

UNIVERSITY OF SOUTHERN QUEENSLAND

EARLY FAMILY TRAUMA:
A COMPARISON BETWEEN ADULTS WITH
SCHIZOPHRENIA AND DEPRESSION

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ABSTRACT

This study explores similarities and differences in the early family history of an adult group with schizophrenia, and a matched group with major depression. Attachment theory, trauma theory and their relation to serious mental illnesses are used to understand the clinical participants' reported early traumatic experiences of emotional deprivation and neglect.

A retrospective design includes self-report questionnaires from clinical participants, and semi-structured interviews with participants' mothers/primary caregivers.

Data analysis includes:

1. Assessment of matched participants' reported prevalence of emotional deprivation and neglect in four different age groups;
2. Assessment of themes of early family trauma and sequelae from the mother interviews;
3. Qualitative analysis of sample mother/primary caregiver interviews from each diagnostic group of the manner in which the interviewees construct their stories around trauma;
4. Quantitative analysis of a conceptualised model representing the arguments developed in the body of this dissertation.

The second and third forms of analysis above include a panel of three experts, blind to diagnosis, validating this researcher's findings.

Standard multiple regression analysis indicates participants' reported neglect across all age groups significantly predicts emotional deprivation, with neglect contributing 27.4% of the variability, but with no individual age band contributing significantly to the equation.

Themes from the mother interviews are clustered into three constructs, guided by the research questions and this researcher's clinical experience, the mothers' emphases and the expert panel into Early Family Trauma, Maternal Fatigue, and Clinical Participants' Early Attachment Difficulties.

The mothers' manner of discussing early family trauma is defined via speech markers as dissociative (disorganised, incoherent, and unresolved) or coherent (grounded, sequential and resolved) according to Attachment Theory and the literature on dissociation. Speakers are assigned as using dissociation or not as a categorical variable.

A model is conceptualised to represent the interrelatedness of data from the participants and their mothers, including the manner in which the mothers relate early family trauma. Canonical Discriminant Function Analysis indicates that early family trauma and maternal fatigue discriminate little between diagnostic groups and that maternal non-resolution of early traumatic events and (possibly related) participant offspring attachment difficulties contribute most to distinguishing between the two diagnostic groups. Finally, a greater number of participants from the schizophrenia sample than from the depression sample continue to live with mother, possibly indicating that the early attachment difficulties remain unresolved.

Discussion offers a reconceptualisation of several major and/or established theories concerning risk factors in schizophrenia, and examines shortcomings in the literature, concluding with suggestions for future research.

Chapter 1

INTRODUCTION

This chapter outlines the structure of the dissertation. It begins with the aims of the research. The rationale for the research is then discussed in light of the current knowledge in the relevant areas of trauma, attachment and related cognitive theories, and their relevance to adult depression and schizophrenia. An overview of the research method and the research questions and hypotheses are presented. Finally the subsequent chapters are outlined.

Aims

There are three aims in this research:

1. To explore the similarities and differences in early family trauma in adults with two distinct diagnoses, schizophrenia and major depression. The clinical participants are selected from a population presenting to an adult mental health centre. Quantitative and qualitative enquiry are used to explore early family trauma reported by the mothers/primary caregivers of the clinical participants.
2. To examine qualitatively and quantitatively potential associations between early trauma, attachment of the participants as infants and later adult psychiatric disorders through self-report and interview methods. Psychosocial stressors provide a context within which the trauma and attachment issues are examined.
3. To propose a model examining ongoing effects of these factors and to quantitatively assess this model.

Rationale

The aspects of trauma theory used in this research have been guided by this researcher's knowledge and interest in the profound and long-lasting neurobiological, emotional, cognitive and interpersonal/relational effects of sustained trauma.

The attachment theory used in this research has two sources: Firstly the ethology based theory proposed by Bowlby (Bowlby, 1988; Holmes, 1993) is used. This theory has been extensively explored both qualitatively and quantitatively by psychoanalytically-oriented and developmental researchers (Cassidy & Shaver, 1999; Holmes, 2000). Secondly the current diagnostic criteria describing childhood disorders of attachment are used (Rutter, Kreppner & O'Connor, 2001). Attachment

theory with its ethological base, focuses on survival of the infant, and therefore shares a focus with trauma theory. Specific attention is given to attachment trauma in this research. Attachment trauma refers to the effects on an infant of significant disruptions in the quality of caregiving by the infant's significant others.

There has been a resurgence of interest in trauma research in the last two decades (Read, Agar, Argyle & Aderhold, 2003; van der Kolk, McFarlane & Weisaeth, 1996). Many studies have linked trauma with the genesis of several psychiatric disorders including post-traumatic stress disorder (PTSD), mood disorders including depression, behavioural disorders, personality disorders, and acute psychotic reactions (Blank, 1994; van der Kolk et al.). Some research has found that over 80% of persons with post-traumatic stress disorder suffer from other psychiatric disorders (Solomon & Davidson, 1997). Vigorous debate has continued on whether these links are causal (Bleich, Koslowsky, Dolev & Lerer, 1997; Low, Jones, McLeod, Power & Duggan, 2000) or co-morbid (Brady, 1997; Kilpatrick et al. 2003). Central to this debate is the contrast between prevalence of trauma in the general population of 40-70%, and prevalence of PTSD of 8-14% (Frueh, Elhai & Kaloupek, 2004). The manner in which traumatised individuals process highly emotional material seems pivotal to whether or not they develop long-lasting symptoms. Not adequately processing or integrating the traumatic experiences after one month is thought to be indicated by the manner in which these experiences are reported. Fragmentation in memory and lack of coherence in speech are keys to identifying this non-resolution of trauma (Zoellner & Bittenger, 2004). It is argued in this research that fragmentation and incoherence are dissociative processes (Chapter 2).

Recent studies have proposed links between childhood interpersonal trauma (abuse) and later adult schizophrenia (Read et al. 2003; Schore, 2002). However Read et al. focused on the primary trauma directed towards the child who as adult recalls interpersonal abuse (that is, after the age of three years when narrative memory is accessible), with the authors linking this childhood abuse with later development of adult schizophrenia. Schore argued theoretically from animal studies for profound neurological sequelae to early interpersonal abuse and/or neglect in humans, with the proposed resultant effects being PTSD symptomatology. Studies of traumatic stress in infants and children have not adequately assessed resultant

developmental disturbances. These gaps in the literature will be explored in this research.

Trauma: Definition

Trauma has been variously defined in the research literature. It is significant that these definitions have been predominantly in the format of consequences and symptomatology and not in the format of specific events. This has not always been the case when events are widely or socioculturally held to be traumatic, for example witnessing or experiencing extreme violence. The Diagnostic Statistical Manual for Mental Disorders Fourth Edition (DSM-IV, 1994) defined a traumatic event as one that involves a person in actual or threatened death or injury, and the person's response involves intense fear, helplessness or horror.

Solomon and Davidson (1997) included the following traumatic events in their review: witnessing death/injury; serious accident; disaster/fire; life threat; robbery; homicide; tragic death; injury to a significant other; molestation; physical attack; rape; combat and physical abuse. Lipschitz, Winegar, Hartnick, Foote and Southwick (1999) reported the following traumatic events occurring for a group of adolescents suffering PTSD who were admitted to hospital: being a witness/victim of community violence; witnessing family violence; and being the victim of physical/sexual abuse. These studies and others have reflected the inclusion of witnessing traumatic events as a potential contributor to PTSD (Frueh et al. 2004).

Trauma: Sequelae

The most common clinical sequelae of trauma are anxiety and depression. Acute Stress Disorder and Post-traumatic Stress Disorder (PTSD) also occur for some people experiencing trauma. DSM-IV (1994) defined Post-Traumatic Stress Disorder (PTSD) according to the following criteria: the nature of the traumatic event, the subject's immediate cognitive response, the re-experiencing of the traumatic event in one or several ways, persistent avoidance of reminders of the traumatic event, hyperarousal, duration of more than one month, and resultant impairment in functioning. The high comorbidity of PTSD with other psychiatric disorders, especially affective disorders, anxiety disorders, somatization, substance abuse and dissociative disorders has been explored (Brady, 1997). Family alcohol abuse has been associated with generational PTSD (Brown, 1994).

Van der Kolk et al. (1996) discussed a two-stage response to trauma. The first stage or core traumatic neurosis, is defined as Post-Traumatic Stress Disorder. The

second stage is any diagnostic manifestation generated by the traumatised person. This is an attempt to adapt to and reorganise in the face of compromised functioning. The extreme complexity of post-traumatic responses have been covered in Blank's (1993) list of the long-term effects of trauma:

1. PTSD and its variants.
2. Dissociative disorders.
3. Brief reactive psychosis and other disorders precipitated directly by a traumatic stressor.
4. Comorbid diagnoses with either a primary or secondary relation to the stressor.
5. Delayed, intermittent or recurrent forms of the disorder.

A DSM-IV (1994) research committee on trauma provided tentative criteria for Disorders of Extreme Stress Not Otherwise Specified (DESNOS). Herman (1992) named this Complex PTSD.

The proposed criteria were as follows:

- A. Alterations in regulating affective arousal
 1. chronic affect dysregulation
 2. difficulty modulating anger
 3. self-destructive and suicidal behaviour
 4. difficulty modulating sexual involvement
 5. impulsive and risk-taking behaviours
- B. Alterations in attention and consciousness
 1. amnesia
 2. dissociation
- C. Somatization
- D. Chronic characterological changes
 1. alterations in self-perception: chronic guilt and shame; feelings of self-blame, of ineffectiveness, and of being permanently damaged
 2. alterations in perception of perpetrator: adopting distorted beliefs and idealizing the perpetrator
 3. alterations in relations with others:
 - (a) an inability to trust or maintain relationships with others
 - (b) a tendency to be revictimised
 - (c) a tendency to victimise others

- E. Alterations in systems of meaning
1. despair and hopelessness
 2. loss of previously sustaining beliefs

In other words, trauma has been acknowledged as affecting a broad range of core psychological functions.

Trauma in Infants and Children

The DSM-IV (1994) reserved the diagnosis of PTSD for adults. Studies of traumatic stress in infants and children have not adequately assessed resultant developmental disturbances. Drell, Siegel and Gaensbauer (1993) stated that the idea of PTSD in infants and toddlers is a relatively new concept. Literature reviews on this subject are scarce (Schore, 2002) and are largely based on animal studies. Pynoos (1990) proposed criteria for PTSD in children over three years of age. These include an event that would be distressing for almost anyone, re-experiencing the trauma in various ways, psychological numbing or avoidance, and increased arousal. In her trauma studies, Lenore Terr (Terr, 1979, 1983, 1988) identified three primary threats that overwhelm children:

1. threats to life/self
2. threats to body integrity
3. threats to the family constellation

Much is left unknown concerning the response of children under three years of age to traumatic events (Drell et al. 1993). Terr (1988) noted that children under five at the time of documented traumatic events maintain memories of the events and continue to react to reminders. The DSM-IV (1994) committee's research on trauma indicated that the older the victims are and the shorter the duration of the trauma, the more likely they are to develop only the core PTSD symptoms. Conversely, the younger the victims, the longer the trauma, and the less protection, the more pervasive is the damage.

“The field trials confirmed that trauma has its most profound impact during the first decade of life, and that its effects become less pervasive in more mature individuals. Early and prolonged interpersonal trauma resulted, not in nonspecific character changes, but in the psychological problems captured in the DESNOS syndrome.” (van der Kolk et al. 1996, p.203)

This thorough text covered the reactions of children exposed to traumatic stress including violence, terrorism, war, life threatening medical illness, sexual

abuse, and witnessing the death of a parent. The authors related PTSD to comorbid psychiatric conditions, including depression and separation anxiety disorder, an indicator of insecure attachment. Reference was made to the work by Pynoos already quoted. Neurological plasticity in the foetus, infants and young children increases both vulnerability to traumatic stress and the capacity for reparation (Perry & Pollard, 1998).

Recognition is given that trauma does not always lead to mental illness. Protective factors as well as risk factors have been listed in the research literature (Cederblad, Dahlin, Hagnell & Hansson, 1994; Rutter, 1993). For some families a significant trauma does not harm the infant as there may be sufficient protection, reassurance and nurturance (Rutter & Sroufe, 2000). For other families trauma sequelae are intergenerational and not induced by a finite externally produced trauma (Rowland-Klein & Dunlop, 1997). However, for a significant number of adults presenting with mental illness at mental health services, the link is evident (Blank, 1993, 1994; Buka & Fan, 1999; Levitan et al. 1998). The above research indicates the complexity of human responses to potentially overwhelming traumatic events, either to the infant, its family, and in the present or intergenerationally. The above also indicates the potential for these responses to increase vulnerability to mental illnesses.

Relating Early Trauma to Adult Psychiatric Disorders

How could early trauma lead to neurobiological and constitutional changes that persist into adulthood? A rationale will be presented here based on recent neurological research on brain functioning during trauma.

Neurological factors

In traditional psychiatry the primary frontline treatment for severe adult mental illness is biochemical. It has long been recognised that there is an indisputable link between stress, brain biochemistry and mental illness (Gemelli, 1996). However, vulnerability to mental illness and indeed to stress has been seen in traditional adult psychiatry as being principally caused by a genetic predisposition (personality and temperament) to neurobiochemical distortions. Biochemical treatment targets these distortions.

It is simplistic to propose that identified trauma at a particular age leads to specific mental illnesses.

“It has been difficult to demonstrate in a convincing fashion that particular patterns of life experience or particular psychological traumas lead specifically to particular mental disorders.” (Hyman & Nestler, 1993, p.143).

Such a proposition ignores the interrelatedness of genotype, temperament, and all the familial factors. Also, single event trauma may differ profoundly from persisting trauma in its psychological sequelae. Winje and Ulvik (1998) examined the long-term outcome of trauma in children involved in a bus accident. They found at one-year follow-up that large proportions of the sample had symptoms of intrusion and avoidance and symptoms of general psychological distress, but no clinically significant symptoms were observed at the 3-year follow-up.

Three main areas of current neurobiological research are contributing to our understanding of the potential for persisting and pervasive effects of sustained or unresolved trauma. These three areas focus on the hypothalamic-pituitary-adrenal (HPA) axis, the hippocampal region, and the generalised effects on the autonomic nervous system of acute stress. Of course, these three areas do not function independently. In fact, it may be that researchers' incapacity to fully understand the rich interconnections between all neural circuitry has led to a somewhat artificial focus on the above. These three areas will now be examined in greater detail.

Maternal stress during pregnancy can affect the foetus, dependent on the mother's glucocorticosteroid output and the gestational period. Research has indicated that the foetal HPA axis could be programmed towards vulnerability as early as the antenatal period, but that interventions or subsequent experiences could reduce or exacerbate the effects of antenatal stress (Glover & O'Connor, 2002). This indicates that maternal capacity to resolve her stress/trauma, and to adequately provide a safe environment for her offspring may impinge on the mental health of her originally stress-affected child.

The amygdala, the fear centre of the brain, is fully formed at seven (7) months gestation (Cozolino, 2005). Later development throughout childhood of the hippocampal and cortical networks assist in organising and inhibiting the amygdala. The concept of amygdala kindling in young children suggests that the original but apparently resolved symptoms of PTSD may actually institute permanent neurochemical changes (Post, Weiss, Smith & Leverich, 1996). These changes may progressively sensitize the person to affective destabilisation and arousal, thus

leading to an apparent overreaction to day-to-day adverse life experiences. While not biologically proven in humans, it is hypothesized that if the original trauma is prior to the development of narrative memory (around three years of age), the concept of amygdala kindling is highly relevant to this research proposal. That is, a biological memory is in place without words to define and integrate it. Also, conscious explicit memory for traumatic events can be interrupted when the amygdala output overwhelms the hippocampal memory circuits (Cozolino, 2005).

It is important to acknowledge that the neurochemical changes as described by Bremner et al. (1997) are a protective response, attempts by the organism to mediate the stressful effects of trauma. They are not a distorted response by a malfunctioning, predeterminedly inadequate organism. Instead, the initial protectively high levels of some neurotransmitters are not reduced over time by those who develop PTSD. If it is correct to link early stress with a broad range of severe adult mental illnesses, then both the biochemical and psychotherapeutic treatments continue to be appropriate and necessary.

Nelson and Carver (1998) discussed the effects of stress and trauma on brain and memory over the first three years of postnatal life. These authors reviewed the literature on brain, stress and memory in the context of early development and concluded that little empirical evidence directly addresses this important hypothesis. They stated that the developing brain is particularly vulnerable to the harmful physiological effects of stress. Uncontrollable stress responses are elicited if all previously learned behavioural or cognitive strategies are inadequate. Above a certain threshold, this may threaten the mental and affective stability, integrity and future development of a child.

Research has strongly linked profound and sustained neurochemical sequelae with trauma. Bremner et al. (1997) listed neurotransmitters and neuropeptides which increase in association with inescapable stressors and which are thought to cause the co-existing symptoms of intrusion and numbing. Studies by Perry, Pollard, Blakley, Baker and Vigilante (1995) and Perry and Pollard (1998) reported neurochemical and structural changes in children exposed to persistent harsh critical language. Schore (2002) reported that relational trauma can result in overpruning of the infant corticolimbic system. This overpruning, he suggested, increases vulnerability to later extreme disorders of affect regulation. In addition, stress in the pregnant mother may result in behavioural and psychological disturbances in the resultant offspring.

Constitutional factors

The brain is geared to perceiving and processing threatening events in ways that attempt to ensure the survival of the developing infant (Bowlby, 1988). These processes include directing reactive responses in order to receive comfort and protection from the mother/primary caregiver. The primary caregiver provides emotional and physical protection to the infant through emotional awareness, resulting in affect modulation or soothing. He/she also gives meaning to the trauma and its sequelae via verbal semantic processing not yet available to the infant. However some parents may utilise avoidant mechanisms in response to their emotional awareness instead of active problem-solving. They may dismiss the trauma and its impact after the immediate threat is removed (Main & Weston, 1981). This process of not attending to the infant may be their attempt to regulate their own anxiety. One result for the developing child is being left with a kind of affect memory that does not fit the family's perceptions of what is relevant. Fonagy (1994) described this affect memory as the precursor to how an individual perceives his/her world, and once formed is difficult to change. Young (1994) described the individual's perceived world as that person's core beliefs or schema. Therefore, cognitive theory is used in this research to further understand what participants and their mothers construct around reported early family trauma.

There is evidence to suggest that trauma affecting the mother/primary caregiver can also affect the infant (Schmeelk, Granger, Susman & Chrousos, 1999) with the potential for effects to last into adulthood. It is important to acknowledge that the threats that potentially traumatise an infant do not have to be directed at the infant. Where a direct threat to the infant's/child's life is recognised, the usual maternal/familial response is to comfort and reassure. When the threat is not directly to the infant but to other individuals in the family or to the family constellation, the trauma response in the infant may go unnoticed as the parents may be too overwhelmed themselves to respond adequately.

If the affect modulation has been sufficient in the first three years of life, then the developing child can rely on a good internalisation of this affect modulation. In addition to knowing with certainty that he/she can turn to the parent for not only comfort but also for explanation, the child is helped in linking emotions with events, and problem-solving with comfort. That is, children develop good resilience to stress because their parents have made sense of their own and their child's reactions

(Rutter, 1993). This ability to make sense of internal states is frequently disturbed in many forms of mental illness. In psychotic disturbance the disruption between thought and emotion and stressor appears impossible to comprehend. This research will explore links between early experiences and core beliefs.

Risk Factors for Depression and Schizophrenia

Depression

Kaplan, Sadock and Grebb (1994) listed the following risk factors for major depression: being female, being aged between 20 and 50, losing a parent before the age of eleven years, family-of-origin psychopathology, having no close interpersonal relationships, experiencing stressful life events, substance abuse, and having a pattern of negative distortions of life experience, negative self-evaluation, pessimism and hopelessness. Race and socioeconomic status are not risk factors. Kaplan et al. stated that causative factors can artificially be divided into biological, genetic and psychosocial factors. The division is artificial because of the likely interaction amongst these factors. For example, psychosocial factors and genetic factors can affect concentrations of certain neurotransmitters, and biological and psychosocial factors can also affect gene expression. Biological and genetic factors can affect the response of a person to psychosocial factors. More recently, Bernazzani and Bifulco (2003) reported that negative pregnancy experiences may place mothers at greater risk of major depression, and Kessler (2000) discussed the long-term effects of childhood adversities on chronic adult depression. He found that studies are uniform in concluding that childhood adversities usually occur in clusters, making it difficult to pinpoint any one particular adversity as the critical determinant of subsequent adult depression.

Schizophrenia

Kaplan et al. (1994) reported the following risk factors for schizophrenia: being aged between fifteen and fifty-five years, being born in winter or early spring, having a first-degree relative with schizophrenia, substance abuse, social stressors, being of low socio-economic status, and experiencing abrupt cultural change. They described the Stress-Diathesis Model. This model postulates that a person may have a specific vulnerability (diathesis) that, when acted on by some stressful environmental influence, allows the symptoms of schizophrenia to develop. The diathesis or the stress can be biological or environmental or both. The environmental component can be either biological (e.g. an infection) or psychological (e.g. a

stressful family situation or the death of a close relative). The biological basis of a diathesis can be further shaped by epigenetic influences such as substance abuse, psychosocial stress and trauma.

Similarities are noted in the above risk factors for both depression and schizophrenia. These include family-of-origin pathology, relationship difficulties and stressful life events, including loss and trauma. Aetiology for both disorders is framed within a biopsychosocial model. Because of these parallels, it is worth comparing early trauma histories between a group of people with depression and a group of people with schizophrenia. It is also important to note psychosocial stressors in the period under study in this research.

Trauma and its Relevance to Depression and Schizophrenia

Some depressive disorders have been linked to trauma, or seen as co-existing with Post-Traumatic Stress Disorder (Bleich et al. 1997). Some neurochemical studies of depression have implicated the limbic system, the HPA cortex (hypothalamic-pituitary-adrenal), and neurotransmitters (Goodman, 2003; Schore, 2002). There is debate in the literature over whether the link between trauma and depression is causal or co-morbid, but what PTSD and depression share is a sense of hopelessness and powerlessness. The links between trauma and schizophrenia are more tentative.

Trauma and depression

Numerous studies have linked childhood trauma with depressive symptoms over the life span (Levitan et al. 1998). Early loss of a parent has been identified as a significant risk factor for the development of depression in adulthood (Kivela, Luukinen, Koski, Viramo & Pahkala, 1998). Lipschitz et al. (1999) reported that both male and female youngsters with PTSD were more likely to report greater depressive symptoms than psychiatric controls. Mollica, McInnes, Poole and Tor (1998) reported a dose-effect relationship between cumulative trauma and symptoms of major depression and PTSD. That is, the greater the number of traumatic events experienced by an individual, then the greater the likelihood that individual will develop depression and/or PTSD.

Some of the symptoms of PTSD overlap with those of depression. Davidson (1997) included sleep disturbance, irritability and difficulty concentrating, and Bleich et al. (1997) listed loss of interest, irritability, difficulties in remembering and concentrating, pessimism about the future and sleep difficulties. Shalev et al. (1998)

found that major depression and PTSD are independent sequelae of traumatic events, have similar prognoses, and interact to increase distress and dysfunction. They also found that both depression and PTSD occurred early on after trauma, whereas Mollica et al. (1998) found that traumatic events continue to affect psychiatric symptom levels a decade later. Tryon (1998) proposed a neural network model of PTSD to explain why people with PTSD develop depression, generalised anxiety and substance abuse.

Bleich et al. (1997) examined psychiatric morbidity following war-related psychic trauma, and reported that depression was extensive, and the most common co-morbid disorder. They also stated that PTSD is often lifelong. This confirmed previous research (Breslau, Chilcoat, Kessler & Davis, 1991). These authors demonstrated that, in community samples, traumatic experiences and/or PTSD diagnoses are accompanied by a relatively higher risk of psychiatric morbidity, mainly depressive and anxiety disorders. Bleich et al. (1997) postulated whether PTSD may be viewed as the major psychiatric consequence of traumatic exposure, with the co-occurring depression developing as a secondary feature, or alternatively, that PTSD may represent a subunit or a variation of post-traumatic depression. Their primary conclusion is relevant to my argument: they concluded that some people have a shared predisposition to both PTSD and major depression, with the traumatic experience serving as a psychological trigger for both disorders. They have not discussed the basis for this shared predisposition. This dissertation may provide support for the concept that early traumatic experiences predispose a person to PTSD and/or major depression with subsequent trauma.

Psychopharmacological studies have also supported a possible link between PTSD and depression (Bleich et al. 1997). Comprehensive research by Weiss, Longhurst and Mazure (1999) associated childhood sexual abuse and other early trauma such as maternal deprivation with adult-onset depression. These authors defined the neurobiological factors (chronic dysregulation of the hypothalamic-pituitary-adrenal axis) hypothesised to link trauma and depression.

Trauma and schizophrenia

Clearly, schizophrenia is not depression, although people with schizophrenia may concurrently have a mood disorder, and people with depression can have a psychotic form of the illness. Baumann and Bogerts (1999) reported on the similarities and differences in the pathomorphology of schizophrenia and depression.

For example, they reported on studies that found hippocampal volume reduction in depression, and parahippocampal cortical thinning in schizophrenia. They concluded that there is a broad overlap in structural findings, with certain sections of the brain more affected in schizophrenia. Whether these neurological changes predate these illnesses or are a consequence of them remains debatable. Trauma research that correlated adult PTSD with smaller hippocampal volume thought to be due to high cortisol levels, was later challenged in several studies that suggested the smaller hippocampal volumes predated the traumatic events (Bowman & Yehuda, 2004). Small sample size, issues of comorbidity and lack of pre-event hippocampal volume measures have contributed to research problems. Individual risk factors have provided a somewhat circular argument to the whole concept of PTSD. That is, a certain reductionist argument has evolved that is in danger of disqualifying an individual's reported experience of trauma, and perhaps resulting in a furthering of denial and non-resolution of the trauma-associated anxiety.

Olney and Farber (1995) proposed a model of neurotransmitter dysfunction that they stated accommodates five fundamental features of schizophrenia. Of interest to the argument in this thesis is their opening reference to Stabenau and Pollin's (1993) work in monozygotic twin studies that suggested:

“nongenetic prenatal or perinatal factors may be powerful determinants of whether the schizophrenic genotype will be expressed” (p.998).

Secondly, in relation to this research argument, Olney and Farber postulated a quiescent period in infancy through to adolescence before clinical manifestations are expressed. In this quiescent period as in all developing brains, there is a process of natural neuronal loss as particular networks are not reinforced (Schoore, 2002). However, Olney and Farber discussed a process of accelerated excitotoxic neuronal degeneration in the developing CNS for those who later exhibit schizophrenic illness. This process is normally mediated by certain receptors which, they proposed, are damaged in utero or soon after by insult or viral infection. This brings the reader back to Bremner's work on stress itself as a causal agent in neuronal loss. It is imperative to be aware that Olney and Farber's proposed viral infections and insults have not been unequivocally identified. There is an ongoing and vigorous debate about whether the intellectual decline seen in adult schizophrenia predates the onset of the illness (Russell, Munro, Jones, Hemsley & Murray, 1997) or is a function of it.

A review of the literature reveals comparatively little research on the links between early trauma and schizophrenia, despite long-standing recognition that stress can trigger the adult disorder. This recognition has been dependent on thinking that the vulnerability part of the model is genetic, and that later stress triggers but does not replicate the original neurological injury (Jones, Rogers, Murray & Marmot, 1994). Ross and Joshi (1992) found that symptoms common to schizophrenia were highly related to childhood trauma, but that people with a clear diagnosis of schizophrenia actually report much lower levels of childhood trauma than other diagnostic groups. This may indicate that trauma-related symptoms are missed once a person has a clear diagnosis of schizophrenia.

Jansen et al. (1998) indicated a clear link between a psychosocial stress and increased heart rate but no protective reactivity in cortisol levels for a group with schizophrenia. They supported their findings of lowered biochemical adaptive responses with the Ways of Coping Checklist. The schizophrenic group used more passive and avoidant coping strategies than controls. These authors did not discuss how or when these coping strategies were initially adopted or learned.

The Jones et al. (1994) study deserves detailed analysis. These authors studied associations between adult-onset schizophrenia and childhood demographic, neurodevelopmental, cognitive and behavioural factors within a very large population. Prospective childhood data were collected from a cohort of 5362 babies born in one week of the year 1946. Thirty (30) of this cohort developed schizophrenia between 16 and 43 years (cumulative risk of 0.63%). Essentially they found the following risk factors compared with controls: delayed milestones, more speech problems, lower educational test scores, preference for solitary play, self-rating as less socially confident, other-rating as more anxious in social situations, and mothers having below average mothering skills and understanding of her child at four years. They concluded that the origins of schizophrenia may be found in early life. It is interesting that they listed pregnancy and delivery complications, and prenatal exposure to influenza and malnutrition as possible in-utero causal factors. There was scant mention of traumatic experiences occurring for the pregnant mothers as the preliminary to poor mothering skills.

However, two significant comments are made, one relating to trauma and one to the attachment state of mind in the pregnant mother. Death of the father during the pregnancy, and maternal unwantedness of the pregnancy separately contributed to a

greater incidence of schizophrenia in the offspring. Also, they acknowledged that foetal or childhood abnormalities are evident in only approximately one-third of adults with schizophrenia. This poor predictive power of trajectories of child development has not prevented multiple large cohort prospective, longitudinal studies, for example, the Finnish cohort study (Jones, 1997), the New York High Risk Project and others (Erlenmeyer-Kimling et al. 1995, 1997; Amminger et al. 1999, 2000; Caspi, Moffitt, Newman & Silva, 1996).

To frame the neurobiological argument simply, it would appear that some neurotransmitters provide protection to the brain against decompensation (in particular depression), and that these neurotransmitters are depleted by chronic stress. This depletion is also seen in schizophrenia with a cytotoxic process continuing until it is arrested by medication or therapy. Therefore it is relevant to research the possible links between early trauma and later adult depression and schizophrenia. Because the trauma models are now indicating a very wide range of long-term psychological sequelae, the lack of studies generally and the reported risk factors in the above studies may not have included all factors. This dissertation will attempt to expand on this by including the mothers' narratives about the foetal and early history of their offspring who as adults have schizophrenia or depression. Regrettably, the direct contributions of fathers is not sought in this research programme, in part because this would greatly reduce the available case numbers. This researcher recognises the pivotal role fathers play in raising their children, and this is discussed further in the next chapter.

Attachment Theory and Implications

Attachment researchers (Bowlby, 1988; Cicchetti & Walker, 2003; Fonagy, 1994, 2001; Holmes, 2000) have suggested that maternal sensitivity is the primary determinant of the quality of a baby's attachment behaviour at twelve months of age. Several authors researching sensitive periods in infant CNS development examined emotional reactivity (Trevarthen & Aitken, 1994), self-organisation (Cicchetti & Walker, 2003), motivation (Derryberry & Reed, 1994), relationships (Zeanah, Mammen & Lieberman, 1993), the overwhelming destructive effect of early emotional stress (Benes, Taylor & Cunningham, 2000) and the sensitisation to those experiences (Post, Weiss & Leverich, 1994; Post et al. 1996). Infant observations with mothers who are depressed have stressed the importance of early interactions for later development (Lyons-Ruth, Zoll, Connell & Grunebaum, 1986). Infants of

mothers who are still depressed when their infants are six months of age may show growth retardation and developmental delay (Field, 1987).

In summary, mothers who are in tune with their infants' physical and emotional needs and are able to respond in an appropriate and timely manner are more likely to have securely attached infants. Inconsistently attuned mothers are more likely to have infants/children who behave ambivalently towards them. Interfering/rejecting mothers can have infants/children with avoidant attachment patterns. It is essential to acknowledge that mothers may for many reasons behave differently to their different children, and that other family members may provide a secure base for the infant if mother is not always optimally available. If mother is emotionally overwhelmed or traumatised, her capacity for empathic attunement with her infant may be diminished.

Trauma and Attachment

Trauma is essentially a threat to a person's safety and survival. Because the mother/primary caregiver's role is to ensure the infant's safety and survival, trauma to the mother may affect her infant. The infant is keenly tuned to all affective responses in the mother (Bowlby, 1988; Winnicott, 1992). Extensive research in attachment has indicated that overwhelming stress/trauma experienced by the mother may result in insecure attachment patterns in her infant. These patterns are firmly established by twelve months of age (Fonagy et al. 1996; Fonagy, 2001). More specifically Main (2000) and Crittenden (1997) and others have furthered research into the three major classifications of organisation of maternal thought around attachment (balanced, dismissing and preoccupied) discovered by Mary Ainsworth in the 1950's. These three classifications of maternal thought around attachment have been shown to be reflected by three major organised patterns of infant attachment, that is, secure, ambivalent and avoidant.

Trauma and disorganised attachment

A fourth pattern of disorganised attachment has been assigned to a group of infants originally difficult to classify using the above patterns. This group is known to have suffered abuse or neglect (Carlson, Cicchetti, Barnett & Braunwald, 1989). Disorganised attachment is considered a type of insecure attachment. It is thought to indicate a child under stress who cannot establish a successful strategy with an attachment figure to resolve that stress because that parent is at times a source of fear or threat as well as comfort. The parent may be directly abusive, or be frightening

when struggling with unresolved loss or trauma (Hesse & Main, 1999; Schuengel, Bakermans-Kranenburg & van IJzendoorn, 1999; van IJzendoorn, Schuengel & Bakermans-Kranenburg, 1999). Crittenden (1997) defined danger as anything that threatens a child's physical or emotional health or safety. This includes natural disasters, severe medical illnesses, parental unavailability for protection, and war. It also includes parentally caused dangers such as spousal violence, divorce, child abuse and threats that are intentionally inflicted or that are not actively assuaged. Rejection, over-involvement, role-reversal, neglect, pressure to perform, deception, and sexualising are included as dangerous to the child. Crittenden stated that evaluation of historic traumatic events is dependent upon the behavioural adaptation and mental coherency of the person being interviewed. She defined balanced or coherent speakers as those who are able to use cognition and affect in an integrated and effective way. Dismissing speakers mistrust affect and depend on cognition, whereas preoccupied speakers mistrust cognition and rely on affect. This will be revisited later in the dissertation as a foundation for its methodology.

Crittenden (1997) conceptualised disorganised attachment as having a particular pattern of sequential display of contradictory behaviour patterns (avoidant and ambivalent) that is prevalent in maltreated toddlers. Infants with disorganised attachment suffer more stress in infancy, may be more aggressive in kindergarten, and may become vulnerable to absorption and dissociation in young adulthood, thus increasing vulnerability to adult mental illness. That is, early attachment patterns may be associated with social and emotional difficulties in childhood and through to adulthood. It is because of this that the mothers' perceptions of attachment difficulties in their participant offspring will be explored in this research.

Even for older children experiencing trauma, a bidirectional relationship has been observed between the mothers' and children's symptoms of distress over time whereas the fathers' symptoms were unrelated to the children's symptoms (Winje & Ulvik, 1998). It is therefore appropriate to examine the incidence of trauma in the mothers of our client groups. It is essential that this be dated from the time just prior to conception because trauma generates high corticosteroid output (Bremner et al. 1997) which may be transmitted to the foetus, and which may have extensive and profound neurological sequelae. Some authors have found that previous exposure to trauma increases the incidence of PTSD effects of subsequent trauma (Breslau et al. 1999; Schore, 2002). Clients at a community mental health centre with PTSD

symptoms subsumed within their primary diagnosis may therefore have as a risk factor early undocumented trauma.

Unresolved Trauma/Loss, Disorganised Attachment and Dissociative Speech

Hesse and Main (1999) provided a detailed summary of empirical evidence relating maternal unresolved trauma and/or loss to subsequent disorganised or disoriented attachment in their infants. They also provided a cogent argument linking unresolved trauma and loss with disorganised/dissociative speech around those events. Hesse (1999) outlined the principles governing the framework of the Adult Attachment Interview (George, Kaplan & Main, 1985) which several researchers have used to assess maternal attachment states of mind, and unresolved trauma/loss. One of these principles is assessing the quality of communication between interviewee and interviewer utilising Grice's four maxims of quantity, quality, relevance and manner (Grice, 1989). These maxims provide the basis for analysing the speech of the interviewed mothers as they discuss early family trauma. The maxims are outlined further in the Method section in this chapter.

The attachment relationship between infant and primary caregiver therefore is thought to be partially reflected in the quality of communication around which shared meaning between infant and caregiver may form. These shared meanings become internalised for the infant, and provide the framework, albeit flexible, for cognitions around self, others and the world.

Cognitive Theory and Implications

Perceptions of oneself and one's world are disturbed in depression and schizophrenia. There is evidence from learning theory that these disturbances can be acquired early in childhood and either challenged or reinforced by later experiences (Corey, 1996). Fonagy (1994) and Object Relations theorists have proposed that this learning begins prior to verbal semantic processing. Fonagy described the pathways through which internal representations of early experiences with the primary figures of childhood come to influence expectations of relationships in later childhood and adulthood. It could be argued that non-narrative memory of early trauma is not accessible via personal schema or core beliefs, but several authors believe otherwise

For example, Auerbach and Blatt (1997) described significant impairments in self-representation in schizophrenia, and McNally and Goldberg (1997) listed cognitive coping strategies in schizophrenia that predate and maintain symptomatology. Evidence of dysfunctional schema has been found in people with

schizophrenia (Perris, 1990). Perris proposed that the dysfunctional schema in clients suffering schizophrenia are comprised of dysfunctional self-image and dysfunctional basic assumptions concerning that person's relationship with the environment. He also proposed that the dysfunctional self-schema and the dysfunctional basic assumptions are continuously sustained by a variety of cognitive distortions in the comprehension and processing of information. Thirdly he proposed that the schema-related, automatic dysfunctional thoughts occur involuntarily and repetitively whenever an external or internal stimulus occurs that is perceived as a threat.

Young (1994) linked clusters of core beliefs/schema with early developmental stages, basing the origins of distorted schema on trauma and/or dysfunctional early relationships. The Core Beliefs/Schema Questionnaire (CBQ/SQ) measures these distorted schema. Schemas have the following characteristics:

1. They trigger high levels of disruptive emotion when activated. For example, an Abandonment Schema will precipitate high levels of painful emotion when triggered by a real or threatened loss of a relationship;
2. They interfere with meeting the person's core needs such as independence, connection with others and self expression;
3. They shape behaviour into self-defeating patterns that are repeating and self perpetuating;
4. They are learnt in early years of life, as a result of dysfunctional experiences with parents and others;
5. They are played out in dysfunctional relationship behaviour;
6. They are maintained by well entrenched patterns of thinking and behaving;
7. They are often accepted by the client without question;
8. They are resistant to change, even when the client recognises their self-defeating nature; and
9. They do not change, even when challenged with logic or evidence.

Perris (1990) did not give examples of dysfunctional beliefs seen in schizophrenia, but did include trauma within the family as a contributor to disruptions in thinking. Although Young (1994) proposed that the CBQ is applicable to those with personality and mood disorders, it is proposed in this research that it is also applicable to those suffering schizophrenia because of the evidence linking some

types of early traumatic experience to increased vulnerability to the later onset of this severe disorder.

Hypotheses

The following hypotheses are made based on theory and research findings identified above.

1. There will be evidence of family trauma in the early histories (from just prior to conception to the age of three years) of CMHC consumers with major depression and consumers with schizophrenia. This evidence will present in two ways: clinical participants will report higher scores on the subscales of the Core Beliefs Questionnaire than the norms from psychometric research; and mothers of clinical participants will report the occurrence of traumatic events from just prior to conception to the age of three years.
2. There will be significant positive correlations between scores on the subscales of the Core Beliefs Questionnaire and scores on the childhood subscale of the Traumatic Antecedents Questionnaire.

Research Questions

The theory and research reviewed above, and the data collected in this study give rise to the following questions.

1. What is the nature and frequency of traumatic events occurring within families with an infant who, as adult, develops either schizophrenia or major depression?
2. Are there similarities and differences in the reported traumatic events between diagnostic groups?
3. Are there similarities and differences between diagnostic groups in the manner in which the mothers report traumatic events?
4. What do the mothers of participants recall of the psychosocial context in which reported traumatic events occurred?
5. What attachment difficulties in the participant offspring do the mothers report from her earliest observations and throughout the participants' childhood?
6. What do the participants report of their early experiences of neglect and emotional deprivation?

7. Are there correlations between early family traumatic events, other reported experiences from that time, attachment difficulties and reported experiences of neglect?

Method and Rationale

Study population

Adult consumers presenting for treatment of a severe mental illness at Toowoomba's Community Mental Health Centre are assessed fully. Selection criteria include medical and family history.

Method

The research methodology used in this research reflects the complexity of the hypotheses and questions derived from the argument presented in this chapter. A retrospective design is chosen because of the nature of the population under study, the impracticality of a prospective design within the time-frame available to a Ph.D. candidate, and the relevance of the construct of maternal unresolved trauma or loss to the potential links to current depression and/or schizophrenia in their offspring. Uncorroborated trauma presents unique challenges to researchers in terms of verification of both the traumatic events and psychological reactions (Rosen, 2004; van der Hart & Nijenhuis, 1999). The use of structured and semi-structured interviews in this research is not dependent on the belief in the accuracy of the participants' and primary caregivers' recall. Rather the information provided is analysed reflectively and structurally from an informed position, as well as quantitatively analysed.

Triangulation is used in this research. Although not without its critics (Benzies & Allen, 2001), triangulation has been promoted as increasing the robustness of research design (Cohen, 1994). Both quantitative and qualitative enquiry in social research presume that individuals operate according to the meanings they ascribe to their experiences (Benzies & Allen, 2001). This emphasis on meaning accords with the focus in research on unresolved trauma conducted by attachment theory researchers, and is consistent with a major indicator of Complex PTSD, loss of meaning (Herman, 1992; van der Kolk et al. 1996). Triangulation is accomplished in three ways in this research:

1. by using both qualitative and quantitative analyses
2. by cross-checking information from two sources, clinical participants and their primary caregivers/mothers

3. by examining reported past events and examining current presentation in two ways: Clinical participants are given two structured questionnaires that purport to measure similar constructs, but access different cognitive systems (Neglect subscale of the Traumatic Antecedents Questionnaire (van der Kolk, 1997), and Emotional Deprivation subscale of the Core Beliefs/Schema Questionnaire (Young & Brown, 1994)); and mothers/primary caregivers are interviewed in a semi-structured format regarding their recall of early family trauma, and concurrently the manner in which they present that information is examined in the light of dissociative processes.

The Core Beliefs Questionnaire assists the consumer participants to make sense of their symptoms of distress and dissatisfaction in the light of their personal histories, and provides opportunities to challenge previously unquestioned schema that underpin patterns of behaviour. Examples of dysfunctional beliefs/schema will be elicited from the consumer groups under study.

Grice's maxims (Grice, 1989) will be used to examine the manner in which the mothers discuss early family trauma in order to assess whether the reported trauma are resolved or unresolved for these mothers. Grice's maxims have been used by attachment researchers. The maxims are quantity, quality, relevance and manner. The maxim of quantity relates to the length of sentences in response to the sort of questions asked. Closed questions normally produce short, concise answers and open-ended questions produce longer answers. Interviewees who say less than is necessary to answer the question are likely to be dismissing, and interviewees who say far more than necessary are likely to be preoccupied. The maxim of quality refers to the appropriateness of the content of the answer. When interviewees provide adequate evidence to support their statements, their speech is coherent and likely to be balanced. When the evidence is inconsistent, the interviewee is more likely to be dismissing or preoccupied. The maxim of relevance refers to the relation of the answer to the question. Balanced speakers more often direct their answer to the question asked than to what is on their minds (preoccupied speakers) or to distracting and irrelevant topics (dismissing speakers). The maxim of manner refers to the way in which the answer is given. When the response is confused, changing from one topic to another, out of temporal order, or requiring presumed but unstated information, it is typical of preoccupied speakers. When it is rigidly ordered but

devoid of feeling, the manner of the answer is more typical of dismissing speakers. Balanced speakers actively maintain the relationship with the interviewer by attending to the questions asked and providing relevant answers of appropriate length, in a manner that is comprehensible to the listener.

Dysfluencies in speech are particularly relevant if they occur when the interviewee is discussing traumatic events. Dysfluencies include amongst others, confusion of persons and confusion of tense. These dysfluencies, when severe, may indicate dissociative processes in the speaker. This research will investigate the mothers' conversation and dysfluencies around experiences of trauma from the time of conception up to the age of three for those children who as adults develop depression or schizophrenia. These dissociative processes are assessed in the speech of the mothers reporting early family trauma. This underpins the rationale for using a retrospective research method. That is, indicators of current non-resolution of past traumatic events is assumed by this researcher to mean that these events have never been resolved by the interviewed mothers. This is critical to the argument that this non-resolution of trauma may relate to attachment difficulties in the participant offspring.

This dissertation will explore participants' and their mothers' or primary caregivers' reports of early family trauma using quantitative and qualitative methods. It will also examine the manner in which mothers report early family trauma, attachment difficulties in the participant as infant, child and adolescent, and the psychosocial context of the family. Relationships between the above, current diagnosis in the participants and their current living arrangements will be quantitatively assessed.

Summary of Research and Rationale

Because of the strength of evidence for profound psychological and neurological effects of trauma, and because these effects can be long-lasting and leave the traumatised person more vulnerable to later traumatic responses to stressful events, it is important to research the incidence of traumatic events in any psychiatric population. For these disturbances/trauma to be maintained, it can be postulated that the adult child does not know of the trauma or if known, has not integrated it. That is, there will be evidence of unresolved trauma via their core beliefs, and evidence of unresolved trauma in the conversations of their mothers. Several studies link early trauma with adult depression. Some studies indicate that the neurological pathways

implicated in depression are affected by trauma. These same neurological pathways of development are implicated in schizophrenia. Therefore it is relevant to compare the early trauma histories of a group with depression and a group with schizophrenia.

Structure of the Dissertation

The remainder of this dissertation consists of Chapters 2 to 9. Chapter 2 presents an overview of the current theoretical and empirical literature on attachment theory, particularly in relation to maternal unresolved trauma and loss and potential effects on their infants. Also reviewed are the potential ongoing effects into childhood and adolescence of early disorganised attachment disruptions, and relation to adult mental illness. This chapter critically evaluates the literature on shared signs and symptoms of childhood attachment difficulties, childhood and adult PTSD and relevant DSM-IV disorders.

Chapter 3 reports the methodology employed in this study, and includes descriptive data on the study population. Descriptions of test materials used in this research are presented, examples of their use in other research are given, and reports of their reliability and validity are noted. The rationale for the structure of the semi-structured interview of the participants' mothers is presented. In addition, the rationale for placing themes from these interviews within constructs that are consistent with the research argument and the literature on psychosocial vulnerability within families is given. Then the system for examining indicators for unresolved trauma and loss in the mothers is presented. To conclude, a model is proposed of the possible interactions between the constructs and clinical participants' diagnoses.

Chapters 4-7 present the results of this research in two sections. The first section (Chapters 4-6) presents detailed qualitative analyses of a select number of mother interviews from each of their participant offsprings' two diagnostic groups, schizophrenia and major depression. These analyses are done per construct as defined in the Method chapter. Chapter 7 presents quantitative analyses of the model proposed in the Method chapter, and concludes with a post-hoc analysis of participant offsprings' current living arrangements.

Chapter 8 presents an integrated contextualised discussion of the complete study results. The model is discussed first in terms of its relevance to the arguments presented in this dissertation, then individual themes within constructs are examined in detail. Chapter 9 concludes the dissertation with a discussion of the relevance of the results to select previous theories which are critically examined. Methodological

limitations of this dissertation are discussed. Implications of this research are discussed in relation to prevention, early intervention and therapy. Suggestions for further research are presented.

Chapter 2

LITERATURE REVIEW

This chapter presents an overview of the relevant current theoretical and empirical literature on trauma and its extensive sequelae for adults, infants and young children. This includes neurobiological sequelae. Attachment theory and its implications in relation to early family trauma is discussed, focusing in particular on disorganised or disoriented attachment and ongoing developmental risk in both affective and cognitive domains. Relationships between these complex areas are then discussed relative to the adult mental illnesses of major depression and schizophrenia. Current controversies across these theoretical and experimental domains are discussed within the body of the chapter. This chapter provides the framework for the methodology used in this research.

Trauma: Definitions and Sequelae

This section commences with selected historical and current controversies in relation to definitions of trauma and sequelae. An argument is then made concerning the relevance of this research's focus on maternal dissociation as an indicator of unresolved trauma.

Historical contributions to the definition of trauma and sequelae

Freud (1939) succinctly discussed the difficulties inherent in attributing specific trauma to specific psychological sequelae, and insisted that the manner in which the individual consciously processes the trauma experience affects long-term psychological outcomes.

“We give the name of *traumas* to those impressions, experienced early and later forgotten, to which we attach such great importance in the aetiology of the neuroses. We may leave on one side the question of whether the aetiology of the neuroses in general may be regarded as traumatic. The obvious objection to this is that it is not possible in every case to discover a manifest trauma in the neurotic subject's earliest history. We must often resign ourselves to saying that all we have before us is an unusual, abnormal reaction to experiences and demands which affect everyone, but are worked over and dealt with by other people in another manner which may be called normal.” (p.72)

Freud thus defined trauma as being specific to the individual, that is, the event itself may not result in the same reaction across individuals, nor be an uncommon event, nor be life-threatening.

Jung (1960) however, presented trauma as an assault upon the common sensibilities of man, that is an event or events that most people would consider profoundly disturbing or threatening.

“Although, by giving way to the affect, one imitates all the bad qualities of the outrageous act that provoked it and thus makes oneself guilty of the same fault, that is precisely the point of the whole proceeding: the violence is meant to penetrate to a man’s vitals, and he to succumb to its action. He must be affected by it, otherwise its full effect will not reach him. But he should know, or learn to know, what has affected him, for in this way he transforms the blindness of the violence on the one hand and of the affect on the other into knowledge.” (p.4)

He thus emphasised the critical element of conscious processing of heightened affect and chaotic thought resulting from traumatic events if man is to make sense of his world. This focus on meaning as critical to defining an individual’s response to a potentially traumatic event has been identified in recent trauma research (McNally, 2004). A failure to ground oneself by consciously working through the event, both cognitively and affectively, may result in emotional numbing and confusion of thought, now identified as common elements of Complex Post-Traumatic Stress Disorder (Herman, 1992).

Current definitions of trauma and recognition of sequelae

Current controversies regarding trauma and its psychological sequelae have primarily focused on what legitimately constitutes a traumatic event, and what psychological sequelae can justifiably be ascribed solely to a traumatic event (McNally, 2004). Within these two major foci, arguments have continued over whether to include unqualified acceptance of what an individual may denote as a traumatic experience (bracket-creep) versus the medicalisation of intense emotions in the face of extreme threat to self or others (Rosen, 2004). Individual vulnerability to unresolving symptoms following a traumatic event has pointed to the adversity-stress model. This model was formulated to account for an individual’s eventual collapse following a particularly extreme traumatic event, or an accumulation of negative events. Lack of support was viewed as contributing to a

reduced opportunity to work through these events. Also, some researchers questioned whether PTSD is a unique disorder or whether it can be better described as an amalgam of depression and anxiety symptoms (McNally). With the resurgence of recognition of individual vulnerability to extreme stress and its lack of resolution, Post-Traumatic Stress Disorder and other trauma-related disorders were described in the current psychiatric diagnostic manuals.

The description of Post-Traumatic Stress Disorder (PTSD) as an adult anxiety disorder appeared first in the Diagnostic and Statistical Manual, Third Edition (1987). This description contained no mention of permanency or reversibility, or purpose (function). Further major difficulties arose with the symptoms clustered under dissociative responses to stress/trauma. These difficulties included whether it is necessary to meet the criteria for PTSD to have a dissociative response, the nature of assessing dissociation (Ohan, Myers & Collett, 2002), and whether or not subclinical forms of dissociation impact on effective functioning and on relationships.

The Diagnostic and Statistical Manual, Fourth Edition, Text Revision (2000) included Dissociative Disorders as a direct result of traumatic experiences. These Dissociative Disorders were described in the following manner:

“The essential feature of the Dissociative Disorders is a disruption in the usually integrated functions of consciousness, memory, identity, or perception. The disturbance may be sudden or gradual, transient or chronic.” (p.519).

This broadening of psychological modalities and severity and duration underpinned the clinical opinion presented in DSM-IV (1994) which stated that dissociative symptoms may be seen in several disorders, namely Acute Stress Disorder, Posttraumatic Stress Disorder, and Somatisation Disorder and may also mimic, for example, depression. However, the authors made clear distinction between dissociative disorders and schizophrenia, with reality testing remaining intact during depersonalisation experiences.

In Acute Stress Disorder (that must precede the development of Post-Traumatic Stress Disorder), the person must have been exposed to a traumatic event in which both of the following were present:

1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others;
2. The person's response involved intense fear, helplessness, or horror.
Either while experiencing or after experiencing the distressing event, the individual had at least three of the following dissociative symptoms:
 1. A subjective sense of numbing, detachment, or absence of emotional responsiveness;
 2. A reduction in awareness of his or her surroundings;
 3. Derealisation;
 4. Depersonalisation;
 5. Dissociative amnesia.

There are other symptom requirements to reach diagnoses of Acute Stress Disorder and PTSD, including persistently re-experiencing the traumatic event, marked avoidance of stimuli that may arouse recollections of the trauma, marked symptoms of anxiety or increased arousal, and significant distress and interference with normal functioning or ability to pursue necessary tasks.

Of major relevance to this research, it is noted that individuals with these disorders may have a decrease in emotional responsiveness, and have symptoms of despair and hopelessness, sometimes warranting an added diagnosis of Major Depressive Disorder. The DSM-IV Text Revision (2000) reported some evidence that social supports, family history, childhood experiences, personality variables, and pre-existing mental disorders may influence the development of Acute Stress Disorder. This Text Revision did not comment on the role that added ongoing severe stressors may play in the maintenance of a dissociative defense, but other research (Post et al. 1994; Pynoos, 1990; van der Kolk et al. 1996) has indicated that continuation of traumatic stress is particularly harmful to the individual. This continuation of traumatic stress may be linked to dissociation as an extreme form of avoidance and thence lack of resolution of one's trauma response.

Dissociation

Definitions

This section reviews definitions of dissociation within psychology and psychiatry, and presents the controversy over whether it is essentially linked to trauma.

The Australian Oxford Dictionary (Moore, 2004) defined dissociation as a disconnection or separation in thought or in fact, and “to dissociate” is to cause a person’s mind to develop more than one centre of consciousness. There is no reference to purpose or process, but “to cause” infers effortful intent. A Dictionary of Psychology (Chaplin, 1975) defined dissociation as:

“Separation from the personality as a whole of a complex pattern of psychological processes which may then function independently of the rest of the personality. The multiple personality illustrates dissociation in its extreme form. However, it also is present in some degree in hysteria, amnesia, and schizophrenia.” (p.149).

This reference to dissociation in schizophrenia is challenged by the diagnostic system predominantly in use in psychiatry, the DSM-IV (1994).

Trauma and dissociation

Although the DSM-IV made a distinction between dissociative disorders and schizophrenia based on a sustained perception of reality in the former, this may reflect a measure of capacity to stand back periodically to observe one’s state of mind (that is, stepping out of a dissociative state), and is not necessarily a constant mental state in either group of disorders. The question remains whether dissociative states of mind require life-threatening trauma as progenitor, and concurrently whether detectable levels of dissociation are reliably measurable in people who appear to function reasonably well by self-report, and who require the trigger of recalling via interview, events that are unresolved. Herman (1997) clearly viewed dissociation as potentially co-occurring with voluntary thought suppression (effortful avoidance), minimisation, and denial, with the purpose of altering an unbearable reality. She borrowed Orwell’s term of ‘doublethink’ to describe the artful holding of two contradictory beliefs simultaneously as in trance states, and this necessarily involves a level of self-monitoring that may be lost in schizophrenia.

The question remains whether repression (denial) and/or dissociation represent unique mechanisms for the purpose of forgetting trauma. Also, it is unclear whether these mechanisms are conscious or unconscious processes (Lynn, Knox, Fassler, Lilienfeld & Loftus, 2004). Herman’s Complex Post-Traumatic Stress Disorder, discussed in Chapter 1, in summary is characterized by avoidance and constriction, a narrowing that applies to relationships, activities, thoughts, memories,

emotions and sensations (Herman, 1997). This comprehensive and clinically relevant diagnosis was ultimately not accepted for the diagnostic manuals.

Kalsched (1996) succinctly presented dissociation as a response of part of the self to a traumatic experience when withdrawal of the whole person is not possible. This partitioning or fragmentation has a protective function in that the person may be able to continue functioning at one level, but at the cost of psychic disintegration.

“Dissociation is a trick the psyche plays on itself. It allows life to go on by dividing up the unbearable experience and distributing it to different compartments of the mind and body, especially the ‘unconscious’ aspects of the mind and body. This means that the normally unified elements of consciousness (i.e., cognitive awareness, affect, sensation, imagery) are not allowed to integrate. Experience itself becomes discontinuous. Mental imagery may be split from affect, or both affect and image may be dissociated from conscious knowledge.” (p.13)

He continued with stating that a full narrative history cannot be told by the person whose life has been interrupted by trauma. This fragmentation of conscious cognition and affect as a metaphor of the loss of coherence within the psyche is therefore conveyed or represented by the relative incapacity of the traumatised person to tell their own story in a fully integrated or coherent manner. For example, there may be a forgetting of the experience, but representations of the trauma may occur as, for example, a fear of loss of control, including loss of control in interview. The presentation in interview may be a mixture of helplessness and rage as the interviewer neither fully comprehends the unspoken, nor provides safety and security regarding what trauma has already occurred. Other researchers consider dissociative processes to reflect a capacity rather than incapacity.

Dissociation as adaptive versus pathological

The DSM-IV required that PTSD be diagnosed only when the person’s initial response to a potentially traumatising event includes intense fear, helplessness, or horror. This automatically excludes those who dissociate or have an emotionally blunted response during and/or after the traumatic event (McNally, 2004).

Dissociation may be a non-specific marker of severe anxiety in a range of psychiatric disorders. In addition to these confounding variables, others have expanded the definition of dissociation from a pathological entity to a common adaptive process, nevertheless acknowledging it as a defense mechanism (Watkins & Watkins, 1996).

These authors included children's creation of imaginary playmates as dissociative, but in that format it has both permeability and flexibility in response to others and the environment. This permeability and adaptability is lost if the individual is compromised by overwhelming stress. They stated that a child, when confronted with overwhelming trauma, rejection, or abuse may dissociate. They also provocatively stated that dissociation may begin at a very early age, at least within the first few months of life and possibly even before birth. This statement is not supported with explicit research references, and they acknowledged the controversies around early memories, and the opposing results from experimental and clinical research.

Of particular note, Watkins and Watkins (1996) attributed an avoidance of guilt and anxiety to the genesis of dissociation, which is then continuously reinforced as the person becomes more unwilling or less able to face reality.

“True dissociation involves strong avoidance of responsibility for one's own behaviour and unwillingness to face the consequences of one's actions.”

(p. 435)

This implies that the individual who dissociates is the agent of the event that causes overwhelming distress. In contrast, falsely attributing blame to oneself for an uncontrollable traumatic event is broadly accepted in the literature on abuse (Herman, 1997).

Foa and Hearst-Ikeda (1996) reviewed trauma research over the last century. They noted that current research interest focuses on the affective and cognitive avoidance that may follow trauma, and that this avoidance is termed dissociation, denial or numbing.

“Common to these constructs is a diminished awareness of one's emotions or thoughts, which is hypothesised to be motivated by self-preservation.”

(p.207).

These authors stated that the presence of dissociation is an indicator of incomplete emotional processing of trauma. They cited many authors from Freud, Breuer and Janet to the present who relied on the definition of dissociation as a disconnection between aspects of memory or conscious awareness observed during and after extreme stress. The focus of their discussion of pathological dissociation centred on alterations in relationship to self, to the world and to memory processes. This is consistent with Herman's descriptors of Complex PTSD, namely alterations

in regulating affective arousal, alterations in attention and consciousness, characterological changes, somatisation and alterations in systems of meaning (Herman, 1992).

Historically, dissociation (splitting of consciousness) was represented as a horizontal fracture by Janet, and vertical fracturing by Breuer and Freud (Lynn et al. 2004). What this researcher deems pivotal is the agreement between researchers past and present, that dissociation represents a conscious or unconscious split caused by a significant threat to the integrity of the individual's psyche. What is shared in the above definitions of dissociation is the concept of fragmentation or loss of coherence, narratively or behaviourally presented.

Definitions of dissociation have identified denial as its purpose. Foa and Hearst-Ikeda (1996) examined the construct of denial proposed by Horowitz (1986) who noted that a common reaction to trauma is the massive ideational denial of the event. Thirdly, Foa and Hearst-Ikeda challenged the DSM-IV (1994) authors' presentation of emotional numbing and effortful avoidance as an equivalent concept, stating that effortful avoidance may be regulated by strategic psychological processes, and numbing by biological mechanisms similar to the freeze response when in terror.

It is clear from the above review that the definition of the word 'dissociation' within clinical spheres is broadening. A thesaurus provides some opportunity to play with the meaning of this word by defining its apparent antitheses, and to play with the concept of dissociation as a form of forgetting. For example, Roget's Thesaurus (Roget, 1988) included with dissociation the words disjunction, disconnection, separation, detachment, fracture, rupture, dismemberment, and disintegration. The opposite of forgetting is remembering, and if hyphenated as re-remembering (Mackay, 2003 - personal communication), one pictures a putting back together of pieces of a story. Opposite to re-remembering is dis-membering, a word that conveys a violent disruption of continuity, coherence, cohesion and self. It is indeed a violent assault on the sensible self. As Kalsched (1996) stated, dissociation appears to involve a good deal of aggression, involving an active attack by one part of the psyche on other parts.

Linking back to Watkins and Watkins (1996), one could say that dissociation is an attempt to weave a story of self-exoneration around collective traumata that threaten to overwhelm. Association on the other hand, implies a communality, a

communion, a partnership and *attachment*, as well as re-remembering. That is, associating implies belonging, relating, connecting and attaching, and making sense of one's own story. Dissociating implies not belonging, not relating, not connecting and not attaching, and the emphasis is therefore on the severing of community ties and resultant social isolation via a process of dissociation. This concept of not connecting, intrapsychically and/or interpersonally, is fundamental to the constructs attributed to Attachment Theory, and this theory will be discussed later in this chapter.

Effects of Trauma on Infants and Young Children

Concerning infants and young children, Herman (1997) succinctly placed trauma responses within the context of a secure base, with the essential requirement for the developing child's positive sense of self dependent on the primary caregiver's benign use of power. Abused children, already in an unequal power ratio with adults, are susceptible to greater psychopathology depending on the age of onset of the abuse. When terrorised, even adults spontaneously respond with a search for maternal or divine protection. However, if the traumatised individual is unable to reconcile the trauma with previously held self/other beliefs, the potential to feel abandoned, alone, alienated and disconnected in all relationships occurs. If the trauma reinforces existing self/other beliefs, the desire to turn to others for comfort and protection would be nonsensical. This author assumes that this includes denial of the meaning of the event to self or to attachment figures, without necessarily completely denying the actuality of the event. It is a distortion of the memory of the trauma, as evident in Complex PTSD (Herman, 1992).

Early trauma and adult schizophrenia and depression

The potential link between early trauma and later psychosis or schizophrenia is now being vigorously researched because of the accumulating evidence for profound cognitive and biological effects of early sustained or unresolved trauma (Morrison, Frame & Larkin, 2003; Read & Ross, 2003). However, these studies restricted their focus on trauma to recalled and reported interpersonal abuse. Self-reported trauma before the age of sixteen years predicted onset of psychosis three years later (Janssen, Krabbendam, Bak, Hanssen, Vollebergh et al. 2004). In contrast, one study found no significant association between registered childhood sexual trauma and later schizophrenia (Spataro, Mullen, Burgess, Wells & Moss, 2004). However, reporting abuse implies intervention, and intervention may assist in

resolving the potentially long-lasting and pervasive cognitive, social and biological effects of the abuse. If there is trauma around the time of the baby's birth, either to the baby or the mother, or to the immediate family, and mother develops some post-traumatic symptoms, even at a sub-clinical level, her reactivity and responsiveness to baby may be compromised. These maternal responses may affect children's avoidance of stressful interactions and experiences of intrusion, whilst father's responses have been shown to affect children's avoidance (Ohan, Myers & Collett, 2002). Evidence is accumulating that multiple environmental risks, in addition to personal vulnerability, are linked to the potential for adults to develop psychosis. This occurs at relatively low rates, particularly the narrow phenotype of schizophrenia (van Os, Krabbendam, Myin-Germeys & Delespaul, 2005). A complex range of risk factors including genetic predisposition, prenatal environmental effects (folate or vitamin D deficiency, viral infections, low or high birth weight), early trauma, minority status with chronic exposure to discrimination, and ongoing environmental adversity (including cannabis abuse and urbanicity) have been implicated in vulnerability to adult psychosis and schizophrenia. This ongoing environmental adversity impacts on risk for psychosis and schizophrenia via cognitive, emotional and biological pathways. However, some studies have suggested that parental absence and poor family environments only predict schizophrenia in offspring who are both genetically predisposed and exposed in utero to maternal influenza (Schiffman et al. 2001).

Early experiences of physical or sexual abuse have been linked to vulnerability to adult major depression. This link has been described as resulting from the overwhelming stress of chronic abuse, with corticotrophin-releasing factor (CRF), the main regulating hormone of the hypothalamic-pituitary-adrenal (HPA) axis, leading to a number of metabolic and neuroendocrine disturbances, and subsequent pathologically somatic and psychological effects (Claes, 2004).

The extensive biochemical changes seen in traumatised infants include enduring alterations in hormones from the adrenal cortex. These hormones have powerful effects on the brain and potential for subsequent psychopathology (Goodyer et al. 2001). High levels of cortisol are damaging to the hippocampus, which is critical to developing event (episodic) memory. This episodic or autobiographical memory affirms a sense of self, and deficits in retrieval of autobiographical memory have been shown to be related to major depressive

disorders in adults (Goodyer et al. 2001). However, hippocampal damage is evident also in schizophrenia (Schore, 2002), thus pointing to the possibility of early (infant) traumatic stress in adults with this disorder.

Summary of Early Trauma and Potential Links with Adult Depression and Schizophrenia

A review of the literature indicates that trauma may have broad-ranging and persisting effects on adults and children. Individual differences in trauma responses occur. These differences may reflect the individual's capacity or intention to integrate the traumatic experiences and to make sense of them by attributing meaning. Not integrating or attributing meaning may be reflected in dissociative processes when reminders of past traumatic events occur. When infants or young children experience prolonged or severe trauma, distortions in self-other representations can occur. These distortions have cognitive and emotional correlates in developmental trajectories.

In the above discussion on trauma and dissociation, this author notes that three principles may be construed. These are safety, integration, and subsequent coherence. These three principles are also central to attachment theory.

Attachment and its Relevance to Adult Depression and Schizophrenia

This section introduces some of the major debates regarding the balance of an infant/child's early experiences, temperament and attachment security to later childhood development, and the relationship of childhood development to the adult mental disorders of major depression and schizophrenia.

In developmental psychology, general agreement has been reached concerning the stability of characteristics of both individuals and environment over time. However, trajectories of child development are open to environmental change. For example, early positive experiences do not inoculate against later trauma or deprivation (Waters, Hamilton & Weinfield, 2000). Much of the research in developmental psychology has sprung from attachment theory.

John Bowlby is credited with developing Attachment Theory in the 1950's. He integrated psychoanalytic concepts with ethology, social and psycho-biology, cybernetics from control systems and cognitive development. He conceptualised that infants have an innate behavioural system that orients them to attachment to primary adult figures in order to maximise survival (Holmes, 1993). Bowlby conceptualised 'internal working models' of attachment figures as integral to infants' capacity to

imagine relationships in the absence of attachment figures. This concept integrated Bowlby's observational studies with the psychoanalytic concept of an internalised world of meaning and relationship. Melanie Klein had already transformed Freud's original idea of our having an internal world into a systematic theory of the structure of the unconscious that included interplay between our internal object world and the world of external objects (Ogden, 2002). She developed spatial metaphors to depict this unconscious inner world inhabited by 'internal objects', that is, split-off or denied aspects of the self, that are bound together in 'internal object relationships' by powerful affective ties that originated in the earliest attachment relationships. That is, the more affectively overwhelming an aspect of the self becomes, the more likely we are to deny its existence, and the more likely we are to project a representation of that aspect of the self into other objects (people) or part-objects. If this denial and projection is complete, then a psychotic break with reality is more possible. Wilfrid Bion considered this evasion or denial of emotional pain to be a hallmark of psychosis that prevents a person from giving symbolic meaning to suffering, living with the pain and doing psychological reparation over time (Ogden, 2002). This is particularly applicable to grief and loss at critical developmental periods, if overwhelming affect is not contained by a sufficiently attuned and sensitive caregiver.

Many authors have provided summaries of the origins of attachment theory, the classification of attachment states of mind, and ongoing research in this fundamental concept. Most begin with crediting John Bowlby with developing an attachment theory that challenged previously held secondary-drive theories based on the pleasure principle (Cassidy, 1999; Holmes, 1993; Main, 2000; Marrone, 2000). Bowlby's observations led to the awareness that the mother's relationship with her infant is critical in both the immediate sense of protection from harm, and for later development. Through his observations of both primates and children, Bowlby developed the concept of an attachment behavioural system that regulates infant safety. At the same time he argued that psychoanalytic theory which traditionally used speech, dreams and retrospective accounts by adults to examine psychological difficulties in relationships could be systematically studied using observational and prospective methodologies. He therefore began with observing children placed in hospitals and residential nurseries and noting their responses to prolonged separation. These responses included anxiety and ambivalence and eventually detachment with

respect to previously loved persons. In detachment, consistent with psychoanalytic concepts, the theory was that both affectionate and hostile feelings are repressed.

Marrone (2000) honoured the progenitors of Attachment Theory in detail. As well as discussing Bowlby's contributions, he acknowledged the major contribution of William Blatz, Mary Ainsworth's professional mentor in the early 1930's. Blatz's research interest was human beings' sense of security. According to Marrone (2000), it was Blatz who linked the start of a child's sense of security in the world to a satisfactory attachment to his/her parents. He also suggested to Ainsworth that a sufficiently good attachment provides the optimum environment for the child's exploration of the world. Ainsworth and colleagues then termed this 'using the mother as a secure base from which to explore.' The task of the parents is to provide protective behaviour via support and safety, and to encourage exploration and learning without fear. These core ideas of the universal human need to form close affectional bonds and the reciprocity of early relationships were concordant with those developed by Bowlby in the 1950's and systematically studied by Ainsworth and Bowlby at the Tavistock Clinic (Bowlby et al. 1966). Bowlby used the term 'internal working models' to represent the child's construction of his/her relationship over time with each significant attachment figure.

In the good enough mother-infant dyad, attachment behaviours of the infant such as proximity seeking, smiling and clinging are reciprocated by adult behaviours such as touching, soothing, vocalisation, and holding. There is a 'musical dance' between mother and infant, thus providing a sense of security in the infant which engenders the development of affect regulation, and simultaneously an environment of safety with mother being alert to dangers. These dangers are not intellectually comprehended by the infant but are organismically known. This is demonstrated, for example, when there is too long an absence of mother on whom the infant depends for survival. The infant then exhibits distress that is meant to signal the need for mother's return.

It is imperative to acknowledge the evidence-based nature of the complex theory of attachment.

"In the fields of social and emotional development, attachment theory is the most visible and empirically grounded conceptual framework." (Cassidy & Shaver, 1999, p. x).

It was Ainsworth who refined her initial observations of infants and their mothers in Uganda in the 1950's to eventually arrive at a standardised method for assessing the quality of infant-mother attachments in a laboratory procedure termed The Strange Situation. In this procedure, the infant's reactions to brief separations and reunions in an unfamiliar environment are noted. Following on from this empirical base, Mary Main reconceptualised the original Ainsworth three categories of attachment behaviour into strategies that are organised around the goal of dealing with stress in the presence of the attachment figure (Main, 2000; Schuengel et al. 1999).

It was found that infant secure attachment organisation could be predicted from the mother's sensitivity to the infant's signals and communications in the familiar environment of home. Attachment theorists have acknowledged the psychosocial context in which the primary attachment relationship is formed. This recognition of social context was a focus for Ainsworth in her Ugandan study in which she noted factors such as severe family illness, marital discord, overwhelming work pressures and other conflictual relationships that potentially affected maternal responsiveness to her infant (Main, 2000).

Other research supports links between maternal mental anxiety and her sensitivity to her infant, and those infants developing higher salivary cortisol levels and more disturbed sleep, but not with developing increased reactivity, behavioural inhibition or ambivalent/resistant attachment (Warren et al. 2003). However, these authors acknowledged the potential link between this increased arousal and later risk for behavioural disturbances.

The two insecure forms of organised attachment, detached avoidance and overtly anxious resistance/ambivalence, were found to be related to maternal rejection and unpredictability respectively (Main, 2000). Infant avoidance was associated specifically with maternal rejection of attachment behaviour, including expressed rejection of giving birth to that particular infant, and direct aversion of physical contact with that infant. Maternal depression or anxiety was not necessarily a significant contributor to this rejection. These avoidant infants were observed expressing high anxiety with small separations at home (mother moving from room to room), or displaying controlling anger to their mothers. Despite being behaviourally avoidant and low in affective expression in the Strange Situation procedure, avoidant infants were highly physiologically aroused (Main, 2000). In

contrast, resistant/ambivalent infants tended to have mothers who were not rejecting, but were unpredictably insensitive to their signals, inept in holding them, and noncontingent in the pacing of face-to-face interaction. These mothers also discouraged autonomy in their infants, observable at the crawling stage when exploration of the world is compelling to the infant.

Disorganised attachment and early trauma

Following Ainsworth's description of three types of attachment as secure (approximately 65% of infants), insecure-avoidant (approximately 20%) and insecure ambivalent (approximately 15%), Main, Solomon and Weston described a fourth pattern named Disorganised-Disoriented, observed in approximately 4% of normative populations (Main & Solomon, 1990; Main & Weston, 1981). This fourth attachment pattern of previously unclassified infants is evidenced by the infant reacting to reunion with mother in a confused and disorganised way (Main, 2000). Several researchers (Carlson et al. 1989; Lyons et al. 1987; Main & Hesse, 1990) argued that mothers of disorganised infants are inconsistently frightening to that child, either via targeted abuse or "in some other way." (Marrone, 2000, p.59). This same parent also provides soothing and comfort, and it is the unpredictability of a parent or primary caregiver that is seen as generating the disorganised attachment pattern. A fifth category has now been allocated to those who cannot be placed within any of the four above attachment patterns.

"Not every individual's behavior or language is sufficiently organized for single category placement. Some infants, as well as some adults, are pervasively unclassifiable, and a fifth attachment category, *Cannot Classify* is coming into increasing use." (Main, 2000, p.1057).

It is clear that this field of research is continuing to provide constructive insights into the internal world of infants under stress, and into the critical role of mother-infant reciprocity to later development in all domains, including cognitive representational processes of attachment figures.

Dissociation and attachment

A bi-directional model conservatively represents the relevant research literature. A caregiver with unresolved attachment (with respect to trauma and/or loss) may be frightened, frightening or non-protecting towards their infant/child who then displays disorganised or disoriented behaviour at an early age in controlled experimental conditions that observe the attachment relationship between that child

and primary caregiver (Main & Hesse, 1990). This disorganised attachment in infancy has been linked to later dissociative symptoms in childhood and adolescence (Carlson, 1998). Main and Hesse (1990) posited an intergenerational model of transmission of dissociative symptoms, with later confirmation by Liotti and Pasquini (2000) who found that 62% of adults with dissociative disorders had mothers who had lost a close relative within two years of their birth.

A cogent argument by Schore (2002) linked foetal/infant right brain dysregulation with traumatic attachment and later vulnerability to adult forms of PTSD. Although Schore relied to a certain extent on animal studies, cortisol and other hormone levels are able to be monitored in infants non-invasively. If mother is at times dissociative and therefore frightening to her infant, the raised anxiety in her infant may be unremitting because during maternal dissociation, her denial of infant distress may also operate. Van IJzendoorn et al. (1999) reported that salivary cortisol levels in infants allocated to the disorganised/disoriented attachment category were elevated, thus indicating that maternal dissociation does not allow resolution of infant anxiety. It is this prolonged anxiety that may cause neurobiochemical alterations in the young child. This may then link with later vulnerability to childhood internalising and externalising disorders, which have been shown to be risk factors for adult mental illness.

Dissociation: communication and speech markers

This section presents a template for detecting the psychological process of dissociating in speech within the context of recalling traumatic events that is in use in attachment theory research. It also includes concepts from the section on dissociation. Embedded within this analysis of adult speech is the concept that as a child, the adult's relationship with the primary caregiver was the primary matrix which organises meaning. This meaning is what is examined in the transference, within the organised meaning for the researcher, and the degree of coherence within the narrative reflects the degree of resolution of both attachment states of mind and of discussed traumatic experiences. As Holmes (2000) clearly outlined, the psychoanalytic concepts of countertransference and transference are used to examine defense mechanisms that are a reflection of insecure attachment.

Transference

The concept of transference as displacement of unresolved feelings has developed since Freud's initial description of a pattern that each person develops in

relation to the capacity to love and be loved. Both the acceptable conscious positive transference and the unconscious aspects of negative transference were originally viewed as not stemming solely from the interaction of therapist and patient, but from the latter's unhappy experiences with early potential love (attachment) objects (Zax & Cowen, 1976).

Transference in simple terms is the repetition of past relationships with significant others, and includes behaviours, feelings, and belief systems that are transferred onto or projected into another person. It necessarily implies misperception of that other person, and that misperception indicates unresolved emotional material that then becomes the focus of some treatment modalities. Although behavioural therapy includes transference and countertransference in its terminology, as phenomena they are construed as learned avoidance and learned dysfunctional thinking, which are then targeted for alteration in a structured manner versus being understood and transformed in an integrated manner by the reality-based nature of the relationship with the analytical therapist (Brammer, Abrego & Shostrom, 1993). Phenomenological therapists, systems theorists, strategic and structural therapists, although emphasising different aspects of 'here and now' relating versus past relationships, all recognise the intention of transference as an attempt (often failing) to reduce emotional pain or anxiety by distorting, denying or ignoring reality, and/or avoiding recognition of personal responsibility to relate more realistically to others. Freud identified transference as a preoccupation with the therapist that interrupted the flow of free association. Free association, or free-flowing communication requires freedom from fear of condemnation. Therefore, loss of free-flowing communication, or loss of coherence in speech may indicate a preoccupation with shame, or a preoccupation with the interviewer's judgment. If indeed the interviewer conveys an attitude of doubting the speaker's related experience via interrogative questioning, further interruptions in coherent speech could be anticipated. These interruptions may be severe enough to be disorganised and dissociative.

Until the process of working through a trauma has occurred, the threat to the person is re-presented in human interaction (Kalsched, 1996).

“..the unconscious repetition of traumatization in the inner world which goes on incessantly must become a *real* traumatization with an object in the world

if the inner system is to be ‘unlocked.’ This is why a careful monitoring of transference/countertransference dynamics is so important..” (p. 26)

In his challenging style, Lacan (1977) perceived transference as providing primarily an ideal opportunity for deception to occur.

“Is not this a fundamental structure of the dimension of love that the transference gives us the opportunity of depicting? In persuading the other that he has that which may complement us, we assure ourselves of being able to continue to misunderstand precisely what we lack.” (p. 133)

Countertransference

Defining countertransference is more complex than defining transference. In essence, countertransference refers to the emotional reactions and projections of the therapist to the consumer. It covers common reactions of resentment towards a consumer’s antisocial behaviour or attitude, with the purpose of gratifying the therapist’s needs, but ideally provides via therapist’s insight greater opportunity for empathic responses (Brammer et al. 1993).

The assumed capacity of the analysed therapist to at all times be disinterested and neutral has met with considerable challenge. Identification and intuition were introduced by Klein (Mitchell, 1986) as feminine/maternal counters to Freud’s masculine ‘neutral’ observational, and ultimately categorising stance. This use of intuition based on accumulated lived experience is seen as providing the capacity for attunement, not just by a mother with her baby, but also within the therapeutic alliance. This shift of emphasis in treatment from vertical or hierarchical relationships to lateral or horizontal ones has been extended in the post-structural sociological phenomenologies. However, both transference and countertransference refer to forms of relating to others, and it is critical to acknowledge that relating in these ways indicates purpose, that is, that this repetition will prevent actualisation of relationship.

Trauma, transference and countertransference

The above definitions of transference and countertransference suggest that a traumatised individual, particularly when attempting to convey something of their traumatic experiences to another, would intensify their disruptions in monitoring discourse and reasoning. Herman (1997) discussed triadic transference, which refers to the disembodied presence of the perpetrator of traumatic experience as an intruder, as if there is a third person in the room. She refers to the patient’s hostility to the

therapist as belonging to the abuser whose injunction for silence/secretcy has been broken. Terror and helplessness (inaction in the face of trauma) are projected into the therapist who then wishes to back away from such intensity of demand that he/she be perfectly attuned to the consumer's needs. The interviewer or therapist may feel overwhelmed, terrified, in a rage or despairing as traumatic countertransference occurs. Revenge by the therapist or interviewer needs to be an acknowledged danger, for example, via mother-blaming.

Main (2000) noted that individuals with apparently unfavourable life histories had secure offspring, provided that they were able to recount their life histories coherently. She therefore shifted her focus from content (events) recalled in semi-structured interviews to the manner (attachment style) in which the information was provided. This link between attachment strategies and the manner of presenting relational or familial stress/trauma is critical to the body of this thesis.

With the advent of the Adult Attachment Interview, differences in parental caregiving behaviour were seen to be mediated by parental representational processes of attachment, which were able to be classified and placed on continuous rating scales. Incorporating Bretherton's concept of infants' subjective world of relatedness, Main focused on the verbal representations of the meaning individuals placed on attachment relationships. Bretherton (1994) proposed that perceptual, sensorimotor, motivational, arousal and emotional factors collaborate in some manner to create meaning at the verbal and nonverbal level, and contribute to personality and relationship development. This creation of meaning is disrupted or altered in Complex PTSD (Herman, 1992).

Following Main's encounter with the examination of discourse by the linguistic philosopher H. Paul Grice (Grice, 1989), emphasis was placed on analysing the discourse properties of the Adult Attachment Interview in terms of his maxims of quantity (succinct yet complete), quality (truthful and evidential), relevance (relevant to the topic) and manner (clear and orderly) in addition to the actual content of the narratives. For example, transcripts of mothers of infants with secure attachment expressed a clear valuing of attachment figures and related experiences, as well as showing objectivity in describing particular relationships. If the mother's own relationship with her parents was difficult in some way, forgiveness was implicit in the narratives. Compassion, humour, and unrehearsed or fresh and original descriptions of relationships were evident. Accuracy was sought in

the moment, that is, rich but contained experiences were able to be processed in an undefended manner, with a flexible regard for one's own perceptions.

Mothers of avoidant infants, dismissive of the effects of attachment-related experiences, either did not acknowledge or discuss negative life events, or did so stating they were stronger for the experience without indicating a working-through of the event. Early relationships were superficially presented as positive, without supportive evidence or evident contradiction. The mothers of avoidant infants often stated they did not know in answer to questions, and avoided discussing anger and distress. This resembled the avoidance or suppression of anger and distress in their infants when in the unfamiliar environment of the Strange Situation procedure. This suggests to this researcher that these mothers also may have heightened physiological arousal with an outward appearance of indifference. As already noted, their infants behaved more angrily and in controlling ways towards mother in the home. Therefore it must be acknowledged that what is presented in interview may be quite different to actual behaviour in the home.

Main and colleagues noted that mothers of resistant/ambivalent infants seemed preoccupied with early and/or current relationships with their own parents. Often this was in a blaming and angry way, with attempts to secure collusion with the interviewer. Subtle boundary failures (self/other confusions), divergence from the topic at hand, and malapropisms (ludicrous misuse of a word, especially in mistake for one resembling it) were evident. Some transcripts were unclassifiable, and were later recognised as having a mixture of dismissing and preoccupied speech patterns, with switches occurring in mid-transcript. These were later allocated to the disorganised or disoriented category, with further in-depth expansion by Crittenden (1997, 2000). It is essential to clarify that it is not the presence of reported trauma or other difficulties that provide relegation of a speaker into one of five categories, but rather the manner in which the trauma/difficulties are presented to the interviewer.

Lyons-Ruth and Jacobvitz (1999) detailed the indicators of unresolved trauma in adults based on the Main and Goldwyn unpublished manuscript of 1998. The speaker enters a state of mind in which he/she loses awareness of the context (disengages), for example, abruptly falling silent and leaving a sentence incomplete. This may suggest that unwanted material has intruded and preoccupied the speaker, who then may later regroup or never return to the original discussion. Also, sudden shifts to odd/bizarre or poetic phrasing/sing-song voice that evoke a feeling of

unreality in the interviewer, brief lapses in the monitoring of reasoning, for example, indicating a belief that a deceased person is simultaneously alive and dead physically, disbelief that the person is deceased by talking of her/him in the present tense (note this is not applied to very recent loss). The above indicate that the way we speak reflects our state of mind. That is, if our speech is disorganised or confused, the listener may assume this is an accurate reflection of our internal state.

Crittenden (1997, 2000) extended Main and Goldwyn's concept of unresolved loss and trauma by considering resolution, or its lack, as a process and not as a categorical state. This recognition of process rather than a defined state parallels Bowlby's original conception of the potential for quality of attachment to be altered by life experiences (Holmes, 1993). Of relevance to this discussion on dissociation, Crittenden described evidence in speech for detecting lack of resolution of trauma and of loss. These 'discourse errors' occur specifically with reference to a dangerous event. Resolution is the product of mental processing of information about events that are dangerous to self or to significant others, and lack of resolution is seen as a failure to mentally process the dangerous event to enhance safety and to cause reasonable prevention of possible repetition. In summary, there is either an intensification of a pattern (preoccupied or dismissing) of engagement with the listener/interviewer seen in the main body of the interview, or a switch to an opposite pattern when discussing the trauma or loss. Resolution is evidenced in the capacity for complex emotional states, such as sadness, regret, acceptance and contentment with what remains. Crittenden stated that speakers who have unresolved trauma display substantial dysfluency around specific self-threatening events, and defined these dysfluencies according to the speaker's general pattern of discourse, whether preoccupied or dismissive.

By dismissing the relevance of a traumatic event to self or to one's offspring, one is protected from the perceived threat of overwhelming emotion and the possibility of not recovering or not being able to function when it is paramount to function in a manner that keeps the family intact.

Overwhelming affective arousal prevents the speaker from shifting from primary process to secondary and then tertiary process (Stevens, 2001). There is no opportunity for perspective, or a working-through of the event. This is relevant to disorganised attachment with its origins in frightening interactions with otherwise potentially caring and protecting parents. Different memory systems (semantic and

episodic) may contradict each other and be activated simultaneously in stressful situations. With semantic memory, information in terms of generalised perceptions about the world are first constructed from the generalisations of others (Crittenden, 2000; Marrone, 2000). These generalisations extend to attachment figures and the self, and represent what Bowlby termed 'internal working models'. Specific episodes on the other hand, are laid down in episodic memory. Conflict between these two memory systems may arise for example, from being told (semantic) by one's parents that they are being loving, and actually experiencing at times (episodic) abuse or neglect. As Marrone (2000) clarified, unresolved trauma is demonstrated by non-integration of these two memory systems.

"It seems that in the case of psychopathology, the individual has failed to integrate these multiple perspectives because he has not been able to accommodate his own perspective with that which he has 'borrowed' from his significant others. Another possible reason for the inability to integrate one type of memory and another may be the need to repress painful feelings associated with some episodic memories." (p.142).

In summary, the five categories of attachment states of mind are Secure/Autonomous (the speaker discusses material relevant to the questions, balances affect and cognition, and has the capacity to reflect on the meaning of past events to present relationships), Dismissing (minimising the discussion of attachment-related experiences, denying memories), Preoccupied (memories are stimulating and the intent of the interview is lost, with the speaker lacking focus or rambling, being overinclusive, with no conclusions drawn), Unresolved/Disorganised (may occur within any of the three previous categories, and exhibit lapses in monitoring of reasoning and/or discourse in relation to the discussion of potentially traumatic events) and Cannot Classify (the speaker displays a combination of contradictory and incompatible linguistic patterns throughout interview). In prospective studies with adults, Coherent speakers have repeatedly been found to subsequently have infants who are securely attached, Dismissing speakers have avoidant infants, Preoccupied speakers have ambivalent infants, Unresolved/Disorganised speakers have infants with disorganised or disoriented behaviour in the Strange Situation but who by the age of six years are punitive or caregiving towards mother (termed Disorganised-controlling), with the Cannot Classify speakers having some disorganised infants. These latter two categories have

been associated with adult psychiatric disorders, marital and criminal violence and sexual abuse (Hesse, 1999). The rigorously designed studies exploring validity have not included the Cannot Classify category (van IJzendoorn et al. 1999). Importantly, the AAI categories are independent of nonattachment-related memory.

Fathers and attachment

The majority of the above attachment research has focused on the relationship between mothers and their infants. Bowlby (1973) and others warned against the implied exclusiveness of maternal influence on infant attachment and development (Bor et al. 2003). The possibility of primary attachment to the father or to multiple attachment figures has now been recognised (Solomon & George, 1999; Carlson, Samson & Sroufe, 2003). Mothers being seen as the primary caretaker has been recognised as reflecting the social order (Taylor & Daniel, 2000). This researcher acknowledges that fathers play a significant role in reinforcing secure attachment via reciprocity during play with their offspring, and in supporting their offspring's exploration of the world. Steele and Steele (2005) reported that longitudinal studies pointed to possible distinctive contributions to be made by mothers, as opposed to fathers, in respect of their children's social and emotional development. Their data suggested that children's understanding and resolution of emotional conflict internally is perhaps uniquely influenced by the mother-child relationship, while understanding and resolving external (interpersonal and world) emotional conflict is perhaps uniquely influenced by the father-child relationship. However, these authors also stated that there can be no simple division between inner and outer conflicts.

Other attachment theories and measures

Other attachment theories exist (Commons, 1991; Shaw & Bell, 1993), but what they all share is a recognition of the organising behaviour of the infant in relation to its primary caregiver and environment for the primary purpose of that infant's survival and subsequent development, particularly socially. There are also of course, other measures of adult attachment (Feeney, Noller & Hanrahan, 1994).

To this researcher's knowledge, a systematic application of the above theoretical links between attachment states of mind and dissociation has been restricted to using the Adult Attachment Interview. This includes questions about relationships with both parents/caregivers and about loss and trauma by monitoring the quality and quantity of discourse. If when discussing trauma or loss the speakers show lapses in reasoning or fail to monitor what they have just said, the implication

is that they are experiencing a brief dissociative state. Major contradictions of fact are also an indicator of this lack of monitoring. Hesse (1999) stated that the discourse/reasoning lapses noted in some speakers during the Adult Attachment Interview when discussing potentially traumatic events suggest temporary alterations in consciousness or working memory, and are thought to indicate interference from normally dissociated memory or belief systems, or unusual absorption in the triggered memories. That is, they indicate microdissociative episodes.

There is danger in attributing attachment theory with the status of Occam's Razor with respect to later vulnerability to adult mental disorders. Occam's Razor (Firkin & Whitworth, 1996) refers to selecting from competing theories, the one that is the simplest and that predicts the greatest number of variables. This ignores the alternative of Saint's Triad that states that an individual may have as many attributing causes and illnesses as they please, rather than one causal mechanism that explains all illness phenomena (Hilliard, Weinberger, Tierney, Midthun & Saint, 2004). However, empirical research into attachment theory and its relation to cognitive and emotional resilience and the capacity to integrate negative life experiences may be the single best explanation for resilience to stress.

Dissociation and schizophrenia

Schizotypy as a personality dimension is a major risk factor for the later development of schizophrenia. Merckelbach, Rassin, and Muris (2000) carefully teased out the link between dissociation as defined via the Dissociative Experiences Scale, and Schizotypy as measured on the Claridge Schizotypal Personality Scale, and concluded that dissociation is not an artifact of fantasy-proneness. In other words, the reporting of dissociative experiences and schizotypy and other schizophrenia-like phenomena can not be fully accounted for in terms of a tendency to report unusual experiences. They concluded, in contradiction with the DSM-IV TR, that dissociation and schizophrenia spectrum disorders may not be distinct nosological categories but may overlap symptomatically. Despite the compelling evidence for early childhood developmental impairments (Rutter, 1995) that are consistent with complex trauma responses in those who go on to develop adult schizophrenia, the conception remains that dissociative symptoms seen in acute episodes of schizophrenia are co-morbid (Alao, Tyrrell, Yolles & Armenta, 2000).

It may be that once the genetic endophenotype for a particular disorder is expressed as a result of extreme stress/trauma, then subsequent generations require fewer distinct trauma, and perhaps at a later age to exhibit the illness. That is, co-morbidity may occur for some populations with schizophrenia, and for other populations the symptoms associated with trauma may be inherent to the index illness. Dissociation (a trauma response) is associated with disorganisation (in attachment strategies) such that in some literature, the terms are interchangeable (Pasquini et al. 2002). This is relevant to schizophrenia because the context-processing deficits in schizophrenia that correlate with disorganisation symptoms are both recognised as executive functions within the prefrontal cortex (MacDonald, Pogue-Guile, Johnson & Carter, 2003). This prefrontal cortex is most susceptible to persisting damage in infants resulting from relational trauma and subsequent disorganised attachment (Schore, 2002).

MacDonald et al. (2003) found deficits in context-processing in well siblings of adults with schizophrenia. However, they did not screen their participants for low-risk (no family history of mental illness) and did not explore early family trauma or trauma symptoms in the parents. Caution is therefore required in allocating a purely genetic explanation for the sharing of particular neurological difficulties in siblings. Several authors are now acknowledging that traumatic life events are deemed to be common among people with severe adult mental illnesses, including schizophrenia (Mueser, Rosenburg, Goodman & Trumbetta, 2002). These authors proposed a model that tracks the interactive process of PTSD symptoms in childhood and adulthood (avoidance, overarousal, re-experiencing the trauma) with its common correlates of retraumatisation, substance abuse and difficulties with interpersonal relationships. They included hallucinations, delusions, depression, suicidality, anxiety, hostility, interpersonal sensitivity, somatisation and dissociation as prevalent symptoms in severe adult mental illnesses. However, they have not focused on traumatic attachment as providing the earliest template for vulnerability to PTSD, nor have they specified discriminatory processes for particular adult mental illnesses.

As noted above (Marrone, 2002), integration of memory systems around complex and sometimes traumatic experiences is lacking in those who develop psychopathology. The process of integrating these multiple perspectives is an ongoing developmental task, reliant on cognitive processes, both conscious and unconscious.

Cognitive Aspects of Trauma Processing and Attachment

Bowlby's hypothesis stated that early relationship experiences with the primary caregiver form the basis for internalised and generalised expectations about the self, others and the world (Bowlby, 1973). This hypothesis has been broadly accepted in the attachment literature (Bretherton, 1994; Fonagy, 1994, 2001; Waters et al. 2000). The cognitive representations of these usually unchallenged expectations, named 'internal working models' are thought to evolve congruent with life events. However, others argue that representational capacity, assumed in adult cognition, may not be present in infants (Smith, 1998). Infant subjective states of mind (e.g. quality of attachment representations) may have little objective judgment, for example, in relation to the safety of the attachment figure. States of mind are seen to be subjective, and therefore an internal representation may be erroneous. Logically therefore, these representations would be unstable across time and experience. However, this flexibility/reactivity of internal representational models is also accepted in attachment research, and is congruent with empirical evidence from early trauma research.

Negative life events affecting the child-parent relationship and secondly affecting the stress loading on the parents have the capacity to destabilise previously secure attachment, and associated cognitive representations. These events include the death of a parent, foster care, parental divorce/separation, chronic and severe illness of an immediate family member, single parent, parental psychiatric disorder, drug and/or alcohol abuse, and child physical, sexual or emotional abuse (Bowlby, 1973; Ross & Joshi, 1992; Waters et al. 2000). Within cognitive psychology, behaviour is seen as subsequent to cognition, with repetitive negative patterns occurring until reparative experiences intervene. However, in challenge to the principal role of these life events to modify internal working models of cognition, maternal negative attitude toward her infant has been shown to independently predict child behaviour problems at five years after controlling for demographic, child and psychosocial family factors (Bor, Brennan, Williams, Najman & O'Callaghan, 2003).

Liotti (2002) cogently linked interpersonal schemata (generalised representations of self-other relationships within a given meaning domain) with secure, avoidant, anxious-resistant and disorganised/disoriented early attachment patterns. He described people with schizoid personality traits, those with psychosomatic illnesses and those with clinical depression as having a tendency to

avoid visual, emotional or verbal interactions with the therapist. The schema constructed around early experiences of rejection and/or neglect are of the unavailability of emotionally meaningful help. Resistant children construct interpersonal schemata in which the distressed or frightened self is portrayed as at risk of being misunderstood, while the potentially helpful other is portrayed as both unpredictable or intrusive. The self-other relationship defined by such a schema generates insistent demands for help whilst simultaneously announcing that the helper cannot be trusted and is experienced as controlling and intrusive.

With disorganised/disoriented early attachment, the frightening/frightened caregiver may not have resolved mourning or trauma, and may project the intense unresolved feelings into their offspring. Liotti (2002) posited that these caregivers respond to their child's needs for help and comfort in terms of their own painful emotions and irrational beliefs concerning loss and trauma, rather than objectively appraising and responding to those needs. He stated that the interpersonal schema related to a disorganised/disoriented pattern of attachment portrays a confused rather than ambivalent self caught in an interpersonal situation in which it is impossible to decide whether the self, another, or some ill-defined external influence is responsible for distressing emotions. Cognitive confusion, incoherence in speech, avoidance of eye contact, dazed expressions and other dissociative reactions, anxious pleading not to be abandoned, and self denigration are presented as representations of the interpersonal schema of role-reversal seen in some cases of disorganised/disoriented early attachment. The expectation (schema) is that all relationships will be exploitative, that both parties will be fraught with suffering, whilst causal attributions for this suffering will be confusing and interchangeable.

“Without stable causal attributions for one's own and other people's deepest emotions, the self-other relationship is bound to be represented at the basic level as both meaningless and 'void.' This 'void' is likely to be filled up with every momentary attribution of meaning that may be at hand - either positive or negative, but in any case highly inconsistent attributions.” (Liotti, 2002, p.384).

Consistent with Bowlby's 'internal working models', Young and colleagues explored specific adult schema in relation to early attachment relationships (Young & Lindemann, 2002). Although the focus for these cognitive therapists has usually been on severe personality disorders, they acknowledged that their model is not a

comprehensive theory of personality or psychopathology. The critical issue is that automatic and pervasive maladaptive schemas may underpin many adult mental disorders, with their maintenance and recrudescence occurring under relationship stress via cognitive and emotional inflexibility or rigidity. Young and Lindemann (2002) outlined the schema titled 'Instability and Disconnection' in which the expectations are that one's needs for security, safety, stability, nurturance and empathy will not be met in a predictable manner within the context of intimate relationships. The familial origin of this schema is seen as detached, explosive, unpredictable or abusive behaviour from primary caregivers. This contains elements of the AAI insecure avoidant, ambivalent and disorganised/disoriented attachment categories.

However, other researchers have focused on trauma caused by bio-genetic abnormalities, excluding interpersonal trauma. Both forms of trauma however, threaten the safety, survival and integrity of the foetus or infant, and must have some cognitively-constructed meaning attached to the traumatic events by the caregivers that may in some manner transmit to the world of meaning of the infant.

Perinatal Trauma, Attachment and Relevance to Adult Schizophrenia and Depression

Schizophrenia has predominantly, in modern Western psychiatry, been conceptualised as a neurodevelopmental disorder predetermined by genetic and in utero processes (Cardno, Sham, Farmer, Murray & McGuffin, 2002; Weinberger, 2002; Corvin & Gill, 2003), and exacerbated by obstetric complications (McIntosh et al. 2002), with further risk factors of environmental stressors eliciting more severe forms of the illness (Cotter & Pariante, 2002). More recent studies have implicated maternal stress during pregnancy as a contributor (Brown & Susser, 2003). This maternal stress has been confined to disease processes. With a primary focus on the human central nervous system, Cicchetti and Walker (2003) have provided recent contributions from several authors relevant to the subject matter of this research, and in particular have acknowledged that psychosocial stressors have the capacity to alter brain development. Because the theoretical contributions to schizophrenia are multiple and not mutually exclusive, it is imperative that the lived experiences of the mothers are sought.

“It has been posited that a severe maternal stress occurring during a critical stage of neurodevelopment may adversely affect the developing fetus, elevating risk for schizophrenia in the offspring.” (Schiffman et al. 2003)

These authors focused on the prevalence of maternal contraction of influenza during the sixth month of the pregnancy, and the resultant potential damage to the foetal hippocampus. Hippocampal volume is reduced in adults with schizophrenia. However, they acknowledged that there is also evidence of a relationship between maternal influenza and depression and also violent offending in the adult offspring. This researcher considers the window of maternal stress during viral infection to be far less than during sustained psychosocial stressors such as poor family supports, absent spouses or chronic illness. Schiffman et al. (2003) remarked on the link between stress response and immune response via the maternal HPA Axis response (hypothalamic-pituitary-adrenal axis), thus acknowledging that other stressors may herald maternal vulnerability to infection. They encouraged further studies via maternal self-report measures on their stress levels and depression. However, this is not acknowledging the potential for the most severely stressed mothers to utilise denial, dismissal or minimising as coping mechanisms, resulting in false negatives on fully structured questionnaires. They also failed to cover the issue of potentially compromised attachment between mother and foetus via stress. This researcher notes the relevance of the sixth month for maternal infection, when quickening generally occurs in the fifth month (Stotland & Stewart, 2001). This quickening alerts the mother to the presence of her baby, and is recognised as the time when intense bonding to the foetus begins.

Wiener (1991) juxtaposed several areas of research and accepted clinical practice. These are the positive outcomes of family therapy in schizophrenia, and attachment theory and childhood disorders, without making links between attachment theory and schizophrenia. Tyrrell, Dozier, Teague, and Falloot (1999) in looking at attachment states of mind in those with schizophrenia, found that 89% were dismissing of attachment when the three category system was used, and 44% were unresolved when the four category system was used. However, Dozier, Stovall, and Albus (1999) expressed extreme caution interpreting these results because the categorising is based on analysing discourse, which in schizophrenia may be characterised by lapses in monitoring of reasoning. This researcher notes that the concept of dissociation in terms of being disorganised in some aspect of

self-integration, and exhibited as lack of coherence in communication is used across the three systems examined in this research: PTSD trauma memories; disorganised attachment; and schizophrenia. From the review of these three areas, it can be concluded that if the participants' mothers have unresolved trauma and/or loss around the time of the pregnancy, birth and earliest life of the participants, then the potential for insecure attachment is present. If this non-resolution is sustained to the present, then the participants as children and adolescents potentially also will retain difficulties with attachment. These ongoing difficulties will be explored in the next section.

Persisting Attachment Difficulties

This section outlines current research evidence from attachment theorists and DSM-IV to define criteria for attachment difficulties in infants and subsequent attachment, behavioural and attentional difficulties in children and adolescents.

Prospective longitudinal research has shown that children with a history of secure attachment are independently rated as more resilient, self-reliant, socially orientated, empathic to distress, and to have deeper relationships (Sroufe, Egeland & Kreutzer, 1990). In fact the attachment style at one year of age is the single best predictor of psychopathology at five to six years. Other longitudinal studies have shown a 68-75% correspondence between attachment classifications in infancy and classifications in adulthood (Waters et al. 2000; Waters, Weinfield & Hamilton, 2000; Weinfield, Sroufe & Egeland, 2000; Weinfield, Whaley & Egeland, 2004).

Disorganised attachment and behaviours

Some work has been done on the behavioural markers for disorganised attachment observed in the Strange Situation and it is this disorganised attachment that several authors argue has links to dissociative states in mother around her traumatic memories (Lyons-Ruth & Jacobowitz, 1999). Below is a list of behaviours thought to reflect disorganised attachment:

1. Sequential display of contradictory behaviour patterns (anxious-avoidant and anxious-ambivalent);
2. Simultaneous display of contradictory patterns;
3. Undirected, misdirected, incomplete and interrupted movements and facial expressions;
4. Stereotypies, asymmetrical movements, mistimed movements, and anomalous postures;

5. Freezing, stilling, slowed movements and expressions;
6. Direct indices of apprehension regarding the parent;
7. Direct indices of disorganisation and disorientation.

If a dissociating mother responds to her infant's disorganised behaviour with confusion or lack of understanding, then it is unlikely that she will be able to provide security and a sense of safety in a timely manner.

It has already been noted that disorganised attachment in infancy as defined by the attachment theorists has the strongest links to later adult mental disorders. It is important to note that disorganised attachment as defined by attachment theorists has similarities and differences from the DSM-IV (1994) Attachment Disorders of Childhood and Adolescence (van IJzendoorn & Bakermans-Kranenburg, 2003). The core aspect of disorganised attachment is fright without solution or resolution, leading to the breakdown of organised strategies of emotion regulation. This breakdown in emotion regulation underpins the extensive list of childhood disturbances seen in four to six year olds who were placed soon after birth in a Romanian orphanage and later adopted (Rutter et al. 2001). This study therefore affirms that early neglect as well as abuse is linked to disorganised attachment. Rutter et al. (2001) found that the majority of infants placed in residential care developed a disorganised type of attachment with their caregiver, comparable to that found in infants whose mothers were depressed, alcoholic, mentally ill or maltreating (van IJzendoorn et al. 1999). Depression also has been linked to childhood sexual abuse and poor parental care (neglect). It is the latter (neglect) that carries a greater risk for developing adult depression in the presence of poor adult intimate relationships (Hill et al. 2001). As already noted, Main (2000) commented on the vulnerability of mothers who display rejection of a pregnancy, and the subsequent potential for disturbed attachment to that infant.

Other indicators of insecure attachment reflect poor transition to age-specific tasks, e.g. failure to develop an attachment to father, not relating to siblings, not enjoying peer relationships, enduring refusal to go to and/or remain at school, difficulties in the ability to concentrate despite normal intelligence, and low self-esteem. These indicators may reflect anxiety about the availability of a good enough internalised representation of an attachment figure.

This is based on two assumptions. The first is that quality of attachment remains increasingly stable and resistant to change unless significant destabilising

major events or reparative experiences occur (Bowlby, 1973). The second is that attachment status predicts other developmental achievements. Sroufe (1979) used the construct of coherence to describe a continuation of the earliest secure/insecure attachment status into subsequent developmental tasks of age-appropriate autonomy, peer relationships, social competence and cognitive and socio-emotional functioning. Sroufe (1988) substantiated the understanding that the earliest attachment relationship and its quality are replicated throughout the lifespan, and that quality of peer relationships, social adaptation and ego resiliency are fundamentally based in the early attachment pattern.

Attachment researchers are careful to acknowledge the possibility of neurological attributes in the infant that may affect quality of attachment relationship with the primary caregiver (Solomon & George, 1999). Smyke, Dumitrescu and Zeanah (2002) noted that disturbances in language, motor movement, and serious peer relationship problems are possibly related to early neglect. This is significant because of the literature on early movement disorders in children who later develop schizophrenia, the comprehensive literature on communication deviance in families with a member with schizophrenia, and the prodromal phase of schizophrenia often attributed to stressors during adolescence. Premorbid developmental and social impairments are recognised in adult schizophrenia and affective disorders (Hollis, 2003). Social isolation, social aloofness, separation or social anxiety, unusual stereotyped interests and preoccupations, deviant social communication or comprehension, quality of affect, suspiciousness and sensitivity, unusual thought content and beliefs, deviant speech and antisocial behaviour are all seen as relevant dimensions in the prodrome for several disorders.

Childhood attachment disorders

The DSM-IV (1994) childhood disorders were distinct nosological entities that were categorical, and required significant symptom clusters to achieve a diagnosis for example, of Separation Anxiety Disorder or Reactive Attachment Disorder. Separation Anxiety Disorder and childhood PTSD share many symptoms, but to attain the latter diagnosis, a specific traumatic event was required to be identified. Scheeringa, Zeanah, Myers and Putnam (2003) revised the strict criteria for childhood PTSD, relying more on behavioural observations and less on verbalisations. Their trauma events included abuse, injuries, and witnessing violence. By reducing the number of symptoms required for a PTSD diagnosis, they found that

changes in Cluster C threshold (avoidance/numbing) produced the most marked increases in the rate of diagnosis. They concluded that one to three (1-3) year old traumatised children with PTSD manifest symptoms of Separation Anxiety Disorder and Oppositional Defiant Disorder, and use more internalising strategies than traumatised children without PTSD, and are more symptomatic than older children (4-6 year olds) experiencing trauma.

Separation Anxiety Disorder

Separation Anxiety Disorder (SAD) is the only anxiety disorder in the child and adolescent section of the DSM-IV (1994). It is specifically identified as a disproportionate fear of losing mother, not any other attachment figure (Kaplan et al. 1994), with the child feeling safe and secure only in the mother's presence. Children with SAD deny and displace angry feelings towards their parents onto the outside world, which then becomes threatening to them. Fears of personal harm and of danger to parents are persistent preoccupations, and the children are often conscientious, eager to please and conform. These symptoms are consistent with role-reversal and false compliance in the Crittenden Insecure-Avoidant attachment category. The DSM-IV (1994) diagnostic criteria for SAD included three of the following:

1. Persistent and excessive worry about losing or possible harm befalling major attachment figures;
2. Persistent and excessive worry that an untoward event will lead to separation from a major attachment figure;
3. Persistent reluctance or refusal to go to school or elsewhere because of fear of separation;
4. Persistent and excessive fear or reluctance to be alone or without major attachment figures at home or without significant adults in other settings;
5. Persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home;
6. Repeated nightmares involving the theme of separation;
7. Repeated complaints of physical symptoms, including headaches and stomachaches, when separation from major attachment figures is anticipated; and
8. Recurrent excessive distress when separation from home or major attachment figures is anticipated or involved.

The DSM-IV criteria necessitated that significant distress and impairment in functioning were involved. Contributing factors included learning to be anxious about dangers outside the home from parents, genetic (parents with agoraphobia have an increased risk of having a child with SAD), and specific events. The latter included actual traumatising separations, e.g. child illness and hospitalisation, parental illness, loss of a parent, or geographic relocation. Lack of an adequate mothering figure was also identified as contributing to the disorder. Consistent with the Insecure-Avoidant attachment category, difficulty with memory and distortions in talking about separation themes may indicate the disorder. Many children with SAD are demanding and intrusive with adults, and seek constant reassurance, and may complain that they are not loved or wanted.

Differential diagnoses

Separation Anxiety Disorder is neither Pervasive Developmental Disorder, childhood Depressive Disorder nor Schizophrenia. Some reports have indicated significant symptom overlap between SAD and Depressive Disorders (Kaplan et al. 1994).

Reactive Attachment Disorder

This disorder of infancy or early childhood was recognised as emanating from parental/caregiving neglect of the child's basic physical or emotional needs, or via multiple changes in caregiver preventing appropriate bonds (Kaplan et al. 1994). Failure to thrive via malnourishment and delayed milestones can be present. DSM-IV specified that before the age of five (5) years, one of the following patterns of inappropriate behaviour is shown:

1. Persistent failure to initiate or respond appropriately to most social interactions, instead showing excessively inhibited, hypervigilant, or ambivalent responses (including approach/avoidance, resistance to comfort, and frozen watchfulness);
2. Indiscriminate expressions of familiarity with relative strangers and diffuse attachments.

The first pattern contains the hallmarks of the Disorganised/Disoriented attachment category, which has been linked to frightened/frightening mothers who may not be at all neglectful of the infants' basic physical needs, but may use denial or rejection of the infants' emotional needs in order to contain her own anger and anxiety (Main & Morgan, 1996). Low socio-economic status, family disorganisation,

social isolation and young parenthood may contribute to the likelihood of the disorder.

Zeanah, Smyke and Dumitrescu (2002) commented that no structured psychiatric interview has ever published validity data about Reactive Attachment Disorder. Researchers in medically oriented fields have paid little attention to quality of attachment as a mediating or causal factor in childhood disorders, and Frankel, Boyum and Harmon (2003) and van IJzendoorn and Bakermans-Kranenburg (2003) urged greater attention to both relationship and trauma factors in diagnostic systems. Quality of the home environment however, has been recognised but often attributed singularly to marital conflict or to genetic transmission, e.g. in childhood anxiety disorders. Comparison of DSM-IV Attachment Disorders and classifications of secure, insecure and disorganised attachment is only very recent, and has given mixed results (Boris et al. 2004), with the authors providing cogent criticism of the diagnostic criteria in the DSM-IV Attachment Disorders. Despite significant associations between presence of an Attachment Disorder and measures of attachment security, they are thought to be discrepant constructs. Their finding that secure attachment classification is associated with not meeting criteria for an attachment disorder is consistent with the developmental literature.

The above discussion of the potential outcome of parental neglect in the developing offspring does not accommodate the more hostile parental rejection now discussed. Maternal rejection is focused on, whilst recognising the contribution of fathers to the complex interplay within family systems. It is assumed that sufficient sensitivity may be provided by any other significant adult, and so the presence or absence of supportive adults is critical for the health of both mother and baby.

Maternal Rejection

Solomon and George (1999) outlined Ainsworth's original observations of four highly intercorrelated variables in the mother-infant interaction that provide a secure base for the infant. These are: maternal sensitivity, with prompt and appropriate responses to the infant's signals; acceptance (versus rejection); cooperation; and psychological accessibility. It is in the insecure avoidant group of infants that maternal rejection is most frequently noted. This rejection is more active and hostile than the benign unavailability of a very busy mother, but may not necessarily lead to severe neglect or abuse. A child's avoidant pattern is seen as a defensive strategy to reduce emotional involvement or confrontation. Crittenden

added placating, guiding or acting solicitously towards the parent (role reversal) as behaviours evident in some avoidant children of preschool and kindergarten years. This avoidant pattern of attachment is thought to reflect a predictable negative parental response to the child's negative affect (Solomon & George, 1999).

Infants with designated disorganised attachment may have experienced maltreatment (Schuengel et al. 1999). Crittenden and Claussen (2000) described a mixed pattern of avoidant and ambivalent strategies as 'defended/coercive', in which the child alternates or coalesces the strategies towards significant others, on the one hand reducing emotional involvement or confrontation and focusing on play and exploration at the expense of interaction, and also maximising psychological involvement with a parent by exaggerating problems and conflict via threatening (resistant, punitive) and/or disarming behaviour (innocent, coy). Crittenden and Claussen found this combined pattern to be associated with maltreatment. They also described children with mixed avoidant and disorganised strategies who displayed sad or depressed affect, who had moments of freeze response with staring, and/or showed extreme distress or panic. These symptoms are consistent with a terror response. The above several theoretical and research studies and debates have guided the research methodology in this thesis.

Methodological Framework

As stated in the Introduction (Chapter 1), the aims of this research are to examine similarities and differences in recalled early family traumatic events for adults now experiencing major depression or schizophrenia; to examine potential links between these traumatic events and attachment difficulties that persist throughout childhood and adolescence; and to contextualise these recalled events and potential outcomes.

Trauma and dissociation

Retrospective research into trauma and its effects has its advantages. It is not assumed that what is reported is a factual portrayal of a past event, nor of the person's response at the time. It is assumed that what is reported reflects the person's current cognitive and emotional processing of the event, and that person's attribution of meaning of the event within the context of the interview.

Evidence has been provided in this chapter that non-resolution of traumatic events can occur if dissociative processes are used to avoid anticipated overwhelming affect. These dissociative processes have been identified by Foa and

Hearst-Ikeda (1996) as effortful avoidance and numbing, by Horowitz as denial (Watkins & Watkins, 1996), by DSM-IV as memory loss, and by Crittenden (1997) as unresolved trauma or loss. All of these processes involve emotional and cognitive domains and may collectively reflect forms of dissociation, which may be detected in people's speech when discussing traumatic events. Crittenden placed these speech markers within the attachment categories of balanced, preoccupied or dismissive. These categories stem from Bowlby's Attachment Theory (Holmes, 1993), and research by Ainsworth, Main and many others.

The preoccupied lack of resolution of loss and trauma involves intense affective arousal and cognitive confusion or uncertainty. The indicators include the following:

1. Images of agents of danger become dissociated from the dangerous person or experience; the images preoccupy attention (a hypnotic quality); and they may be spoken of as if they were occurring in the present (a re-experiencing of the trauma as seen in PTSD).
 2. False beliefs that avoid a full recognition that the event or danger occurred, and that in some manner may still be prevented.
 3. Confusion of time or sequencing of the traumatic event, or shift to present tense.
 4. Erroneous self-blame for the traumatic event.
 5. Confusion of person.
 6. Erroneous placement of self either at the dangerous event or not when the reverse is true.
 7. Confusion regarding the causes or implications of the trauma via simplified emotional responses.
 8. Intense and uncontrollable affective arousal around the topic of the trauma.
- The dismissing lack of resolution of trauma include:
1. Omission of the dangerous event from early parts of the transcript and from all but the most direct probes of the event.
 2. Extreme brevity regarding the danger or death.
 3. A noticeable lack of affect about the danger or death when affect would normally be expected.
 4. Overt claims that the event had no importance to the self.

It is this latter indicator or marker of lack of resolution that suggests a cognitive process more active/extreme than a spontaneous dissociation, and reflects the tearing apart of reality already discussed.

Previous research (Dozier, Stovall & Albus, 1999) emphasised caution in analysing discourse of adults with schizophrenia who may have lapses in monitoring and reasoning, with the intention of defining their attachment states of mind. It is relevant therefore to instead analyse the primary caregivers'/mothers' discourse, in particular around early family traumatic events.

Because the original questionnaire and coding systems for the Adult Attachment Interview remain in unpublished manuscripts, secondary sources were accessed. These secondary sources have provided a list of behavioural and speech markers for unresolved loss and trauma. Since the original observations of behavioural and speech markers are related to discourse about traumatic events, the same observations could be made with any semi-structured interview enquiring into loss and trauma affecting attachment figures.

This researcher has had three weeks of intensive training with the Adult Attachment Interview conducted by Patricia Crittenden in March 1998. However, the AAI is not used in this research because this dissertation's focus is not on the participant's mother's attachment experiences with her parents, but on her representation of the families' experiences of trauma around the time of conception up to age three years for the clinical participants. In addition the complexity of the AAI coding system, its low interrater reliability without extensive experience and training (Feeney et al. 1994), its lack of unequivocal links to specific disorders, and continuing alterations to the questions limit its usefulness to this research. To remain qualified to use this instrument, twenty-five transcripts are required annually to be correctly classified according to the trainer.

No attempt will be made in this research to categorise in a quantifiable manner the attachment states of mind of the interviewed mothers (dismissing, autonomous/balanced, preoccupied), because this researcher considers the evidence to date suggests that the more unresolved a speaker is with regard to trauma and loss, then the less stable will be their pattern when under potential threat in interview. However, observations will be made in the detailed analysis of fully transcribed interviews on whether the speaker appears to be dismissing, balanced or preoccupied

when discussing traumatic events, in addition to commenting on their lapses in monitoring of reasoning and discourse.

If a primary caregiver/mother responds to actual or threatened trauma/loss to herself or her family by using dissociative processes, and this continues so that no resolution of the trauma occurs, neglect or rejection may occur towards the infant proximal to the event. This rejection is the antithesis of bonding, a positive attitude from the mother towards her infant. Attachment between mother and foetus may begin around the fifth month of the pregnancy (Stotland & Stewart, 2001). Mother's health during the pregnancy with the participant will therefore be sought.

Indicators of maternal rejection/neglect (bonding) and clinical participant's attachment difficulties

It is acknowledged that many intervening variables such as major childhood illnesses may interrupt a smooth transition to developmental tasks, but it is beyond the capacity of this study to partial out such events after the age of three years. However, delay is not the same as non-achievement, and therefore a consistent or sustained pattern throughout childhood will be sought from the mother interviews before a classification of attachment difficulties is ascribed to a case. It is also acknowledged that the fathers play a significant role in reinforcing secure attachment via reciprocity during play with their offspring, and in supporting their offspring's exploration of the world. Therefore the mothers' reports on fathers' presence and quality of relationship with the participant infant/child will be noted.

The following comprehensive list covers the sequelae of deprivation/neglect and/or abuse utilised by Rutter et al. (2001) to examine the outcomes for infants in poorly-equipped institutions. This deprivation/neglect and/or abuse is frequently titled relational trauma (Schoore, 2002) to emphasise the profound impact it has on the developing child.

1. Attachment problems - definite lack of differentiation between adults; clear indication that the child would readily go off with a stranger; definite lack of checking back with an attachment figure (adult) in anxiety-provoking situations.
2. Inattention/overactivity - very restless, has difficulty staying seated for long; squirmy, fidgety child; cannot settle to anything for more than a few moments and inattentive and is easily distracted; and demands adult attention.

3. Emotional difficulties - tearful or refusing to go to school; giving up easily on tasks; often worried, worried about many things; often appears miserable, unhappy, tearful or distressed; cries easily; tends to be fearful or afraid of new things/situations; stares into space and often complains of aches and pains.
4. Autistic features - odd repetitive behaviour, e.g. rocking; poor or no eye contact; disturbed by change in routine.
5. Cognitive impairment - Normal advancement in school but with attentional difficulties are included.
6. Peer difficulties - not much liked by other children/not popular; tends to be solitary; does not get on well with other children; does not differentiate between children (few or no special friends); non-equivalent age preference of peers; disharmony in peer interactions; teased by other children; teases others; picked on/bullied; and picks on/bullies.
7. Conduct problems - often destroys own or others' property; frequently fights or is extremely quarrelsome with other children; is often disobedient; often tells lies; has stolen things on one or more occasions; disturbs other children; bullies other children; blames others for things; is inconsiderate of others; kicks, bites other children.

Psychosocial context

Several authors have examined the relevance of familial psychosocial stressors/circumstances to psychological and behavioural difficulties in the offspring. Other researchers have focused on these same psychosocial issues in relation to attachment difficulties. This research will note any reported psychosocial context in the interviews with the mothers of participants as they disclose early traumatic events and attachment issues for their participant offspring.

This researcher assumes that an ongoing threat of loss of partner, child, parent or principal support that fails to eventuate would perhaps be capable of generating heightened arousal and the potential to utilise denial, numbing and dissociation from reality. This will be explored in interview. If the primary caregiver's dissociative response to early family trauma has the potential to impact on the infant's attachment relationship, it is relevant to examine both the caregiver's current resolution of that trauma and indicators of attachment difficulties of that infant throughout childhood and adolescence.

Neglect and cognitive schemas

Because of the previously outlined association between Young and Lindeman's (2002) schema of 'Instability and Disconnection' and the AAI disorganised attachment categories, clinical participants' schemas will be assessed in this research.

Evidence for any of the previously outlined indicators of maternal rejection or neglect will be sought in the mother interviews, and additionally in the structured questionnaires to clinical participants. The attachment criteria discussed in the body of this chapter will be used in this research to determine participants' attachment difficulties in infancy and childhood, as reported by their mothers in interview.

Summary

This chapter has presented current research in the complex but interconnected fields of trauma theory and attachment theory, specifically with respect to their potential lifelong sequelae. Note is made of constructs/principles shared by these theories, notably the importance of safety, integration and narrative coherence. Absences in current research linking adult mental disorders with early traumatic and attachment disturbances are noted. These absences have provided the basis for examining the possible associations between early family trauma and insecure attachment to adult schizophrenia and major depression in this research.

Chapter 3

METHOD

This chapter provides an outline of the research design formulated to assess the hypotheses and research questions, the ethical considerations of the method, the population from which the samples were selected, descriptive statistical analyses of the two samples under investigation, descriptions of the assessment instruments used and examples of questions formulated for the semi-structured mother interviews, and the procedural steps taken in data collection. It concludes with a proposed model of interactions between reported past traumatic events and current presentation of those events and participants' diagnoses.

Research Design

Hypotheses

1. There will be evidence of family trauma in the early histories (from just prior to conception to the age of three years) of CMHC consumers with major depression and consumers with schizophrenia. This evidence will be presented in two ways:
Clinical participants will report higher scores on the subscales of the Core Beliefs Questionnaire than the norms provided by the questionnaire designers; and
Mothers of clinical participants will report the occurrence of traumatic events from just prior to conception to the age of three years.
2. There will be significant positive correlations between scores on the subscales of the Core Beliefs Questionnaire and scores on the childhood subscale of the Traumatic Antecedents Questionnaire.

Research questions

1. What is the nature and frequency of traumatic events occurring within families with an infant who as adult develops either schizophrenia or major depression?
2. Are there similarities and differences in the reported traumatic events?
3. Are there similarities and differences in the manner in which the mothers report traumatic events?
4. What do the mothers of participants recall of the psychosocial context in which the reported traumatic events occurred?

5. What attachment difficulties in the participant offspring do the mothers report from her earliest observations and throughout the participants' childhood?
6. What do the participants report of their early experiences of neglect and emotional deprivation?
7. Are there correlations between early family traumatic events, other reported experiences from that time, attachment difficulties and reported experiences of neglect?

In order to assess Hypotheses 1 and 2, evidence of family trauma in the early histories of Community Mental Health Centre consumers with major depression and consumers with schizophrenia were obtained for comparison of frequency and type of trauma. This evidence was attained via semi-structured interviews with the mothers/primary caregivers of the participants. In order to assess Hypothesis 2, two structured questionnaires were given to consumers with the designated diagnoses. Hypothesis 2 was examined using regression analysis. The research questions, embodying inquiry into the evidence for early and sustained attachment difficulties were explored qualitatively.

Ethical Considerations

Risks to participants

In the initial stages of conceptualising this research project, a primary concern for this researcher was the potential harmful impact on participants and their families of enquiring into their experiences of trauma. A consultative process with psychiatrists, university supervisors, the Secretary of SANE Australia and fellow researchers in the field of trauma was conducted. In summary, encouragement was given to proceed with sensitivity, ensure confidentiality and to include as standard, offers of debriefing via professional counselling.

Risks to researcher and expert panel

Several authors have presented evidence of transmission of trauma responses via counter-transference (Herman, 1997; Ogden, 2002; Jackson & Williams, 1994). The attitude of active listening without judgment has the potential to invoke delayed responses of horror, anger, blame, etc. To address these issues, debriefing for the interviewer and expert panel was arranged and accessed.

Addressing ethical considerations

The Toowoomba Health Service District Human Research Ethics Committee detailed the following requirements to protect the well-being of the participants and their families. The Consent Form (see Appendix A) includes clear information to the participants that they can have the interview and taping stopped and erased at any time during the time of the interview; the Consent Form clearly states that the participants may withdraw from participating in the research at any time, without it affecting their future treatment; maintenance and security of records; and compulsory immediate reporting to the Committee of any proposed changes in the approved protocol; mandatory reporting of any serious or unexpected adverse effects on participants; and mandatory reporting of any unforeseen events that might affect continued ethical acceptability of the project.

The University of Southern Queensland Human Research Ethics Committee concurred with the above protocol and included the maintenance of records in a locked filing cabinet to be kept for five years from the date of completion of the research project, and one interim report and one final report to the Committee outlining compliance with the protocol.

Participants

Community Mental Health Centre population

At initiation of this research project, the Community Mental Health Centre, Toowoomba District, covered an area from Gatton in the east to Charleville in the west, Kingaroy to the north and Stanthorpe and Goondiwindi to the south. This area is the State's largest producer of agricultural produce. Toowoomba, the commercial and industrial hub of this areas has a population of approximately 92,000, with the remaining area's total population being approximately 295,000 at the 2001 Census. The Community Mental Health Centre had a client population of approximately 1,000 adults aged 17-60 years. At previous estimates, approximately 21% of that number had a primary diagnosis of schizophrenia. A comparative number of clients (28%) had a primary diagnosis of major depression.

Selection criteria

A high percentage within each diagnostic group (schizophrenia and depression) had co-morbid disorders that could have confounded explanations of findings in this research. For example, alcohol and drug abuse are strongly linked to both mood and thought disorders. Therefore those consumers with ongoing alcohol

and drug abuse were excluded from this study. This automatically reduced the number of consumers who are most likely to have trauma histories as evidenced in the literature. Those consumers with head injuries or borderline I.Q., assessed at Intake Interview from autobiographical reports, previous clinical records and school achievement, were also excluded. Those consumers with first order relatives with a history of treated mental illness were excluded. Therefore the sample was consistent with low risk populations. The remaining consumers who had a primary caregiver available for interview were few in number (Table 1). In the matched participant samples, only eleven pairs of fathers were potentially available for interview, and therefore fathers were not included in this study.

This study attempted to have as many participants with schizophrenia from a Community Mental Health Centre as possible. Once they were determined, a group with depression was chosen matched on age, sex, marital status, education level and socio-economic status. This latter category is debatable since having a serious mental illness may cause poor socio-economic circumstances regardless of family of origin status.

Selection of potential participants by case managers

Eleven (11) Case Managers from four disciplines (Nursing, Psychology, Social Work and Occupational Therapy) and three (3) Medical Practitioners participated in selecting potential participants from their caseloads. Each Case Manager/Medical Practitioner completed a form which progressively eliminated potential participants via the stated selection criteria. The collated results are presented in Table 1.

Case Managers, following the protocol approved by the Ethics Committees of the University of Southern Queensland and the Toowoomba Health Service District, approached potential participants. The following resultant further exclusions are enumerated. Of the forty-six (46) potential participants with schizophrenia, six (6) refused to be interviewed. Following the remaining forty (40) potential participants approaching their mothers/primary caregivers in accordance with the protocol, the number was reduced by three (3). Of this thirty-seven (37), further questioning of the treating doctors by the case managers indicated a number were being considered for a trial of antidepressants, and were thus omitted from the sample (33). Case manager reviews of the charts indicated that a parent or sibling of the potential participants had been treated for a mental illness, leaving thirty (30). Questioning by case

managers also indicated that some of the potential participants with schizophrenia had ongoing drug or alcohol abuse, and with two of the potential participants, a consultant psychiatrist recommended for safety reasons that they not be interviewed. The majority of potential participants with schizophrenia were male and never married.

Table 1

Progressive Selection of Potential Participants Conducted by Case Managers using Selection Criteria by Diagnosis

Consumers With Schizophrenia		Consumers With Major Depression	
Total <i>N</i>	143	Total <i>N</i>	160
No Mood disorder	115	No Psychotic Symptoms	158
No Current Drug/Alcohol Abuse	83	No Current Drug/Alcohol Abuse	139
No Head Injury/Low IQ	75	No Head Injury/Low IQ	136
No Family History of Schizophrenia	68	No Family History of Depression	120
Mother Not Deceased	54	Mother Not Deceased	110
Mother Not Estranged	47	Mother Not Estranged	92
Mother Not Overseas	47	Mother Not Overseas	88
Mother Not Demented/Low IQ	46	Mother Not Demented/Low IQ	84
Potential Participants (<i>N</i>)	46	Potential Participants (<i>N</i>)	84

For the potential participants with major depression, a greater number of consumers at the Mental Health Service were female and married. Therefore large numbers were excluded by these demographic variables. After this research project commenced, a General Practitioner training programme targeting consumers with major depression was started. The admission criteria to the Mental Health Service altered such that fewer consumers with major depression were referred and accepted by the Mental Health Service. This meant an extended period of time was required to identify potential matched participants with major depression.

All of the above exclusions reduced the number of available clients to twenty five (25) per diagnostic group in terms of those who agreed to be interviewed, and those whose mothers/primary caregivers also gave their consent to be interviewed.

As a result the sample of participants was not entirely representative of the clinical population of clients with major depression and schizophrenia from this service. It is representative of low-risk populations, thus strengthening the focus of this research. The exclusion criteria contribute significantly to the robust nature of the research design.

Twenty of the participants with schizophrenia were male, and five were female. The males ranged in age from nineteen to fifty-one years and the females from twenty to thirty-eight years (Table 2a).

Table 2a

Sex, Age and Marital Status of Participants by Diagnosis

	Sex			Age		Marital Status		
	Male	Female	Total	M	SD	Never Married	Married	Divorced
	<i>n</i>	<i>n</i>	<i>n</i>			<i>n</i>	<i>n</i>	<i>n</i>
Schizophrenia	20	5	25	31.68	8.75	19	2	4
Depression	20	5	25	31.76	8.94	19	2	4

Highest educational level achieved was obtained by direct questioning of the participants. All levels of education excluding university postgraduate qualifications were represented in both diagnostic groups. Completion of undergraduate university qualifications was represented by a larger number of participants with schizophrenia than depression. A greater number of participants with schizophrenia also started but did not complete university studies compared with participants with depression (Table 2b).

Current socio-economic status of participants was defined according to whether they were on Disability Support Pensions or working, and whether that work was unskilled or skilled, part-time or full-time (Table 2c).

Procedure

Phase 1

Selection of consumers at the Community Mental Health Centre: Each person on admission to the centre was given a Psychiatric Intake Assessment (see Appendix A) after which in consultation with the team including a Consultant Psychiatrist, a

formulation, diagnosis on four Axes and a treatment plan were made. Primary diagnoses were given in accordance with DSM-IV criteria.

Table 2b

Educational Level of Participants by Diagnosis

	Primary Completed	Junior High Completed	Senior High Completed	Trade Not Completed	Trade Completed	University Not Completed	University Completed
Schizophrenia	0	9	3	0	2	5	6
Depression	2	7	8	2	1	3	2

Phase 2

Selection by case managers: Each case manager had a list of his/her consumers. The case managers were asked to list the number of consumers they case managed who had primary diagnoses of schizophrenia and depression. In a format similar to the table in Appendix A, the case managers progressively recorded those consumers who did not fit the research criteria previously stated.

Phase 3

Contact by case manager: Case managers were asked to contact potential clinical participants identified for the two diagnostic groups in the following manner:

“Sue Littler is a psychologist at this service. She is conducting research for her Doctorate of Philosophy degree at the University of Southern Queensland. She is looking at the incidence of early trauma for adults with schizophrenia and adults with depression. Would you be willing for her to contact you to ask you some questions about your early life? She would also want to contact your mother/primary caregiver to get details of your early history that you might not remember. As well, she would like to have your views on the world and your place in it in terms of what you expect in relation to others. If you are willing for her to contact you, she will answer any questions you may have about the research, and tell you about the steps that will be taken to ensure complete confidentiality. Then she will ask you to sign a release form that gives her permission to use the information you provide. She will give you a withdrawal of permission form, so if you change your mind at any time, your information will not be used for research.”

Table 2c

Socio-economic Status of Participants by Diagnosis

	*DSP	Unskilled Part Time	Unskilled Full Time	Skilled Part Time	Skilled Full Time	Student Part Time	Student Full Time
Schizophrenia	9	3	6	2	3	1	1
Depression	7	2	11	1	2	1	1

(*) Disability Support Pension

Phase 4

Contact by researcher: This researcher contacted the potential participants after their agreement was gained by their case managers. The participants were informed of the processes that would ensure confidentiality, were asked to sign the release form and were given the withdrawal of consent form (see Appendix A).

The interviews with the mothers/primary caregivers were introduced in the following manner: “I will also need to contact your mother/primary carer to get your earliest history. Please contact her/him and ask if it is O.K. for me to phone her/him, and what times would be convenient. I would like to audiotape your mother/primary caregiver’s conversation so that I can listen objectively later. Anything your mother/carer wishes to keep confidential will be respected. If you are willing to participate, please sign the release form. You will see that you can withdraw your permission at any time, and if you do so, your information will not be used for research. If you do wish to cancel your permission, just sign the withdrawal of permission form and send it to me or the Department of Psychology, or just tell your case manager. Withdrawing your permission will not affect your treatment in any way. Do you have any questions for me?”

Phase 5

Data collection: Participants were given a screening questionnaire to measure the presence and strength of depressive symptoms (Zung Self-Rating Depression Scale - see Appendix A). The Core Beliefs Questionnaire was then administered, followed by the Traumatic Antecedents Questionnaire (see Appendix A).

Then with each participant's permission, the primary caregiver/mother was interviewed in a semi-structured format to elicit her recalled history of her pregnancy from conception to birth as well as her emotional state at that time. These interviews were conducted at the location of their choice, either at the Community Mental Health Centre or at their place of residence. This recalled history included family events such as separations, deaths, major family crises such as severe family conflicts, alcohol abuse, and life-threatening illnesses or accidents. The existence of mood disorders was also sought. Post-partum history was then taken including mother's health, baby's health and any causes for concern. Family and the child's history up to the age of three years was then taken. In each part of the history, the mother was asked about how she coped - what her supports were, and how she solved problems that she raised in interview. Maximum clinical skill and sensitivity was utilised to obtain painful material that may never have been shared before. It was therefore imperative to emphasise confidentiality safeguards as well as the availability of withdrawal of permission to use the material obtained.

Phase 6

Debriefing: Debriefing of both clinical participants and mothers/primary caregivers included asking the participants if the questions had caused any distress, answering any questions that arose after completing the questionnaires, notifying case managers of any concerns, and providing opportunities for further discussion with participants, case managers and this researcher. Mothers/primary caregivers were offered future contact with this researcher, service case managers and/or other helping agencies if concerns arose. This researcher is not aware of any mothers needing or accessing this follow-up.

Assessment Instruments

Psychiatric Intake Assessment

See Appendix A. DSM IV Axis I diagnoses were used to classify those with major depression and those with schizophrenia. Those consumers with depression who were not prescribed an antipsychotic were deemed not to be psychotic. Those consumers with schizophrenia who were not being treated concurrently for a mood disorder were not assumed to be not depressed. Those with multiple diagnoses were excluded from this study.

Zung Self-Rating Depression Scale

See Appendix A. The Zung Self-Rating Depression Scale (Zung, 1965) was used to screen out those potential clinical participants with schizophrenia who rated themselves above the cut-off score for depression. The Zung Self-Rating Depression Scale is comprised of twenty statements covering four areas specific to depression. These areas are somatic, psychological, psychomotor and mood disturbances or changes.

Examples of statements measuring somatic disturbance are:

1. Morning is when I feel the best.
2. I get tired for no reason.

Examples of psychological disturbance are:

1. I feel that others would be better off if I was dead.
2. I still enjoy the things I used to do.

Examples of psychomotor disturbance are:

1. I am restless and can't keep still.
2. I find it easy to do the things I used to do.

Examples of mood disturbances are:

1. I feel downhearted, blue, and sad.
2. I have crying spells, or feel like it.

Opposite the statements are columns headed: *None OR a Little of the Time*, *Some of the Time*, *Good Part of the Time*, and *Most OR All of the Time*. The measure is given with instructions to consider each statement in terms of a person's condition in the last week, month, or period of interest, and to tick the column of choice per statement. In this research, clinical participants were asked to consider each statement in terms of their condition in the last month. The completed scale is placed under a transparent overlay for scoring, and the indicated value for each item is written in the margin and totalled. The raw score is then converted to an SDS Index expressed as a percentage. For example, a raw score of 65 may mean that the participant demonstrates 81% of the depression measured by the scale. Depression ratings are assigned for ranges on the SDS Index. Scores below 50 are assigned to the normal range, 50-59 are rated as minimal to mild depression, 60-69 are rated as moderate to marked depression and 70 and over are rated as severe to extreme depression.

Several studies have used the scale, including one study with people presenting to primary care (Zung et al. 1993). Reliability and validity data are presented in a study by its author (Zung, 1973). The scale has good internal consistency with Cronbach's alpha of 0.88 for depressed consumers and 0.93 for non-depressed consumers. The scale discriminated between depressed and non-depressed consumers, and between depressed consumers and family members. The scale predicted 92% of depressed consumers, and 77% of non-depressed consumers (Gabrys & Peters, 1985). The scale correlates highly with the Beck Depression Inventory and the Hamilton Depression Scale.

The Traumatic Antecedents Questionnaire

The Traumatic Antecedents Questionnaire is part of the Psychological Trauma Assessment Package (van der Kolk, 1997), and is a self-administered assessment. The TAQ was used in this research to assess reported recall of traumatic events by the clinical participants from early childhood to adulthood.

Publication of this package is covered by copyright. Therefore only selected items are presented in Appendix A. This package essentially follows Herman's Complex PTSD or Disorders of Extreme Stress Not Otherwise Specified (DESNOS) formulation as described previously. It is a 78 item questionnaire to identify exposure to traumatic life events. It gathers information about lifetime experiences in ten domains:

1. Competence
2. Safety
3. Neglect
4. Separations
5. Family secrets
6. Conflict resolution
7. Physical trauma
8. Sexual trauma
9. Witnessing trauma
10. Exposure to drugs and alcohol

These domains are assessed at four different age periods:

1. Birth to 6 years
2. 7-12 years
3. 13-18 years

4. Adulthood

Although this author is not aware of studies using the TAQ with people with schizophrenia, the final question asks how upsetting was it to answer the previous questions. This provided the opportunity for the case manager to closely follow-up any participant who answered positively to this item. The researcher recommended to the case managers that they follow-up the participants within 24 hours after the questionnaire was administered.

There are two further assessment tools in this package. The Modified PTSD Symptom Scale is a 17-item questionnaire that asks participants to rate the frequency and intensity of symptoms in the past two weeks. Responses to the questions enable ratings of DSM-IV symptoms for PTSD. The Structured Interview for Disorders of Extreme Stress (SIDES) & Self-Report Instrument for Disorders of Extreme Stress assess presence and/or severity of the Disorders of Extreme Stress Not Otherwise Specified (DESNOS) diagnostic construct. However due to resource and time constraints, and because they did not provide significant additional information to the thesis, they were not included in this dissertation.

Several studies have used the TAQ. A pilot study using the TAQ (Low, Jones, McLeod, Power & Duggan, 2000) investigated associations between childhood trauma, dissociation and self-harming behaviour. A recent study of seventy (70) consecutive adult admissions to a trauma centre (van der Kolk, 2001) reported that 91.4% of these adults endorsed a lifetime prevalence of Neglect. This trauma type was scored highest of all the trauma types for the age group 0-6 years. Age group 0-6 years = 58.2%; 7-12 years = 71.4%; 13-18 years = 81.1%; Adult = 80.0%. This indicated that early neglect may be related to lifetime experiences of neglect, and supports face validity of this questionnaire.

To date no reliability or validity data have been presented to Buross Test Reviews Online (www.unl.edu/buross).

Core Beliefs Questionnaire

The Core Beliefs or Schema Questionnaire is copyrighted (Young & Brown, 1990), and therefore only selected items are listed in Appendix A. The Schema Questionnaire was used to examine the clinical participants' reported cognitions related to their current perceptions of self and their relationship to significant others and their social world. The Schema Questionnaire is a 205-item self-report inventory designed to measure sixteen (16) early maladaptive schemas that reflect early

relationships with significant caretakers and that persist (Schmidt, et.al., 1995). Each item is rated using a 6-point scale -

(1 = completely untrue of me; 2 = mostly untrue of me; 3 = slightly more true than untrue; 4 = moderately true of me; 5 = mostly true of me; 6 = describes me perfectly).

Scoring is at the practitioner's discretion (Young, et al., 2003). For each subscale, the number of statements scored 5-6 are sometimes added, and converted to a percentage. Range of subscale scores therefore is 0 - 100. This instrument was used to assess evidence of early trauma that may be otherwise denied. This researcher scored items rated 4, 5 or 6 (moderately true to perfectly true) thus maximising the opportunity for participants to disclose sensitive material. Schemas of particular relevance to this research are Emotional Deprivation, Abandonment and Mistrust/Abuse. A decision was made after all data was collected to restrict analysis to Emotional Deprivation on this questionnaire due to time constraints. Emotional Deprivation is comprised of nine statements, and refers to the expectation that one's desire for a normal degree of emotional support will not be adequately met by others. The three major forms of deprivation defined by one author of the questionnaire are:

1. Deprivation of nurturance - absence of attention, affection, warmth or companionship;
2. Deprivation of empathy - absence of understanding, listening, self-disclosure, or mutual sharing of feelings from others;
3. Deprivation of protection - absence of strength, direction, or guidance from others (Young, 1995).

Examples of the nine Emotional Deprivation statements include:

1. Most of the time, I haven't had someone to nurture me, share themselves with me, or care deeply about anything that happens to me.
2. In general, people have not been there to give me warmth, holding and affection.
3. For the most part, I have not had someone who really listens to me, understands me, or is tuned into my true needs and feelings.

Introduction to Core Beliefs Questionnaire (Young & Brown, 1995)

The standard introduction to this questionnaire is as follows:

"Listed below are statements that a person might use to describe himself or herself. Please read each statement and decide how well it GENERALLY describes you. Do

not answer in respect of one particular person, or one particular incident in your life. It is your GENERAL perspective that is required. When you are not sure, base your answers of what you emotionally *feel*, not on what you *think* to be true. If necessary, alter the wording of the statement so that it would be a better description of you. Then choose the highest rating from 1 to 6 that describes you (including your revisions), and write that number in the space before the statement.”

In order to inform the clinical participants of the purpose of this research, the questionnaire was introduced with the following added statement: “I am interested in the different ways people view the world and their place in it in terms of what they expect in relation to others, that is, your core beliefs. I am also interested in how these core beliefs might or might not relate to your earliest years, and how both may or may not relate to your current illness. Do you have any questions so far? All the information you give me will be kept strictly confidential. Your response sheet will be coded so that your name does not appear in the data. Do you have any questions?”

Statistical norms have not been provided by the scale’s authors. Scoring is at the practitioner’s discretion (Young et al. 2003). One reliability study has been published (Schmidt et al. 1995). Test-retest coefficient for Emotional Deprivation was 0.82 with an interval of three (3) weeks. Alpha coefficient was 0.94. Convergent and discriminant validity were tested in relation to conceptually relevant constructs such as self-esteem, psychological distress, personality disorder traits, and dysfunctional attitudes related to depression. Means and standard deviations of Emotional Deprivation for clinical and non-clinical populations were:

Non-clinical ($N = 84$) $M = 22.9$; $SD = 7.4$

Clinical ($N = 79$) $M = 31.7$; $SD = 11.6$

Mother/Primary Caregiver Interview

Qualitative data were obtained via face-to-face interviews with the mothers or primary caregivers of the already-interviewed participants. This semi-structured interview was designed after consultation with academic supervisors and literature reviews of trauma and attachment fields, and included psychoanalytic and learning theory perspectives. Lines of inquiry were established to explore both the research hypotheses and the research questions. These lines of inquiry included exploration of early family trauma and its resolution/non-resolution in the speakers, and early and sustained attachment difficulties in the speakers’ participant offspring, and the speakers’ perceptions of their support networks during times of trauma and stress.

Meanings attributed by the mothers to the traumatic events both then and now, and what impacts the trauma may have had on family members then and now were explored.

The in-depth semi-structured interviews were conducted using an interview guide. The interview guide included set questions and selected themes of interest relevant to the research questions. A combination of open and closed questions were presented in an invitational manner, providing the opportunity for a collaborative exploration of recalled perceptions. This structure also allowed for the emergence of themes not imposed by the researcher. A non-interrogative approach allowed maximisation of a supportive milieu most conducive to disclosure of sensitive material, and lessened the potential for researcher-imposed paradigms (Denzin & Lincoln, 2000; Lincoln & Guba, 2000; Patton, 1990).

A grounded approach was used to obtain the mothers' basic stories of their and their families' lives just prior to pregnancies with the participants, the mothers' experiences during the pregnancies and the births, and their reflections on their participant offsprings' temperament and interactions with parents, siblings and peers. The interviewer needed to be clinically experienced and able to combine rapport with neutrality. The mother/carer was perceived as the expert, the one most familiar with events and their impact on family members.

Clarification of the speaker's implied meaning and affect was sought using an invitational approach to deepen responses. At times when the speaker introduced a theme and then abruptly shifted away from it or displayed raised anxiety or denied the meaning of the theme to the current focus, the interviewer returned to the theme later in interview. At these times, the interview was constructed according to the principles described in the Adult Attachment Interview.

Operational principles from the AAI used in this research

Three fundamental operating principles from the Adult Attachment Interview (Hesse, 1999) were utilised:

1. The interviewee (speaker) was required to simultaneously recall and actively think about memories related to family trauma and attachment to the participant child, and to do so with coherence, consistence and in collaboration with the interviewer.
2. The interviewer deliberately maintained a relatively rapid pace, covering complex issues, whilst also providing prompts for more in-depth reflection

when emotionally disturbing or cognitively confusing information was presented.

3. Potentially traumatic events related to attachment were a major focus in the interview.

The above operating principles provided the potential for slippages in conscious monitoring of what had been said, sometimes producing extreme violations of coherence, such as major contradictions (Hesse, 1999).

Sample questions

Set open questions included: “First of all, I wonder if you can recall when you first knew you were pregnant with (participant). What comes to mind recalling that time now?” “What was going on for the family when you were pregnant with (participant)?” (Follow-up on any mention of fears about the pregnancy, absence of support, traumatic losses or fear of loss, family arguments, alcohol abuse, etc. Very truncated, dismissing responses were pursued by returning to the issue when the speaker was more comfortable with the interview. Style changed from open to closed questions when mothers were consistently unfocused, divergent or evasive in their responses, or attributed an attitude, opinion or action to another that may have been their own (that is, speaking through another family member). For example, if physical violence was raised by the interviewee but in a manner lacking clarity, a closed question was asked: “Excuse my asking you directly, but did it ever come to blows?” Or: “Are you saying that you used to hit (participant)?” Such direct clarification was particularly required with material evoking intense and mixed emotions.

“What was the birth like for you? And for your baby?” Follow-up questions were asked after any mention of not being able to hold and gaze at baby within the first week after birth, life-threatening illness in mother or baby.

“Was there a time when you and (participant) were separated when (participant) was very young?” (Follow-up questions were asked about the circumstances, mother’s response and what she assessed as her infant’s response).

“Who was your main support person when (participant) was very young?” (Follow-up questions were asked about what this support actually was by asking for specific examples).

When trauma, major fears or loss were mentioned, follow-up questions included: “Who have you been able to share this with? When was that? Do you talk

of it now? Was there anyone you could talk to then about it? And what about later? How do you feel talking about it now?"

Data were analysed from the perspectives of trauma and attachment theories. A provisional list of trauma and attachment themes was selected via a deductive process from the first ten interviews in each diagnostic group. This was facilitated by these twenty interviews being fully transcribed. The remaining interviews were closely examined for fit and explanatory power. The first step in this qualitative analysis involved selecting conceptually meaningful phrases that were related to the areas of research interest. These first order themes were then grouped into more general second order themes or categories. Three categories and eighteen themes were generated from content analysis of the data. A fourth category was generated from the manner in which the mothers presented their stories. A frequency count for the rates of various themes was calculated for each variable.

Credibility of this qualitative research methodology was provided by using triangulation, peer debriefing and audit checking. Triangulation was accomplished by using both written standardised questionnaires and semi-structured audio-taped interviews and two separate sources, participants with mental illness and their mothers/primary caregivers. Multiple modes of analyses were conducted through the quantitative and qualitative designs.

Peer debriefing occurred at several levels. This included the supervision process within the PhD programme, extensive discussions with work colleagues with particular interests and expertise in trauma and attachment, and discussion with experts in these fields presenting at conferences. Accuracy of the transcriptions and reliability of the thematic content analyses were checked by a panel of three colleagues expert in both trauma and attachment theory within psychiatry (child, adolescent and adult). Audit checking was provided by the PhD examining committee, and a complete description of the methodology has been provided in the body of this thesis. A full record of the transcribed interviews is available for further checking.

Summary

Twenty-five adults with schizophrenia and twenty-five adults with major depression matched for age, sex, marital status, educational and socioeconomic status (see Tables 2a, 2b and 2c) who met the criteria for this study were given the Zung Self-Rating Depression Scale, the Traumatic Antecedents Questionnaire and the

Core Beliefs Questionnaire. Taped interviews with their mothers/primary caregivers were separately conducted.

Because of the similarities in type and frequency of traumatic events for both diagnostic groups, speech dysfluencies in a select number of taped interviews (the first ten interviews per diagnostic group) were also noted, and their possible relationship to the themes under discussion were explored in a reflective manner. Speech dysfluencies and responses to the mothers' narratives by this researcher and the expert panel are broadly different between diagnostic groups. The next chapter defines what this researcher considers to be non-resolution of trauma via processes of dissociating traumatic events from meaning and denial of their emotional impact. The purpose of the next chapter is to outline this process of analysis.

Hypothesis 1

To determine the incidence of significant early trauma histories of CMHC consumers with major depression and consumers with schizophrenia, quantitative data were obtained from clinical participants' scores for Neglect in four separate age groups on the Traumatic Antecedents Questionnaire. The categories have intensity and frequency scores. Quantitative and qualitative data were obtained from thematic analysis of the mothers'/primary carers' interviews. Incidence of themes of early grief and loss; life-threatening illness in mother, infant or primary supports; severe family conflict; physical, sexual and emotional abuse were noted.

Hypothesis 2

To determine the relationship between early trauma and cognitions, correlational analysis was conducted on the subscales of the Core Beliefs Questionnaire and the incidence of trauma on the childhood subscales of the TAQ. The subscale of the CBQ of particular relevance is Emotional Deprivation.

Differences in the number of traumatic events between diagnostic groups obtained from mothers' reports were analysed in power and discriminant analyses.

Differences in the types of dysfluencies between groups as measured on the mothers' reports were qualitatively analysed, and categorised as including dissociative processes or not. This construct was analysed in relation to past traumatic events, reported maternal fatigue, and indicators of attachment difficulties in the participant offspring as reported by the mothers, and in relation to participants' scores on the Emotional Deprivation Subscale of the Core Beliefs Questionnaire using power analysis statistics and discriminant analysis.

Trauma Response Constructs and Speech Markers

In summary, the literature supports categorising trauma responses into effortful avoidance and numbing (Foa & Hearst-Ikeda, 1996), denial (Watkins & Watkins, 1996) and memory loss (DSM-IV, 1994), with Crittenden (1997) defining unresolved trauma and loss via speech markers that are summarised below. In the attachment literature, unresolved trauma and loss have been defined by incoherent or disorganised speech, with incoherence, disorganisation and dissociation used as interchangeable terms (Liotti, 2002). This researcher has chosen the term dissociative processes to describe what others have defined as disorganised, incoherent, or dissociative speech indicating unresolved trauma and/or loss. The events raised in some of the transcripts were disclaimed by the speakers to be traumatic despite their volunteering the information in the knowledge that the interviews were principally about trauma. Crittenden (1997) defined speech markers that signify cognitive and affective distortions that this author considers more appropriately defined as dissociative when talking of traumatic events. For example, affective states may be falsely presented with their opposites, e.g. inhibition of negative feelings and false display of positive feelings. Crittenden concludes that a reduction in assistance is then given to the person who falsifies their underlying anger and fear. Because a systematised method for discreetly categorising the above constructs and/or quantifying them has not been a part of this thesis, they have been collectively defined as 'dissociative', either from meaning or emotional impact or both. It is acknowledged by this author that a certain artificiality is inherent in allocating certain speech markers solely to one construct.

1. Effortful Avoidance: This construct is viewed as a strategic cognitive process that leads to cognitive confusion in the counter-transference. The speech markers used in this research are:
 - Incomplete/interrupted thoughts
 - Thought blocking
 - Major contradictions
 - Minimising
 - Distancing
 - Major dysfluencies
2. Numbing: This biologically based 'freeze' response, resulting in wooden emotional expression or lack of emotional groundedness results in

countertransference anxiety in the listener, which in some authors has led to blaming the mothers.

The speech markers include:

Incongruent laughter

Minimising

Distancing

Affect words abruptly leading to change of topic

Direct quotes with emotional disengagement

Stuttering/repetitions

3. Denial: This process denies recognition of danger to self or others, and creates alarm and wariness in the listener. It includes:

Denial of potential life-threatening events e.g. inability to state that an event could have led to death; allowing a child under ten years of age with uncontrolled epilepsy to play with guns, ride motorbikes, and climb trees without supervision.

Loss of personal pronouns when discussing traumatic events, not as a general conversational style.

This author considers this loss as an incomplete denial of the effect of the traumatic event on the speaker or her participant child via a process of splitting of the whole self.

4. Memory Loss: This is confined to statements of not being able to remember despite effort, or with an understanding of why one might choose not to remember, and includes:

Confusion of person/place/event

“Cannot remember” used as statements, implying a recognition of process of active forgetting.

5. Unresolved Trauma and Loss: This depends on the analysis of interactive speech around trauma, and covers dissociative processing in all spheres of imagery, affect, cognition including denial of meaning, etc.

Images dissociated from person or event

Avoidance of full recognition of event

Confusion of time/sequence/tense/person/causes

False self-blame

False placement of self at event or not

Intense and uncontrollable affective arousal/absence of affect around the trauma topic

Not volunteering information

Extreme brevity re.the traumatic event

Overt claims that the event had no significance to self or others.

Attachment Difficulties throughout Childhood

Several authors have provided consistent evidence for continuity in attachment based behaviour throughout childhood and adolescence (Weinfield, Whaley & Egeland, 2004). Even institutionalised infants and young children in orphanages who experience initial rejection from birth parents for social reasons of poverty, parental substance abuse, domestic violence, etc. and who then experience less than optimal substitute parenting in the institutions provide insight into attachment difficulties that are sustained throughout childhood and adolescence despite successful later adoption experiences (Smyke et al., 2002; Zeanah et al., 2002). Disorganised or controlling children give contradictory responses on hypothetical reasoning tasks, and are thought to be particularly vulnerable to disregulated thought processes generated by their anxieties regarding the reactions of others (Lyons-Ruth & Jacobvitz, 1999). Behavioural problems are associated with attachment disorganisation (Lyons-Ruth & Jacobvitz). Altered states of consciousness in young adulthood are also related to disorganised attachment.

School refusal, if sustained, provides an example of strategies that involve avoidance of peer-related activities, and coercion of a parent by the child (and vice versa) in order to retain proximity to an attachment figure that the child cannot depend on being emotionally available. Also, by the age of seven (7) years, the thought of an overnight separation from parents is usually no longer very disturbing (Solomon & George, 1999).

In summary, indicators of attachment insecurity for the purposes of this research include:

1. Clinging behaviour in the infant with mother, which includes being very slow to settle after separation from mother;
2. Failure to relate to father;
3. Rejection of rough-and-tumble play in boys;
4. Self-sacrificing/taking care of mother/rescuing troubled peers;
5. School refusal;

6. Difficulty making or keeping friends, including being bullied/bullying;
7. Low self-esteem;
8. Intense and very sensitive nature;
9. Controlling/coercive behaviour towards parents/peers;
10. Difficulties concentrating/attending at school despite average or above IQ;
11. Misinterpreting friendship for romantic attachment in the quiescent developmental period;
12. Unable to join peers in activities away from home due to anxiety, e.g. school camps, overnight stays with friends.

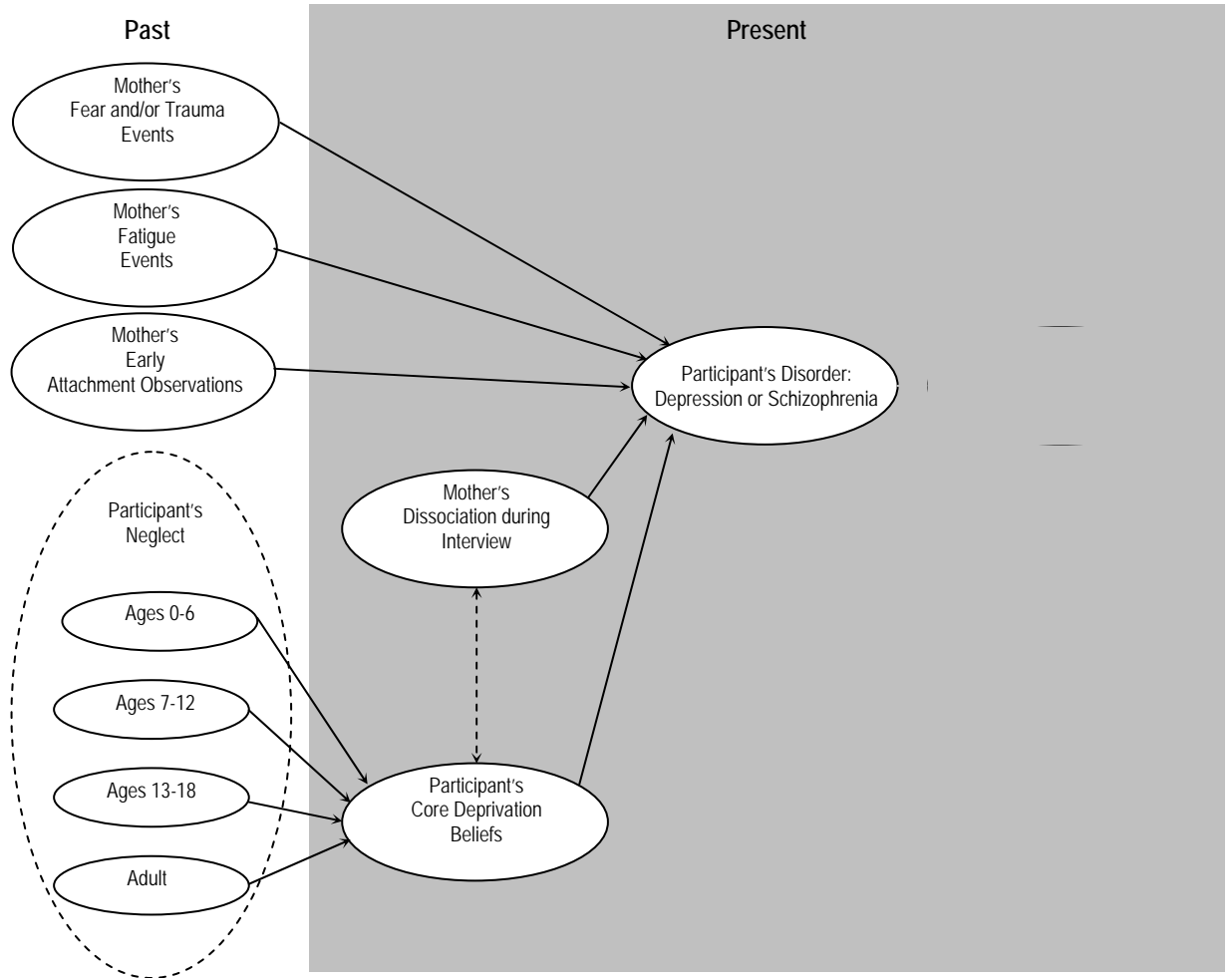
A number (three or more) indicators were required before attachment difficulties were assigned to a particular participant, and evidence was required for persistent difficulties throughout infancy and childhood.

Proposed Model

This model is derived from the extensive literature review and arguments contained within the body of this thesis (Chapters 1 and 2). The proposed model represents potential links between past events and present representations. Past events include mothers' recall of early family traumatic events and the context within which they occurred, and mothers' observations of the participant offsprings' attachment difficulties, as well as the clinical participants' recall of neglect throughout childhood, adolescence and adulthood. Present representations include mothers' manner of reporting past traumatic events (dissociative or not), clinical participants' core beliefs and participants' diagnoses.

Figure 1a.

Proposed Model of Interactions Between Past Events and Present Representations



Chapter 4

RESULTS

The results of the research programme are described in the next four chapters. Chapters 4-6 present qualitative analyses of mother interviews. The fourth chapter (Chapter 7) presents quantitative analyses of:

1. Participants' reports of neglect within the family environment throughout the life span
2. Participants' reports of core beliefs related to emotional deprivation, and
3. Quantitative analyses of participants' mothers' interview themes within a conceptual model of associations between early family trauma or severe stressors and their non-resolution, attachment difficulties in participant offspring, diagnosis and current living situation.

Qualitative Analysis of Mother Interview Themes

The first ten interviews in each diagnostic group were fully transcribed. The remaining interviews were summarised. The fully transcribed interviews were typed using the following identifiers:

I denotes interviewer, and *S* denotes speaker or interviewee.

Words spoken with emphasis are underlined.

Direct quotes by the interviewee of others' speech are in parentheses.

People and place names are initialised followed by three spaces.

Pauses are identified using full stops with no spacing.

Stutters and mispronounced words are maintained.

Inaudible speech is denoted by a series of question marks.

All twenty of the fully transcribed interviews were checked for transcript accuracy and accuracy of defining traumatic events and thematic concepts by a panel of three expert colleagues who were blind to diagnosis and identity of participants. For qualifications of the expert panel, see Appendix A.

The researcher and expert panel adopted a process in which any disagreements as to transcript accuracy and identification of themes were openly discussed. Identification of themes reached 100% consensus, and transcript accuracy greater than 90%. Minor disagreements not affecting the manifest nature of the interview were in this percentage.

Thematic Analysis of Mother Interviews

All taped interviews ($N=50$) were listened to at least five times each to determine repeated themes. Single themes presented in one interview and not repeated in other interviews were not included. Traumatic events occurring to non-immediate family members/not significant support figures are not included. Themes were clustered according to both this researcher's informed focus as prescribed by the literature review and the emphases of the mothers. Each item was scored as absent or present in each mother's interview, with numerical values of 1 or 0. An exception was indicators of attachment difficulties throughout childhood and adolescence, which was scored 0 (absent) or 2 (present).

Table 3

Frequency of Themes Occurring in Mother Interviews by Diagnosis

Themes	Diagnosis	
	Schizophrenia <i>n</i>	Depression <i>n</i>
<i>Trauma Themes</i>		
Mother miscarried just prior to pregnancy with participant	6	1
Mother ill/stressed during pregnancy with participant	15	8
Birth trauma	13	15
Participant (0-3 years) very ill/accident	14	16
Mother had prior traumatic birth	5	4
Parent violent/often angry/symptoms of PTSD	11	12
Family member seriously ill when participant 0-3 years	15	14
<i>Maternal Fatigue Themes</i>		
Mother ill/stressed during pregnancy with participant	15	8
Mother stated exhausted	16	10
Mother's parents not available for support	15	13
Father away often	11	12
Father alcoholic	7	4
Poverty	8	7
Mother had many children close in age	7	2
Mother stated participant child was difficult for her	12	11
Family moved close to birth of participant	10	4
<i>Attachment Themes</i>		
Mother stated pregnancy was shock/unplanned/unwanted	9	3
Mother stated participant was 'wrong' sex	6	1
Participant had early attachment difficulties	16	10

Three major constructs were identified from the mother interviews by this researcher and confirmed by the panel of experts (see Table 4). These constructs were:

1. Early traumatic events
2. Maternal fatigue
3. Attachment difficulties

Each of these constructs were examined for contributing events or content and also for the manner in which the events were narrated by the mothers.

The incidence of traumatic events in the early history of the participants is high for both diagnostic groups, and the contributors to maternal fatigue are greater for the schizophrenia group than for the depression group. Also, the indicators for attachment difficulties are greater for the schizophrenia group than the depression group.

Table 4

Means and Standard Deviations of the Mother Interview Constructs for the Total Sample of Respondents by Participant Offspring Diagnosis

		Diagnosis	
		Schizophrenia (<i>n</i> = 25)	Depression (<i>n</i> = 25)
Early Family Trauma (7 items)	<i>M</i>	3.12 (44.57%)	2.80 (40.00%)
	<i>SD</i>	1.05	1.35
Maternal Fatigue (9 items)	<i>M</i>	4.00 (44.44%)	2.84 (31.56%)
	<i>SD</i>	1.47	1.49
Attachment Difficulties (3 items)	<i>M</i>	1.88 (41.33%)	0.96 (18.76%)
	<i>SD</i>	1.09	1.02

Early Family Traumatic Events

Traumatic events include any event that was potentially life-threatening to a family member, or which potentially created a high and/or sustained level of anxiety or distress in mother or her participant child in the period from conception to age three years. Close examination through several readings of all fifty mother interviews identified seven frequently occurring events of a traumatic nature.

These were:

1. Mother had a miscarriage immediately preceding her pregnancy with the participant. If mother had a miscarriage followed by an uneventful pregnancy and delivery before her pregnancy with the participant, this event was not counted.
2. Mother was very stressed or physically ill during the pregnancy with the participant. Some of these illnesses presented a direct threat to the survival of either mother or foetus or both.
3. Birth trauma in which the mother or participant had serious difficulties that potentially were life-threatening or physically damaging.
4. Participant aged 0-3 years had a serious illness or recurring illness, or had an accident that may have led to death or maiming or serious physical compromise.
5. Mother experienced a traumatic birth just prior to pregnancy with the participant. Again if there had been an intervening pregnancy with no difficulties as in (1), the event was not counted.
6. A parent or both parents were violent, frequently angry, or had either a diagnosis of or symptoms indicating Post-Traumatic Stress Disorder.
7. A family member was seriously ill or had a serious accident when the participant was aged 0-3 years.
8. The noting of traumatic events was restricted to the period from conception to age three (3) years in accordance with the argument developed in the literature review of this thesis. Case examples in this chapter will be presented inclusively of all trauma items in order to maintain the richness of each mother's story, and to maintain contextual integrity.

The above traumatic events were explored first in terms of the nature of the illness or accident, their severity, and response of the mother first to the safety needs and secondly to the emotional needs of the child. Note was made of the manner in which the information was presented to the interviewer, and the interviewer's reflections and reactions are presented in summary at the end of each analysis.

Speech Indicators of Unresolved Major Stress/Trauma

As concluded in the literature review on Dissociation and tabled here (Table 5), speech markers indicate both thought blocking and emotional numbing, responses seen in PTSD and a number of serious mental illnesses. Crittenden (1997) defined

speech markers that signify cognitive and affective distortions that this author considers more appropriately defined as dissociative when talking of traumatic events. For example, affective states may be falsely presented with their opposites, e.g. inhibition of negative feelings and false display of positive feelings. Because a systematised method for discreetly categorising the above constructs and/or quantifying them has not been part of this thesis, they have been collectively defined as ‘dissociative’, either from meaning or emotional impact or both. It is acknowledged by this author that a certain artificiality is inherent in allocating speech markers solely to one construct.

1. Effortful Avoidance (Foa & Hearst-Ikeda, 1996). This construct is viewed as a strategic cognitive process that leads to cognitive confusion in the countertransference. The speech markers used in this research are: Incomplete/interrupted thoughts; thought-blocking; major contradictions; minimising; distancing; major dysfluencies.
2. Numbing (Foa & Hearst-Ikeda, 1996). This biologically-based ‘freeze’ response, resulting in wooden emotional expression or lack of emotional groundedness results in counter-transference anxiety in the listener. The speech markers include: Incongruent laughter; minimising; distancing; affect words abruptly leading to change of topic; direct quotes with emotional disengagement; stuttering or repetitions.
3. Denial (Main & Morgan, 1996). This process denies recognition of danger to self and others, and creates alarm and wariness in the listener. This author considers this loss as an incomplete denial of the effect of the traumatic event on the speaker or on her participant child via a process of splitting of the whole self. It includes: Denial of potential life-threatening events e.g. inability to state that an event could have led to death; loss of personal pronouns when discussing traumatic events, not as a general conversational style.
4. Memory Loss (DSM IV, 1994). This is confined to statements of not being able to remember despite effort, or with an understanding of why one might choose not to recall, and includes: Confusion of person/place/event: ‘cannot remember’ used as statements, implying a recognition of a process of active forgetting.

5. Unresolved Trauma and Loss (Crittenden, 1997; Hesse & Main, 1999). This construct depends on the analysis of interactive speech around trauma, and covers dissociative processing in all spheres of imagery, affect and cognition. It includes: Images dissociated from person or event; avoidance of full recognition of the event; confusion of time/sequence/tense/person/cause; false self-blame; false placement of self at the event or not at the event; intense and uncontrollable affective arousal/absence of affect around the trauma topic; not volunteering relevant information; extreme brevity regarding the traumatic event; overt claims that the event had no significance to self or others.

Table 5

Trauma Response Constructs and their Speech Markers

TRAUMA RESPONSE CONSTRUCTS	SPEECH MARKERS
<p>EFFORTFUL AVOIDANCE (Foa & Hearst-Ikeda, 1996) A strategic psychological process (thought process) that leads to confusion in the transference</p>	<p>Incomplete/interrupted thoughts Thought blocking e.g. 'don't know' 'can't remember' 'probably' Major contradictions Minimising e.g. 'a little bit traumatic' Distancing 'you's', 'the child', 'it' Major dysfluencies</p>
<p>NUMBING (Foa & Hearst-Ikeda) A biological 'freeze' response so that there is no emotion in the speaker, but it is detected in the transference</p>	<p>Incongruent laughter Minimising (affects both cognition and emotion) Distancing 'you's', etc Affect words that precede abrupt subject change Direct quotes (with emotional disengagement) Stutter/repetitions</p>
<p>DENIAL (Main & Morgan, 1996)</p>	<p>Denial of danger/near death Loss of personal pronouns (in order to deny the relevance or emotional impact on self and others of the event)</p>
<p>MEMORY LOSS (DSM IV-R, 1994)</p>	<p>Confusion of person Some of the 'can't remember's (if the speaker is distressed at not recalling)</p>
<p>UNRESOLVED TRAUMA AND GRIEF (Crittenden, 1996; Hesse & Main 1999)</p>	<p>Change of tense to the present as if the trauma is still occurring Direct quotes (with emotional engagement) (see above for complete list)</p>

Examples of Early Family Trauma in the Schizophrenia Sample

SCZ001: Four trauma are identified. This mother was seriously ill with high blood pressure throughout her pregnancy with the participant, and the birth was traumatic. She almost died during this birth, and had experienced a traumatic birth with her previous child who nearly died. In addition, mother remained ill with high blood pressure and other complaints including when her participant son was aged 0-3 years.

At the opening of the interview, this mother loses personal pronouns perhaps as a distancing technique when speaking of the traumatic birth of her participant son.

S: Umm...yes. He was the um, the second um, ah child, and ah...um. I often wondered whether ah..I had a very bad..not so much pregnancy, but birth...with him I went fifty hours dry labour. And uh, I often wonder whether that had a lot of...you know....repercussions of what is nowadays, and...

And:

S: No. Um, as I say...ah...water broke on the Wednesday and it...wasn't until Friday, late Friday when he was born...and ah....

And again:

S: And ah, and...ended up with a caesarean, that was the first caesarean that I had. And ah..was....

She begins to tell the interviewer of the traumatic nature of this very difficult labour, and without warning switches focus with an abrupt end to a line of thought, perhaps to avoid experiencing the heightened affect that is then experienced by the listener.

I: Did they decide to do a caesarean because the baby was in distress?

S: I think so, and another thing he was turned upside down, you know, and doctor tried to..uh....

I: So he was trying to come out feet first.

S: Yes, yes. And ah...oh, they had...X-rayed me, uh....to make sure that..you know, I ended up with a caesarean, as I say.

It is her near-death experiences with the births that seem the most elusive in the narrative. With her first birth, it is only at the end of interview that she relates that her daughter would not have survived but for expert treatment, and this is embedded in irrelevant detail. The direct quotes may also indicate unresolved or unprocessed material.

S: Oh, S___ was born on Tuesday and I didn't see her until Friday..and uh, course you can imagine I was in.a.being first child and that, you know and uh, I was.a little.little bit unsettled with that..and uh, I had a lovely, well I had two lo..three er, Sister B___..er three of these are all deceased now, and uh..oh there was Sr. B___, Sr. N___ and uh, er another one, uh..um...oh er.I can er.see her but, she used to be ah, a great..ah.she'd come in and have a chat with me, and uh..she.er.was telling me that uh, only for..I was under Dr.L___ at the time, and she said only for.ah.Dr. G___ ah, delivering.er.S___, er, she wouldn't have been here, you see..and uh..apparently Dr. L___ tried.tried to get her, and uh..'cos carrying high up, you know..and uh, she was really wedged..wedged in that's why they had to do the epitiotomy..ah, down below and uh, she said only.only for uh, Dr. G___ coming.coming in.'cos Dr. L___ and Dr. G___ had the same rooms and uh...um...he came.came up straight away. And er, 'course when D___ was.was born, um..oh, more or less coming, and er...anyhow uh..they were trying to introduce me to Dr. G___, and I said "Oh yes", I said "I met you", I.I said er.. "You curreted me, you know..um...couple of years ago." He said "Yes", he says "I delivered your little girl for you too."(sotto voce), and I thought 'Oh yeah, talking as barmy as ever' (laugh), you know, and I.I said to this..ah...nice.ah, Sister, and she says "yes", she says "That's right, only for Dr. G___ you wouldn't have had, you know, your little girl..at the time" and uh and I said "Yes, fan.fancy waiting over two years, you know, before I found out."

This researcher notes the abrupt shift away from recognising the relevance of this trauma to the impending birth of her next baby (the participant), the minimisation, the incongruent laughter and the emphasis on her not knowing. And yet once the listener has the space to process the information, it is all there. Embedded in this last page is information that she had a miscarriage (requiring a curette) before the birth of her first baby. The near death of herself (from high blood pressure) and possibly baby during the difficult labour is concurrently spoken of and denied:

S: Yes. Yes. And as I say, a difficult ah..birth..ah, at that.

I: Were you concerned at any time for your safety or the safety of your baby D___? (participant)

S: No. No. No. Um..except as I say, for the um, our caesarean, and uh....aah....my....Reverend W___ as he was then, um...he..must...have been of some concern because he had come up to hospital twice to see me. And ah, they wouldn't let him in, so you know so...ah, which is unusual especially...where a minister's concerned, you know.

I: What do you make of that now?

S: Ah...just a little bit, you know...ah...astounded. A.a funny thing, one of the..ah, Sisters that was..you know, ah, in the hospital at the time, she is also a member of our Mothers Union, ah..group, and ah..she always...'cos I used to wear my Mothers um, Mothers Union badge, see, and ah..I wouldn't go anywhere without it on, I'd put it..ahm, you know, on the side, and it...was always there, and she said she can always remember that. And ah...oh, but she always says I had a difficult time, you know, and uh...

I: So, from your memory, you remember always, even though that difficult time was happening, that you were quite sure you'd be OK?

S: Mm. Mm, oh yes. Mm.

I: You didn't have any reason to worry really?

S: No. No.

But later in the interview, she acknowledges tangentially that it was very serious.

I: So how did you keep your spirits up with, with these..

S: Oh..I've got ah, great faith, I suppose. Um...I'd never class ah, myself as religious, at all, you know, but I remember when um..Reverend W___ ah, came to see me and ah...when D___ was born..um..he was doing something or other and um...he just.run in his car and rushed up to the hospital that's when..he.he knew like there was...the caesarean was going to be on, and ah....um...oh he said to me once, he said it's your faith that's got you through, you know, and uh, you know I've never classed myself as..uh..like a lot of..every Sunday, ah, person you know...but ah...ah, I still believe I've got something...um...J___ often says to me he says it's your spirit, you know.

It would seem that for this mother, it is safer that other people hold the knowledge of how life-threatening the above events were. Throughout interview, this mother tangentially mentions major stressors but does so without connecting dialogue. That is, there is a fragmentation in her presentation of information that

suggests a lack of coherence at both cognitive and emotional levels that may indicate unresolved trauma.

SCZ002: Four trauma are reported. This mother had a miscarriage just prior to discovering she was pregnant with the participant. Shortly after his birth, the participant had a serious accident. Following the participant's accident, mother reports she was so stressed that she almost miscarried the next baby. This mother discloses her own volatile temper, and hints at the possibility of father's anger also.

This mother begins the interview by stating that the earliest years were 'dreadful' in a dramatic manner, but because of the rapid shifts in topic, emotional depth and congruence appear to be lacking.

*I: Do you remember when you first knew you were pregnant with A___?
(participant son)*

S: Yes.

I: Can you tell me what that time was like for you?

S: Dreadful.

I: Was it?

S: Yes. And I had already had a miscarriage, just before he was born, and I had another baby seven months, huh, and and so it was um...I was happy I had the miscarriage in the sense, it wasn't a deliberate one, and then I became pregnant straight away with A___.

The statement about being happy to have a miscarriage appears emotionally incongruent. This lack of emotional coherence is confirmed later by mother's denial of worry during her next pregnancy with the participant. The possible emotional effects of a miscarriage on the mother during the next pregnancy is relevant.

I: Mm. Um...with the concerns about the pregnancies and miscarriages, was there any time during the pregnancy that you feared you'd lose A___?

S: No.

The participant at age seven months had a serious accident, and mother informs the interviewer of this at the beginning of her narrative. Evidence of its traumatic impact on mother and its unresolved nature include the strength of the image, her major contradictions, confusion of her whereabouts, minimising, incomplete thoughts, a reference to forgetting, and later her comment that the event caused her so much distress that she almost miscarried the next child.

S: A very good baby and when he was seven months, we were building a house and my friends were there, and A___ (participant) was on the verandah in a stroller, and you know those straight ones like this, and there was no steps and it was about 2'6" off the ground, so I jumped down and my skirt must have pulled the stroller...and I fell on the side of my head and I grabbed it...I picked him up and there was nothing wrong with him and he opened his mouth and he had a broken jaw. He was bleeding everywhere, and ah...my husband had hysterics and we took him to the hospital to see if we could get a doctor..and he was um, he wouldn't allow...they were going to operate, and er, he wouldn't...I was at home with the other children, and he wouldn't allow them.

I: Your husband wouldn't allow them...

S: Allow them to operate. He insisted on getting a specialist, and specialist said, it was just as well because, like he would have, he didn't got a bone there, he only had a piece of um..gristle...it hadn't formed a bone, see, and so it would..it healed itself...and he was in there two days and...he was alright.

She continues with a truncated 'because', perhaps indicating a failure in truly attributing meaning, and she continues leaping from one topic to another. She indicates her memory loss was a result of the traumatic accident to her participant son.

I: It must have given you a terrible fright.

S: Well, my friend, she came in the boat with us, she said I never thought you were so mad A___. Because I really...I just went mad you know. The fright of it.

Mother reports almost losing the next pregnancy and that she was extremely stressed at this time. Essentially she blames her son's accident for this stress, but there were other major stressors. She makes no mention of any impact of her distress on her son who was fourteen months old. She reports poor memory of this event, and it is likely that she accessed dissociative strategies in order to cope.

S: I don't know really, because I had another baby soon afterwards. My daughter's only fourteen months...you must think I'm a nut. My daughter reckons it took six children for me to find out what caused them (laugh).I..I don't remember too much,and I nearly miscarried her as well...after the shock of what happened to A___.

Mother brings up her anger, but at the same time denies its impact on the participant. The interviewer is forced to seek clarification with direct questions.

I: OK. Um..now this is just another general question again. Um..who was the problem-solver in the family?

S: Um..P___ (father). But P___ never smacked. Whereas I did. And I had a real Irish temper.

I: Had you?

S: Yes. (softly)

I: Now you tell me when I'm in your house! (laughter)

S: Yes. I had a terrible temper, and um he says that...this is when he was growing up that I walloped him. Can't remember. I really can't, I mean...

I: Does that mean you didn't? Or you think you might have?

S: I could have. You know. I mean I know that I..I hit..the twin I told you that was a very naughty boy, I..I walloped him, but..which was horrible you know, walloped his backside and I was really upset about it, and he looked at me and said "Oh mum, I was wondering when you were going to do it." (laugh) He was a different type of child altogether.

I: So he used to tweak your dials..

S: Yes.

I: Whereas A___ (participant) was a good child..

S: Very good child and took everything seriously.

I: He was sensitive?

S: Very.

I: Who was he most like out of you and P___?

S: I would say me. But then as he grew older, he gets more like P___.

And later, when talking of how the anger was resolved between her and her husband:

S: And I think in later years, like, when he and I lived alone, we got on much better. Things were different.

I: Life was simpler?

S: Yes. And I..I calmed down a bit. He could go to the pub without my screeching the place down. (laugh)

I: So how did he manage to ignore you and go anyway?

S: Oh P___ was very...yes, well he wouldn't come home, you know, and things like this. And so.

I: This is a tough question too. So um, right from the very beginning he was drinking, and as with most alcoholics it just gets progressively worse, um..and you know..your way of trying to get him to not go to the pub was to yell a lot...can you remember how was A___ as a little one when you were screaming for P___ not to go to the pub?

S: It would be when P___ came home so A___ would be probably, be in bed, they'd all be in bed with...they'd still hear me, you know, I mean...it started off alright but...and um, A___ never said anything to him, but my elder son, er, would, and my elder son I don't think I could have managed without him, because he was only seven and a half years old when he used to...he'd do...what his father was supposed to do.

There is instant denial that the above had any effect on the participant, followed by a shift of focus from this child to another son.

Towards the end of interview, mother relates the participant's brief marriage and breakdown, confirming that the violence repeated a pattern between mother and son.

S: And um, but he was very sour because..he took her pl...oh we didn't take, we did in a sense. That's all. (eyes darting, looks uncomfortable)

I: How do you mean?

S: He wouldn't talk about it. And they really rowed dreadfully and um...a friend of mine who lived across the road from them, and..she..all she ever said to me was that um..they used to go over and have dinner with her and all that, she's a very..nice woman, and she said "I'm really worried about A___." You know, she never mentioned M___, (participant's wife) but. But they did so well, they got their house and...they had a great wedding and....And he was very hard to get through..in the doctor's he went to, and..

I: Are you trying to tell me that M___ yelled at him a lot?

S: He said. Yes. Oh, and she told me herself that she used to belt him. Yeah, yeah.

I: Right.

S: You know. I mean she didn't...hold anything....and he said he never hit her.

Major dysfluencies, irrelevant detail and lack of conclusion are noted. There is effortful avoidance, and emotional numbing, and yet the interviewee wants the interviewer to know what was going on.

Father may also have had a bad temper, as he needed to go on Tegretol. Mother is very unclear about why.

S: But P___ (participant's father) did have um..I suppose A___ might have been um...six or seven, he had a bad breakdown.

I: Did he?

S: Yes. But it wasn't schizophrenia. He had to go to the M___St. clinic in B___, and he went there for about a year, and um, they put him on...Tegerol or Tegeratol? Yes. And because, and he would have to bring...he went every week at first. And, he...it was just that he wasn't coping with life. And er...he er...

I: Sometimes they give Tegretol for mood disorders, like depression, but usually a depression where you're not keeping your temper very well.

S: Yes. (softly) P___ had that, don't forget. Yes. And he had something else, and...and eventually he came off it altogether. And he's um...this is the psychiatrist..he had a wonderful effect on him, gave him the will to...to go on.

I: Right. So at some stage, you feared that he might take his own life?

S: I never did actually! (laugh) I'll be honest about that!

I: When you say 'the will to go on', I think the worst.

S: Well yes. But in a sense, like...but..he...he..he'd often say he wished he was dead and things like this, you know. But I mean, I didn't ever take it too...I mean, I say...I'd say if A___ said it to me, I'd take it very seriously. But I don't think I ever heard him say anything like that.

I: So when P___ said it you coped by not believing it?

S: Yes! And well...we all have our blue moods, don't we?

There is minimising, change of tense, and a shift to talking away from the issue of her husband's temper. There is also no resolution until the children have left home.

This interview illustrates the interviewee's sudden shifts from topic to topic, often including confusing denial or reversal of what has just been stated. It is confusing without being actually chaotic: the interviewee is not confused, but

confusing. The listener is being invited to become mindless. Agreement is sought, perhaps in order to avoid judgment.

SCZ003: Two trauma are noted. This mother presents some information suggestive of significant stress during the pregnancy with her participant son, her first. She also briefly refers to birth trauma. This mother appears anxious throughout interview, and is open about her highly strung nature. It is not until the very end of interview that she discusses her attempts to remain flat-stomached and physically fit during the pregnancy with the participant, an event that was not thought possible. She expresses some fears of her unawareness of the pregnancy until five months. She speculates on the harm her dietary restrictions may have had on the foetus, whilst also seeking exoneration.

At start of interview, this mother reports no difficulties at all during the pregnancy.

I: And I usually start off by just saying, can you recall when you first knew you were pregnant with your son?

S: Yes.

I: Mm. And what was that time like for you?

S: Oh, happy time, yeah. Very happy time.

Her speech becomes disjointed when she reports working until six weeks before the birth. At the beginning of interview, the interviewer assumes this major dysfluency is due to mother collecting her thoughts, but at end of interview, it becomes clear that she is earlier avoiding a sensitive subject that invokes mixed emotions.

S: Yeah, I stopped working when I..yes, when I became when I had w.I worked a six up until six weeks before I had R___ (she pours her tea), and then I um...stopped.

At end of interview, mother becomes more expansive after she has spent considerable time explaining the genetic and illicit drugs contributions to her son's illness.

S: The only thing I can really think of that possibly may have affected his development in utero was um..no doubt and this is drawing a very long straw. I did read somewhere that in some article, that...ah, that research was done on people with..schizophrenia who were born during the war years..ah,

World War II, and people who had.been.through..um, famine..um. Have you read anything like that?

I: I've read, and heard about a lot of.theories that.um..

S: Starvation. Famine, not ???may have led to it.

I: Within.that famine.a.a lowered, um..oh, what is that thing they give to mums now?

S: Um...oh, um, iron?

I: No, not iron. Um, the one that's associated with spina bifida.

S: That is iron. That is iron, it's um..er, it's um..it's um..FE, FE. Yep. Oh well.ah.I.um.didn't actually know I was pregnant with R___ 'til I was five months pregnant, because I had..been on the pill for quite a long time.. 'cos I didn't have them 'til I was twenty-nine..and.um...I went off the pill..thought I was pregnant six weeks later, went along and had a test.my GP just laughed, and just said "Oh, it's come back negative" he said. "Look", you know, "Wait for a year, then come back." S.and.my..father who was a drug rep said the same thing, so you know. "You've been on the pill for five years", you know, "and hoping really to get pregnant".but I actually was pregnant.at six weeks. It was a false.negative..and then I started putting on weight, so I started dieting..'cos I hadn't.I hadn't had any periods for.a full year..before I went off the pill anyway, so I didn't know whether..you know, so I started dieting, and I was.very.conscious of my weight, and I.I was probably eating very healthy foods..ah, I was getting lots of exercise.swimming...four lengths every morning, and then walking to work..and um..but I was still very well. I.didn't have any morning sickness. Probably..

I: And you weren't.you know, experiencing fainting spells?

S: Oh no...only once.when I had too much to drink..at a par.Christmas party, and I just wonder whether I drank too much in the first three months, I mean.I just don't know.I mean.I met.I didn't drink on a regular basis, but.at a party or something, whether I had too much to drink. You just.and then.at five months.I went.I finally went to my GP, and I said "Look, I need to go to a specialist. I'm not getting pregnant." And so he referred me to a specialist who.who examined me, and said "Look, you're five months pregnant." (laugh) So...um..yes, anyway..ah, that's the only other thing I can think of.

I: Yes. And you certainly search for absolutely anything, don't you?

She then immediately returns to reassuring herself that the above is entirely irrelevant, and this shift is experienced by the listener as mother disconnecting from sensitive material, and disconnecting so abruptly as to be dissociative. She then closes the interview with a reference to her busy schedule.

S: Oh, I think it's the genetic tendency..without a doubt. Um, which is um..triggered off by LSD. And..and as I say, you know, if it had been around, and I'd used it, there for the grace of God go I. Um..anyway, look I probably need to..Can you think of anything else, or..?

I: I can't.

S: Ahm..I just can't think grade one, grade two developmental problems, um..special ed. OK.

I: Was that for reading, or..?

S: It was for reading..His maths was OK, it was just for reading, and I he had a fairly hard tea..had a teacher who was second to the headmaster in grade one, because he was getting things wrong, I mean..that's ridiculous. Um..er, grade three, grade four, nice teachers, did well, grade five, grade six, grade seven..lovely teachers.all liked R___, had had plenty of friends, um....yep, but he's a lovely boy.

I: Thank you very much.

S: That's OK.

This mother also volunteers information about some difficulty with the birth, rapidly closing down on any possible significance, and not referring to it again in interview. Because she has researched extensively on risk factors for schizophrenia, she may be aware of the increased incidence of birth trauma in this population.

S: Mm. Very well. Ahm, R___ was a..forceps delivery, but that was only..wasn't major forceps delivery, it was a fairly reasonable birth. It was only to save me a few extra hours pushing, so I don't think that would've affected things

Mother's initial avoidance of disclosure of any difficulties, later tangential references to potential stressors and concurrent denial of their relevance suggest lack of resolution.

SCZ004: Four trauma are discussed. This mother reports being stressed during the pregnancy with her participant son, and the birth was traumatic. Mother reports

father was very angry and threatening. His PTSD was not diagnosed until recently but according to mother it was present when the participant was aged 0-3 years.

This mother embeds her emotional stress during the pregnancy within a complex tale of an unwanted pregnancy (covered in the Attachment section), marital conflict, and inadequate supports from her immediate family. Although she reports heavy involvement in a church, she does not disclose any support from fellow parishioners. She admits to feeling frantic during the pregnancy, blaming her husband initially for her half-hearted attempt to abort, and then revoking this towards end of interview to explain that she was under extreme stress, and that he probably had not felt that way. At the same time, this family has taken advantage of relatively recent counselling for father's PTSD, and have remained a relatively intact family unit.

Her opening remarks indicate literalness and a defense of not remembering. However, she then quickly reports an extreme conflict between herself and her husband over the pregnancy.

I: Now with this, it's not about, um, um.you know, set questions at all, it's just about.um, you getting into a bit of a reminiscing space, and.I usually kick it off by saying can you recall when you first knew you were pregnant with M___? (participant son)

S: Ummm....Oh, not exactly..but I do remember being pregnant with him. I don't remember exactly...I don't think I remember exactly. Mm.

I: Now just recalling that time, um.what comes to mind, just remembering that?

S: Um..I s'pose remembering that I.I remember.I'm going to cry (wavery voice, then laugh). Yeah. Probably can't talk about it.....Just that my husband gave me the impression he didn't want another child. And um...and I can remember being really upset about that..um...but talking to him years later, he never..um, he never..he never did infer that he reckons. But then he's got a terrible memory. Um, he never did infer that, and so um...yeah, so that was a bit upsetting really because..yeah I had it in my mind that he didn't really want another child, and so, um..yeah.

She appears unable or unwilling to calmly reflect on this distressing time twenty six years ago, and rapidly moves on to her husband's extreme anger and

potential for killing others, later diagnosed as PTSD. She relates this as the major cause of the ongoing stress for herself and the whole family.

But it's just..only come out in the last say four or five years that J___ (husband) was suffering from Post-Traumatic Stress, ever since Vietnam, and so..yeah.

I: And how did that affect him?

S: Um.cranky, angry, frustrated, angry.all.well.he really.um, we're Christians, right? Had a lo.life was terrible for many many years, um.

The interviewer clarifies that she was stressed during the pregnancy with the participant.

I: So..while you were.carrying M___, um..you were having a tough time with.with J___..and um..

S: Yeah. Because of his angry outbursts. He was an angry person. But he wasn't.when I first met him he was a loving.he loved kids, he..everything. Mm, just incredible.

This mother then seems to dissociate from her distress to describe in an unconvincing manner how she had wanted more children. The interviewer's disbelief is conveyed in her response, but mother ignores it. Mother also talks at this time in a sing-song voice.

S: Um, I loved having babies. I just loved having, ah..yeah. I wanted two more children. Mm. J___ didn't want any more.

I: That would have been.six.

S: Six. I would have liked.six. And I even grieved for those two children, really. Um.er.like when we did that marriage course that time and.God showed J___ that he was hard as nails, then women (forced giggle) who couldn't have babies, or had lost them, and here.I couldn't.get over.here I am.I'm.I'm..really sad, that I didn't have two more children. These poor women! They can't have any or they've only got one, or something and.but I realised that it was.something that I really longed for.

The interview ends, and then mother returns to disclose what must have been on her mind all interview. She comes very close to saying that it was she who did not want the pregnancy, but severs connections as soon as she expresses her emotions at the time, either with denial of any impact, or via other-blaming, or by major shifts in time.

S: Anyway, I remember when I was pregnant with M___ that um, and I felt J___ didn't want another child, that I jumped off these steps and I didn't even jump off the top it wasn't really that far, you know, thinking that oh, maybe I'd have a miscarriage. You know I didn't really want to do that, I just felt really distraught and..

I: You must have been feeling pretty desperate.

S: Yeah. Pretty ah. distraught, so. and of course nothing happened. Other. but. I still remember doing that, that I did that and that it was a. an issue, and I always felt guilty about that. I thought well maybe that. maybe M___ suffers from this rejection because, well in the womb I think they do.. I mean I think they're aware of rejection and whe.. aware of whether they're wanted and, but I didn't not want. I did not personally not want him, I felt J___ didn't want him, and when I told J___ about this years ago, he said that that wasn't true. And so I realised in my mental state, 'cause I was really depressed as a child.

The difficult labour is described in a fragmented manner, with irrelevant detail, not remembering, not understanding, blaming the doctor and incongruent laughter.

I: Yeah. And the birth was fine?

S: Mm probably um....no probably. having my fourth child, I w. went into labour but it kept on, um...you know, when I lay down the contractions were really strong, when I got up they weren't. And someone was telling me um, J___'s cousin's. a. a midwife, and she was saying that, as you get older, your muscles can..you know, not be as firm and strong and. and that's what she. 'cause I was asking her one day why. why. I don't understand, why did that happen, you know. And she was explaining that to me. And see I went to this doctor and, I still remember when I was in St. V___'s, um..and this nurse. and like. he. the doctor came in, just for his lunchtime, and he um, I think he was going to cut me or some. or do something. forceps. She was really upset because I was. he was making me push before I was ready, and I still remember she was an old nur. elderly nurse, she was really angry at him. She came and saw me later. and she was really. She didn't put him down, in as much, but she was really angry with him, because she felt that I wasn't ready to have the baby, and he was pushing the issue, because he was in a hurry.

She was really annoyed at him. I really. I do remember that happening.

(laugh)

I: So it was a pretty long labour?

S: Um..probably. Oh. I think.they might.did they put me on a drip? I can't remember.

This mother reports immediately about her husband's capacity for extreme violence, but at the same time states that she did not know. She links the birth difficulties with her husband's angry outbursts, and blames him for her attempt to abort the foetus. However it is she who refuses to name the baby for several days.

S: J___ (husband) was suffering from Post-Traumatic.he went to Vietnam.

And so.I didn't know him a lot before he.went to Vietnam, we were.knew each other for a year but he was in Borneo in a war situation for a ye.half.six months, and then he came home. (details about moves, children born, etc) But it's just.only come out in the last say four or five years that J___was suffering from Post-Traumatic Stress, ever since Vietnam, and so..yeah.

I: And how did that affect him?

S: Um.cranky, angry, frustrated, angry.all.well.he really.um, we're Christians, right? Had a lo.life was terrible for many many years, um.

(describes counselling later in the marriage, blaming husband for all ills) And that um, and that he could.you don't have to put this in.that he could.he.God showed him that he could look at a person, you know, shake their hand, and shoot them.kill them. If he had to. Well he was in Special Air Service.

Much later mother in a confusing manner talks about the necessity for discipline, and the way father did not follow the family's rules about punishment. Once again, there is inclusion of irrelevant detail, major contradiction, and making a nonsense of the child's reactions.

S: There's that fine line between...oh.well.you know, you've got to set boundaries for them and.and they've got to.but I think th.personally if you were to ask me, I would say personally that it was extreme from J___'s side.

I: Did he yell a lot?

S: J___? Yeah. And.and he.um.and that was something M___ .he.M___

reckons that J___ .belted him a lot.and that wasn't the case. If they.they did get the paddle at school for something, um..which the p.you know, the parents gave their approval and I know today they don't paddle the kids and all that.

Mm. And you show me that the kids are better off for it though that they don't have the discipline. You tell me that the kids are better off, that society's better off and I'll believe that it's a good thing. Um, so, but the idea was that you didn't get punished twice. If you were punished at school you did not get punished at home. Well J___ was a bit..um, punish 'em at home like, as well. And M___ would say, M___ says, that he was really belted a lot and yelled at a lot and um..but as I would say to you, no different than the others. I don't think.and..so, but, but his inability to cope with it was probably..um.

The item that includes a family member being seriously ill when the participant was aged nought to three years is covered by the above descriptions of father's PTSD, manifested in his anger by mother's account. She is aware of a connection between early trauma and memory problems for her husband.

S: The only thing is, emotionally...um, I don't know emotionally what he can't remember anything in his childhood. So emotionally I imagine, there's something you know like..well they say that if you can't remember your childhood.can't remember things, there's something there blocking it out perhaps, I don't know, so. He can't really remember anything.

Father also had two bypass operations, the first when the participant was around ten years of age, so it is not included as a contributor to early family stress. Mother also at end of interview describes being depressed as a child, and recently again due to menopause, but denies any depression in the many years between. At times, the listener's normal responses of empathy and support are invited and then curtailed by her blaming others. She thus conveys a sense of helplessness and non-resolution, utilising denial and disconnection, fragmentation and avoidance of emotional groundedness.

SCZ005: Two trauma are presented. This mother describes a traumatic birth with the participant, followed by difficult premature births when the participant was aged between 0 and 3 years. When this mother describes her first three children who were very close in age, her narrative becomes confusing over which child she is discussing. It is difficult for the listener to determine which of her children were premature, but it appears that her first child, a boy, and her third child, a girl, were both premature, with her participant son, her second child, being full term. Her opening comments contain both major contradiction and a shift in time to the present, as if she is continuing to have babies at the age of seventy.

S: Yes. Yes I was, I felt real good...I really feel good.with all the births. I don't have much trouble, except..one..he was premmy.

I: Was that the first one?

S: No. Yeah, he was premmy too, but I never had any trouble with him.

I: T___ (participant son) was premmy?

S: No. He was a full time baby.

I: The girl?

S: And.the girl was premmy. So I've had three premmy babies. Out of six.

The above contradiction is followed up later in interview, but the inference that one or both of the other premature babies did cause her trouble was missed at time of interview.

I: Mm. Now, casting your mind back again, just remembering what you've already told me, the first three children were premmy?

S: No! Not all premmy, T___ wasn't.

I: No. T___ wasn't. OK. That's clearer.

Because of this confusion, the interviewer did not pursue how life-threatening these premature births were. However, her incoherence in the above narrative indicates that she and/or the infant were compromised with the premature births, and her disturbance may have had an effect on the participant.

At one point in interview, mother asks for the tape to be switched off, and a section erased. Later she refers to three murders, and many deaths by suicide in the early years of the family, and her dissociative response to her own remarks is evident in her comment about not thinking.

I: Yeah. Now, while you were pregnant with T___, um, did you lose anyone close to you, or...

S:Well I can't remember at.but I would.would've. I would've over the years, I would've lost a lot of people at...certain times..um..there was a lot going on in our family, I mean..there was eleven of us. There's only half of us now..and there was always someone very sick or dying, some of our relations. Some of them shot themselves, hung themselves...and all sorts of.terrible things..so, and then, as I said, we've had three murders.

I: Mm. Is there any um, I know this is.hard to.to recall, but um, I'm just wondering if you lost anyone close to you while you were..pregnant with T___.

S: With T____.I can't think at.at the moment. I don't think so. I don't think.

This statement of not thinking is considered by this author to be a primary indicator of a failure to process highly emotionally charged material.

SCZ006: Five trauma are discussed. This mother describes previous traumatic births (miscarriages), her intense fear during the pregnancy with her participant son who she describes as almost dying at birth, and who was very poorly for many months. Following his birth, she continued to experience miscarriages and threatened miscarriages which necessitated bedrest. Her husband was a volatile man with possible PTSD from the war. There is immediacy (she opens her story with the trauma of the participant's birth), relevance to the known research interest, the visual imagery is vivid, her speech is congruent, there is no confusion of time, person or sequence of events, and there are no intrusions or irrelevant detail. She puts the event in the context of her emotional state during the pregnancy, and is able to hold both the baby in mind and her emotions during the telling. However, her intense arousal is evident.

S: Well, I'd lost.er.er.a few babies, in fe.you know, before that, and so when I...er.you know I (bangs table with knuckle).discovered I.was pregnant with J____, (participant) I certainly was.I wanted him, but I was.scared stiff.

I: Yeah..I bet you were.

S: But at.the same thing had happened. Well now, the same thing didn't happen, and he.but in the meantime, I had a father who hated my husband, and he really made life hell, and stupid me, worried about..trying to please dad, and trying to please my husband and I.I was a wreck when I had J____. And so he was born.he was full-time, but he was only about five and a half pound or something.

I: So he was tiny.

S: Yeah. And he was weak. And he couldn't suck. He was tired, and he was sleepy, and struck a couple of pretty tough nurses who use.it was the middle of winter, no air-conditioning, and they poured.the ta.poured.put him under the tap. How he didn't die then, I don't know. So, I was in the hospital for..quite a few weeks with them trying to make him suck and.and.putting this tap on him and God knows what, until I said that I w.wanted to go home. So I came home and he was.oh..just skin and bone, and still couldn't suck. So I expressed and.and.put it in a bottle and.dug a big hole (grinds R index finger

into L palm), and ah.but he couldn't make warmth and.he was a very.you know, it's a wonder he didn't die.

I: You must have felt desperate.

S: I was desperate. And mum wasn't game to come near me on account of dad and, you know I was here on my own trying to do it (sharp inbreath) ..and so that was pretty bad and.by the time he was six months old he weighed about.seven.pound.

I: Gosh.

S: He was just dreadful. No don't worry about me shaking. And um, anyway eventually I got him onto Farex and got him going and he turned into.a nice little boy by the time he was about ten..m.months old or so.

I: So all that time you were terrified you'd lose him?

S: Oh, yes! So I was terrified I would lose him. And uh, anyway, well he eventually.you know, walked and did all the.things.

This mother was very distressed from several miscarriages, usually as late as five to six months into the pregnancies, and she speaks coherently about this, but her heightened emotion is conveyed in her banging the table and shaking. Some time later in interview, as mother shows a photograph of the participant as a young toddler, now thriving physically, the interviewer returns to this theme, and without hesitation, mother talks with emphasis.

I: Yes. He looks very bright, doesn't he? Yeah. Yep. Looks very healthy.

Gosh.Yeah. Mm. The miscarriages must have been quite a worry.

S: I had five of them. Between..oh.oh.sort of in between the sh...five or six months. It wasn't funny. It was dr.n.n.nerve-wracking and, nerve-wracking on me because I.I've had the complaint. I would d.be depressed.for months afterwards.

Her heightened emotion is conveyed in her stuttering, and this researcher is uncertain about which complaint she means as she does not have schizophrenia. She again makes reference to her extreme stress and the miscarriages, and then states her uncertainty, but not with denial or major contradiction.

S: And ah, so that's how, you know.not.er.um.I shouldn't have been like I was. I think some of the miscarriages I had were.were up.months caused through upset.

I: Yeah.

S: I don't know. I.I wo.just wonder if they were.

This mother is relatively coherent, but at one point she cuts off the flow of her narrative with both false attribution and major contradiction.

I: Now M___. Let's concentrate on J___'s earliest years. Anything at all you can remember..was going on for the family, for all of you, when J___ was anywhere between nought and three. Anything come to mind?

S: Oh. Ahm...No, not really. I..he and P___ (sister of participant) were pretty good mates and that. I don't.I.I just think the first..twelve months of his life was terrible. And so I can't really think of..anything.bad.

Clearly this was a trauma for both baby and mother during which she was largely unsupported by her husband and parents.

This is an interview with minimal dissociative processes. However, she is avoidant when discussing her husband's temper, for which he was publicly well-known.

S: ..and there was always rows about that. And it.just.was no good.

Meanwhile, his father..um, now don't get me wrong, D___ was a good man.

I: Was that always the way it was between the two of them, or..

S: A little bit...I don't know whether..I don't know whether D___ was jealous of him or what.

I: Why would that be?

S: I don't know why. I don't know why it would be, but this is what used to happen. And it was.it was heartbreaking..to see.

I: So you were saying D___ was jealous. You mean, in that you and J___ were very close?

S: ..No. It.w.wh.w.w.whether it was the word jealous um..I don't know what it was.

In the middle of the interview, when the interviewer asks about discipline, she immediately suggests it was not father who hit them.

I: Mm. Out of you and D___, who.who did the disciplining in the family?

S: Me. Mm.

I: Well I'd certainly do anything you told me to do, M___!

S: (both laugh) No I.er.no I did. He was.no. I don't think you could.think.I think he.could count the times he hit the kids. He didn't hit them.

Towards the end of interview, mother states:

S: Well see D___ in his own way was a kind man. He just had.the.see he'd been to the war, and um..he was.he was kind enough to the kids here but he.he...mm.wasn't as kind as he might have been. (laugh)

I: Did he yell at them much?

S: Oh, if he got the occasion, it wouldn't happen very often, but if something happened that..he thought was really bad, he'd yell. Yeah. (laugh)

I: What did.what did J___ do when he used to yell?

S: Oh well the kids d..s.er..oh, they used to hate it. 'Cos he had a temper. He never hit them, and he never hit me. I used to tell him if he ever hit me I'd be out the gate. (small laugh) But no, he never hit..but he really had a tongue and a half when he got going, and J___ had some bad.times with him. I mean, I know he's dead now (quavering voice), and everything else, but it's true.

She is also very open about her distress with her many miscarriages, and how that left her emotionally unavailable to the participant, including in the earliest years. This researcher considers this as a major threat to family integrity, especially with father away so much with work responsibilities.

I: Can you recall, um..when J___ was really young, um. Were you well.straight after the birth?

S: Oh! Well you wouldn't know. I wouldn't say I was well. I.I was so worried.

I: Mm! Yeah.

And later:

I: No. No. Do you think he worried about your.you? When he was really little?

S: ...I don't know. He could have.ah, I don't know whether he did or not, but see I'd be losing the.these.you know, having these miscarriages, and I'd certainly would be upset and.at.and for all I know, that could have been upsetting him a lot too. But I was so self-centred with how I felt, I.I wasn't aware of what anybody else thought. Mm.

She is now able to reflect on the possible impact on her family of her bouts of post-miscarriage depression with a frankness missing from the majority of interviews with the mothers of participants with schizophrenia.

SCZ007: Two trauma are reported. This mother reports a premature birth and tragic death with her first child, followed by a successful pregnancy, another miscarriage at six months following a fall, then two successful pregnancies prior to the unplanned

pregnancy with the participant. Because this mother had her four surviving children within four years, the panel considered it appropriate to include this under the item of previous miscarriage. The miscarriage is mentioned without comment on worrying during the next pregnancy.

S: But I was pretty well through the pregnancies really. I mean. I. we lost two along the way. Our first one was born nine weeks early, and he. didn't live. Then we had one after J___ who was ah...oh, I. I nearly lost it at the start, and then. when. when I was six months pregnant, I fell down some steps and..but apparently the baby..was ah. only joined by..two vessels instead of three, the. cord.

I: OK. Mm.

S: So..it's. was probably trying to miscarry in the first place, because of that.

In response to this interviewer's direct question, mother denies worrying during the pregnancy.

I: Ahhah. And you didn't have any worries about miscarrying him, at any stage?

S: No. No, I didn't. Nup. No, he was fine all the way through.

Later mother talks with emotional coherence (a sad voice) but with an irrelevant reference to a frog when describing the premature birth and death of her first child due to lack of immediate medical attention. There is an unexplained reference to plural losses.

S: Yeah. I became pregnant. oh, about three months after we got married I think, but that was with our first one actually yeah. Oh we had floods out on the farm, there's a story behind that too, mm.

I: Would you like to tell me?

S: That's how I lost them. Well I mean, these days you would live, no problem at all, 'cos he was a good size and he was nine. only nine weeks to go. He didn't live.

I: Because of the floods?

S: Yeah. That was it. I jumped out of a jeep when I nearly fell on. sat on a frog. (laugh) Big frog. Yeah.

I: Yeah. That's pretty sad for your first.

S: Well it was, because ah..everyone. my mum was looking forward. my father'd died, um, she was really looking forward to it, it was going to be her

first grandchild, and ah, my grandmother, mum's mother, she was looking forward to a great-grandchild and that, yeah. Mm, anyway. These things happen.

The interviewer ignores the startling distraction about the frog, and this seems to allow mother to proceed to a more emotionally congruent ending.

This interview is interesting as the same issue of veiled anger, violence or PTSD is offered in a disconnected fashion, and the meaning dismissed. Not long into the interview, the mother raises the issue of her husband's PTSD, briefly mentions his temper some time later, and the interviewer revisits it later again. Mother becomes markedly dysfluent.

S: Yeah. Mm. Mm. My husband is a Vietnam Veteran, and ah...we have read...that schizophrenia is more common amongst sat.sat.st.statistically...amongst Vietnam Veteran's childhood, but I don't know if it's true.

Further to this:

I: Who is he most like...out of you and B___? (husband)

S: ..Ahm....well he's probably you can see bits of both of us in him. Probably he's more reserved strengths, probably a bit more like me. He's got a bit of a temper at times, B___ has...you know, so. But not many problems....very much really. I don't know.

The abrupt ending distances mother from knowing, and therefore being expected to reflect on the emotional impact father's temper may have had on family members, including the participant. The interviewer tries again later to engage her in this issue.

I: You were saying B___ was a Vietnam Vet, and..he's got a bit of a temper. Ahm, are the two things related do you think, or..

S: Well I don't know that much, 'cos I didn't know like we became engaged and then he went. I sort of knew him, but even right from when I knew him he was. he was a National Serviceman. And he wasn't really..around that much, so (laugh) I didn't know him that much before.

I: Yeah. But the reason I'm asking, is that um, sometimes Vietnam Vets, um come back with, you know, some trauma and um..

S: Yeah I know that, yeah. But he hasn't really um..never talks about it that much. Yeah. Sometimes he does oh I mean. I just the last couple of years, he's

said a few things. But he doesn't say a lot. He used to go to the RSL, when he was in. like at B____. But he hasn't done anything about it since he came to town. Probably be good for him really.

I: So you think it still affects him?

S: ..Well, I mean, he gets annoyed when these people get on and say they want this and that and the other things. I mean..

I: Compensation?

S: Yeah, all that s..he does get annoyed about it, but..I still think it probably does.in a lot of ways. I think Vietnam Veterans..they had a rough time when they came back really, I mean even to this day..Vietnam, Korean.fellows. I mean, they're not really.because Vietnam was such a.a war that was.you know, a lot of people didn't really agree with. And everyone just went on with their.normal lives here anyway. I mean, we.has..mm. So the..I mean, they certainly didn't get what the.fellows over in.are getting in Indonesia these days. Mm. Which is a.which is a good thing, I mean, that they are being recognised, what they're doing.

I: Mm.

S: Whatever it is they're doing. (both laugh) I don't know. But I mean, I.yeah, they did get a rough time, and I do think they probably have a.got a complex, a lot of them.

I: Mm. Mm. B____ doesn't have nightmares about...

S: No, not now. He did..when he first came back, mm. But not really, no. If I ever s.ah, if he's ever on his back, I always make him turn over. I read once where um..

I: Uhhuh. So you learnt to..

S: People from wars.yeah, if they're sleeping on their back, they have..often have bad..dreams about it. I don't know whether it's true or not, but I reckon he does. Mm.

Contradictions, and change of tense to the present are noted. The pattern of mentioning something and then pulling back occurs throughout this interview, and the listener is left confused.

SCZ008: Two trauma are identified. This mother reports a potential birth trauma, followed by the participant experiencing chronic illness aged 0-3 years. Mother

describes her second pregnancy with the participant as planned and uneventful. However, she becomes markedly dysfluent whilst describing the birth.

I: Yeah. And um..so I'm getting a bit of a picture of..what it was like..during the pregnancy with N___, (participant) um..you were saying fairly relaxed and happy.

S: Yeah, yep, yep. Only thing I remember about his birth..was that he had..what they called a..hood over his face, and that the doctor..immediately said "This child'll never drown."

I: Oh..

S: I don't know what they call that. It was skin, a flap of skin, I think it must have been, over his clothes.

She does not describe her emotional reaction at the time, nor what treatment if any was needed, but the direct quote and the odd substitution of 'clothes' for 'face' may indicate heightened emotion in the telling.

She was isolated without transport, and both her young children were often ill with tonsillitis. She also becomes dissociative describing an imaged memory of one walk into town for treatment.

S: Yeah. But ah, it was pretty traumatic when the kids were sick with tonsillitis or..flu, or something like that, and you had to..get 'em..into the town, with no..buses coming out there, you had to walk. Took a while.

I: Right. Can you remember a particular incident?

S: Yeah, I can remember..walking..into town, and it was probably two or three..K's, and..to the doctor, and getting halfway home when a neighbour..picked me up, ah..I had one kid in the stroller, and one sitting on the roof. Bit windy sitting on the roof, I s'pose.

In her attempt to be matter-of-fact, she changes tense to the present, and later presents a bizarre picture that makes no sense. She soon returns to her participant son's struggle with chronic tonsillitis.

S: Mm. But N___ used to cry a lot, because um..he got tonsillitis if..if he got a cold, straight away get..middle ear infection and tonsillitis, so....

This interviewer did not offer her an opportunity to reach a conclusion, nor to describe her level of stress, but once again she has changed tense to the present as if it was still happening. Much later in interview, this researcher attempts to bring mother back to her son's earliest years.

I: Was there any time when he was really little, that you worried about him?

With the tonsillitis, and so on?

S: No. No, because L___ (her daughter) had it too. and some of the other children, it was just..common.er.thing to happen when..when they get.ahm.a cold, some of the children just actually get middle ear infection, and the infection goes to the tonsils.

She appears to falsely attribute not worrying to having two children to worry about with chronic tonsillitis. Earlier in the interview, mother talks after about her participant son being stressed whilst playing the lead in a school play in his Senior year, as if that was the first time anyone in the family had had stress.

S: But then, when he was.doing...Senior, he was in the school play, he might've told you about he was in the sch.sch.play, and he was..he was.the lead guy, and apparently he was.doing good through all the rehearsals, but the nights of the play, he was like...he wasn't in.tune.it.so maybe the stress of it might have got to him on the nights. So maybe that.may have even been back then, don't know.

I: Maybe, yeah. So..

S: I never heard him in rehearsal, but I gathered that he wasn't.as (???) as what he was, you know, on the nights, so maybe it went back as far as there.

I: So.I mean, it's a bit hard to.to um..

S: Mm. You don't know.

I: Pin things down, but certainly stress plays a role in um..someone becoming ill. But how had he handled stress before then?

S: I don't think we ever had much stress er, that I know of.

It is apparent from the full interview that this family had many stressors to contend with. The above denial may indicate little resolution of these stressors.

SCZ009: Three trauma are raised by mother in interview. The participant at age three months stopped breathing one night. It gradually emerges in interview how seriously and chronically ill the participant's father was with severe diabetes. It is this illness that mother holds responsible for his outbursts of anger.

This mother describes her participant infant girl as stopping breathing one night. This baby was unplanned and unwanted, but 'only for two weeks', and this is more fully explored in the section on Attachment.

S: Aah..but ah..H___ (participant daughter) said “Oh mum” she said, you know, she’d said to me “Any traumatic experiences”, and I said “Gosh H___ I can’t think of anything great or”..the only thing I can think of.. (sigh) was only three months after H___ was born, my husband was..had to go and help his.sister out in her business just for a week, ‘cos her husband got sudden appendic.itis, and uh...I woke up in the middle of the night and I thought..actually I thought.H___ wasn’t breathing. And that was when she was about three months old, and uh....I ah, got a bit of a fright, and it took me about five minutes before I reckoned everything was right (small laugh), and that’s the only really.traumatic experience in childhood..that I can remember with H___.

Once again, there are direct quotes, incongruent laughter, and a statement that she only worried for five minutes. It remains unclear whether baby did stop breathing, or whether mother awoke in fright, already anxious about her husband being away.

In this interview, mother presents the idealised family, stating that they have never fought and that they are a close family. The father’s volatility is minimised, although it is ongoing, and is explained by his diabetes. Until halfway through interview, there has been no mention from interviewer or interviewee regarding anger:

S: But..you know we uh...I mean, every so often P___ would be..not well, but I mean it was a case of just giving him some food and..let him relax for a while, then we’d be right. There was never any big..arguments or fights or anything in the family we were very..very close family all got on pretty well together.

Everything is ‘fantastic’ until later:

S: Aah...s.my husband is fairly strong on discipline which..ah..I sometimes wonder if whether that worries H___. Aah..

The above inference is followed up by the interviewer as it relates to a comment made by the participant.

I: Mm. H___ said she was a bit frightened of her dad. Was that why she was a pretty good kid?

S: Yeah. Well as I said dad, P___’s..pretty strong on discipline and that’s..that’s probably..I know that sh..she feels she hasn’t had the relationship

with him that she may have done, but in many ways now that see I'm early to bed person, and H___ and P___ are out there and, you know, they have a go.

I: Mm. They get some time together.

The interviewer misses the possibility that mother means they have a go at each other.

S: Oh, they have time together, yes they do. And he teases her a bit..but uh, you know, oh no..P___..P___'s a..gets a bit gruff and.the grandchildren don't know where they are sometimes either but..ah, I think that.you know.I.I.think sure that H___ would like to get into her own home and have.do her own thing, but who wouldn't at that age, you know..and I don't blame her for that..ah.I just don't know how she'll handle it.

And again:

I: Now, without wanting you to tell stories on P___, but how would he discipline the children?

S: .Oh he..he..he's..because he's a diabetic, see..there were times when he wasn't well and he was pretty quick off the mark..and I was quite often..say to the children "Dad's not feeling real well. Just do.everything." And they usually did. But now and then dad would react and he used to react with a smack, but he..he..um....

Just before the participant was born, father had a crisis that could have been life threatening, but mother is unable to clearly say so.

S: But ah...no, I think..probably P___'s health was our main worry at that stage. It was..because.

I: Can you remember him having any crises?

S: Oh! Yes, he did have from time to time. Yeah, would have been....he had one crisis one night before.....yeah would have been before H___ was born...and I had ah..herd recorder staying with me, so that.he was able to. 'cos P___..wasn't physically able to.take the um.honey and syrup, you know, he..he was fairly um.much ah...he..he was.had a very high bad hypo, anyhow.

I: Mm. So he was really out to it?

S: Ye..well, not quite. 'Cos we had one here recently. And he was..out to it. I know the whole (laugh) ..but it was the worst one at that stage.

I: Mm.

S: At that stage. That would have happened while H___ was pregnant, I think while I was pregnant, sorry, with H___, but ah...but you know, within two hours, P___'s up and going and..going on with the job no.nothing..so..I..

Mother is still implying in interview that her husband's health was not a burden, but her dysfluency belies this, and then she projects this concern onto her participant daughter, but cannot stay with this.

S: so I was able to get him to come in and..get him to s.sit.sit him up a bit, until I could get some food into him. H___'s probably worried um....a fair bit about dad's sugar in many ways. She's a...ah, because she did a work.at high school on..I don't know whether it was insides or what it was, on diabetes, you know, she sort of studied these things up a bit more..probably...in her own way. But H___'s always been a.more talkative person, or was, until she's on this medication she's not real talkative now. She's alright one on one I think with..with...her friends.

Even with direct questioning, mother cannot state her worry.

I: How worried do you think you were about P___'s health, ah, when you first knew he was ill?

S: Well, he become ill six weeks after we married.

It is only towards end of interview that mother expresses strong and mixed emotions around father's illness and its effects on the whole family.

S: Ah I.I believe the dia.my husband's diabetes, and the....and.he.be.because of the way.it affects him, it has changed what our life would have been otherwise, a great deal. But, we've still lived.a pretty good life. (loudly)

I: You have definitely managed, haven't you?

S: And my husband..has done tremendously well to achieve what he has done.

I: Yes. Yes.

S: And I respect him..'cos I don't think I could have done it (laughter and tears), 'cos he's on four.four injections a day. He's done a terrific job. (tears)

I: Yes. Yes.

S: But, it does affect the family.

Once again, this is a case of mother's report including dismissing and minimising remarks in an unsuccessful attempt to contain intense emotion that is revealed in speech dysfluencies.

SCZ010: Four trauma are presented. This mother had miscarriages prior to adopting the participant, whose petit mal epilepsy was undiagnosed until school years. Mother was seriously ill with Ross River fever when the participant was a baby, and father had a violent temper. Mother appeared very guarded in interview. Father reluctantly agreed to leave the room for the sake of uniformity in research method.

This mother appears to frequently use distancing techniques over disturbing events. She and her husband decide to adopt after attempts to have their own children failed.

I: And um..so p'raps.what I could ask you is.um, can you tell me a little bit about.your decision to adopt?

S: ...Well we had..had various disappointments and.and.it looked like we were't going to have any of our own.children, so we just decided oh well, we'd adopt. That was.yeah.

I: Ahhah.

S: And we both liked children.

I: So you had some difficulties with..

S: Yeah.

I: Yeah. With having children of your own? Yeah.

S: Mm.

I: Um..sorry for asking this straight up, but.um, had you had some miscarriages?

S: Yeah.yeah.yeah.

This topic does not arise again in interview.

Her participant baby son was ill with measles at the same time that mother contracted Ross River fever, a debilitating illness. The family also moved at this time. Both children had asthma and epilepsy. Her son's epilepsy began at an unknown age, and it was only due to mother's diligence and efforts to get specialist attention that led to the diagnosis. However, she continued to let him drive a car at the age of seven, go shooting with his adopted sister from a very early age, climb trees etcetera, against medical advice.

I: Yeah! Um..was there any time when..you, or your husband, or..O___ (participant son) or.A___ (participant's sister) were.very ill with anything?

S: ..O___ had ah...measles when he was about.three months old.

I: Mm. In C___? (far-west country town)

S: Yeah we.um.I had him at the doctor one day, and he said tonsillitis and about forty-eight hours later (small laugh) he had.the measles. I think that's pretty normal, actually (laugh). Ah, he was quite ill with that. He had chickenpox probably when he was five. Other than that, no great illnesses. And then he.er.he.he.ah during the process of the.remedial work, and the um...ah..the problems with it..ah, he was assessed by various people to try and...ah, you know, sort out why he would be having trouble, 'cos he was bright enough.and he still is.as bright as a button. It's just that the um..writing things down..that gets to him, um..they discovered that he had some...oh what do they call it.patit.petit mal.um..

I: Mm. Some epilepsy?

S: Epilepsy, and A___ (participant's adopted sister) had grand mal epilepsy, so between the two of them, yeah! (laugh) And they both had asthma as.youngsters. Oh.well, O___ still gets it, so does A___ actually, it never.actually.entirely..disappeared.

I: Mm. Was there any occasion when you were really worried about their health?

S: ...No..just sort of.well, when it happens, you just go on with it, don't you? (laugh) There's not much you can do. The doctor said.. "Don't let them ride horses. Don't let them climb trees what.oh..don't let them go swimming." By that time they were doing it all and I thought well..when I didn't know it didn't do any harm, so it's probably not going to do much more harm.so I just.kept a bit of an eye on 'em.but.left them doing it.

Direct quotes and the denial of worry over her son's health are noted.

I: Yeah. Um, just going back to his measles at three months, um..did he have to go into hospital?

S: No.

I: No.

S: He was..oh..probably no sicker than most kids are with measles I wouldn't think. He had a temp for a few days and he was grumpy, but..

I: Mm. So he didn't..

S: He wasn't blind.

I: Become unconscious, or..

S: No.no. He never did at that stage.

I: Yeah. And.and you've been basically really well?

S: ..Oh, except when I got Ross River.that sort of.threw things.cat amongst the pigeons for a while.

Then follows an attempt by this researcher to define when exactly in relation to the family moves, and the participant's illnesses and accidents that she contracted Ross River fever. It is not entirely clarified, but doing the sums, it appears it was close to when the participant at age three months contracted measles and the family was on the move.

I: When did you get that?

S: Oh, sometime when they.somebody asked me that the other day, 'cos I still get relapses of it.despite their..

I: Yeah.

S: Probably round about the time.well it was.during the time that w.I was living in town, and going out of town. Yeah. Probably be thirty years ago or better.

The participant is aged thirty-one years at time of interview.

The participant sustained a head injury, but it would not seem to be the cause of his petit-mal epilepsy.

S: Wh.when you're um..twenty miles from your nearest neighbour or something, you become very self-sufficient, yeah.

I: Mm. Can you recall any.major dramas, that you really needed to.handle?

S: Oh (sigh). Probably the kids, they.O.O___ did have a motorbike fall on his head once, when he was...and I'm not sure of that.date either, but it would've been before he went to school. He climbed up on the motorbike when.it wasn't really stable, and fell on him, and it had rained, oh.some.inches and inches, we couldn't get out, and he did wake up screaming that night.

Wh.when I did get him to the doctor, well he said he probably had.concussion. But um..and other than that, his father cut his hand.once on a.circular saw. One of the neighbours flew him in. There was neighbours with planes.close and handy.

The above examples display a vagueness and tangentiality regarding the infant and childhood illnesses and accidents, but also evident is her insistence on medical treatment.

The participant has told his case manager that his father is violent. In the middle of interview, mother trivialises the participant's evaluation.

I: Yeah. So looking back on it, how would you size up that part of your life?

S: ..Oh I think we were all happy enough. To.to hear O___ (participant son) talk now sometimes you would think that he'd been belted and bashed and goodness knows what, but there's really not much.basis to that. I mean he had a smack or two like most kids do, but he was never.treated.the way he says he was treated.

I: Mm.

S: Which is very worrying, because it makes you feel that he's.he's.carrying a load he doesn't need to carry.

I: Mm. What do you make of that?

S: I don't know.....I've often wondered how much is.power of suggestion. I mean he would've..been whacked a few times for different things, but he certainly wasn't belted.to the way that he thinks he was belted.

I: Mm. Ahhah.

This client developed petit mal epilepsy in childhood. His adopted sister had grand mal epilepsy. Mother describes what a handful he was halfway through interview, and her rapid defense is noted.

I: How would he react when he was.yelled at, or disciplined?

S: Oh, he never took discipline very well. Yeah.

I: Mm. Can you think of an example early?

S: I thought you were going to ask me that, and I thought "No I can't", but yeah, he was always a difficult child. If he didn't want to do anything, he didn't want to do it and..the Devil himself mostly couldn't make him.

I: Mm. What would you do? You couldn't just let him do things that might be dangerous.

S: Aah....well dangerous things you just removed him from the area...sometimes I'd send him to his room, but that used to send him round the bend too. (laugh) He didn't like that very much. Ah..I don't know what I used to do, but I used to do it. But he was a very difficult child to.to...he didn't take..discipline in any form, he..thought he knew best, and he meant to know best, and that was it. But.we had brought him up that way too.

Towards end of interview, she talks of smacking him to no avail.

S: So..yeah, mum was always reasonably supportive, although she always said if you smacked him more, he'd be better but it never made any difference, so I gave up on that one.

Essentially she is unconvincing to this researcher in her denial of physical attempts at discipline.

Examples of Early Family Trauma in the Depression Sample

In comparison with the above examples, the mothers of the participants with depression who talk of a parent being angry, violent or having PTSD either outline specific incidents with some expression of guilt or concern regarding long-term effects, or set limits on the partner either by leaving the relationship or by demanding changed behaviour. These stories are more emotionally connected, congruent in affect, and where dissociative, the mother is more likely to spontaneously report a reason for it. Also, where death has occurred, or been threatened to mother, foetus or infant, or another immediate family member, the interviewed mothers are more able to clearly say so.

DEP101: Two trauma are discussed. This mother reports a reasonable pregnancy, and stays on track despite the interviewer's interruptions about concerns for recording quality because of mother's absent dentures and noise from the TV and a parrot. She describes a difficult birth and subsequent breathing problems for her newborn, and she and her husband were very concerned about the infant's survival. Even her use of distancing 'you's' are invitational to the listener to empathise. The story is sequential, logical and real, with contained and appropriate affect. She is able to talk about the possibility of her son not surviving, and it is this ability that is the strongest indicator of her emotional coherence.

S: Aah....it was a reasonable pregnancy. No..I don't think I was as sick with S___ (participant) as I was the other two. Um..and ah.but.um he was a difficult birth, and..uh, he.couldn't keep his lungs full of air. He had lack of oxygen.and that and ah...for a couple of days we didn't know whether he was going to make it or not for sure.

I: Mm.

S: He was.baptised.and everything in the.nursery..and they used to push him.to a window so I could look at him through the window. Um...it's a funny feeling.er, you don't know whether you want to look at 'em and get to know 'em or not know what you've missed out on, but it's.and I think if you hadn't

looked, you'd have been really disappointed.then.if anything would've happened, you know. Er, when I left the hospital, a sister said...don't expect a lot.ah, he'd never be a normal healthy baby. But.he walked when he was nine months old, and he.talked reasonably early..ahm...he was.he was.demand fed.and I used to walk around with him at the hospital so he wouldn't cry. So his lungs wouldn't empty, and I really thought I was going to have a terrible spoilt baby when I got home. (small laugh) But.I didn't, he was a really good baby.

However, a little further on, she blames the sister at the hospital for not calling the doctor sooner, and it is this that may be a prelude to her denial that anything was the matter.

S: Well just.um.I..yeah I.he was nine and a half pound, and.and.I wasn't sort of.ah, built.for a nine and a half pounder (small laugh). But.the nun at St. V___'s who delivered all the babies.I asked her to get the doctor, and she said "There's nothing he can do that I can't do." And I remember when he did walk in, he really went for her.

I: Right.

S: And said she had no right not to call him.a.an hour or more before.it all happened. But he.he eventually was born and, you know. Everything was alright.

I: Mm. And after the birth, you were well?

S: Yeah, I was fine.

I: You got to see him straight away?

S: Ah.ye.well.yes, and then they took him straight away.

I: Yes.

S: And I didn't really.other than peekin' through the window, I had no more contact with him for about four days, three or four days.

I: Right. Yes.

S: But I used to see him, I'd walk around all the other wards.with him, so he didn't cry. Take him upstairs to the.post-op (laugh). He was a well-travelled boy. (Both laugh)

I: And who did you have for support at that time?

S: Nnn.obody. (sigh)

I: Mm. What about your parents? Where were they?

S: Aah..I.think.they had our little.our two little girls. They would've stayed with.with my husband. Mm. And they had the two little girls.

Mother may have felt isolated in hospital as she waited several days being unable to hold her very ill baby. All her energies appear to have been focused on him, whilst she was able to 'not think' about the needs of her family.

A little further on in the interview, mother links this traumatic birth and sequelae to her son's current depressive illness.

S: I think that part of his life has got a lot to do with.now.

This suggests that this mother has attempted to make sense of her son's mental illness within the context of these early traumatic events.

DEP103: Three trauma are explored. The birth was traumatic, and the infant initially compromised. Mother indicates in an obscure manner that she may have caused some physical harm to her participant son when she was under stress.

This mother also attributes her son's mental health difficulties to his traumatic birth during which he almost died. She links this trauma to his learning difficulties leading to low self-esteem and then depression. Mother's parents were available for support, and although mother describes father as not being there emotionally, he was not physically absent. However, the traumatic nature of the birth is clearly indicated by mother's dysfluencies in the telling, as well as her poor recall of events. She uses minimising and denial initially, but quite quickly gets to the point that her baby's heart was not beating.

I: Yeah. And um, how was the birth.for you and.and L___ (participant)?

S: Aah..it.it.ah.it was a little bit traumatic, um.at one time.I can remember.ah, towards the end..ah, it was sort of normal.

I: Mm.

S: But..I think it was fairly long..oh well.few, you know, a few hours, but I think it was.normal.

I: Mm.

S: Um.but um..I can.I must.har.you know, they were giving me.gas, and ah..and I must have sort of passed out for a little bit, then I (sigh) when I came to, I can remember.the.they.they seemed to have this box thing, you know, they put.the.to get the heart beat.for the.on your tummy and.

I: Mm.

S: And they said they couldn't find it, and I didn't know what they were talking about for a while, so for a while they..um..they lost his heartbeat, so his heart wasn't beating, and um.

I: Mm!

S: When he was born, the cord was wrapped around his neck, and I can recall the doctor going you know, and one two three four, and he was unwinding the cord from around his neck.

I: Right. Mm.

S: Yeah. I've always been worried that um..that, you know, he'd have brain damage, or.

I: Mm.

S: Something like that.

I: Mm! How long was it before you were reassured about that?

S: Ah, well probably never.

There is no inclusion of irrelevant detail, or a sudden shift away from a very emotionally charged topic. The focus remains on the infant after this disclosure. Mother reports having two boys close together in age who both 'escaped' at different times, causing mother a level of anxiety. Her remark that she reprimanded the participant 'rather severely' hints at the level of her distress, and perhaps also her fears of her skills as a mother.

S: So..I you know, he..he'd driven out there himself and that was my constant fear. I've got a creek at the back, and the road at the front.

I: Yes.

S: That was my, you know, fear that they little that they'd go wandering either down the creek or..on the road.

I: Yeah. Mm.

S: Which they did. Ah each one..month..so I.

I: Yeah.

S: I think I reprimanded him rather severely.

I: Yes.

S: Probably gave him a..smack, or something.

I: Yeah. Yeah.

S: So that he'd remember and would never do it again. He didn't do it again.

Later there is a passage in which mother describes the participant's brother trying to smother him when a baby in talcum powder. Why mother raises this is uncertain, and she does state that he did not come to any harm because of it, but later she talks of being unwell and stressed at this time, and the panel consider the passage indicative of some harm mother feared or carried out on her youngest child. Her level of distress in her narration is not consistent with the manifest content.

S: I can recall that his brother tried to um...smother him when he was a baby.

I: Mm.

S: I must have been away from here. he was in his little cradle, and ah, I went in, and....a.g.er.C____. (participant's two-year-old brother) was at the end of the bed, and I suppose he, you know.

I: Mm.

S: It bunny rug or whatever you changed their nappy and powder, and I.I must have put the powder.(sigh) on the bed and he.my oldest son would've been about.almost two, a toddler.

I: Mmhm.

S: And he'd decided he would ahm...sprinkle him with powder. I don't know what he thought he was doing. You don't know what children think, do you (small laugh) when they're this old?

I: (small laugh) No.

S: And here was the.the hold.the everything was just completely.white.

I: Right.

S: It was.got the.p powder and kept sprinkling.

I: Wow!

S: And it was (small laugh) everywhere.

I: Yeah.

S: All over the.you know, over.over the baby, and over the.bedclothe.you know the..

I: Mm.

S: In to bed and..so that was a bit of a fright.

I: Mm. What did you do?

S: But he (small laugh). Ah, think I.I probably scolded the um...the eldest son, but ah. It.ah.you know, probably. I don't think it was.as bad as it.looked. It didn't.it wasn't detrimental to..L____ anyway.

It remains unclear whether this mother has searched for events only vaguely related to the research focus, or whether she is expressing concerns or doubts about her role in her son's adult depression.

DEP104: One trauma is described. This mother discloses a violent but brief marriage, with father leaving when the participant was about eighteen months old. The violent incidents she describes are vivid in imagery and emotionally congruent, even though the interviewee has to prompt, and initially she minimises the impact and blames herself in part. She relates a comfortable pregnancy and reasonable caesarean birth, but these events are quickly followed by extreme violence from her husband:

S: Um..but um..afterwards I can remember.there was.some parts that um..but he was.that seemed to happen while he was.only a baby, I.I just can't remember exactly, um. He was born in.. 'seventy-three, and I was divorced from his father in. 'seventy-six. Um..but we hadn't been together for ah probably.I'm not sure, eighteen months perhaps before that. Um...can't remember details of it.now.

And soon she is describing how frightened they were.

S: But ah....I.I can't really....ah..the kids seemed to grow up happy and ah, all.all.you know, ah..But we had to.a.lot of problems....in so much we just.we just.ah.we'd go and stay with ah.my aunt, we stayed with my aunt.for a while, because.their father sort of caused so much trouble around here and.terrified them.

I: Mm.

S: Basically because.um.I was.here with two little children ah.a little bit isolated in those days, and ah..um..well, we went from.went to one aunt and stay.aunt and uncle and stayed there for a while, then we.came back for a while, then we.shifted again. We didn't have a.a real...ah, until I sort of um, coped.felt I was coping better, and got my ex-husband out of the house, which took.three.three months..I'd say, to get him out of the place, aah.so as I could come in with the kids, um..but even then, we weren't..a bit fearful.of things..er.I.

I: Mm. What had he done that was.frightening for you?

S: Oh.....We had a few episodes..um, I think the worst.actual physical time for me.I.I can't.remember.exactly what happened, but.I can remember.coming

home and and I still don't know..(sigh)..whether..I still can't work out whether.it.w.S___ must...(sigh) whether I was.just pregnant with him. No! It was after that.um...but.I remember..we came home here, and he said "Put the baby down." Oh it had to be S___, but then I don't know where D___ could have been at the time. Um, "Put the baby down".and.and I.I.got.well if he's.if he's going to hit me..I'd better get the ba.get the baby put down so as..he.he.the baby doesn't get hurt, you know? So I put..it must've been S___, but really, I can't picture where D___ was. Um....and then he sort of.came.at me and.and nearly choked me and.and I had.blood on my face, and I got away from him and I ran to the bathroom, and um..I can remember.trying to hold the door.closed, but he..it.it came in on.against me, and I had blood all over me face and that.um.I think he.he hit me again, and then he just walked out, as much as to say.he didn't do anything, you know? It was.it was me. Um...that was one time, that was.pretty bad.ah.when.and I can remember.I just forget.I'd.only.don't.it's no good me trying to remember what ages they were.but.I can remember.they had an old scooter out in the backyard, and he came here one night, and broke the.the.st.the doorway in.um...kids would.they would.and.in those days, they were in the bed.they slept in the.the bedroom with me, we just.had ah.one bed there, and um, I remember breaking.ah.running.from there, and I went to grab the phone, and I thought no, I ca.I haven't got time, and so I ran out of the door here..and he grabbed me at the top of the steps, and I.I.I don't know, I just broke away from him and I ran up to the people across the street and said "Please can I use your phone?" I think I was in a nightdress I just can't..remember exactly, but.but there was.a.a.you know, a few times w.thing something like that.

I: Yes.

S: But.

I: He terrified you.

S: Oh well yes.

I: What was it like for the children?

S: It.it must have been terrible, because.I can remember being across the road there, and trying to ring the police, and.not knowing how.what was happening here. But by the time we.the police came and we'd come back into the house, ah, the kids were still asleep.

Her dissociation in interview is interesting as she is aware of it, and she gives a reason for her poor memory.

S: But.ah.ah.I.like I say, I'm confused with times and..

I: That's understandable.

S: Mm, but um, you know. Different ones in the family will say different things to me and that. "Do you remember this?" And.and.I just cannot remember, you know. Sometimes they.when.when they do say that, it'll jog my memory, and I think "Oh, that's right. We were so-and-so", you know.

But.ah.a lot of times, in fact I.I don't think I even try to reach back sometimes, because I think.I want.to get on with things.

This mother's memories of the traumatic events are rich in detail, and highly emotionally charged, combined with her recognising that her effortful avoidance of some memories serves a purpose. Also, the listener is invited to join this mother in recognising the emotional impact of the father's violence on herself and the young children.

DEP105: Three trauma are presented. This mother had a history of previous traumatic births, followed by the participant's birth trauma. This baby then had severe childhood illnesses. This participant's early history is graphically conveyed by mother who appears to thoroughly enjoy the interview. She begins her narrative with a statement about all her pregnancies and births being difficult, without losing focus on the purpose of the interview, her participant son. She has her first baby at age eighteen, moving to the bush straight afterwards.

S: And then I was..having this other baby, and.I wanted a little boy.. 'cos.that was my big aim. Um, but.I.always had.really bad morning sickness for the first three months with.all the family.

I: All of them.

S: But..as time went on...I sort of just got over that, and um...I think.everything sort of went smoothly with them. I did have bad births.with..all of my babies.

I: All of them?

S: Yeah. And I had a very very bad birth with J _____. (participant's eldest sibling)

I: Mmhm.

S: And um.well I had um..

I: She was your first?

S: First. She was nine and a quarter pound born. And I was about eight stone at the time. Very small, and she was coming breech.the doctor turned her. He was drunk.

I: Mm.

S: It was.going back.fifty odd years, which J___ is now...it was..I was in hospital a month.

Her second pregnancy also led to a difficult birth. After a relevant interruption, she continues:

S: And um...a.a.then when P___ (participant son) was born, I.I..when I.when I.a.after I had D___, the doctor had to operate. And.stitch all my tummy back where it should've been.

I: Mm! Mm.

S: So.anyhow but.when I had him, the doctor was there, and he.had to cut me, to make sure that I didn't tear again, or anything like that. And um..anyhow.

This interview was conducted in the mother's residence, with a bulldozer demolishing a building next door. The interviewer was distracted, mother was not. She only takes a short time to get to the trauma of her participant son's birth.

S: So then um..er, when he.mar.as he was being born, he swallowed.a lot of the.mu.mucus and everything. So he vomited.for five days after he was born. And he was only six-three, he'd got well down under premmy weight. They put him in the cot. I never saw him for about five days. That was.straight on Christmas really.

I: Yeah.

S: And um..anyhow ah.every time I.would go down to see him, he'd have clean clothes on, and I'd say "What he's.he's got clean clothes on again!" They said "Oh yes, he sicked up." (small laugh) And he was sicking up all the time.

I: Mm.

S: You know.er.in those days they didn't tell you anything, and no-one sort of, took you under their wing and said "Well, this happened and that happened", and the doctor said "Oh he's fine, he's fine, oh yes, he'll be fine." So ah, anyhow he eventually.I was home.in..ten days, twelve days or something like that with him. And um....when.I went home then.um...he got measles.

I: Straight away?

S: Seven weeks old, and he had measles. really, really bad. They were more like scarlet fever than measles. They were dead, he was just red.

There is no explanation of why exactly she did not see him for five days, and it is contradicted immediately by her describing with direct quotes what transacted whenever she did see him. She promptly goes on to describe her frequent visits to the doctor with this child, and the eventual diagnosis after specialist referral.

S: Anyhow, I've...had him backwards and forwards to the doctor. We lived at the doctor's. He had these terrible colds, he used to get terrible bad ears. He's had abscesses in the ear. ears...for ages. Every for if I went a fortnight, it's the longest I'd go.

I: Mm.

S: Without taking him to the doctor. It was a big big thing, if I went any longer than a fortnight.

When mother had her fourth child, her sister visited to mind the children whilst mother takes her participant son to a specialist hundreds of kilometres away, without a clear diagnosis until much later. Her narrative is rich in detail, with direct quotes, and the focus remains on the child throughout. She clearly conveys her concern when another doctor changes his treatment.

S: As soon as he run around or anything, he'd cough until he almost choked. Anyhow, he called me straight in, as soon as I got there. He said "That child" he said "with that terrible cough" he said. "Come in here." So I went in and I had an appointment and he said "Is this the child that's been doing that coughing?" I said "Yes." And I told him then about him having measles and the everything when he was..that age, and ah he..he said "Right!" he said, "Strip him off" he said "and stand him here on the table." So I stripped him right down, and he went right from his top of his head to the soles of his feet.

I: Mm.

S: So anyhow, when he'd finished, he said "Well.." he said "I'm not telling you what I think he might have.. But" he said "I'm giving him a course of injections.." he said "And if he's no better..when they're finished.." he said "he has to go straight to B___." He said "It's more than..I know what's the

matter with him.” So.in the meantime, he had to go off to a court case, so.I was passed over to another doctor, but not the same one that.I’d been going to all the time, because.you don’t do those sort of things.

I: Mm.

S: When I goes to this doctor, he was a really old doctor. He was..in A___ when I was born. He said “I don’t believe in this damn rubbish.” I thought oh.oh God! What am I going to do with the kids, you know? So anyhow, I went ahead and I got the..the.injections..and when I went back..it was about three weeks after I first went to Dr. F___, he told me then, he said “Well I’ll tell you now” he said “what your child had.” He said “He has had prolonged whooping cough.” He said “It was caused from those measles”, he said “when he was seven weeks old.” He said “He should’ve been treated, and should’ve had his.immunisation then.” And it.it wasn’t done, see.it wasn’t.I think they were nearly..twelve months old before they started.immunising ‘em in those years.

She is able to acknowledge that she feared losing this child.

S: And ah, I used to think to myself.and I know I used to say to the lady, I don’t think I’ll ever rear this fellow.

This family has many of the risk factors seen in the schizophrenia sample, but mother was able to leave her alcoholic but by her account non-violent husband. This is covered in more detail in the qualitative analysis of maternal fatigue.

DEP106: Two trauma are related by this mother. At the age of ten months, the participant as a baby had bad measles and possibly pneumonia, and at age three years (close to four years old) he almost drowned but was rescued by his father who did drown soon after. Mother discusses this tragic loss of her husband first before going on to her baby son’s illness which predated the accidents. She becomes dissociative at one point, forgetting what we are discussing, and is occasionally dysfluent with stuttering and incongruent laughter, but the overall narrative is congruent as she tracks what she is saying.

S: And ah, and B___ was working....he was.he was.s.working with a group over at G___, so he was sort of away..all through the week, and come home at the weekend, you know. And um, he was on this.flood mitigation work. It w.wasn’t always G___, it.sometimes it was B___ or.was around ah.er, not B___, G___, or round B___, or somewhere.round about.wherever they were

working on this flood mitigation.but it with the same firm, you know..sort of thing. And ah.yeah he came home for a.of a..of a weekend..yeah. And ah..I've lost me track.what.what we were talking (laugh).

I: Mm. Yes. Just about..

S: Oh! What happened? Yeah, well.ahm.then of a weekend.he.h.had some friends that had fishing boats, and because he.worked on the boats before, he used to occasionally go out with them. Ahm, and they were trawling ah..prawns. And um, this happened to be on ah.two days after.Christmas..on the um...oh...ahm, sixty-three.Christmas of sixty-three, yeah. And um..he ah, he went out and they just didn't come back.

I: Mm.

S: And they were.there were ah..f.five.five men on the boat. Two of them were.married, their skipper.that was.that he went out with, he had.he was married with....three or four children.

I: Mm.

S: And then I had.three. And the others were all ah, one of.one of the lads was only.sixteen, another one was twenty-one. Ah, I don't know what the third one was, but there were five of them that went out.

Her participant son had not turned four years of age, and mother describes having to remind him from time to time that father would not be back, but she does not volunteer any relationship between this major tragic loss and her son's later depression. She quickly moves on to her son's illness at ten months.

I: So that was a.very traumatic time for the whole family.

S: For the whole family. Yeah, it was, yeah. Yeah. I don't know.um....when.when R___ (participant son) was about.ten months, I suppose.I don't know whether this.but it um...he got ah, he was cutting teeth, and then he sort of got ah..ah, measles..the Eng.the.bad English measles, you know.

I: Mm.

S: And um...ahm...don't know whether he got pneumonia with it too or not, but he was pretty sick anyway, and he was in hospital.for.quite a while.for.but he was only about ten months old then.

I: Yes. Um..how sick was he? Were you.frightened that you'd lose him?

S: Ahm..no, I don't say it was quite.quite.that..bad, but he.he was bad enough. We were.pretty concerned about it, you know.

I: Mm.

S: At the time, yeah. But um..

I: When you say you don't know whether he had pneumonia, did he have pneumonia at some stage?

S: Ahm..w.well it.it.not.not, no, not really.ahm, as I said I'm not sure, I think it might've been just.the fever, and the bad.with the cutting of the teeth and everything, that um..so.I.I doubt if it was. I.I should remember, shouldn't I? (laugh) No, he was pretty sick at the time.

Much later, mother returns with prompting to the father's drowning and its effects on the participant. She describes her husband, who was away often, spending a lot of time with the children when home, and this triggers a memory of her son's near drowning.

S: ...yeah, he certainly missed his dad, and ah...'cos they used to, you know, wherever he went of a weekend when he was home, he always had.ah.R___, all the children with him, you know, he used to.take them with him, you know. He used to.take them with him. Ah, actually on the um...the Christmas.that ah, we lost his father.ah.a few days after, um..they'd all got swimming togs..for Christmas, you know, sort of thing. And.of course, I'm not very interested in.in.in the water, I.I.I can flap around a bit but I don't..

I: Mm.

S: I'm not.not real keen on it. And so.they all went over to.um..ah, the swimming part at.B___, can't even think of it now.it's.um..and they were swimming away there, and the two bigger children of course were.were in swimming and ah, and ah (sigh) ..B___ happened to take his eyes off of R___ for a minute and ah..he'd gone into the water. And, of course, when he came back and ah, and noticed him, he.he.he dived in again 'cos he was.he was.going up and down, you know.

I: Mm..

S: And um..and when B___ got him out, he said "Oh, I was divin', daddy. I was divin'." (laugh) He was diving alright. (laugh) And um, yeah, so that gave us a bit of a scare.

She uses minimising, and makes sure the interviewer knows she was not there without blaming her husband for not taking more care. There is no suggestion that the participant three-year old had lost consciousness, or had any ill effects from this event.

DEP107: Two trauma are discussed. This mother is initially unwilling to be expansive in interview, with some signs of nervousness, and states that it is just as well to forget unpleasant events. However, soon she is able to talk about the traumatic birth, focusing on the baby's suffering.

I: C.can you tell me a little bit about the birth?

S: Um..yes, it was a bit.traumatic. Um.because I wasn't.e.I sort of had a lot of back pain, and.I.just wasn't dilating enough. So it was sort of fairly intense pain, and..I think.they had to.take him by forceps.forceps at the end.

I: Mm.

S: Which I think was.fairly traumatic for him as a baby.

I: Mmhm.

S: And..I didn't see him for two days.

I: Mm.

S: When.um, they said he needed to rest. And he had.they had this bonnet on, and I was really upset about it, because they didn't tell me, and he had a bonnet on him and when they took it off he was really..bruised, his head..from the forceps.

This is immediately followed by this being the explanation for his poor feeding and irritability, and her subsequent exhaustion. That is, she makes sequential logical links between traumatic events and emotional responses within the context of the mother-baby relationship.

S: And I think because of that as well, he.didn't breastfeed easily. He just was exhausted, so they just put him on to the bottle.

I: Mm.

S: I sort of felt.you know, you still feel a bit guilty that you didn't feed him yourself, but, yeah. But anyway. (laugh)

I: It's a very natural reaction.

S: Yeah, yeah.

I: So what did you..do in those two days when you couldn't see him?

S: Um...I think I went up, and I was allowed to have a look and everything, you know. I felt a bit upset, because he was crying, and he had nappy rash and you'd think "Oh they're not looking after him like you would."

I: Yeah.

S: No. So, yeah, yeah. And then I..I stayed in hospital I think for ten days. Um, because I had haemorrhoids (laugh). Really badly.obviously from.you know, trying to push him and not getting anywhere. So..I suppose it was a little bit of a.negative experience for the first time.

When she and baby were home, baby was very unsettled, and this will be covered in the next section on maternal exhaustion. At six weeks of age, baby was readmitted to hospital with bronchitis.

S: And we used to put him in our bed, but he wouldn't settle, so you'd put him in the cot and you'd.he was always really sniffly.so you'd always be listening and.I think when he was six.six weeks old.actually, he was in hospital with bronchitis.

I: Mm.

S: For six...oh no, for two weeks, I think. And.but he.he was really happy.like he.he cried a lot, and I think he was really stuffed up all the time, his nose and he really couldn't breathe, and that's why he woke.

Again the focus remains on the child and the information is logical, emotionally congruent and relevant. The apparently contradictory remark about the baby being really happy and crying relates to mother's previous comment about him having a happy disposition despite being ill. She uses distancing 'you's' without losing focus on the child. He was a very active toddler, and mother describes having to be ten steps ahead of him, and then relates his near-drowning accident. The change of tense to the present, the vivid imagery, direct quotes and heightened emotion in interview indicate unresolved trauma for mother.

S: Um..we had to keep an eye on him. We had to keep.like..we really had to be.ten.like.ahead of him, like you do with all little kids. And..um, I think.I think he might have told you about the time he.nearly drowned and.

I: No, he didn't.

S: Oh didn't he? Oh delib.he...I wonder if.I wonder if I.I still ??? (laugh) He was only fourteen months old.

I: Right.

S: Yeah, he..we..we went away to um..G___'s (husband) parents looked after him, and we went to..oh.like a.C___ Lakes I don't know it's sort of around.it's a..oh.like a little country place to stay and, we went there and.had time together and they brought him up..sort of at the end, it had this big lake..and um, G___ said "I'm going to take him over..We'll go over to the club and h.have a drink" and whatever, and I said "Well don't bring him back on the.on the lake!" Because you know those paddle..

I: Mm.

S: 'Cos he was just so attracted to water, he just loved water. Anyway, I had a feeling he would, so I stood out there and I watched..and he did.bring him back, and he just..turned around..he had his hand on..one like..a couple of times, and just let go and he's going along, and G___'s just..not watching him and choo! He just went straight in (indrawn breath). It was just..um..it was just really..it was horrible, 'cos you couldn't do anything.

I: Mm.

S: But.G___ had sort of done a fair bit of diving, so he sort of..I don't know how many times he went..he found him anyway. Yeah, so he was only fourteen months old. (exhaled breath)

I: Gosh.

S: Yeah.

I: Was he unconscious?

S: No! Not..not..breathing with no worries. (exhaled breath, small laugh). Yeah, he just took him and put him under the shower to warm him up and..yeah. He wasn't crying or anything. (exhaled breath) So..

I: And you?

S: Oh! Well..no, I just sort of..just stood back and (small laugh). Still today we love to say "I told you so." (small laugh)

This has clearly become part of the family's narrative. There is no abrupt subject change or statement that it did not matter or meant nothing, as seen in some of the schizophrenia sample interviews.

DEP108: Two trauma are reported. This mother had back pain during her pregnancies and an ill mother to look after, and she experienced a miscarriage when her participant son was aged 0-3 years. This is a very open and fluid interview, with mother expressing appropriate concern for her participant son, without

over-involvement. Mother volunteers information about her health during her pregnancies.

S: The only trouble I had was um. I had a bone in the back that it used to slip out.

I: Right.

S: The end. And ah..that caused me a quite a bit of pain I suppose. Um, you know, just towards the end.

I: Yes.

S: And that. with the result of that, they brought R___ on. (participant's youngest brother)

I: Ahhah.

S: The youngest fellow.

I: Mm.

S: About six weeks premature.

I: Right.

S: The others were, you know, I went full-time.

I: Mm. What did you have to do to look after your back, in the last few weeks?

S: I was supposed to rest, but with R___ I had my mother with us and she wasn't well.

I: Mm.

S: And um, I was looking after her and..in the end, they put her in a home just 'til I went into hospital.

I: Uhhuh. Yes.

S: Other than that, just take. um, well I didn't even take painkillers. Nothing, you know?

I: Right. You toughed it out?

S: Yeah! (both laugh) Yes.

Mother describes her participant son as an easy baby who did not protest, and who adjusted well to moving abruptly to the bottle.

S: And um..when ah..when I was breast-feeding him, I got an abscess and. I had to just take him straight off the breast. He took to the bottle. Just ah, you know, an extremely good baby.

This mother discusses the order of her children, including a miscarriage after the birth of her participant son.

I: Right. How many children did you end up having?

S: Four.

I: Uhhuh.

S: We had a miscarriage between ah, B___ (participant son) and the next fellow C___.

I: Right.

S: And we had another...C___ and R___ after that.

She uses the plural form to describe the loss, inferring that she felt supported. She does not report any noticeable distress in her then youngest child, the participant. DEP109: Three trauma are identified. This mother was ill and stressed during the pregnancy with her participant daughter, father was an angry and argumentative man, and mother's sister who lived with the family died when the participant was aged three years. Mother immediately reports her illness during the pregnancy.

S: But later in the pregnancy, just before she was born I got really sick.

I: Did you?

S: With liver..problems.

I: Right.

S: I spent a week in hospital. Just couldn't stop vomiting. They didn't really know what caused it. They just put it down to something (laugh) to do with the pregnancy, you know? 'Cos I've never had it since.

I: Mm. So you had the last week in hospital.

S: Mm, yeah. Well I.I had a week in hospital (bird screech), then I had a week at home, then she was born.

This mother appears vague and obtuse, and confuses one child with another. Mother's sister died suddenly in their home when the participant was aged three. Mother describes a close relationship between her sister and the participant and then states that the sudden loss went unnoticed by the participant. This denial is perhaps indicative of a dissociative process.

I: Did she take to the bottle OK?

S: Yeah, yeah. Mm. Oh she was a pretty good baby. On the whole. There were restless times, like all kids I think.

I: Mm. Is there any particular.thing that stands out?

S: When she was a baby?

I: Mm.

S: Not really. Mm, she was pretty spoilt. My sister used to spoil her, 'cos she was staying here with.us. She idolised her. She died, so whether, you know.

I: (Words unclear)

S: She was only twenty-one when she died. That would be.it was just before L___ was born, so it would be about thirty-three years ago.

I: Mm. So..

S: She really wasn't old enough to.know, you know, what was going on.

I: Mm.

S: Well, you think they're not, but I s'pose.they do. They.they know something's wrong.

I: What happened to her?

S: Her heart.valves collapsed.

Father is described as having a poorly controlled temper, just like the participant, but mother concurrently infers this is irrelevant. The bird signifies otherwise.

I: Mm. How'd she get on with her dad?

S: (bird screech) Oh....They're too much alike I think. She loves her dad (bird screech) but as I say they.their natures are too much alike. And he..she um.they used to fight (bird screech) you know. 'Cos he.he used to.get stroppy with all of them, I think. He was pretty.quick-tempered (laugh) I think. Not.not that he's ever, you know, he's just really prickly. He flies off the handle pretty easily. Gets over it in two seconds, but.

And towards end of interview mother revisits her point that both father and daughter are frequently volatile, which in her daughter she puts down to epilepsy (not confirmed medically) and for father there is no explanation.

I: Has G___ (father) always um.defended her?

S: Oh yes. Mm. As I say, they argue and fight, but they're very close really.

I: Mm, mm.

S: But as I say I think it's just because they're the same natures (laugh). But A___ too, I find that she's very..changes her moods very easily, you know? She'll be all lovey dovey one minute and all of a sudden she'll fly off the

handle, and she'll walk out that door and come back.as though nothing's happened.

This interview leaves the impression of much that is unspoken, and there are contradictory messages about the ascribed origins to the participant daughter's early behavioural disturbances.

DEP110: Three trauma are presented. This mother gets straight to the point concerning her marriage at sixteen and her inexperience and isolation, her husband's drinking and violence, and all within the context of relationship. Her three children were well spaced in age, and her husband did settle down around the birth of their third child, a girl. She links her son's depression to these early stresses, and it is a very open and frank interview. Because she focuses initially on her husband's drinking and the effect this had on her and the children, and then on her mother needing to take care of her dying father, it is not until halfway through interview that she talks about her participant son's near-death from gastroenteritis, and the sequelae.

S: And of course, when he was three..he was around three, yeah, he had gastroenteritis. And we nearly lost him, he.he.he was really bad, he just..went completely down.that quick, the doctors couldn't believe it. But ah, he come through.

I: Can you tell me a bit more about that?

S: He was.oh, he was very sick. He.just..and I had the doctor around here and..he just couldn't keep anything down, it was just..coming.butt end.top end..and doctors.try.trying..glucose, and that.that'd even still come up. So he was very sick, and they put him into hospital, and he was in there for.a couple of weeks.and he was only a little guy. In fact he was only a baby and..I don't think he realised what was going on.

I: Mm.

S: Poor little devil. But ah, he pulled through really good.

I: Yeah.

S: Mm.

I: You did say you nearly lost him.

S: Oh yes! Mm. That was.that was a real worrying time. And he was a very sick boy.

I: Yes.

S: Mm, very sick little fella.....no, he's come.and now he's the biggest of the lot. (small laugh)

I: Did you have to watch.watch him and.more closely after that?

S: Oh yes, because he was left with a bowel problem then. And.like.and

I.that's when...school teachers..really annoyed me at that stage.

I: Mm.

S: Because I told 'em about the problem. "Now.if he puts his hand up.wants to go to the toilet, let him go, and let him go quick."

I: Mm.

S: 'Cos it's.his bowel was weakened by it.

I: Mm.

S: No! They'd ignore him. And of course naturally, what would he do? He'd dirty his pants. And he was.given a hell of a lot of hell at school for that.

Her empathy and protectiveness towards her son are evident.

Earlier she talks briefly about being stressed during the pregnancy with the participant, but that she was dealing with these same stressors before the pregnancy.

I: And..nothing stands out.as happening during that time, that would've been..upsetting for you?

S: No. No. No..no. 'Cos ah.it was upsetting to see my dad as s.sick as he was. And that's.was around the time that he really started to deteriorate.

I: Right.

S: 'Cos he.I was.what, about three months pregnant with T___ (participant's sister) ..when he died.

I: Right.

S: And he really started to deteriorate then.

I: Yes.

S: And.that was hard to take, because.him and I were very close.

I: Yes.

S: And, yeah, that was a bit hard to take. But ah, no. Nothing.you know, nothing that wasn't.already happening, anyway.

She is also very open about her husband's drinking problem, but takes her time to disclose the domestic violence, and is even less forthcoming about the effects on the children when little, implying that they played with their toys.

S: It was stressful seeing the husband (small laugh) ..like the way he was.

Mm. It was very stressful.

And:

S: Yeah. (small laugh) Yeah, we're still together, surprisingly. (laugh) We still have our rows too.

However, she volunteers that her two sons' adult depression is directly linked to this domestic violence. The minimising of 'a couple of times' is noted, and the contradiction of rapidly idealising of father's responsible nature, when previously she had presented him as irresponsible.

I: Yeah. And you were saying that both boys have depression, and that you put that down a lot to their earliest years.

S: By dad.mmm.

I: Can you say more about that?

S: Yeah well..well, that's really..what it was, you know. And of course him coming home drunk, we'd fight.

I: Mmhm.

S: Naturally, which is (small laugh) it'd get me so wild. only time we see him..and he was drunk.

I: Yeah.

S: You know.th.this is you know, and no good.

I: They're not good things to remember.

S: No. They're not.

I: Did you ever come to blows?

S: ... Yeah well he hit me.he hit me a couple of times.

I: Right.

S: Yeah. And I think that affected the boys, 'cos that was a no-no. And ah..yeah.but.in..when he was when he was sober, though he was a w.wonderful.provider and father and..

Later when pressed to be more disclosing, mother is able to respond.

I: Yeah. Now this m.this might be really difficult to remember, but um.just with the.drinking and the fighting..can you remember..how early that started in terms of..um..the fighting.

S: Mm.

I: Ah, and especially the hitting you.in terms of how old.W___ would have been.

S: W___ would've been.oh, he would've been about t..two.three.

I: Mmhm.

S: Mm. He would've been about two or three, yeah.

I: OK.

S: And sometimes they got.quite ugly really. Because.temper's'd flair and.you know, and then the kids'd suffer for it.

I: Mm. What.what did the children do when the fights were on?

S: Go in their bedroom and shut the door.

I: Right.

S: And play with their toys and n.you know. 'Cos he wouldn't.he wouldn't remember anything next day.

Essentially this mother is able to present the interviewer with emotionally congruent and coherent narratives around the traumatic events.

Summary of Trauma Themes Presented by the Interviewed Mothers

It is evident that the type and number of traumatic or severely stressful events is similar for both diagnostic groups. Frequency of self-reported maternal illnesses or severe stress during pregnancy with the clinical participants is particularly noted as similar for the two diagnostic groups (Table 6).

What is different is the manner in which the mothers present their narratives around these events. These differences are collectively named dissociative processes. These processes are more evident in the speech of the mothers of the schizophrenia group than of the depression group. These processes include noticeable shifts from a capacity to freely discuss less stressful topics in detail to a constricted, confusing use of denial of potential for death, dismissal of the emotional impact of traumatic or severely stressful events, not remembering, affective blunting, and less resolution via problem-solving.

These indicators of unresolved trauma have an impact on the listener in the transference, and this impact mirrors trauma in its effects. This researcher considers these speech processes to indicate intense unresolved affect in the mothers towards the child to whom they may have a troubled attachment.

Table 6

Frequency of Reported Maternal Illnesses/Severe Stress During Pregnancy with Clinical Participants

Maternal Illness/Severe Stress	Participant Disorder	
	Schizophrenia N	Depression N
Threatened miscarriage	3	3
High blood pressure	5	0
Toxaemia	1	0
Influenza	1	0
Severe morning sickness without Debendox	2	0
Morning sickness with Debendox	2	1
Medical concern re. foetus, including small foetus, bowel outside, not carrying normal (mothers' terms)	1	2
Accident to mother (electrocution)	0	1
Rhesus incompatibility	2	1
Severe stress - numerous causes	3	3
German Measles injection	0	2
Anaemia	1	0
Gallstones	1	0
Thyroid disorder	1	0
Calcium levels erratic	1	0
Amniocentesis	0	1
Self-starvation	1	0
Attempted self-abortion	1	1
Liver abnormality	0	1

In contrast, the mothers of the depressed group describe their participant children's illnesses and accidents usually with a full range of expressed emotion, inviting the listener into relationship with both herself and the child. This researcher reflects on the possibility of intergenerational transmission of trauma to a vulnerable child who is associated in mother's mind with the trauma.

Chapter 5

RESULTS

Qualitative Analysis of Maternal Exhaustion Themes

This chapter outlines the process of defining this theme and its individual items. It then presents detailed examples from the mother interviews followed by a summary of similarities and differences between the diagnostic groups.

Identification of Maternal Exhaustion Themes

In this research, the interviewed mothers reported several contributing factors to their exhaustion or fatigue in the time period under investigation:

1. Mother was stressed/ill during the pregnancy with the participant. This item was included in the trauma construct, and will not be repeated in this chapter.
2. Mother reported a state of exhaustion or prolonged overwork after the birth with the participant.
3. Mother's parents were unavailable for support after the birth for several reasons.
4. Father was absent physically very often or for long periods of time.
5. Father was alcoholic and of little help.
6. Poverty.
7. Mother had many children close in age.
8. Mother stated in interview that the participant child was very active, or too much for her in some way.
9. The family moved close to the birth of the participant.

Mother stating exhaustion/hectic in the period close to the birth of the participant will be presented with the explanations or associated themes as stated by the interviewees, and secondly examined for the manner in which the information is given to the interviewer. Themes already covered in the first construct (Trauma) will not be revisited.

Examples of Maternal Fatigue in the Schizophrenia Sample

As in the Trauma section, individual narratives will be presented to maintain context. SCZ001: Six themes were identified. In addition to her severe illness during pregnancy, this mother talks of her husband beginning night-work just as she came home from hospital with her second baby (the participant). She then had two more children in quick succession, with her mother dying before the birth of her participant child who was difficult to manage.

Table 7

Frequencies of Fatigue Items from Mother Interviews by Diagnosis of Participant Offspring

Item	Diagnosis	
	Schizophrenia (N=25)	Depression (N=25)
Mother ill/stressed in pregnancy		
Total	15	8
Transcribed	4	2
Mother states exhausted/hectic		
Total	16	10
Transcribed	9	3
Mother's parents unavailable		
Total	15	13
Transcribed	8	5
Father away often		
Total	11	12
Transcribed	6	3
Father alcoholic		
Total	7	4
Transcribed	3	2
Poverty		
Total	8	7
Transcribed	4	2
Many children close in age		
Total	7	2
Transcribed	5	1
Child 'too much' for mother		
Total	12	11
Transcribed	6	3
Family moved close to birth		
Total	10	4
Transcribed	3	1

Embedded throughout the interview are inferences to mother's ongoing physical unwellness, and with several children, her life was hectic and tiring.

I: When you came home with the next one.

S: Mm. Fairly hectic. As I say, I..wasn't particularly well at the time, and uh.....

And later she is talking of being too busy with all the children.

S: Things got me down, more than a person, you know...ah.....

I: Because there was so much to do?

S: Mm, mm, mm...

And to conclude a rambling section:

as I say it was a hectic time..and uh.....

Mother's mother died when mother's first-born, a girl, was aged fourteen months, and just seven months before mother fell pregnant with her participant son.

I: OK. Now your parents. Were they around at all when you were...

S: No. Now..mum was..al.alive when I was ah, married, but um, S___ (participant's sister) would've only been about fourteen months old, when she passed away and of course my dad passed away well before then.

I: OK.

S: Aah....

I: And how much older than D___ (participant son) is S___?

S: Aah.....just over two and a half. Um..and ah....

I: Mm. So you didn't have your mum there.

S: No. No. Like, like...not like nowadays.

This researcher wonders if the nonsensical last statement inferring that nowadays mothers with four children do not lose their own mothers at inconvenient times is an indicator of unresolved grief. However it could be that she meant she is available to her own daughter who is married with children.

Father started working night-shift as a taxi driver just as she had her participant son, was unwell with high blood pressure, and was recovering from an exhausting birth. She conveys her difficulty with accepting his absence, without centring her comments within her own needs and feelings.

I: And dad was working?

S:My.my husband? Umm....yes he was....was it then? Don't think 'til D___ was born actually. Ah, he went into the taxi service...and ah....'cos ah...ahh.....I belong to a....I suppose an era, ah where there should be a man around the house, you know, so and especially of a night time, and that distressed me a bit. And ah....

I: So he was working night shift?

S: Mm, mm. Some..sometimes.

I: And you had a new baby..

S: Yes. Yes. And as I say, a difficult ah..birth..ah, at that.

She is able to get some support from a relative and a friend, but quickly returns to a comment that she was more or less on her own.

I: Um, so when you came home with D___ as a baby, you had high blood pressure then, and um, yeah. Um..what help did you get around the house, 'cos that really makes you feel unwell, doesn't it?

S: Yes. Oh, well, oh ah...I had good..like my sister-in-law was very good she used to..ah..come over to me, and ah...unfortunately she passed away last year, and ah..ahm, sort of upset ah, the family a little bit, and ah....she was very very good in the house and then I had another good friend..ah, would help, and uh...um...

And then:

I: OK. Now, um, what sort of a help um, was J___ (participant's father) um, with looking after the kids and so on. Now he was working.

S: Yes. Oh..always felt I was on my own a lot ah, because he used to work long hours, you know...ah...and uh.....well I.I suppose he got me down a lot but...ahm.....(softly)

The researcher questions her about whether she had depressive symptoms, and this is denied. Therefore the above is seen as an indication of her frustration with having the responsibility and work with the four children largely to herself.

The participant was the second of four children, born over a period of about six years, with at least the first two births being very difficult due to mother's small pelvic area and carrying very high up. It is therefore likely that all the births were difficult. Her logic in explaining having four children disintegrates in the telling. The interviewer does not discover she has four children until much later in interview.

I: Mm. Can you remember what all of that felt like for you?

S: Aah. I was a little bit distressed because ah..ah...I had a a girl..pro....she was the oldest in the family, and uh...ah, 'cos I always believed that a boy should be head of the family, you know, and ah...ahm...things never...she was born under anaesthetic. And uh, of course..if she..if D___ would've been the first, ah...like, the first child, I wouldn't have had the last child...as the three. Um...Dr. G___ at the time. And uh....

The story is fragmented, with abrupt closure on sensitive material (note the minimisation in 'a little bit distressed'). Factual information gets lost in the chaotic presentation of emotionally charged material which leaves the listener with the task

of organising it all into sequential, emotionally congruent information. That is, it is disorganising in its effect.

The indication for the participant being very hard to settle is mother's comments about the participant's behaviour at the time of her next confinement, and includes her previous remarks about his being very lively.

I: Mm. You were telling me he was very lively, that both the boys were into everything.

S: Yes, yes.

I: When he was a toddler, say, um...can you remember anything he got into?

S: Only that..when I was due to go to hospital, nobody wanted to mind him (laugh). You know.

I: So, who did?

S: Aah...well...between J___ and uh, like relatives, you know..ah...two sisters-in-law, and then..a girl, uh..I went to school with her actually and..uh, you know, we're the best of..best of friends..and ah, he just screamed the roo..the roof down you know.

She discusses having four children and this being too much for her on her own, having lost her mother between the first baby and the birth of her participant son. Mother rapidly shifts time-frame and topic from the loss of her mother between her first baby and her becoming pregnant with the participant, and indeed appears to confuse the loss with a much later period when she had her four children. This confusion of time is perhaps an indicator of unresolved grief.

Now..mum was..al.alive when I was ah, married, but um, S___ would've only been about fourteen months old, when she passed away and of course my dad passed away well before then.

I: OK.

S: Aah....

I: And how much older than D___ is S___?

S: Aah.....just over two and a half. Um..and ah....

I: Mm. So you didn't have your mum there.

S: No. No. Like, like...not like nowadays, and ah, we had four children and ah, they used to come everywhere with me, church and...and uh, it was a little bit difficult at times, especially shopping trips, and uh....

I: Yes. You've only got two hands.

S: Mm. Mm. And then we had a.a boy ah, straight after D___, and uh, they was only fourteen months apart, you know, and that.that was two caesareans, fourteen months apart, which I..G___ he just about went through the roof.

And later, mother enriches this part of her story but quickly shifts ground again.

I: OK. Now, um, what sort of a help um, was J___ um, with looking after the kids and so on. Now he was working.

S: Yes. Oh..always felt I was on my.own a lot ah, because he used to work long hours, you know...ah...and uh.....well I.I suppose he got me down a lot but...ahm..... (softly)

I: He got you down? (softly)

S: Things got me down, more than a person, you know...ah.....

I: Because there was so much to do?

S: Mm, mm, mm...and ah.....as I.I say now, you know, didn't play bowls, I don't think, when the kids were younger it was more.ah, later on that I.I started playing bowls.

SCZ002: Seven themes were noted. This mother identifies having many children close in age, with her participant son being hard to settle, living in relative poverty early in the marriage, with a move into a new house soon after her son's birth, and having an alcoholic husband as contributing to her hectic life. They had emigrated to Australia after marrying and thus her parents were unavailable for support. She has six children in all including twins over a period of several years, with the first three over a period of two and a half years. Some of her non-tracking of significant developmental markers for her participant son is put down to the children arriving in rapid succession.

S: Yes. And I had already had a miscarriage, just before he was born, and I had another baby seven months, huh, and and so it was um...I was happy I had the miscarriage in the sense, it wasn't a deliberate one, and then I became pregnant straight away with A___. (participant)

Her next child was born fourteen months after the participant.

S: I don't know really, because I had another baby soon afterwards. My daughter's only fourteen months...you must think I'm a nut. My daughter reckons it took six children for me to find out what caused them (laugh). I..I don't remember too much.

Mother describes, via sudden unheralded transitions from one topic to another, her struggle with two small children close in age.

S: Yes. Seven or eight months old. He'd smack his dad, and then um, you know, but he couldn't walk when she was born see. He wasn't old enough to walk, and I used to carry him everywhere and all the ladies'd say "Oh put that big boy down. You can't carry two of them."

The participant child would not go to his father, and was inconsolable at times.

The poverty was memorable for this mother, but relatively short-lived. Her comment is suggestive of a dismissive style of coping with numerous severe stressors.

S: He (husband) was a carpenter and joiner and a shopfitter...and it was hard to get work at first, but we met this couple coming out and...we're still very great friends with them, and she's...my husband died three years ago and she died four months after. And we were great friends, and I don't think we might have managed only for them. So they helped us, we bought this hut. It was an ex-Army hut, it was unlined. We felt we would um....no water, no nothing, but, and money was very scarce because um, P___'s boss gave him the money to buy it, and we had to pay it back in a year and uh..

I: Gosh, that was stiff.

S: Yes. So we did. But we couldn't get the money to build. Eventually when A___ was five months we got the money to build, and um, P___ and A___ came down every weekend to help build it. It was a nice home then, but um...other than that, there was nothing else. That was the only really terrible thing that happened to us was that A___ broke his jaw.

Father's alcoholism and non-coping gradually emerge in the interview.

Mother reports reacting by screeching at him not to go to the pub, but also states that she did not know it was a problem. This is another example of major contradiction, and it appears in this interview to be a device for coping with false guilt.

S:Well, he (husband) died of cancer of the lung, and the bone. But he developed dreadful um...he used to swell. All his skin would burst out and he was...most violent (whispered)...and I think that might have been alcohol. I'm not too sure. He also had emphy..it started with emphysema, and um...how he suffered so much you know?

I: So..pardon my probing, but um..you said he had alcohol problems. Was that right from the very beginning of your relationship?

S: Yes. But I didn't realise it, you know? We married in England. We met in England, we married in England, and um..everyone knows the Irish get drunk you know, eheheh. And so we came out in the ship, and they were all getting drunk. It never appeared to me..and it ah..but I think it got worse because he um...it was such a hassle for him, life was. Trying to provide for all these children, and um..and um..I suppose, living, coming second best to them..there was nothing else I could do, you know, and so...but he was a very, very good man, you know. And I think in later years, like, when he and I lived alone, we got on much better. Things were different.

Mother reports her infant son as being difficult in temperament around twelve months of age, without explanation. It was of sufficient concern to her to take him to a specialist.

S: But then when he was twelve months, he became desperately contrary. Cried and...it could have been his teeth, so we took him to a specialist on the T___ in B___, and he couldn't find anything wrong with him, just maybe his teeth or...but it always struck me as strange, that he was so cranky at that time.

I: Mm. How long did that go on for?

S: I don't know really, because I had another baby soon afterwards.

Mother returns to this theme after discussing their early financially straitened circumstances.

S: No. The only thing was um...he didn't fancy his father, even as a baby. He um..if P___ (father) went to take him, he would not go to him. And then...

I: How would he get this across?

S: Smack him.

I: So even when he was very little....

S: Yes. Seven or eight months old. He'd smack his dad, and then um, you know, but he couldn't walk when she was born see.

This discussion leads on to further comments by mother about her participant son's clinging to her, and this is covered in the chapter on Attachment Difficulties.

SCZ003: This mother reported three themes related to her fatigue. Mother was stressed/ill in pregnancy, her parents were unavailable for support, and she indicates

her child was difficult to settle. This case presents some difficulties which are important to clarify. Mother emphasises her participant son's social relationships and social acceptance prior to illness as being normal, and this emphasis derives from her extensive reading and exploration of causative factors in schizophrenia, which she concludes are genetic and drug-related. This interviewer has the feeling that the interview had been all tied up before she got there, and that the whole interview was tense and truncated. In contrast to this, mother was very open about her own difficulties around the same age as when her son became ill, but she did not require psychiatric intervention. She appears to identify with her son throughout interview, for example, with similar temperaments, similar age when mental difficulties emerged, and so on. Also in marked contrast, mother reports her participant baby son as being very demanding, but that as she had a similar temperament, she infers (and likely correctly) that she was sufficiently attuned for this not to lead to major attachment difficulties. The emphasis here is on the word 'major', as this researcher has identified certain indicators of insecurity. (see next chapter on Attachment Difficulties).

I: And ah, he was a.comfy baby to ah..

S: Oh...very.oh, he was probably demanding, but I mean, he probably takes after me, I'm fairly demanding. Characteris.personality characterist.

I: Are you?

S: Characteristics are inherited. Well some of them are, some of them aren't.

I: Um, can you say a little bit more about that?

S: Aah, well.some people are demanding and some aren't. That's.just.simply it. Um..he.wanted.his.food when he wanted it, and if he didn't get it then he'd.get..well, demanding..which he can, yeah. Um..

I: And that was.a bit different from the other two?

S: Oh..J___ was..er, the next baby J___ was a very big baby, um.but then J___ the.third child was.half.in between the two of them. R___ wasn't exceptionally demanding, he was.just um...um, a little bit impatient, but he always has been, I always have been too, so.

I: You like to know.exactly what's happening and when.to get it done by.

S: Yes, that's right, yeah. He wasn't a baby who screamed, um, you know, some people have very difficult babies. R___ wasn't, he was just.first child,

and I think with the first child, you're always a little bit more nervous, as you probably know.

I: Yeah. I haven't had children, but I can certainly understand that.

S: Oh, first child you're always very nervous. First child's a bit of an experiment.

I: Yeah. Yes, and um..so.you were both well, and you were pretty in tune with.um, his demandingness and, you..

S: Mm, he wasn't essentially demanding, he was just..you know, that was just R___.

However, mother herself may have attachment insecurities, as her explanation for her own mother's unavailability at the birth of her participant son was inadequate and a closed book.

I: Yep. OK. Um, who did you have for..support, when you were..

S: Uh.oh, friends. I came.grew up.well, we were living in a um..country town, and so I had a lot of friends, so um..I wasn't isolated in that way.

Um....support, um....my husband's very supportive um...my husband's family are very supportive..ahm, my parents.my mother was too busy look.looking after my father.to be..you know, with me.be ah.I didn't expect her.to be..um.an awful lot of help, but she lived.um, over an hour away anyway.

Um, oh no..um..yeah. Probably.er when..I'd.left work.mum used to work an awful lot, and being home with the baby..um, it was difficult..um..to get used to.

I: Ahhah. How did you..cope with that, in terms of..

S: Does this really have any bearing on your..

I: All I'm.all I'm doing is.sort of, following.wherever the conversation goes.

SCZ004: This mother ties in three themes with her exhaustion: her stress during pregnancy has been covered already, and she reports having a very active toddler who was too much for her. She presents her parents as not being supportive.

Her distress may have been worsened by her not wanting this infant, but she blames her husband for this at the beginning of the interview. Note the apparently high affect which is quickly diverted, the minimising effect of 'a little bit upsetting' and her emphasis on her poor memory as a process of effortful avoidance. She makes a nonsense of her husband's denial.

I: Can you recall when you first knew you were pregnant with M___?

(participant son)

S: Ummm....Oh, not exactly..but I do remember being pregnant with him. I don't remember exactly...I don't think I remember exactly. Mm.

I: Now just recalling that time, um.what comes to mind, just remembering that?

S: Um..I s'pose remembering that I.I remember.I'm going to cry (wavery voice, then laugh). Yeah. Probably can't talk about it.....Just that my husband gave me the impression he didn't want another child. And um...and I can remember being really upset about that..um...but talking to him years later, he never..um, he never..he never did infer that he reckons. But then he's got a terrible memory. Um, he never did infer that, and so um...yeah, so that was a bit upsetting really because..yeah I had it in my mind that he didn't really want another child, and so, um..yeah.

No conclusion is reached. When the interviewer attempts to hold the thread on her emotional response, she briefly does so, incongruently laughs and then shifts rapidly again to her husband as the major issue.

I: What was that like for you?

S: Um....I just felt really terrible (laugh). Yeah. Felt really terrible about it. But he..see since then we've had. J___ was suffering from Post-Traumatic.he went to Vietnam.

Her husband is later described as a workaholic, and that she was left to manage the four children on her own. At one point in the interview, she describes being so desperate that she contemplated leaving the marriage, but could not follow through. Ownership for the thought of leaving, in order to lessen the internal conflict, is projected onto her daughter via direct quote. Distancing 'you's' are also employed to maintain emotional distance. Her dichotomous 'either-or' style of thinking in crisis supports her appraisal that her parents were not available to her. Talking to Lifeline leads to no conclusion.

S: And um, L___ (daughter) asked me one day "Mum, why did you stay with dad?" And once I went to.um...went to Lifeline, 'cause I thought.like if you're going to.this is what I.I reckon..if you're um, serious, ah.um, about leaving someone, you don't care what'll happen, you know, well I've got four kids, where will I go what will I do, I can't go home. But if you're serious.like, you

don't care. But, up until that stage, you think well where will I go what will I do there's nothing I can do, but I got to the stage that "I can't stand this any more. I've got to do something." So I went to Lifeline and, talked to the woman there. But, anyway, L___ (daughter) said to me "Mum, um..why did you stay with dad?" And I said "Well L___, I know God meant me to marry dad", I said "And we love each other." And she said um. And we still do, and she said, um.and years later, she told me, she said "Mum, if you'd said you'd stayed together for us" she said, "I would never have forgiven you, and I would never have wanted to see you again."

I: Gosh.

S: Because.to stay.because they went and had a terrible time, why would you stay? For our sake. What.wel.well.what sake was that? You know, we had a terrible time, so. But I mean, um..L___ would say now "I never thought I would get this close to my dad, I wouldn't".you know, and my son A___, I can remember years ago he said "Oh..if um, dad hadn't changed, mum I wouldn't have anything to do with him." But see, they're good mates now. So it's just.that whole.whatever happened way back then.

She has had enough of this discussion and dissociates from knowing what went on. Her parents were not available for the measure of support she needed.

I: Mm. When um..when you were pregnant with.M___, and.you know, in the first few months, who did you have for support?

S:Nobody. (very quietly, with tears)

I: No...and just recalling that time.it's still upsetting. Yeah. (hands tissues)

It's not what I'm planning to do, but yeah. Yeah. It's tough. Mm. So, where were your mum and dad?

S: (blows nose, speech garbled by tears and tissues)

I: Mm. And did they have any idea what you were going through?

S:I don't know. My mum and dad.um, they did come up to.they come up to Q___,for (sharp inbreath)..probably five years um...up at N___ and then four down the coast, much to the...my family.my sister's never forgiven them. Hah! Funny thing they were leaving their..grand..their grandchild.their kids down there at that time. Never forgiven them really. Dad just passed away.a little while ago, but um. But mum and dad were really quite.selfish in a way. They never.involved themselves in anything the kids my.sister's older than me and

my brother, they never went and saw the kids do anything, they were very..in to themselves really. And never um.

The tears are not dissociative, in fact she is connecting with her emotions, but there is little opportunity for empathic listening because of her quick switch to resentful blaming. This may well be a long-standing pattern for this mother, and has the potential to heighten her sense of isolation.

Mother talks of her participant son as always lacking restraint, and that she could not contain him.

He was really a.a.boist.um.not boisterous, yeah, really. Yeah, he just always pushed the limits, always and, we used to encourage his.I think.I think the teachers.oh one teacher in particular, he's now a pastor, and he was a teacher, he um..I think he thought well J___ (father) was too hard on M___ 'cause J___ used to say "J___ (teacher) you've got to bring M___ back in, you can't let him push through the fence. The more he pushed through, the more he'll want to go further. You've got to bring him back". And I think J___ (teacher) thought J___ (father) was too hard, and J___ was pretty hard, but M___ was like that, and he did need to have those boundaries.

Filled with irrelevant microdetails, mother expands on her participant son's early behaviour and its continuance into adulthood.

And he would drive me.like he wanted to go across the road and play with B___. There weren't many kids round out where we live, and there still aren't. It's on T___ Street, main street, not many kids, and B___ lived across the road. M___ would want to go over there and he'd say "Mum, can I go, can I go, can I go?" And I'd say "No M___ you can't no you can't no you can't" but he'd keep on and on and on and on and on. One day I said to him "M___, look it's being disobedient you keeping on asking me, 'cause I'm saying no you can't." Um, he was.he would just continually.but..and then he would try to do.g.get me.to give in to him for something, and he'd.on and on and on and on, and so. "Ask dad ask dad ask dad" or.whatever, but when J___..when he realised he couldn't get it, he would stop dead. You know, he would push you and push you but then he'd.J___ said "No M___, you cannot do that!" He'd forget it as though he never wanted to do it. He's still very much like that today. Still very much. He'll push and push want want want something, but when he finally resol.realises no I can't have it, he can stop

dead. As though he never asked for it. And he was like that as a little kid as well, and he still does that today I've noticed, yeah. So um.

Although mother complains about her son's insistent pleading, she delegates discipline to father, and then criticises him for being too hard. Later mother tells of an incident when he got away from home, and was rescued by a stranger from a busy road. Once again, father is blamed although mother is home all day.

S: And do you know, another time he got out on the road..in the middle of the road, cars tooting and a woman brought him across.and.the family was supposed to be watching him. And he.got out the front and.the patio had these.it's got..the end of it.it's got this, and it's got.squares, and it's holes, some of them are holes. And I'd been at J___ to.to wood it up, 'cause he was older, and could get out. No he hadn't. He had this bright orange jumper and I heard this tooting and I look out, and here's M___ in the middle of the road. (laugh) So, yeah.

In the latter part of the interview, when the tape is restarted after she returns to the interview room to relate her half-hearted attempt to abort, this mother reveals a capacity for self-analysis and reflection that is not apparent in the rest of interview. SCZ005: Three themes were described. This mother had her first three of six children in two years and two days, the family was relatively poor, and father was alcoholic. She reports being very stretched physically, and mentions her fatigue several times.

S: ..Well...I mean eh eh, I was really flat out at the time, I had.three children..in two years and two days. T___ (participant) was the middle one. And um...I mean they were all babies together, so.I really had no time.to do anything...ahm, once one'd cry they'd all cry, once one was hungry they were all hungry. So, if I went shopping..I never had.anything to carry them in, I used to take 'em on a bus, and have to nurse two and let one walk. But they were good kids really, they all kept one another..company, they'd be like triplets because (laugh) they'd all.play...as I said, they were all hungry at the same time. But I never really noticed anything wrong with T___.

This opening part of her story is relatively coherent, but she is speaking in a confused manner about having only her second child as if all six were already there. Later again she talks of the time when she only had two children as if all six (or at

least the first three) are at home. There is a sense of the participant child being lost. The interviewer again has to drag her back to the focus of the research.

I: How long were you and T___ in hospital after the birth?

S: Well, in those days, for the first two, um, you were in hospital for..you were in bed, for er..ten days, and then you were allowed up for two days before you went home.

I: Mm. That was the standard.

S: Mm. That was the.the pro.procedure, yeah you didn't get out of bed.

I: And that gave you plenty of time to..

S: To rest, yeah. That's right. And, then when you'd get home and the kids'd start screaming, you wouldn't know what to do with 'em! (laugh)

I: So, what was it like?

S: Well! It was chaotic..you know, as I said, they'd all cry, because one'd start crying, that'd set the others off.

Quite early in interview, she becomes focused on a major cause of her fatigue, with a flavour of resentment.

I: While you were pregnant with him, um, what can you remember was.happening in the family? Other things that come to mind?

S: (Sigh) Well (ahem), when we first married we were living.in a..flat, and ah...my husband was working, and I was working at the time, but I gave it up..and I was earning more than what he was. So from then on, we found it pretty hard.

I: Financially?

S: Financially. And we moved into.a.a flat..where there was no water...no running water..we had an underground..tank, and we used to have to pump all the water... and I was pregnant..and have to go out and pump water for the.the wash. I use to feel pretty sick sometimes, I didn't feel like going out and pumping water to do the washing...and ah...it was really traumatic.

I: Mm. What was traumatic about it for you?

This seems to be an over-dramatisation, and her explanation of being ill with morning sickness is quickly relegated to insignificance. The listener becomes uncertain whether the initial comment about their living conditions being traumatic is because the interviewee is being falsely compliant with what she correctly perceives

as the focus of the interview, but is making a nonsense of the term, or whether the interviewee has found the interviewer's response inadequate.

S: Well, as I said, I was sick..you know, I'd be.have morning sickness...and then I'd have to go out and..pump up water to do the.the washing of the first little boys, you know like..wash his little clothes and...no I was um...I wasn't..you know, really that sick...it was just, you know I had morning sickness but I soon got over that.

Throughout interview, mother is determinedly avoiding discussing her participant son's earliest years, and focuses instead on his record achievements at school in academic and sporting arenas. When the interviewer brings her back to the earliest years, she returns to the theme of resentment, hidden within a presentation of helpless acceptance.

I: Just going back to the very earliest years, um..in the family, who was the main problem-solver, between you and your husband?

S:We didn't have any problems. We..we didn't have much of a life but we just put up with it. We accepted everything..tried to help, you know, one another along..but..we never used to have any problems, we never used to fight, or..argue about anything.

I: Mm. So, when there were decisions to be made.um, who would do that?

S:We didn't have any decisions...we only ever..he only ever went to work, and I looked after the children. We went on holidays once a year...but..as I said, we just put up with..our life the way it was.

I: What was good about it?

S: (Sigh)...I really hadn't expected much I s'pose, and I still don't. I try to make.you know, life...well, I live it the way..I can. There's no..I don't try to..you know, be someone else or..try to better what I've got. I just accept what I've got....I've never tried to.you know to.. push my husband into working harder or, saving more money..I mean we just..just go along with the.flow, as the saying goes (laugh), and put up with...We'll always be poor, but..I mean, we've had plenty of good times in our lives. Plenty of sad times, but..the good outweigh the bad, I suppose.

Father's drinking is presented as not relevant to the purpose of the interview on the one hand, and then of being a major intergenerational problem with disastrous consequences on the well-being of the family, including financially.

I: What are your thoughts about how come he's got this illness?

S:That it's in the genes. They reckon it's in the genes..I don't know, his father's an alcoholic now, he wasn't then, but he's been drinking since he was 17 years old..and his father before him..yes, they were alcoholics, so I mean he's just..just like his father..but he's not..really like his father, because..he used to sell up everything to pay for his grog..where J___'s (husband) still working to pay for his.

There is confusion of person for the listener throughout this interview, as if mother's disconnecting style is habitual.

SCZ006: This mother notes three contributors to her exhaustion, and as stated before, is the least dissociative in her narrative. She makes connections between her worry and stress and effects on both herself and her offspring from the beginning of interview. She describes the unavailability of her parents for support in the context of over-burdening responsibility on herself as eldest of eight children, her father's potential for sexual abuse and his hostility towards her husband, and her mother's fear of disobeying her husband.

S: I had a father who hated my husband, and he really made life hell, and stupid me, worried about..trying to please dad, and trying to please my husband and I.I was a wreck when I had J___.(participant son)

And:

S: I was desperate. And mum wasn't game to come near me on account of dad and, you know I was here on my own trying to do it (sharp inbreath)..

And:

S: But the worst thing was the fam.my.family..not being sympathetic or not caring about me. Huh! And my father was very possessive of me.

I: Yes. With good reason.

S: And..there were times when he would have gone a little bit far, if I hadn't had the instinct to...know what he was about.

This mother also reflects meaningfully on her own illnesses with all her pregnancies, and this is covered in both the Trauma and Attachment sections. Her post-miscarriage distress would have added to her chronic fatigue after having several children.

S: I had aw.awful trouble having babies.

Her insightful reflectiveness is maintained as she discloses more about her traumatic pregnancies and miscarriages.

I: Yes. M___ was there any time when J___ was really little that you were frightened that you were going to die?

S: No. I haven't thought I was going to die but I thought I'd just go out of my mind and I yeah. I'd just couldn't cope. And I'd be trying to hide this and I've had. I really had more times feeling like that than I've had being normal.

The parlous physical state of her infant son has been covered in the previous section. This child became very active according to mother, and her repeated emphasis on this suggests he may have at times of her illnesses been too much for her. At start of interview, she spontaneously remarks:

S: But he was a fidgety. he couldn't sit still. And he was always building something or making tree houses and making little farms. He never stopped. She continues soon after this:

S: It did, but I was always worried about him, because he couldn't relax, he couldn't stop he..w.was..you know, on the go.

Somewhat later, mother focuses again on her participant child's activeness.

I: No. Ahm, did you have any worries..um, about..you said about when he was about twelve months, you were a little more easy in your mind about him. Um, so from twelve months to say, three or four, did anything happen to cause you concern about his health, or..

S: Oh no, not really, except that he wouldn't keep still. But ah (laugh)

I: (laugh) Did you always know where he was?

S: Oh yeah, w.n.he never. no he wasn't a bad kid. He never ran away or..never, no he was a good kid. Mm.

And further on in response to the interviewer asking in what ways her son was alike and different from his siblings:

S: Well he was always on the go, and that was different from the girls. There was none of them..like him...on the go. And the only one. I mean. d.er. Y___ was the one, I told you about the bad breakdown, she certainly did work hard at school and all that. But she wasn't...go go go like J___. He was just ah..

Father was away a lot because of work responsibilities. Mother talks of his lack of understanding and support initially for herself during her illnesses, and then also when her participant son became ill with schizophrenia.

S: Mm. He was a member of (organisation). Member of everything.

This participant is aged 50, and his father died some years ago. Mother speaks of her husband with some cynicism, but also with ambivalence.

S: 'cos dad was always away

And later:

S: No and he (husband) wasn't understanding with me.

She repeats this in response to the interviewer later tying the threads together:

I: Did you have anyone that you could..share with? You were saying D___ didn't understand. Was there anyone that you had?

S: No. He didn't understand.

Clearly this mother reports little support from her husband and her parents at times of extreme stress due to her history of recurrent miscarriage.

SCZ007: Three themes were noted. This mother opens very succinctly stating that she had four children in quick succession, and that she at the same time helped run the family farm and a school bus run. Her mother lived on the property, and helped with the babysitting, but her participant son on at least two occasions could have been seriously hurt or killed due to his escaping mother's care.

S: Ye..yeah.yes, I do remember, because he's.he's our.we've got four children, he's our youngest one.

I: Mmhm.

S: And there's only just twelve months between the last two, between..A___ and G___. (participant)

I: OK. Mm. So what was it like for you, when you knew you were pregnant with.G___?

S: Oh I was quite happy. I mean.our children are all close together, but our eldest one J___, she would've been..she wasn't quite five when we brought G___ home, so..I sort of did have my hands full.

I: Mm!

S: But I say, I still.reckon in that year, I was more organised..than I ever had been before or since, which you just sort of.had to be.

I: Had to be, mm.

S: Mm. We had a school bus run too, which I used to do..you know, plus the farm.

By inference, father was occupied much of the time due to work commitments.

We used to do the school bus run, and we did it for twenty-five years actually, so we did it all the way through his..all their schooling

Mother reports a very settled baby who slept through the night from very early on, but expands throughout the interview on her need to be very watchful of him because of his liveliness as soon as he was able to walk.

S: He was no problem at all. As a baby.

And:

S: He was really very good, a really happy baby.

I: Yeah.

S: And..and..a little..he was a very mischievous child.

I: Was he?

S: Yeah. As he grew up, he ah..

I: What can you remember?

S: Oh no! B___ (laugh) got a new tractor, and he went over to the shed..he walked at ten months..he just ran off actually at ten months old, he took off and..and he um, got a hammer and he smashed (laugh) the ah..you know, the little..what do you call them, sort of a..oh, sort of control panel thing.

I: Gauges?

S: Yeah, gauges things, yeah. He hit th.it (laugh) fair with the hammer.

He'd..he'd take keys and..

I: What did B___ do?

S: Well he wasn't very happy, but he couldn't do too much about it.

I: How old was he when he did that with the tractor?

S: Oh. Probably not that old. I mean, fourteen, fifteen months he could have been, I don't know. I can't exactly remember, but he wasn't very old, but I mean he was..you had to watch him all the time 'cos he was so quick.

Again later in interview, mother describes her participant son's activeness, sufficient to put his life in danger.

S: Oh, when he was young, when he was a baby, he was absolutely no problem. When he was..then he got a toddler, he was always..

I: Off?

S: Yeah.

I: How on earth did you keep an eye on him?

S: Oh well. I don't know. We did. (laugh)

I: (Laugh) So he didn't um..

S: OK. One night um...like as I said, my mother lived not very far from us, and my sister.had come over. And we'd sort of been over there, I don't know whether we'd.both been with mum, but we'd always go over and have a cuppa tea anyway, and then I'd come home with the kids, and I was sort of getting tea, and C___(mother's sister) was.it was just on dusk, and she was just going to.go home with her kids, and she came to reverse out.she just heard this little voice behind her, and it was G___. Yeah, so he'd.been home and.he'd raced all the way back to grandma's.

I: Mm.

S: And that was lucky. He's got nine lives. (laugh)

Mother had not noticed his absence. This researcher is not implying bad mothering, but that fatigue through having too much to do plays a major role in the potential for childhood accidents. Mother recalls a specific incident at a public park when her toddler son got away and is rescued near busy traffic by a stranger.

I: Mm. So just casting your mind back to say...when he was three and younger, nothing stands out as..um.

S: Only that he was such a tiger that you had to..I mean I know one.day, we were down at.it was.I think it was C___ time, we were down at ah..oh what do they call that place down where the.W___ M___ is? They've got sort of a lake there. It's probably changed a bit.

I: Lake A___?

S: Is that Lake A___? It might be, but..anyhow, it's down there.

I: Yeah. Near Q___'s Park.

S: Yeah. Across the road..from Q___'s Park. There was a whole lot of people there, and there was ah.loudspeakers, I don't know whether it was loudspeakers or what was there really. But we were down there and ah.just turned around and.G___ wasn't there. He was about, probably about eighteen months old at that stage. Yeah (sigh) I couldn't see him anywhere. And.and B___ went up and they.announced it over the loudspeaker, and then

I was just walking out towards um, M___ St. and this woman came along, she said she picked him up just as he was.go.walking out onto..yeah, ah, M___ St. Just about to. Yeah, but I mean he'd get away very quickly.

I: Mm. When did that stop?

S:Oh. I don't know, probably when he was.old enough to know a bit better, four or five or something.

The above is all relatively coherent, and mother expresses warmth and concern, but retreats frequently into 'not knowing'.

SCZ008: Seven themes were presented. This mother reports family events related to her exhaustion. Following a failed business venture and resultant financial stress, her husband was 'sent away' for six months the night her participant child was born as he could not get work closer, and they had moved recently away from other family. Her son's behaviour is challenging for mother. Father's alcoholism is gradually exposed late in interview. Mother's opening remarks cover his physical absence due to work from the time her participant son was born, and the resultant problems of bringing up two small children in an isolated new community.

But no, we come back.L___ (husband) was working away..at.by then they'd sent him out to B___, and um.the night N___ (participant son) was born..'til he was six months old, he was only coming home occasionally for weekends. So I was bringing him up..two little ones on my own more or less.

I: Yeah. How was that for you?

S:Oh, can't remember it, but I did have close friends.neighbours either side, you know, we used to be.quite friends with, so..ah...I don't think it worries me that much. I knew...ah..housing..like, there were only a few houses around, so..we had our.each other, kind of thing, the other mothers.

She raises how difficult it was bringing up two small children on her own, but when the interviewer focuses on her feelings, she retreats into not remembering, and appears to dissociate from her feelings. Her son was frequently ill with tonsillitis, and her not remembering is interesting, particularly in the immediacy of her response to an invitation to reflect on her own feelings of being isolated. By inference, her parents were not available for geographical reasons until the family moved back to be with the mother's parents when the participant child was eighteen months old. Embedded late in the interview mother states that she had to start work as soon as

they moved back to C___ P___ when her participant son was eighteen months old. They moved from a caravan into a house during the pregnancy with the participant.

S: We moved into a house...when she.about the time I was pregnant with.ah..found I was pregnant with N___(participant), I s'pose. L___ (participant's sister) was about ten months old.

Mother does not report any stress or difficulty with the move.

No, it was..a pleasant time I think, you know. We'd just moved in to a house, and done all the things out.we were.getting a garden.done.

But the next move, when the participant is eighteen months old, appears to have been generated by needing to help out on the parent's farm, as well as soon after needing to look after other family members' property. The work her husband had in G___ did not work out.

I: They do. Yeah. So just.reminiscing as much as you can, um....

S: Well we moved back...from.to C___ P___ to my dad's farm, when N___ was..six months old. No, he might have been eighteen months old. Yeah, might've been eighteen months old, 'cos L___ would've been just three, I think. And there's eighteen months between them.

This researcher becomes confused with times, names, relationships and reasons, reflecting the interviewee's style of communication around what is later revealed to be a very stressful time due to the participant's father's alcohol abuse. Note the incongruent laughter, and mother's regret over moving from a new house to an old.

S: (laugh) Mmm. Yes, and then when..um....brother-in-law, No___'s sister's husband.ah..had massive heart attacks, we moved in to look after his place, so he was in hospital ah..L___ managed his place as well as the irrigation, and um.everything had to be done in harvest times so, we moved down.to their pla.or um.L___ might have managed while we were still at the old place then.we went into the really old house I grew up in.from.like.new house up at.G___, and then they.moved a house in, when L___ was out.the other L___, that's brother-in-law L___, came out of hospital, ah.they moved a house onto the property, and we lived in that, until we moved to J___, when N___ was about...he was in Grade 7, I think so he'd be about eleven.I s'pose, when we moved to J___.

Part of the confusion throughout the interview is due to the fact that mother's husband, brother and brother-in-law have the same first name.

I: Yeah! That's good. Yeah. Um...just to, you know, get a clear picture..you were saying, um..was it your..brother-in-law had massive heart attacks?

S: Yes. Brother-in-law L___.

I: And um, yep. And L___ helped out..very much there.

S: And we looked after their children for..probably, up to a month.while..sister used to be in the city all the time.

I: Yeah.

S: They'd come and stay with us.

It is later in interview, and not in response to a particular line of enquiry that mother is keen to tell the interviewer about her participant son's difficult behaviour. The incident with the tank is important in a rural environment, as the household depends so much on rainwater.

S: No, no. What I remember of N___, when he was young.you'll probably want to know this, is when we were living in the old house and he was young.three, four, five.he was so determined, and obstinate, and.and..loving. At that age when he was two to three, you'd tell him not to touch the TV, he would go and touch it, turn around, look at you and grin. You'd take him away, probably smack his hands, take him away..he'd just deliberately go there and do it again, and watch and grin and laugh at you. And the same with the rainwater tap, you know, in those days, you'd have.you only had rainwater, um..we had one little tank, and he'd.go and turn it on and just let it run. You'd.find him, you'd.rouse, you'd take him away, and he'd just go back and do it again. So yes, he was a very determined little boy (laugh).

I: Yes. So what.what did that do to you?

S: Made me mad, of course! (laugh) But yeah, as I said, in those days, you did smack them and yes, but ah.he'd just go and do it again. It was as if he was trying yo.you out, see how far he.would go.

I: Mm. So when you smacked him, he didn't get up.upset?

S: Probably. But yeah. But he did that in.with everything, he just.was very determined little boy.

Mother then appears to completely misunderstand this interviewer's next question about the participant's behaviour being different from his two siblings.

Mother appears keen to present more information about her participant son's early behaviour.

I: And L___ and S___ were different? (participant's siblings)

S: Not at that st.age, I.ah.I don't think so, but growing up they.grew apart

It is very late in interview that mother finally talks of her husband's alcoholism, and then very circumspectly.

S: Me. L___ was never there. When we were on the farm, he'd work 'til dark and ah, kids were little then. S___ was only..N___ would have been elevenish I s'pose..when we moved, and then..we had to go over. L___ pulled the doors down in the garage and went in the pub next door. Ah, by the time he come home, the kids were ready for bed, so..

Then follows another confusing passage about moves and reasons and times.

And he did.L___ didn't want to leave but, I did, and the children did, so.

I: Why didn't he want to leave?

S: Because the pub was next door. Am I allowed to say that? (small laugh)

And the fact that probably, ah, he'd just given up on his job I s'pose, yeah.

But he loved the farm, he grew up on a.a farm, he was a farmer too.

I: Had he had a bit of a drinking problem?

S: Not 'til we moved in next door.

This interviewer cannot follow mother's compressing time to a degree that nonsensical statements appear linked by emotional states rather than by grounding events in a sequential timeframe.

I: So who was the problem-solver? You know, you were saying..

S: Well I had the children.all the time, and if I went anywhere the children went with me..because L___...just wasn't there for them, so..Even at J___, he played bowls..weekends, so...After G___, I had to get a job, but by then...oh yes, N___..N___ was home, because I used to dread going to work..um, N___'s not going to hear this, is he?

Mother skips from the time she had her participant baby son and they moved from G___ back to her parent's farm, to when her son as adult became suicidal. Note that she comments on having to get a job after their move from G___ when the participant was eighteen months old. They were in financial difficulty, without reasons given. Mother ends the interview commenting on her son and husband having little relationship, and putting that down to her husband's drinking.

S: N.no, they.no, they just.huh! Live in the same house (laugh). When they're together, you know. L___ doesn't go out of his way to talk to him, and.and N___ doesn't go out of his way to talk to L___, so..maybe it's something to do with L___'s drinking on N___'s part. I don't know. Like um, he knows how.I.suffer because of it, so maybe.emotionally him and I might be connected..that he, you know, resents it a bit, or something. I don't know.

I: Mm. So you're able to say..you resent it a bit.

S: Oh yes. Affected my whole life. Mm.

I: And you're still together.

S: I don't know why (small laugh).

As already evident above, father was away throughout the upbringing of the children, either through work commitments or alcohol. Mother has a confusing manner of presenting information about the many reasons for her fatigue, as if tracking of events would force a construction of agency upon her.

SCZ009: This mother narrates three major contributors to her exhaustion. Her parents were unavailable, father was away frequently and she had many children close in age.

S: (indrawn breath)..Probably.ah..first week or two..wasn't quite so happy but then.I'm.one of these sort of persons realistic persons I accept things as they go on.because I'd had three children, I had four children in four years. So she come along.(small laugh) we had a.and I was milking cows as well, so, you know, we were very hectic ah..but..you know I.I wasn't one of those people to get too upset.just.

The busyness is repeated for emphasis almost immediately, with justification.

I: What else was going on at that time? You said you..

S: Oh! We were very busy.um.....no, eh.nothing extraordinary as I can remember, but uh....three weeks before H___ (participant) was born, P___'s (husband) father died very suddenly, ah...wasn't any.great.problems there..uh, as I said I was fairly re.fairly realistic and just got on with the job. It did make a big difference in our life after H___ was born..'cos P___ had to..t.take over looking after the..family.business.which was another dairy farm.help his mum a lot..in that respect..ah..

I: Was this farm close by?

S: Yes, only about five mile away. We used to visit two nights a week. We were always very tired (small laugh). That was par for the course.

I: I can imagine.

This interviewee presents no complaints, but continues to emphasise how fatigued she was, and the reasons for that.

Aah, no.that's the way it was ah...P___...used..after..when H___ was small was away a fair bit..looking after family business and then..got involved in business in B___ that sort of thing and.my brothers used to come out and help, but we.we were really a fairly happy.family on the whole, you know. Very busy but.very busy and er, and lived a very simple life, we didn't go anywhere, do anything much.

This mother and father were already helping father's father during mother's pregnancy with the participant.

S: Oh well, th..probably the fact that he realised that.we were working pretty hard and.and I mean ah..

I: So, you were already helping out a bit..

S: Oh I was.I was milking cows all the way through, you know, and ah..we didn't have electricity.so..at that stage, we didn't get power on to the bales until..H___ was about three year old we got.we bought new bales, so..you know, things weren't..simple.

I: Yes.

S: But ah..'cos you never know when the old cow engines wouldn't work, and so then you'd be nine o'clock at night before you finished milking cows and that sort of thing, but.when you're young you can accept a lot of that. Or we.we did anyhow. That was par for the lot, of course.

Then mother focuses on one of the major stressors for this family, father's unstable diabetes and frequent crises which was covered in the previous section on Trauma. After this is explored, this interviewer asks for further memories during the pregnancy with the participant, and mother again focuses on their busyness, with her retired parents not really able to provide practical help.

S: No! No, I'm trying to think..P___'s dad died..was the traumatic one probably ah.....No I ah...you know, we were just very very very busy. Very very busy.

I: And where were your parents?

S: Oh in S____. Only about ten mile away. They had retired. They used to live on the next door place and they retired..ah...just a few days before our second child was born, and ah..they lived in S____, and ah... You know, the children always got on..very well together on the whole, when they're so close in age that they do. Ah...

I: Bit like having quads.

S: To a certain extent! (laugh) But the eldest son he was..such a responsible person still is, and I think..that's what the eldest one always does become..when you have a close family. Because they become very responsible.

I: How um, how many months between H____ and the next one up?

S: Fifteen. Mm. And there's thirteen months between ah...the second and third, and there's twenty between the first and second, and uh..but, you know...I had a miscarriage between those two.

I: Between?

S: Between the first and the second one, that's why there's twenty months I suppose (laugh).

In response to a general question to encourage reminiscing, mother again returns to father being away a lot, and her unresolved anxiety regarding his safety is evident, perhaps more so because of his uncontrolled diabetes. The possible effects on the participant's attachment relationship with her father is discussed in the next chapter on Attachment.

I: Um...what about um, that same sort of question um..can you think of five other things going on..for the family, or for you um..in H____'s first year of life?

S:Oh.....I..nothing stands out particularly. P____ had to...look after the..do a lot of work for the family business and was..up and down for the family and doing things..ah.....early..no I..I really can't think of anything..that was..ah...stood out, at that time. You'd have little everyday things..ah...but..there was no big thing that's happened in our life, you know, we....as I keep saying we're a most fortunate family.....ah..there were no road accidents. P____ was away. H____ always..I think..sh..she felt she didn't get on with her..dad as well as she might, her and I we thought..she wrote a poem when she was in high school about..how she could always talk to me, and..and

that, but I kn.know she sort of felt a bit apart from.P___ in some respects because he was away so much. But then, some of the children may have done a little bit of that, the rest of the family too, because Ph___ (participant's brother) says well, when he was young, he can remember dad being away a lot, and dad was, he was away in B___, on business.and all sorts of things and doing things for the family.

SCZ010: This mother reveals five contributors to her exhaustion: The family lived a very long way from mother's mother; both she and her infant son were very ill, and the next adopted baby also was very unsettled with feeding problems and her son who was adopted was very unsettled, difficult to comfort and hard to discipline; father was of necessity away a lot; they were poor because of the drought; and they had to move frequently for the same reason. As noted in the previous section on Trauma, one needs to do one's sums to realise that mother contracted Ross River fever around the same time the family had to keep moving because of drought, and at the same time, the participant as infant contracted severe measles. This researcher is unsure whether the mother's lack in interview of tying these themes together is because of lack of insight, or whether shame or guilt (a common maternal theme when offspring have a mental illness) inhibits open disclosure, or whether it is too overwhelming.

Mother responds to a question about who she had to confide in, and she tells of a close-knit community, with father away a lot to check dams, etcetera.

S: Yeah. Mm. 'Cos a lot of the families, the fathers'd be away.

I: Mm.

S: Checking dams and fences and so on.

I: Yeah, it's....Ahm..you said you were in C___ first, and then moved to L___.

S: Yeah.

I: What.ah, how old was O___.

S: Oh he was only.when we shifted, he would've been...oh, probably six months old. Yeah.

As previously covered in the section on Trauma, mother was very ill at the same time as her participant son had measles, and her fatigue has been episodic.

I: Yeah. And.and you've been basically really well?

S: ..Oh, except when I got Ross River.that sort of.threw things.cat amongst the pigeons for a while.

I: When did you get that?

S: Oh, sometime when they somebody asked me that the other day, 'cos I still get relapses of it. despite their..

I: Yeah.

S: Probably round about the time. well it was. during the time that w. I was living in town, and going out of town. Yeah. Probably be thirty years ago or better.

Mother had some support from her geographically distant mother. Again we have a mother who has lost a parent within the two year period before the arrival of her participant son.

I: Mm. Mm. I know what I forgot to ask you. Um..what about your parents? Um..were they able to give you. some support when you were. when O___ was young?

S: Ah, well. bearing in mind that we were a long way apart (laugh). And my father had died when I. O___ was. before..before O___ was born. You know, before we took O___ home.

I: Just before?

S: Oh...I think it was a couple of years. So..yeah, mum was always reasonably supportive, although she always said if you. smacked him more, he'd be better but. it never made any difference, so I gave up on that one.

I: Whereabouts was she?

S: She's at C___ H___.

In practical terms, mother's mother could not have been available in the early years.

I: Mm. So it was mostly. phone contact?

S: Yeah. Oh, letters in those days. It was too expensive to ring. (laugh)

I: Mm. Well that's a point.

S: Probably couldn't hear anyway. (laugh) When you did get through, so that didn't help much either.

Their poverty was due to drought and having to move as circumstances dictated.

S: No....oh, our biggest worry then was drought. More drought, drought, more drought.

I: Yes. But um..what did it actually.do? That's a silly sort of question, but..um..with the drought, I imagine you had to keep.revising decisions..

S: Oh yes. You would've had to. Um..drought always meant.bogged animals, animals dying..um.and.and a revision of your.financial states continually I mean, that was just..

I: Yeah. Was there ever a time when you really felt with your back to the wall?

S: Oh often! (laugh) That just became part of your daily..

Although life was tough, poor nutrition does not seem to have been an issue, and mother's focus is comfortably practical when describing her coping with drought.

I: So..how did you manage that..um, emotionally?

S: ...I think it goes into the basket where.you can only do your best..and really there's nothing you can do about it. Whether it rains or not's entirely out of your..you have to accept somewhere along the line.there are those things you can alter and those things you can't. Well if you can't, throw them out and just get on with living, you've got to do something.

I: Yeah.

S: It did curtail the fact that if you wanted to go for a holiday you couldn't go, or things like that but, yeah.

I: Yeah. Was there ever a time when.things were so financially tight, you worried about.having enough food for everyone?

S: Oh no. That's one thing about being on a property, there's always meat.

I: Mm.

S: Unless they've all died of starvation (laugh). That's if they.I mean they got a bit tough now and again, but no, there was always meat and milk and.and we grew our own vegies so we weren't in that.that situation.

This mother impresses as being resourceful and determined to do her best for her children throughout interview, but there is also a defensiveness which leaves the interviewer wondering what has not been said.

Examples of Maternal Fatigue in the Depression Sample

In the depression sample, 3/10 mothers in the fully transcribed interviews, and 10/25 mothers in all of the interviews reported maternal exhaustion or being hectic/very busy when the participant was an infant. Six more of the ten fully

transcribed interviews have indicators of potential fatigue, although the mothers do not complain or present it as such.

DEP102: One theme, that of mother's parents being unavailable for support was evident. This interview is somewhat problematic. The participant identifies his mother's cousin as his primary caregiver, but she does not have a full history of his earliest years, nor his middle years growing up. The information is very patchy, and caution is exercised in defining which themes are present. However, when his biological mother abandoned the participant at the age of five years, it was mother's cousin who took him in, rather than mother's mother.

S: Yeah. And he's sort of still one of my kids sort of.

I: Yeah.

S: I still care. Probably. why he mostly he calls me mum.

I: Mm. (both laugh)

S: But um, yeah well when he. when we're talking, it's always F___ and M___, (participant's biological parents) and I'm mum.

I: Yeah.

S: He calls me mum to me face. You know, so, his parents are F___ and M___ so, he must feel..you know, that I do care, you know. He must have that feeling.

She had already done a lot of baby-sitting of the participant as infant because of his mother's restlessness, and clearly knew him from birth.

I: Yeah. Mm. Now H___, what's your. very earliest. memory of J___?

S:Mm, I don't know, when he was a baby in his mother's arms, about that size, yeah.

It is by inference that the participant's mother's mother was unavailable to take care of this child.

S: Yeah. Mm. Yeah, I think J___ has always been probably closer to me than anyone else in my family.

I: Yes.

S: And..mm. He said he was. close to his. grandmother S___.

I: Mmhm.

S: But I didn't know her, so..

I: That's his dad's mother.

This interviewee reports looking after many street children, and this interviewer wonders how available she truly was to the participant as a small child. DEP103: Two themes were identified. Mother says she was exhausted, and that the participant child was sometimes too active for her. This mother relates her fatigue as being due to her very active child. The participant is her third child, with reasonably well-spaced pregnancies, her husband attends the birth, while her parents come to mind the other children. There were birth difficulties, covered in the previous section on Trauma, and as a consequence she explains her ongoing concern about her participant son's intellectual ability. Somewhat later in interview, she describes having a toddler and a baby together as stressful and tiring, but the emphasis is on the active getting away of the toddler, the participant's older brother.

S: And (small laugh) I.I can recall..I think it was a bit hard...I think..oh..having the two year old was.I found it..at.my.I thought, well..two years.you know, I'd planned, you know, two years apart, that'd be fine.

I: Mm. Mm.

S: Um..the other.baby'd be starting to..be, you know, fairly independent, and easy to look after, but I forgot.that there was a thing called the terrible two's.

I: (small laugh)

S: So that was a bit.traumatic, trying to, I think.the other fellow.must have missed.um, felt that he was...um, missing out.on some.a lot of attention I guess. We had to give little babies more attention and..

She seems to have lost the thread of staying with the 0-3 years.

S: But uh, I can recall..well, I don't know how.how.young you want to go.ah, how.this one, well he wouldn't have been very old when.he..it was before he went to school.so.

I: Mm.

S: We had.we got a um.a shetland pony, and..shetlands seem to be notorious, you know, because.adults can't ride them, they are.they.they seem.to put..and of course you only..only a.a small child can ride a shetland, therefore..and small ch..n..normally can't ride, so..

I: Mm.

S: The...shetlands seem to put it over kids.

I: Yep.

S: And they can't ride them, but anyway. And this one was a little bit. like that, it was. we got it from some people, and the kid hadn't ridden it very much, or. you know, put it over them and uh, it was a bit. bit stroppy, little bit sour-like you'd say, but. but um..it didn't seem to. worry L___ (participant son) he's..it was small, so that they, you know..he used to be able to put the bridle on himself, he'd catch it and bring it over..to the houseyard, and..um..if he didn't want to ride it..we have a trampoline here, so he'd tie it up to the trampoline and then proceed to jump on the trampoline, the horse'd be going berserk but.it didn't seem to worry him that.the horse is carrying on like that.

Mother then indicates that his behaviour was of some concern.

I: Sorry. I was going to say, looking back, can you. think of something that L___ was good at when he was really little?

S: Oh!....Um.....oh, like what?

I: I don't know! (laugh)

S: Good at (laugh) good at getting into trouble. No, like most children. No...

I: (laugh) Can you think of any trouble he got into?

S: No..not really. No.no more than ah.normal little.children. And I.I can't recall any incidents.

This would not appear to be in the least evasive, but mother then describes her son's impulsivity and recklessness.

I: It sounds like L___ was a lively little boy.

S: Yes. I think so, whereas his older brother was.they were very different, both.you know.that.the three children were all different of course but, the two boys, because they're.close in age..um, are very different. One..M___ was always slow and..and a.a deep thinker, and L___ is very impetuous and..and always..you know, dived in.

I: Mm.

S: Whereas.and um..

I: So out of you and your husband who is L___ most like?

S: Oh!..Neither one of us want to claim that! (both laugh) Ah, well, he's most like my brother actually.

I: Right. Yeah.

S: Yeah. But ah..

I: Can you say in what ways?

S: Ohh, he's just.he's just very much like him, very impetuous I think.

I: Uhhuh.

S: And sort of little regard for um..ah..commitment or.that type of thing or..like, you know, I suppose you can't..my brother was like that, he..he's still a kid and he's forty years old..footloose and fancy free and..

I: Has that impetuosity got L___ into.any serious trouble?

S: Probably, yes. Um..yes. It has.

Mother then shows that she was not able to monitor his safety, that in that respect he got away from her.

I: Has he ever done anything impetuous that's put his.life at risk?

S: Aah....mm...I'm not sure. Ahm..he.when.er, they both.we've had motorbikes and he was always the one that drove.fairly.although he wasn't that interested in riding, but when he did ride them, he was quite.you know.

I: Mm.

S: The eldest one'd just putter around on it, you know, he was always.very cautious and L___..ah, had no fear and..but ah.went for it. Yeah. And.and I guess that the riding is a bit like that too..the way he rides the horses. But we've always had um.quarter horses and they're.notoriously um.well behaved.

I: Mm. Mm.

S: Oh! And then.but then again that was..L___ decided to ah, he'd like to do rode.you know, ride um.saddle bronc in rodeos.

I: Mmhm.

S: That was.probably more dangerous. I've got a brother that is very er.follows rodeos with the calf-roping and..which was more, you know, and he taught L___. He'd go on out to his station and he taught him how to rope and that but.that wasn't enough adrenalin rush, he didn't.wasn't interested in that.

I: Mm.

S: He didn't do that, he'd rather..he.went for the ah..ma.mainly for.we thought it.more dangerous.

I: Yeah.

S: He seemed to.like the danger.

Mother is quite dysfluent when first describing her son's interest in rodeo-riding, and this may indicate her anxiety about his safety. These personality traits are considered to be life-long, and when mother describes not being able to get him to listen to her, there is a change of tense to the past.

S: And I try and reassure him that he wasn't, but he.he doesn't.he would just.block it out and would not.you know, wouldn't listen to me.

I: Right.

S: But he rarely listens to anything I say anyway. He doesn't like me..lecturing him, or telling him. Doesn't.he.didn't like.he doesn't like the sound of my voice.

I: Oh.

S: He's paranoid about that too.

I: Oh dear.

S: (laugh) I think because I used.I used to try and get.through to him all the time, but.but he just didn't.he didn't want to know.

I: Mm.

S: My opinion.

DEP104: One theme was presented. This mother had much to contend with, having an extremely violent partner and a failed previous marriage. Her parents were not available for support, and she describes turning more to a female friend and neighbours when things were at their worst shortly after the birth of her participant son.

I: Mm. D___, did you have anyone for support during that time?

S: Um..when we had.when I had problems..not really. Um, you sort of suppress those sort of things. You don't say "Oh well, my marriage is.a mess".um, you know. Um.so we didn't um.basically I didn't.I had.family around me, but not...I didn't even confide in them, because you thought you know, like it's.they'd say it was.it was my second marriage, um, I didn't want.I did.I wanted it to last, because.I thought.having two children.ah, that was..you know, that was the way it should have been.

She then describes going to an aunt rather than her mother who did live in the same town.

But we had to.a.lot of problems....in so much we just.we just.ah.we'd go and stay with ah.my aunt, we stayed with my aunt.for a while, because.their father sort of caused so much trouble around here and.terrified them.

I: Mm.

S: Basically because.um.I was.here with two little children ah.a little bit isolated in those days, and ah..um..well, we went from.went to one aunt and stay.aunt and uncle and stayed there for a while, then we.came back for a while, then we.shifted again.

Later she explains her mother's unavailability as due to fear of her husband.

I: Your parents. You were saying before that you couldn't really.tell them, um, or lean on them too much when you were going through that.dreadful time. Were they here in T___?

S: Mum was, yeah. We lost dad when I was about twenty.

I: Right.

S: Um, so.but.but.m.mother um..mother was here, and.I mean...she used to.ahm..well, she'd be around, but I think..their father sort of.had her a bit frightened too, you know.

DEP105: Five themes were reported. This mother describes moving out west away from her parents at a very young age, having a baby soon after, and struggling on her own with father going away to work, being alcoholic and no help when home. She had many children close in age, and she had to supplement their meagre finances with menial labour. Her situation had not improved much when she had her participant son, via a very difficult birth.

And um, I was only eighteen at the time, so..I had no-one to.ask, or no-one to do, and I.I.I didn't know whether I was coming or going.

When her very ill participant son needed specialist medical attention, one of mother's sisters arrived to help, but mother's mother remains unidentified as a source of support throughout the interview.

S: Anyhow, my sister came..to.to A___, and she said to me "Look" she said. "There's something the matter with him" she said "You'll have to take him to another doctor." She said "And I'll look after." by that time I'd had.K___my.

I: Your fourth?

S: Fourth.

Mother's mother did visit when mother has already had five of her seven children, all close in age.

S: And yet the other little fellow that was...thirteen months older.younger.he was gettin' round and doin' everything. Well the two of them sorta..I think K___ sorta helped P___. (participant son)

I: Mm.

S: Um..they were very ah, very close, the two of them. They were like twins.

I: Yes.

S: Wherever one was, the other one.was. I remember my mother coming out from T___ once and.she said "I don't know" she said to the neighbour "I don't know what H___'s rearing here" she said "but they're like two little Chinamen" she said. "They get down in the yard", she said. "They dig in the ground" she said "talk to one another" she said, and.see.h.h.see he.and by that time I had D___. So.she said.and she'll sang out "Come on you fellas, get your dinner" she said. "And they'd come up" she said "and they talked to one another" she said. "I'm sure" she said "there must be Chinese in 'em somewhere" she said "there talking this lingo".and..and it was a knife and fork they were saying but my mother couldn't understand it.

As well as the seven live births, she tells of having ten pregnancies in all.

I: You said you've had seven.

S: Yeah. Yeah, I had seven.

I: Over what period of time? How many years would you have..

S: Well.um..V___Jo___ was.um...Ju___ was fourteen when Jo___ was born.

I: Mm. Mm.

S: So, and then I had three miscarriages in between those.

I: Right. Can I just ask you..when those miscarriages happened. Um, were they after.child number..

S: Yeah, well I had the first.first miscarriage after..after I'd had um..D___.

I: Mmhm. After the fourth.

S: After the fifth.

I: Fourth.fifth child.

S: And then I had.another one.after that again. I can't remember when the next one was.

As well as her having to work part-time whilst looking after all these children, this mother's husband worked away a lot, and when home was of little help because he spent most of his wages on alcohol.

I said "Look! Don't ever worry..about.how you're going to keep your babies." I said.. "My husband..loved his.rum bottle more.than my kids."

I: Mm.

S: They would say to him "Well how did you get pregnant?" I said "Well!" I said "When they're out in the bush, and they come home..you'll do anything to shut 'em up.so that they're not.annoying you, and.annoying the kids..It's.put up with it." I said "Well, that.was life." "But today", I said "they've got everything." I remember when the father came home one.once.it was when.I was having.K___, that's the.boy.next to.P___(participant). I was having him baptised. He came home and he said "I'll be there for the christening, oh yeah." He went away with his brother, and they'd been at the pub all day, and he come back and.talk about drunk! "Oh" I said to him.and I had P___..a little fella asleep in the cot, and I was getting dressed.and.g.dressing.K___, and the two girls, getting them ready for church, and ah, I said I'd.to my neighbour I'll go" I said "because" I said I couldn't trust....R___(husband) looking after P___.

She continues with this story of despair:

the rum bottles there without any corks or anything in 'em..water running all over the floor, and I just sat down and I just bawled and bawled. Anyhow he said to me.ah "What are you bawling for?" he said. "Nothing to be bawling about" he said. "You've just had your baby christened." He said "You just had your kid christened" and I said "Yeah that's alright".I said. "Listen" I said "if you.ever.do this.to me again..when I've.put you.in charge of a baby, and you have not looked after it" I said "and drunk". I said "How did I know now".I said "I realise now, I should never have left you." I said "You could have had.."er.I said.he was.they were.both smokers. I said "You could've set this house alight" I said "and that baby could've been burnt alive."

I: Mm.

S: Ah, he said. I said "I".he said "Well what will you do?" I said "I'll clear out and leave you." Huh!

I: Mm.

S: "Ha!" he said. "Don't worry about that" he said "Where would you go?" he said "Nobody'd want you with four kids." See today you could get help.

I: Mm.

S: In those days, there was no help. There was no..

I: So you were stuck there.

S: Yeah! You had to stay, whether you wanted to or not.

Despite all the stress and trauma, this mother reports embracing responsibility and getting on with the job.

S: And I thought this is my life. I can't there's not much I can do about it. But, I can keep myself straight...and look after the kids as best I can..which I did.

Having enough money and food on the table was a chronic stressor.

'Cos at that time, I was..I was going out, I was doing housework, I was..with my last one, I was wheeling her around the town in a pram with a playpen over the top and, that's the way V___, the youngest daughter ?????we????? I was cleaning houses and doing ironing or whatever..to to keep the kids, because...father was spending his money on rum.

I: Yeah. Did you ever get to a point where you didn't think there'd be enough food on the table?

S: Well, that happened many a time. Well! You know very well that well you always tried to keep rice and potatoes and..and that's what you made your meal off.

I: Mm.

S: Many a many a night, we b.I boiled a big pot of rice and, cut up one onion and that's the only onion you'd have in the house. Whatever else bit of herbs or something. And the kids'd have the biggest feed of that, they'd all go to bed, and they'd be happy.

I: Yeah.

S: And um, the next I always made sure I had Weetbix. They all all would eat Weetbix don't I always had the Weetbix, and I always got the big tins of milk.

I: Mm.

S: And that's the way we lived. And then when I found when I was going to work, on some days, I would only earn two dollars. I'd iron all day for two dollars. That was the what the people gave you, and you had to manage on it.

I: Yes.

S: But I was very lucky. I worked for a butcher and his wife, and she was marvellous to me. And whenever I got the meat, he always put a little bit extra something or other in for us.

I: Yes.

S: You know, things like that, that's where. I sort of that did help.

DEP106: Three themes are described. Mother early in interview discloses all the moving the family did around the time of the pregnancy and birth of her participant son in order to attempt to secure regular paid work, which often necessitated her husband being away. This mother does not stress her fatigue but does disclose how busy she was.

I: OK. And just casting your mind back to..the actual pregnancy. What comes to mind thinking of that nine months?

S: The nine months? Um...yeah well it was quite quite um...I took it all in my stride, you know which you usually do..ah, but at that particular time, we were..doing um..shifting around a little bit. We um...ah, jobs weren't terribly secure at that time, and so we did a bit of moving around..um..yeah. But ah, everything went off fine, it was actually a great pregnancy really.

Mother had to work throughout the pregnancy at labouring jobs.

S: Aah but at the time that that R___ (participant) was actually conceived and that, I think we were in the um..ah, doing the f.fishing. We used to we run a.a.an iceworks at um..M___ W___.

I: Mm.

S: And we used to ah pack the fish for the fishermen.

I: Mm.

S: And then send it to market.

I: Mm.

S: Yeah. So ah..yeah we were..that's what we were doing. (laugh)

I: (small laugh) Very busy.

S: Yeah! Yeah, yeah, we used to um..um..B___ um, R___'s dad, he used to um..we had a boat, and he used to go out and do a little bit of fishing himself, so it was quite often left to me to to, you know, pack the fish and and that's ah well, the men used to more or less pack their fish, but we used to have to supply the ice and crush the ice and that sort of thing for them, you know.

I: Yeah. Yeah.

S: Mm.

I: You were well during the pregnancy.

S: Yes.

I: Did that mean you worked all through?

S: Mmhm, mmhm. Yeah! (laugh) Yes, that's right.

A little later, mother is talking of feeling a bit desperate when the new baby was at home, then when the interviewer asks her to say more, she mentions money, and then immediately talks of her busyness and then again of how tight things were financially, then concludes that things were alright really.

I: Yeah. Were there any times that did feel a bit desperate? You were saying "if things got a bit desperate."

S: Um....well. (sigh)...financially, perhaps, we did..ah, not..not really um..ah, you mean a.as far as handling.the coming home and.and that sort of thing?

I: Well just picking up on what you said.

S: Yeah, yeah. Well when I say 'desperate', I mean, you know how.you can sort of get overcrowded with ah.the cooking and your meals are not ready when they ought to be, and that sort of thing, but nothing.nothing serious. (laugh)

I: No. Um, just with the..things being.a bit stretched financially, were you ever concerned about.say, not having enough food on the table, or..not being able to go to the doctor when you had to?

S: Ah.....well, there were times.ah, I suppose, that we were.um...we had to be very, very careful, you know. I mean there were times that..um...but that might've been before R___ was born.you know, we'd get about three.three pound a week it was to sort of live on, you know. Well it.didn't go too far..um..no, I think after R___ arrived, things were sort of um, he.h.has.we'd got into a pattern..ah, and by that time his father was working at um...they were building the high school at.at M___.

I: Oh yeah.

S: And so we sort of had permanent work there, you know, so.that work carried us on OK.

After the participant's father tragically drowned when the participant was aged three years, the community collected monies for the families involved. As

mother begins to talk of this tragedy, she talks of father being away most of the week of necessity due to his work.

S: And ah, and B___ was working....he was.he was.s.working with a group over at G___, so he was sort of away..all through the week, and come home at the weekend, you know. And um, he was on this.flood mitigation work. It w.wasn't always G___, it.sometimes it was B___ or.was around ah.er, not B___, G___, or round B___, or somewhere.round about.wherever they were working on this flood mitigation.but it with the same firm, you know..sort of thing. And ah.yeah he came home for a.of a..of a weekend..yeah.

DEP107: One theme is reported. Mother states her exhaustion was due to her child being very active when young.

S: Oh! Yeah. Well I was sort of.once I went home I was fine, I think. Yeah. He was um...he was a quite difficult baby in that he woke.um..every.like, every two hours.

This pattern of restlessness never really settled, leaving mother exhausted and desperate.

S: But um...and then, it sort of just went on, and I was really, really..exhausted, and so was G___(husband). We sort of felt we've got to do something about it, so I went to the doctor and I said that he's waking all the time. I said "He'll go back to sleep, but it'll take twenty minutes, but.he's.awake at.every.two hours." I don't think he believed me, so (sigh) put him in hospital, and um..and.they said "Oh yes" but didn't matter bec.to them really because, they were there all night. So they'd just put him in one of those little walkers (laugh) and he'd be up all night and he'd be walking around.

Mother reports disturbed sleep at least until the age of two years, and then a very active little boy who was always into things.

S: Yeah. Yeah.yeah.but.no he is..I s'pose once he was about.two, he sort of stayed sleeping all night and..

I: OK.

S: Waking up. He'd wake at four though (laugh). He sort of never wanted to miss out on anything. Yeah, but he seemed a.happy little fellow, he was..you know, he..he.never sort of um..he got over things quickly, he was always

happy to go out.he was.he was not sort of one that would.cling to you or anything.

Before discussing her participant son's near-drowning, covered in the section on Trauma, she describes having to watch him all the time.

When he was little, he was always like.ten steps ahead (laugh). He worked wonders, sort of thing, behind you and..

I: Yeah.

S: Yeah.

I: Yep.

S: He was always in.like adventures, and.yeah.

I: Did that ever cause you any worries?

S: Um..we had to keep an eye on him. We had to keep.like..we really had to be.ten.like.ahead of him, like you do with all little kids.

And again:

S: But I have better ????because you'd feel bad enough but.yeah. But um, no, he was always having little accidents. He'd climb things and.he was always climbing.like, you know, a lot of kids and.he's just lucky.he's still alive (laugh) and for ages he had this little bike.

I: Yeah.

S: And um, we lived, sort of close to a highway, and you couldn't keep him in. You had to..you had to practically put chains on everything, 'cos he'd get chairs to get up and..and he.he got up the top.remember those little plastic.bikes they had that used to be in years ago with the little.just a little low one?

I: Mm. Mm.

S: You know, the blue and yellow? I don't know if..yeah, anyway. I don't know if you've got children, but they were the thing, yeah, and um.he.he'd get up the top of.of the hill on that, and he'd be racing and zhoom! and cars'd be going (laugh) yeah, so.you really had to.he was extremely active, so you had to watch him.a lot.

Mother sees her child in a very positive light, not as naughty, but as exhausting with his level of activity.

I: So how would he.take discipline or.what did you have to do to get him to.behave, when he was little?

S: Um, he didn't really misbehave. (small laugh) Ah, there wasn't sort of...um... there weren't any occasions. I think the only time I did ever smack him, was in really dangerous situations, you know, and you'd think "Oh, he's just got away!" (laugh)

I: Mm.

S: And um..like you know, he'd climb, he'd be very proud of climbing to biggest tree he could find, after being told a thousand times not to, so (laugh). Um, I, anyway, that key, that tree, the fellow next door owned it, he used to cut it down because he was so worried about it (laugh). But, yeah, I never, he never really, like he got into everything. I think I even taken him to a psychologist when he was about two, because I couldn't cope (laugh) with him. And he said um..he said he's, his brain is just faster than yours, or something or other, and, I don't know what the words she used were. I said "He's got everything out of the cupboards" I said "He's got the fridge open, he's pulled everything out of it." She said "Put a lock on the fridge, then he can't get it open all day." And um..so I did, so he got a chair and undid it. (exhaled breath, laugh). But, um..so that sort of wore you out, but he was not, he was never naughty.

This mother attributes her son's current problems with his early unsettledness, and she is able in interview to reflect on her feelings at the time and her appraisal of things now.

S: So if there's any problems..maybe I see it as sort of, during the birth or..in those early times, when he was sort of, crying a lot and..

I: Yes.

S: Ahm..I suppose I used to get frustrated, that way, you know, um, and then perhaps, later, as he became a teenager, with that..um, isolation between him and his father.

I: Frustration with..one's babies is, fairly hard to um, admit.

S: Yeah. Oh..well, I can sort of remember it, because I was exhausted. I was absolutely and completely exhausted.

I: Yes.

S: So, I just used to put him in the pram, and off we'd go and he'd still cry in the pram, and I'd think oh now, I don't know what's wrong with him and..

DEP108: This mother describes a very settled life for herself and her husband and four children, but she had difficulties late in the pregnancy and a subsequent difficult birth, covered in the previous section, with her mother too ill to be of help.

I: Oh right, yes. Yes. Yeah. And um.were your parents alive.um..

S: Yes, my parents were alive in B____.when I was expecting B____. (participant son)

I: Mmhm.

S: And I____'s (husband's) parents were alive then.

I: Mm. Mm. And.everyone was well?

S: Ah, well my mother..my mother was a bad asthmatic all her life..all my life.

I: Uhhuh.

S: But other than that, yes, they were well.

Before the above passage, mother talks of her back problem that resurfaced during the last weeks of her pregnancies. Her participant son is her second child, and by the time she has her fourth child, her mother is needing her care. For consistency, although this mother does not complain of exhaustion, this item is included.

I: Mm. What did you have to do to look after your back, in the last few weeks?

S: I was supposed to rest, but with R____ I had my mother with us and she wasn't well.

I: Mm.

S: And um, I was looking after her and..in the end, they put her in a home just 'til I went into hospital.

I: Uhhuh. Yes.

S: Other than that, just take.um, well I didn't even take painkillers. Nothing, you know?

I: Right. You toughed it out?

DEP109: Mother describes her daughter as aggressive and difficult for her to manage. Mother's brief illness towards the end of the pregnancy with the participant is described in the previous section on Trauma. This mother presents her participant daughter as having epilepsy, then pseudoseizures that started at an early age, along with severe headaches of unknown origin, leading to a lifetime of consulting and arguing with medical experts. By the time she was in school, this young girl was roaming the small town in which the family lived, seeking company. Mother is somewhat vague about her daughter's earliest years.

I: And..tell me a little bit about um..what A___ (participant daughter) was like as a toddler.

S: Oh, she was a happy little girl. She was.very.very happy actually. She used to..as she got older she got more aggressive, you know, as she got older.

When she was at school, things you know, if she couldn't do what she wanted to do, she'd fly off the handle. But as a baby, she was very good. But I think, you know, I put a lot of that down to the epilepsy you know, 'cos she was.about five or six I think when they discovered she.she might have been a bit older.

This interview was truncated by father returning from work and immediately attacking doctors over his daughter's diagnosis over the years.

But A___ (participant) too, I find that she's very..changes her moods very easily, you know? She'll be all lovey-dovey one minute and all of a sudden she'll fly off the handle, and she'll walk out that door and come back.as though nothing's happened.

I: Right. And you were saying that started very early.

S: Yeah.

I: And you think it's the epilepsy.

S: Yeah. Well I sort of blame the epilepsy for (???) I don't know.

I: You're the expert as the mum.

This interview was difficult due to a noisy home, father's intrusion, and a certain intangibility to accounts of the daughter's illness and behavioural problems. DEP110: Three themes are reported. This mother describes being very young when she married and soon after had her first son and then her participant son. Her husband worked away, and when home would mostly get drunk with 'the boys'. Her own mother, although supportive, was not available to offer practical help because of her husband's illness. She opens the interview very frankly.

S: Well I married young. Put it that way. I married very young, and.yeah.and..it was hard getting..you know, everything together.at that age, being a mother so young and.and more or less, you know, everything.was.m.husband was.it was a bit hard for him to settle down. (small laugh)

I: Mm. How old were you?

S: I was sixteen.when I married.

I: Right.

S: And I was.nearly eighteen when I had.W____. (participant son)

Initially her comments appear blaming, but as the interview progresses she rounds out the picture of her husband and his relationship with herself and the children. In the earliest years when the participant was very young, she had little support.

S: But ah.yeah, the husband had a bit of a drinking problem, you know, at that time.

I: OK.

S: Mm. And that caused a few problems.

I: Mm.

S: Caused quite a few problems.

I: Right. (dog barking) Can you..

S: We're going to get him all morning! (laugh)

I: Can you say a bit more about.what problems that drinking caused for you?

S: (dog barking) Caused he.caused quite a bit of problems. 'Cos he was a truckdriver at the time.

I: Mm.

S: So that meant I was at home with the.children..through the week, and then when he used to come home of a weekend, he'd be out with his mates drinkin'.

I: Mm.

S: So yeah, it caused a lot of problems.

I: So not much support for you.

S: No. None whatsoever from the earlier.beginning.

She had three children to bring up more or less on her own.

I: Who.did you have for support?

S: ..Nobody really. I more or less muddled along.through meself (dog barking). 'Cos.my mum, she had her own worries, because my dad had Parkinson's disease, he was dying..

I: Gosh.

S: So.yeah. Yeah, it was just myself really.

I: Mm.

S: Just muddled through on me own. (laugh) Muddle.muddled through. But I muddled through and, yeah. But I think, you know..that's what.caused a lot.'cos.I hated seeing the kids.the kids seeing their father come home drunk, and..

I: Yes.

S: But he spent very little time with them.

I: Mm.

S: But.you know, the time that he did spend with them, he was drunk. I hated that. (small laugh)

I: How did you protect them from seeing him drunk?

S: I really couldn't.

I: Yeah.

S: Dad was everything, you know? Dad was still dad.

There is no denial from this mother that father's drinking disturbed the whole family.

Summary of Contributors to Maternal Fatigue

Father being absent physically on a regular basis was raised by many mothers in interview as contributing to their exhaustion as they dealt with complex factors that would be potentially overwhelming for almost anyone. Often the reasons for the absences were benign rather than reflecting marital disharmony. With a new baby, particularly after a difficult birth, father needs to operate as the protective agent who frees mother to devote herself to her baby. Some fathers were alcoholic, with little to offer by way of practical support, according to the mothers in interview.

Poverty, a known contributing factor in mental illness, is also described as a significant stressor for several of the total sample with an adult child with schizophrenia, and a comparable number of the total sample with an adult with depression.

A number of mothers in the schizophrenia sample begin their narratives with statements about the number of children they had who were all very close in age, and what effect that had on mother. Some mothers offer information about their adult child's behaviour as being very active, naughty, or too much for her, and as contributing to her fatigue. It must be emphasised that having a difficult temperament as a child does not of necessity equate with insecure attachment, unless mother is not attuned to the specific needs of this child and thus is unable to reassure this child that

he/she is not too much for her. Her capacity for this attunement is affected by her sense of security and availability in practical terms of physical capacity, that is, not being chronically fatigued. The numbers within each diagnostic group were comparable.

Finally, mothers in interview reported moving house or town either just prior to the birth of their participant child or soon after, thus severing them from a known environment with established supports just when as mothers they are called upon to focus their energies on establishing settling routines for themselves and their babies.

The mothers of the schizophrenia group in this study volunteer more statements than the mothers of the depression group that relate to their hectic/overly busy/tiring lives in the period when their participant child was aged 0-3 years. With the mothers of the schizophrenia group, this information is emphasised in comparison to the traumatic events noted in the previous section, and is somewhat more coherently presented. It must be emphasised that their reasons for fatigue appear justifiable, particularly with having many children close in age, and being relatively unsupported by partners and/or parents for a variety of reasons, or via social/geographic isolation. Fatigue can be an indicator of post-partum depression, but there is no evidence of this diagnosis in the interviewed mothers. There is a sense of emotional numbing as necessity in order to soldier on with what had to be done.

Chapter 6

RESULTS

Qualitative Analysis of Attachment Themes from Mother Interviews

This chapter firstly outlines the process used to define the themes contributing to attachment difficulties in the participants, and then gives detailed examples from the fully transcribed mother interviews. A summary of differences between diagnostic groups is then provided.

Selection and Definition of Attachment Difficulties

Twenty fully-transcribed interviews with the mothers of the participants, ten from each diagnostic group matched for age, sex and marital status, were read and re-read. Notes were taken of comments made by mother that related to her potential attachment to the participant during pregnancy, birth, infancy and childhood. Notes were also made of mother's comments on her participant offspring's relationship to herself, other immediate family members and peers. Transition to school and other developmental milestones, essentially peer-related, were also noted. These comments were placed beside the comments made by the expert panel who all have extensive experience in child and family therapy. Literature review was consulted to check the relevance of these themes to attachment difficulties. From this review, it was decided that persistence of attachment difficulties throughout childhood and adolescence was essential to allocate this as a theme. Therefore, three indicators were required for a particular participant to be given this allocation. The final decisions on what themes were selected was reached by consensus with the expert panel.

Three themes relating to attachment difficulties were extracted from a detailed analysis of all fifty (50) interviews. These themes are essentially in two categories: mother's statements around her acceptance of the existence and sex of her participant offspring, and also mother's observations of her participant offspring's relationship to herself, father, siblings and peers. All of these statements are contextualised within the psychosocial circumstances of the family. The mothers volunteer these three themes.

1. The pregnancy was unplanned, a shock, or unwanted.
2. Mother reports in interview that the participant child was the 'wrong' sex.
3. Mother indicates in interview that her participant child displayed insecure attachment throughout childhood and adolescence.

Table 8

Frequencies of Themes Indicating Attachment Difficulties by Diagnosis

Diagnosis	*'Shock' Pregnancy	'Wrong' Sex	Attachment Difficulties
Schizophrenia			
Total Sample (N=25)	9	6	16
Select Interviews (n=10)	6	3	7
Depression			
Total Sample (N=25)	3	1	10
Select Interviews (n=10)	1	0	3

* Includes unplanned, mistimed and unwanted pregnancies.

Examples of Attachment Difficulties in the Schizophrenia Sample

SCZ001: Two themes are presented. This mother describes her participant son as being the 'wrong' sex. He was inconsolable when she went to hospital for the next birth, and did not settle. He did not fit in at school.

Mother is being asked in interview about the difficult birth, and becomes confusing in her narrative when implying that if her participant child, a boy, had been her first-born, then she would not have had all of her children.

I: Mm. Can you remember what all of that felt like for you?

S: Aah. I was a little bit distressed because ah..ah...I had a.a girl..pro....she was the oldest in the family, and uh...ah, 'cos I always believed that a boy should be head of the family, you know, and ah...ahm...things never...she was born under anaesthetic. And uh, of course..if she..if D___ (participant son) would've been the first, ah...like, the first child, I wouldn't have had the last child...as the three.

She had four children. When clarification is sought, the confusion intensifies.

I: Mm. So your first-born was a girl.

S: Yes.

I: And you weren't looking forward to that, you were wanting a boy first.

S: Some..yes, something, er, like that.

I: And she was born under anaesthetic.

Mother suggests that she should not have become pregnant, and that her doctor was angry with her, perhaps because of the previous difficult birth described in the Trauma section.

I: What, angry with you?

S: Angry, yeah, yes for being pregnant, and ah, and ah...always wanted ah, another girl, like two, two of each well we had a girl and then two boys, and they were two boys of that...you know....we think, I mean, uh, at Sunday School the um, the ones in charge and that, attendance and that, he said D___'d get up from his uh, chair and he'd be looking out the window...all the time, and ah, they'd have to..ah, go and get him.

I: Right. So he wasn't um, good at concentrating?

S: No. No. And uh, he turned out a very good scholar though, that was the..um..funny, um, funny part and he got a very good 875 as it was then, you know.

The participant child was fourteen months old when his brother was born. His distress at mother's absence did not apparently settle within a reasonable time, but mother becomes dissociative to the thread of the conversation, and confuses who we are talking about.

I: Mm. You were telling me he was very lively, that both the boys were into everything.

S: Yes, yes.

I: When he was a toddler, say, um..can you remember anything he got into?

S: Only that..when I was due to go to hospital, nobody wanted to mind him (laugh). You know.

I: So, who did?

S: Aah..well...between J___ (father) and uh, like relatives, you know..ah...two sisters-in-law, and then..a girl, uh..I went to school with her actually and..uh, you know, we're the best of..best of friends..and ah, he just screamed the roo..the roof down you know.

I: Mm. So he didn't want to..he really let you know he didn't want you to go.

S: Mm, mm, mm.

I: So you heard these stories that he screamed the roof down..

S: Yes, yes.

I: Did he settle?

S: Um...I s'pose, s'pose only when he went to sleep..you know of a nighttime, but he was very..very fretful I suppose.

I: Mm. When you came back home, um, can you remember what that was like with D___?

S: Umm...when he was a baby?

I: When you came home with the next one.

S: Mm. Fairly hectic. As I say, I..wasn't particularly well at the time, and uh.....

The above conveys to this researcher a very sketchy and incomplete picture of the participant as infant and young child, with mother disconnecting rapidly when clarification is sought. It is as though seeking clarification triggers an increase in confusing one child with another.

SCZ002: Two themes are discussed. This mother reports the unplanned pregnancy with her participant son as a dreadful time, and later talks of his refusal to go near his father from a very early age. Mother raises her ambivalence to the pregnancy immediately and puts this in context but quickly changes topic. However, she has a lot of ground to cover and is reasonably sequential at the beginning of her story.

*I: Do you remember when you first knew you were pregnant with A___?
(participant son)*

S: Yes.

I: Can you tell me what that time was like for you?

S: Dreadful.

I: Was it?

S: Yes. And I had already had a miscarriage, just before he was born, and I had another baby seven months, huh, and and so it was um...I was happy I had the miscarriage in the sense, it wasn't a deliberate one, and then I became pregnant straight away with A___.

I: And you weren't expecting that?

S: And when he was born, he was big and beautiful. And very good.

There is no opportunity to pause and reflect on why she was happy to have the miscarriage, and how that attitude may have reflected on her acceptance of the following unexpected pregnancy. Soon mother describes an infant who was difficult to comfort, with parental concern but mystification as to cause.

But then when he was twelve months, he became desperately contrary. Cried and...it could have been his teeth, so we took him to a specialist on the T___ in B___, and he couldn't find anything wrong with him, just maybe his teeth or...but it always struck me as strange, that he was so cranky at that time.

I: Mm. How long did that go on for?

S: I don't know really, because I had another baby soon afterwards.

Mother is implying that she is distracted, and with good reason, and this is covered in the section on Maternal Fatigue. It is plausible to suppose that her participant son's rejection of his father and clinging to mother was a reflection of her distractedness, and that she accepted it perhaps without having the energy to engage with him at a level that provided sufficient comfort and security.

S: No. The only thing was um...he didn't fancy his father, even as a baby. He um...if P___ (father) went to take him, he would not go to him. And then...

I: How would he get this across?

S: Smack him.

I: So even when he was very little....

S: Yes. Seven or eight months old. He'd smack his dad, and then um, you know, but he couldn't walk when she was born see. He wasn't old enough to walk, and I used to carry him everywhere and all the ladies'd say "Oh put that big boy down. You can't carry two of them." And but he was sort of a bit clingy. But that was very normal. Yeah.

I: How old was he before he stopped being clingy?

S: He always favoured me a lot, to be honest. And..

I: What do you make of that, A___?

S: Nothing.

Once again, a line of enquiry is abruptly diverted, but later she discloses with a hint of embarrassment that there were issues of attachment.

S: Yes. And then as he got older, he said once or twice that he...he was sorry about...that it was dreadful afterwards, that he should have been an only child. He didn't seem to get on so well with the boys. It wasn't that..he used to say a lot of things like um.. "It's not fair." A lot of things were not fair.

I: So he felt hard done by?

S: Yes. He still does.

I: And um..there's nothing that that brings to mind for you? It's not like there were unusual circumstances when he was little compared with the others?

S: Nothing. And um...he was a very good child, and a very good young man...and has a..he had...very different from the other fellers..they were all kind of rough toughs, you know, and A___ wasn't. And um, he didn't get on..there was twins, who got on very well together, and there was two older brothers who didn't get on at all, but at least they fought all the time right? And so he was sort of left out as Johnny in the middle.

Mother speaks with empathy and psychological awareness, but with all the demands of her large family she may not have been able to assist her participant son with finding his place in the family. She describes a good child who may have worried about being less good.

I: Whereas A___ was a good child..

S: Very good child and took everything seriously.

I: He was sensitive?

S: Very.

This case is remarkable for the number of accidents and medical conditions suffered by the participant child in his earliest years. The accessing of specialist medical services, presented as being at the instigation of caring and protective parents, but resulting in no diagnoses or treatment being forwarded (except for the infant's wry neck) is suggestive of help-seeking behaviour from parents in extremis. And yet this critical appraisal needs to be balanced by the evidence presented regarding solicitous parenting in treating the infant's wry neck, by mother's account, a procedure which caused the infant no pain, but throughout which he screamed. This child also did not grow. Once again there was a trip to a specialist, where the parents received reassurance. Mother reports to the interviewer that it was nothing to worry about, and quickly moves to the next threat to the participant's physical integrity. It would seem that the failure to grow was delayed maturation rather than the severe 'failure to thrive' thought to be a sign of serious neglect. Mother is able to show her sensitivity to her son's possible teasing at school, but does so via her daughter's comments.

S: And we did take him back to that specialist I took..we took..And he said there was no worries because...he was um....you judge by your wrists, you know. And he said he would grow. But my daughter does a lot of study and

things like that, and she's younger than him, but she said that boys that don't grow, they have a harder time.

I: They get picked on, do you think?

S: Yes.

I: So, how small was he?

S: Very short. I did actually see him one night..

I: So when he was actually say, about six, how old did he look?

S: Oh, he looked alright then. But he didn't grow after that. So, like when he was twelve, he didn't grow.

And a little further on:

S: Yes. Nothing to worry...he'll grow out of it. Oh! He did..I forgot to tell you this! When he was...young...I had a wry neck, and he had a wry neck. I went to every doctor, and they wouldn't..eventually I got a doctor to refer me to..a physiotherapist who showed P___ and I how to...put his head (looking distressed)

I: OK

S: And we fixed that.

I: So did it go out several times?

S: Oh no. It was..it was like mine, like you know. See it here? The muscles are shortened. And it's from being a big baby. You get stuck in the wrong position, before birth..and that was something else. We had to pull his head, and he used to screech a fair bit, but.

I: How long did you have to do that for?

S: Couple of months. Mm.

I: And how old would he have been then?

S: Five months.

I: Any self-respecting baby would screech.

S: Yes. Yes. But he did. It wasn't hurting.

Mother mentions three significant things: that she has the same problem, that it comes from being a large baby stuck in the wrong position before birth, and that treatment did not hurt. Her visible distress in interview conveys the opposite. Also she says earlier in the interview that the pregnancy and birth were fine. However, when the opening comments are re-examined, the fact that the baby was big is surrounded by other adjectives that are more compelling.

S: And when he was born, he was big and beautiful. And very good.

I: So he was a good baby..

Much later in interview mother talks of her participant son as the one with whom she has a special relationship.

And he's still better to me than any of the others. I mean, they're all good, but in a different way, but it worries me, in the sense, if...oh, I'd prefer him to have...a girlfriend?

I: A bit more of a life of his own?

S: Yes. Yes. I mean I'll miss it, but I'm very...I want the best for him.

This child, and continuing into adulthood, appears to be self-sacrificing. *You know, and er...I don't think maybe A___ um...much more honest and more conscientious...and I imagine...this sounds rotten but it's..more from me. You know.*

I: That doesn't sound rotten at all.

S: The other boys are tougher, and didn't have...not as conscientious in some ways.

I: Mm. That fits with him being more sensitive.

S: Yes. And um, he'd help all people and do all sorts of things like that.

His ongoing need for a special relationship with mother may have contributed to his marital breakdown soon after the wedding.

And um..you see, I loved her, I listened for months to M___, (participant's wife) and he had hysterics because he said I took M___'s part, and in a sense I did. (whispered)

I: Mm? Did he tell you that?

S: Noo..

I: Can you say more about that?

S: Well. She..we..both had..you know, I really thought she was lovely. We didn't know she had been married, or anything, and we weren't very happy about them living together, and um...but they were grown up, and so when eventually they got married, and.....but he didn't seem happy at the wedding, even though they had come from I___ and everywhere, and it was a great wedding, and then they weren't married long and...this happened. She came..and told us, and then..I went with her and..to see a...in the psychiatric clinic just there. Aah, and I told her just what I'm telling you that he was just

a bit different, but nothing...you know, and ah, she was heartbroken, and...I don't know really. But..he said that she was playing up. That I..I find difficult to understand because they were always together. Yes, you know..but he knows.

I: You don't know whether it was true or not.

S: No, no. Yes. And um, but he was very sour because...he took her pl...oh we didn't take, we did in a sense. That's all. (eyes darting, looks distressed)

I: How do you mean?

S:He wouldn't talk about it.

And with that, mother decides not to as well.

SCZ003: Two themes are outlined. This mother appears very anxious in interview and indeed states that she has always been highly-strung, as was her son as a baby. Initially she perfunctorily reports her pregnancy with her participant son, her first of three children, as being good. It is only at the very end of interview as she is trying to wrap it up, that she reports being told by her G.P. that she could not get pregnant after being on the pill and having a long history of absent menses, and indeed she treated her expanding waistline as something aberrant that she needed to control with vigorous exercise. She then becomes anxious in interview about the possibility of starvation being harmful to the foetus, and the interviewer is left wondering if she had an eating disorder.

I: And I usually start off..by just saying, can you recall when you first knew you were pregnant with your son?

S: Yes.

I: Mm. And what was that time like for you?

S: Oh, happy time, yeah. Very happy time.

I: Right. Um, what else can you tell me was..going on for you, or the family at that time?

S: Oh, I was working..um.at.well.and.R___ (participant) was my first son.

Her stuttering may indicate hesitancy to be completely frank at this opening part of the interview.

I: Yeah. OK, so..and you'd start..sorry, you'd started working..stopped working..

S: Yeah, I stopped working when I..yes, when I became..when I had..w.I worked..a.six.up until six weeks before I had R___ (she pours her tea), and

then I um...stopped. So I didn't start again until..um, J___, our youngest was..er..in year 9 at school, although.in the interim I'd.did a.visual arts degree.

Soon after she reports being well throughout the pregnancy.

I: Right, mm. OK, um..what else? And.you were well during the pregnancy?

S: Very well.

I: Mm.

S: Mm. Very well.

But she then reports a demanding baby who was hard to settle.

I: And ah, he was a.comfy baby to ah..

S: Oh...very.oh, he was probably demanding, but I mean, he probably takes after me, I'm fairly demanding. Characteris.personality characterist.

I: Are you?

S: Characteristics are inherited. Well some of them are, some of them aren't.

I: Um, can you say a little bit more about that?

S: Aah, well.some people are demanding and some aren't. That's.just.simply it. Um..he.wanted.his.food when he wanted it, and if he didn't get it then he'd.get..well, demanding..which he can, yeah. Um..

I: And that was.a bit different from the other two?

S: Oh..Ju___ (participant's sister) was..er, the next baby Je___ (participant's brother) was a very big baby, um.but then Ju___ the.third child was.half.in between the two of them. R___ wasn't exceptionally demanding, he was.just um...um, a little bit impatient, but he always has been, I always have been too, so.

She shifts tense to the present, denoting an intensity of relationship between herself and her participant son. She reports some difficulty adjusting to being at home as a new mum.

S: Oh, first child you're always very nervous. First child's a bit of an experiment.

And the next piece of conversation is about her mother not being able to provide support.

Probably.er when..I'd.left work.mum used to work an awful lot, and being home with the baby..um, it was difficult..um..to get used to.

I: Ahhah. How did you..cope with that, in terms of..

S: Does this really have any bearing on your..

I: All I'm.all I'm doing is.sort of, following.wherever the conversation goes.

This mother is keen to get on to explain that the illness is genetic and triggered by illicit drugs, and this may contribute to her hesitancy in discussing any other potentially relevant stressors.

But I.I would say it was a.major catalyst, because he didn't show any signs of..of the tendencies that all the books say about children being um..ahm, not being outgoing, not.being isolated, being loners, being difficult.to get along with, he was not like that at all. He was a..um..fairly.amenable.sociable.little boy, always.loved having friends. He was..he was quite popular..um... he's.very.yeah, um..so he didn't show any of the..traits that are commonly.associated with people who...per.perhaps will.you know, who do go on to develop.schizophrenia. Ahm....perhaps..the only thing I can think of is that he.he like me, is.fairly.highly.st.well, slightly highly strung, I guess. Ahm..very intense. Very.intense, yeah, very intense..um, and very..extremely sensitive, as a child.um..um.yeah.sure.you.very soft-hearted I s'pose, really..um...but...ah.

This sensitivity, although not in itself sufficient to define anxious attachment, may indicate a greater need for sensitive understanding from an attuned mother. This child did have difficulties when first at school, and as previously stated was difficult to settle.

I: Um..just going back, I'm.particularly interested in.from 0 to 3, and, just looking back, um..as far as you know, it was.pretty uneventful?

S: Yeah, it was.ahm....yep. R___ was a very.clinging baby, um.very.a little bit insecure, but I don't think..um..I think a lot of.children are like that.um. He um (sigh) always wanted to be cuddled, um..and being of course he was the first child, we didn't mind that um..he was breastfed for a long time, 'til he was.fourteen months old, um.'cos he just didn't.and in the end, the only way I could wean him, was by just cuddling him, and rocking him to sleep, and then putting him to bed..um...he.because he never liked being.put down in the cot and he cried, and I couldn't.stand the crying, um...I think um.we were just.one thing I find very difficult. I found it very difficult to cope.with listening to my own children.my own babies crying.

Mother may be expressing her own anxieties as a new mother transmitting to her participant son, but the following is at odds with her previous description of him not having the personality type attributed to children who later develop schizophrenia.

Um..never went to day care.um. Well I tried once or twice, but he just.couldn't stop.that's it. Well no, he'd just get so.upset.and.um...so I couldn't.bear the thought of leaving him there crying, so..

It is at the end of interview after discussing any possible traumatic events in her participant son's earliest years that mother gets to the issue avoided at the beginning of interview.

The only thing I can really think.of.that possibly may have affected his development.in utero.was um..no doubt.and this is.drawing a very long straw. I did read somewhere that.in some article, that...ah, that research.was done on people with..schizophrenia who were born during the war years..ah, World War II, and people who had.been.through..um, famine..um. Have you read anything like that?

I: I've read, and heard about a lot of.theories that.um..

S: Starvation. Famine, not ???may have led to it.

She then quickly gets to the heart of her concern.

Oh well.ah.I.um.didn't actually know I was pregnant with R___ 'til I was five months pregnant, because I had..been on the pill for quite a long time..'cos I didn't have them 'til I was twenty-nine..and.um...I went off the pill..thought I was pregnant six weeks later, went along and had a test.my GP just laughed, and just said "Oh, it's come back negative" he said. "Look", you know, "Wait for a year, then come back." S.and.my..father who was a drug rep said the same thing, so you know. "You've been on the pill for five years", you know, "and hoping really to get pregnant".but I actually was pregnant.at six weeks. It was a false.negative..and then I started putting on weight, so I started dieting..'cos I hadn't.I hadn't had any periods for.a full year..before I went off the pill anyway, so I didn't know whether..you know, so I started dieting, and I was.very.conscious of my weight, and I.I was probably eating very healthy foods..ah, I was getting lots of exercise.swimming...four lengths every morning, and then walking to work..and um..but I was still very well. I.didn't have any morning sickness. Probably..

I: And you weren't, you know, experiencing fainting spells?

S: Oh no...only once, when I had too much to drink..at a par. Christmas party, and I just wonder whether I drank too much in the first three months, I mean. I just don't know. I mean. I met. I didn't drink on a regular basis, but, at a party or something, whether I had too much to drink. You just, and then, at five months. I went. I finally went to my GP, and I said "Look, I need to go to a specialist. I'm not getting pregnant." And so he referred me to a specialist who, who examined me, and said "Look, you're five months pregnant."

(laugh) So...um..yes, anyway..ah, that's the only other thing I can think of.

Although wanted, this pregnancy was unexpected, perhaps contributing to the apparent anxious attachment between this mother and her first child.

SCZ004: Three themes are revealed in interview. This mother depicts a family in which she and the children are united in their blaming of father for all the family's problems. Therefore at the beginning of interview, she reports her husband as not wanting the participant son's arrival, then at end of interview that she was in turmoil over the pregnancy and that she had made a very half-hearted attempt to abort. She refers to this unwanted baby as being the wrong sex, and describes his oppositional behaviour as intense.

She concludes with a frankness not evident in the body of her narrative:

another child, that I jumped off these steps and I didn't even jump off the top it wasn't really that far, you know, thinking that oh, maybe I'd have a miscarriage. You know I didn't really want to do that, I just felt really distraught and..

I: You must have been feeling pretty desperate.

S: Yeah. Pretty, ah, distraught, so, and of course nothing happened. Other, but, I still remember doing that, that I did that it was a, an issue, and I always felt guilty about that. I thought well maybe that, maybe M___ (participant son) suffers from this rejection because, well in the womb I think they do..I mean I think they're aware of rejection and whe..aware of whether they're wanted and, but I didn't not want, I did not personally not want him, I felt J___ (participant's father) didn't want him, and when I told J___ about this years ago, he said that that wasn't true. And so I realised in my mental state. 'cause I was really depressed as a child. Big time depressed as a child, wouldn't

have my photo taken, wouldn't cross the road before I talked to anyone, I wouldn't talk to..I was just depressed as a child. Mm, so.

I: Mm. And there's another story.

She may have been depressed after the birth, but does not say so. However, she cannot immediately name this baby, and it appears that the hospital staff's comments are indelibly printed on her mind. She also refers to his being the incorrect sex, a fundamental aspect of a child's identity.

S: Ummm. I'll tell you something we didn't have a name picked out for him. I really wanted him to be a girl. Really wanted him to be a girl and I didn't have a name picked out, and I was really disappointed at first that he was a boy. And, as my daughter-in-law and son have been, every other time. not every other time, but they've got. boy girl. four boys. And the last two they really wanted a girl. (laugh) Um, so anyway I was really disappointed, and I. ah. just for a little while, a day or two and he didn't have a name for a couple of days 'cause I'd picked out B___, and. if I did have a boy. didn't really have a boy's name picked out, but I. um.. I had B___, picked out if. you know, family, but he didn't look like a B___ and I didn't call him B___ and so he didn't have a name for a little while, and they used to come in and say "Oh this is the. no name R___ baby" or something like that, just for the first day or so, and then. we called him M___.

I: After?

S: Just after. probably a couple of days.

I: Yeah. After whom?

S: I don't know. I think I looked through the papers and. 'cause my. our first two children. three children were named after someone but M___ wasn't. You know so. so. I used to babysit children and. may have first one named after one of the children I minded 'cause I loved the kid and I loved the name so. But M___ no. Not after anybody particular, no.

Her next comment leaves this researcher searching for meaning in her narrative. When she is less effusive, she is more believable.

S: Um, I loved having babies. I just loved having, ah.. yeah. I wanted two more children. Mm. J___ didn't want any more.

I: That would have been. six.

S: Six. I would have liked six. And I even grieved for those two children, really. Um.er.like when we did that marriage course that time and.God showed J___ that he was hard as nails, then women (forced giggle) who couldn't have babies, or had lost them, and here.I couldn't.get over.here I am.I'm.I'm..really sad, that I didn't have two more children. These poor women! They can't have any or they've only got one, or something and.but I realised that it was.something that I really longed for.

Mother reports her participant son being cuddly, well-liked by adults, and having friends. However, once again her story is difficult to piece together. It is unclear whether his earliest school difficulties were behavioural, social or academic. Her lack of clarity may reflect her reluctance to explore his difficulties at the time. The following passage, although long, is included in its entirety in order to indicate the incomplete thoughts, the chaos, the non-conclusions and the irrelevant detail.

I: So he had friends..all through school?

S: Yeah, he did. Mm. I can remember a few.f.funny things about M___ though. You know, unusual.to me unusual.and I'm sure you'd like to know those.things.

I: Sure.

S: Right. Well when M___..um, went to preschool he went to H___ preschool, his teacher told me.now we put our kids in.to a Christian school.we.our.like...we belonged to.I don't know what it was called then, it had so many name change.T___ City Church it is now but, um...whatever it was, I don't know, CLC, Christian Life Centre or something we were in B___ Street.in R___ Street to start with, then we were in B___ Street and we started our own school, the parents, and the pastor..she was a school teacher one of their ladies whose children went to the school as well, we started a school in B___ Street there were nineteen children. Three of them were ours, and um..so OK so.the first year wasn't grade one, so M___ was in preschool that first year, uhm...so three of them went, that's right, and then M___..and then..er..ah.Mrs. B___ her name was the teacher, I still remember Mrs. B___ I think that was her name, B___ or B___. Anyway, she told me, she knew.like we did talk to them and everything, and she knew M___ was going to a private school where.they used the ACE..Accelerated Christian Education they had like little.things of their own, they worked on

books.through.books.like magazine size.books. OK. She said to me..she said "I'm really pleased M___'s going to a school like that" she said, "I think he would be lost in a classroom. He would be up the back." She must have seen this in him at.preschool. Must have. She said "He would just get lost in a.a large class, and he'd get away." Whether she meant he'd get away with not doing much, I don't know, but that's what she said. "I'm really pleased M___ is going to the type of school you're sending him to." So that was fine. M___ was e.the sort of kid that always.uhm, pushed through the fence. If there were any l.limits, guidelines, he would.push through. And um, you had to.bring him back all the time. He was really a.a.boist.um.not boisterous, yeah, really. Yeah, he just always pushed the limits, always and, we used to encourage his.I think.I think the teachers.oh one teacher in particular, he's now a pastor, and he was a teacher, he um..I think he thought well J___ was too hard on M___ 'cause J___ (father) used to say "J___ (teacher) you've got to bring M___ back in, you can't let him push through the fence. The more he pushed through, the more he'll want to go further. You've got to bring him back". And I think J___ (teacher) thought J___ (father) was too hard, and J___ was pretty hard, but M___ was like that, and he did need to have those boundaries. And so um..so, that was..

I: And what do you make of that?

S: I don't know, but see M___'s like this, he's still like this. He would want to do something. And he would drive me.like he wanted to go across the road and play with B___. There weren't many kids round out where we live, and there still aren't. It's on T___ Street, main street, not many kids, and B___ lived across the road. M___ would want to go over there and he'd say "Mum, can I go, can I go, can I go?" And I'd say "No M___ you can't no you can't no you can't" but he'd keep on and on and on and on and on. One day I said to him "M___, look it's being disobedient you keeping on asking me, 'cause I'm saying no you can't." Um, he was.he would just continually.but..and then he would try to do.g.get me.to give in to him for something, and he'd.on and on and on and on, and so. "Ask dad ask dad ask dad" or.whatever, but when.J___..when he realised he couldn't get it, he would stop dead. You know, he would push you and push you and push you but then he'd.J___ said "No M___, you cannot do that!" He'd forget it as though he never wanted to

do it. He's still very much like that today. Still very much. He'll push and push want want want something, but when he finally resol.realises no I can't have it, he can stop dead. As though he never asked for it. And he was like that as a little kid as well, and he still does that today I've noticed, yeah. So um.

Embedded in this wealth of disconnected detail, the impressions are that this child could not find his place in the family of the classroom, and that mother is the one who found him too much for her. Mother then relates a tale of failed romance, not realising it is the attention and warmth her son is seeking at the age of eight years with a sixteen year-old babysitter.

and lovely with kids.tells them she loves them and, you know, she's still one to.'cause she's this gushy.you know, all her attention while she's talking to you sort of person, she still is. Well with the kids, this is what she was like, and she told M___ she loved him, see. And he saw her at the park, um.gr.kissing another fellow. She was sixteen or something, and that night, he was cr.sobbing in his bedroom, in his bed and, we said "Mi".he was only seven eight or nine. We just can't remember how old, we said "M___, what's wrong with you?" You know, what's wrong, you know, and he wouldn't tell us, and then finally he told us "R___ said she loved me (in a whining voice) and she was kissing.B___" or whoever it was. And he was devastated (very loud whisper) and we thought my goodness, that is unusual in a child his age. To us it seemed unusual, we've never had anything like that happen before. So to me that was an unusual..bit unusual thing.

Eventually his distress at not fitting in at school is evidenced in school refusal, with mother cooperating in his avoidance, even though he is too much for her at home.

And um..the other thing, he used to get a lot of tummy pain. He.he would miss school one day a week, he would have some reason why he couldn't go to school. Have a tummy pain or..."I'm sick" or..I'd always be in trouble off J___ (father) "Why didn't you make him go to school?" I mean I didn't want him to stay home but..but he did legitimately have.this wasn't for years and years, this was later. You know, probably..early high school years. He um...J___ was always "Well if you stay home, you don't watch TV. If you're sick you h.you're too sick to watch." (laugh) Well I tried to do those things,

you know, but he just.he just seemed to oh, be sick once.at least once a week and.tummy pains and.and actually when we..there was one time when he got really bad tummy pains, that was when he was probably...um, '89, how old is.that's ten years ago, tw.fifteen.fourteen, fifteen. He probably.really bad, so much that we got the doctor. And um, yeah.

I: And he found..what?

S: Well he thought it was stress I think.

It is as though the parents were unable to tell their child was stressed. Mother does not specifically say that he was insecure, but at age twelve he begs to come home from being with his peers.

Oh.at.I'll tell you what he was like. He went one time with friends..he was probably eleven twelve he might have been. He mightn't have been that old, but he wasn't really old, and he wasn't really young. He had a best friend from school, and he um, went out to.with them somewhere out on a property. Well they had to bring him in, he wouldn't stay there. He was upset, he didn't want to be there.

I: Mm. Was he homesick?

S: Well he said. Yeah. Would seem as though.upset, yeah, didn't want to be there. But then that passed, and.'cause I can remember him doing something and I thought "Oh he won't want to do it" but he did and he was alright, so. Nothing really..weird or anything. But other than that, I don't think he was..yeah. Away.

The above narrative covers several indicators of attachment difficulties for the participant, beginning with being unwanted and the wrong sex, through to difficulties with feeling secure enough with peers to enjoy an overnight stay away from home.

SCZ005: Two themes are covered. At opening of interview, mother is asked about her memories of being pregnant with the participant, and immediately there is a sense of contradiction in her story of it being planned but overwhelming. This interviewer concludes that her pregnancy with the participant was unplanned, and in addition that he was the wrong sex.

S: ..Well...I mean eh eh, I was really flat out at the time, I had.three children..in two years and two days. T___ (participant son) was the middle one. And um...I mean they were all babies together, so.I really had no time.to

do anything...ahm, once one'd cry they'd all cry, once one was hungry they were all hungry. So, if I went shopping..I never had..anything to carry them in, I used to take 'em on a bus, and have to nurse two and let one walk. But they were good kids really, they all kept one another..company, they'd be like triplets because (laugh) they'd all.play...as I said, they were all hungry at the same time.

This mother initially has trouble maintaining focus on her participant son as an infant and toddler, repeatedly mixing him in with his brother, not twelve months older, despite this researcher's efforts to keep her on track. Also, she states that all her pregnancies were planned, and immediately qualifies this with a remark about the next child, a daughter being unplanned because the parents thought she would be a boy, indicating that if the second child (the participant) had been a girl, there would have been no problems. This may be drawing a long bow, but later mother describes never having a life, that it was sacrificed to her large family, and at close of interview, to her participant son.

I: Right! Were they all planned?

S: Oh yes! Oh not, not J____. (participant's sister) No, we thought, we wouldn't have any more after the two boys because my husband wanted a daughter. And we thought..having 'em so close that they'd all be the same sex. Well..we were ah, devastated when..found out we were having another baby...so close! Two years and two days. But it turned out to be a beautiful girl. The only one we had.

Her participant son is something of a wag with his insightful remarks.

I: Um, when I first came, T____ said (in front of his mother) his problem was an oedipal complex. What do you make of that?

S: No idea. They must have told him that. Don't you think?

I: I don't know. (small laugh)

S: Well, I think one of the psychia..he might have asked them..what was wrong. And they must have told him that.

I: Goodness knows.

S: (laugh) I wouldn't know.

I: Can..do you feel that you can lead a fairly independent life?

S: I haven't been able to, for twenty years I've just looked after T____.

This vignette of failed separation between mother and son is seen by this researcher as a classic indicator of a form of failed attachment.

SCZ006: One theme is examined. This mother describes her participant son as not transitioning well to school, despite it being a very small country school and his older sister being there. Mother describes his preoccupation with farming as the sole cause of his hating school.

S: Well, eventually he went to school. And it.country school. And the teacher used to say if he was interest.interested in the.school as he was in the farms outside the window, he'd be um. So, he went on and hated school and.sent him to school and.and ah.well, he just didn't like school and we tried to get him to do.Junior.

And again later in interview:

S: Yeah. But with this bloke, I mean he hated school. From the day he started.

I: Do you think he hated being separated from you?

S: Oh! I don't know what he.oh.oh. I don't know whether he was that bad about me, but he just was a pain..about school. (laugh)

Mother does not seem to have assessed her son as having attachment difficulties, but this researcher considers the indicators in interview significant.

S: But poor old J____.he'd do this so dad'd, you know, for when dad came home..you know, 'cos dad was always away, and he'd do something else. And so he'd be so happy because he did it, and then dad'd say "Oh, but that's not what I told you to do." And.oh it used to go through me..just.it just.w.was terrible.

I: Was that always the way it was between the two of them, or..

S: A little bit...I don't know whether..I don't know whether D____ (father) was jealous of him or what.

I: Why would that be?

S: I don't know why. I don't know why it would be, but this is what used to happen. And it was.it was heart-breaking..to see.

I: So you were saying D____ was jealous. You mean, in that you and J____ were very close?

S: ..No. It.w.wh.w.w.whether it was the word jealous um..I don't know what it was.

I: Mm.

S: It's just hard to know what it was.

I: Can you recall, um..when J___ was really young, um. Were you well.straight after the birth?

S: Oh! Well you wouldn't know. I wouldn't say I was well. I.I was so worried.

I: Mm! Yeah.

S: And I had to.I.I.only thing that saved me were potplants and things to try and, you know, get it off my.mind. No I wasn't well, no. But see I worried too much about it. If I had my time over again (laugh), I wouldn't worry about them.

I: (laugh) It's easy enough to say now but, we make the b.best decisions we can at the time, don't we?

S: Ohh! I used to write them letters and ah. But getting back to J___, well that.and see he's been.it's.what.he's down there.what, about eighteen years or..

Mother is aware of some failure in continuity of care, but does not really identify attachment difficulties per se. She does however volunteer that she was so ill that she might not have noticed how her participant son felt about her absences and long periods in bed. Suddenly it is her problems with him rather than the participant's reactions to mother's unavailability that she wishes to disclose. Apparently with father being away for long periods of work commitments, people would come in to mind all the children, but this is not expanded upon. Whether it was people well-known and accepted by the children or not is unknown.

I: Did he follow you around at home a lot?

S: Oh well he was a..I don't suppose you could call him mummy's boy, buthe.he.he.yeah. He.he used to, mm. I don't know whether.. (splutter) whether he knew that.all the trouble I'd had with him. Wouldn't have known all the trouble I had with him.

I: No. No. Do you think he worried about your.you? When he was really little?

S: ...I don't know. He could have.ah, I don't know whether he did or not, but see I'd be losing the.these.you know, having these miscarriages, and I'd certainly would be upset and.at.and for all I know, that could have been

upsetting him a lot too. But I was so self-centred with how I felt, I.I wasn't aware of what anybody else thought. Mm.

She does however retain the interviewer's line of enquiry, and later comments on some pre-school play in which her participant son built a model farm and looked for her approval and interest.

I suppose he did lean on me a bit, he'd come in and say "Mum, come and come out and see how much I've done now", and you know, he'd.ah.he'd made.it was a lovely little place, that he'd made.

The above refers to a model farm which mother tries to find to show the interviewer, indicating that she has proudly kept it. It is tempting to dismiss the above as solely due to the speaker wishing to please the interviewer, but this mother recounts her anxiety about his survival as an infant, his reluctance to attend school, his conflict with and fear of his father, and reports that she had a lot of trouble with him.

SCZ007: Two themes are disclosed in interview. This mother describes an unplanned pregnancy with no overt negativity expressed, but she speaks in a dull, flat tone. There is dismissal about the impact, and mother states that with four children, she was from necessity the most organised she had ever been. The participant also experienced some difficulties when first at school.

I: Yeah. And um....it.it was an expected pregnancy, or..

S: No. It wasn't. I mean, we sort of.like um.none of them are two years apart, though, and I mean, that's what we really planned but..but I.we weren't worried. 'Cos we wanted four, anyway.

I: Mm. Mm.

S: Didn't really matter.

It is in this next passage that the panel are impressed by her flat tone, and interpret it as meaning the opposite.

S: But yeah, we were....we were quite delighted when he was born.

I: Yeah. And..

S: And he was a lovely baby..I mean they said he was the best baby in the nursery up at the Mothers.

I: Ahhah.

S: He was a very happy..he was a very happy..baby, he slept through the night at a very early age. Practically when I got him home he'd sleep through the night.

I: So he wasn't any problem?

S: He was no problem at all. As a baby.

Somewhat later in interview, this theme is revisited.

I: Mm. And when he was a baby, you had.no ideas that anything would be.going wrong.

S: No, not at all. He went f.he was ah...oh he had a couple of teachers who I don't think were.that good for him really. Like he only went to a one-teacher school.

I: Mm. In what way weren't they.good for him?

S: Ahm...well one in particular I think, you know, his self esteem.which he wasn't good at all apparently, and I don't think she was a good teacher, and anyway that's beside the point, but I mean some kids can cope but others can't.

I: How would he let you know that he wasn't coping with it?

S: Oh, just different things he'd say and that. He still.he still says to some.to this day, that something he did that he got right, and he reckoned she changed it and marked it wrong, I don't know. But I don't really know. We used to do the school bus run, and we did it for twenty-five years actually, so we did it all the way through his..all their schooling at N___, then they went to P___ High School. But he was actually going, you know, pretty well.

There is no recognition from mother about reasons for her son's poor self-esteem and non-coping from his earliest school years, and no specific learning difficulty is mentioned. There was no maternal illness during pregnancy and no birth trauma to suggest neurological impairment, and this researcher has interpreted the above as signs of attachment problems and insecurity. Mother has retreated again into 'not knowing', as if she is one step away from not being there. Mother tells of the doctor wanting her in hospital after the birth, the implication being that she needed to rest.

I: Mm. When he was born, you didn't have any difficulties with the birth?

S: No. Nup, not at all.

I: And.how long were you in hospital for..with him?

S: Ah, a week.

I: Mmhm.

S: Because the doctor..would.g.well, he was circumcised, and the doctor wanted me to stay.in a week, well he also knew I had the other three. Yeah.

Mother speaks very fondly of her mother who did a lot of the childminding whilst both parents were running the farm and doing the school bus run. She does think her mother's death impacted on her participant son and contributed to his illness.

I: Um..just going right back to.his earliest years again, um..where were your parents when..

S: Well my father died in 1969, so he wasn't..there at all, but I mean.G____ (participant son) knows about him and that, but my mother lived just ac.not.very far from us. Like.the houses were.we were on a farm, and she was in the cottage on the farm. So he..like she was like a.another mother really. She was always around and that, she.mum was really good with all of them.

I: So she did a lot of the minding, while you were..

S: Yeah.

I: Driving the bus and so on?

S: Yeah, she.she did, yeah. Yeah, they grew up very close to home.

I: Yes? Very hard to manage, on a farm, um.you know, without some.help, isn't it?

S: Yeah, well it can be, yeah. No, she was really good and they were very close to her.

I: Mm. Has she passed away too?

S: Yeah, in 1993. Well that was another thing probably affected him a bit. But I mean, she.she was 83. She'd been really well..until the last six months of her life. Was only a little thing, 4'11 and a half, but ah, plenty of go in her.

(laugh)

Her comment that the children grew up very close to home may have meant close to her home, but is conveyed as if her mother's home was more like home to them than that of their parents. This mother recognises the effect of her mother's death on her son, but at the same time minimises it.

SCZ009: Two themes are discussed. This mother's manner in describing the shock pregnancy with her participant daughter seems contradictory, and her daughter's

attachment problems are pieced together from an interview in which mother appears to idealise her family.

I: And um, for example, can you cast your mind back to when you first knew you were pregnant with H___? (participant daughter)

S: ..Yes. Mm, uh.

I: And just recalling that now, um, what's the first thing that comes to mind?

S: (indrawn breath) ..Probably.ah..first week or two..wasn't quite so happy but then.I'm.one of these sort of persons realistic persons I accept things as they go on.because I'd had three children, I had four children in four years. So she come along.(small laugh) we had a.and I was milking cows as well, so, you know, we were very hectic ah..but..you know I.I wasn't one of those people to get too upset.just.

I: So, you just accepted that..

S: Just accepted that..

I: And um, the first two weeks were..

S: Oh it'd only be the first two or three weeks you know, ah.you.you get pregnant, you're pregnant. That's it. (laugh)

I: So, you're saying it wasn't..it was a surprise.

S: Ohh..I wasn't really expecting it no.because she's only..oh what, fifteen months younger than I____....and uh, you know I.I had them all fairly close together. But then I was happy because..I believe in children, families coming up.pretty close together anyhow so that didn't worry us too much.

I: Yes, so you took it in your stride.

S: Mm. (sigh)

Father's chronic condition of poorly controlled diabetes was severe enough to lead to the young couple having to decide whether to have children or not.

S: Ah..our main problem ..d.decision to make then was whether we should have.children or not because there's sugar diabetes in my family..ah..in my father's family.and so we.we made a decision to carry on, and uh..never regretted it, and so far all our children have been healthy, except for.H___ having her.worries.

Mother describes the worry this caused, but not until near the end of interview. Because of the severity of the illness and unpredictability of crises, she

must have been very worried whenever he was away. Once again, distressing or traumatic stressors are volunteered and simultaneously denied.

S: No! Well you know, as I said..we were all blessed.with...good health, except for my husband, whose a dia.has been a diabetic since about six weeks after we married.

I: Mm. H___ said he'd um, you know, he'd had it since about age twenty-four.

S: Yeah. Yeah, yeah. So.you know, as I said.uh.all things considered we've been..healthwise we've been very.very happy?

Father's chronic ill health and the debate about having children may have meant considerable stress with their unwanted fourth child.

There are indicators of difficulties with attachment for the participant when attending boarding school.

S: Yeah, yeah. They're amazing. No! H___ wasn't real ah..all the children went to boarding school because we bought property out west and.had to go out there.ah, quite often. H___ was probably the least happy there, but as I said she's also the least logical one..of the family..ah, probably there's a few..a few disagreements along the way because..the (laugh).

Mother does not recognise the anxiety as that but rather that this child is not practical like her. The child's pattern of self-sacrifice is seen by this researcher as a sign of insecure attachment and poor sense of self.

S: Yeah. Yeah. But anyhow, ah...no, she's had a few.a few more personal problems as she.went through Uni. and everything than.the others did but then maybe that's because H___'s H___. She's a most soft.soft.softest-hearted girl. She really is.

I: Tell me a bit more about her being a softest-hearted little girl, when she was really little.

S: Well! Yeah, she was..she'd stand on her dig at times, but I mean she was always.er..soft, and mainly probably that come through.when she started at.High School..and she was helpful I believe er, in primary school too. She was the one that used to take the little children under their wing, you know, one-teacher schools..er.everyone sort of joins in together. She was always been the one to take 'em under the wing. And that's always followed through because she's.even when she come to university you know, she.she had the

car, and ah, she was always there.to help people, you know, and, I mean.one fellow got..her to go to B___ to hospital.to a doctor down in B___. She gets in the car and drive him down. She's always been a caring girl, you know.

That's the way she is.

This child seems to have had an early retreat into fantasy, and mother speaks several times about herself being realistic and her daughter not.

S: Oh golly....the neighbour.used to take her into school.and she said to me once "J___", she said, "I hope you don't mind...ah.H___.H___ talks about everything." I said "Yes, she does. But", I said, "if it's the truth I'm not worried." Ahm..she would always..she was very open.girl, always. Ahm...just a little incidence, jolly jumdrops..ahm..

I: What was that? Jolly..?

S: Jolly gumdrops. Ah...you know, there are just little instances..things'd come along and she'd talk about them and.and I'd try to st.you know, just..they weren't big things, but just to make her see what was a.reality if..if you did something, what would..reactions, you know?

I: Mm.

S: And.and what.'cos everything you do there's a reaction (laugh) one way or the other, somehow or other.

I: Consequences, you mean?

S: Yes. Certain consequences and..sort of.I'd always sort of.talk to her about that, and I mean, ah the friends she made..at ah.Uni..probably didn't fit in to our family. I think that's probably the.one of the hard things for her, as well as they may have done although we always tried to make them welcome, ah...it's very difficult if you've got a totally.different attitude to life I mean..ah..they.tended to be people..that had problems. And H___ was always helping them.

I: Right.

S: You know, and ah..

I: Were you worried about that for..her..

S: Oh yeah! Well, we were worried because.we worried about people taking advantage of her.as.a.as she was herself, you know.

I: Ahhah. Right.

S: Ah..she..she felt..she made a friend, she went to high school, she made a friend and a friend from primary school came..and they became best friends and H___ was third. She's always had this..bit of feeling about..being a little bit out. She also had the feeling..this come through and I'm..said to P___, (father) "Never felt we made anything of it", she didn't achieve scholastically..as well as the other children. 'Cos they're all maths, scienceminded, you know, even though one's dyslectic..ah..he still managed very well science-wise. I just..(sigh)..she didn't want to stay at..boarding school, but I couldn't see any other..way.out of.'cos we were going back and forwards to the property all the time and P___'s being diabetic..ah..I had to be..not far away, you know. That always had to be first. So she had to..handle that. We were fortunate when she come up the..Institute...ah, our..second son was at..College, G___. So he could come up every now and then and see her, so that helped out..there. But she had to..we couldn't get her into a..the college, which wasn't so ah, which we would've loved to have happened because then you'd get a..better m.a.a bigger mix of people, and she tended to be just always with her artistic..group.

It would seem that the message to this girl was that her friends did not belong in her family, and that in some way she did not either.

SCZ010: One theme is discussed. This mother had miscarriages but was unwilling to expand, except to say that she and her husband decided then to adopt. She reports a very insecure baby and toddler, without saying that adopting at six weeks may have contributed to this.

I: Mmhm. G___, can you tell me a bit about..that process, um. Just what you can remember.

S: Oh..pretty straightforward actually. Ahm..we went to B___ and picked him up. He was about..oh, probably six weeks old. Very insecure. It's surprising, because he..used to look at every ceiling when he went into a room. If he didn't know the ceiling, well that was it, he cried.

I: Right.

S: Yeah, you wouldn't think that at..that age, they would've..I s'pose he got used to the hospital ceiling didn't he..(laugh) That was all he was looking at. I don't know, but (laugh). You know, it seemed to be very nervous and early on. Yeah.

Mother focuses on the baby looking at the ceiling, instead of noting that he did not look at her. The substitution of 'he' with 'it' seems to underline this focus on an object rather than the connection between mother and baby. In an attempt to access her feelings about what may have alarmed her as a new mother, this researcher returns to the participant's earliest experiences of comfort-seeking.

I: Just going back to what you were saying about O ___ being really insecure right from the start.

S: Mm.

I: Can you tell me more about that?

S: ...Well probably not a lot. I mean he was a pretty happy little chap otherwise, but he just did not like strange houses. He really didn't. It was something that was very strong very early in the piece.

I: Mm. What could you do to settle him?

S: Oh probably just sit with him. If you sat with him and he'd he knew the security of that you were there, he was fine. But if you left him in a strange room in a...a strange environment, he just seemed to look at the ceiling (laugh) and that was the end of that, he'd just cry his little heart out.

I: Right. Yeah.

S: Yeah. Probably s.you know, different kids get different security things.

The laughter is incongruous, and appears nervous in origin. She sounds detached at one moment and then tender. Mother seems to try some self-soothing in interview with an attempt to normalise insecurity.

I: I'm particularly interested in the period nought to about three, ah..

S: Oh right.

I: The very earliest memories.

S: Mm. Well I would say there was nothing really out of the....probably one of the things that stands out as being a...probably at that stage a difficult time to to handle...if his father was away anywhere. Now we didn't have TV...um, so it wasn't that he saw a lot of TV as you'd think nowadays, but as soon as his father was away (bangs chair arm) for a few hours he'd be quite convinced, even at a fairly early age, probably mightn't be as young as three..I can't remember the first couple of times he did it.he'd become quite obsessed, that something was going to happen to daddy.

I: Right.

S: Yeah, it was really.and.and you couldn't comfort him. You couldn't do anything to comfort him.

I: Mm! I know this is hard to cast your mind back, but..your impression is that.that he was incredibly difficult to comfort, or you couldn't comfort him.

S: Well at that stage, no, in that particular.I mean in anything else you could, but just those odd things like that, that you couldn't. And that.that was one that really.you know, he really would become distressed, and I could've understood it if he was in the depths of TV and people had accidents or something like that, but we didn't have TV at that stage.

I: Mm. Mm. So what sense do you make of it now?

S:Not a lot, because I didn't feel that his.childhood was any different to.his sister's, and I mean, she didn't finish up with any problems.

She does not indicate that she realises that father's absence itself was distressing to the participant, and does not explain her inference about television, and the listener is left to guess that perhaps she means that dire imaginings could not be generated alone, and she may be correct. The interviewer holds onto the above, and returns to it later in an attempt to clarify mother's perceptions.

I: Right. Now just getting back to.O___, when he was really little, you were saying he.would worry terribly when dad was away.

S: Mm.

I: And.so..were they really close?

S: Yes, at that stage, they were.

I: Yeah. Uhhuh.

S: Yeah. But at.yeah, it.it was uncanny, because it was.it's just something that you.you don't understand when.'cos as I said if we'd had TV, I could've understood it, but. He was quite sure he'd had an accident or something, he'd just..

I: Mm.

S: You know, he'd become quite distraught.

I: Mm. So he couldn't sleep at night?

S: Oh no! He'd just cry and cry 'til dad come home. Then he'd be right then.

(laugh)

I: (Small laugh) What did that do to you?

S: Well! There wasn't much you could do. You could sit with him, you could talk to him, you could cuddle him, but...there's not...yo.you can only just comfort to a certain extent. If they won't accept it after that, well there's not much you can do is there?

I: Yes. Yes.

S: I mean it gets very nervewracking, but you just.cope with it.

Mother has heard my question regarding what her child's incessant crying did to her, but she delays her response and interjects first with relevant but indirect material. The distancing 'you's' and incongruent laughter may demark distress. Much later when mother has relaxed into the interview more, the interviewer asks more about their circumstances. She volunteers the following:

S: And he always had a stress with...ah, making friends.

I: Ahhah.

S: Now..when you have.kids in an isolated situation..I've always wondered how much of that, you know, had I packed him off to boarding school at.year.as a six year old, which I couldn't bear to do (laugh). Seemed a terrible thing to do to a child, whether he would've learnt.as a social skill.

I: Mm.

S: To handle that better. I can remember him bribing kids to be his friend.

I: Mm.

S: And to me that.that seemed the most dreadful thing to have to do. And we did lots of things, I mean.we had..ah, even when I was teaching, we used to go to school.around.we used to go to.town once a month to shop, and we used to take him to.school and leave him for the day. Very traumatic, 'cos he used to howl the whole eighty.K's to town...or eighty miles to town it was, and..and A___ (participant's sister) used to go, she used to go.too, but it never worried her to that.that extent, but the teachers always said "Half an hour after you'd left, he was fine." And.and they weren't worried about him, I mean..

I: He was.really anxious mostly about leaving you do you think?

S: ..Whether it was leaving us, or leaving that environment that he was.comfortable in. That he knew.

I: Mm.

S: I don't know, but I did lots of things to try and..give him that skill, but it.it you know..was very much a thing of his early childhood.

This mother conveys that she tried her best to provide her participant child with the best available in medical and educational services.

I: Yeah. Sounds like you really racked your brains to try and come up with things that would help him.

S: Yeah. He um, we always had...um, say tennis group that that met every month, you know, as a social day, they had a tennis day and a BBQ and, and the kids of the district got together much like a playgroup does here you know, and they all had fun, but O___ always had trouble coping with those environments he had. As a little child, another thing he was obsessed about, and at that two year old stage too, I'd forgotten about. If you went out anywhere, and I sat on that chair..I had to stay on that chair. If I moved from that chair, and he looked back from wherever he was, he was insecure, he would scream and roar. And they all knew to come and grab me by the ear quick and lively (laugh), but he'd be stressed, or grab J___ (father) or somebody. But quite often I was there on my own because J___ would be, er, doing something else.

I: So you think he was pretty insecure, um..when you got him home from..

S: Mm.

I: From the hospital, and that didn't really settle.

S: Not entirely, but that was very pronounced. I mean, they all knew that you know, if you sit in that chair, you stay in that chair mum. It doesn't matter, you can go off and play, but you must be there when he needed you to come back to.

This participant still lives with his parents.

Examples of Attachment Difficulties in the Depression Sample

DEP101: One theme is discussed. This mother had a very compromised baby and saw him initially after the birth but only very briefly, and then could only see him through the nursery window for the first four days. He required specialised nursing, and she reports being worried in hospital about spoiling him with demand feeding, but then follows this up with a description of a fairly settled baby at home. However, this child displayed significant separation anxiety via school refusal. Mother reflects that her giving in to this may have contributed to his school difficulties, but essentially she blames his poor learning skills. However, this child managed very quickly to learn all the lines of the lead character in a school play.

He.you know..probably missed a bit more school than he should've again and...I used to take him to school and by the time I drove home, he'd be sitting on the back steps. He'd come a short-cut. (small laugh)

I: Right.

S: Very fast.

I: So..when did he far.first start refusing school?

S: Oh gee! Right from kindergarten. Because I.I thought.the girls didn't go to kindergarten, and.and I thought oh well, a.a.just a couple of days, because he was by himself a lot and, and with the girls and, unless he.had.got dressed up.and played their games, they wouldn't play with him (laugh) sort of, basically. And ah, yeah, he hated kindergarten. I.I.he used to just hang on for grim death when you got.there and..and that and.that didn't work. Maybe I shouldn't've give in and..and that, that might've been the start of school problems, I don't know, but I.he.he could never learn. We started teaching him Humpty Dumpty.when he was about two, and he still didn't know it when he went to school.

The stuttering and change from an 'I' statement to 'he' may indicate that it was mother who felt anxious about parting with this child whom she almost lost at birth.

I: Mm. Mmhm. Mm.

S: And ah..

I: Do you think that was the..cause of him not liking school?

S: I think so. Yeah. And he never ever did like it to.let me out of his sight.

I: Mm.

S: Even if I left him with his nanna, he'd scream blue murder..'til I got out to the car to go shopping, you know?

I: So this was..

S: This was before he started school, that was.

Mother later shifts back to school as being her participant son's major stressor because of his size and learning difficulties. She reports him developing friends out of school.

S: But ah..you know he.I think in that way he had a fairly happy.out of school time.but hated school with passion.

I: Mm.

S: Because he was big. Everybody expected him to act older than he was. Aahm..little kids.his.his age, they.they could pinch him or.do whatever, but if he pushed them over, he was the school bully.

I: Mm.

S: And ah...no, he had a.tough time at school.

I: Mm.

S: I always.remember he.they had a.um a.they always did a high school play, and they did Mikado. And the young boy that was to.do the lead, their par.his parents got a transfer.through the year, and.and he had to leave..and only had a.oh..a month or six weeks.to teach somebody else. So, S___ loved music and.stuff like that, and ah..they taught him.Mikado in that..short period. They used to take him in his dinner hour...and I said to the.teacher, I said “You know if you spent half that time on S___ in school hours”, I said, “he’d be OK.”

She and father have struggled to expect responsible adult behaviour from their participant son after his severe episode of depression in which he expressed suicidal thoughts.

S: So. But some people probably think that is.the best way for ‘em to get back on their feet.without someone thinking for ‘em and doing everything for ‘em. ‘Cos we do...spoil him, I guess.

I: Mm.

S: Take his dinner in and..

After about three years at home, his parents are now charging him rent, and thinking of him living more independently of them.

S: We’re going to try and get him in to a flat this year. But ah..even, you know...we’re not too sure..we were thinkin’.we might go away for a while. Give him the flat..and see if he can manage by himself but.we don’t know.we don’t want to abandon him, and we don’t know how that’ll.go because if he feels like something else, he’ll buy it and won’t pay his rent. And then who’s going to pay his rent? Well..muggins. Us.

There appears to be a well-established dependent relationship now.

S: And ah, we went to a BBQ and didn’t.out and around, and didn’t get home until about oh.about one o’clock. And I.found a note.and it had on it. “If I didn’t have..to leave everybody, I would die.” And he told us in hospital.he

was suicidal and we knew that. "The only reason..I didn't do it was because I knew how much I'd hurt you and dad."

I: Uhhuh.

S: "If I did do it." So..there's a lot of love.there, you know? All of us sort of thing and.and I think that's what upsets you too (tearful) so much, if you could just.get 'em back on their feet and give them something to look forward to and..some reason to get up in the morning.

The participant did leave home at the age of sixteen to work on a property, and returned at the age of thirty-two with little explanation of why and does not actively look for work or any significant activity.

DEP105: One theme is presented. Once again, we have a story of a difficult birth and a very sick baby, with mother not able to see him for about five days. Her relating is in dramatic detail, with direct quotes. Mother reports a little boy who played with his siblings, but never talked about them.

And ah, anyhow...he sort of developed alright and everything. Played with the other kids, but.never.ever sort of.talk about them.

Mother also reports a private language between this boy and his older brother.

S: And yet the other little fellow was...thirteen months.older.younger.he was gettin' round and doin' everything. Well the two of them sorta..I think K___ sorta helped P___. (participant son)

I: Mm.

S: Um..they were very ah, very close, the two of them. They were like twins.

I: Yes.

S: Wherever one was, the other one.was. I remember my mother coming out from T___ once and.she said "I don't know" she said to the neighbour "I don't know what H___'s rearing here" she said "but they're like two Chinamen" she said. "They get down in the yard", she said. "They dig in the ground" she said "talk to one another" she said, and.see.h.h.see he.and by that time I had D___. So.she said.and she'll sang out "Come on you fellas, get your dinner" she said. "And they'd come up" she said "and they talked to one another" she said. "I'm sure" she said "there must beChinese in 'em somewhere" she said "there talking this lingo" .and..and it was a knife and fork they were saying but my mother couldn't understand it.

I: Mm.

S: And they'd say "Awkatawkahawkatawk..hawkawawkatawk." Anyhow um.they said ah.

I: So they had a language of their own.

S: Their own. Yeah, they used to talk to one another in this..

I: Mm.

S: And that was it. Well P___'s always stuck to me.

I: Mm.

S: P___ always really.really stuck. The others did, but not like.P___did.

However, mother states categorically that he was not clingy as a child and did not protest about going off to school.

I: So he stuck with you. Um..when he was.old enough, did he go off to school quite happily, or did he want to stay at home with you?

S: No! No, no, went off to school, and went off to work. He was working when he was fourteen, out in the bush, driving tractors and doing things whatever there was to do. Well then he went into.slaughtering. He was..and ah, things like that.but, no, he..

I: Mm.

S: He.he wasn't sooky. He.no.no sookiness about him.

Mother reports however that he got lost in the classroom, and this sounds more like a developmental delay than an intellectual disability.

S: And.he had all this trouble at school. Anyhow, it wasn't until he got to grade..five or six.that.um.a school teacher, the ha.the headmaster's wife.was teaching that grade. She used to take him out.to her table, and she said "When he was close", he could see what.she was talking about. But.they used to.the others'd just put him in the back of the class and forget about him, you know?

I: Mm. Mm.

S: He was a dunce.the.but he sort of picked up from her.

I: Mm!

S: And that's how he learned to do..

It is only half-way through the interview that the apparently enmeshed relationship with her participant son is spelled out.

S: And I thought this.is.my life. I can't.there's not much I can do about it. But, I can keep myself straight...and look after the kids as best I can..which.I did.

I: Mm.

S: And I sort of.as er.time went on, and.next boy.reared kids'd mm.

I: Single-handedly.

S: Oh! Well this.this is.you know. That's why P ___'s like he is today. Got to look after mum!

I: Mm.

S: And he told 'em.told the.specialist down in B___ when he was having his heart..surgery. He said "As long as I live.out.outlive my mother" he said, "I don't care what happens to me."

I: Right.

S: He said "As long as I'm there..I can.watch.look after her."

This mother's anecdotal style makes it difficult to piece together when her participant son returned home.

DEP106: One theme was reported by this mother, who relates an unexpected pregnancy many years after having two daughters.

I: Well G___ thanks for agreeing to talk with me. Um.and I always start off with can you recall when you.first knew you were pregnant with R___, (participant son) and what comes to mind.recalling that time now?

S: ...Yes, I can remem.remember (small laugh). When um.I first found out I was pregnant, we um...we were a little bit surprised, because the sis.sister.the next one, is eight years. There's eight years in between 'em.so um, we were sort of um, you know, taken by surprise. But um, aah, we.were weren't in any way..disappointed, or anything like that.you know. We weren't angry about it or anything, no. We were quite happy.

I: Yeah.

S: And um, as time went on of course and he arrived, we.we really.enjoyed.having him, you know (small laugh). Again, it was.like having a first baby all over again. You know, having the.break in between.

Mother presents this information at the beginning of interview, and repeats her comment about this being just like having a first baby all over again. Her laughter appears incongruous.

S: (small laugh) And he was the smallest of the three of 'em.

I: Yeah?

S: Yeah. They usually tell you, you know, the babies get bigger as they go along, but ah..he wasn't, he was the smallest. I suppose having the big break in between..was like startin' off again. (laugh)

I: Maybe! (small laugh)

S: (laugh) Don't know. But anyway, yeah. So um..yeah, we all um.the.the other two absolutely.adored him and.oh we did too. (laugh)

There are indications in this interview of mother regarding her participant son with warmth and affection, and appreciation of his adult skills. His father died by drowning when he was aged three years, and this is covered in the section on trauma. DEP110: One theme is presented. Mother is at pains to point out that her participant son was and is very close to her, and to point out that her eldest son was always and still is close to his once violent and alcoholic father.

S: And.it's.surprising even to this day they're.so very very close. Especially the eldest fellow..and..his father. They are very close.

I: That's Z___? (participant's brother)

*S: Z___, yeah. W___..there was a..wasn't that.closeness.with W___.
(participant son)*

I: Mm.

S: He was more or less.mine. (small laugh) You know?

I: Yes. So.out of the three children, you and W___ were the closest?

S: Really, yeah, when.when they were little, yes.

Mother strengthens her position as the one who knows her participant son is special by talking about her protectiveness towards him in the extended family dynamics. Her husband's grandparents are reported as favouring the eldest grandson, the participant's brother.

S: Yes. Number one and.number two it was with them. It really was. Specially with the grandmother.

I: Mm.

S: And it.I know W___ felt it. But he..he's very very much like my father..W___. Sometimes a little too sensitive. He's a very, very sensitive bloke, and.he leaves things get a little too much to him. (sigh) Yeah, he's a.he's a lot like my father..on my side..

Mother is indicating that this sensitive son reacted badly to rejection, a sign of insecure attachment, and again insists that they had a special relationship.

S: But just that little special..thing with W___.

Mother's protectiveness can be readily understood when she relates his near-death from severe gastroenteritis which left him with a weakened bowel and subsequent difficulties at school.

I: Did you ever let him stay home from school?

S: Yes.

I: Yeah.

S: 'Cos it just got to him, that he was so..he was in tears.

Mother emphasises her participant son's vulnerability again, and is quite resentful towards his school teachers.

S: 'Cos it got..but it was a..quite a while, you know. That's a long time in a child's life to be picked on and..

I: Mm.

S: Chucked off at, specially by teachers.

I: That's right.

S: Specially by teachers.

I: Yeah.

S: So yes, he went through a lot, in a way. Tremendous amount. More than he should have.

And to further highlight his difficulty with peer relationships:

I: Now H___, with his um..bowel problem, um..can you tell me..about his um, easiness with making friends, was he um..was there a difference between..before he got the gastro to..after in terms of mixing with other children?

S: No..well see..oh well, he was..he was only a baby when he got it.

I: Yes.

S: You know.

I: You were saying about three.

S: Oh yes, he didn't..he didn't..he was..good with other kids, you know.

I: Yes.

S: Specially with littler ones than him.

I: Uhhuh.

S: But ah, yeah, he had a problem after that. All the picking on. He used to have..one or two good mates.

I: Yes.

S: And that's it.

It is only after the interview has initially ended that mother revisits her participant son's clinging behaviour after hospital, and the tape is re-started.

I: H___, you were just telling me a bit more about when W___ was desperately ill in hospital with the gastro..and that every time you visited him you.he really clung to you and..

S: Yeah.

I: It was hard putting him down again. And you were saying when.he came home from hospital, it stayed like that for a long time.

S: It did. Until he.more or less entered into high school.

I: Right.

S: And then.it wasn't clinging then, but it was still.that closeness.

I: Yes.

S: Yeah.

I: Looking back.looking back to the.more clingy time, can you think how long it took for him to.not be quite so clingy when you.leave him.

S: Oh.n.it'd.oh, it kind of.took him a couple of months not to be so clingy.

This interviewer has slipped into thinking of the clinginess as an ongoing dynamic, and mother is now quite contradictory, perhaps defensively.

I: Mm.

S: Yeah. But then he.you know, he got.he got back to being the.adventurous little boy that he was.

I: Yeah.

S: And the little sticky-beak. (small laugh) But then he was alright, you know. In with the other kids, and that was it.

Mother's appraisal of her son's attachment difficulties are reasonably consistent but are all attributed to his early gastroenteritis, whereas his adult depression is attributed to the domestic violence that occurred when he was little.

Summary of Attachment Themes

The mothers of the depression group are more likely than the mothers of the schizophrenia group to make links between nearly losing their participant child and that child as adult having difficulties now. In some interviews, mother herself

appears anxiously attached to this infant child, perhaps because of the traumatic events during pregnancy, birth, or soon after.

The mothers of the depression group are also more likely to reminisce with warmth about the participant child, rather than describing understandable stress reactions in their infant as 'odd'. The mothers of the depression group are more able to state that death via perinatal trauma, chronic childhood illness, domestic violence or serious accidents like near-drowning was a possibility, and in juxtaposition, the interviewer gains a picture both of the participant child and the relationship between mother and child.

In the schizophrenia group's mother interviews, there is often a sense for the interviewer that the child is lost, either via a sketchy incomplete description of the child as a person, confusion of one child with another by mother, or via her use of dismissing comments in relation to her participant child, in particular statements that indicate the child was not wanted or the wrong sex. Rejecting comments from the mothers about the existence of the pregnancy with the participant child and its gender are included. The child is powerless to change these two immutable facts (its existence and sexual identity). These comments from the mothers are considered to reflect an unresolved ambivalence towards these particular children, and are contextualised within particularly stressful periods for the families, but also reflect a rigidity in how the world should be. Dismissing speech may signify an ambivalent relationship to that child, and dismissing speech has been related to parental neglect (Crittenden, 1997). Type of insecure attachment is not formally assessed. It is noted that many of the fathers are described as physically absent often, and/or alcohol abusers, or display considerable anger. The fathers' narratives regrettably were not a part of this research programme due to time constraints.

None of the participants in this research were reported by the mothers to have been treated for any DSM-IV childhood disorders, but these mother interviews indicate symptoms consistent with attachment (social and emotional) difficulties that persisted throughout childhood and adolescence.

Chapter 7

RESULTS

This chapter firstly presents the descriptive statistics of the clinical participants' self-scoring on a depression scale. This depression scale is used to screen out those with a diagnosis of schizophrenia who may also have depression symptoms. Then descriptive statistics of clinical participants' self-reports on the Neglect subscale of the Traumatic Antecedents Questionnaire are presented. Means and standard deviations of the clinical participants' self-reports on the Emotional Deprivation subscale of the Core Beliefs Questionnaire are presented, and compared with previous clinical and non-clinical groups. These analyses address the research questions and questions related to the incidence of early family traumatic events and the potential for these events to be associated with the attachment difficulties between mother and child. The conceptual model proposed in the Method chapter is then extensively analysed using quantitative methodology. This conceptual model, derived from current empirical and theoretical knowledge of trauma and attachment, allows for examination of complex interactions between contextualised variables associated with these two bodies of knowledge.

Potential clinical participants selected by case managers were screened with the Zung Depression Scale to ensure that no participant with a diagnosis of schizophrenia had a concurrent depressive disorder (Table 9a).

Table 9a

Minimums, Maximums, Means and Standard Deviations of the Zung Depression Scale SDS Index of Participants by Diagnosis

Diagnostic Group	Minimum	Maximum	<i>M</i>	<i>SD</i>
Schizophrenia (N=25)	20	47	37.52	6.63
Depression (N=25)	34	69	53.16	9.79

None of the participants with schizophrenia score as depressed on the Zung Self-Rating Depression Scale (cutoff score = 50). Some of the participants with depression also score below the cutoff, indicating successful treatment for their illness.

All clinical participants completed the Traumatic Antecedents Questionnaire, using recall for specific traumatic events throughout childhood, adolescence and adulthood. In this research the Neglect subscale is selected because of the potential for this trauma to affect the attachment status and ongoing mental health of the recipients of such neglect (Table 9b).

Table 9b

Minimums, Maximums, Means and Standard Deviations of the Traumatic Antecedents Questionnaire Neglect Subscale of Participants by Diagnosis

Diagnostic Group	Neglect Reported At Age (Years)	Minimum	Maximum	<i>M</i>	<i>SD</i>
Schizophrenia (N=25)	0-6	0	2.67	0.37	0.74
	7-12	0	2.67	0.40	0.64
	13-18	0	2.67	0.58	0.71
	Adult	0	2.00	0.61	0.67
Depression (N=25)	0-6	0	1.00	0.17	0.33
	7-12	0	1.50	0.43	0.50
	13-18	0	2.40	0.67	0.69
	Adult	0	3.00	1.27	0.94

Cronbach's alpha for TAQ Neglect subscale for all participants was calculated for the separate age groups (0-6 years = 0.75; 7-12 years = 0.63; 13-18 years = 0.66; Adult = 0.41).

The Core Beliefs/Schema Questionnaire Emotional Deprivation subscale for all fifty (50) clinical participants is compared with a previous clinical group in which the results are summed using the same formula (Schmidt, et al. 1995). See Table 10.

Table 9c

Minimums, Maximums, Means and Standard Deviations of the Core Beliefs Questionnaire Emotional Deprivation Subscale of Participants by Diagnosis

Diagnostic Group	Minimum	Maximum	<i>M</i>	<i>SD</i>
Schizophrenia (N=25)	0.00	100.00	25.78	31.38
Depression (N=25)	0.00	100.00	53.33	39.93

Cronbach's alpha for CBQ Emotional Deprivation Subscale for all participants is calculated (0.95).

The Core Beliefs/Schema Questionnaire subscale of Emotional Deprivation for all fifty (50) participants, when scored similarly to a clinical group (Schmidt, et.al., 1995) provides the following comparisons (Table 10). The participants with depression in this research score higher than both the participants with schizophrenia and the prior clinical group, with the participants with schizophrenia scoring in the non-clinical range. This was only partially consistent with Hypothesis 1.

In order to assess the model (Figure 1a), a number of sequential analyses are conducted. In the first instance the association between Traumatic Antecedents in relation to Neglect at various ages, and the participants' Core Beliefs specifically in relation to Emotional Deprivation are assessed with Standard Multiple Regression analysis. This analysis is chosen because the intent is prediction, that is, does Neglect at various ages predict self-report of emotional deprivation? Then any association between the Mothers' dissociation during interview and the participants' Core Beliefs in relation to Emotional Deprivation is assessed with Spearman's rho.

Next, any association between the Mothers' recall of various early events, and the manner of her reporting (i.e. whether or not it is in a dissociative manner), the participants' Core Beliefs in relation to Emotional Deprivation, and the participants' diagnosis is analysed with a Discriminant Function Analysis. This analysis allows prediction of group membership (diagnosis) from the chosen set of predictors listed above. Finally as a post-hoc analysis, any association between the participants' diagnosis and current living arrangements (i.e. whether or not they are still living with mother/primary caregiver) is assessed with a Contingencies Chi Square.

Table 10

*Means and Standard Deviations of Emotional Deprivation
for Participants with Depression and Participants with Schizophrenia*

Sample	Emotional Deprivation	
Current research:	<i>M</i>	<i>SD</i>
Depression (N=25)	40.44	36.84
Schizophrenia (N=25)	13.33	23.57
Total (N=50)	26.98	33.53
Previous research:		
(Schmidt et al., 1995)		
Clinical (N=79)	31.7	11.6
Non-clinical (N=84)	22.9	7.4

Because previous research (Foley et al. 2000) has indicated that the greater the number of traumatic events, the greater is their individual impact, the number of different types of Trauma, Fatigue, and Attachment events are squared. These transformed variables are used to conduct the following analyses.

Neglect and Emotional Deprivation

Data are screened for parametric assumptions. While the number of cases is somewhat lower than what Tabachnick & Fidell (2001) recommend, *post hoc* power analysis established the reliability of the solution ($1-\beta=.99$). According to Mahalanobis Distance there are three multivariate outliers which are excluded from further analysis. Examination of the correlation matrix indicates no Multicollinearity. Assumptions in relation to Normality, Linearity, and Homoscedasticity of residuals are not violated given examination of normal and standardised residual plots.

The independent variables are Neglect at four separate age bands (0-6 years, 7-12 years, 13-18 years, and adult). The dependent variable is Core Beliefs in relation to Emotional Deprivation. The set of Neglect at four separate age bands significantly predicts Emotional Deprivation ($F(4)=3.958, p<.05$). Neglect across all ages accounts for 27.4% of the variability in Emotional Deprivation ($R^2=.274$).

Table 11 indicates (according to the standardised coefficients) that recall of Neglect during adult years, and between the ages of 7 and 12 years has a greater impact on Emotional Deprivation than Neglect at other ages, but no individual age band contributes significantly to the equation.

Table 11

Standardised Regression Coefficients

Independent Variables	β	t	Sig.
Neglect 0-6	-.044	-.229	.820
Neglect 7-12	.249	.920	.363
Neglect 13-18	.114	.502	.618
Neglect Adult	.272	1.653	.106

Mother's Dissociation and Emotional Deprivation

Spearman's rho indicates that there is only a small association between the Mother's dissociation during interview and the participant's Core Beliefs in relation to Emotional Deprivation ($\rho = -.132$). Two-tailed analysis indicates that this association is not significant ($p > .05$).

Mother's Recall of Early Family Events, Dissociation, Emotional Deprivation, and Diagnosis

Data are screened for parametric assumptions. Assumptions relating to unequal sample size and missing data are not applicable because the two groups are equal (25 participants in each), and there are no missing data. The power of the analysis is assessed *post hoc* and found to be very good ($1 - \beta = .99$), indicating that the results are reliable. Multivariate Normality and Linearity are not assessed, as recommended by Tabachnick & Fidell (2001). Mahalanobis Distance statistics identify two multivariate outliers (one from each diagnostic group) which are excluded from further analysis. The correlation matrix indicates no Multicollinearity. Box's M indicates that the assumption of Homogeneity of Variance-Covariance Matrix may be violated ($M = 48.398$, $p < .05$). However Tabachnick & Fidell (2001) note that this test is over-sensitive. Inspection of the plots of scores on the only discriminant function for the two diagnostic groups indicates similar distributions,

hence the assumption of Homogeneity of Variance-Covariance Matrix is not violated.

The independent variables are Mother's recall of various early events (Family Trauma, Maternal Fatigue and Participant Attachment Difficulties), the manner of her reporting (i.e. whether or not it was in a dissociative manner), and the participant's Core Beliefs in relation to Emotional Deprivation. The dependent variable is diagnostic group. A canonical discriminant function significantly distinguishes between the two groups (Wilks' $\Lambda=.435$, $\chi^2(5)=36.252$, $p<.05$). Table 12 indicates that Mothers' recall of the number of different types of Trauma events (squared) and Fatigue events (squared) contributes less to the distinction than other independent variables. Table 12 also indicates that the participants' Core Beliefs in relation to Emotional Deprivation load negatively on the canonical function, meaning that depression is associated with higher scores on Emotional Deprivation.

Table 12

Standardised Canonical Discriminant Function Coefficients

Independent Variables	Function
Attachment (squared)	0.61
Trauma (squared)	0.31
Fatigue (squared)	0.17
Dissociation	0.66
Emotional Deprivation	-0.60

Table 13 indicates that the canonical discriminant function correctly classified 83.3% of participants. The low number of incorrect classifications appears to equally effect both diagnostic groups.

Diagnosis and Current Living Arrangements

Contingencies Chi Square analysis indicates that there is a significant association between participants' diagnosis and current living arrangements ($\chi^2(1)=8.013$, $p<.05$). Sixty-eight percent (68%) of participants with schizophrenia are currently living with their Mothers, while only twenty-eight percent (28%) of participants with depression live with their Mothers.

Table 13

Classification Results

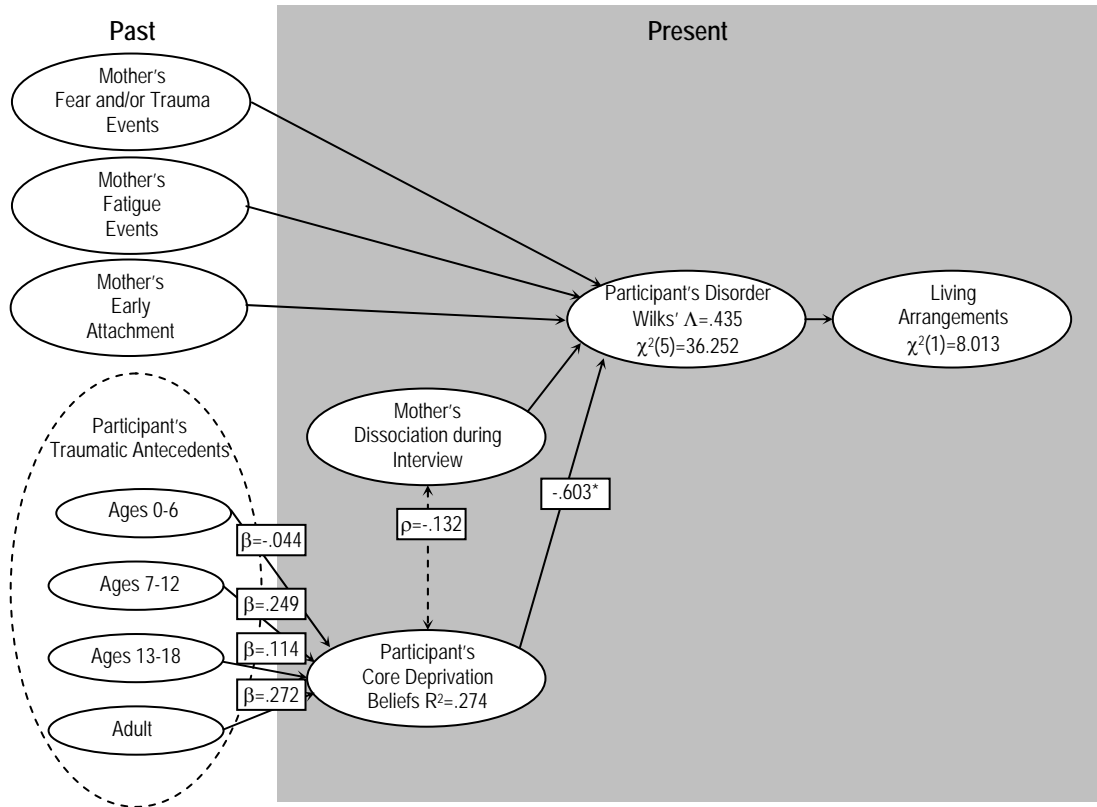
Actual Diagnosis	Predicted	
	Schizophrenia	Depression
Schizophrenia	21 (87.5%)	3 (12.5%)
Depression	5 (20.8%)	19 (79.2%)

Summary of Statistical Analyses

These results are added to Figure 1a presented earlier (here now Figure 1b). Figure 1b illustrates that Neglect at four separate age bands significantly predicts Emotional Deprivation. Further, recall of Neglect during adult years, and between the ages of 7 and 12 years has a greater impact on Emotional Deprivation than recall of Neglect at ages 0-6 years and 13-18 years. There is no significant association between the Mother's dissociation during interview and the participant's Core Beliefs in relation to Emotional Deprivation. In addition, Mothers' recall of the number of different types of Trauma events (squared) and Fatigue events (squared) contributes less to the distinction than the other independent variables, Dissociation and Attachment Difficulties (squared). And finally, the results indicate that there is a significant association between participants' diagnosis and current living arrangements.

Figure 1b

Results of a Model of Associations Between Past Reported Events and Current Representations



(* denotes standardised canonical discriminant function coefficients)

Chapter 8

DISCUSSION

This chapter integrates the quantitative and qualitative results of the previous chapters in the light of the hypotheses and research questions posed in the body of this research.

The hypotheses posed in this research are supported:

1. There is evidence of early family trauma (from just prior to participants' conception to age three years) for adult consumers of a community mental health service with major depression and consumers with schizophrenia. Clinical participants reported higher scores on the subscales of Emotional Deprivation on the Core Beliefs Questionnaire and Neglect on the Traumatic Antecedents Questionnaire than the norms provided by the questionnaire designers. Mothers/primary caregivers of clinical participants reported the occurrence of traumatic events from just prior to conception to the age of three years.
2. There are significant positive correlations between scores on the subscales of the Core Beliefs Questionnaire and scores on the childhood subscale of the Traumatic Antecedents Questionnaire.

In addition, some mothers report their family trauma experiences in a manner classified in this research as dissociative. Also, some mothers report several contributors to their fatigue in the early years, and provide information about their participant offsprings' attachment difficulties throughout infancy and childhood. The model (Figure 1b) principally indicates that the participants' mothers' current dissociative processes whilst reporting early family trauma, and these mothers' reports of the participants' attachment difficulties throughout childhood and adolescence contribute most to discriminating between their participant offsprings' diagnoses of major depression and schizophrenia. The number and types of early family trauma, and number and types of psychosocial stressors which the mothers associate with their fatigue contribute least to this discrimination. Participants' reports on structured questionnaires of parental neglect and lifelong emotional deprivation are not significantly correlated with maternal dissociative processes in interview. Those participants with a diagnosis of major depression score higher than participants with schizophrenia on schema related to emotional deprivation. Finally,

those participants with a diagnosis of schizophrenia are more likely to reside with their mothers than those with a diagnosis of major depression.

What meanings can be attributed to these results in the combined framework of attachment and trauma theories? Firstly, the disparate traumatic events reported by the mothers are discussed and secondly the non-resolution of the trauma via dissociative processes is considered. Thirdly, the contributors to the mothers' fatigue are discussed, and fourthly the evidence presented by the mothers for early and sustained attachment difficulties in their participant offspring is explored. Fifthly, what the participants contribute with respect to early neglect and its ongoing effect on their perception of lifelong emotional deprivation is discussed. Lastly how diagnosis predicts staying with mother or living more independently is discussed in the theoretical framework of both non-resolution of trauma and ongoing attachment difficulties.

Mothers' Reports of Early Family Trauma

All of the events included in defining this construct have the potential for severe stress because of their life-threatening nature. The impact that these events potentially had or are having on the mothers and on the participants as infants are discussed.

Miscarriage just prior to pregnancy with participant

Maternal reports of miscarriage occurring prior to pregnancy with the participant without an intervening full-term pregnancy is 24% ($N=6$) for the schizophrenia sample, and 4% ($N=1$) for the depression sample. The combined sample ($N=50$) has 14% of reported miscarriages just prior to pregnancies with participants. This percentage parallels that seen in the general population (Boyce, Condon & Ellwood, 2002; Goldstein, Corbin & Fung, 2000). The reported percentage in the schizophrenia group is higher than in the depression group. The emphasis on 'reported' is important, because enquiring into miscarriages was not a standardised question in the semi-structured mother interviews, relying on the mothers to volunteer this information.

The effects of miscarriage on the emotional life of the mother have been inadequately researched, in particular the emotional impact on the mother of discovering soon after a miscarriage that she is again pregnant. Craig, Tata and Reagan (2002) provide compelling evidence of the high risk of emotional distress for mothers following recurrent miscarriage as measured on depression and anxiety

self-report questionnaires. They also comment that their results correspond to previous research on single miscarriages. The levels of moderate to severe depression in their study are approximately 17%, with a remaining 16% with mild depression corresponding to non-clinical dysthymic mood. Approximately 20% experience levels of chronic anxiety similar to psychiatric outpatients. Maternal peritraumatic dissociation following miscarriage is reported at a rate of 70% in one study involving a normal population (Engelhard, van den Hout, Kindt, Arntz & Schouten, 2003), with the relationship between this immediate response and acute PTSD symptomatology thought to be mediated by memory fragmentation and thought suppression.

It is more likely that repeated trauma is responsible for a transition from acute to chronic PTSD symptoms, including dissociation. In a well-constructed study using the Adult Attachment Interview and measures of dissociation, Schuengel et al. (1999) included miscarriage as a significant loss within a non-clinical sample of mothers. Their findings suggest that insecurely attached mothers with unresolved loss/trauma are at times frightening to their infants when dissociating, and that these infants have a disorganised pattern of attachment to their frightening mothers. Harmon, Plummer and Frankel (2000) reported that miscarriage is as major a loss as the death of an adult family member, with both parents' grieving being marked by feelings of guilt and failure, and sometimes anger and bitterness. An estimated 25% of these grieving parents develop significant emotional difficulties within two years of a perinatal loss, thus making subsequent pregnancies vulnerable to raised anxiety in the mothers, characterised by self-protection and control, hypervigilance and emotional vulnerability, the hallmarks of PTSD. Less than optimal conditions are then in place for secure attachment between mother and her next infant.

Harmon et al. (2000) summarised pathological grief reactions following perinatal loss, including inappropriate cheerfulness or hostility, agitated depression, isolation, medical conditions, and lack of coping. Perception by mothers of lack of family support, additional stressful life events, and parental mental health problems predict extended grief. Anecdotal evidence (Campbell, 2004; personal communication) from a community liaison psychiatric service to new mothers indicates the negative and ambivalent responses these mothers often have to the news of a subsequent pregnancy, and that this may last for the duration of the pregnancy. The predominant fear expressed by expectant mothers in the first trimester of a

wanted pregnancy is a fear of miscarriage (Philipp & Carr, 2001). Craig et al. (2002) described the most significant protective factor leading to a successful subsequent pregnancy following miscarriage as being 'tender loving care'. That is, the availability of support, as well as the mothers' acceptance of the need for support, are predictive of positive outcome in the subsequent pregnancy. If the mothers' anticipated supports are unavailable for any reason, or if the mothers use denial or dissociation from distress in order to cope, or the mothers are too busy to avail themselves of opportunities for counselling, then stress throughout the subsequent pregnancy could be anticipated. Craig et al. reported that the distress following miscarriage may be long lasting with significant levels of depression and anxiety present at least ten (10) months later. Falling pregnant soon after may lessen the opportunity for expressing grief, as family and friends wish to focus on the 'good news', seeing it as a reparative experience in itself without acknowledging the fears it would naturally generate.

Traumatic birth prior to participant

Five (5) of the mothers of clinical participants with schizophrenia and four (4) of the mothers of participants with major depression describe traumatic births prior to the pregnancy with the participants. This researcher found no relevant literature. It is possible that a previous traumatic birth would have parallels with the impacts of miscarriage described above, with prior traumatic birth perhaps leading to nine months of anticipating and dreading a similar experience in which the survival of mother and/or baby is not guaranteed. A mixture of dread and hope may lead to ambivalence about the baby that may not be fully resolved if mother has few resources to do so.

Mother ill/severely stressed during pregnancy with participant

Several authors have presented compelling evidence for the foetal neurobiological sequelae of severe maternal stress during pregnancy. There are many unanswered questions about the most likely risk factors, with maternal influenza in the sixth month of gestation being posited as the most likely candidate (Schiffman et al. 2003). These authors have acknowledged, without expanding, that schizophrenia may be a 'two-hit' disorder, with maternal influenza affecting foetal neural development, followed by delivery complications, disrupted early family rearing conditions or other environmental traumas. They did not mention post-traumatic responses in the mother or attachment difficulties. Previously, Buka et al. (2001)

reported on the possible link between maternal infections and subsequent psychotic illnesses among offspring, specifically identifying the sexually transmitted herpes simplex virus type 2. This researcher is struck by the information the mothers in this study provide on several disparate threats during pregnancy (Table 6, Chapter 4).

It is acknowledged that a greater number of mothers of offspring with schizophrenia ($N=15/25$ or 60%) report severe stress or potentially life-threatening illness to self or foetus (depression sample $N=8/25$ or 32%), but the variety is extensive. Table 6 (Chapter 4) indicates that some mothers report more than one illness/stressor during pregnancy. The compartmentalisation that occurs when looking for specific disease entities/infections denies two things: normal maternal concern whenever anything threatens the viability of her foetus, and the context within which this stress is embedded. Schiffman et al. (2003) discussed maternal hypothalamic-pituitary-adrenal response to influenza infection during pregnancy and its potential impact on the developing foetus, without fully acknowledging that it is the stress, not the infection, that may be the critical factor. The above threats to maternal/foetal health or survival have as their single common theme the stress to the mothers. The fact that some mothers concurrently deny their fears of the potential impact of their illness or stress upon the foetus, or the emotional impact of distressing events such as previous miscarriage and unwanted pregnancy, and the manner in which this information is imparted to the interviewer indicates heightened arousal during the telling and a possible pathological grief response. Philipp & Carr (2001) covered the psychological stages during high-risk pregnancies, including the first task of paradoxically accepting the pregnancy and facing the possibility of foetal loss, with this heightened ambivalence continuing sometimes for the duration of the pregnancy.

Attachment to the foetus in high-risk pregnancies is under-researched. Recent findings have indicated potential for attachment disruption. Clearly more research needs to be conducted on the attitudinal shifts that may occur for both parents during a high-risk pregnancy, including a reduction in health-protecting and health-promoting behaviour.

Traumatic birth with participant

Perinatal trauma has been recognised as a major risk factor in schizophrenia, particularly with neonatal hypoxia and prematurity (Schiffman et al. 2003). Levels of the foetal stress hormone, corticotrophin-releasing factor, are implicated in premature

birth. Several studies (Baumann & Bogerts, 1999; Benes et al. 2000; Risch et al. 1992) predominantly indicated a higher proportion of adults with schizophrenia having traumatic births compared with other diagnostic groups. Some studies investigate the relationship between maternal stress-induced cortisol levels and autonomic arousal levels in the neonate, with little attention paid to the direct effects on attachment/bonding behaviour.

It is of considerable interest that the mothers in this current study report a high incidence of traumatic births in both diagnostic groups. Again, the difference appears to lie in how well-informed the mothers became (self-agency), how emotionally congruent and cognitively coherent they are in the telling, and whether the baby is presented as a real live entity to the interviewer. In some cases, the metaphorical question arises: Is the baby born yet? The implications for separation-individuation are discussed in the section on participants' current living arrangements.

Participant aged 0-3 years is seriously ill/accident

Once again, a wide range of life-threatening illnesses and accidents are reported, and it is the manner in which they are reported that indicates whether the event appears to have been successfully contained by mother or not. Near-drowning incidents are relatively common in both diagnostic groups. However, specific illnesses in the schizophrenia group are presented as having an unknown or mysterious origin, with the mothers reporting that the doctor did not know what it was, followed by claims that no harm occurred. Stopping breathing as a baby is presented as a single event occurring during times when mother was alone with the baby, father being away on business.

Family member is seriously ill/accident when participant aged 0-3 years

Father, mother and siblings are all included in this variable. Young children and toddlers are capable of existential crises in the face of loss of a parent via death or separation (Stolorow, Atwood & Orange, 2002). The effects may continue into adulthood (Kendler, Sheth, Gardner & Prescott, 2002). Some research has indicated that the effects into adulthood occur via HPA mediation of cortisol levels (Nicolson, 2004). Children are also potentially distressed by a shift of attention to an injured or ill sibling (Carandang, Folkins, Hines & Steward, 1979). Numerous self-help websites exist for families with a child experiencing chronic illness, thus

acknowledging the effects (kidshealth.org/parent/system/ill/seriously_ill.html; www.asiblingsite.com).

With chronic potentially life-threatening illness, for example, a father with poorly controlled diabetes, familial grief is necessarily incomplete as postponement is implemented. Grief and pathological grief have not been well-explored in families with a member with schizophrenia, but if unresolved grief is part of the adults' method of coping, then emotional consequences would be expected for offspring.

Parent of participant is violent/frequently angry/has PTSD

Warshaw (2001) discussed the oppressive nature of all forms (physical, sexual and psychological) of ongoing domestic violence. She stated that being isolated and entrapped, verbally intimidated and threatened, ridiculed and humiliated, witnessing destruction of property, having access to money controlled, and being refused personal items and contact with friends and family undermines autonomy and sense of self. Overcontrol is exercised with emotional withdrawal, threats of abandonment and threats to harm or to take away the children.

“Psychological abuse is more predictive of low self-esteem, depression, and posttraumatic stress disorder (PTSD) than is physical abuse” (p.480)

It is this latter diagnosis that is of particular relevance in this research, as dissociation is symptomatic of PTSD following abuse. The habitual use of dissociative techniques (e.g. denying the relevance of trauma, abuse or extreme stress to one's emotional life) is indicated in the speech of some of the mothers who report domestic violence, and is recognised as symptomatic of Complex PTSD (Herman, 1992). One could assume from this theory that guilt or blame would be projected onto others, and/or the sufferer might attempt to elicit exoneration of guilt from others. If so, a nominated person within a family could assume such a burden without knowing the subject/object of the guilt. One could then postulate that a protective idealisation by the nominated protector of the dissociating family member may occur.

Marital discord has been investigated as a contributor to infant disorganised attachment via meta-analysis of four separate studies, with mixed results (van IJzendoorn et al. 1999). This suggests that closer analysis of severity of threat, attempts at limit-setting, effective help-seeking behaviour and, in particular, mothers' capacity to 'hold the baby' despite marital discord, would be fruitful. The relevance to this research is in the potential for both parents to therefore be frightening and/or

frightened, thus providing no secure attachment figure in the absence of extended family or support networks as reported by the mothers.

The listener is in danger of dismissing the relevance of anger and yelling as a risk factor for the development of mental illness in offspring. This trauma item (SCZ $N=11/25$; DEP $N=12/25$) is guardedly presented in the schizophrenia sample, with sudden shifts away from the topic, often in the same sentence, or not presented until specific questions are asked about problem-solving. In the depression group, the information is more immediate, emotionally present, and includes indications of some resolution, either through early separation or divorce or strict limit setting, or a lessening of intensity.

Dissociative Processes in the Mother Interviews

Because of the interactive nature of the semi-structured interviews with the mothers in this dissertation, and the focus on attachment issues, use was made of the well-established concepts of transference and countertransference to reflect on the impact of the mothers' narratives on this researcher. These concepts are discussed in Chapter 2. Note was made of countertransference responses in this researcher and discussed with the principal supervisor and clinical colleagues.

Self-reflection in the process of interviewing mothers and analysing transcripts

The interactive space between speaker/interviewee and interviewer/listener is where the world of meaning sits. If meaning is fractured by the speaker and not rapidly reconstructed by the speaker or the listener, intense anxiety and confusion may be generated in the listener. This countertransference response underpins the importance of attachment theory in understanding intergenerational transmission of trauma. For countertransference to occur, there must be a significant break between the interviewer's 'world view' and that of the speaker, or alternately, a form of parallel process, and this is why it is imperative to use independent markers blind to diagnosis. In some of the interviews when trauma is discussed, attachment via language between speaker and interviewer is lost, and metaphorically the baby may also have been lost, and in some cases not retrieved. This suggests a sustained level of anxiety and a focus on doing rather than being. This focus on busy-ness in many of the transcripts was not anticipated, but a conceptual fit can be constructed around the central idea of 'dissociation'.

Normal empathic and supportive responses by the listener to expected suffering in the mothers is truncated by this cutting off of meaning, and may reflect the very isolation and lack of practical support they report. That is, the dissociation around trauma is not only severing connections within aspects of the speaker's self but also severing attachment to the listener and the environment. However, it is not essentially psychotic in its level of disintegration, and the speaker and listener are not completely engulfed by irrationality. Unmodified disintegration of rational thought and subsequent unfathomable anxiety are the hallmarks of psychosis. Jackson and Williams (1994) summarise this anxiety as 'unthinkable' by Winnicott, 'disintegration' by Kohut, and 'nameless dread' by Bion. None of the mothers in interview are evidently psychotic, even though at times they do not make sense. Temporary suspension of the capacity or willingness to relate to the listener/interviewer in a coherent manner when discussing traumatic events may indeed provide an insight into parallel process, that is, the disruption of meaningful relating to an infant who reminds mother of that trauma.

Trauma research has stated that the triggers for dissociation are extreme fear and/or a sense of powerlessness (van der Kolk et al. 1996). It is a way of pretending that the violence is not occurring to oneself, but to a split-off aspect of the self. Another split may be to deny the reality of the trauma itself, either as historical fact, or as a meaningful and emotionally challenging intrusion upon one's preconceived expectations of the world. The capacity of the human mind to perform such a split indicates a determination of the human organism to survive, even if it requires a tearing apart of reality. It is this purposeful fear-avoidance that may generate a conjoint shutting out of the listener, and at the same time, a locking in of the listener via raised and unfocused anxiety that is detected in the countertransference. It is at once intrusive and elusive. One impression in the interviews with the mothers who are defined as using dissociative processes in their story-telling is that they appear to live between the two worlds of reality and fantasy, but are 'forgetting' to conduct the traffic. For example, one mother describes a serious accident to her seven month old baby, stating in the one sentence that he was uninjured and that his jaw was broken.

SCZ002:

S: A very good baby and when he was seven months, we were building a house and my friends were there, and A___ (participant) was on the verandah in a stroller, and you know those straight ones like this, and there

was no steps and it was about 2'6" off the ground, so I jumped down and my skirt must have pulled the stroller...and I fell on the side of my head and I grabbed it...I picked him up and there was nothing wrong with him and he opened his mouth and he had a broken jaw.

The interviewer cannot maintain a role as a dispassionate trained observer, but is alternately in an interactive space with the speaker, and then is left to retrieve perspective and to track the unsaid and the unanswered. In fact, the interviewer has the considerable if not impossible task of organising into a coherent story that which the speaker presents in a disorganised and detached, fragmented and incoherent manner.

This suggests that there may be procedural links between the pathological process of habitual dissociation, and a form of anxious attaching and detaching from both the intended content in a conversation and from the listener in terms of interactional space. This is conceptually different from the double-bind communication style defined by Bateson, Jackson, Haley and Weakland (1956) which is framed in a manner perceived by many as pejorative, neglecting the context of overwhelming collective trauma, stress and fatigue. As a form of parallel process, it seems to this author that the mothers described by Bateson et al. also 'cannot win'.

In the speech of some of the interviewed mothers, apparent non-tracking of what has first been presented as traumatic or highly significant events and soon after denied or distorted in some manner, is typical of one form of dissociative process found in these interviews. The mothers of offspring with schizophrenia in interview often make a nonsense of emotions, and indeed infer that the expression of emotion is irrelevant. This researcher reflects that the expression of emotion may be dangerous in terms of unsettling family members who rely on denial to cope. Mothers of participants with schizophrenia describing the above trauma examples frequently display a vagueness and tangentiality regarding impact upon herself and her infant that some authors have described as coldness, incompetence or indifference (Bateson et al. 1956; Jones et al. 1994). This researcher in contrast considers the speech markers as indicating intense unresolved affect in the mothers towards the child to whom they have a troubled attachment. In contrast, the mothers of the depressed group describe their own trauma experiences and their participant children's illnesses and accidents more often with a full range of emotion, inviting the listener into relationship with both herself and her child.

With the mothers who use dissociative processes, the interviewer is not engaged in a social interaction, but rather is offered sketchy disconnected pictures with tangential references to meanings peculiar to the speaker. There are disjunctions occurring at times of tension between what is said and unsaid. For example, one mother (SCZ003) reports initially that her husband did not want more children, that she grieved over not having at least six children, and at end of interview that she attempted to abort her fourth and last pregnancy with the participant because she (mother) was depressed as a child. The listener is engaged and then disengaged, as if what has just been said is of no relevance, or even that the role of listener is irrelevant. The unendurable truth is presented in a manner lacking substance. At times, events are reported that would cause most people extreme distress, followed by a pulling away into trivial detail and inconclusive discursiveness. By negating, minimising or dismissing the meaning of trauma, these mothers disqualify the validity of their own emotional experiences, and that of their family. The definition of dissociation used in this research is therefore shame/guilt/fear-generated incomplete avoidance of trauma reminders, which elicits confusion, frustration and sometimes apprehension in the listener who feels what the speaker refuses or is unable to fully enter into and resolve. This countertransference highlights the importance of self-reflection in the interviewer, and reference to an expert panel. The use of the interviewer's and expert panel's countertransference responses to reflect on the speakers' states of mind around their reported traumatic events is affirmed by Szajnberg and Crittenden (1997) and Hobson, Patrick and Valentine (1998).

Previous research (van der Kolk et al. 1996) found a high incidence of self-reporting of dissociative experiences in those suffering from schizophrenia, but this can be argued to represent post-illness phenomena, as the experience of being diagnosed in late adolescence or early adulthood with a usually severe and lifelong illness is in itself traumatising. Current research literature appears to have categorised dissociation in schizophrenia as a direct response to abuse (emotional, physical and/or sexual) directed at the child (Ross & Joshi, 1992; Holowka, King, Saheb, Pukall & Brunet, 2003; Janssen et al. 2004) or to attentional difficulties also found in well relatives. Other researchers have related childhood abuse with adult depression (Levitan et al. 1998; Weiss, Longhurst & Mazure, 1999).

With sudden shifts in the interviewee's focus, the listener is thrown into disarray, and forced to place a construction upon the scattered bits of information

that, of course, is guided by the interviewer's own agenda. But the apparent disorganisation of the interviewee clearly is a response to what the speaker knows is relevant to the purpose of the interview, otherwise the defense would not be activated. In other words, the interviewees' dissociation has a disorganising effect on the listener. It is noted that some mothers who dissociate in interview make no comment on that process, and some make observations and construct a meaning around it.

DEP104

S: Mm, but um, you know. Different ones in the family will say different things to me and that. "Do you remember this?" And.and.I just cannot remember, you know. Sometimes they.when.when they do say that, it'll jog my memory, and I think "Oh, that's right. We were so-and-so", you know. But.ah.a lot of times, in fact I.I don't think I even try to reach back sometimes, because I think.I want.to get on with things.

This mother reports several extremely violent episodes with her husband, who she reported to the police and separated from shortly after her second child, the participant, was born. This combination of capacity to take charge of causative factors in extreme stress, and to reflect on internal states is antithetical to chronically living in a world of spontaneously and unconsciously produced microdissociations.

SCZ004

S: But it's just.only come out in the last say four or five years that J____ (participant's father) was suffering from Post-Traumatic Stress, ever since (overseas war service), and so..yeah.

I: And how did that affect him?

S: Um.cranky, angry, frustrated, angry.all.well.he really.um, we're Christians, right? Had a lo.life was terrible for many many years, um. But anyway, we st.we started.doing um..after starting.listening to a.a man talk, and realising just what was happening with our children like.um, this man was saying, if you wound a ch.your child's spirit, that child won't do what you.tell it to do.

This mother reports staying in this at least emotionally violent marriage, and only recently receiving family counselling with her husband and adult children. Although the above passage implies that she was aware at the time of the impact her husband's chronic anger had on her young children, she is actually referring back

with a recent insight. This confusion of time is qualitatively different from what this researcher understands by Herman's or Crittenden's definition of not being able to accurately report the sequence of highly emotionally arousing or traumatising events. However, this researcher considers the above example to be a form of confusion of time indicating heightened emotional arousal within a pattern of non-resolution of trauma via dissociative processes.

Mothers' Reports of Fatigue during Early Family Life

The term 'maternal fatigue' is adopted in this study following the mother interviews, replacing the term 'psychosocial stressors'. This is in accord with the manner in which the mothers report the information. In the schizophrenia sample, maternal exhaustion is presented with more coherence than discussion around trauma in the same speakers. Support and understanding are sought from the interviewer. Maternal fatigue or busy-ness (Schizophrenia $N=16/25$; Depression $N=10/25$) may be a factor with potential links to emotional abuse and neglect and potential for the establishment of insecure or disorganised attachment. The indicators for effects on the child participant of maternal fatigue include the mother not reporting any effect, and in fact, tending to idealise the relationship, or to confuse one child with another.

It could be argued that each contribution to maternal exhaustion is in itself not necessarily highly stressful, but the accumulative effect is potentially powerful. A further significant difference in the narratives of the mothers of offspring with schizophrenia compared with depression is the emphasis placed on busy-ness and fatigue. Although trauma is present its significance is dismissed, and fatigue is emphasised. Several contributions to busy-ness and fatigue are identified by the mothers, including being ill or stressed during the pregnancy, the activeness of the toddler, having several children close in age, and lacking support from partner and family for several reasons. These reasons include socioeconomic conditions (relative poverty) requiring frequent moves in search of work, distance from or conflict with parents, partner absence due to work commitments or unavailability for support due to alcohol abuse. Literature search of maternal fatigue and its impact on the mother-baby dyad has resulted in few references.

Several authors in both animal and human studies (Burke, 2003; Galler, Harrison, Ramsey, Forde & Butler, 2000; Goodman, 2003; Kurstjens & Wolke, 2001; McCarty & McMahan, 2003; McFarland & Sanders, 2003; Newport, Wilcox & Stowe, 2002; Wekerle, 1996) have discussed maternal post-partum depression and

the effects on the neurobiological, behavioural, and social development of their offspring. Some authors (Assel et al. 2002; Hirshfeld, Biederman, Brody, Faraone & Rosenbaum, 1997; Levy-Shiff, Dimitrovsky, Shulman & Har-Even, 1998; Rones, 2003) focused on maternal anxiety and stress and similar sequelae in their offspring. None of these texts made fatigue itself distinct from maternal post-partum depression, anxiety or stress, thus pathologising what these mothers may report as fatigue within contextual bounds similar to the collection of trauma and major stressors found in this research. In depression, levels of functioning classically decline across spheres, that is, work, leisure and relationships (DSM-IV, 1994). The mothers in interview who describe being either fatigued or overly busy report that they continued to function in practical spheres, and specifically denied depression.

Non-recognition by professionals of maternal fatigue is long-standing, and this researcher has not found any references that focus on fatigue as a major contributor to non-resolution of trauma or loss. Current literature searches under maternal fatigue even more remarkably do not have any reference to schizophrenia.

Some articles (Newport et al. 2002) based on animal studies have supported a link between maternal stress and depression and a diverse array of neurobiological and behavioural alterations that persist into adulthood, but there is no discussion of attachment sequelae. A comprehensive meta-analytic study on precursors to disorganised attachment in early childhood (van IJzendoorn et al. 1999) specifically examined the link between maternal depression, including unipolar and bipolar depression, and disorganised infant attachment from sixteen (16) studies. They concluded that there is no substantial association between maternal depression and infant attachment disorganisation.

Self-report measures however were used for the mothers, and this author has already discussed the shortfalls of relying on self-report alone with adults who utilise denial to cope.

Infant/toddler is 'too much' for mother

Making a distinction between difficult childhood behaviour or temperament and attachment difficulties is supported by the meta-analytic research previously quoted (van IJzendoorn et al. 1999). In the current research, mothers of both diagnostic groups report almost identical very lively/active, defiant, or unsettled behaviour in their infants/toddlers (Schizophrenia, $N=12$; Depression, $N=11$) in the context of stretching their maternal resources, whereas Attachment Difficulties were

more represented in the schizophrenia group (Schizophrenia, $N=21$; Depression, $N=13$). Debate continues in the literature on whether infant premorbid personality traits affect maternal bonding (Willinger, Heiden, Meszaros, Formann & Aschauer, 2002) but the meta-analytic study of van IJzendoorn et al. (1999) again provides one of the most carefully presented findings, that across thirteen studies with 2028 participants, constitutional and temperamental aspects of infant personality are quite independent of disorganised attachment.

Maternal fatigue and lack of support

One article has been found (Thome & Alder, 1998) that investigated the reduction of fatigue and symptom distress in mothers with difficult infants with the introduction of telephone support, thus indicating that even minimal support significantly enhances the capacity for positive mother-infant interaction and presumably resultant maximisation of the potential for secure attachment. It is remarkable in the mother interviews the number who reported being isolated from potential support close to the birth of the participant child, or during a difficult pregnancy for several reasons, and only rarely because of interpersonal conflict. Moving around the time of birth often involved interstate moves, with its organisational demands and loss of close contact with friends and family. Sometimes father would have already left to find accommodation or settle into new employment, leaving mother to manage the children, her pregnancy and the packing. The mothers subsequently have their babies in a strange environment with few supports. The mother's deepening dependency on social and family supports in the final weeks of the pregnancy highlight the importance of the availability of the marital partner and the mother's parents (Philipp & Carr, 2001). Evidence is emerging on the increased vulnerability of migrant populations to have higher numbers of next generation adult offspring who develop schizophrenia, with social isolation and environmental factors being posited as contributing to risk (Jones, 2001).

Poverty

Socioeconomic deprivation above a certain level has been found by some researchers to exponentially increase the risk of schizophrenia (Jones, 2001). Paternal social class (occupation) and maternal residential area (deprived or non-deprived) at time of birth has been associated with increased risk of schizophrenia in adult life (Harrison, Gunnell, Glazebrook, Page & Kwiecinski, 2001). Links have also been established between depression and socioeconomic

disadvantage, via the increased incidence of loss occurring in poverty (Brown & Harris, 1978). Recent research concluded that adult hypothalamic-pituitary-adrenal axis sensitivity to current social stress does not mediate vulnerability to depression in these adults (Strickland et al. 2002). These authors discussed the relevance of early life experiences increasing the potential for some adults to have a primary dysregulation of the HPA axis, stating that further research is required to clarify this important issue.

In this dissertation, there is no evidence for differences in socioeconomic disadvantage between the diagnostic groups, either at birth or as adults.

Fatigue and Dissociation - Possible Links

Fatigue and dissociation may be separate factors affecting quality of attachment, but may have a multiplicative effect when occurring together. Indeed, they may interact as a self-feeding loop because dissociation prevents resolution of emotionally charged material and prevents problem-solving and a sense of mastery. This would naturally promote a sense of defeat and fatigue. Dissociation is also related to an unwillingness or inability to reflect, and this indicates a lack of relationship with 'self', a fundamental impairment seen in schizophrenia (Auerbach & Blatt, 1997).

Attachment Difficulties

The focus in this construct is on the mothers' perceptions of attachment difficulties in their participant offspring, and therefore mothers' attitude towards the child as well as her selected observations of that child's interactions with other family members and peers is included. The inclusion of unplanned and unwanted pregnancies as a factor in the cluster of attachment difficulties is justified both by the manner in which the mothers volunteer this information in interview, and by previous research on maternal rejection (Hirshfeld et al. 1997). It must be stressed that the mothers in this research also display love and concern for their participant offspring, and that the potential for neglect is not in the extreme forms of denying food or needed medical attention. It is the ambivalence or unpredictability of the relationship that is crucial.

'Wrong' sex as maternal rejection

Statements by mothers, sometimes quite directly but often indirectly, that reject the male sex of their participant offspring ($N=6$ schizophrenia; $N=1$ depression) suggest that there may be a link between being a male infant and mother

offering rejecting statements. The sample size in this study is not large enough to compare sexes. However, van IJzendoorn et al. (1999) indicated that no association has been found between male sex and disorganised infant attachment. Mothers who categorically state or infer that their child is the wrong sex are rejecting their fundamental identity. One has to rely on the literature on maternal depression to understand the differential effects on female and male infants. This is significant because of the greater numbers of males compared with females who develop schizophrenia.

Weinberg and Tronick (1997) discussed the greater effect of maternal depression on their infant sons compared with their daughters. They posited that infant boys require more assistance with internal regulation of their affective states than girls, and are thus more affected when mother is either angrily intrusive, frightening, withdrawn, disengaged or unresponsive, or has a mixed and unpredictable pattern of interaction with her baby. Prolonged experience with an emotionally unavailable mother, they suggested, may lead to infants who lose self agency, feel fragmented and depersonalised, and may result in reducing the quality of subsequent relationships and successful engagement with the child's expanding world. Coates and Wolfe (1997) placed children's rejection of their gender within disorders of attachment that result in chronic anxiety reactions, with the parents subtly encouraging opposite sex behaviour. Children between the ages of two to three years begin to develop in two hugely significant ways: sexual identity, and an autonomous sense of self separate from the mother. By twelve (12) months, infants have tacit categories for gender (Coates & Wolfe, 1997), and by twenty-eight (28) months, they can correctly label self and peers. This becomes an important part of their self-concept and leads to preference for play with same-sex peers and for stereotypic same-sex activities. At the same time, children's increased capacity to explore at ever-increasing distance from mother introduces the potential for separation anxiety, either in the child or mother or both. The authors place major difficulties in gender acceptance in the context of severe family stress, often involving trauma to the mother, serious marital difficulties, parental alcohol or substance abuse, loss of health in either mother or father, death of a family member, severe financial loss or serious life-threatening illness or accident to the child that results in mother becoming depressed, anxious and emotionally inaccessible to the child. Mother's unexpressed rage at the father may be taken up by the male child

who simultaneously refuses to relate to father, and who avoids expressing normal levels of aggression, using emotional over-control and internalisation instead. The disclosure by mother of the triggering traumatic events often only emerges long after initial assessment, denoting effortful avoidance, denial or dissociation. These mothers report using authoritarian and intrusive forms of control towards their sons, are fearful of their sons' aggression, and misinterpret healthy aggression as destructiveness, and fail to encourage their sons' emotional ties to father. If father is inappropriately angry and therefore frightening, the child may fear by identifying with him that he will also be out of control, thus destroying his tie to mother. It is imperative to realise that father's failure to intervene effectively perpetuates this catastrophic disturbance in identity and attachment security, and while not within the scope of this dissertation, warrants further investigation.

Unplanned, unwanted and 'shock' pregnancies

Robinson and Stewart (2001) reported that persistent rejection of the newborn (seen in approximately 1% of mothers in the U.S.A.) is found most frequently in unwanted pregnancies, exacerbated by painful or difficult childbirth experiences, and worsened by socioeconomic or environmental stressors. In persistent disorders of attachment, mother expresses disinterest, neglect, and failure to protect, nurture or interact with the infant.

Making a statement, directly or indirectly that a pregnancy carried to term was mistimed, unplanned or unwanted infers ambivalence. It is essential to acknowledge that an unplanned pregnancy may not meet with sustained parental displeasure or have pathological consequences on the ensuing attachment relationship between mother and baby. However, if contextualised within the traumatic or severely stressful periods for families revealed in this research, the potential for sustained ambivalence towards the infant is possible. A small number of large cohort studies (Blomberg, 1980; Myhrman, Rantakallio, Isohanni, Jones & Partanen, 1996; Kubicka, Roth, Dytrych, Matejcek & David, 2002) indicated that unwanted or mistimed or unplanned pregnancies carried to term are linked to offspring having several poorer outcomes than peers or siblings, including developmental and clinical outcomes that fit a model of attachment difficulties. The prospective nature of two studies, with mothers being interviewed whilst pregnant about the wantedness of the pregnancy, reflects the retrospective results of this dissertation. One of these studies (Myhrman et al. 1996) has supported the

hypothesis that maternal stress during pregnancy is a risk factor for schizophrenia. They concluded that mothers' expressed unwantedness of the pregnancy is linked to increased risk of birth and pregnancy complications, and twenty-five percent (25%) of offspring diagnosed with schizophrenia in late adolescence/adulthood correlated with their mothers' statements of rejection of the pregnancy at first perinatal clinic visit. Twenty-four percent (24%) of the schizophrenia sample mothers in this dissertation state that the pregnancy was unplanned, a shock, mistimed or unwanted. Kubicka et al. (2002) also reported higher percentages of psychiatric inpatient treatment for adults whose mothers during pregnancy reported rejection of the pregnancy. It is inferred therefore that falling pregnant soon after miscarriage is often unplanned, and this in itself may be a risk factor for both the neurobiological impact on the foetus, and on the capacity for both mother and foetus to begin positive bonding at around five months into the pregnancy. This time of quickening is recognised as the start of bonding for most mothers (Stotland & Stewart, 2001). The likelihood of this ambivalence being exaggerated during a traumatic birth is not difficult to comprehend.

Attachment difficulties

As previously noted, there are difficulties arising from DSM-IV (1994) classifications of attachment disorders compared with secure/insecure categories described in attachment theory based research. It is the latter that has been more researched, but the training required is extensive, and the categories flexible over developmental stages, suggesting that in classifiable disorders as per DSM-IV, inflexibility is the key. That is, there is little developmental shift in early insecure strategies, and a generalisation of insecure strategies to peers and other adults. Insecure attachment as evidenced by lack of basic trust, feelings of alienation, a sense of social incompetence, reluctance to invest in relationships and vulnerability to emotional hurts was found in matched samples of Brazilian and U.S. adults with schizophrenia (Bell & Bruscatto, 2002).

Clinical Participants' Reported Experiences of Early Neglect and Emotional Deprivation

The clinical participants' reports of early neglect and lifelong perception of emotional deprivation are now presented. There is consistency/congruence between results on the Core Beliefs Questionnaire Emotional Deprivation subscale and on the Traumatic Antecedents Questionnaire Neglect subscale (age 0-6 years) for both

diagnostic groups. This supports the concept that early patterns of mother-infant or mother-child interaction set a pattern for lifelong interpersonal experiences for the total number of clinical participants ($N=50$). Crittenden (2000) argued, based on single case studies, that the potential for maturational change at two critical developmental periods in childhood and throughout the adult lifespan is common except under environmental circumstances related to later pathology. Neglect in this research is conceptualised as potentially traumatic, as in extreme form it is life-threatening to infants and young children. It is accepted in the literature that neglect is potentially more dangerous than abuse to mental health because of its profound effects on all aspects of functioning, including attachment (Rutter & Sroufe, 2000; Zeanah et al. 1993).

In this research the depression group score higher than the schizophrenia group on both of these self-report measures, and this holds for all of the TAQ Neglect subscale age ranges. Thirdly the results indicate that for the total number of participants ($N=50$), ages 7-13 years and Adulthood on the TAQ relate most strongly to the Emotional Deprivation subscale scores on the Core Beliefs Questionnaire. It could be naively assumed that this indicates that recall of traumatic events in the ages 7-13 years and again in adulthood (and the onset of illness may itself be a trauma) is of greater emotional or psychological impact than recall of earlier traumatic events, including parental neglect. It could also be assumed that the results indicate depression is a common outcome of unresolved loss and trauma. However, studies on resilience (Rutter, 1993) and on attachment indicate that the earliest nurturing, protective and emotionally attuned attachments provide the basis for coping with both external and internal threats to the integrity of the self, that is, traumatic events.

As previously noted, episodic or autobiographical memory is influenced by cortisol-induced damage to the hippocampus, and that the more sustained or enduring (unresolved) the stress or trauma is, then the more permanent is the damage (Goodyer et al. 2001). That is, the earlier and more sustained is the trauma, then the less capacity one has to recall it. The above emphasis in the quantitative results on the age ranges 7-13 years and adulthood may reflect a capacity to 'think about' and recall the traumatic events and stressful familial interactions in the more quiescent developmental periods. The relative incapacity to recall and reflect upon and ultimately integrate traumatic processes or events in the most developmentally critical periods (early childhood and adolescence) may also reflect a familial pattern

of using denial or dissociation to cope. Early memories are jointly construed with attachment figures who relate to children what they consider important to remember, what is to be trivialised, and what should remain outside of cognitive and emotional recognition (Crittenden, 1997).

The capacity to complain denotes a sense of self, and in schizophrenia, a sense of self is largely absent. Consistent with previous research using self-report measures, participants with depression report a higher incidence of traumatic or negative experiences across the life span including the earliest years than participants with schizophrenia (Breslau et al. 1999). This researcher considers that the incapacity to complain is fundamentally linked to both levels of insecure attachment (that is, the fear of catastrophic rejection is greater for those with less secure attachment) and the utilisation of denial, dismissal of the relevance of highly disturbing or traumatic events and dissociation as a powerful collection of defense mechanisms. Crittenden (1997) indeed describes a group of insecurely attached children who display role-reversing protection towards their psychologically unavailable attachment figures as a way of eliciting some level of care from them. However, the allocation of patterns of attachment via analysis of speech dysfluencies when discussing attachment issues has met with two major obstacles: firstly that the classification system itself, although soundly based on early observational data, is difficult to learn and hence potentially low in interrater reliability, and that attributing types of attachment patterns to specific mental illnesses has largely met with failure (Dozier et al. 1999). It is possible that the more disturbed a person is, the more transient are their patterns of communicating with others, as they attempt to attune to the listener's level of threat to their extensive self-protective systems that would include cognitions and affect, and all of the memory systems.

Mothers' Dissociation in Interview and Participants' Reports of Early Neglect/Emotional Deprivation

Extensive research using an attachment measure (the Adult Attachment Interview) has linked several adult psychiatric disorders to recollections of childhood interpersonal trauma. The type of early attachment pattern most associated with later severe mental illness is the Disorganised category. The mothers of infants with disorganised attachment display marked distortions in discourse surrounding the discussion of loss or trauma. To date the adult disorders linked to early disorganised attachment have not included schizophrenia. Hesse & Main (2000) stated that these

indicators for adults with the above disorganised speech around loss and trauma predict infant disorganised attachment. In other words, the offspring of individuals whose language, attention or behaviour becomes disorganised when recalling their childhood extreme stress or trauma have the potential to have offspring with disorganised attachment. This research suggests that this tendency towards disorganised speech is relevant to ‘next generation’ traumatic events, that is events surrounding the pregnancy, birth and earliest years of their offspring. Hesse & Main (2000) also postulated that this disorganised infant representation of approach and avoidance is a direct result of a parent who is seen as frightening. This is supported by this research, in which the interviewed mothers may have been both frightened of the traumatic events and frightening to the infant whilst dissociating. Violent fathers would have also have been frightening to the offspring. To quote Hesse & Main (2000):

“We have proposed that such conversational/linguistic slips may be attributable to unintegrated or partially dissociated fear aroused by the discussion of these interview topics, and that anomalous forms of threatening, dissociative, and fearful behavior may occur at times in (otherwise “normal”) parents. We expect that parental behavior of these kinds will be frightening to the infant (Hesse & Main, 1999). If this is the case, then disorganisation may appear not only as a result of an infant’s directly traumatic experience of maltreatment, but also as a *second generation effect* of more subtle behaviors resulting from the parent’s own frightened or frightening ideation surrounding experiences of trauma.”
(pp.1102-1103)

Hesse & Main (2000) have noted that even microdissociations disrupt the reciprocity between mother and infant, and thence secure attachment is much harder to establish and maintain. These microdissociations are much more likely to be triggered by proximity to, eye gaze with, or demands from the infant most associated with the traumatic events. It may be said that these mothers are caring but not connected. In some sense, for them, baby is the trauma and therefore the mothers are not connected to the emotional vulnerability of the infant that reminds them of the trauma. Paradoxically this can be conceptualised as the mothers not being adequately disconnected from the pain of the trauma. Indeed, the linguistic slips seen in the discourse of some mothers in this research convey ‘fright without solution’,

replicating the pattern seen in infant disorganised/disoriented attachment. As Pasquini et al. (2002) concluded, maternal loss and trauma around the time of birth and subsequent childhood traumatic experiences for the offspring may lead to dissociative disorders in adulthood.

Participants' Living Arrangements

Post-hoc analysis of the model (Figure 1b) indicates that, in this sample of adults attending a Community Mental Health Centre, living with mother is more likely in participants with a diagnosis of schizophrenia than those with major depression. A simple explanation revolves around the relative disorganisation seen as symptomatic of chronic schizophrenia, and the pervasive nature of the disorder affecting all areas of adult functioning. However, this research indicates that the potential for later failure of autonomy may begin with the habitualised denial of infant distress by mothers who surround themselves with busy-ness as a continuation of denial or dissociation from their own traumatic experiences. This then inhibits resilience in that particular child by not providing a secure enough base for the expression of a full range of emotions and cognitions. Also, aspects of role-reversal and controlling behaviour by the child extended unchallenged into adulthood may be relevant. Autonomy and related complex social skills can be conceptualised as synonymous with a trajectory of secure attachment, whether initially secure or developed later via reparative experiences (Allen et al. 2002).

Brennan, Le Brocque and Hammen (2003) identified high levels of maternal warmth, low levels of both parental psychological control and maternal overinvolvement as predicting resilience in adolescents despite maternal depression, and others have identified transmission of vulnerability to mood disorders in childhood, dependent on whether depressed mothers were intrusive and angry, or withdrawn (Crockenberg & Leerkes, 2005). This vulnerability may continue into adulthood. The mother's narratives around early family life, in particular when describing traumatic events, have been shown in this research to include dissociation, denial and 'making nonsense of' the trauma/major stressors, and these are seen as indicators of unresolved trauma. In the attachment literature, dismissing speakers may cut off reflection on their own and other's experiences, thus invalidating or killing off an authentic sense of self. If one's earliest existence has already been threatened as foetus and/or infant, a biological sensitivity to such threats may overwhelm one's capacity to fully embrace one's intention to survive. Applied

intergenerationally, at critical developmental stages when moving on relies on our very sense of existence, a sense of never having truly existed may result in failed attempts at growing autonomy.

As noted in the Literature Review (Chapter 2) on attachment, with a mother who is traumatised and dismissing, the potential is for the infant to develop powerful fantasy internal representational/working models that are critical (dismissing or minimising) of the infant's need for safety and comfort, particularly in an imaginative or sensitive child. It is possible that these internal working models recrudescence at the critical period for independence in young adulthood as persecutory delusions under stress, and that this contributes to the participants never leaving or returning to the parental home, and in some, seeking comfort from drugs and alcohol. It has been noted that children who have learned to minimise their attachment needs by ignoring both their own distress and doubts of caregiver availability have limited access to their own feelings and develop an unrealistic or idealised portrayal of parents' availability (Dozier et al. 1999). If this remains unresolved in adulthood, the capacity to establish autonomy away from the parental home may be compromised, particularly under stressful circumstances.

Summary

The central thrust of this thesis has evolved into making sense of what this author considers to be dissociative processes in the speech of some of the mothers in interview when discussing traumatic events, and the possible impact of this pattern of non-resolution of trauma on her attachment with the participant child who later develops an adult mental illness, either depression or schizophrenia. These dissociative processes appear to serve a function of relegating potentially overwhelming events to non-significance, and to reinforce a dismissal of their relevance to the emotional lives of the family unit. As previously outlined in the Literature Review, dissociation in non-clinical adult populations is associated with the use of emotion-focused coping strategies, in particular distancing and escape-avoidance strategies (Collins & Jones, 2003). These authors also found that the tendency to dissociate was positively correlated to external locus of control, and to a sense of the unpredictability of the world which the research participants inhabit.

Other-blaming and a non-questioning lack of problem-solving was noted but not isolated as a variable in many of the mother interviews in which dissociation was identified. For example, when in domestic violence relationships, there was less

likelihood of the mothers who dissociated in interview to report leaving the relationship or in some manner setting limits.

Dissociation makes suffering an absurdity. Responding with comfort to the absurd creates even greater cognitive dissonance. This self-feeding loop has the capacity to severely disrupt meaningful communication. It is clear from the results of this research that there is no significant difference in the large number of early family trauma experiences between the two diagnostic groups, and that the participants with depression rate the intensity of their suffering via Core Beliefs as much greater than the schizophrenia group. If denial and dissociation is offered as a core element in the attachment pattern between mother and a vulnerable child, and is a habitual response to stress and trauma, problem-solving even minor stressors of everyday events becomes challenging. Attachment difficulties necessarily ensue if no significant other (e.g. father, grandparents) is available to provide consistency and comfort and more importantly, safety. Fantasy may offer a retreat from a world filled with the potential to overwhelm. However this retreat is no solution, and the elevated levels of stress hormones remain unabated, eventually perhaps leading to depletion of their protective capacity. The delusions seen in schizophrenia may be symbolic of the early failure to connect, and indeed the delusions may hold a greater attachment power for the sufferer than intimate relationships with others. In other words, delusions become transitional objects.

It is also much harder to transition from childhood to adolescence and adulthood from a parent-child relationship that commences with a degree of uncertainty as to its viability, either through the threatened death of the infant or disintegration of the family unit, particularly if these intensely emotionally arousing trauma are unresolved. The adult world is unnavigable without the capacity to realistically problem-solve and without the ability to form secure attachments to peers.

Parental neglect may of course be benign in origin, for example via fatigue. However, the emphasis in this country and other Western countries on the genetic origins of severe mental illness including major depression and schizophrenia may be conceptualised as a form of neglect as parallel process. That is, researchers may have been seduced by the dynamic of neglect to perpetuate, and this seduction contributes to the continuation of making meaningless the experiences of early family trauma

and major psychosocial stressors that deplete mother's resources to attune sensitively to her infant.

Quantitative analysis of the model (Figure 1b) proposed in this dissertation supports the following: that maternal reports of early family trauma/loss presented in an unresolved manner and complicated by maternal fatigue leads to greater possibility of sustained attachment difficulties in the offspring closely associated with the traumatic events, which then increases susceptibility to later schizophrenia, and loss of agency and resultant capacity despite relative recovery to leave the parental home. Maternal reports of trauma without dissociation in interview and somewhat fewer contributors to maternal fatigue are associated with lesser possibility of sustained attachment difficulties, and a greater likelihood of the alternative diagnosis of adult depression. This may be related to acknowledgment of loss and trauma being more consciously available, and a greater success with autonomy. The model thus represents for both diagnostic groups, the intergenerational transmission of trauma responsivity via quality of early attachment.

In conclusion, this research indicates that we can now add as potential risk factors for schizophrenia early maternal fatigue and ongoing maternal dissociation as a habituated response to severe stress or trauma, and related attachment difficulties for the offspring most associated with those accumulative maternal stressors that make it difficult for the adult with schizophrenia to successfully negotiate the world independent of the family. It is also possible that the familial pattern of dissociation and denying the meaningfulness of major stressors is continued for the offspring who develop schizophrenia in adulthood. Survival for the infant may depend on an attunement to mother such that the language of avoidance via dissociation and non-resolution becomes the ground of mutuality. Separation at age-appropriate stages then becomes too great a challenge in that neither party has the resilience to negotiate the raised anxiety of separate lives.

Chapter 9

CONCLUSION

This chapter begins with a discussion of some previous theories relevant to this dissertation. Then, some methodological limitations of this research are presented, with some counterarguments. This is followed by a discussion of implications for current and future early intervention programmes. Suggestions for future research combining qualitative enquiry and quantitative analyses conclude this thesis.

Language, Thought and Schizophrenia - A Re-analysis

Because this research depends heavily on the organisation or disorganisation of the mothers' speech around themes of trauma and loss, it is pertinent to briefly review the considerable emphasis in psychiatry on speech disturbances in schizophrenia. It is perhaps not surprising that 'errors in communication' are detected in the mothers' narratives, since Bleuler and Kraepelin both define schizophrenia as disorders primarily of language and/or thought, with Andreasen's model of disorganised language comprising communication disorder, language disorder and thought disorder now used for the DSM-IV diagnosis of schizophrenia (Thompson, 1995). However, two critical points need raising: Firstly, in this dissertation, the greatest number of these communication errors occur when the mothers recall emotionally charged and traumatic events. Secondly, these errors fit a model of dissociation that includes effortful avoidance (whilst paradoxically volunteering the events to the interviewer), emotional numbing, denial, memory loss and other indicators of unresolved trauma. That is, it is both incorrect and unjust to conclude from this sample that the mothers of participants with schizophrenia intentionally 'cause' illness in their offspring, but rather they may have had no opportunity or insufficient support to resolve overwhelming traumatic events.

Much research has focused on detecting communication errors both within the disease entity model of schizophrenia, and within families with an offspring with schizophrenia. Communication Deviance (Wynne & Singer, 1963), Expressed Emotion (Vaughn & Leff, 1976), Language Disorder (Andreasen, 1979), Cloze and Modified Cloze procedures (Newby, 1998), and the recent Thought and Language Index (Liddle et al. 2002) all focus on errors in communication, their relationship to first rank symptoms, disturbed or deviant cerebral organisation of language and possible heritability. It is imperative that work is done on investigating the

relationship between communication disturbance seen in the general population (van Os, Hanssen, Bijl & Ravelli, 2000) and capacity to resolve highly stressful or traumatic events, and the possible subsequent mental health status of offspring.

Andreasen's model of disorganised language is of considerable interest. Her model shifts emphasis from Bleuler's focus on disorders of thought and association to more objectively measurable language behaviour, and includes:

1. Communication Disorder with poverty of content, pressure, distractibility, tangentiality, derailment, stiltedness, echolalia, self reference, circumstantiality, perseveration, blocking or loss of goal;
2. Language Disorder with incoherence, clanging or neologisms; and
3. Thought Disorder with illogicality or poverty of speech production.

The parallels with Grice's maxims of relevance, quality, quantity and manner are notable. The disorganising effect on the listener of the interviewed mothers' narratives around trauma does not suggest a disorganised mother, but an avoidant, dismissive and sometimes hostile one as she attempts to protect herself from being disturbed by what she cannot completely suppress. As communication and attachment are in some aspects synonymous, either a learned set of errors could be posited to occur between traumatised mother and vulnerable infant, or a form of synchronicity between disorganising or disorganised styles as a way of collaborating in avoidance of suppressed hostility which is then inadvertently expressed via microdissociations.

As Ceccherini-Nelli and Crow (2003) pointed out, some of these systems for analysing language in schizophrenia require considerable training, and their use in clinical practice is questionable. However, these authors provide a major contribution to ascribing significance and meaning to these disturbances in communication:

“..delusions can be considered as deviations in the capacity to attach significance to the phonological representations that are the primary building blocks of words, and Schneider's nuclear symptoms can be conceived as disorders of the transitions from thought to speech, and from perceived speech to meaning, within a reference frame that distinguishes the self of the speaker from that of the interlocutors in the outside world.” (p.239)

The emphasis in several of these systems for detecting speech or communication errors is simply that of the deviations themselves, and not on their

intent of self-protection by making a nonsense of the real world. The researchers are in danger of losing sensitivity to the traumatised world of these families.

Double-Bind Theory Revisited

This researcher considers it possible that the ‘double bind’ communication identified by Bateson et al.(1956), and later rejected more by political argument focusing on ‘mother-blaming’ than definitive research, is a result of disrupted, conflictual or incomplete attachment associated with accumulated trauma and major unresolved stressors occurring around one particular child, or within the family when one particular child is at a vulnerable age. Bateson and colleagues’ original paper is based on careful field observation, and the authors’ conclusions cogently argued. However, they reject trauma as the origin of ‘double bind’ communication, and do not attribute it to any specific cause. The later empirical evidence that this communication style is not restricted to families with schizophrenia does not cancel its relevance as an indicator of disturbed attachment. Herman (1997) contributes to this researcher’s reconceptualisation of double bind communication style by referring to the chronically traumatised person’s capacity to dissociate, voluntarily suppress thoughts, minimise and deny in order to alter an unbearable reality via simultaneous conscious and unconscious processes. Herman borrows Orwell’s term of ‘doublethink’, the capacity to hold two contradictory beliefs in one’s mind simultaneously and uncritically. The conscious element is aware of ‘playing tricks with reality’, but the unconscious element accepts that reality has been achieved.

This capacity for trance-like states in the chronically traumatised person has the potential to allow for two opposing and unintegrated states of mind in attachment relationships, and specifically towards an infant or child who is on the one hand loved and loving, and on the other, the source of potential threat via, for example, unwanted/mistimed pregnancy, maternal illness during pregnancy or life-threatening difficult birth, and via reminders of unresolved trauma. As previously noted, the mothers of the participants with depression were more able to “present the baby to the interviewer” via empathic holding statements in relation to trauma, whereas the mothers of the participants with schizophrenia were more likely to “lose the baby in the telling”. This is not in itself a statement of lack of empathy on these mother’s part. In fact, their ongoing distress and self-blame (with exoneration sought simultaneously) evident in interview indicates the unresolved nature of the trauma. Instead it suggests that the events during pregnancy and childbirth and up to the age

of three years were unresolvable despite these mothers generally being competent in many spheres of adult life, because these events trigger habituated trauma responses.

Expressed Emotion revisited

In contrast to Double-Bind Theory, Expressed Emotion (Goldstein, 1985) in the families with a member experiencing schizophrenia has continued to elicit considerable research interest. Dozier et al. (1999) acknowledged its empirical base, but stated that its link to the aetiology of schizophrenia is limited to a single study. High levels of expressed emotion are characterised by familial overinvolvement (intrusiveness) and/or critical attitude evidenced in judgmental statements towards family members. These high levels of expressed emotion have been shown through replicated studies to influence relapses of acute episodes of schizophrenia. The research does not suggest that expressed emotion is causal to schizophrenia, but that families in which EE is high tend to have members with schizophrenia who have relapses. In this dissertation, the results suggest that heightened emotional responses in addition to avoidance of resolution of stressful or traumatic events via dissociation predate the onset of illness in adult offspring. The adults experiencing schizophrenia who participated in this dissertation research often have relapses, but the frequency of these relapses was not a part of this research programme.

Social Context, the Nature/Nurture Debate and Genetics in Psychiatry

As the search for genetic markers for various mental illnesses continues, including for schizophrenia and major depression, it is politic to argue that the failure so far to provide replicative findings indicates the possibility that a large number of non-dominant genes may be required for initial presentation of an illness, and therefore a large percentage of the general population may have these genetic markers. This refocuses attention on trauma/stress and its psychosocial management as fundamental to the expression of genetic predisposition. Indeed, van Os et al. (2000) demonstrated that psychotic phenomena present a continuum of experiences, and are applicable to the general population. Further to this, Wiles et al. (2006) reported that 4.4% of the adult general population in a large longitudinal study of the British Isles reported incident psychotic symptoms. Vulnerability factors included living in a rural area, having a small primary support group, more adverse life events, smoking tobacco, neurotic symptoms, and engaging in a harmful pattern of drinking. Also, adolescents and young adults who reported psychological trauma were more likely to develop psychotic symptoms within 3-4 years (Spauwen et al. 2006).

As Eisenberg (2004) eloquently wrote, heritability estimates for many diseases are context-bound, and therefore the emphasis in research should remain on the psychosocial triggers that determine gene expression. With particular reference to attachment behaviour (in rats), he stated that positive maternal responsiveness shapes behavioural stress responses in offspring, and that this maternal care regulates gene expression in brain regions controlling stress responses (increased hippocampal glucocorticoid receptor expression, higher central benzodiazepine receptor levels in the amygdala, and lower corticotrophin-releasing factor in the hypothalamus) and sets the pattern for the lifespan. It also signifies intergenerational transmission of stress responsiveness. This researcher has not assumed that the link between maternal dysfluency and schizophrenia in their offspring *must* represent a trans-generational transmission of trauma responsiveness. However, the evidence for a genetically determined subclinical language is more tenuous. Main, Hesse and Kaplan (2005) stated:

‘Because a genetic basis involving infant disorganised attachment status has yet to be substantiated, researchers are continuing to turn to the investigation of potential contributory experiential factors, including any situation in which the infant is frightened by the attachment figure(s).’ p. 282.

It is clear therefore that a nature/nurture reciprocity model carries maximum potential for contextualised interventions, particularly with early intervention via maternal support. The need for this maternal support is best ascertained via, for example, community liaison psychiatry to new mothers with poor supports, multiple stressors, and life-threatening illnesses to self or baby. This service could be particularly sensitive to those mothers who use denial of stress, or have dismissing, minimising and/or dissociative responses. It is imperative that collusion in denial of trauma and its relevance does not continue between traumatised mothers and psychosocial researchers.

The context-based nature/nurture reciprocity model in relation to the spectrum of schizophrenia disorders is well illustrated in research by Tienari et al. (2004), which compared high and low risk offspring (biological parent with or without schizophrenia) who are adopted into families with high or low dysfunction. However, no evaluation is made concerning early family trauma, nor biological maternal trauma. Their research supports the contention that once genes for schizophrenia are expressed, then fewer subsequent traumatic events or stressors are

required for intergenerational transmission. It is important to stress that the argument therefore becomes one of initial gene expression for families that have no significant history of mental illness. This Finnish study also supports the argument of intergenerational transmission of resilience via secure rearing environments.

As Hobson (2003) argued, much can be gained from integrating psychoanalytic method with the research ethos of experimental psychology, via integrating attachment theory contributions to analytic thought and neuroimaging discoveries of the 'mirror' neurons that facilitate mother-infant mirroring of facial expressions and hand movements, thus placing emphasis on the need for enquiry based on relationship between self and other. Hobson stated that it is essential to see how certain modes of emotional exchange between people serve defensive functions and contribute to psychological difficulties. He supports the application of rigorous detection of transference and countertransference in intersubjective engagement via interrater reliability in judgment. Secondly, he presents the use of systematic, qualitative analysis of people's accounts of their experiences as essential to this evidence-based enquiry. Lanman, Grier and Evans (2003) indicated how this may be done in practice. There is the capacity to extend this procedure to any dyadic investigation, including the relationship between parents of a person with schizophrenia, and perhaps even in terms of exploring the relationship a person with schizophrenia is having with their inner world.

In conclusion, psychoanalytically or dynamically trained researchers are ideally placed to apply techniques of scientific rigour (replicated studies, interrater reliability via video/audiotaping of interviews, double-blind experiments, etc.). Pure scientists may be less likely to welcome the application of meaningful constructs to their internal reflections generated by the context-bound narratives of their interviewed participants. If the genetic and social researchers do not collaborate well, how can they provide comprehensive treatment experiences for the consumers of mental health services? Scientific objectivity must not 'thing' the patient, and analytic understanding must not be naive about the power of overwhelming stress to alter gene expression and neurochemistry.

Some Methodological Limitations

Methodological limitations are inherent in any body of research (Lincoln & Guba, 2000). A major methodological issue with this dissertation research is that it centres on retrospective evidence of trauma and offspring attachment difficulties

from mother interviews, thus introducing recall bias. However, prospective studies in schizophrenia are both extremely time consuming and costly. Both methods often result in low participant numbers, thus reducing the power of statistical analyses (Keshavan, 2003). False positive reports of past trauma have been shown to be unlikely, and under-reporting is considered more likely (Read et al. 2003).

No structured measure of dissociation was given to the participants or their mothers, and a methodological concern might be that the dissociative processes in the mothers' narratives are qualitatively described. A review of the literature on transference and counter-transference (Chapter 2) leaves this researcher in the position of having to acknowledge several things:

1. That all the nuances via transference and countertransference of other's (also necessarily incomplete) narrative necessitates a confession of personal bias, that is announced as the fear that this researcher has found only that which she searched for;
2. That what is defined as occurring in the interviews represents something of meaning at this specific time, and in the context of both the researcher's and the interviewee's current intentions;
3. That this interviewer brings with her agenda which include a subtheme of questioning whether an interviewee was a 'good enough' mother, and an attitude of both protection and exploitation towards the consumer participants and their mothers;
4. That reactions during and after the interviews may reflect primary concerns of unresolved relationships and unresolved trauma within the researcher. This highlights the imperative of independent expert markers.

However, the focus of this research argument has been with the relationship between trauma and attachment, with emphasis on quality of discourse around trauma. Given the arguments in the Discussion chapter, one could anticipate under-reporting of all symptomatology measures given to participants with schizophrenia as they protect their mothers (role-reversal) and from the mothers themselves who utilise denial.

Other questions may be raised from this researcher nominating mothers' references to being extremely busy, managing multiple things like a full-time job and child-rearing to the construct of maternal fatigue. Some mothers in the schizophrenia group portray a level of competence not evident in their accounts. For example,

being the youngest people not from the land to make an extraordinary success of experimental farming, then blaming others and the unpredictable environment for subsequent abject failure. This false competence as avoidance of negative feelings of shame and guilt may also indicate the dismissing category of speaker. It could be assumed that this indicates a major contradiction with the van IJzendoorn et al. (1999) meta-analysis of several studies in which category of speaker is restricted to attachment themes. However, the mothers raise their exhaustion, and their competence appraisal in the context of the interview regarding the early mother/child relationship. Several mothers in the schizophrenia group do use the term exhaustion (16/25), and it is less frequently used by the mothers in the depressed group (10/25). This construct in a much larger sample could be ascribed to specific contributors to chronic maternal fatigue.

There are also limitations in this research with regard to analysis of the dismissing style of some mothers in interview, without attempting to categorise attachment states of mind as in the Adult Attachment Interview. However, this method was not available as the researcher is not highly experienced nor qualified in the particular instrument and scales. Furthermore, the researcher is aware of the mixed pattern in many of the interviews, in which overinclusive detail without logical conclusion is juxtaposed with denial or lack of meaning, non-recognition of danger, etc. when discussing potentially life-threatening events. A further criticism may be that, although it is clear that the mothers of participants with schizophrenia use a range of dissociative strategies when discussing trauma, there is no evidence that their infant participants had or have disorganised attachment. However, there are some retrospective indicators that these offspring had/have sustained attachment difficulties (social and emotional problems) throughout childhood from mothers' reports, with research showing that disorganised attachment subsumed within the insecure categories is the most stable manner of relating to significant others over time.

This thesis focuses on early family trauma from conception to age three years for the clinical participants. It does not refute the possibility that the clinical participants' diagnoses reflect later or cumulative trauma. However, it does enhance our understanding of the vulnerability of particular children to later pathology if their primary caregivers remain traumatised by early family events.

Limitations with the Core Beliefs, or Schema Questionnaire may have impacted upon results in this study. The limitations reported by Schmidt et al. (1995) are that the questionnaire is strongly associated with psychological distress, in particular, anxiety and depression. Also, they indicate that prospective studies are needed to evaluate whether the CBQ measures a cognitive vulnerability to developing Axis I symptomatology.

Recommendations for Further Study

A considerable number of consumers in the Community Mental Health Centre population were estranged from their family of origin. In a larger study it would be possible to compare the group who were estranged with the group who have maintained relationships with their family of origin. The estranged group may also be more likely to have trauma histories than the group with intact family relationships. Those who did not give consent (participants and/or their mothers/primary caregivers) may also be more likely to have trauma histories since loss of trust is a known result of trauma. Also, a larger study that includes a matched control group may clarify environmental factors. The gender bias inherent in this research (more males with schizophrenia, more females with depression) may be countered by having a much greater number of participants of both sexes.

Clinical Implications and Applications

Implications of this and associated research include prevention, early detection and intervention, therapy and psychoeducation.

Prevention

Interviews of pregnant mothers in the first trimester who indicate that the pregnancy is mistimed, unplanned or unwanted carries the potential to avert the increased risk of attachment difficulties with that infant, and having an increased incidence of schizophrenia in their offspring (Myhrman et al. 1996). Sensitive exploration of what is contributing to the unwantedness of the pregnancy may generate internal shifts in the mothers' narrative constructs and external practical solutions to stressors, e.g. financial help, social networking and parental conflict resolution.

Early intervention

Early intervention in schizophrenia is the term currently used for early detection of psychotic-like prodromal symptoms in adolescents and young adults (Krstev et al. 2004; McGorry, 2005; McGorry & Yung, 2003). In the light of this

research, early intervention may include relatively simple, cost-effective strategies already employed for fatigued new mothers, such as telephone support (Thome & Alder, 1999). The benefit of this form of early intervention is that it is based on the mothers' signalling a non-pathologised need for added support due to difficult infant temperament consistent with this research, and not based on clinical objective measures of the infant's actual behaviour. The second benefit is that this brief intervention has been shown to be effective in reducing maternal stress (Thome & Alder). Thirdly, non-resolution of maternal distress would be evident, and further interventions more acceptable because of the rapport already established. This research indicates that denial of depression, anxiety or stress and lack of coherence in the narratives of pregnant mothers who have experienced life-threatening events in themselves, the foetus or immediate family members are risk factors for later attachment difficulties in their offspring.

Queensland Health has initiatives in place for early intervention across the State for at-risk families, identified via known vulnerability factors including family violence, childhood abuse and neglect, poor attachment to the newborn, sole parenthood, psychiatric illness, drug/alcohol abuse, low income or financial stress, low education levels, unemployment, social isolation, maternal depression and non-attendance at a child health centre. These initiatives include specialist psychologists and social workers, capital equipment and recurrent expenditure for child health centres, targeted home visiting to at-risk families with newborns, expanding programmes targeting young parents and positive parenting programmes (Hudson, 1999). With this structure and specialist training already in place, adding other at-risk families identified by non-resolution and/or denial of family trauma is feasible. Federal government initiatives also focus on early childhood intervention from birth to age five years, recognising that those families most in need rarely seek help, and recognising that the earlier the intervention, the better the outcome (Ford, 2003).

Families with marital conflict and aggression, and parental cold, unsupportive or neglectful interactions with their offspring have been identified as placing their offspring at risk for later mental illness (Repetti, Taylor & Seeman, 2002). This research expands these risk factors to include otherwise caring but frightening/frightened maternal states of mind via dissociative processes, and maternal unavailability due to fatigue within the context of poor social supports.

Emotion processing as an aspect of coherence increases conflict resolution and coping versus maintenance of dismissive, controlling or dissociative responses.

Early intervention could also include biological measures of foetal well-being. Foetal heart rate reactivity has been shown to respond to maternal distress, particularly in depressed mothers (Monk et al. 2004). The benefit of this relatively low cost, non-invasive procedure focusing on the health of the foetus/infant allows funding to focus on supportive counselling as an early intervention. Further research may or may not support the proposed link between maternal stress in the third trimester, foetal HPA axis development, and later adult mental illness in the offspring.

Confirmation of the molecular processes that potentially link foetal hypoxia to later schizophrenia is required before such a singular cause is accepted (Rosso & Cannon, 2003). The authors reported that reliable indicators of foetal oxygenation and acid-base conditions at birth are assayable via umbilical cord blood pH and gas composition, general immune function and viral antibodies without risk to the foetus. With our current understanding of the profound effects of unresolved stress (maternal and infant) on the infant hypothalamic-pituitary-adrenal cortex (Repetti et al. 2002), lobbying for research funds for early intervention is enhanced. This argument for research funding is strengthened by the knowledge that illness outcome is highly probable, but nonspecific in diagnosis. That is, portions of funds to specific illness interventions, depression and schizophrenia, can both be accessed.

Therapy

Problem-solving is an established technique within several therapeutic models with measurable outcomes. Reflective belief utilises the attribution of meaning to critical events and internalised experiences of those events (van der Hart & Nijenhuis, 1999). The current trend in focusing on reflective belief and mindfulness as therapeutic tools is now well-established in psychology, and there is no evidence to suggest that this can not also be applied to adults with schizophrenia. Also, when reactivity to daily stressors are present for adults with schizophrenia (versus numbing, avoidance, dissociation), neuropsychological test scores are higher (Myin-Germeys, Krabbendam, Jolles, Delespaul & van Os, 2002). This may support the therapist's endeavours to focus on reinforcing accurate, predictable and normalised responses to everyday or severe stressors, and this may also increase functioning neuropsychologically, that is, a process of integration may have

occurred. This integration may increase resilience to those stressors, and thus reduce the intensity and frequency of relapse episodes. In addition, re-learning to accurately express emotions that are experienced may also benefit those people with schizophrenia and depression (Sweet, Primeau, Fichtner & Lotz, 1998). Assisting people to train themselves not to dissociate from affect recognition and processing could be most efficiently and cost-effectively conducted by psychologists.

Psychoeducation

Psychoeducation need not be restricted to educating consumers and families when a family member has an expressed illness. In line with prevention and early intervention, public education of the risks to the mental health of offspring from non-resolution of traumatic events, parental violence, alcohol and drug abuse and social isolation, etc. has the potential to increase relevant help-seeking behaviour without shame.

Future Directions

Exciting developments are occurring in the exploration of risk factors in serious mental illnesses. These include a conceptualisation of the interplay between early developmental neurophysiological and psychological mechanisms under extreme stress, and the importance of attachment relationships in ameliorating or resolving these stress reactions. As noted above, biological measures of stress, even in the neonate, can be non-invasive, and family processing of trauma, or severe and chronic stress, can be enhanced with relatively cost-effective counselling that acknowledges the personalised context for these families.

Conclusion

Low risk studies provide an ideal opportunity to contextualise people's trauma stories, humanising schizophrenia and depression, both as process and strategy for survival in a seemingly unnavigable world. It also provides a foundation for psychotherapy based on making sense of symptoms in terms of relationship. This thesis, by combining qualitative and quantitative enquiry, has contributed to understanding the complex interconnections between early family trauma, non-resolution of trauma, attachment relationships and adult schizophrenia and depression. By selecting low-risk populations, this study offers a reconceptualisation of four major and/or established theories concerning risk factors in schizophrenia:

1. Genetic predisposition with expression in late adolescence/early adulthood with equivalent age stress factors as novel events;

2. Perinatal trauma of viral or biological origin with neurodevelopmental consequences that are not expressed until late adolescence/early adulthood;
3. Bateson's Double-Bind theory focusing on mothers of people experiencing schizophrenia; and
4. High Expressed Emotion in the families of people experiencing schizophrenia.

This thesis also offers an opportunity to further examine two major shortcomings in the literature:

1. Early attachment trauma and its relevance to schizophrenia; and
2. The supposition that problems of mentalisation and coherence symptomatic of schizophrenia are predominantly genetically or neurodevelopmentally related to a specific perinatal event.

The above reconceptualisation is represented by a model of intergenerational transmission of trauma via dissociation, denial and subsequent incoherence in the narratives of mothers of participants with schizophrenia, and supports an interaction effect between this maternal dissociation in relation to early family trauma and attachment experiences in offspring who later develop an adult mental illness, with a possible parallel dissociative masking of depressive reactivity in the participants with schizophrenia.

Maternal histories from both groups challenge the theory that slow viruses, in particular, maternal influenza in the second trimester of pregnancy play a part in the neurodevelopmental aspects of schizophrenia. The mothers' narratives clearly indicate major interpersonal and environmental stressors and a wide range of maternal illnesses that could compromise the foetus in both diagnostic groups. Maternal reports of enduring fatigue post-natally do not indicate clinical depression, but rather the reality of their overwhelmingly busy lives with few supports. The study also challenges the early adulthood triggers to first episode schizophrenia to novel stressors.

Suggestions for future research include larger international sample populations and obtaining lifelong trauma histories from the mothers and fathers of people with schizophrenia without a known family history of treated mental illness (via semi-structured and not structured questionnaires because of the relationship between denial and dissociation), and establishing clear and testable guidelines for defining speech markers for dissociation.

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APPENDIX A

Names and Qualifications of Expert Panel

Mrs. Gloria Starkey (RN, RM, RPM, B.Hlth.Sc.Nurs.) has been a Registered General Nurse since 1972 (New South Wales) and worked in Queensland since 1973. She qualified as a Midwife in 1974, and worked in both general nursing and midwifery until 1994, and again between 1996-98 part time. In 1994-96, she completed her Psychiatric training and is a registered Mental Health Nurse. In 1993, she gained a Bachelor of Health Science Nursing, a post-registration degree. She is currently working full-time as Clinical Nurse Consultant in a Crisis and Assessment Mental Health Team.

Ms. Julie Crosbie is a Registered General Nurse, Registered Midwife, Registered Psychiatric Nurse, has a Bachelor of Nursing (USQ) and is enrolled in the Grad. Dip. in Human Resource Management (USQ). She has belonged to the State Police Service as Cadet and Constable, and managed her own businesses, including as a Child Care Centre Director. Currently she is Acting Manager for a District Mental Health Service, and is usually incumbent as a Team Leader in the Acute and Community Mental Health Service. In the past seven years, she has worked as a Clinical Nurse Consultant, Nursing Director and Team Leader in several Mental Health Services. She is a State Health Trained Mediator, a Trained Investigator, has training in Fraud Risk Assessment, Recruitment and Selection, Clinical Risk Assessment, Total Quality Management, Workplace Health & Safety and Supervision.

Dr. Robert Craig (MA, MB, BChir, DObstRCOG, MRCGP, FRACGP, FACPsychMed) is a Medical Practitioner. His experience is extensive, including working in the United Kingdom, Solomon Islands and Australia in general practice. He has also in the last ten (10) years worked in the practice of psychological medicine, and for four of those years worked in positions accredited for training in psychiatry by the Royal Australian and New Zealand College of Psychiatrists, including in the Child and Youth Mental Health Service and Adult Mental Health Service. Currently he is working part-time in an Intellectual Developmental and Disability Service, and part-time in his own practice, offering treatment to people with emotional and behavioural difficulties. He is the Coordinator for psychiatry for a District Division of General Practice, and as such has been involved in the Commonwealth Government Better Outcomes in Mental Health Initiative.

CASE MANAGER'S PROMPT SHEET
WHEN CONTACTING POTENTIAL
PARTICIPANTS IN RESEARCH

Sue Littler is a psychologist at this service. She is conducting research for her Master of Philosophy degree at the University of Southern Queensland. She is looking at the relationship between the incidence of early trauma for adults with schizophrenia and adults with depression. Would you be willing for her to contact you to ask you some questions about your early life? She would also want to contact your mother or the person who raised you to get details of your early history that you might not remember. She would also like to have your views of the world and your place in it in terms of what you expect in relation to others, as these may relate to your early experiences.

If you are willing for her to contact you, she will answer any questions you may have about the research, and tell you about the steps that will be taken to ensure complete confidentiality. This will include you being able to stop the taping of your interview, and to have the tape erased. She will ask you to sign a consent form that gives her permission to use the information you provide. Your name and any identifying information will be removed from all the data. She will give you a withdrawal of consent form, so if you change your mind at any time, your information will not be used for research. If you do withdraw your consent, this will not affect your future treatment.

CONSENT FORM

I, _____ agree to be interviewed for the purposes of research being conducted by Sue Littler, Post Graduate student in the Psychology Dept., University of Southern Queensland , and employee of the Toowoomba District Mental Health Service.

The purposes of the research and how my information will be used has been explained to me. I understand all personal information will remain completely confidential, and that anonymity is ensured by using numbered coding. I understand that at any time during the interview I can have the tape stopped and erased. I also understand that I can withdraw from participating in the research at any time without it affecting my future treatment by submitting the attached form, or by phoning Sue or another staff member.

Signed:

Date:

WITHDRAWAL OF CONSENT FOR USE OF PERSONAL INFORMATION
IN RESEARCH

I, _____ withdraw my permission for any personal information previously collected to be used in the research conducted by Sue Littler, Post Graduate student in the Psychology Dept., University of Southern Queensland and employee of the Toowoomba District Mental Health Service.

Signed:

Date:

Mental Health Intake Assessment

DSM IV Axis I diagnoses were used to classify those with major depression and those with schizophrenia. Those clients with depression who were not prescribed an antipsychotic were deemed not to be psychotic. Those clients with schizophrenia who were not being treated concurrently for a mood disorder cannot be assumed to be not depressed. Those with multiple diagnoses were excluded from this study.

ACUTE MENTAL HEALTH ASSESSMENT FORM

UR No _____

Surname _____

Given Names _____

Address _____

Phone _____

DOB _____ Sex _____

Date: / / Assessment done by:

History of presenting complaint: onset and duration of presenting complaints, precipitating stressors, symptoms review (mood, psychosis, anxiety, neurovegetative, other), consequences of symptoms including risks, inappropriate behaviours and effect on functioning (normal and current)

Current medication: (prescribed by, dose, duration, effect, compliance, side effects)

Medication	Route	Dose	Time of dose	Medication	Route	Dose	Time of dose

Effect, compliance, side effects

Previous psychiatric history: (previous consultation, admission, diagnosis, treatment and effects, previous risk taking behaviours, follow-up: case manager, medical officer)

Past medical & surgical history: (illness, risk factors: DM, hypertension, obesity, cancer, asthma)

Substance and alcohol use (past and present): (tobacco, alcohol, prescription drugs, illicit drugs, caffeine intake) – age at beginning of usage, type, quantity, route, duration, pattern, consequences, follow up.

Current use:

Method of administration:

Patterns of use:

Use of other substances:

Severity of dependence:

Risk behaviours:

Periods of abstinence:

Previous or current treatment:

Insight/motivation:

Impact of use on illness:

Signs of current intoxication/withdrawal:

Blood born virus status:

Family history: illness (physical and psychiatric) of family members and relatives, family dynamics and support, suicide and risk taking behaviour, parents' and siblings' personalities

Personal history: developmental history, childhood, adolescence, adulthood, traumatic experiences, education, peer interaction, sexual/marital/parental, occupations, income, abode, interests, social supports and strengths

Forensic history (past and current): type of crime, frequency, legal status, consequences (sentences or imprisonment, probation, bail, Community Corrections Service)

Mental state examination: appearance and behaviour, speech, mood and affect, thought process and content, risk assessment (suicide/homicide/self neglect/absconding/inappropriate behaviours), perception, cognition, judgment and insight

Appearance & behaviour

Speech

Mood & affect

Thought process & content

Biological/neurovegetative

Risk assessment

Cognition

Perception

Judgment & insight

Collateral

GP:

Previous discharge summary:

Family:

Other:

Summary (subjective & objective)

Diagnosis

Axis I

Axis II

Axis III

Axis IV

Axis V

Management plan/follow up: (inpatient or outpatient, Mental Health Act, investigations, treatment, observation)

Print name & designation:

Signature:

Date: / / .

Team discussion_____

Accepted for treatment

No further action required_____

Not accepted for treatment

Referred to:_____

Print name & designation:_____

Signature:_____ Date:____/____/_____

Zung Self-Rating Depression Scale

This scale has good reliability, discriminant and predictive validity (Gabrys & Peters, 1985) and correlates strongly with the Beck Depression Inventory and the Hamilton Depression Scale.

Core Beliefs Questionnaire

One validity study has been published (Schmidt et al. 1995). This instrument will be used to assess evidence of early trauma that may be otherwise denied. The Schema of particular relevance is Emotional Deprivation. Although this questionnaire has set questions and a Likert scale, there is an opportunity for the respondent to clarify, add or otherwise alter the set questions.

Introduction to Core Beliefs Questionnaire

This questionnaire was introduced with the following statement: I am interested in the different ways people view the world and their place in it in terms of what they expect in relation to others, that is, your core beliefs. I am also interested in how these core beliefs might or might not relate to your youngest years, and how both may or may not relate to your current illness. Do you have any questions so far? All the information you give me will be kept strictly confidential. Your response sheet will be coded so that your name does not appear in the data.

I will also need to contact your mother/primary carer to get your earliest history, as it is not stored in memory. Please contact her/him and ask if it is O.K. for me to phone her/him, and what times would be convenient. I would like to audiotape our conversations so that I can listen objectively later. Anything your mother/carer wishes to keep confidential will be respected.

If you are willing to participate, please sign the release form. You will see that you can withdraw your permission at any time, and if you do so, your information will not be used for research. If you do wish to cancel your permission, just sign the withdrawal of permission form and send it to me.

Sample questions from the Core Beliefs Questionnaire

The following selection of questions are from the items used to rate Emotional Deprivation.

CORE BELIEFS QUESTIONNAIRE

Second Edition

Developed by Jeffrey Young, Ph.D. & Gary Brown, M.Ed.

Name _____ Date _____

INSTRUCTIONS: Listed below are statements that a person might use to describe himself or herself. Please read each statement and decide how well it **GENERALLY** describes you. Do not answer in respect of one particular person, or one particular incident in your life. It is your **GENERAL** perspective that is required. When you are not sure, base your answers on what you emotionally *feel*, not on what you *think* to be true. If necessary, alter the wording of the statement so that it would be a better description of you. Then choose the highest rating from 1 to 6 that describes you (including your revisions), and write the number in the space before the statement.

Example: 1 ____: ____ I worry that people will not like me

RATING SCALE:

- 1 = Completely or almost completely untrue of me
- 2 = Mostly untrue of me
- 3 = Slightly more true than untrue
- 4 = Moderately true of me
- 5 = Mostly true of me
- 6 = Describes me perfectly or almost perfectly

1 ____: ____ People have not been there to meet my emotional needs

2 ____: ____ I haven't gotten love and attention

3 ____: ____ For the most part, I haven't had someone to depend on for advice and emotional support

4 ____: ____ Most of the time, I haven't had someone to nurture me, share him/herself with me, or care deeply about everything that happens to me

5 ____: ____ For much of my life, I haven't had someone who wanted to get close to me and spend a lot of time with me

6 ____: ____ In general, people have not been there to give me warmth, holding and affection

7 ____: ____ For much of my life, I haven't felt that I am special to someone

8 ____: ____ For the most part, I have not had someone who really listens to me, understands me, or is tuned into my true needs and feelings

9 ____: ____ I have rarely had a strong person to give me sound advice or direction when I'm not sure what to do

*ed

Traumatic Antecedents Questionnaire

The Traumatic Antecedents Questionnaire (TAQ) is a self-administered assessment. It gathers information about lifetime experiences in ten domains:

1. Competence
2. Safety
3. Neglect
4. Separations
5. Family secrets
6. Conflict resolution
7. Physical trauma
8. Sexual trauma
9. Witnessing trauma
10. Exposure to drugs and alcohol

These domains are assessed at four different age periods:

1. Birth to 6 years
2. 7-12
3. 13-18
4. Adulthood

Although this author is aware of no studies using the TAQ with people with schizophrenia, the final question asks how upsetting was it to answer the previous questions. This provides the opportunity for the case manager to closely follow-up any participant who answers positively to this item.

Sample questions from the Traumatic Antecedents Questionnaire

The following sample questions are selected from the construct of Neglect.

Traumatic Antecedents Questionnaire (TAQ)

Name _____ Date _____

Age _____ Sex _____ Marital Status _____

Education _____

Occupation _____

Instructions: This questionnaire asks you to describe experiences you may have had as a young child (ages 0 to 6), as a school age child (ages 7 to 12), as an adolescent (ages 13 to 18), and as an adult. For each item, indicate the degree to which the statement describes your experience at each different age period. The scale has both frequency and intensity words; please choose the highest applicable number. If there are any age periods for an item that you are unable to answer, please indicate this by choosing DK (“don’t know”).

Use the highest applicable number

0=never or not at all
 1=rarely or a little bit
 2=occasionally or moderately
 3=often or very much
 DK=don’t know

	AGE	INTENSITY/FREQUENCY
2. Someone made sure I got up in the morning and went to school	0-6	0 1 2 3 DK
	7-12	0 1 2 3 DK
	13-18	0 1 2 3 DK
6. Somebody in my family had so many problems that there was little left for me.	0-6	0 1 2 3 DK
	7-12	0 1 2 3 DK
	13-18	0 1 2 3 DK
	adult	0 1 2 3 DK

7. I felt that nobody cared whether

I lived or died.

0-6 0 1 2 3 DK

7-12 0 1 2 3 DK

13-18 0 1 2 3 DK

adult 0 1 2 3 DK

22. I spent time out of the house

and no one knew where I was.

0-6 0 1 2 3 DK

7-12 0 1 2 3 DK

13-18 0 1 2 3 DK

adult 0 1 2 3 DK

29. My caregivers were so into

alcohol or drugs that they

couldn't take care of me.

0-6 0 1 2 3 DK

7-12 0 1 2 3 DK

13-18 0 1 2 3 DK

adult 0 1 2 3 DK

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Mother/Primary Caregiver Interview

This semi-structured interview was designed after consultation with academic supervisors and literature review of trauma and attachment fields according to the principles described in Patton (1990) and Goering and Streiner (1996), and combined both open and closed questions in an invitational manner, providing the opportunity for a collaborative exploration of recalled perceptions. A non-interrogative approach allowed maximisation of a supportive milieu most conducive to disclosure of sensitive material.

The interviewer needed to be clinically experienced and able to combine rapport with neutrality. It was also important to perceive the mother/carer as the expert, the one most familiar with events and their impact on family members.

Introduction to semi-structured interview

This was introduced with the following statement: Thank you for agreeing to speak with me. I will be asking you about what you can recall of ___'s earliest years, since this is the time in our lives we are not able to remember for ourselves. I am researching the importance of this earliest period, especially from conception to about age three, and its relationship to two diagnostic groups. I would like to tape record what you have to say so that I don't miss any of it. I don't want to take the chance of relying on my notes and thereby miss something that you say or change your words. So if you don't mind, I'd very much like to use the recorder. If at any time during the interview you would like me to turn the recorder off, just say so. Also, if there is anything you say to me that you do not want ___ to know, just let me know. Everything that you tell me will be kept strictly confidential. Once the tape is transcribed, the tape is secured in a locked filing cabinet, and the transcription is given a code, and all identifying information like people's names, towns, etc. are altered. Is there anything you would like to ask me about this?

Sample questions

First of all, I wonder if you can recall when you first knew you were pregnant with ____. What comes to mind recalling that time now?

What was going on for the family when you were pregnant with ____?
(Follow-up on any mention of fears about the pregnancy, absence of support, traumatic losses or fear of same, family arguments, alcohol abuse, etc. Very truncated, dismissing responses need to be pursued by asking for specific examples).

What was the birth like for you? And for your baby? (Follow-up on any mention of not being able to hold and gaze at baby within the first week after birth, life-threatening illness in mother or baby).

Was there a time when you and ___ were separated when ___ was very young? (Follow-up on the circumstances, response of mother and what she assessed as her infant's response).

Who was your main support person when ___ was very young? (Follow-up what this support actually was by asking for specific examples).

If trauma, major fears or loss are mentioned, follow-up with: Who have you been able to share this with? When was that? Do you talk of it now? (Or: Was there anyone you could talk to then about it? And what about later? How do you feel talking about it now?)

APPENDIX B

Summaries of Remaining Mother Interviews

SCZ011: Mother first knew of pregnancy with participant when in hospital with gallstones. No treatment for gallstones given because of pregnancy, and mother claims no pain. Fell pregnant almost straight after a miscarriage at sixteen (16) weeks – “long dead”. Dissociated – “I went into another world I think.” “In a fog.” (trauma response). Threatened to miscarry at six weeks with participant (“hazy memories”), also with next child. At same time, father of baby was very ill with heart problems – first bypass when participant aged 18 months. Husband worked shifts during pregnancy, present at birth. Moved towns just before the birth. Parents came regularly (3-4 hour drive).

The birth – straightforward, but two weeks early. Mother very overweight, had high blood pressure in last stages. No need to go into hospital early. Excessive milk production – mother relates funny stories (congruent). Father shouted at baby when crying (but not often). Mother returned to work when participant aged 3 months, baby then was badly sunburned because of neglect by babysitter. Husband had affair with one babysitter when participant aged 18 months – parents’ relationship unsettled after that until separation when participant aged 8, 9 or 10 years (=mother’s vagueness). Mother mentions that as a couple they avoided problem-solving.

Sister born when participant aged 3 years. Accidents/illnesses – participant got rabbit bone stuck in throat, and stye at age 3. Mother reports stye very distressing to treat. When pulling self up to walk, hit chin, putting teeth through tongue, and did it again the next week (told with clarity of detail, empathy). Participant never liked to walk, always wanted to go in the pusher. Mother returned to full-time work when participant aged 6 years. “Things got worse – he was extra clingy.” Participant’s nature: Looks like mother’s father; placid and sensitive (to criticism and concern for others); mannerisms and interests in computers, trains like father; impatient, impulsive and quickly frustrated like mother. Mother was disciplinarian, but said he was not a behaviour problem.

Recent history – got depression first, then psychotic in year 11 (age 17). Good school friends visited him in psychiatric hospital. Triggers seen by mother as “one move to many at age fifteen”, some conflict with stepfather, moved to be with father but it did not work out.

SCZ012: Mother had thyroid operation when two (2) weeks pregnant with participant – “I worried it might affect the baby. I was a bit run down because of overactive thyroid.” Post-surgery, calcium levels were chaotic, and “Not the best surgeon, and I think he upset the parathyroid.” Mother put on calcium during the pregnancy. She worked until 6 months pregnant, doing night duty nursing.

Baby arrived quickly at term. Big baby – 9lb.11oz. Mother scared she would end up with diabetes. Good baby, natural delivery, saw her straight after the birth - “all rosy”. Note: “I fed her until she was four months pregnant and then and then I was a bit run down.” (confused speech=dissociative process). Put her on bottle until 7 months old, and then cup. Mother went back to weekend work when participant aged 14 months, with dad doing babysitting.

Mother’s father drowned when mother was fifteen years old. Mother’s mother was there to help out following the birth, but very hostile relationship with mother. Mother’s sister had anorexia for 25 years, and died two years ago.

Participant never naughty, always timid, clingy and shy. At 18 months, “hysterical with fireworks, wouldn’t let dad go”. Frightened of crossing roads, hated going shopping. “She just liked being home.” But also played for hours across the road with neighbour’s kids. Father whacked her occasionally – very upset about it. Didn’t like kindergarten – mother doesn’t know why. Ran home to neighbour one day. At preschool, teacher told mother that her daughter didn’t cope and said she’d never get a job. Participant sensitive and easily upset “all through the years.” High school – mother first noticed something wrong – participant used to get upset and hyperventilate, got upset with the other kids being bitchy and horrible. Had acne. Uni – completed nursing studies and was more settled, but never coped with relationships with boys. Worked as a nurse, including overseas, but found it very stressful.

Father got Parkinson’s disease at age 40 (same age mother’s father drowned) – participant was 14 years and very upset (same age as mother when her father drowned). His speech is now affected. “She loves her father – I think she was very close to him.” (change of tense). Participant reminds mother of a mixture of everyone; don’t know; a bit like me; like my mother with timidity. Mother also describes participant as honest, giving, do anything for you, happy, likes to join in. Doesn’t try to take over like her sister, not practical but not silly, creative. Had asthma from age 4/5 to about age 8, plus lots of nosebleeds. Always had trouble with sinuses, and missed a lot of school.

Participant initially became depressed with suicidal thoughts whilst overseas nursing, and had to come home. Later diagnosed with schizoaffective disorder, and finally schizophrenia. Participant requested hospital admission when parents away on holidays even though at that stage she was well and living independently (query insecure attachment/separation issues).

After 50 minutes of interview, mother raised again “I often wonder if having that thyroid done..”.

SCZ013: Mother states she was pleased to be pregnant with participant after two years in marriage, as she went off the pill deliberately, though they were still settling. Can't remember which house they were in for this, their second child. Father had steady job. Moved towns when got married. Mother had good friends. They struggled financially, as neither brought anything to the marriage but the roof over head; both were from large families.

Pregnancy normal, with a little bit of morning sickness. First birth was “face forward instead of face up”, so participant induced at less than full term – “Because I'm short from the waist down.” Sister helped mother at home. Baby breastfed up to 10 weeks. Good sleeper and eater, not a difficult baby. Mother described participant as looking like a skinned rabbit (query hostile comment). Took brief separations OK. Cheeky little boy, endearing. Had both sets of grandparents nearby.

Normal milestones. Sister was quieter, participant was active. Family moved first when participant aged 5. He changed when aged 13 following move to T___ and he missed his friends, and started high school, and father started working away from home. Not particularly fussy or sensitive, was outgoing and made friends easily, all-rounder at school, but preferred sport. Some difficulty with maths. Parents split up for about 9 months when participant aged 13 due to father's affair – described as very traumatic to mother, came out of the blue. Participant very angry, very hurt, resentful. Started to think he was the man of the house. Mother thinks he felt displaced when father returned. Mother feels he hasn't worked it through. Participant left home at 22 for about 3 years, and he became ill at age 23 when parents went overseas for a 15 month holiday. Mother returned to be with him.

Triggers according to mother: all the stress at age 13, nephew moving in with them, workmate committed suicide. Got depressed due to lack of work around age 23, then paranoid. On drugs for a while.

Parental disagreements – mother denied yelling, saying they talk things over, father makes the final decision. Father is not a war veteran.

SCZ014: Mother says news of pregnancy was “wonderful.” Doubt about when became pregnant, thinks baby born 3 weeks early. Mother had the ‘flu and morning sickness, and took Debendox. Natural childbirth, no problems – “You learn how to cope.” Had 4 children under 5, 7 in all. “You sleep when they sleep, it just happened, we coped.” Husband very helpful getting up in the night for feeds, etc.

Participant is firstborn, born just after the war, and was Rh+ve. Mother then reported in a confused manner what happened with subsequent births - stated the first Rh-ve baby sets up antibodies, and the next Rh-ve baby threatens to kill the mother, and the third Rh-ve baby usually dies. That is, the participant would have been under 5 when his siblings and mother were at risk of dying. “I only had to stop breast-feeding for a month and I’d fall pregnant no matter what I did.” Refused the pill because she thought it harmful. Mother worked for the first 6 months of the pregnancy doing postgraduate studies. Lived at home on her own, with husband studying at the same time on acreage on outskirts of a capital city – lived in a poverty-stricken street, 22 families of non-English speaking immigrants. Only had contact with a couple of neighbours.

Participant’s birth – when asked re. this, mother states “I’m all for a bit of discipline” in relation to ward policies. Participant was first grandchild on both sides. “He was delightful in every way, and very responsive.” Slept well, fed well, put on weight properly, played on own constructively when a little older. “We thought he’d be good at swimming. He had a very nice style, but he never really put his heart into it. He said he never had the energy.”

Age 14, participant found to be long-sighted. All the children were dyslexic, and both parents. All had learning problems. “As long as the system puts up with them, they eventually learn to cope.”

Mother put cause of schizophrenia down to a chemical/plastic fire in a car which participant extinguished, she doesn’t think this now. Thinks now it might have been the Debendox. Age 5, client had measles, and all the kids had glandular fever – taken to child specialist, and told to take aspirin and sit it out. Participant didn’t pass English to go to university, so repeated at another school. School magazine had picture of participant with a stone wall – mother reports this as student editor having insight that participant would have schizophrenia. Sees it herself as meaning the

other kids had trouble relating to him, but he was in charge of a busload of kids. “He was too responsible really.” His nature – “He’s always adopted passive-resistance” – asked for an example, and she said “arguing with his father.” Sees trigger to first illness episode as all the trouble he had with his wife.

Although participant passed university, he got into mysteries and alchemy under influence of a lecturer. Participant takes after “None of us”, “probably his father – he gets worked up”, when born looked like “a frog” (?hostile). Mother denies post-natal depression, but “One of them died.and ah.ah.I.I.er.ah, I went shopping one day, and this.this.this jolly woman she hadn’t heard about it, she said ‘Oh I’m so sorry’.and I cried (laugh). I was so ashamed of crying in front of a.a stranger.” Mother lost 3 babies to Rh-ve factor, but didn’t know about this until the 5th baby. Participant is +ve, then 2-ve babies. Participant aged 7 when first baby died – “It didn’t affect him.”

In 1974, B___ (third child) died in an accident – participant was affected, but parents didn’t realise it. Mother sees this as the main trigger to his schizophrenia. The following highlights the listener’s confusion around family names. The participant has the same first name as his father, and then the 3rd child was nicknamed the same (?displacement). “F___ and I were too selfish. We just kept to ourselves. And B___ had been called F___, F___ too, and everyone assumed that it was F___ that had died..and found he was alive and..and I.I think that ah..I think he had more internal unexpressed emotional upset..over that..than anything.”

Nil major separations. Father away to property on weekends sometimes. Close to mother when little, late teenager no. Friendly when young. Mother described participant as sitting on her lap and looking out at the world, whereas second child clamped onto mum, anxious and sensitive. Participant didn’t take off, always attended school, was reliable and responsible. Mum was disciplinarian – gave example of participant going near road and she made “Plenty of noise and fuss so he wouldn’t forget it.”

SCZ015: This mother was a very poor historian due to poor if any schooling and late adulthood head injury. She reports first knew of being pregnant with participant (first of 8 kids) when 4 months pregnant – lots of vomiting. No miscarriages. No problems with birth –weight 9lb 5oz, both well. In hospital 9 days. Mother’s mother helped her at home. Very healthy baby, breastfed “real good”, active and early walker. Good little boy who she took with her as she worked as a washing and ironing woman.

Father worked on railways. They lived in a small house with a dirt floor. She can't tell me how far apart in age the kids were. The second boy walked late. When I asked her about the one that died in a house fire, she said "Ah. I don't talk about the little fella, no." (avoidance). Staff think participant was about 7.

Participant reminds mother of "Me. Like me all the time. Done good at school. He can draw too." Mother nearly killed in MVA "when E___ was a babe in arms" (I couldn't clarify which child this was in terms of order, but mother thought participant was age 12). "He was crying and all." Husband was driving and they were hit by a semi-trailer, mother was unconscious several months and the children were looked after by the Salvation Army first, and then by Bush Children's.

Mother thinks trigger to schizophrenia was death of participant's grandmother – "She loved him so much." Questioning when this happened was answered "Nine years", and I couldn't get her to clarify whether that was 9 years ago, or to what it referred.

Father won't help mother, expects her to work still. Mother visits participant every afternoon with his meal – "That's what mothers are for." He wants to move next door to parents. Only at end of hour did mother talk about father's violence, not needing to be drunk to be like that, and it started at time of marriage. States father is very hard on participant and has always. She states she stands up to him now (?allegiance shifted to son). Father used to bash mother up, and she would hit him with a book when he was dead drunk. Admitted that the violence scared the kids, and said they used to go into their room and lock themselves in. "It was hard on me. Hard on R___ (participant) as well. He used to tell his father to settle down. 'You get out of it, or I'll smack you in the head too.' And I said 'Yeah, you gotta hit me first.'" (Another example of mother staying in very violent marriage with little resolution, and child unable to leave home as adult).

SCZ016: Mother is a very rapid speaker. Asked usual question re. when she first knew she was pregnant and she replied "Happy to have a girl. Already had a boy." Eighteen months between first son and male participant. Mother stated she was apprehensive about how she'd cope with two toddlers, but figured she'd be fine. Mother and younger brother were reared by grandmother, they'd always lived with her and then mother's mother became ill around age 28 – "I think it was schizophrenia" (no idea whether this is true, or a reconstruction). Having a sick mum – "I just wanted her to get better." Grandmother was very loving, grandfather had

died when mother was 6 or 7. Mother's father never lived with them – “We were both illegitimate.”

Met husband, drawn together by “Don't know. He lived close by.” When 4 or 5 months pregnant with participant, she was at a friend's place while father was out spotlighting. She had a threatened miscarriage, with cramps and clots, but just went home to bed and saw doctor a couple of days later. Denied worrying for rest of pregnancy about having more trouble. “No actually. I never gave it a thought. Never worried about it after that, yeah. Yeah, never thought about it, so..yeah.” (dissociative process).

Pregnancy went full-term. Short labour, and again a reference to ‘wrong’ sex of baby. “There were problems when she was born. I was a bit fuzzy...they used gas. I pushed him away. They handed him to me..and I was nursing, and the next thing.they grabbed him off me. He was going blue. His lungs were full of fluid, so they drained him out. It turned out he was fine.” In hospital 5 days. Not worried – “Ignorance is bliss.”

Breastfed participant for about 6 weeks – fed eldest boy for 7 months..but moved house just after coming home with participant, and not making enough milk, so supplements and then swapped to bottle. “He was the happiest, most contented baby (emphasised). “You fed him you changed him you put him down and he was always laughing.” But – at 9 months, “I don't know what was wrong with him.” Wouldn't stop crying, and she couldn't get him to sleep. Mother's brother came to help – “he'd take him and hold him while I was getting tea.” Neighbour said “That child's got Pink's disease.” Mother got sedative drops for baby from GP. Mother said she recently heard something about it being low salt levels. “For about.3 weeks he cried.and cried and cried and cried.” GP told her baby was spoilt – mother at end of tether. One day, put baby down and went up backyard and cried. Baby also had croup “a couple of times”. Went blue once – aged 2 or 3. Had last attack when in school.

Participant was happy when little to play by self. Wandered off a lot. “You couldn't take your eyes off him for a minute because he was off.” Fell out of trees, off washtub, but mother denied she ever worried he'd really hurt himself. Brother was very placid.

Participant reminds mother of father with looks, nature like mother as he likes to do his own thing, and mother always encouraged this – “He listens to me.”

Mother became denigrating re. father being in same job for 50 years. Stated participant is resentful and always was, towards father. “His father is not an easy man to put up with. He used to drink, come home and be abusive with the kids.” (and herself). Participant always close to mother, helped her when little with chores, and tried to push between fighting parents. Heaps of fighting and yelling, even during the pregnancy.

Mother first noticed problems – stated participant excelled at everything without studying, breezed through, and excelled at sport. Then went to high school – “big fish in little sea to little fish in big sea.” “He never would conform.” Repeated grade 10. Left school age 16 halfway through grade 11. Constant battle getting him to school. Went roustabouting, changed jobs a lot. Seen as restless by parents. Used marijuana when with friends, used to make him physically sick. Age 21, had a row with a girlfriend, came home for a week and seemed restless about future, etc. and went to another State. This is the age mother keeps mentioning as when participant first became ill.

Mother described self as the problem-solver. She and participant would talk for hours. During interview, mother kept eye on father in yard, obviously fearful. SCZ017: Mother reports she knew when one month pregnant, happy, looking forward to it. One son five years older, and trying for that length of time for another child. One doctor told mother she wouldn’t have any more – “Some of the..one of the tubes was twisted inside..but um..it just righted itself.” No miscarriages. Lived in a capital city with father in Army. “Just a normal family.” Easy pregnancy, never sick. Delivery was after 5 hours labour and easy compared with the first. First delivery after 24 hours labour – “too big for me” with forceps and tearing. Husband there at the birth of participant. In hospital 5 days. Saw baby straight away. Father’s parents looked after father and other son during mother’s stay in hospital. Her parents were too far away.

Older brother wouldn’t let participant cry (attentive). “Very spoilt little baby.” Personality – very laid back. When young, both boys were full-on all the time. Changed since breakdown. Used to live for sport, all weekend. Walked at 12 months, the usual. Older brother did the talking – participant used own language only brother could understand, always stuck up for participant, did everything for him. Mother tried to change the language issue, and participant got own friends at

playgroup and pre-school. Participant reminds mother of herself in looks, nature like father (quiet, laid back).

“He was just a normal, you know, very protected. Neither of the boys liked going to playgroup, preschool or school at first because of the separation from mummy. They cried and cried. I cried at first...it was heartbreaking I suppose and then, I del. I’d...go and help at the school so they knew mum was there...” She didn’t allow school refusal. They slowly settled down. “They were just sooks I suppose. Mummy’s little boys. (laugh) It’s awful. They don’t like me talking about that. (laugh)” Didn’t want to leave school in the end. They never liked staying over at anyone else’s place – mates used to visit them for sleepovers.

Husband away a lot with the Army – away when first son born. When participant aged 2, moved to N___ for 6 months, then father moved to D___ to look for work, followed by family for 12 months, then to B___ for all of participant’s schooling. “First son had too many schools” but had an outgoing nature. Mother frightened re. effects of frequent changes for this child. Says she didn’t mind the moves for herself and not a problem for participant. “He would sleep 20 hours a day if you let him, as a baby” (up to the age of 12 months). “I had to wake him up to feed him.” First son was “terrible” – used to cry “24 hours a day I reckon.” Mother was major decision-maker and disciplinarian, but good kids.

Mentions how spoilt participant was again, e.g. “If he was naughty and I took something off him, his brother would sit with him until he got what he wanted. And you couldn’t rouse on his, ‘cos his brother would..” Claims no sibling rivalry.

Relationship breakdown began 12 months before separation, no big fights “fell out of love, outgrew each other.” Both at fault. Father left the marriage when participant aged 8. “But they never went through anything bad with that because...I just went for custody straight away and I got it. And then um..J___ (father) was supposed to have them every second weekend. Not a problem I said, whatever...he got married straight away.” Then father got cancer and died. Participant saw a lot of his father – “Very upsetting for him but I couldn’t stop him.” Father died when participant age 17. Mother lost her defacto 3 years ago from renal failure. “But M___ (participant) was kept well away from that. I’d let him go to the hospital if J___ was sitting up as if nothing was wrong, for half an hour.”

Mother feels father’s death triggered depression in participant. Mother first noticed something wrong just before end of high school when participant aged 17 –

had repeated grade 12, mother not happy about that, but participant wanted to be a professional golfer and just mucked around and did no better. No idea how come participant has schizophrenia – no family history of mental illness. Some marijuana use but minimal and a long time ago. Seen by mother as a strong-willed child who wouldn't accept second-best, and had to win and was a bad sport (?hostile comment). Had good friends. Nil girlfriends, would go out in group.

Mother stated father never yelled, she did a bit – sounds non-significant. Nil natural disasters, nil accidents, mother's father died before participant was born, mother's mother died when participant age 2. Lived a long way away – mother stated she handled it well “because we had to. That's life. Get on with it. You've got to get over it or go down with it.” Says can let self feel sad, cried definitely, and OK after 6 months.

SCZ018: Mother reports pregnancy with participant was a shock. “I had four children. The youngest was 8 and here I was having another one.” Complete surprise. Was playing tennis twice/week. Had the children was going to have. Threatened miscarriage at about 3 months – went to bed for 2 days. Lost 2 previously at about the same stage but not between second youngest and participant – “Husband and I had the different blood groups” (she is Rh-ve, he Rh+ve). “They said after I had the first miscarriage I wouldn't have any more. They were wrong. I had 5, and lost 2.” Mother's father died when mother 4 months pregnant with participant but not close – mother not seen him for many years. No morning sickness, normal birth. In hospital only 2 days. Participant is the only child not breastfed – mother couldn't. Good eater. Had grown-up kids at home to help, the eldest being 16. Mother's mother died last year aged 92.

Participant reminds mother as a baby of: very long pause before “I don't know. They all looked different, and had personalities of their own.” Photos brought out. Mother became very tearful when pointing to participant. “They all doted on her. They're all very protective, and they still are.”

Good kid, nothing outstanding, average girl, very loving, average at school. Used to go to tennis and weight watchers and trips with mother. Participant was teased at high school re. weight. Mother was shocked that participant got schizophrenia. Father (nurse) worked at psychiatric hospital for many years. He is now depressed, not earlier.

Mother puts participant's illness down to participant's husband renovating the parent's house, and the participant wanting her bedroom painted black – “We tried to talk her out of it, and she didn't get it.” (bizarre explanation). Mother's second husband then walked into the interview room and said that participant asked her if he minded her going out with A____, and asked him to give her away, but her natural father was paying for the wedding so participant torn. Participant started going out with A____ at age 15, when mother took up with her second husband. After participant's first child, she became unwell. Mother stated “I didn't know. I didn't get it.” Now sees the early photos of participant as having a false smile, adding “I didn't know it at the time.” Claimed participant was a settled happy child – “She had a household of people that loved her.” Good kid. “I can't elaborate on that, 'cos that's what she was.”

At end of interview, mother stated “My reaction to dad dying was that he hadn't..ah..I wasn't mentioned in the will..and I couldn't even get a copy of his death certificate..to see..when he died and what he died from.” Mother's parents “divorced for..since..I was about...ten. Another broken home.” She finally mentions that the marriage breakdown (in response to question whether it could have been stressful to participant) “She wasn't isolated from her father at all. I went through the same thing many years ago with my mother and father, and it didn't ah..upset me to..a great....See he's still here (sigh) so she doesn't have..she's not been cut off.” “I can't think of anything” (that would have stressed the participant early on in life).

SCZ019: Mother found out was pregnant when still working, had just finished midwifery training. Really excited because married 3 years, waited until financially secure. “He was very special.” Pregnancy was fairly uneventful, but small for dates, and periods irregular. Medical staff were concerned about his size, right up to birth. Induced (mother gave big sigh). “I can't even really remember. It must have been a rupture of membranes in those days, and just a a...???drip I think.” In labour 6-7 hours. Forceps delivery because “maternally exhausted. I'm not a 100% sure on that.” Had episiotomy “which later turned into a...um..haematoma, which had to be evacuated, it was pretty scary that night. So that sort of took away the shine of things a bit..on his actual delivery but apart from it was..you know, it was great. He was gorgeous and..” Weight 6lb7.5oz. Mother had raised BP towards end of pregnancy also, “but nothing major.”

Participant breastfed for 13-14 months – when ceased, participant got bronchial asthma and was quite sick. Not hospitalised. “Life became a bit hectic after that because I was pregnant with K____.she’s.21 months as I said I think between them.” When she was born, mother very sick – had Debendox..with nearly all of them – “the whole time with B____” (participant). Was so sick she had to stop working. Moved to T____ (Army) just after K____ was born – father already had moved there. Hectic was stressed again. Father a heavy smoker and drinker, still is. Mother then said “K____ was a horrific child.baby” who screamed and screamed “I could easily have killed her.” Then followed comments indicating that participant got lost in all this mayhem. K____ caused parents a lot of angst as a baby, having lots of tests and had a hearing problem. “In the meantime, this little boy.just sitting in the background.quiet, gentle..never caused..a minute’s problems except for the.when he had a bad asthma attack or something like that. So he.she dominated the..family.from the minute she sort of arrived, and I often.sort of think he was..just in the background there.” Mother says they’ve queried everything in terms of aetiology of schizophrenia. With the asthma, she stated there were no serious episodes but the medication “sent him up the wall” (and her?) The family got moved on compassionate grounds. Husband away a lot – “It was very traumatic for me” because she had never been away from home before.

Mother stated there were no supports in T____, as she wasn’t in to the heavy drinking scene of her husband. She had a couple of friends – “I guess they were.probably friends.” Participant went to Montessori kindy, playgroup and mixed well. Always quiet, placid, good kid, good sleeper from the start. Hated going to kindy – “very upset, a big trauma for him” (laugh). He screamed and screamed. Liked it after a while, and coped very well. Mother stated it was awful for her. “Cos he was just so upset.” Not clingy according to mother, but stubborn, no tantrums but wouldn’t wear X if wanted Y. Even if it was very important, she couldn’t get him to do..(mother couldn’t think of an example).

Mother had one friend in T____ who lost a child in a freak accident. Participant was age 3 and in the same playgroup. Mother stated she never thought about it affecting the participant. Stated again that she can remember feeling very lonely. In preschool, participant lost a little friend to cancer, and in grade 3 or 4, another friend died of measles slow virus. In grade 4 or 5, participant didn’t like a teacher who thought he was arrogant, and he started wetting the bed – mother

described him as sensitive and artistic, but didn't express it, and she still doesn't know what goes on in his head. Participant and sister fought "like cats and dogs", but now very supportive of each other. Mother thinks participant was jealous of attention to sister.

Participant reminds mother of his father in being quiet and stubborn, and very reserved and standoffish, and "wouldn't go things without me." He asks mother now to take him places, but hostile to mother when he is unwell, and has now formed a bond with his father. Husband's parents never attended any of the births, won't leave their small town. Mother sees father's father as unable to deal with anything. She sees army life as insular too. In 1993 when participant aged 15, father retired after 23 years in army. Mother thinks participant first became ill in grade 9 at age 14 when his best friend was killed in MVA. Participant has since denied there was any friendship, hasn't addressed the trauma, didn't cry but withdrew instead. Mother keeps the photos because he was participant's best friend since preschool.

Mother became upset (whilst laughing, indicating the incongruence of unresolved issues) when I asked her to say more about her comment "priorities change". She stated the 3 children are still exhausting. She cried when saying "We had a lot of expectations for B___, 'cos he was very bright." He initially smoked marijuanha and felt better, so mother concluded he was unwell before that. Became ill in high school, would fall asleep in class. Mother still angry with teachers for not telling her. Participant is about to do year 12 again via correspondence (age 24), and is refusing TAFE. Participant told GP his mother was "overpowering" (Mother related this to me, stating that she had to push him to go for things). She said she doesn't push him now, and was surprised that participant agreed to be interviewed.

Mother sees father as a better parent now – when participant ill, father deliberately did a lot of overtime, "didn't bother coming home. There was very.lots of..things weren't real good with us.because.I was so engrossed in what's wrong with B___ .and trying to work and.figure this out.." Stated they just survived it, and are much closer because of it. Gave husband a couple of ultimatums – "If you can't handle it, get out." When participant first ill, mother let husband take over, never happened before. She sees him as relishing that control, suits both of them much better, now very supportive of each other, and participant is more responsive to his father.

Mother described her father's explosive anger towards her gentle mother, that he is very critical and judgmental and she is very wary of him, and that he had a breakdown in his 40's – no diagnosis, no treatment. Mother's older sister was born with pyloric stenosis leading to brain damage and epilepsy, and she is in a psychiatric hospital. Sees this as baggage her father has never resolved, plus her mother lost 2 babies to stillbirth.

Mother thinks participant was initially depressed. She feels father being away a lot was more significant than any yelling or arguing the parents did, or her state of constant worry. Participant said when first ill "I don't know why you don't leave him. You've got nothing in common."

SCZ020: Mother can remember when first pregnant – happy because had trouble falling pregnant, tried for 10 years. Excited – claims she knew she was having a boy. Father is a war veteran (Navy) and was on a warship (sank, killing many). He was overseas for 6 months, and returned just before she fell pregnant. Post war – "He's never talked about it, not even to his good mates." Busy time moving to very hot C___ to help out in her father's business. Rapid delivery (half hour) brought on by injection because overdue 2 weeks. Nil foetal distress, and both well. Saw baby straight away, and was in hospital a week. Mother's mother came up from NSW after the birth. She was in fairly poor health with rheumatic heart. Mother's mother got rheumatic fever just after mother was born, so participant's mother was reared by her aunt to age 5. Then mother's mother got diabetes. Her father was well.

Next child was a girl, 15 months younger than participant. Participant as a baby was a good sleeper but very overactive. Very curious child that checked everything out. Had to keep an eye on him or he'd disappear – neighbours had to search. Not gone for long periods. No dams, no dramas, according to mother. Used room dividers to keep him confined. Had a lovely childhood with lots of kids playing in the yard, with an above-ground pool. Mother thought he was pretty easy to comfort, and was a cuddly boy.

When he went to school, participant became very quiet – this worried mother. Never talked about what he did at school – "He went right through school like that. He's still very quiet." Mother was so worried she used to encourage him to bring his mates home. They'd watch TV and participant would be in his room doing electronics, since age 7. Mother sees this as an over-interest, very

mechanically-minded. Participant used to work at fixing video cameras, and quit university for a while to do this. He repeated grade 12. He reminds mother of his father when born, he gets on well with his sister, with occasional fights. He had no dramas in his life, nothing to indicate what went wrong. No marriage problems. First unwell – changes at 16, but first episode age 25 after a car accident and some use of marijuanha (not current).

I brought up yelling and arguing early in interview – “I don’t think there was so much yelling, but of course when my husband came back from.drink a lot. And probably, I was tense because he was drinking, and C___ being an outback town is prone to not drink. Actually I was very careful not to have arguments in front of the kids. It was dreadful. I never grew up with it.” (Her husband is in the next room, and mother is speaking very softly with dysfluencies and contradictions). “He drank all the time we were in C___” until they moved to T___ 21 years ago, participant age 9. She talked about her working all time in C___ and then working at night when participant started school. She stated participant missed C___ a lot.

I asked about serious illnesses – “We went through a lot, yes. But not in the very early early years.” Only at end of interview does she remember that her daughter was very sick when little with UTI’s. Very sick every couple of months – backwards and forwards to specialists. The UTI’s stopped when left C___ (this is now known to occur often in infants at C___ due to poor water quality). Mother thinks that might have been stressful to participant, but he wasn’t unhappy. Daughter also had convulsions with high temperatures. Participant had influenza and bad tonsils a lot when young – tonsillectomy age 4, nil problems with surgery. Participant age 3 was hit by a taxi, got gravel rash and a huge fright.

Mother recalled C___ winters as very cold – used to bring participant into bed with her. Very spoiled and very upset about being put out of bed. Mother described participant as always being spoilt – but couldn’t come up with an example. “We never chastised him, but he got a smack once. He was a very naughty child.” For example, mother provided a long story about a lolly given to participant in pram, stolen by dog, participant screamed and knocked over stack of condensed milk in supermarket (laugh). It was so hot at night in summer, they would drive around until the kids fell asleep.

Mother thinks participant is depressed, but hides it. She finds him very hard to talk with.

SCZ021: Mother reports a good feeling when she knew she was pregnant with participant, her second child, and that both pregnancies were planned and close together. Her first girl was premature, and a dynamo. They were living on an estate farm, described by mother as a traumatic time with other family members not happy with the allocation to this young and inexperienced couple. This mother presents her story initially as ideal, but when describing her daughter's birth, she becomes very dysfluent – “and it was quite funny, because I was abused..oh, young mum, twenty-one or how old I was.old I was when I had her.they abused me of.um accused me of being an alcoholic or a drug taker or a cigarette smoker and (clears throat). I'd had a couple of Lions, that was it.so I.I was quite offended at that.” She never does manage to clarify what the staff concerns were for her and her baby. She also confuses her two daughters when describing the early years, as if she does not have a distinct picture of that participant, who she later describes as “it”.

Participant was induced “Um, she was induced..so that was quite funny ‘cos you still actually was underdone, stuff like that.” (this mother is well-educated). She used to set up a playpen in the car, and go off to do stockwork. This mother was keen to emphasise her competence as a young married farmer despite not coming from that background, but in reality they suffered serious disasters due to bad decisions. Mother's father died the year before she married at age 19. Her mother and her husband's mother remarried when their first girl was born and moved away.

Moved interstate when participant age 3 to another property but in drought. Mother stated they got bad advice, that was very testing but “great fun” for the kids, “just magic” socially, still have friends from there. Further moves to other properties, reasons not specified. Mother kept referring to their great family life, only stating that she and husband split up when participant was “year nine.eleven between” when pressed, intermingled with a story of how the school had not handled the suicide of a school friend of the participant. Participant and sister rode horses – odd story of parents deciding that since that was something the parents had liked, despite the participant refusing to get on her horse, and when she did it bolted because she screamed (mother laughs at this dangerous situation).

Both girls were sent to boarding school – same dysfluencies and major contradictions re. participant. “It was a real flowering when she went away, so she actually ended up coming home.only after about a year and year and a half away.” Later in interview, mother described when participant went to boarding school as the

disintegration of the family – mother inconsolable, devastated. Wailed loudly in interview – “Once again my children are letting me down.” Later still she told me of the receivers coming in and that’s why she had to pull the participant out of grade 12 boarding school. Too dysfluent to follow timeframe. Mother claimed she never confided in participant about the marriage, so “she didn’t take on my pain.” Attempts at clarification led to mother stating that participant was disinterested in mother’s suffering.

Mother described herself, husband and first daughter as incredibly conservative, but participant as airy-fairy because she was distressed with the culling of kangaroos on their property, and because she suggested they farm them instead, and because she questioned everything.

Participant did photography at TAFE, and did well. Mother stated that she would never be a commercial success, as not practical enough. Then did childminding – mother thinks she failed because participant thinks children should stay with their mothers. Went to join her sister overseas for a working holiday, got depressed and father went and got her. Became psychotic soon after returning home.

Mother stated there was no family history of mental illness, then stated her mother committed suicide but that it wasn’t a big drama for anyone as she was a very unhappy woman due to social circumstances, liked being miserable “funny, funny person and then she was a very loving person and um, I really loved my mum...” (this is all very jumbled). At end of interview, mother started to tell me of participant as a baby being breastfed in mother’s bed and mother having been warned about accidental suffocation, and then she abruptly stopped, gazing in a dissociative manner, and then bolted from the table.

SCZ022: (Telephone interview, as mother resides interstate) Mother began by asking me if I wanted her to talk, or did I want to ask her things. She then immediately read out what she’d prepared. Because of this, it had a peculiar unreality to it. When she later spoke without notes, she became very scatological and sexually explicit. Participant is adopted, mother now aged 75, participant aged 42. Mother began her reading with a story of her being the youngest of 7 children, brought up during the Depression. She had love, respect, good values, good parents and the security of home, togetherness, and warmth of family. So when she got married at 21, she wanted most of all to be a good wife and mother “like me mum.” But “there was no sex before marriage, and not much after it.”

They bought a one-room shack on 5 acres with gratuity money – sold chicken eggs to supplement husband’s wages as an electrician. After 6 years, still not pregnant – she went 3 times for testing, but he refused. She described her husband as having mumps in his testicles while a soldier overseas. He let her take the blame for 10 years. Adoption papers went in, she started a frock shop which grew over 30 years to a big business. She left husband for 3 months to force him to have a sperm test. When she returned, he had 3 lots of pills. Infrequent sex. After 12 years of marriage, and 4 years of trying to adopt, participant arrived aged 3 weeks. Nothing known about natural mother’s pregnancy or birth history. Mother then described feeling “all dead inside, and eaten out” after the adoption, but denied depression. Mother claimed her parents never had fights but were quiet and passive.

She left husband when participant aged 3 and a half, with father having fortnightly access. She claimed they had to be separated for 7 years before they could get a divorce. Mother had a live-in housekeeper, and mother would drive participant to kindy and then go to work. The shop staff also looked after participant. Mother now thinks adopting was one of the stupidest things she ever did – not having a “wholesomeness of family.” She asked for a girl, then was notified of a girl 6 months after adopting participant – thinks this might have been an upheaval affecting participant. Both adoptive parents remarried when participant age 8, father’s new wife very fastidious and wouldn’t let participant play in house with shoes on or into bedroom during the day, not allowed to play with football, so father stopped access visits.

Mother stated “I tried to do everything right by him with immunisations, etcetera.” He had chickenpox. Age 4-6 months, participant would get on hands and knees and bang head on pillow and moan. But “Never a grizzly baby.” Would stay quiet if woke in cot – “Just ideal” baby. “Wonderful caring and sharing relationship that he grew up under.” (contradiction with above comment about it being a mistake adopting him).

At high school, participant had lots of friends. “Home was like a youth hostel.” More of a loner since illness. She can’t think of any setbacks between the ages of 0-3. “My husband used to overwhelm him with gifts. He was a very surface sort of fellow. He’d talk about having sex when we had visitors, but they’d leave and there was nothing.” Had marriage guidance, but “he was totally inadequate, a barrier

around him.” Never wanted to show his feelings. “I felt empty inside, even though R___ (participant) made up for a lot.” Father became a workaholic.

Mother stated she explored all avenues when participant first mentally ill, e.g. homeopathy at age 25. Outwardly the adoption didn’t seem to bother the participant, but mother wonders if the “rejection” worried him. He could have contacted his natural mother, but ARAFMI advised against further rejection experiences.

Participant was vice-captain of grade 12, then did 2 years at S___ College of the Arts in ceramics. Before he got ill, mother planned to develop her property into a craftsman’s village “because he was a potter, and I do spinning and weaving.” This didn’t happen because he had his breakdown. Participant was attacked by a Vietnam Vet with an axe when he worked on a cotton farm. But participant had brown belt in Tae Kwan Do and fought attacker off. Then 10 days later, his favourite cousin was killed on a pushbike. Some months later, participant fell ill, saying to mother that something was wrong, that his head didn’t feel like it belonged to his body. When he was ill, he carried an axe and had a machete in his car, and pokers under the bed. Went 12 months without treatment.

Second husband accused mother of not disciplining participant enough when young. Mother then stated she belted the participant when little with the ironing cord a few times because of her frustration. “But he would never cry, so you’d get another one (laugh)”. Participant only got treatment after he attacked mother and was scheduled. Also mother got husband to leave when participant first ill because he wasn’t supportive. Then mother divorced second husband on grounds of cruelty – he hit her a few times in front of participant (age 12), and used to put both of them down. Participant would walk away. Then mother went overseas for 3 months, and participant stayed with the cousin who died. After the divorce, the second husband refused to leave their home – “But he never touched me again.”

When I asked how her parents had reacted to her first divorce, mother stated “My father had died. My dad was a first.first warworm.first world.worm.ah.you know.world war man, and he died when he was only 52. That was back in 1940. So I never knew my father as a man.grown up.one on one, you know, I only knew him as ‘dad’. So I was about 11 or 12.no 13 I think. So..m.mum.yeah my mother, didn’t.really didn’t.want.me to leave..to leave him.” Then she went back to talking about sex again.

At end of interview, mother told a story of participant age 5, 6 or 7 asking “Why did you pick me? Did I put my little arms up in the air and smile at you?” She thinks he had a good life in childhood. Then she stated “We never talk about sex or anything.” Then she talked about the medication and erectile dysfunction and lack of ejaculation. Then supposed that the participant masturbates....

SCZ023: Mother reports that she found she was pregnant, so got married. Participant was her second child. Mother stated she and partner were happy, although it was unplanned. Mother described it as lovely, she was happy, everything was settled – “Before the breakup, everything was good.” Had a lot of trouble in the pregnancy around 5-6 months with toxemia and anaemia. Mother spent the last 6 weeks in hospital having injections and BP monitored. No morning sickness. Big baby – 9lb3.5oz. Took a lot out of mother. I asked with the medical problems, what thoughts she had had about what might happen, and she answered – “Oh nothing no, nothing really, I just wanted to have the baby and get it over and done with.” Sick of being sick. She denied any fears re.self or baby, and does so throughout interview.

Husband’s family was supportive at the birth. Mother’s parents were separated. Her mum was nearby and supported her a lot. Mother had her first child (boy) at age 18. “I had a good pregnancy and she was a good baby. I never had any trouble with her or that.” Participant reminds mother of her father with mannerisms, faces she pulls, things she says, and in looks like father’s sister.

Mother stated participant was “always healthy” and then followed with information on baby’s thrush – spent 8 days in hospital whilst still breastfeeding (2 months old). Mother stayed in hospital, but then said it was visiting really. Described baby as placid, went readily to babysitters, easygoing, still lovely. Participant had asthma, never hospitalised. When I asked when did the participant first get asthma, mother replied after 9 seconds “Oh..probably when she was about 7 I think, something like that.” Stated it was brought on by the move from the country to the city smog. Mother later revealed this was herself and the kids, minus husband. Mother stated they separated because they were too young. “It just didn’t work out. I dunno (laugh)”. Mother wasn’t ready to settle down, but he was. Got back together a few times. He had the kids for a few months..and holidays, then he’d have them for a year, or two years. Mother saw this as good because that way they saw both parents, not as a major disruption.

Participant always well-behaved, happy to see mother or father – “As long as she could see both of us.” The boys would rebel a bit. Mother said he was never violent. After the city, mother and the children moved a few times, trying to sort herself out. I asked her if there was much arguing. She replied not, and then said “I lived with a man who was really violent. He used to bash me.” He used to drink a lot, and the participant witnessed a lot of that, aged around 11 or 12. So participant and younger brother went to father. Mother felt her life was in danger, and she finally escaped after 5 years when her mother and stepfather came and took her away when partner was at work.

When participant was 18 months old, mother had to lock doors when in the shower, because her sister lived across the highway. One day, the participant walked across the highway with the dog, but this was the only recalled mischief, and mother blamed son for leaving the door open.

Mother described herself as working hard, doesn't relax much because of stress, she worries a lot. She reported feeling relieved that alcoholic son has moved out as he was the main source of tension. This eldest son is to another father, an aggressive alcoholic who has had no contact since son 3 months old. Eldest son and participant got on OK as kids, and participant always mixed well with other kids because of large extended family.

Mother described having a lot of problems during pregnancy with youngest son – very sick baby “might have had a lot of effect on A___ (participant) because she was about 3, 3 and a half.” He ‘died’ in hospital, was baptised, had bronchial pneumonia. Had a lumbar puncture because doctors thought it was meningitis. “I don't like to think about it.” (mother keeps bringing things up that she initially denied).

Mother sees adult participant as able at many things, creative, good with people, children. First became mentally ill at 17, unable to sleep and hallucinating. SCZ024: Mother described great joy when knew pregnant. They were in the process of building a new home, having returned to a capital city from another capital city. Excited to be home again. Mother stated she was ignorant about pregnancy – lack of education, but it went smoothly. Participant was born 6 weeks premature, and a very quick birth. She was in hospital 10 days, 5 days in a wheelchair because of lots of stitches. Baby's lungs collapsed so he spent 1 month in hospital and was in a humidicrib – “I don't know for how long”, with mother visiting every second day.

Participant was 5lb8oz when she took him home. Colic set in about 6 weeks old, and very colicky baby for 3-4 months, with no sleep for mother at night. She described the participant as crying for 2 years, and this irritating his father. This set off stress between the parents, and she asked him to retire from Armed Forces, but he found it very hard to be in civvies. He was discontent and unsettled in jobs, “not a people person,” Then he decided to sell up – participant aged 9 months, and bought 5 acres on outskirts of B____. The plan was to build – mother described this as “happy times.” Husband ran into problems in employment and was on compensation – did a butchery course and bought a business when mother pregnant again – “bad financial decision.”

Father very strict. Never yelled at mother, but was regimental towards participant. Family life all ran on his rules, she “just went along.” But he was also generous, she had a free hand with money. Second child (girl) was born when business set up – mother returned to her mother when this baby was 3 weeks old – “happy times with the children.” Father wouldn’t allow talking at the table while eating. Mother sees their 19 years of marriage as “shocking stress”, which caught up with her much later on as she was “always ready to comply.” Says now he should never have been a father. Then she and the kids returned to their own home, and father had left, leaving meat to rot in the shop. “I was breastfeeding, crying, had two mortgages. What was I going to do?” Was up to 3-hourly feeds for baby, plus participant hadn’t settled at night. So she returned to her parents, and she cried all night.

Mother stated that father’s tension came out in his voice..he turned up one day, and they started again. Sold the house, moved again. When A____ (girl) was 15 months and participant aged 3, the next job fell through. Never got into debt. “I can’t remember a lot of that. I blocked that out.” They bought another house, and husband took off again. “At this stage, M____ (participant) wasn’t speaking.” (regression). Mother described taking participant to a bird sanctuary, photos showing “that little boy just couldn’t smile.” Mother sat up all night wondering what they were going to do, where will they go..husband would go to bed and sleep. “And every 2 hours, the children would wake and cry.” “And I had bronchitis into the bargain.”

Mother described participant as “there was always that ‘watch what you’re doing and watch what you’re saying’” with his father, and his sister would hide from father. Specialist said “It all comes through the father” – the tension, how he held the

children. “The rot set in two years after marriage.” Husband was musician in Army, with lots of moves. Whenever husband disappeared and came back, he never said where he’d been, just that he couldn’t cope and had to get away. “Maybe I can’t remember.” Mother now thinks father was depressed, and that participant is also. (Much of her discourse is very hostile towards the father, describing his attitude as ‘ugly’, with raised voice to the children, but never to her, e.g. snarled at them “You. Get! Stupid!” all repeated with strong emphasis, like it was still happening).

I returned to the participant aged 3 stopping speaking, and being a sad little boy – mother replied with her explanation that it “followed the trauma of A___, a new baby, his father disappearing. Maybe he was gone for months. I can’t remember. I’ve never been back over that. Maybe it was for months. The children were happy then, because we lived with my mother and father.”

Mother described getting up one night to A___ aged 5 months, and husband had got to the bassinet “And I remember screaming, and my parents banging on the door to let them in. So..... (mother started to cry).....” I said “Your worst fear.” Mother replied “Yes....so...that was the tension. And I think he tried to suffocate her.” GP told mother participant had had a breakdown at age 3. Mother can’t remember ever losing her temper, despite all the sleep deprivation. She thinks the participant was silent because he was sad and terrified, but stated she didn’t know it at the time. Participant would try to please his father, and would stand there frozen. “M___ bore the brunt of it all, and I didn’t recognise it. Maybe I was too weak.” Then they moved to T___ with a 3rd baby, and mother experienced extreme isolation.

Participant was hospitalised at 4.5 years because of extreme weight loss from diarrhoea, “looked Biafran-like” – staff thought he had cystic fibrosis because of dry cough for many years. “The child was never anything but stressed.” Mother was afraid she’d lose him at this time, because he was fading away. “His whole mouth had collapsed more or less. His face had gone and his teeth were protruding.” Took 2 years to get weight up. Participant was diagnosed with coeliac disease age 8.

The divorce was ‘ugly’, as father didn’t want the marriage over. Had counselling for the kids after the divorce. Had 6 months separation, participant went to father for 2 years. Mother thinks he didn’t want to go, but father needed him to lean on. Via court, mother was declared unfit because she had joined Parents Without Partners – the children were dragged through the family law court, which declared

mother okay, but it took 3 years. She sees this as taking an awful lot out of the participant, but he was unable to talk about it.

Mother then went overseas with her mother and sister, “but I couldn’t leave A___ with him for 5 weeks”, so this child went to a girlfriend’s. The story is now becoming rather jumbled time-wise, but mother stated that A___ was terrified of father but stood up to him, and therefore “that didn’t help. One day she went to school with gashes. There were broken arms and..From picking them up, not M___, you only had to speak to M___, and M___ was shrool. But A___ and J___ would fight back a little. So J___ went into a big.window one day, big sliding door...smashed his arm.” J___ was age 7.

Ex-husband had the boys while mother was overseas, and he rang mother to say the youngest age 8 was very ill, but he was refusing to take him to the GP. When she returned, she took the child to a specialist who said it was a bad asthma attack and father had to “treat the children with kindness.”

Participant first became mentally unwell at 19 when he worked at a Bank. Mother was in a new relationship, and she and all the children moved to S___, with participant getting a transfer. Daughter was placed in a Juvenile Home in S___ at age 15, and J___ had school refusal, locking himself in the bathroom. “We were all happy together.” They all split up until mother returned to B___ . Participant returned to high school at age 21, and the extreme weight loss began again, and he collapsed. He was on a drip for 5 months, diagnosed with an eating disorder and OCD.

Mother described participant as taking everything seriously, very sensitive, and felt everything, whereas his younger brother is dismissive. Mother sees herself as chronically insecure, and in and out of her current relationship. No family history of mental illness. She described participant’s first day at school – he didn’t settle and ran away. She found him walking home, so pulled him out of school. When they moved to another town, he ran off again from school for the day, but settled down eventually.

SCZ025: Mother reports that the pregnancy with the participant was a total surprise (says “because” but then doesn’t explain). “Happy I s’pose.” Stated she was expecting it, but was naïve. Second child was 3 years later. Pregnancy was quite good until high BP “at about.I don’t know what stage.” Never been sick before – “It can worry a bit.”

She and husband were living remotely in Northern Territory, and she had to be flown back to a capital city for the last month in hospital. She was away from all her family and friends. Didn't like lying in hospital "all that time" plus had to have 2 amniocenteses because there wasn't any movement. When participant was born he was very long and skinny – her first thought on seeing him was "What a wide nose because it was all flat and squashed." "They were just concerned. There was nothing wrong, but they were. were just concerned (small laugh)." It was a caesarean birth with general anaesthetic. Mother stated "I was shocked. It. it was sort of a shock, because. naturally you always expect a natural birth I think, and then you. it's sort of a shock to see the baby and. um. if you haven't been awake during the birth. to realise that's actually your child (small laugh)."

Mother was in hospital for 2 weeks after the birth because of an infection – found it "a bit traumatic" being in hospital all that time, "everyone's looking at you, can't relax." Not terrible, but then described being doubled over with pain from sutures and accidentally dropping a nappy and being roared at - "it affected me a bit." Glad to be out of hospital, then went to stay with her mother in the same capital city.

"Gorgeous baby" but had severe colic, and was very difficult for 6 months. Breastfed for 11 months. Managing all that was "quite difficult." Mother stated she couldn't tell if he was crying from hunger or colic, getting enough, etc. Breastfeeding Association told her not to supplementary feed.. When on solids, participant was a lot better. "H was starving hungry all the time." Normal milestones and weight gain. Participant had a terrible time teething "of all things", "absolutely shocking pain." He would go rigid. Mother described having to take him to outpatients over a 2 month period and this was really terrifying. "He had a low pain threshold." She described the headmaster having to carry the participant kicking and screaming to be vaccinated.

At end of interview, mother described participant as not clingy, but she knew he wouldn't cope with boarding school. "He doesn't realise. that we have tailored our life to him." "I've based my whole life on him really (laugh)." She cried when talking of his current plans to leave home.

Husband worked as a dentist in a remote western town, and mother felt very isolated there. They moved to a country town in another State when participant was a toddler. He started preschool at age 4, and mother didn't work. She stated she really

enjoyed being a mum, and read a lot to her son. Can't understand why he "didn't go ahead with his schoolwork when I devoted my life to him really (small laugh)." (participant is actually a university graduate). He was well-liked always, but in grade 4, he could hardly write – a shock to his parents. Mother "instinctively felt" he could only do one thing at a time. Preschool teacher said participant was in his own world. Then family moved to S___ H___ and participant had lots of mates and piano lessons "but he couldn't get beyond a certain point." Couldn't write very well. "A better school might have picked it up." Her explanation is that there is some kind of blockage "He just got through university, but really my husband is a one who sat down with him just about oh.the whole 3 years and.helped him.to actually get it in."

In year 7, participant went on a school trip to the snow – did reckless things. "He was totally uncoordinated" but joined basketball in year 4, worked at it "and became an expert." Got to A grade by doing it non-stop – always wants to do well. In years 11 and 12, mother described participant as going into a huge panic re. getting into university, wanting to do chiropractic, but he got glandular fever at 17, and was jaundiced and in bed for 6 months. He did PE year 12 studies in year 11 – mother sees it all as too much, and contributing to his mental illness. Father has that sort of drive – "I'm a moderating sort of influence (small laugh)." Father is still studying, and never has a sick day. Participant lost his drive when he got sick, but still wanted to go to university. Mother thinks participant felt he had to be a professional like dad, but that he "put that on himself."

At age 17, parents took participant to a specialist – "Absolutely nothing wrong with him, probably a psychiatrist or something I don't know who it was, but he said there was no mental problem." Then they moved to T___, the participant was lying down for the whole trip. Participant had a girlfriend at this time that father didn't approve of, and contact was severed with this move. Mother said to this "We hardly ever know what.ah.um.her name was." Then parents and brother went away on a basketball trip, and participant kept ringing them every couple of hours, very anxious, so they came back early. Mother then said they "never talked about the girlfriend to him, too touchy to bring up." "He wasn't thinking properly."

Then mother described the participant as hardly ever hurting himself as a kid, that he wasn't clumsy (odd contradiction to previous comments about being totally uncoordinated). At age 10, participant had a fever for ages. Mother doesn't remember taking him to a doctor. "He pulled out of it. I tend to think he was very ill

at that time.” Between ages 0-3, “he fell off something, and had stitches in his forehead.” Nil major arguments between parents.

I asked about traumatic experiences mother may have had in her life. She answered that she lost her father when she was 16, then her mother remarried only after she did. Her mother’s second marriage was a difficult one, and she was always concerned for her mother because of it, but stated that wasn’t traumatic. However she then said that she carried these burdens silently, and she thinks it gets passed on to the kids. She thinks her husband’s uncle may have had emotional problems, but is uncertain. Nil other family history of mental illness.

DEP111: Mother fell pregnant with participant when first child a toddler. This one was the easiest pregnancy, with “horrific” other pregnancies, all girls. Mother reported being really excited. A chance of miscarriage at the beginning “healed itself, not a really big issue.” Huge baby “for me” at 8.5lb. Straightforward birth, with mother going to hospital for planned induction because foetus was so big. But she had labour pains all night, leading to exhaustion, her water broke and 3.5 hours later, baby was born.

Mother described a fairly normal childhood for the participant, but he had problems with adenoids, tonsils and ear infections when little. Had grommets, and a tonsillectomy and adenectomy at age 3. Participant was attending preschool at that time. Mother recalled participant being white as a sheet in hospital, tears streaming down his face – all went OK.

Mother stated participant was teased a fair bit at primary school because of overweight and insecurity, no friends really, and a lonely child. Participant’s father and participant do not have the relationship mother would like, but it was good when participant was very little. Father’s father died aged 36. Father has eased off the pressure, and really is a compassionate man, “but not as compassionate as I was”, says mother. After participant attempted suicide, father broke down. (all of this is an emotionally rich, balanced and connected account).

Father was a good support during pregnancy. Mother sees him as avoidant over what the kids have done, and she feels shut out – he’s her only support. Her parents were not supportive - “My mum couldn’t even hug me.” Mother’s sister lost a baby and did not come near mother for weeks after participant’s suicide attempt. Parents thought participant would attempt it, and were vigilant. “I just can’t believe how desperate and lonely T___ must have felt..sitting upstairs, swallowing pill after

pill.” Mother remains scared, and woke her daughter once, fearing she may have overdosed. Mother did night checks on participant every hour for 8 weeks ‘ “I was mentally and physically exhausted.” Now her husband and she do it alternatively.

Participant reminds mother of – “I don’t know really.” States he was a beautiful, gorgeous baby, and has a good attitude. Family are Christian, and mother stated participant doesn’t believe God loves him. Participant has been cruel and hurtful to parents, as a way of venting his frustrations – he is proud of the fact, and sees it as powerful, getting in first, according to mother. She can see an improvement, as before he didn’t think he had a future and now gives hugs. Participant was affectionate when little, but didn’t like living on their farm – the girls would help with milking but participant would stay in house playing with Barbie dolls. Mother described participant as a child as forever tying things up – including a sister when he was 5. He is afraid of spiders, lizards and frogs – “absolutely terrified.” He gets housebound still is something is outside.

Participant really enjoyed preschool, not clingy. Had problems in grade 5, with teacher expecting 110% from every child every day, and yelled a lot at the kids. Participant went downhill, and mother challenged this teacher. Any problems between parents are “just discuss it”, don’t really argue and no yelling.

Participant had (Perthés Disease) hip problems, diagnosed only by a GP, and parents had to swing him upside down – “I just can’t remember what it was.” Nil other medical problems. Participant always comes to mother with problems. He writes beautiful stories, didn’t like schoolwork, loved cooking, good at Leggo. Hated mowing, the cows. Now he dances for hours, clubbing. Mother stated both parents support his going out and having fun with friends.

When suicide attempt, mother wouldn’t let her parents see participant, because they are critical. She has talked freely about the suicide attempt to work it through, and with the participant. “There’s no use pretending everything’s alright when it’s not. I.I did that for years, I was molested as a child, and I think I probably did that for years and years..pretended there was nothing wrong..when the whole time there was. So I learned to be more up-front.” Mother spent years in and out of hospital with migraines, on pethidine and phenergin. Was becoming an addict and was told she was giving mental problems to her children and was not a good mother, so psychiatrist got the story of abuse out of her. Her parents don’t want to talk about it.

Mother stayed at home with the children. Has only started working recently, partly to help participant out financially as he cannot work yet, but he doesn't know this. Mother then stated that father worked most weekends for much of the marriage, but they talk about this stuff now. She always had migraines, even as a child. All the children have them. Mother was molested by a school teacher, so the migraines were worse when the kids were at school. She was at the school all the time helping in class, tuckshop, etc. but unaware of why. She got help when the kids were 5, 7, 9 (participant) and 11.

DEP112: All mother's married life, her husband was really cruel – bashed her a lot, and it wasn't a very good pregnancy (information is readily available, affect is congruent, tonal qualities reflect groundedness). Husband electrocuted mother when pregnant with participant – he called her out of the house and dropped the power line to the house on her. "I'm lucky I'm here, hey?" Neighbours called Emergency Services. She had burns to her hands, and was in hospital. Husband was constantly violent. Mother not close to her own family, so no supports. "There was me for the kids, that's it." She has had 4 children, one son is almost blind, but is married and working.

Mother left husband after rape to which she fell pregnant with a son. "I.I never got close to S___ (participant) when she was little..for the simple reason..S___ was very little...and he used to bash the boys up, but they were stronger than S___..so that he wouldn't hit S___, I sort of wouldn't cuddle S___ that way.if.if I cuddled the boys, I knew he'd bash them. So I tried not to cuddle my kids." Mother put husband in to the police, but his mother got him out (on bail). Mother has a daughter-in-law living in the same house because her son bashed her.

Grandfather interfered with mother aged 5, and she was raped at 15, married and got bashed for 11 years. She remarried a good man for 5 years when participant aged 6. This man was killed in a fall. Mother married for a third time, and was fleeced of all her money, and she left this relationship. She reckons she's strong, and has choices. She was terrified of her first husband, but isn't now, although he still tracks her movements. Mother stated she got to a point and then was able to leave. He threw her out of cars, down steps, attacked her with a knife, choked her with a cord, held a gun to her. He punched the participant as a child off a fence and hit her, but not as much as he hit the boys.

Now participant cannot separate from mother. Participant lived away for a while but couldn't handle it. This was 11 years ago, when participant's son aged 2. Now mother lives with participant who rents the house.

Participant reminds mother of herself, except for suicide attempt. Mother stated she likes herself and her life, unlike participant. Participant gets pleasure out of hurting herself. Age 0-3, no major illnesses or hospitalisations. The birth was 3 weeks premature because of the electrocution and bashing. Mother reported they thought they might have to change her blood "because J___ and I weren't compatible." I asked was this the Rhesus factor, and mother replied "I don't know." The next child was 7.5 weeks premature, and with the third child, the afterbirth came first and mother had a caesarean. Mother described being worried all through the pregnancy with the participant that she might lose it (grounded).

Mother then related losing one pregnancy to bashing – husband made her wrap it up in newspaper and put it in the garbage bin. She wasn't game to do otherwise. She stated she tried to leave a lot of times, but had no money. At age 50, mother was told her 'father' was not her father. Her first child, a boy, was to another man, and her parents took him. She had to go to court to get him back and won. After this, her parents refused to talk to her for 3.5 years. The second child was the one she 'lost' to the bashing, then participant, then another boy. Her first husband was an alcoholic and gambled his wages. There was no food in the house lots of times.

After the birth of the participant, father put them out of the house, and they camped on the footpath under a tarpaulin (in outer suburb of a capital city). Participant has contact with father, and stands up to him. Mother described participant as being naïve about the world, as being too close to mother for a social life, and never going out. Mother is now on antidepressants because of worry and insomnia. She had past care and control of 2 nieces and a nephew as well as her 4, and a streetkid. There were 8 children in the house on the day of interview.

DEP113: Mother can pinpoint the day when first pregnant with participant as she was a smoker, and found she couldn't bear it for 9 months. She was very excited, had morning sickness of 9 months – "So much so they thought I was having twins." She was desperately tired, was on Debendox, and ate what she could. She had her whole family for support, husband and his parents (almost immediately contradicted this). She reported sleeping a lot during the pregnancy. There was conflict with husband during the pregnancy because he drank. She left and went to her parents, and was

back and forth, stressed a lot. There were arguments, and she stated she was mentally and physically abused – very traumatic because she had had no previous experience of same. She told his parents, but there was familial violence of father to mother, so they did not react.

Mother first left husband not long after participant was born, but went back after a few months. She described the baby as “highly strung”, mother saying to herself she’d never have another. Colic very bad for 6 months. She described participant as a child who loved food, never settled, didn’t like getting dirty, and was easily frustrated. He never crawled much, but was up and ran, “go go go.” Mother stated she was exhausted when she was pregnant with second son, and participant took off whenever she breastfed this baby, 2.5 years younger. Mother stated participant was never in any real danger. Mother stated participant was good at reading, as he was read to from a very young age. He was a country boy who liked animals. Mother recalled an early separation from participant when she was hospitalised for 4 days with a centipede bite, with participant going to an aunt – he handled this OK, and did not have trouble going to preschool or school.

She stated that father was never there really because he went contract mustering. She stated the arguments only happened when the kids were asleep (?fantasy). But the boys gave father a wide berth – wary, but loved him deeply. She stated he never hit them, but was surly. He dislocated her jaw and broke her nose whilst she was driving the car. He then told her to drive home. When they arrived she was too afraid to walk up the stairs at home – “I just knew I’d be thrown down them.” The kids weren’t there. When apart, the kids had contact with father, with mother concerned for their safety because he drove when drunk. Participant reminds mother of her father in looks, like herself with sensitivity, maybe like herself with high expectations and easy frustration, and nervousness like his father’s mother.

DEP114: When first pregnant, mother was very pleased. She had no trouble with the pregnancy. Confinement was hard because of forceps delivery. “The grandfathers thought he was great.” The participant was an “excellent baby”, a big brother for his 3 sisters, and was an excellent brother to them. He liked his chooks, liked school until he had a bad teacher, then switched to Agriculture.

Mother had worked in maternity as a nurse, but “I wasn’t aware of what forceps could do to mother, but they can also do to child.” She said “we wondered what we had! There was no crown.” But after 2 days, baby’s head was back in shape.

Mother described this as scary. She had to have 40 stitches, claiming it didn't worry her. She and baby were in hospital 2 weeks. She breastfed him for 12 months. She stated the participant knew he was loved.

Father worked on the Main Roads, so didn't have much time with participant in early years except for the weekends, but mother's dad rapt in first grandson, and was over every day. Mother stated the participant had a normal childhood, and not seeing dad during the week wasn't a problem. She then said her husband could have been more helpful to her, with 4 kids. They had a big home and she did everything, outside and inside. She stated she had no support during the delivery, as her mother was not easy to get on with, and came only occasionally to visit. However, her mother did look after the participant when the next 2 babies were born. Mother had a very good girlfriend, but that's it.

Mother had a miscarriage when participant was 12 months old (another boy, 12 weeks). Mother was still breastfeeding and didn't know she was pregnant. She went urgently to hospital with severe pains. Following a curette, she was anaemic and was in hospital for 2 weeks having blood transfusions. She didn't tell participant until years later. Next live birth was 2.3 years younger than participant – nil trauma.

Participant reminds mother of his father, liking outside work. Mother stated participant did well at school, good at everything. "Got too smart for himself" and left after Junior with good marks. He started an apprenticeship in carpentry but hurt his back, and withdrew from the course in 3rd year. He still wears a brace. He then did Agriculture but there was not much future in it, and he was unemployed "for a while."

Participant age 6 lost both grandfathers in 13 months, with 14 other relatives dying in between. All the family were grieving, and there was a new baby. Doctor told mother she was a nervous wreck, and would be better off working, so she went back to nursing. She stated the participant missed his grandfathers, especially her father. He had emphysema from mining and was gassed during the War, and had a heart attack. "It his us all."

At age 3, participant had measles, but not severe. Two of the girls were born with bronchitis. Mother was the disciplinarian, hitting only occasionally as they were good kids. Participant had good mates, and had a paper run from age 10 – responsible kid. Husband and she solve disagreements by walking away, have their say and walk away. Mother thinks participant has depression because of his marriage

breakdown. He has 2 children aged 21 and 19, worked his guts out for his wife, tried too hard. He is now with a nice woman who has 3 boys. He does all the housework. Participant also has Hashimoto's disease (thyroid) as does one sister. Neither parent has it.

DEP115: When mother was expecting, she was happy. When participant was born, she described him as a happy, intelligent little boy who was mischievous. Mother then quickly got to the fact that when the participant was babysat, he was molested by a neighbour, a teenager who used to steal mother's underwear and leave dirty notes. She didn't see that the abuse was happening, and thinks she should have. Their own business took up a lot of the parent's time. The participant became withdrawn about age 7. The police were involved, but the perpetrator got away with it, so the family moved house. Mother described her parents as very supportive, and that she had come from a happy family.

In high school, the participant wagged a lot. He looked at all boys with suspicion, according to mother, and didn't play with others. Mother kept returning in interview to being very self-critical for not figuring it out. Parents had a milk-run, with the eldest boy helping father out. This boy picked on the participant, with punching (3 years difference). Father not violent, she says at this stage in interview.

As an adult, participant couldn't keep a job because he felt insecure, suspicious, and worried a lot. He started drinking in his teens – miserable. Mother contacted AA. Participant was put in hospital, and “we nearly lost him” to alcohol poisoning. He has been dry for many years, and is on a Disability Support Pension. He continues to check obsessively that the doors are locked.

Mother couldn't think of any dramas or illnesses between 0-3, except for one occasion when participant age 3 ran off looking for mum who was visiting someone. She described him as a good little kid, and happy. Participant reminds mother of herself, not like his father, didn't get on well with his father. Mother described father as never being home, of breaking promises to the kids often. Participant turned to mother because couldn't rely on father. She described this as a strain on her. She lost one pregnancy “through the marriage.” At 3 months pregnant, husband bashed her up, and she almost lost one arm – but refused hospital, with a GP coming every day with injections. She lied to protect her husband (and did at start of interview). Participant was a teenager when the bashing happened. Mother spoke of an unhappy marriage all the way through. She doesn't think this affected the participant (since

she puts everything down to the sexual abuse). She stated she stayed in the marriage because of the kids, and now calls that decision “foolish.” She has had 4 children, the participant being the third. “We were a happy family. We loved one another. Close-knit family”, etc. Mother remarried a “good man”, but she didn’t want him knowing about this interview, and asked for it to be in her son’s flat.

DEP116: Mother stated she was happy to be pregnant, and she was over 40 years of age. Happy to have her first child. She was working, the pregnancy was good. Nil morning sickness. She has good memories of this time. A natural birth was not possible, so caesarean because foetus was in the breech position. She doesn’t know if there was foetal distress, but doesn’t think so. Husband did not attend, but saw the participant next morning. Mother couldn’t breastfeed, and on the bottle he was a good feeder. Her parents were supportive. Participant reminds mother of her father in looks.

Mother then went on to describe a very isolative little boy, who didn’t want to mix with other children, although he had the chance to with cousins. He was not cuddly. Mother thinks this was all because she went back to work in their smallgoods factory straight after the birth, and participant was raised mostly by grandmother up to age 4. Mother became tearful in interview describing participant calling grandmother “mum”. Grandmother worked as a dressmaker from home.

At kindergarten, he always wanted to go home, and played in a corner by himself. He would stay back and watch, and then would go to others. Mother thinks grandmother really spoiled him, but couldn’t think of an example. In primary school, participant was a very quiet boy. He pulled toys apart to see how they worked, and reassembled them – very good mechanically. One teacher was on exchange from USA, and got along very well with him. In high school, participant was OK to begin with, but was unhappy in second year, after a maths teacher called him stupid. Mother argued with this teacher. In third year, participant started to take the bus to school instead of being driven by mother, but he took the bus to the city instead and began wagging. He refused to go to the toilet at school – “Something must have happened there, but I never could find out.”

At age 12.5 years, mother took participant to a psychiatrist – “Nothing wrong with him.” Mother described participant as doing stupid things, and of being in trouble with the police. After school, participant worked in the factory for a while and was a very hard worker. He adored his mother’s stepfather. Participant became

an apprentice panelbeater, but in 3.5 years, only completed 0.5 years and didn't finish. He got a commercial pilot's license.

Mother's father died age 31 back in Europe when mother aged 7. Stepfather described as a very good man. Mother migrated to Australia in 1953, age 18.

At age 6 months, participant had tonsillitis, and couldn't swallow. Always a very, very poor eater. At age 5.5, he had tonsils out, and started eating better then. Mother stated participant started cooking his own meals at this age. Mother can't think of any traumatic events when participant was little. Participant first became ill when driving taxis. He was in hospital frequently, taking off a few times, and was often suicidal.

Mother described participant as never getting on with his brother, who is 2.5 years younger. She described participant as very jealous, throwing baby out of the bassinet once. Participant has always had trouble with his temper, and tried to shoot his brother once, but father came between them. Then she said "Everybody liked him very much, he was a good worker." Participant has never been in a relationship, and is lonely. Mother stated he was welcome to stay with her, but he was ambivalent. She rings him every week.

I asked about parental disagreements. Mother stated that when she was angry, father would go to the garage. She reported stopping father hitting participant with a belt buckle once. Mother finally reported being very tense during the pregnancy, but didn't know why. Thought it might have been because she had a lot of responsibility then, starting work at 4am. and back home at 7-8pm., and she was overtired.

DEP117: As soon as I asked about knowing when she was first pregnant, mother laughed and said it was funny because 2 weeks before she knew, she had been looking in baby shops. It was a very stressful time at conception and at the birth. Mother wonders if the stress affected the participant. There was a cyclone in D____, and they were trying to rebuild their demolished home, with all sorts of obstacles. Husband was working night-shift. Mother's parents were in a motor vehicle accident and mother flew down to them for 1 week – "another bit of stress." They were OK. Mother looked forward to having the baby, as she hoped it might bring the family back together again emotionally – it didn't work out as a cure. The participant is their third child.

Mother was 37.5 years old when pregnant with participant, so had ultrasound and amniocentesis, which she wouldn't have done if she'd known the risks, and it

was the first one the doctor had done. She stated she was stressed by this. It was an instrument delivery. Participant had normal milestones, but didn't talk. Mother worked out that the family was talking for him, so 2 weeks after that revelation he started, and mother stated he is a great talker now. Mother described participant in high chair insisting on feeding himself and making a mess. He used to follow his older brother around (6 years difference).

Participant was "an absolute joy of a child." Mother was well during the pregnancy, but very overweight, and she was warned by her GP to lose weight. She and baby were in hospital only 2-3 days, and she saw him straight after the birth. Mother described participant as a very settled baby whom she bottlefed. She could not recall any significant separations when young, and he had the usual childhood illnesses. At 12 weeks old, baby had bronchitis, but was not hospitalised.

When participant was 18 months old, family life was more settled, but husband was still a shiftworker and on edge a lot. Everyone had to be quiet. Mother recalled having to have the participant on a lead when out because he would get away from her. He would refuse to walk, always mischievous, kept mum on her toes. Mother cannot recall any dangerous situations he got into. She stated the siblings helped look after him. His older brother hit him a few times, but they are good friends now. Participant reminds mother of her in attitude – "She'll be right, mate. Wait and see. Don't panic too much." They talk a lot together. Parents are still together. Mother can't understand why participant has depression, and thinks it is mainly loss of work. Nil family history of mental illness.

DEP118: When first pregnant, mother felt "My goodness me. Not another baby so soon." She already had 4 and one adopted in 6 years. Contraceptive failed. The participant and next child up are 14-15 months apart. Mother stated she adjusted to it. "I loved having babies actually." Knew instinctively she wasn't carrying "normal." "I can't remember what the problems were, but it was all different." She was overdue and mother was in hospital for a day and something went wrong, the priest was sent for, then mother had a caesarean. She was told later that she nearly lost the baby, and that she herself almost died. "They didn't know what it was."

Mother didn't see the baby for more than a day, and mother thought she was dead because she was blueish, and was a long bony baby. Mother couldn't breastfeed her because mother was too sick. "I don't know what it was, despite asking over and over." Baby – "nothing wrong with her after that", a healthy baby but a finicky eater.

Participant reminds mother of baby's father in looks.

Mother spoke of next child up age 2 years started to have "funny turns" which were not epilepsy. If she fell and bumped her head, would lie there for ages. Mother got the other kids to watch out for this kid. Father away always working the bush, building houses, and home once every 6 weeks. "I was always by myself. I liked that, did nothing else." Parents adopted a boy – "Shouldn't have. A lot of conflict there." Mother then related that participant was always cruel to this boy, and was a stirrer. She would say to the next eldest that she was a spastic, and was cruel to her brother too. Mother stated she never punished them "very much." Never hit them, put them in bedroom.

Mother described participant as a good baby. "Never thought I.I dodged her around M___(participant's sister). We all sort of went everywhere together." (Participant feels left out and rejected by family). Participant at kindergarten – "bawled her eyes out, squawked and yelled". Always bright at school, brighter than M___. She had a good relationship with her father, and she used to smoke up the mulberry tree with her adopted brother. The family always had pets, and participant loved them but was a bit irresponsible feeding them.

Participant became more of a loner around age 12-14. She was good at schoolwork but not sports. Mother lied about earache to get participant out of swimming "Cos they threw her in when she first learnt." Mother couldn't think why participant gets depressed. She stated participant was a quiet child, and that she could take the kids anywhere as they were polite and well-behaved. "The nuns loved them." When mother and father had a disagreement – "I used to head for the cemetery. If it got very serious and it was knocking me about..um..I used to go...and sit out there for half an hour. I had a lot of deaths when I was a kid." (lost 3 siblings). Mother would talk to them at the cemetery, and would sit in a section where young people were buried and tell herself not to be selfish.

Mother contradicted previous statement re. enjoying being by herself with the kids by then saying she missed her husband a lot when he was away and that when he returned he had a lot of trouble with the girls, like having to start over all the time. They were very poor from time to time, surviving on mince and sausages when husband was out of work. Mother stated they were always broke, but had enough food and warmth.

Mother stated that participant had trouble turning adult, although her parents were always there for her. Adopted son turned into “a dreadful boy”. He held a gun to participant’s head when she was 20, and he was 16. He was on drugs, and participant lived in fear of him for a long time as he always blamed her for putting him in to the police. “But she was cruel to him.” Mother stated participant has married 3 times, and that mother tells her it doesn’t suit her. Parents have never separated.

Mother reported having several operations when the kids were growing up for gallbladder and then said “No, not really.” She showed me the family photo albums, and stated the participant has always worried there were no baby photos of her – this is the case. “We couldn’t afford a camera.” “I’d hate to think R___ (participant) thought I was a bad mother.” All the girls married heavy drinkers despite father never being a drunk.

DEP119: When asked about first knowing when pregnant, mother had a long pause before saying they had only been married 10 months, and she couldn’t take the pill. She reported being surprised but happy – “worked out lovely” as she had 6 months to go in her training as a nurse, and husband had just finished his double certificate in nursing. They had no money, and lived in S___. Mother didn’t get maternity leave, so did part-time agency work with husband doing shift work.

Mother had her 2 sisters and her parents for support after the birth as they all lived close by, and were available as babysitters. She said she only ever did night duty with the kids. Second child is 3.5 years younger, and the next 2 years younger again. Pregnancy was alright until the last 2 months – mother’s pelvis not big enough, plus thought via ultrasound that foetus’s bowel was outside the body cavity – parents worried. “We’re Christians, so we looked to the Lord all along, we didn’t care how he came out.” Mother had a caesarean and a 9lb. baby with nothing wrong with him. “That was traumatic. They whisked him off to intensive care,” and mother didn’t see him for several days and then only in a pethidine haze. “I fell in love with him. I couldn’t believe this big baby was mine.”

Mother got mastitis very badly with all her children, but breastfed all of them. Participant was very hungry always. Mother stated she got down to 7 stone from 9 stone – “He took everything.” She battled on with supplementary feeds and it was a really difficult time. The participant as a baby was a good sleeper. Father would wake him up for a cuddle, and now rings him all the time.

Mother stated she was withering away when participant was 8 months. Her mother “came to the rescue”, taking baby to her place to wean him over the week. He screamed for 2 days whilst mother had a holiday. He came back sucking on a bottle and it took 4 years to get it off him. The family went overseas when participant aged 4, and mother threw bottle back to her parents at the airport. Mother had her second baby overseas and breastfed it until 4 months pregnant with 3rd baby. Mother described participant as lonely in the foreign country as they were in a compound with guard dogs. She stayed as a housemother whilst husband flew off to remote areas doing missionary work.

Between ages 0-3, mother described participant as happy to go to grandparents, but otherwise was “my shadow.” Clingy, but not to the point of being annoying. But then mother said participant “Has always been...a sort of person who’ll emotionally drag everything of you that you can possibly give, and I’m...probably not the best person. And he’d do it.do it with me. Wouldn’t do it with J___ (father).” Mother stated participant is emotionally-based like his father, who was one of ten children and needing lots of love. Participant did all the boy things but was fastidious to the point of mother pulling her hair out e.g. participant would change clothes as soon as they got dirty. He still gets annoyed if you interrupt his train of thought. Participant was good in primary school. In mid high school, he worried about what he would do, and knuckled down.

When I asked her how the parents solved their differences, mother had another very long pause before saying they have never solved most of them. She stated that minor decisions are left up to her. In the mid 90’s, participant (15 years) got sick with multiple UTI’s and headaches and had to have scans and tests – kidneys abnormally joined. At the same time, father was charged with assaulting a patient. “He was exonerated because it was a trumped-up story.” It took 3 years to get thrown out of court. Mother thinks participant has depression probably because of the stress of getting through university and not doing very well, not finishing it. Also his mates have moved away, as have his parents. She reported participant as being in an ambivalent romantic relationship currently, and is also unhappy at work. And a friend committed suicide. She stated participant is sensitive and a worrier like his father, and that his personality hasn’t changed since the day he was born.

DEP120: This interview was conducted in a public park with the participant cooking the dog’s meat on the public BBQ (the power has been disconnected at home for

non-payment of bills). After initially agreeing, the participant refused to set up a time for his mother to be interviewed for quite a while, stating he was worried I would be paying more attention to her than to him.

Mother stated when she first knew she was pregnant, it was a relief, but at the same time “it wasn’t real pleasant.” She was 18-19 and unmarried, and scared of her violent stepfather who didn’t understand. A friend of mother’s told her mother when she was 7 months pregnant. Mother’s mother put on a scene, and then accepted it, but mother couldn’t stay at home longer than a week after the birth. She had deep vein thrombosis and couldn’t walk around and both she and her mother ended up in hospital at the same time. Also the baby had green motions and colic, and screamed a lot. Mother and baby stayed in hospital for 2 weeks. Then she and partner and baby went...”Can’t remember” and then to M___ when participant was a few months old.

Mother returned to talking of stepfather as a mongrel, a very physically violent man to everyone, but especially to her “because he was my stepfather.” She described father’s family as being just as bad. She and partner stayed together for 5 years. Then she came back to T___. Baby was “pretty good”, but a poor eater and father used to force-feed him, mostly as a toddler. Participant was “a runner”, and mother was forever chasing him, into traffic. She had to get the police at least once per week – “escape artist”. Mother stated she was panicky over that. Participant would play up if mother not there. She recalled the participant when little was good at drawing, Leggo, and putting things together.

Participant reminds mother of father with stubbornness, looks, everything. Mother then stated she always rebelled against partner’s stubbornness. He would take his annual leave alone, leaving mother and participant alone, so she’d come up to T___ and her family. He never gave her any money except for food and she had to bring the change back – very controlling. Lots of major fights, with father hitting her sometimes, but not in front of participant. “He nagged, talking at you.” On one occasion he tried to strangle her and she was afraid she’d die, so she pretended to pass out. After this incident, she left with the participant. Participant has contact with father, and are friends now.

Between 0-3, participant was well, but burnt his arm by pulling a cup of tea on himself. He was not walking at that stage (under 12 months), was in hospital 5 weeks and took his first steps in hospital. Also between 2-3 years, participant took antihistamines and was in hospital for 4 days.

Mother described her mother as supportive but a hard woman, unforgiving. Mother learned from an early age not to upset her too much. When pregnant, the father nagged mother to get rid of it, and took her to W___ Unmarried Mother's home, but she refused to stay, and screamed a lot. Up until the participant was born, the father stated the baby would be adopted out, but mother and her mother had bought nappies, etc. Mother described 3 days of hard labour, with her losing a lot of blood, and this was pretty stressful, along with the whole pregnancy. After father saw the baby, he accepted him.

Mother sees herself as a survivor, not a victim any more. She brought participant up by herself, and comes from a line of strong women. "Strength comes from inside." Mother was on the Rainbow Warrior, was a hippie, and a free spirit, "still am." "There's life after relationships."

DEP121: When mother first knew of pregnancy, it was a joyous, happy time. Overjoyed and hoping for a girl because already had a boy. Mother was fit as a fiddle, and played sport during the pregnancy. She had caesareans with both deliveries, because she is only a small frame. This was planned weeks beforehand. Mother stated she was disappointed but nothing could be done about it.

Baby had jet black long hair – "absolutely beautiful." Mother's parents were too far away, but in-laws were helpful. Mother described participant as a "fantastic baby" who slept all the time, hardly ever cried. "She still loves her sleep." Father went away in the Armed Services to England when participant aged 10-15 months. When he returned, participant was wary for about 5 hours, then OK with him. Mother stated she accepted that was his job, she had the first child already in school (3.5 years older), had plenty of friends, and was living on the Army base. She felt she could fall back on several people.

Participant talked at 6 months, but walked at 15 months and only had 3 teeth at 15 months, and was very late losing her teeth. She was 8 before she lost her first tooth. Mother stated participant was teased at school, and was very small in size. Participant reminds mother of herself, with a mind of her own, very independent.

Father was away a lot, but when home would read to participant every night. Then brother would do so when father away. Participant was very close to brother, only rarely fought, shared well. Participant was a very good reader, starting at age 2. She could write before school and was very keen to go to school. On her first day, she raced in without a backward glance.

When participant aged under 2, mother had an appendectomy, but father was home and there was a babysitter. Mother stated participant not upset with her absence. Mother stated participant was a cuddly baby, never threw tantrums. If she couldn't get her own way, she tended to cry and was sent to her room. She was never smacked. Mother disciplined her by taking her favourite toy off her. Mother denied any yelling in the family home. Participant had her tonsils out age 4, with no complications. There were normal childhood illnesses, and no fractures. Mother stated participant was afraid of water – terrified, but loved the bath. When she was afraid of the wading pool, mother thought to call it a bath, and that fixed it – participant learned to swim, and is OK now. She didn't like walking in sand, and doesn't like spiders.

Mother claimed the children enjoyed moving around a lot because they made lots of friends, having 3 schools in 2 months when participant first started school. Mother moved a lot too in childhood, but she didn't like it. Her children not shy, very outgoing.

Father died suddenly of a heart attack when participant aged 17 in year 12. "I mean, he was fit. So you never know." It was a complete shock. Also a lot went on between 1993-1999: 17 months after father died, his mother died, and a few friends. In 1999, mother's father almost died 3 times and had 7 operations in 12 months – he is still alive. Last year, the other grandfather died. "It's tough on all of us." Mother thinks all this is why participant has depression.

DEP122: When mother first knew she was pregnant with participant, she was quite happy because it was more or less planned. There are 2.5 years between eldest (girl) and participant. Mother reported one concern – husband had contracted German measles, "Goodness knows how", and she was in a bit of a panic about that. Mother had the injection, but heard later that it wouldn't have helped. It was a good pregnancy, with mother relying on doctor's advice and the injection, and forgot about it. She was a little bit overdue, but an easy birth. Mother was in hospital 24 hours before the birth, with the doctor trying to stop the birth being too quick. "He must have knocked me out, I think...and I didn't come to until back in my room." She breastfed with supplementary feeds.

Mother described participant as an exceptionally good baby who didn't cry much. She then said the next one made up for it 3 years later. He was a very hard baby to manage (another boy), and mother wonders if the participant could have got

lost in that. The parents had a business, and lived at the shop for 5 years, shifting to a house when participant aged 2.5 years. Mother stated that when he saw his cot pulled to pieces, he was very upset. “But what little bloke wouldn’t have been.” Participant had both sets of grandparents whom he saw a lot. When they moved to the house, participant saw less of father because he was at the shop long hours.

Mother stated participant was never a sick child, and had no accidents. He used to suck his thumb, and had a bunny rug. She thinks he was a cuddly boy – very good, and easy to get on with including with his brother, he was a good eater, unlike his sister. There were no dramas with toilet-training. Participant was scared of going to kindergarten, and put on turns. School was OK, and he had friends. The parents were well. One grandfather died before participant started school. This grandfather was in and out of hospital, so his death was not a surprise. When I asked about arguments and disagreements, mother stated that her husband is quiet and hard to argue with. She stated there were times when she has felt he was too avoidant of conflict.

Next brother down – mother had a very bad ear infection and thrush before he was born, and she couldn’t have treatment. This baby had gastric problems, chest infections, and used to black out. I asked her how did she cope with 4 children, and she replied “Well that was the joy of it. It wasn’t easy.” She stated they coped somehow, it was hard, and that she had forgotten a lot of it because so much was happening at once. There were no disasters, the worst being the death of pets. Mother has no idea why participant has depression, but some of it may be because of unemployment. He has a degree, and occasionally gets casual work at the university. DEP123: Mother had been trying for 12 months when she fell pregnant with participant. At the time, a lump was discovered in mother’s breast, and pregnancy tests were negative until she was 4 months pregnant. Mother stated she was over the moon, but also concerned that she mightn’t have taken care of herself. She had lots of worries re. local aerial spraying. She described a mixture of excitement, happiness and worry. The lump was benign and due to the pregnancy.

Participant was first child, with the next girl 7 years later. Mother had been told she would never have another baby by gynaecologists because of low hormone levels and she was “virtually menopausal”. She reported being upset about that. The parents considered adopting. Mother continued to work during the pregnancy with the participant, living in a rented house, with husband working as a canecutter.

Mother was well all through the pregnancy, and ate properly. But she had an emergency caesarean because her pelvis was too narrow. Participant was born with a massive bruise across her head – “nearly lost her”, had “foetal distress big time.” Labour lasted 6 hours. Baby was otherwise healthy, and mother was OK too.

She saw the baby 24 hours after the birth. Mother stated “She was a screamer”, demanding feeding constantly, was very colicky, and stressed with wind a lot. There were lots of sleepless nights. At 7 weeks, participant was teething really badly, and would become very ill whenever she cut teeth, plus bad tonsillitis. The tonsillitis went on until participant was 9, as doctors refused to take them out. The participant was always on antibiotics, and mother stated her immune system was “shot to pieces.” Vomiting and diarrhoea was common, and mother thought she was so compromised she would die – mother expressed a lot of anger re. doctors in interview re. this. Participant missed a bit of school, not as much as her sister with chest infections.

When mother was 7 months pregnant with participant, their rented house went up for sale, so they moved in with her mother (her parents had separated when she was 18). She was a great help, and baby was named after her. Mother reported having an inverted nipple, and the other was flat, but she persevered with breastfeeding for 12 months, then weaned baby straight on to a cup. She didn’t need supplementary feeding, and was healthy. Mother stated she couldn’t feed the next child though, and mother felt a failure.

When participant was 18 months, mother would put her to bed at 8pm and go to work from 10pm to 4am in the pub doing late night cabarets, but get up at 6am and spend all day with baby. But then baby would wake early..mother described this as too hard on baby, so mother gave that work away, and started cleaning houses. Participant had pneumonia age 6 and was hospitalised. Also had pneumonia twice in late adolescence, and a lung collapsed. As a toddler, she was always on the go – never crawled, but ran from 8 months of age. Always happy, always a loner, still is. Sits back and analyses people (mother calls this “devious”, and like herself). Mother described participant as always very well-behaved, very disciplined. Always had lots of friends/companions (contradicts ‘loner’). Always had kids over at home, sleepovers. Always wanted to help mummy. Then mother got into “Today I’m going to test mummy”, e.g. participant put dog bedding in washing machine. Mother stated there was nothing outrageously bad, and never any real danger, but a daredevil,

gymnastic, confident. Mother stated participant lost this confidence in grade 2 at a Catholic school. Participant found the work too demanding, mother seeing this as the teacher's fault. The majority of the class failed that year, so mother changed schools. The participant was also bailed up in the school toilets by kids with knives. State School was good and the participant "excelled."

There was however trouble again in grades 5 and 6, good in grade 7, but mother's mother was killed that year by a shunting train, and the family moved to T____. When I asked mother why they moved, she stated that she couldn't live there any more, husband was offered a job, and there were more choices for the girls. Mother never really got to say goodbye to her mother, who lived for several hours post-accident. Participant was very close to grandmother, and "saw" grandmother often after death.

Mother described participant as compassionate and caring, and being taken advantage of by others. Mother sees this as a failure in parenting that they didn't build up her strength so well. Participant good at running, swimming, dancing, gymnastics (trophies). Currently lost "her guts", lost her confidence and mother doesn't know why, but "the boyfriend did nothing for her."

When I asked about how the parents resolved arguments, mother replied "See, that's the the part.probably....we've been married for.god, '79, we've been married legally for 23 years. We've probably been together 26 years. Um.in the early stages probably when M____ (participant) was a baby yes there were.arguments, and things like that. I left him a couple of times. But...the girls being older and that, I can't.remember..arguments." The parents had counselling when participant was a baby. Mother stated there haven't been arguments for years. I had to ask specifically if in those early years did it ever come to blows, and then mother said "Yes. That's why I left." Described it as bolting.

DEP124: When first pregnant, mother was very happy even though shocked because she had been told she wouldn't have any more kids, and this was 12 years after the others. When I asked why she couldn't have more kids, mother answered "Don't know really, I never ever actually ask." "We had also gone through a trauma" and then spoke of her mother going through hell with a late pregnancy, and her mother saying to her "If it ever happened to me I wouldn't react like that." This is not convincing, but later it becomes clearer that mother reacted badly to this pregnancy. She stated she did not have morning sickness, had "a show" early in the pregnancy

and went to bed. Mother was also in contact with German measles, and got 2 injections for it.

Participant has 2 older sisters, one born 3 weeks early and the other 2 weeks early. Participant was 2 weeks overdue, and the labour lasted 12 hours. The baby wouldn't cry when they slapped him, so he had to have an injection, mother doesn't know what. She described both herself and baby as well. Baby was born with a cluster of warts on the back of his neck, and still has them. Mother then stated she fell up the stairs about a month before the birth. She has not had any miscarriages.

Mother had high BP with second child, but not with participant. Mother stated she lost her migraines in her last pregnancy and has not had them since. She had two friends and her sister from overseas for support, and was in hospital for 4-5 days. He was a "beautiful baby", middle child was jealous and refused school and had to see a GP. She got over it and they became good friends. Participant reminds mother of mother's father, but he doesn't look like either parent, good personality and sociable like his father, good-natured.

Mother said she had no trouble with any of the kids, and he was placid. The girls had bronchitis a lot, with the participant well except for earache from swimming when older. Mother then stated the participant didn't separate well. Before 18 months to 2 years, he didn't seem to mind. But for mum he played up. At just under 3, she caught him swearing and put Tabasco sauce in his mouth which caused blisters – "I was horrified. I thought if I've got to take him to the doctor's, what will I say. I thought oh well, I'll just have to tell him the truth."

At age 2.5 years, participant "nicked off" with the neighbour's kids – "I whopped him all the way home" with a wooden spoon, and "whopped him every time he stopped crying." Participant was never allowed out of the yard after that. Mother then stated she had post-natal depression after having participant, calling it the blue depression, and said she was irritable with husband and baby pooping on her dress. Her parents weren't much support as they were too far away. The eldest daughter age 14 stayed off school to help mum manage the baby. Mother stated at end of interview that when he was age 6 he would make cups of tea for her.

Participant had part-dyslexia, but is clever. Mother read with him twice a day for half an hour, and he caught up in primary school, but went backwards in high school. Mother stated he is a good reader now. Excellent talker and "photogenic" memory. He had quite a few friends at school and was not teased. He was good at art

at school but hated sport except swimming. Mother thought this was because of a “visual blockage”, so she bought him totem tennis to help with his visual tracking.

Family history of mental illness: mother’s father was a bad nerve case – “Never had to have treatment.” This father’s father committed suicide because of nerves and the taxation department. Mother’s uncle also “nervy” but no treatment was mentioned.

When participant aged 4 or 5, father’s mother died, but there hadn’t been much contact. Just after high school, participant had a good friend die from a heart attack. Participant’s current female friend who lives with him has heart problems, and he saved her life once. Father died 8 years ago, participant age 27. “I was always the meat in the sandwich” because participant wasn’t what father wanted him to be. Participant was never interested in farming, and wanted to do interior decorating instead. When mother’s mother died, mother was on Serepax for 4 years. Participant was 14, and was very close to her because she lived with them.

DEP125: Mother was a prostitute, with participant brought up in a brothel where he was raped by clients. Mother does mention the rape in interview, but in an odd way, and some of her history giving is questionable.

Mother stated she was ecstatic when first knew she was pregnant. She “knew” instinctively it was a boy. She also “predicted that the father wouldn’t see him grow up.” Her first child was 4 years older, a boy to another man. She then had a daughter 4 years after participant to another man.

The pregnancy was quite good until later stages – father became very irrational, and she decided to separate. Father was a heavy drinker, belligerent and disillusioned with the world. They continued to see each other, and mother described this time as lots of worry for her. She stated she had a pattern of taking up with heavy drinkers, but can’t stand drinking herself. She stated that when she had the participant, she lived on a pension and had friends for support. Her mother plus her stepmother, as she was adopted, were not much support. Mother stated she sees herself as helping anyone, but not wanting help herself.

She continued working after participant was born, and partner had died. She stated she then had a breakdown. Father binged and “fell” off a bridge when participant was 2 weeks old. “I was very pissed off for a very long time.” Father’s workmates blamed her for his death, for leaving him. He had 2 children in another

country to a previous relationship. Mother claimed she did not show her anger to the kids, but cried alone at night instead.

She went back to work in pubs with a neighbour or a friend minding the kids. She started stressing out over balancing the till and started hallucinating, and went to hospital and participant went into care when 6 months old. Mother was diagnosed with catatonia, but thinks herself she decided not to talk, to have a break. She stated she is a trained nurse (currently runs a boarding house for ex-psychiatric hospital patients and the elderly). She was in hospital for 5 weeks, and then went back to work. She stated “Babies are pretty bloody fickle, so I had to visit (participant) to get him used to me again” over a 2 week period. They then moved to S___, one of several moves. Participant “was always the kid that would try anything”, had no fear. Mother stated she gave “shocking floggings to both boys, especially J___ (participant).” “They’d shit ‘emselves when I went off (laugh).”

Mother described participant as a blueprint of his father. At age 18 months, both boys were cut by a glass door – mother gave a bizarre explanation in interview of thinking it was caused by a ghost of participant’s father “because he never wanted a boy.” Mother continued with “He didn’t want that bloodline to go on.” In summary, mother thinks that when participant’s father travelled overseas before she met him, he got sick and another being entered his body, an evil presence and that’s why he didn’t want his bloodline continuing in a boy. I asked mother what was it like for her knowing that, and yet seeing J___ look so much like his father, and she replied “Scary. I don’t know how to get past this thing with J___ with his dad.”

Mother, when asked why she thought the participant had depression, stated that participant can’t get over a past girlfriend, and that he internalises things and can’t talk it out. He was a high achiever in school until year 11, and then used marijuanha. He withdrew from a business management course at university. He also sustained a severe football injury, fracturing his jaw in 3 places. She stated the pain in his jaw has triggered a childhood memory of rape by a 16 year old male friend, when participant aged “I don’t know.” “It’s blown all out of proportion. After all, he’s had a breakdown.” She then stated the participant enjoys his depression, and needs to “get over it, get on.” She then stated he was a shit of a kid. She then told me that when participant broke his jaw, she wanted to be there for him but she couldn’t because she was having treatment for cancer. “So you can imagine how I felt.” She had 6 weeks of radio- and chemotherapy. She stated neither of them has talked about

this. “I’ve always been there for him.” “There’s nothing out of his early childhood that would be...except shame, toxic shame.” She then rambled on about herself.

