of loving connections with their children were flawed. Irene recognized that her efforts to protect her children contributed to their problems:

> They came first and for a long time, I was totally stunned that my child umm needed to be here [a psychiatric inpatient unit for children] and needed the help. I had thought that we always had a very open relationship umm but [her child] didn't tell me. [He/she] hid it, hid it well, but I guess [he/she] learned from the best.

For mothers in illness, addressing the demands of caring for children was always uncertain without guidance. Some mothers did not realize that some of their circumstances were beyond their control, including partners who were also ill or abusive, poverty, and inaccessible or unsuitable housing. Tracy berated herself for not having any idea of how to better prepare for the arrival of her baby; the seriousness of such an oversight meant losing her child:

> All through the pregnancy, my [partner] was wanting to get his truck into working order so that umm when it came time to bring me to the hospital his truck would work. See a man doesn't think like a women. And and all that time we should have been looking for an apartment because we were just living in a room at that time. /He had a room and I had a room beside him so we should have been looking for an apartment for the baby and stuff for the baby you know and things like that so when it came time to leave with the baby I had no place to bring her you know so that is why the Children's Aid stepped in and said, "Well, we have a place for her." It was very very hard... By myself I didn't know anything. I didn't know anything about taking care of a baby.

Acknowledging their lack of knowledge of how to keep close in illness marked their sense of responsibility as mothers. In considering those who could teach them, the mothers realized that they had few people they could trust to guide them. For several mothers, their own families-of-origin were not able to help them nurture their children. Susan describes her own situation:

> My mother is absolutely psycho. She [loudly sighs] what I am becoming. I don't want to be that way, screaming one minute, crying the next, ducking coffee cups, very rageful. My father was very abusive.

To rely on outside support took courage, as mothers perceived formal help as being powerful enough to remove the children. For these mothers, the information about being able to mother in illness had to be specific to their own situation. Despite Brook's awareness of ways of managing her anxiety and depression, she realized that she could not integrate this knowledge in her day-to-day mothering:

> Phyllis: As your expectations [as a mother] were not being met, you began to question more and more your abilities.

> Brooke: Definitely. There was lots of that. But like they say, "the first step is being aware", and I'm at the point that I can say, "I am aware." You know taking action is probably a different, different story but I can say that I'm aware.

The mothers became uncertain about their own and their children's futures and for some, their future orientation was reduced to minutes, not years. In turn, these minutes "dragged on", creating a sense of feeling entrapped in the illness as others progressed in 'normal' time. Being unable to convey this sense of loss, they felt doomed. They feared

that their connection with their children would not endure as they were left behind in

illness. Joyce clarified:

> My kids are changing and I'm staying the same. I'm still sick. Other people don't
> understand – period!...I don't want to be with sick people no more. I want to be
> with more, I don't know, better people. Around sick people, I don't get a good
> feeling about myself.

With suffering, the mothers shifted their focus from portraying the ideal to thinking about

their actions as they would affect the legacy of their children. Paradoxically, their new

knowledge was filtered through idealistic notions. Joan, who wanted to learn how to

protect her child's future, stated:

> You try to protect your kids, especially those who are vulnerable, susceptible to the
> illness itself, like if she's got a genetically – she's got a good chance of carrying
> whatever it is and they say in most books, umm, in the research I've done, you keep
> your child in a happy, healthy, environment and the chances are less than if they
> lived in a depressed environment or whatever.

On behalf of women suffering with mental illness, Anna explained, "our kids are

our life. It involves my whole self. That is all we have. That is all we know we have." The

presence of their children helped them persevere; despite their own despair, it was worth

surviving for the sake of their children. Paradoxically, the not knowing what to do

encouraged persistence, even if with clouded reasoning. These mothers felt the need to do

something, albeit within either/or choices. For instance, Brooke stated:

> So basically that was the black and white of the situation at that point. I was
> incessantly tired, and started thinking very negative and no being able to see beyond
> it. If I want the best for my children maybe I need to disappear in the sense that,
> "Yeah, OK, finish it off then." However, obviously not [pointing to self]. In
> retrospect, that was the moment - that's what happened and I was able to actually
> get up and go to the hospital and do what I had to do. There was still a part of me

that wants, was hoping that maybe, you know, maybe get out of this [being admitted] and maybe, there is some light at the end of the tunnel.

These mothers wanted to spare their children from their visible suffering. Kathleen was so desperate that she "begged" her partner to "gas" her, and planned that her sister would care for her child. The purpose of this elaborate plan was to protect her child from witnessing her anguish. For others, balancing multiple responsibilities was overwhelming. Prior to Heather's admission, her struggle to address the competing demands in her roles as mother, housekeeper, worker and wife proved life threatening:

> Going over the edge, I had no choice…before I came, I tried to hurt myself umm, then realized what I would put my children through if I would be dead right now [pause] suicide, if it would have worked what would that have done to my children.

Despite the mothers' desire to remain responsible for their children, they had difficulty making choices relevant to the situation. Exhaustion and confusion accentuated their self-doubts and vulnerabilities. When they sought information about mothering, they found that others could not get past their illness and its related symptoms. Anna stated:

> It's getting harder, very much harder and I think that part of the problem because right now we are always being second judged by everyone else so having this illness doesn't help yourself because you are second judging yourself and then you have others second judging yourself so it doesn't work good together. If anything, it's getting worse being a mother. You got everyone telling you, "You can't do this, you can't do that." You look at yourself and say, "Well, holy shit, what can I do?" You second-guess and third-guess what decisions you're making yourself, "Were they right, were they wrong?"

At the bottom, the mothering choices were limited or removed. The mothers were ashamed of losing place and not being able to care for their children. Tragically, the

choices vacillated between two opposing options, to live/die and stay/leave in relation to their children. Rachel spoke of "hitting bottom" prior to being admitted to hospital:

> I've never been this low, never to that, never to the point that I thought of dying. I've never felt like that. I had a plan to do it. I had a very serious plan. I was very suicidal. My husband came home. I was at a point where I didn't care.

In summary, becoming visible through suffering was shaming for these mothers. The force of illness shifted their desired center of being with their children to battling the illness and its implications. The presence of persistent illness circumstances caused them to lose their bearings. The "ideal" signposts that they thought would guide them did not fit the reality of their mothering contexts. Their strategies of in/visibility were now perceived as "senseless" and served to compound their circumstances. Thus, mothers became caught in alienation and uncertainty. How to be a mother and mother in illness could not be known in the chaos. Despite their efforts to persevere in chaos for the sake of their children, they hit bottom. Bottom symbolized the meaninglessness of what they had done in their efforts to keep close. The realization of the inauthenticity of a fragmented self compounded feelings of vulnerability and loss because of what they had done. The impact signified an awakening whereby their mothering actions became visible to themselves. Confronted by their fragmented selves, mothers sought help.

Reconciliation

Psychiatric treatment was considered as their last alternative for reconciliation of their fragments of self, allowing them to keep close to their children. Reconciliation is the

last section of the model (Figure 6). Attending to inner wounds held the promise of

restoration to the desired mother. Paula, whose children were removed by Children's

Protection Services prior to admission, stated that her reason for being in hospital was to

"to find out who I am right now." Further, she stated,

> I kind of gave up on them [children] because I feel I'm more important to take care of myself in order to take care of them later on. They will always have a place to come back to when I not mental like.

Longing to recover self necessitated reconsideration of the belief that children's needs

were more important than those of the mother. To care for their own needs under

professional guidance and support, they believed was self-serving, and this created a bind.

They needed to attend to self in order to endure as "mother"; there was no more "fooling

self." Although they recognized they needed treatment for illness, they did not want

illness to preclude their mothering abilities. Brooke explained:

> I am aware and know that I need to take care of me before I can take care of those children. Umm and that's that's a constant battle because like it is never ending. These kids' needs are immediate and so sometimes you kind of tend to put everything on the back – on the back burner as far as you're concerned and take care of that. By the time you get to what you need, you're you're tired or you're just gone. So it's a catch 22 I feel.

Mothers struggled to find some window of opportunity for treatment. Brooke

informed us that only at the bottom was such an opportunity presented, and even then it

might be against the mother's wishes. Hitting bottom necessitated a shift from the needs

of the children to their own needs. Yet, they wanted to remain responsible to the children,

and to keep close was their goal. When Irene was "at the end of [her] rope" she

contacted the psychiatrist who was also treating her children. He suggested admission and

she agreed only on the condition that he would treat her since he was aware of some of

her history as a mother.

> I've had depression most of my life absolutely but it wasn't this bad. ... I had kids
> to deal with, and there wasn't time for me to be sick sort of speak. I'm learning now
> that I have to take the time because I'm no good to anybody if I'm sick. Trying to
> keep going wasn't helpful at all. It just made things worst. I had a feeling something
> was coming [pause]. The issues are very tough ones ... they're just very
> overwhelming.

Taking medication was the next best option to care for self without having to leave

the home. Taking medications that controlled the symptoms assisted them to "balance"

their mothering responsibilities in illness. Some mothers put off dealing with their issues

because they were "not ready" or were "too busy doing" motherwork. Melanie declined

offers of help in favour of:

> ... the pills, just get this over with like. You know I got things to do here. I got kids
> to take care of, I got a job, I got to drive my [child] here, I got to pick up my [other
> child] there, I got this to do, I got that to do and on and on. I don't have time to talk.
> I don't want to talk. You know it's like I'm last on the list. Don't forget that like
> mom is last on the list.

Unfortunately, medication could not control their suffering; indeed for some, it only

"masked" their symptoms. Despite this realization, they delayed seeking psychiatric

services. Their negative attitudes towards the effectiveness of treatment, the pain

associated with treatment, repetition of family's history, further shame and stigma all

enhanced their fears of seeking inpatient treatment. The label of mental illness equated

with "incompetent" or "inadequate" to mother. Although circumstances became out of

control because of mental illness, the mothers believed that others saw them as "bad" mothers; in other words, it was because they were "bad" mothers that the circumstances were out of control. The label of illness was inconsistent with the strong mother norm and value that they should be able to manage their situations. For Betty, receiving a mentally ill diagnosis marginalized her as an "unfit" mother. Others' responses were dependent on the mother's diagnosis:

> Your mother got cancer, I'm so sorry. "How can we help the family? Oh your mother has mental illness. Oh my God! Let's get you [children] out of there". It is the total opposite. There is no help for them [mothers with mental illness] at all. We're the outcasts I guess you could say. So it is harder. Every time you can't open your mouth, "Oh you are overreacting because of your illness." Oh well. Sometimes I could be me - sometimes.

It became a moral wrong to be a mother with mental illness, and several mothers were ambivalent toward inpatient treatment. On the one hand, it held the benefit of treatment and distance from children, but on the other, their perceived risk of losing their children was increased. Distance, however, through inpatient treatment, provided them the opportunity to make sense of their mothering situation. It was hoped that the distance from the situation would enable them to discern their issues, and that this way they could return to the bond with their children as a "new mom". Several mothers believed that the distance, for a short period of time only, benefited the children, since the children would not have to witness the mothers' suffering in illness. For several, hospitalization was the best choice because they could get better with treatment, and examine their situation in

order to return to their children. It was hoped that they then could be seen as a "good" and

"responsible" mother, worthy of belonging with the children. Alice:

> It's a good thing I'm not home right now, like I had the choice of being at home for
> a while, taking time off work and seeing how things were, and then if things don't
> come here but I choose to come here first. I wouldn't be [not finish thought]. I
> decided to come here [inpatient unit]. It was scary but umm, it was like getting off
> the roller coaster because I couldn't go on. ... umm, embarrassing too and then also
> my dad's side there's a few that do have mental illness so umm, I think I was afraid
> of that. "Oh my God, they're schizophrenic and all that." So I was very afraid of that
> type of thing.

Despite the benefit of distance via hospitalization, an element of threat for them as

mothers remained. Being away from the home meant that family and others had to

provide caregiving to the children. The mothers feared that these caregivers might not

have validated the mothers' absence. Alternative parent(s) attempted to comfort the

mothers with reassurances that their children were being cared for during their

hospitalization. Believing that their presence was irreplaceable, mothers, seeing others

step in, became aware of the risk of losing their children. Despite reassurances, Connie

explained that such arrangements were "not the same" as being cared for by the 'mother'.

The mother could not be replaced. Brooke elaborated:

> And the other thing is that while you are in here seeking help you are away from
> your children. The whole balance is shot, and ah, while you are in here trying to rest
> you are also worrying what is going on out there. And no matter what, no matter
> what your husband, your partner says, "Life is ok", it is not the same because your
> expectations are so high that, it's like, "Are they getting what they need right now?"
> You are constantly battling that part of it with the part I need to get well.

These mothers' willingness to separate from their children pivoted on their comfort

with alternative parent(s). With such comfort, they were freed to some degree to direct

their energy to their own needs. While Heather stated that the responsibilities of mothering made her irreplaceable, she was still aware of how much she was needed by her children. Heather's children:

> ...miss having mom at home – they are home sick, home sick. Umm, they are my kids. I should be raising them you know. Umm, I should be with them. Umm the guilt of not being there. Umm a child without a mother does miss out. To have your children come up to you and tell you, "Well, I love you mom" you know regardless of your sickness you know. "I miss you mom."

When mothers were distanced via hospitalizations unexpectedly and unwillingly they were more than worried; they were terrified that their children would be removed from them. In this regard, hospitalization was not a place for respite - its sole purpose was to control their symptoms with the goal of keeping their children. Gloria was involuntarily admitted after she attempted to harm herself. During this time, there was conflict between her and her husband. Being in hospital prevented her from protecting her children from those whom she considered as having power to remove them and ultimately, displace her:

> I wanted to get back home you know to be with the kids, my husband and mom were taking over. There was a lot at home. I had a fear that my kids would be taken away you know. With being sick you have that fear that because [you are] in the hospital and you're sick and they might take them away and it came close you know.

The possibility of speaking on behalf of their children was delimited when removal was imposed upon these mothers. Mary described how decisions about custody were forced upon her during a vulnerable time:

> Well, he [former husband] served me papers while I was in the hospital for divorce. It was like I don't have to drink anymore that was the first thought I remember crossing my mind. ... So I had to work to get home ... my child had a choice of who to go with, father or me, and [the child] picked father. And I said, "Oh." [crying]

Ironically, the mothers depended on the appearance of participating in treatment. They couldn't risk what would happen if they were deemed "difficult" patients. The pretence in mothering shifted to pretence in illness to protect their place as mother. In other words, some mothers may have downplayed their illness to save place as mother. Inevitably, they became guarded in order to secure discharge, returning to their children fully aware that they remained unwell. Thus, they were not able to take stock and learn how to mother in illness. Joan admitted to how she had sought discharge during a previous hospitalization because of concerns for her child:

> Like this time, the arrangement then – my mother [Joan's] came in from out of town and took over my job as a mother and let the routine be the way it was so this time I'm ok and the only reason I've been here [in hospital] for a month. The last time however when I was in [an inpatient unit] it was just a game. I played the well patient part and I got out after seven days and I knew I wasn't well but back then I didn't have the insight that I do now. Like if I do this [participate in treatment], I do it well then I will be able to take care of her for longer period of time. But yeah I can say that I've put on the mask to let doctors know "I'm fine." And go about my little life but it's the hardest thing to go back to that life because I wasn't well.

Pretences in illness made it difficult to receive treatment and precluded others' understanding of their struggles while frequent hospitalizations made it all the more difficult to keep close to their children. Tracy, who had frequent hospitalizations, worried that her situation would be harmful to her child:

> Well, if I had a baby at home and I'd had to go to hospital, "Who would take care of my baby?" You know and there was the dad there but still that would have put a lot of pressure on just on him and usually I stay about a month when I go to hospital. Just that aspect that would have tore me apart just to think of that, 'I'm not there for my baby'. ... So that would have really interfered with the, with the baby's upbringing you know how - [jump in idea] "Mommy's gone." "Where's mommy?" and you know.

Frequent hospitalizations verified for others that the mothers were "crazy." With time in hospital, their parental input was dismissed or ignored. Further, their children were primarily parented by family, leaving the mothers "in the dark" about their children's lives. Sally considered herself a "good mother" despite progressive schizophrenia, requiring more frequent and longer hospitalizations:

> Yeah, ah, I don't know what to say. Ah, it [presentation of illness] changes, like ah, I was well for six years, I didn't have to come to the hospital and then, not this summer but the summer before, I was hospitalized again so I am kind of disappointed a little bit because I was hoping I would never come in here again. ... The nurses told me to get a little tougher [laughs] ... Like in other people's eyes I probably look like an awful mother you know. Well, I did things that I wasn't proud of...

For most, frequent hospitalizations meant worsening illness; infrequent and unpredictable contact throughout hospitalizations also left mothers questioning their being recognized as mothers. Significantly, creating their own personal mothering history with their children became problematic when they had no contact with their children. Despite efforts to keep close, mothers with frequent hospitalizations found their core gradually began to fill with the confusion of trying to mother. Peggy's frequent admissions to hospital were:

...so hard on the kid. It just breaks your heart. I came back here tonight [from a pass] I felt so guilty. Just tears you apart because you want to be with them but the damn illness. It is so overpowering. I'm having trouble with my family now because they don't understand that I'm trying to fight this illness, but it is a part of me. It is me now. ... I'm chronic and I just hate what it does to my [child]. It's just ... when I'm home [the child] so happy to have me home. She smothers me ah.

Milestones of mothering became lost as illness made recall difficult, or, in three mothers, was replaced by suffering. These mothers came to realize that to maintain a relationship with a child in illness, they had to "forgive" others and "accept" the reality of their ill circumstances. Forgiveness lessened the pain of separation by illness, a lessening necessary for "peace of mind". Tracy explained acceptance:

Phyllis: Can you explain to me how you go about that, the acceptance.

Tracy: I don't know but it's got to be done because it can become, it can make me sick. It could make me sick you know get me all unbalanced again and so I have to find a – like a truce somewhere inside there that I can't take care of my baby and but somebody is taking care of my baby for me.

Coming to terms that mothering in illness was different helped the three mothers direct energy away from pretences. They could be more authentic with their children. Accepting illness negated the need for strategies of invisibility. In that acceptance, they hoped that as their children grew they would come to understand their mothers' struggles. Sharing their illness experiences showed clearly how these mothers struggled to keep close in illness and suffering.

"Surrendering" to the illness released all pretences. Their wounds were mirrored by their anger, withdrawal, rage, anxiety, profound sadness and tearfulness. To be faced with these emotions too was painful, but to reconcile necessitated understanding of their

suffering. This included acquiring knowledge about the "how to" of mothering in the

context of illness and suffering. Mothers defined understanding as being "available" to

"listen without judgments". This became especially important as treatment, in and of

itself, could be retraumatizing. As Nancy stated,

> I am experiencing such pain. I can't keep going to therapy because it is too painful...
> While I was always under the belief that psychiatry and psychotherapy was a bit of a
> joke. I am one of the more challenging patients to extract information from.

Many, unfortunately, perceived only limited understanding of their distress as mothers in

suffering. Rachel wanted to go home to her children on a weekend pass, but while making

arrangements with her husband on the phone, she became frustrated:

> So they [nurses] came down, two of them, under the arms [gesturing how held her
> arms] and carried me away in front of everyone. How humiliating to be treated like
> that. It was the most humiliating experience. So finally they let me go. The doctor
> [explained to the nurses], "she's on antidepressants, she's not on tranquillizers, she
> not on anything else, she's just on antidepressants." ... I'm an adult here and I said
> to [the nurse] there is nothing that [my psychiatrist] had written that I needed
> accompaniment or anything. Let me go.

Professionals who placated or informed them of their lacking derailed mothers'

reconciliation. Presumptions such as "your kids will grow up fine without you" or

judgments such as "bad mother" shifted attention away from their place and struggles as

mothers in suffering. The absence of an understanding other shut down their ability to

address mothering in difference. Disregarding the realness of their mothering engendered

distrust in a professional's ability to guide their recovery. Trust was based on the belief

that only a "respected" professional could safeguard their shame and guilt. Having finally

found a professional she trusted, Melanie was not willing for the relationship to be short

term:

> Now that I've found him and I know that he can make me feel better, he becomes a
> support and actually, its almost like he becomes umm someone to lean on even
> because I've haven't told anyone. So he is the only one that really knows
> everything. Even though I've always had my parents ... they've never known the
> extent.

With distrust and disillusionment, mothers did not feel safe, so again, they engaged in

silence, withdrawal, watchfulness, meaningless words, features of "game playing". Mary,

in her numerous admissions , was seeking another person who would:

> Pull it out of you. Initiate it, not sit there and wait for it to start and come out of your
> mouth because it may never come out of your mouth ... if you [the professional]
> don't realize that there is a certain problem that it's my marriage, it's my illness, it's
> my responsibilities, it's how I have so much pain, how the heck are you going to
> know.

Without addressing strategies about how to mother in illness and suffering,

reconciliation was a mere facade. Several mothers returned home to do what they had

done before, to rely on their pretences. Hence, the return of their strategies of in/visibility

as seen in Figure 6. Hailey returned home to do mothering because she does not want to

risk losing her children. She hopes for:

> ...Cooperation from my [oldest] and [youngest] not to fight so much because I
> wouldn't have to yell at them and discipline them for nothing because they just nit-
> pick at each other all the time. Why? There is no reason for that. You are supposed
> to love each other, not nit-pick. Like they say [in general] brother and sister they're
> always fighting. I'm surviving. ... I guess I'll survive. Back then when my mom
> raised us she could use the hand on the bum and I now I get charged. Us, we use
> that [lifts her hand] on the bum and we have a social worker at the door taking the
> kid away and they [the children] know it. ... It's a routine now. You get up, you

feed the kids, you wash them, you bath them, you clean their clothes, and get them ready for school, get their lunches ...

In situations where symptoms were managed by medications, what remained absent were maps to guide the mothers with the day-to-day reality of mothering in suffering. Kate stated:

> Since I've been in treatment I'm not anxious, I'm thinking better, I'm sleeping, I can focus but what about when I leave go home? I will keep seeing [the psychiatrist] but it is the other stuff that worries me. ... when I have to get up at night, when I have to play with them but I'm tired, when I have to make their meals but I'm not feeling well.

Medications seemed to fill the void of reconciliation when there was no recognition of their experience of mothering or their integrity. Mary:

> So it was always maintaining and trying to medicate, that all it's been and even her [health care worker] you know like they're – there for you are like – you're talking but they [professionals] just don't go inside.

Certain medications at least helped to "mask" the fractured self so that they could return to their children. Gloria:

> But I was in the hospital for two months or so three months – two or three months – I never kept track of that but it was really hard and then they put me on some medication and then I got better but the thing was it's the mask without the underlying cause or or being taught. ... It's masking by pilling without going inside to find out.

Inadvertently, health care services as experienced by these mothers may reinforce false pretences. Leaving hospital "still broken", some mothers required community programming; others were readmitted, and some defaulted to old patterns of mothering. Connie:

The only thing I'm frustrated about is there is not a lot out there that you can go to for help. You know other than the hospital. I wish – I phoned the Schizophrenia Society and I thought, "Well great, I can get involved with them" but they told me it is just for family members. ... Once my child starts school I'll have more time [to attend to own needs].

Mothers dreaded the return of illness and suffering as they might not have the energy to endure as mother. To endure required them to portray a charade of normalcy, a behaviour that can re-initiate separation between mother and child.

In summary, being normal, secure and responsible were undermined by strategies of invisibility. The mothers were required to be watchful as a means to keep close. In the turmoil of illness, the strategies of masking, censoring speech and doing motherwork contributed to their chaos. Despite mothers' attempts to portray the ideal image as mother, they became distanced from their children. This was suffering as mothers were uncertain of how to keep close: chaos juxtaposed against their ideal expectations. Isolated from their children, recognition as mother was diminished. At bottom, mothers recognized how far they had unwittingly come from their ideal image and their children. Being visible was shaming as it exposed their inability to protect their children from illness, but their sense of responsibility helped them persevere for the hope of reconciliation. For these mothers, reconciliation meant mothers could return to the valued position of mother. Often, however, their expectations for reconciliation were not met as the focus of treatment was symptom management.

CHAPTER 5

DISCUSSION AND IMPLICATIONS

In this study of 20 mothers, the women I interviewed provided a brief glimpse into their private lives as mothers. These mothers recounted moving stories about their desire to construct meaningful relationships with their children in the context of serious mental illness and suffering. To keep close to their children equated with having agency. To mother *between* the opposing forces of the desired mothering and the hostile reality of suffering was described as "cruel" and requiring their creativity. Actions of in/visibility served as possibilities to protect their place as mother and to safeguard their children from the effects of illness. Mothering in illness and suffering was not inherently static. Instead, they saw a variety of possibilities within each of these mothering approaches for asserting self-as-mother. The precarious balance between hiding illness and highlighting status as mother, however, became more difficult to maintain as their context of mothering became out of control. Unfortunately, their mothering practices for the purpose of keeping close cost them their integrity and dignity.

The purpose of this chapter is to examine this study's model, *To Keep Close*, in the context of the existing literature. In particular, literature focussing on agency seemed to make this study's substantive theory more explicit. As Glaser (1998) predicted, the theoretical explanation took me outside my professional literature into less familiar areas,

such as feminist writings. The discussion will begin by examining agency in difference, followed by a discussion concerning how these mothers came to lose their sense of agency. Implications of the findings for nursing will be addressed, followed by a description of this study's limitations.

Agency in Illness and Suffering

Agency is defined as the ability to create meaning (Oliver, 2001), and that meaning is the purposeful crafting of a life in relation to significant others (Liaschenko, 1997). Agency, according to Oliver, involves the two processes of address and response. In this study, address and response refer to the mother's position in difference. Address refers to their image of being a mother in relation to their children and important others, while response is the obligation the mothers undertook to keep close to their children. Through mothering practices, these women hoped to create and sustain a coherent sense of self as agent.

These mothers' sense of agency was nurtured through their abilities to address and respond to the needs of their children. Being responsible mothers required that they protect the children from their illness. Because of their situations, mothers undertook strategies that camouflaged illness, seeing possibilities for meaning-making inherent in their situations. Through actions of invisibility they hoped to keep close with their children, and the enacting of strategies would, it was hoped, secure their identities as mothers. By hiding illness, the mothers believed that they could be viewed as 'normal:' in

this way, their parenting would not be questioned and their value would be affirmed by their children and others.

As with other groups of disenfranchised women, motherhood offered them the opportunity for agency (Abbey & O'Reilly, 1998; Nardi, 1998; Scarborough, 2001; Tangenberg, 2000). The place and identity of 'mother' signified possibilities of normalcy, security and responsibility that were otherwise not part of their severe mental illness experiences. Cox and Holmes (2000) support the notion that when one knows one's place is valuable, one feels safe. Mothering engendered recognition and support.

Recognition for these mothers referred to affirmation of their ability to care for their children. These mothers, like others (Nicholson & Biebel, 2002) wanted to do their 'best' for their children within the difficult circumstances of illness. Since these mothers' valued their sense of connection highly, their well-being depended on their ability to address and respond to their children. When women perceive a disruption in connection to others, their mental status is seriously compromised (Cogan, 1998); thus without a relationship with their children, the women lacked agency. The women of this study existed as mothers only when in a relationship with their children. They could not find meaning outside of being mother, hence, the value of closeness with their children. Even when the children were removed, the mothers were unwilling to forego their valued status as mothers.

Chronic mental illness alters a person's agency, and the kind of life one leads can be radically changed as well (Liaschenko, 1997). Historically, the diagnosis of mental illness

has re-placed the identity of mothers as "pathological" (Herbert, 1986; Maushart, 1999; Phoenix & Woollett, 1991). They have been labelled "schizophrenigenic" mothers, dependent, detached, overprotecting, double-binding (Herbert). Such negative constructions of mothers with mental illness calls into question their mothering competence. As an abject group, the need for professional intervention was needed for the sake of the child. I am by no means negating the affects of parental illness on children. I agree with Oyserman et al.'s (2000) contention that children's well-being is determined by multiple factors. Often mothers are viewed as the cause of whatever goes wrong with their children (Maushart). It is unsatisfactory to judge only mothers for children's developmental problems. For most children the risk of child experiences and maternal illness is likely contingent on the interplay among onset of illness, illness severity, the child's development phases, and the sociocultural context of parenting (Oyserman et al., 2000). That is, the complex interplay of the severity and chronicity of parental mental illness, frequency and duration of separations due to hospitalization, and the characteristics of children themselves impact on the children's well-being (Hearle & McGrath, 2000). Thus, for SMI mothers in this study, downplaying the appearance of illness minimized the risk of creating a context that could potentially harm their children. In other words, acting normal made for a "happy, healthy" environment for their children. Further, they hoped their pretences would reduce the risk of exposing an illness that signified lacking, or their object position.

Believing that the context of mothering was just illness, several mothers hoped that medication could alleviate their symptoms. Mothers sought to find the combination of medications and treatment that would facilitate their ability to keep close. The mothers who accepted the biomedical explanation of mental illness valued the professional guidance. However, this perspective involved a shift of control away from the mother and was replaced with a dependency on the experts (Caroline & Bernhard, 1994; Miedema & Stoppard, 1993; Schreiber, 2001). Some women required several hospitalizations as their symptoms were difficult to manage. Although this belief was identified in this study as one means of accessing help to continue mothering, this biomedical view has been criticized for not acknowledging the reality of women's lives in illness (Schreiber & Hartrick, 2002).

Thorne and Paterson's (2000) meta-synthesis of chronic illness research describes chronic illness as typically following an uneven trajectory. This suggests that the unpredictable waxing and waning of illness is not only dependent on the disease process, but can also be precipitated by situational factors. In the "spinning" of illness, the mothers' ability to manoeuver in chaos became constricted. For example, in this study if the mothers perceived others' vigilance over their illness behaviour, they were fearful of being removed as mother. To prevent this, they focussed their energies to portray a 'normal' mother. Unfortunately, such acts left little energy for their mental health care needs. Over time, as Thorne and Paterson predicted, illness and the concomitant circumstances become out of control. For these mothers, this meant that eventually, they

were overtaken by suffering. According to Eriksson (1997) the "most profound suffering related to illness involves person's perception of having been deprived of dignity, not being understood, not being taken seriously, being reduced to symptoms" (p. 6).

For these women, suffering became the context of mothering. Suffering undermined their address and response as mothers. Suffering, as defined by Copeland (1993), is a disturbance of inner harmony caused by physical, mental, emotion, and spiritual forces that jeopardize their being. For Copeland, suffering

> ...always means pain, disruption, separation and incompleteness. It can render us powerless and mute, push us to the borders of hopelessness and despair (p.109)

The only means for mothers in this study to make sense of their situation was to attribute it to the signs and symptoms of illness; otherwise, their sense of self as mother became meaningless. To mother in suffering eroded the meaning of being a mother and how to mother. Because of the threat of losing identity and place, mothers struggled to keep something of their own. According to Deegan (1993), mental illness in itself is not necessarily despairing. However, being devalued as mother was disaffirming. For the sake of keeping close, the mothers were willing to sacrifice their own needs.

The context of suffering displaces the desired self-as-mother. Mothers acknowledged that their suffering made their mothering appear unacceptable. A devalued self represents the identity within this place of suffering. Alienation and uncertainty are the contexts within which the mothers struggle to regain meaning. Ingram and Hutchinson (1999), in their study of HIV-positive women, identified a discredited self

that arises not only from the experience of illness but also from the definition of self that is constructed in their efforts to cope with the stigma of HIV. Like the mothers with SMI, Ingram and Hutchinson's sample of women dealt with isolation and alienation. To delimit their unacceptability, both samples portrayed what they perceived as 'normal'. The tension between the mothers' awareness of their lacking and attempts to be perceived as 'normal' trapped them in suffering.

Being trapped in alienation and uncertainty undermined the mothers' abilities to enact mothering, and thereby their place as mother was risked. They became lost and despairing, unable to discern how to keep close. To keep close in suffering constituted a struggle over the meaning and practice of mothering. The suffering weakened the 'bond so strong' despite their strategies of masking, censoring speech and doing. Meaning-making was constrained by their difficulty in making a coherent choice while suffering. Isolated from valued others, they lost the ability to be guided across the uncertain terrain of mothering in suffering. Under such circumstances, they could only mimic "normal"; that is, they were unable to use authentic ways of being mothers. Their pretences, ultimately, served to highlight that they did not know what else to do. Thus, their ability to craft a life in the chaos of suffering shifted to survival only, a means to preserve their place. Their response to being addressed as mother for the sake of agency compounded the chaos of their situations and the suffering (or the context of mothering) got out of control.

With respect to pretences, Laing (1990) writes:

The trouble is that the individual may find that the pretence has been in the pretending and that, in a more real way than [s]he had bargained for, he has actually lapsed into the very state of non-being [s]he has so much dreaded, in which [s]he has become stripped of his sense of autonomy, reality, life, identity, and from which he may no find it possible to regain [her] foothold "in" life again. (p. 111)

The strategies involved in masking, censoring speech and doing motherwork could not preserve their place as mother. In fact, because of their meaninglessness, pretences perpetuated the chaos, even for the sake of keeping close. Further, the pretences in chaos amplified the turmoil, bringing attention to the very problems inherent in keeping close. As Oliver (1998) suggests, there are no guarantees that one's attempts at securing agency will not be harmful. In their attempts to 'keep close', the mothers' strategies undermined their agency. The pathos is that, despite their desire and efforts to keep close, they wounded themselves and others. Despite being isolated, others suffered along with them.

The Loss of Agency in Mothering in Difference

The women in this study embraced and took pride in being mothers and their strategies of invisibility offered them the hope of keeping close to their children. In the context of illness and suffering, however, their possibility for agency was delimited by their adoption of a romantic blueprint of mothering, their access to resources, and their sense of self as mother. The context of chaos was so foreign and exhausting that they could focus only on the immediate issue of surviving as a mother. Tang and Anderson (1999) state that in oppressive situations individuals may become incapable of participating actively in meaning-making. In my study, the mothers' ability to craft a life

as mothers, to make sense of the meaning within chaos, became a struggle. Along with

the effects of illness, they had no blueprints by which to mother in the unpredictable

circumstances of illness and suffering.

Romantic Blueprint of Mothering

All the participants of the present study wanted to have meaningful relationships

with their children. To this end, in suffering they strove to represent what they believed to

be a good, or normal, mother. Being a good mother was defined and reinforced within the

romantic image embedded in a valued construction of what constituted normal. Some

mothers were aware that they did not fit what constituted 'normal', such as being raised

in what they considered an abusive upbringing. Despite this, they chose to be responsible;

however, they did not know how to transpose the blueprint to their mothering in

difference. Tang and Anderson (1999) contend that the power of agency becomes undone

when the purposes and ideals do not transform the constraints of the circumstances. That

is, mothering became a conflicting site of engagement when the mothers attempted to

hide the "bad" with the "good".

Several feminist writers would argue that the popular romanticized representation of

motherhood is a myth (Abbey & O'Reilly, 1998; Maushart, 1999). In general, the 'joys of

motherhood' embedded in the intimacy between the mother and child bond

> have been exalted, and traits of nurturance and selflessness have been defined as the
> essence of the maternal, and hence of the womanly. Mothers were, and continue to
> be, ascribed the social, legal and ideological responsibility for the care and

upbringing of children. ... According to this model ... the child's needs take precedence over mother's, and she should anticipate and respond to all her child's needs and desires. (Krane & Davies, 2000, pp. 38-39)

Unfortunately, such an ideological structure discounts and conceals the realities of mothering practices. Maushart (1999) argues that in Western culture motherhood is hidden behind semblances of control, serenity, half-truths and even lies. In addition, O'Reilly (1998) suggests that because of the romantic construction of the good mother, both mother and child are at risk for losing "the ability to hold on to the truth of their experiences" (p. 80). In essence, such pretences keep mothers from knowing and speaking about the diversity of mothering experiences. In light of the romanticized image, it is not uncommon that the mothers question the value of their own experiences. By defining self-as-mother in oppositional terms, a part of self becomes inherently opposed to its other (hooks, 1993).

More recently, several authors have challenged the traditional ideals of mothering by illustrating a variety of marginalized maternal experiences[1]. As supported by this study's findings, it seems that there is no static or universal meaning and practice of mothering. Instead, mothering constructions vary significantly in different contexts and can also be re-constructed pursuant to the unfolding of health challenges. In difference, mothering actions appear complex, strategic, and sophisticated, as there is no one blueprint of mothering. As much as their mothering actions draw attention to their

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[1] These included the voices of mothers who are disabled (Hollan Baskin & Riggs 1988); mothers in addiction recovery (Nardi, 1998); mothers with economic difficulties (Scarborough, 2001), lesbian mothers (Lewin, 1994), and a mother with cancer (Weingarten, 2000).

difference, they also serve to highlight the mothers' struggles. This attention also

increases the mothers' fear of losing their place. As illustrated in Scarborough's (2001)

study of mothers receiving welfare, the mothers' protection of their children from harm

was regarded as a higher responsibility than obeying welfare regulations.

Sense of Self as Mother

The strategies of invisibility suggested an intentionality in relation to keeping close

rather than a passive experience of connection. The mothers of my study were compelled

to assume the mantle of invisibility as a means of hiding all traces of their illness and

suffering. The pretences undertaken in mothering made it difficult for them to be

authentic. As such, significant others could not recognize the mothers for who they really

were. Rather, they responded to the inauthentic presentation. Over time, the mothers

could not understand the meaning of their suffering because of their façade. As suggested

by Fredriksson and Linsdtrom (2002), although patients employ a façade to hide or cope

with suffering, its presence contributed to the chaos in suffering as they had no control

over their actions. Like the mothers in this study, they too had no sense of what to do or

who they were in authentic terms. Having no agency served to annihilate their sense of

self-as-mother. What did make sense to these mothers was maintaining connections with

their children, for the sake of the children. This selfless act happened even at the cost of

losing themselves. The well-being of their children governed the craft of mothering. From

their perspective, their salvation in suffering was the well-being of their children, a

rational choice for disenfranchised mothers (Ingram & Hutchinson, 1999; Scarborough, 2001).

Doing motherwork gave the lives of participants in this study meaning; routines gave them a subjective sense of mothering. For them, doing motherwork put the children first and yielded self-worth; being a 'good' mother was synonymous with the extent to which they were able to do motherwork. According to Schreiber's (2001) research on depressed women, acceptance by others depends on productivity; these women realized that they could not belong merely for who they were. In this study, to do motherwork was *proof* of being a mother and made them similar to "normal" mothers.

In illness and suffering, however, the daily life routine was disrupted (Liaschenko, 1997) because it was reduced to being mechanical. In a "zombie-like" state, it was difficult for a mother to discern the purposeful benefit of her actions for the children. The tension between how to address and how to respond became limited. As Oliver (2001) explains, one is a zombie when one's agency has no meaning. For the mothers in this study, routine did not help them maintain order in chaos. Rather, routine contributed only to exhaustion as the mothers could not consider beyond the mechanics of the doing. Safety resided in the pretence of doing.

When doing was no longer possible, watching was at least doing something. According to Broucek (1991):

> ...vision, in its broadest nonsuperficial sense, is more than sight; it is emotionally and intuitively informed seeing that penetrates mere appearance, integrates the other

senses, the emotions and the body as a whole. True vision depends on the eye of the heart. (p. 142)

For mothers in this study, watching involved the least energy with the most impact. It kept them focussed on their children and hence was a means to keep connected. Even without the benefit of meaning, watching meant that they were in the presence of their children, and this was their connection.

Censored speech also delimited closeness in illness and suffering. Mothers believed that censoring speech was essential for the sake of protecting their children, that to share their authentic thoughts and feelings would risk disconnection. These mothers, like other disenfranchised parents, were confronted with the dilemma of how to create a meaningful connection through voice without harming the children:

> If I don't tell you what I really think and feel, I will feel disconnected from you. I will end up withdrawing from you. In silence. But, if I do tell you what I really think and feel, you will withdraw from me. What I have to say is so heinous, horrible, toxic, unacceptable, that you will not be able to stand me. (Weingarten, 2000, p. 391)

The mothers of this study were caught in a bind. On the one hand, they valued a meaningful connection with their children. On the other hand, they knew that it was not wise to be truthful with their children. Hence, mothers judiciously withheld their reality from their children. In such situations, acts of silence seemed appropriate moral responses in the interest of survival (Weingarten, 2000). Silence, viewed from the perspective of "good" mothers, gave them a false sense of agency as "it [did] not correspond with actual power to effect changes in [their] daily social reality" (hooks, 1993, p. 28).

Masking signified mothers' attempts to conceal from others and self their illness and suffering. According to Maushart (1999), a motherhood mask, a prop of pretence, projected the semblance of uniformity, strength, control, serenity and all-knowingness. As a socially-constructed representation of the ideal mother, it served to mute the chaos and complexity of the reality of mothering. The mask

> ...is a disguise of our own choosing, a form of personal armor that ... ensures the viability of the self as well as our relationships. Pretending, in other words, is a form of self-protection. From this point of view, the mask of motherhood is like a camouflage, rendering our experience safely indistinguishable in a hostile environment. (Maushart, 1999, p. 6)

For the mothers of this study, the mask was associated with their responsibility to their children. The negative impact of masking, however, was betrayal of their own self-as-mothers in their commitment to secure a 'bond so strong' with their children. In this situation, agency, which entails responsibility, was in double jeopardy. According to Oliver (2001), responsibility has two meanings. First, it is the ability to respond; for example, mothers projected what they perceived as the most appropriate mothering disguise in view of their situation. However, their capability to be watchful became overshadowed by illness and suffering. Second, responsibility was the ability to be responded to. For these mothers, others responded to their inauthentic representation, an illusion. As such, the authentic self lost the capacity to know who she was, what to do, and what she needed and desired (hooks, 1993). Situated behind the mask, the authentic self became disempowered. Self-as-mother became an object of her own actions (Meltzer,

1972 , as cited in Schreiber, 2001). Therefore, as object, a mother was unable to reflect critically on her 'response-ability'.

Lack of Resources

Choices and resources were required for agency. The availability and accessibility of resources, such as energy, respite, coherent thoughts, or in mothers' view "understanding others", affected the degree of agency (Scarborough, 2001; Tang & Anderson, 1999). In this study, as in others (Mowbray, Schwartz et al., 2000; Nicholson, Sweeney, & Geller, 1998), mothers relied on family to assist them with mothering. However, family too may have become overwhelmed. Despite the mothers' intention to be responsible for their children, in the context of few options, dwindling resources or no good choices, the mothers' agency was placed on trial. Others, including professionals, became increasingly vigilant over their mothering practices to ensure the safety of the children. Others may not have recognized the mothers' sense of responsibility to their children, and consequently, unwittingly thwarted the mothers' agency (Brunette & Dean, 2002; Nicholson & Biebel, 2002).

The Bottom

The mothers' loss of agency led to their collapse–their everyday world of mothering undermined their attempts to create meaningful connections with their children. For the participants in this study, the weaving of human events and circumstances that arose from

being a mother in difference and the meanings they assigned to mothering fuelled their

fall to "the bottom." According to DuPont and McGovern (1992), "hitting bottom" is also

a term used to describe the final stage of suffering in addiction. It occurs when a person

recognizes their loss of control, not only of their illness but also of their entire life.

Further, when persons with addiction review their lives at bottom, they confront their

powerlessness and often seek help. Similarly, as suggested by Cox and Holmes (2000), in

situations that severely disrupt personal cohesiveness and undermine the meanings

constituted in self-identity, loss of agency contributes to suffering.

At the bottom, the minds and bodies of the mothers in this study were exhausted

and few, if any, possibilities existed. The bottom symbolized that they had no place as

mother, and without place, they could not enact mothering practices. The actions of

invisibility were incapable of sustaining the fractured self in affective relation to others.

When response to another was no longer possible, agency was cut off (Oliver, 2001). No

agency equated with no responsibility, no security and not being normal: only their self-

as-mother to oneself was visible. They saw themselves in non-desirable terms, saw how

far removed from their children they had unwittingly become. They had no means to

advocate for self at bottom, despite their lingering sense of responsibility to their children.

The visibility of self-as-mother at bottom was shaming.

In situations involving loss of interpersonal connections, shame involves being

regarded as an object by self and others (Broucek, 1991). The experience of self-

objectification

...is as if the ground under one's feet were giving way; depth and spatial relationships may seem altered and one's "place" in space uncertain, resulting in a kind of vertigo. Such experiences dramatically illustrate to what extent the reality of our everyday phenomenal world is dependent on an intact sense of self and an intact set of interpersonal coordinates and not simply on an intact brain .... (Broucek, p. 40)

At bottom, mothers saw themselves as lacking or inferior. When self is viewed as a thing, it becomes inert and alien (Sacks, 1982 , as cited in Gadow, 1989). Mothers were unable to even be mechanical at this point. Shame was compounded by the guilt of having contributed to their dis-placement from themselves as mothers. Reconciliation involved reconstructing their agency in order to return to their children. If agency was not supported in treatment, new possibilities for mothering could not be known.

Implications for Nursing

Practice

The study findings demonstrate that the context of mothering goes beyond signs and symptoms of mental illness. These mothers emphasized that the biomedical entity did little to represent their mothering realities. It is only within the past decade that nursing has empirically studied suffering (Duff, 1992). Yet, nursing's understanding of suffering remains delimited as it is narrowly conceptualized in terms of physical or psychological pain (Starck & McGovern, 1992; Younger, 1995). The mothers of this study shifted ways of understanding suffering to include the cultivation of their own agency in relation to their children. Regardless of illness and suffering, they wanted to be responsible for their

children. To keep close within the suffering of mental illness was their focus. In suffering, however, the mothers could only hope to protect the subjectivity for their children. In order to address the needs of mothers with SMI, it is essential to recognize their responsibility in difference. Such recognition would support their agency and desires in mothering. Indeed, a prerequisite to engaging with the family is addressing and responding to the agency of the mother. From the stance of the suffering, health care professionals would be required to shift their clinical lens from illness to the mothers' total life situations, a perspective echoed by nurse theorists (Chinn, 1988; Younger, 1995; Watson, 1999).

Further, these nursing theorists discuss compassion as a means to heal, a need also identified by the mothers in this study. For the mothers, an expression of compassion enabled them to share their intimate struggles for the self awareness needed for reconciliation of being mother. To them compassion meant that the listener appreciated their difficult choices in the midst of limited resources, their lack of affirmation and their heightened sense of shame. This enactment of compassion requires that professionals accept mothers' difference, as opposed to judging them. When mothers in this study perceived a lack of acceptance by professionals, they usually provided only the facts related to the signs and symptoms of their illness. Professional recognition of agency in difference may provide a foundation of compassion for these mothers. Acknowledging their difference and the importance of their strategies of in/visibility may also foster the development of caring relationships built on the value of creating mothering possibilities

sensitive to their situation. In this sense, compassionate care for mothers with SMI, as demonstrated in this study, takes on new significance.

Compassion rooted in the acknowledgement of difference helps women restore a lost sense of agency. Several mothers participating in this study were hospitalized during their most vulnerable time and their testimonies were hidden behind discourses of protection and illness. Some mothers were unable to find the words to communicate their suffering. They had difficulty making sense of their suffering and finding the words to express their meaning. According to Younger (1995), crying, speaking in language that is difficult for others to comprehend, or even yelling are "inarticulate" or "mute" expressions of suffering. In such instances, a compassionate professional can help mothers with SMI to find a way to restore agency that permits their suffering to be articulated. This can be through such creative means as speaking, writing, or art. Indeed, assisting mothers to find meaning and value in their realities is a way out of alienation.

For the nurse to bear witness to in/visible strategies would require a commitment that extends beyond collecting psychiatric assessment data. To bear witness is to hear what may seem obscure or contrary to a nurse's traditional conceptions of mother and mothering. This means appreciating the circumstances rather than judging the mothers against the backdrop of the ideal image of mothering. For these mothers, agency was lost in their attempt to straddle their reality of mothering and the elusive ideal image. For the nurse to understand the complexities of mothering in suffering requires a long-term commitment respecting the temporal dimension of agency. In addition, the needs of the

mothers and their children change with time. Hence, the long-term relationship must be in concert with the changing nature of mothering in illness and suffering. It is essential that the nurse be ready to address and respond to mothering needs at various points in time.

Further, it is important that professionals share their stories of caring for mothers with SMI. By sharing professionals can come to know these mothers and they, in turn, learn about the professionals. However, because of mothers' difference – their lives and situations, – some of their stories might be beyond professionals' understanding. Although this may be an unsettling situation for the professional, it is not necessarily a barrier to connecting and helping these mothers. Indeed, as Liaschenko (1997) contends, completely knowing another is not desirable. In terms of the mothers' agency, for participants in this study, such *knowing* would only have served to expose to criticism that which they need to protect most; the connection with their children.

Administration

There is recognition of the gap in services for mothers with serious mental illness. Indeed, several authors (Anderson, Blue, & Lau, 1991; Caroline & Bernhard, 1994; Owen, Repper, & Perkins, 1998; Schreiber, 2001) encourage service planners to expand their understanding of the needs of women with SMI beyond biomedical or behavioural orientations. Knowledge about mothering in difference would challenge the status quo for nursing administrators. In order to address agency in difference, nursing administrators would need to participate in shaping an environment that is not dependent on the

romantic constructions of mothering. This would require, for example, that services move

beyond *fixing* others because of their difference–an orientation that diminishes their

realities. Hence, nurse administrators need to secure resources that help professionals to

help care for mothers with SMI.

Service delivery changes will involve questioning how our current delivery of

psychiatric services affects the agency of vulnerable mothers with SMI. For example, how

can nurses who plan services advocate for mothers who resist visibility because of their

difference? How can the nurse administrator design services that respond to and address

the agency of mothers with SMI? What are relevant services to be administered by mental

health for mothers with SMI? Further, how can the administrator's decision be sensitive

to the value of these mothers' addressing and responding to their children?

Education

Education is important for mothers' reconciliation. Educational sessions can

provide mothers with ways of knowing that enhance their capacity to mother

meaningfully. As suggested by Belenky, Clinchy, Golberger, and Tarule, (1986), the

structure of learning can be another way to support women's subjectivity. In dialogue,

mothers would have the opportunity to ask each other questions, clarify issues or give

guidance to each other. Mother-to-mother sharing could provide an opportunity to lessen

isolation and raise awareness of taken-for-granted assumptions of mothering. As

identified by this group of mothers, an important role of the educator would be to provide concrete guidance in the *how to* of mothering work.

The question that needs to be answered is "How can nursing bring together mothers who hide their suffering by strategies of in/visibility?" Perhaps one place to start seeking an answer to this question is to review the literature on how other high risk groups come to find comfort in exposing their "secrets" with each other while maintaining mutual respect. Another consideration may be to utilize primary care providers to advertise available and accessible parenting education. For some mothers, for example, this would mean that they would be informed by their trusted professional. Hosting an educational session in conjunction with a women's centre may also allow mothers with SMI access to other resources. Further, in order to convey respect for their lack of resources and intent to mother in adversity, it may be necessary to consider novel venues when providing these educational opportunities. For example, child care services may need to be provided for the mothers during the sessions.

Given the importance of mothers' watchfulness in this study, it is not only what the professional says or does that determines the sharing of mother's suffering, but *how* the professional says and does it. In other words, education of mothering in mental illness is not only about the "facts". To support nurses to *see* beyond the mother as eyewitness may require a forum for the nurses' sharing of their struggles of caring for mothers with SMI. This type of forum may provide one way for nurses to problem solve how to help mothers in chaos and allow them to question their own beliefs about mothering. Although the

realization that there is no prescription for care may be unsettling for nurses, such awareness may illuminate many creative ways to help sustain the nurses' commitment to the mothers and enhance the development of meaningful intervention strategies.

Theory

The model developed in this study supports Oliver's (2001) understanding of an alternative construction of agency, in that she considers subjectivity in the othered position. In a recent discussion of the term *othering* in nursing, Canales (2000) conceptualized the experiences of a group of marginalized women in the dialectic. To persist in the belief of other in terms of the dialectic negates the possibility of subjectivity and displaces responsibility for their lives to those perceived to have agency. The dialectic necessitates a hostile interaction. As Oliver argues, one cannot be placed in opposition to another while simultaneously offering help. For example, mothers who participated in this study felt professionals were poised to remove their children.

Unfortunately, these mothers compared themselves to the powerful others, thereby reinforcing their own shortcomings. In this regard, they doubted their value as mothers, a perception which reinforced their strategies of in/visibility from powerful others. To continue to care for mothers from the dialectic frame of reference delimits the abilities of nurses to understand the mothers' value of keeping close. Mothering in otherness is more consistent with Oliver's idea that a meaningful life emerges from agency. According to Oliver, subjectivity comes from creating personal meaning, regardless of status. By

challenging the fundamental tenets of nursing care for mothers with SMI, nurses can avoid the subject/object binary and focus on recognizing the mothers's struggles.

Research

Qualitative methodologies are well suited to elicit women's experiences of their every day lives and to identify the patterns and commonalities that emerge (Abby & O'Reilly, 1998; Benoliel, 2001). Grounded theory methodology was well suited to explain how these mothers with SMI coped with being able to keep close in illness and suffering. As a method, it yielded a novel perspective of how women manage mothering in the context of SMI and suffering. The participants' perspectives on mothering, as discussed in chapter 2, challenge those identified in previous literature. The data from this study constituted the emergent model, a beginning framework for further modification to our understanding of what is happening with mothers who have SMI. In order to expand on this knowledge, further research is needed. This analysis was limited to 20 mothers who were receiving some type of psychiatric treatment. It would be useful to repeat this study with other groups of mothers in difference, both inside and outside of formal treatment. Questions arising from this research include: "Does 'bottom' have varying depths?" "From the mothers' perspective, how can services be planned to meet their needs?" "What factors promote mothers' reconciliation?" "What helps women with SMI who are not mothers persevere?" "Would the same happenings–in/visibility– occur for mothers with different diagnosis?"

Rather than viewing future research as particular techniques—"soft" as opposed to "hard" or possibly a combination thereof – I suggest creating methodological perspectives that focus on helping mothers broaden their blueprint of mothering and honour the complexity of their circumstances. The appropriateness of a particular approach must always be considered with respect for the mothers' agency. Therefore, the question I would ask is: "What methodological practices are best suited to understand the experience of mothers *othered* by lack of recognition"?

Although quantitative research may have historically obscured the experience of women, this need not always be the case (Jayaratne & Stewart, 1991). Indeed, quantitative research findings have influenced how health care services are delivered and, despite repeated claims of the value of qualitative research in nursing, its influence on the practice of nursing to date has been limited (Hall & May, 2001). Given this reality, perhaps it is the qualitative researcher's role to present the research findings to service planners incrementally and in an accessible manner. I would contend that to respect the subjectivity of vulnerable mothers with SMI means to go beyond methodology. That is, the researcher, regardless of the paradigm, must also give consideration to how their findings translate to use in practice and advocate for service delivery change. As previously discussed, it is important to present the realities of mothers with SMI to professionals in a way that respects their "theoretical sensitivity" and hence, has an impact on practice. Such behaviour by the researcher would validate the research as being *for* women and not just *about* them.

Grounded theory gave me the honour to meet mothers in the context of difference. As research participants, these mothers shared their stories of mothering while safeguarding their personhood. To many, I was an outsider and recruitment was initially difficult. I suspect that the mothers did not want to expose their situations and practices of mothering to a stranger. In speaking with several mothers I became more cognizant of this protective feature. Other possible barriers to engage mothers in this research may have included their degree of suffering, their sense of shame, their numerous responsibilities, and their fear of the consequences of disclosing their struggles. How do we recruit mothers who want to remain in/visible? To increase marginalized women's willingness to participate in research, Andersen (1999) stresses the importance of affirming them as persons of value in relation to others. For this study, what became evident was acknowledging the mothers' value in relation to their children. Several of the mothers knew or recognized me from my role as a nurse. Being visible in the treatment setting provided them an opportunity to "watch" me. This engendered a greater willingness to participate as some mothers were familiar with my nursing approach.

For mothers who did not know me professionally, I initially made myself available, in part, for acquaintance. I introduced myself as a nurse interested in learning about mothering in illness. I mentioned that little was known about mothers with SMI and emphasized that my focus was on them as mothers. Prior to consenting to an interview, several mothers asked if I was a mother. Possibly mothers were more receptive to engaging in the research with someone who they believed could relate to them from their

own experience. Further, by way of support, they often used a common phase, "Well, *you know*", inferring that they perceived that I knew from my own experiences. I recognized that although this is a colloquial saying, it invited me to enquire further about their meaning within the experience. As a psychiatric nurse, a mother and a novice researcher, the utility of field notes expanded from a data collection tool to include an expression of my presence and its implications on the research process. I suspect that my identity as a mother had more value for this group of participants regardless of the specific methodology. When studying persons living in difference, Andersen (1999) suggests that if the "research[er] remains too tightly bound by the framework of scientific methodology, [they] miss much of the texture and nuances inherent in the engagement through the research process" (p. 137).

Is this feminist research? This question became apparent with regard to my ethical and methodological considerations. In part, feminist research focusses on women's experiences for the purpose of improving their condition and position in society (Speziale, 2003). Although the understanding of mothering was the focus of this research, I do not believe that this study improved "the lot" for these women. My understanding of their lives is only partial. For some women it was beneficial to speak about their mothering experiences; however others participated to help me. In order to advocate politically on mothers' behalf, I would need to understand the structures that influence their current place in society.

Limitations of this Study

This project yielded a unique view of parenting from the perspective of mothers with SMI. Additional knowledge in this field, however, is required and must include research with others, such as fathers and extended family members who parent. That is, it is essential to develop a research agenda that identifies themes and projects that involve different members of the family and the community in order to understand mothering in difference. Further, as the body of research evolves, it must support the view that there is more than one way to think about motherhood. In addition, given the complexity of mothering in illness and suffering, the value of longitudinal studies would better represent the fluidity of changing circumstances.

It is not uncommon for the content of an informed consent in qualitative research to be more consistent with the assumptions of experimental research (Field & Morse,1985, as cited in Munhall, 1988); as such, it considers subjects as information givers rather than collaborators. Valuing participants as persons is particularly important when their subjectivity is already compromised. For example, the purpose of engaging a mother in this research was not merely for the acquisition of data for theory generation. Collecting testimonies of mothering to the exclusion of the mother as person would have served to undermine her sense of agency. As suggested by Oliver (2001), my ethical obligation was to recognize each mother as a person in her own right. This conceptualization entailed my being "address- and response-able" to her.

Openness to the mothers' subjectivity necessitated consideration of the sociohistorical nature of mothering. According to Finch (1999), research ethics has often overlooked the collective nature of women's existence. She explains that securing a woman's research rights with guarantees of confidentiality, and anonymity does not specifically address the collective interests of others. For example, a participant's allegations of abuse brought to the forefront the rights to privacy and protection of other family members who were not directly involved in the study. I did not anticipate the potentially harmful use of the data for this mother or her family. To this end, Finch stresses the need to "make a clear distinction between structural position and women's own experience of it" (p. 77) so as not to potentially undermine the mothers as a group in the presentation of the findings.

Another limitation that arose was that I was uncertain how to move through the process as described by Glaser. His assurances of placing trust in the process were not necessarily reassuring when confronted with rich data. His emphasis on "just doing it" did little to guide me in planning how to proceed through the steps of analysis. This was particularly challenging in view of the significance of these stories for all the mothers. I realized that rather than trusting the process, I needed to trust what was offered though their stories. Even now, there may be more messages that I have yet to recognize.

Conclusion

No qualitative research could be identified concerning the subjective meaning of mothering for women with serious mental illness. In my use of grounded theory, the focus for 20 mothers suffering mental illness was to keep close to their children. For this group of mothers, keeping close equated with having agency. Their sense of responsibility to protect their children from illness shaped their use of in/visible strategies: as agents in difference, they masked, censored speech and did motherwork to the point of being 'mechanical'. Unfortunately, such actions were life-threatening for some and became the signifier, the moment of visibility. Reconciliation of self-as-mother then depended on the understanding of caring professionals. Mothers sought guidance on how to be with their children more fully while also meeting their own mental health needs. Placing mothers' experiences at the center of analysis offered a different perspective from the historical one that views them primarily from a deficit perspective. Nursing practice and future research in this area must be sensitive to SMI mothers' need for in/visibility.

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APPENDIX A
APPROVAL BY RESEARCH ETHICS BOARDS

Appendix A

Approval by Research Ethics Boards

A. Emailed approval from McMaster University

August 16, 2000

PROJECT NUMBER: 00-229

PROJECT TITLE: "Motherhood and serious mental illness:
                A grounded theory analysis"

PRINCIPAL INVESTIGATOR: **Phyllis Montgomery**

As you are aware this study was presented at the August 15th, 2000 Research Ethics Board meeting where it received **final** approval. The submission, including the consent form was found to be acceptable on both ethical and scientific grounds. The REB did suggest you make a few minor revisions to the consent form - delete the line after *I.* as the participant states their name at the bottom of the form; include a line for the participant to also print their name and add a statement indicating how long you plan to store the audio tapes. Please forward a copy of your revised consent to the REB Office for our files.

We are pleased to issue final approval for the above-named study for a period of 12 months from the date of this letter. Continuation beyond that date will require further review and renewal of REB approval. Any changes or amendments to the protocol or consent form must be approved by the Research Ethics Board.

Investigators in the Project should be aware that they are responsible for ensuring that a complete consent form is inserted in the patient's health record. In the case of invasive or otherwise risky research, the investigator might consider the advisability of keeping personal copies.

A condition of approval is that the physician most responsible for the care of the patient is informed that the patient has agreed to enter the study. Any failure to meet this condition means that Research Ethics Board approval for the project has been withdrawn.

PLEASE QUOTE THE ABOVE-REFERENCED PROJECT NUMBER ON ALL FUTURE CORRESPONDENCE.

Sincerely,

Jeff Weitz, M.D.
Acting Chair, Research Ethics Board

McMaster University

Hamilton Health Sciences
EXEMPLARY CARE • ACADEMIC EXCELLENCE
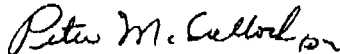
RESEARCH ETHICS BOARD

September 19, 2001

PROJECT NUMBER: 00-229

PROJECT TITLE: "Motherhood an Serious Mental Illness:
A Grounded Theory Analysis"

PRINCIPAL INVESTIGATOR: **Phyllis Montgomery**

This will acknowledge receipt of your letter dated September 10, 2001 which requested annual review and renewal of the above-named study.

This request has been reviewed by a member of the REB Executive and was found to be acceptable. This information was presented and approved by the full Research Ethics Board at their meeting held on September 18, 2001 and your study has been granted *annual* renewal.

Sincerely,

Peter McCulloch, M.D., FRCP(C)
Chair, Research Ethics Board

/dm

**HÔPITAL RÉGIONAL DE
SUDBURY
REGIONAL HOSPITAL**

Dr. B. Aitken
Chairman
Research Ethics Committee
Telephone: 705/523-7113
Fax: 705/523-7112

11th September 2000

Phyllis Montgomery
Laurentian University
School of Nursing
Ramsey Lake Road
Sudbury, Ontario
P3E 2C6

**Laurentian Site
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**Memorial Site
Emplacement Mémorial**
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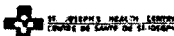
700, rue Paris St.,
Sudbury (Ontario) P3E 3B5
(705) 674-3181

RE: Motherhood and Severe Mental Illness: A Grounded Theory Approach

Dear Ms. Montgomery:

Attached please find the signed approval form for the above noted research study.

The committee requested the following revisions to the consent form:

1.   Witness and Principle Investigator signature line to be added.
2.   Consent form must be on letter head.
3.   Add the phrase **"If I wish to speak with a hospital resource person who will answer any questions about my rights as a research subject, I may contact the Senior Management Office in Charge of Research at Hôpital régional de Sudbury Regional Hospital at (705) 523-7113."**

A revised consent form is to be submitted to the Medical Affairs Office for our files. If you have any questions, please do not hesitate to contact me.

Yours sincerely,

Dr. B. Aitken
Chairman
Research Ethics Committee

/pz
Attachment

HÔPITAL RÉGIONAL DE SUDBURY REGIONAL HOSPITAL

APPROVAL BY RESEARCH ETHICS COMMITTEE

INSTRUCTIONS TO PRINCIPAL INVESTIGATOR:
PLEASE COMPLETE THE TOP PORTION OF THIS FORM.

TITLE OF PROPOSAL (Include all identification required for approval by the Research Ethics Committee, i.e. version number, amendment number, etc):

Motherhood & Severe Mental Illness - A grounded theory approach

Check where applicable:

☑ Initial Approval of Protocol Dated: _Aug 11/00_

☑ Original Informed Consent Dated: _Aug 11/00_

☐ Revised Informed Consent Dated: _____

☐ Amendment(s) # _____ Dated: _____
    Provide details of amendment:

☐ Annual Renewal   Dated: _____

☐ Serious Adverse Events   Dated: _____
    (Principal Investigator to summarize, including report numbers)

FOR USE BY HRSRH RESEARCH ETHICS COMMITTEE:

The above item was submitted to the Research Ethics Board for review and approval.

☐ Expedited Review

☐ Approval Pending _____

☑ Approved at Full Board Meeting (with a quorum present)

Sept 11/00   _____
Date of Meeting   Chair, Research Ethics Committee

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École des sciences infirmières

Referral by Psychiatrist

It is my opinion that there __ARE or _ **ARE NOT** contraindications to _____

(participant's name) being approached or participating in the study "Motherhood and serious mental illness: A grounded theory approach".

_____
Date

_____
Psychiatrist's Signature

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Motherhood and serious mental illness: A grounded theory approach

The Psychiatrist's (or Designate) Explanation of the Study
to Potential Participants

Phyllis Montgomery, a Registered Nurse and Professor at the School of Nursing, Laurentian University, is conducting a research study in cooperation with _____ (the agency). She is interested in speaking with individuals such as you, who are mothers to young children. She would like to know if you would be willing to share with her concerns, thoughts, feelings and experiences of being a mother.

Phyllis would like to contact you to explain the study and ask if you would like to participate in it. This will take about 10 minutes of your time. You are not obligated to speak to her and even if you do, you are not obligated to participate in the study. If you decide not to speak with Phyllis, your decision will not affect the care you receive.

Will you agree to my giving your name and a contact number to Phyllis so that she may explain the study to you?

If yes: Inform individual that you will be giving Phyllis her name and number.

If no: Thank person for her time and consideration

Laurentian University	Université Laurentienne		
Ramsey Lake Road Sudbury, Ontario Canada P3E 2C6	Chemin du lac Ramsey Sudbury (Ontario) Canada P3E 2C6		School of Nursing
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Motherhood and serious mental illness: A grounded theory approach
Explanation of Study To Participants

Hello (Name of Participant)

My name is Phyllis Montgomery. I am a Registered Nurse and a teacher of nursing at Laurentian University. I, in cooperation with_____ (the agency), am conducting a nursing research study. This study is a requirement for my doctoral studies in nursing at McMaster University, Hamilton. I am especially interested in your concerns, thoughts, feelings, and experiences as a mother. The focus of the study is you as a mother to your children, not the children themselves.

Your participation in the study would involve one or two interviews which can be as short or as long as you like. Most likely, an interview will take about one hour of your time. During the first interview, I will ask you about your expectations of self as a mother, the rewards and challenges of mothers and your nurturing behaviours. If there is a second interview, it would take place only if you are willing to assist me to clarify my understanding of your experience as a mother. The interviews will be taped recorded so that I do not have to write while we talk. The recordings will be used for research purposes only and that at the completion of the research, the tapes will be destroyed.

I will ask you to sign a consent form before we begin the interview. Your name and any identifying information will not appear with any of the data reported from this study. I will use only your first name while the tape recorder is on. Information from the interview will be identified only by a code name. Your name, phone number, and the consent form will be accessible only to me. I will not share what you tell me with the staff except if you give me information that indicated you are at imminent risk to do harm to yourself or others. Than I would be obliged to inform the appropriate staff members, but I would tell you first that I would be doing this.

You will not directly benefit from participating in the study, but it may help in an better understanding of the role of mother in illness. The information you share with me may help health care professionals working with other mothers who live with serious mental illness

Whether you decide to participate or not is up to you. If you refuse, your care will not be affected in any way. If you decide to participate now, you can change your mind later and withdraw completely at no consequence to yourself. Or you may refuse to answer any of the questions. A copy of the findings will be available in the treatment setting and will be mailed to participants at their request.

I would be pleased to answer any questions you may have at this time. As well, if you have any further questions or concerns about participation in the study, please do not hesitate to contact me at the School of Nursing (675-1151, extension 3818).

Would you be willing to be a participant in the study?

Yes - Refer to consent form
No - Thank you

Laurentian University   **Université Laurentienne**

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School of Nursing
École des sciences infirmières

Motherhood and serious mental illness: A grounded theory approach
Participant Consent Form

I, _____ , have been asked to take part in a study by Phyllis Montgomery (RN) in cooperation with _____ (agency).

I understand that Phyllis will ask me to describe my concerns, thoughts, feelings, and experiences as a mother living with illness.

I understand that I will be interviewed once or possibly twice at a time and location convenient to me. An interview is expected to take about one hour. However, it can be as long or as short as I like. I understand that interviews will be tape recorded. During the recording only my first name will be used. The recording will be used for research purposes only and that at the completion of the research, the tape will be destroyed.

I understand that my name and any identifying information will not appear in connection with any of the data reported from this study. What I say will not be shared with any staff members unless Phyllis thinks that I am at imminent risk of harming myself or others. Then she will be obliged to inform the appropriate staff member, but only after telling me first that she will be doing so.

I may choose to withdraw from the study at anytime or refuse to answer certain questions with no consequences in the care I receive.

I understand that I may not directly benefit from participating in this study, but that the information learned may help other individuals in the future.

A copy of the findings will be available in the treatment setting and will be mailed to participants at their request.

I have been given the opportunity to ask whatever questions I desire, and all such questions have been answered to my satisfaction.

I have read and understand the above and I have received a copy of the explanation of the study and this consent form.

I consent to participate in this study described to me by Phyllis about the mothering experiences of women living with illness.

_____
Signature of Participant

_____
Date

APPENDIX B
Letters

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School of Nursing
École des sciences infirmières

Motherhood and severe mental illness: A grounded theory approach

Dear: (Psychiatrist or appointed designate)

This letter is to request your support in the carrying out of a nursing research study which has been approved by_____ (involved agencies). Dr. Katta, Chief of Psychiatry, is aware of and supports this study. Conducting this study is a requirement for my doctoral degree in Nursing from McMaster University.

The purpose of this study is to explore the experience of mothering from the point of view of women with serious mental illness. The findings may assist psychiatric nursing understanding of the social processes that mothers with serious mental illness use to deal with their situations. Ultimately, the information gained may assist in the planning and implementation of programs that promote women's health within long-term illness.

Your involvement would consist of identifying prospective participants. Any woman who meets the following sample criteria will be eligible to participate in the study:

a) under a psychiatrist's care for a major mental illness
b) is mentally competent
c) is English speaking
d) is 20 years of age or older
e) is a mother of (a) child(ren) between the ages of two and sixteen years

I request your assistance in indicating whether there are any contraindications for approaching and possibly including the identified person in the study. Attached is a form I ask you to sign indicating whether or not you believe there are contraindications.

Being known to a potential participant who meets the inclusion criteria, I also request that you introduce and ask her for her permission to be contacted by me to describe the study. Attached is a standard introduction to the study. If the individual agrees, I will contact her as soon as possible to provide a thorough explanation of the study. Interviews will be arranged with participants who give written consent to participate.

I would like to meet with you to answer any questions you might have and to discuss ways of implementing these arrangements. I will be contacting you soon to schedule a meeting.

Thank you for your consideration of my request.

Sincerely

Phyllis Montgomery, RN, MScN, PhD(Cand.)
School of Nursing
Laurentian University
675-1151 extension 3818

**NETWORK
NORTH**
The Community
Mental Health Group

**RÉSEAU
NORD**
Le groupe communautaire
de santé mentale

September 26, 2000

Grants Officer
Ontario Mental Health Foundation
Suite 508, 489 College St.
Toronto, Ontario
M6G 1A5

To whom it may concern,

I am aware of Phyllis Montgomery's doctoral thesis entitled "Motherhood and Severe
Mental Illness: A Grounded Theory Approach". I support this initiative and will work
collaboratively to this end.

Sincerely,

Dr. B. Katta
Chief of Psychiatry

APPENDIX C
Field Note Guide

Field Note Guide:

1. What happened?

2. What were the main themes or issues for this mother?

3. How does such data build on other?

4. What new hunches arise from this data?

Date:
Location of interview:

APPENDIX D
The Mothers of the Study

Irene

Irene was married and a mother of two adolescent children. This was her first psychiatric admission for depression. Prior to this she had been involved in a variety of community services. Illness and the trauma of childhood abuse had invaded her most sacred space, being a mother. Hence, she sought treatment to learn another way of being with her children. "Dealing with it" inferred not "hiding from it" any longer. Being separated from her children via hospitalization was painful as she had never spent extended time away from them. An essential theme in her story was how she weaved a web of "protection" around herself and her children. Weaving the web with hiding and secret-keeping threads led to exhaustion and shame for Irene. Further, she had wrapped the web so tightly that she didn't realize her children were being "suffocated" by it. This only became apparent to her when both her children required psychiatric services. To her, these acts of hiding and keeping secrets were means of preventing loss of her family and of her ideal image as mother. Such strategies also offered her assurance that "narrow-minded" others could not judge her or her children as lacking because of her history. Ironically, the family's symptoms spoke louder than her projected image, heightening her fear of being removed from the relationships she worked so hard to create.

Hailey

Hailey was a mother of two children, one an adolescent and the other a pre-schooler. The father worked away from the home for extended periods of time during the year. Therefore, Hailey was responsible for balancing numerous daily roles, in addition to illness. Although she didn't want to work outside her home, she needed to because of the family's financial circumstances. In her efforts to meet the social expectations of motherwork, the meaning of her "doing" became meaningless. To "survive" in her specific context required her to do things by rote, to the extent that she "could do it in her sleep." Routine allowed her to remove self from her overwhelming demands. The interaction between Hailey and her children was described as hostile, the hostility fuelled by family circumstances such as her husband's substance use, her children's "constant fighting", her limited support, one of her child's behavioural problems and her own exhaustion. Her involuntary hospitalizations within the past year were each described as "all of a sudden." Hailey stated that she doesn't recall the events preceding each admission. This may suggest the severity of her illness and overwhelming circumstances. Hailey acknowledged that she doesn't understand what her psychiatric problem entailed.

Kathleen

Kathleen was a married woman and mother of a adolescent child. She had a long history of bipolar illness. Prior to admission, she "begged" her partner to assist her to commit suicide. She was difficult to interview since each of her story themes seemed wrapped in chaos. Often, she diverted the topic of conversation. For example, she began by identifying that one of her strategies of parenting involved guiding her child to be

"street-wise." To elaborate on her meaning she would begin by giving a concrete example. However, the example would become mixed with other events that appeared, from the listener's position, extraneous to the story. It was only after numerous readings of Kathleen's audiotape transcript that I 'heard' her fear concerning her child pulling away from her completely. This was especially stressful for Kathleen as she saw herself in her child. If she lost her child, she would be left with illness, debt and guilt. Loss of a child equated with being "weak." Hence, to keep her child close in illness, she "camouflaged" by pretending, removing self, keeping secrets, focussing on others' problems and abusing substances. These pretences compounded the chaos in the home.

Melanie

Melanie was a mother of two adolescent children. The father of the children had left the home when they were young. She spoke about how she had endured her depressions for over fifteen years for the sake of her children. She believed that her main responsibility was to keep illness away from her children, to hide it behind the ideal image of mother. Such an expectation was also reinforced by significant others. Eventually, her reliance on pretences to support the ideal image exhausted her "on all fronts." The ideal pretence was shown as false by her "spiralling out of control." With increasing turmoil, Melanie found that there were not enough facades to keep illness hidden from others. To alleviate her suffering, she regularly prayed for a "natural death." Self-harm was not an option because of her love for her children, but to seek psychiatric help was shaming for her. Yet, by this point, her choices were limited and her psychiatric pain was overwhelming. She wanted to know how to live as a mother in difference without shame or guilt.

Mary

Mary was a divorced mother of an adolescent child. She attributed her former abusive marriage to frequent relapses and admissions. Over time she had been given "many" diagnoses. Mary lived with another partner and her child resided with the father. Her child visited Mary on a regular basis. She looked forward to being interviewed as often she was dismissed as 'mother'. During most of the interview, she cried tears of regret, loss and shame. Mary acknowledged that she was unaware of how to mother in illness and feared hurting her child. Mary expressed shame and guilt concerning her inability to be present for her child when she was ill and in chaos. When she sought help, often it was not consistent with her needs. Being maintained on medication "masked" her inner suffering. Others dismissed her as 'mother.' Yet, she endured for her son. She hoped that in the future her child would understand her struggles as 'mother'. For Mary, the "most important thing in the world" was to help her child "go in the right direction." She wanted to give to her child "what was taken" from her so that her child would not be "lack[ing]."

Sally

Sally was a separated woman in her early 30s who lived alone. Her two children lived with their father. Her most recent diagnosis was schizophrenia. Sally articulated how she moved from a culture of wellness to illness. During this unexpected and unpredictable transition, she lost joint custody of her children. Since she was considered as lacking, others maintained her separation from her children. Although she continued to talk to, write to and make space for them, when she saw them depended on either the father or the children. Seeing her children affirmed her as mother. Her mothering efforts were to create "a bond so strong" with her children that it could not be broken by others, or by illness circumstances. Her children needed her to guide them away from illness. By sharing her experiences with them, she hoped they would not "end up" hospitalized on numerous occasions. She reserved "her wisdom" for her children hoping that in time they would understand her as their 'mother'. The sharing of experiences was a means to maintain her connection with her children.

Brooke

Brooke was married and parented two school-age children. This was her first psychiatric hospitalization, despite a long history of psycho social treatment in the community. What precipitated this admission was her attempted suicide, a circumstance that was not comfortable for her to talk about. Through years of treatment and therapy, she became familiar with mental health promoting strategies. Brooke struggled with manipulating such strategies in the context of illness and turmoil. Brooke explained that to appear "normal" in difference was exhausting. To project a false self was described as an art. Brooke described herself as a "Master of Disguises," a craft that involved hiding authentic self behind the ideal mask. To project an inauthentic self was an art form in that the choice of pretence depended on the context. When masked she could deflect attention away from herself and toward the children. The pretences, however, created confusion for both Brooke and her children as she became increasingly alienated from self-as-desired-mother. Brooke wanted the professionals to teach her how to be more authentic with her children.

Kate

Kate was a married woman and mother of three school-aged children. She was unable to work during the past year. Kate has had two admissions to hospital within a one-year period for "crazy thoughts." Prior to her last admission she recalled how she had "lost it" and required police intervention. With increasing symptoms, she had to abandon several of her mothering responsibilities that, in turn, led to her being isolated by others. Consequently, Kate's place as mother became increasing threatened as her children, husband and extended family were also caught in turmoil. In addition to Kate's inability to recognize herself in illness, others might not have recognized her either. Or example,

she mentioned, her husband "didn't know how to take me anymore." For Kate, being removed as mother was suffering. She wished her family could hear her despair.

Peggy

Peggy was a mother of a school-aged child and in a marriage she described as abusive. Peggy had numerous hospitalizations for varying diagnoses; some of her lengths of stay were over four months. To stay in hospital removed her to some extent from the turmoil in her home. Her husband and family attended to the day-to-day needs of her child. Peggy acknowledged that to be removed via hospitalizations was "heart breaking" yet necessary as "best for" her child. Peggy described how suffering has invaded her core and even day-to-day survival was a challenge. Peggy wanted a connection with her child - to be "close" or "in child's space," but she was unsure of how to achieve this in the context of illness and suffering. She described how she did not value self-as-mother and worried for her child's future. Unable to fulfill her responsibility as a mother in illness was shaming. With time, her resources became increasingly limited and now much time was spent in anguish over the choice to live or die. Yet, she explained that she persists because of her child.

Betty

Betty was a mother of four school-aged children. The father suffered with mental illness and was unable to work. Hence, she needed to work to support the family. Betty described a long history of mental health problems. Her distrust of professionals was a barrier to her participation in psychiatric treatment. At the time of the interview, Children's Protection Services were involved with her family. Under their "watchful eye", Betty became increasingly self-doubting of how to mother. As illness imposed a "second guessing" with regard to mothering decisions, being watched had a "triple guessing" effect. Others often did not hear her explanations about how difficult it was to mother, especially in mental illness. Betty became caught in that she did not want to appear ill or vulnerable as others unwittingly equated this with unwillingness to mother. Appearing "strong" become all that more important as Betty perceived herself to be in a "fight" for her children. As Betty's control of the situation became more tenuous, however, she believed that removing self, keeping secrets and pretences helped her to protect her children from "what might happen."

Gloria

Gloria was a married woman and mother of one pre-schooler and two school-aged children. She was now receiving outpatient services. Despite her psychiatrist's assessment that Gloria was seriously ill, she perceived herself as "not ill" at the time of the interview. Being "so sick" as to require three acute psychiatric admissions was in the past and she preferred to leave it there. Possibly, to recall this experience was too painful for Gloria so she truncated it from her identity. During all of her involuntary

hospitalizations, Gloria feared that her children would be removed from her. The chaos in Gloria's home at the time of her hospitalizations impeded her from focussing on her own needs. With each admission, she was determined to leave so that could fight for her children. Now, being with her children, having a partner who is not threatening to leave her, having money, and having some free time were signifiers of wellness. She was fulfilling her desire to be a mother, a role threatened by illness. Her children provided her a sense of purpose and identify.

Nancy

Nancy was a married woman and mother of two school-aged children. This interview lasted less than twenty minutes as she became increasingly anxious. She experienced illness and suffering as painful and meaningless. To persevere as 'mother', she masked, spent less time in the home, kept secrets and abused substances. Her efforts to keep illness away from her self-as-mother became increasingly difficult as she became lost in the "blue haze" of illness. Unable to see though the haze, Nancy's vulnerability to removal as 'mother' increased. She came to doubt her value as 'mother.'

Rachel

Rachel was a mother of four children who ranged in age from two to eight years of age. Her marital relationship was problematic, but she trusted her husband to provide the basics for the children. Although Rachel loved her children, the role of mother was not a choice but an expectation. Parenting has not allowed her to do what she "wanted to do." Yet, she maintained pretences for the sake of appearing "good." She has considered leaving her home, but her obligation as a mother held her back. In view of her "unbelievable" suffering, she chose to remove herself from the turmoil at home. Work offered her refuge, a respite from the continuous demands of mothering. At work she could function and be authentic, while at home Rachel described herself as "someone I don't want to be." As Rachel was unable to keep up pretences at home, her children were becoming frightened. The more her illness became "unbelievable" and "crazy", the more protecting her children from witnessing it became a struggle. Her illness was not meant to hurt her children. Rachel perceived her only remaining option was suicide, an attempt that precipitated hospitalization.

Heather

Heather, who was in her late twenties, was a mother of two school-aged children. She separated from the father of her oldest child and was married to the father of her youngest child. Heather had numerous stressors. These included the unravelling of her children's parentage, her husband not working, financial problems, stress associated with her work, the vicious circling of illness, concerns expressed by a teacher, and her children's being "unhappy." Heather perceived the situation as "out of control" despite her efforts to exert "a ton of it" without success. Her idealistic image of family began to

fall apart in illness and chaos. As 'mother', she knew she shouldn't have thoughts of intolerance towards her children. To avoid being seen as lacking, she enacted several pretences. "At the end of [her] rope", Heather attempted suicide and was admitted to a psychiatric inpatient unit, a setting she had attempted to avoid since her teenage years. Sadly, she came to realize that her mothering acts may have inadvertently harmed her children.

Janice

Janice was a single mother of a school-aged child who worked to cover her expenses as well as to provide "the best" for her child. She described her child as the center of her world and desired the "ideal" family structure for the child's sake. Janice trusted her sisters and others to identify when she needed help. She knew that exhaustion, thought distortions and questionable judgments required her to rely on others. She described illness as "breaking" her into unknown parts. When she experienced an imbalance between her energy levels and medications, attending to her multiple roles became extremely difficult. When her energy was diminished, she was unable to do the motherwork. Instead, she reserved the limited energy she had just to be physically present with her child. To protect her son from her illness, she moved her child among family members and also hid chaos, literally, behind closed doors. She questioned how the health care system could help her as a mother since professionals have been unable to manage her symptoms. She was willing "to be watched" by health care professionals so that they could discover the right medication. Yet, with time and a perception that she was being treated like a "guinea pig" Janice became less patient with and more cautious of professionals. Being hospitalized removed Janice from her "life" with her child without a promise of symptom control. This increased Janice's uncertainty of her future as mother.

Paula

Paula was a single mother in her mid-twenties. She had two school-aged children. Prior to her most recent hospitalization, she had just signed documents permitting her mother to be her children's legal guardian. In the context of illness and difficult circumstances, Paula sought mothering guidance. In response, she heard, "you're a bad mother". Paula's goal as a mother was to protect her children "from trauma". When she was ill, she could not discern the rules or meet the expectations as determined by others. Wanting to see her children, she would defy the guidelines as set by Children's Services, but this served only to complicate her chaos further. The more resistance she encountered, the more "explosive" she became. Now that her children are with her mother, she wanted to focus on "finding out who she was" so that she could re-connect with her children. With treatment, she was now allowed to visit with her children.

Tracy

Tracy was in her late thirties when she had her child. She has a long history of bipolar illness and numerous psychiatric hospitalizations. Her partner, the father of the child, also had mental health issues. Tracy's desire to be a mother was not matched by her resources to fulfill such a role. Giving birth was a milestone of womanhood and being normal. Since she had not secured suitable accommodations, Children's Protection Services removed the child and placed her with extended family soon after the child's birth. The child was now school-aged. Tracy openly acknowledged her need for guidance to mother and her limitations that were interwoven with illness and treatment. To remain connected to her child she waited, watched, and used words cautiously so as not to upset either her child or the 'surrogate' mother. Extended family determined when Tracy could see her child. For Tracy, to see her child affirmed her as mother. Gradually, others dismissed Tracy as 'mother' because of her illness. For example, unbeknown to Tracy, her family changed her child's last name. Tracy's heart "breaks" every time her child referred to her as "Aunt Tracy," but she conceded to a point. This point was marked by her perception of what was best for her child. Hence, she accepted the name change to lessen the child's confusion as a member of the guardianship family. Tracy was willing to preserve what her child knew as family. Although Tracy didn't deal with the day-to-day parenting, she attempted "to distract" herself and waited for mothering moments.

Alice

Alice was a married woman and mother of two pre-school children. She appeared to be in her twenties. She has a history of anxiety, depression and an eating disorder. Although she worked outside her home, she expected to lose her job following hospitalization. This was her first psychiatric hospitalization, an experience that she considered shaming. Prior to being admitted, she had frequented the emergency department believing she was having "major chest pains, heaviness", indicators of the severity of her distress. Alice attempted to mask her inner turmoil since she did not want to be seen as lacking. In chaos, mothering became "a chore". To be a mother was "like I no more" as she became increasingly frustrated and angered by her inability to achieve her high expectations despite her best efforts. She did want to reveal the depths of her inner turmoil to others. Instead, for the protection of her family she chose to be alone in suffering. She feared that speaking about her concerns about "dying" from within, secondary to the "spiralling", "spinning", "falling" and "cycling" in illness, would overwhelm those she loved. "In the fog" of illness, she became lost, unable to navigate her way back to her children whom she values. Eventually, her body "spoke" her suffering – she became unable to sleep, tearful, agitated, and struggling with her mothering responsibilities. She described her husband's and children's confusion concerning her mothering practices.

Joan

Joan was a young, single mother of a pre-schooler. She was in her twenties and having just completed post-secondary education, she wanted to work. Her child was Joan's sense of purpose. Speaking to her child "with her heart" inferred that their relationship was sacred. Joan repeatedly mentioned that she was not aware of the words to use in order to help her child understand without frightening her. As her child was "in the dark", Joan had to ensure that her explanations were clear. Keeping her illness away from her child by "camouflaging" may have given Joan time to search for the most appropriate words. Joan clarified that acknowledging and accepting illness were two different processes. On the one hand, to acknowledge illness entailed Joan's realizing she had a condition known as bipolar illness. On the other hand, to accept illness required more time and was overshadowed by the fear that her child might reject her in the future. Often, others could not distinguish between her-as-mother and her-as-illness.

Connie

Connie was a married woman and mother of a pre-schooler. She has received a variety of diagnoses, the latest being schizophrenia. Soon after the birth of her child, a Children's Protection worker became involved with the family. This same worker continued to visit, attending to the needs of both Connie and her child. Her relationship with her worker was described as positive as the worker monitored, as opposed to removed, her child. With Connie's fears of child removal addressed, she was able to discuss parenting issues. A pronounced theme in Connie's story was worry for her child's safety. Connie feared her child may be hurt by others or abducted by strangers. Hence, Connie needed to keep close to her child and continuously monitor her environment for any potential risks.