

Chapter 6

General Discussion

This was to our knowledge the first study of its kind investigating HIV associated psychotic disorder in the context of parenting and the parent-child relationship. Qualitative investigation of the mothers' experiences revealed that mother-child relationships were sometimes crippled by symptoms of psychosis such as aggression and impaired functioning in the mother. These qualitative observations together with theoretical arguments led to the hypothesis that this group would be particularly vulnerable for insecure and disordered patterns of attachment when compared to a demographically similar HIV positive, psychotic control group. Unexpected therefore was the lack of differences in the attachment classifications between the two groups. However, when compared to other normal and high risk populations, disordered attachment was heightened in both groups (HIV with and without psychosis). Social support in the form of emotional support moderated the association between attachment security and psychosis. The support network can alleviate the mothers' caregiving burdens by attending to the needs of their children, but they need more information in the form of psychoeducation to understand the illness.

A literature review of the links between the variables HIV/Aids, psychosis, and parenting revealed that before 2011, when the review was conducted, no studies focused on all three variables simultaneously (Chapter 2). HIV associated psychosis was surprisingly overlooked in Africa and Asia, where the prevalence is highest but where no studies were reported from. HIV in mothers predicted either positive or negative outcomes depending on the individual context of the affected mothers. However, links between psychosis and parenting always predicted unfavourable outcomes. HIV positive mothers reported that having a child can be motivational to take better care for oneself (Wilson, 2007), and that having HIV could strengthen the mother-child bond (McKee et al., 2007) and encourage mothers to actively seek social support (Sandelowski & Barroso, 2003). On the other hand having children while HIV positive can lead to incapacitated feelings in the mother role.

Some mothers reported missing out on the child's life and they were not always able to discipline them or provide routine (Murphy, Roberts, & Herbeck, 2011). For the children from mothers with psychosis, there are multiple negative outcomes such as impaired interactions, reduced caregiver sensitivity and inappropriate responses to the child (Wan, Moulton & Abel, 2008; Wan, Penketh, Salmon, & Abel, 2008). The linkages between the factors HIV, psychosis, and parenting have been established pairwise. The review showed, however, a need for research considering the combinations of these factors.

Mixed methods allowed for an empirical study of the mothers' experiences of their illness in their roles as caregivers and their perceptions of the support networks (Chapter 3). The qualitative inquiry provided rich descriptive data of the illness context (Creswell & Plano Clark, 2007). The mothers reported emotional and physical disruptions that contributed to dysfunction in their relationships with their children. Talking with mothers and family members revealed maternal behaviours towards their children that were characterized by aggression, avoidance or rejection. Children were reported to react with fear and avoidance towards their mothers. The importance of the support network was underscored in both their roles as support figures for the mothers as well as for the children. Quantitative data about the mothers' support network compositions highlighted the relatively small supporting role played by professionals and spouses especially in the psychosis group. It was methodologically triangulated in the qualitative narratives from the interviews where mothers talked about the responsibilities of support figures such as spouses in their lives (Boeije, Slagt, & Van Wesel, 2013).

Despite the strengths of a mixed methods approach during the investigation of the mothers' experiences, a large portion of the study was retrospective and the mothers had to reflect on experiences about a time when they had impaired reality contact and judgment and

poor insight (De Ronchi et al., 2006). For this reason their recollections, although rich and descriptive, can only be viewed as portions of their perceived reality at a specific point in time. Due to the nature of acute psychosis, many of the mothers could not clearly remember their experiences when they were floridly psychotic and based their recollections on what was said to them afterwards as well as on their experiences when they were already less psychotic.

The attachment relationship was a central component of the mother-child relationship in this study as it plays an important role in the child's development over the lifespan (Sroufe, 2005). Based on the results of previous studies on maternal psychosis and attachment it was expected that insecure attachment patterns would be heightened (D'angelo, 1986; Näslund, Persson-Blennow, McNeil, Kaij, & Malmquist-Larsson, 1984). These studies were conducted before the disorganized classification was proposed by Main and Solomon (1986) and thus this study was the first to take the possibility of this classification into consideration. We hypothesized that the nature of the psychotic behaviour of the mothers would be experienced by their children as frightening (Loughland et al., 2009) and that the frightening maternal behaviour would create a "fright without solution" situation, thus increasing the odds for developing disorganized patterns of attachment in the mother-child relationship (Main & Hesse, 2000). It was further hypothesized that the children from the mothers with HIV only would not experience such frightening and unpredictable behaviour and therefore the number of children classified as disorganized would be significantly less than the dyads from the HIV and psychosis group (Chapter 4).

Surprisingly, there was no difference in the distribution of attachment between the group of children from mothers with HIV versus the group from mothers with HIV and psychosis, despite evidence from our qualitative and mixed methods studies indicating

unpredictable, aggressive and rejecting behaviour from the mothers with additional psychosis. Attachment was also not associated with specific psychotic symptoms. A possible methodological limitation that may have had an effect on the predicted outcomes is the fact that mothers were already stabilised on antipsychotic treatment and thus relatively symptom-free when the Strange Situation Procedure (SSP) (Ainsworth, Blehar, Waters & Wall, 1978; Cassidy & Marvin, 1992) was conducted. For ethical reasons children were not exposed to acutely psychotic mothers as they may have posed a danger to the children and the effect of psychosis on attachment could not be measured more accurately. The children's timing and duration of exposure to the mother's psychotic behaviour was also unknown.

An additional limitation pertaining to ethics was a lack of differentiation in the HIV only group between HIV and Aids, as was done by Peterson (1994). Information could not be retrieved from hospital files indicating whether a person with HIV had Aids. Mothers from the HIV group were thus not homogenous in their health statuses as some mothers may have been HIV positive and healthy whereas others were already ill because of Aids. This may have had an effect on their illness experiences, their interactions with their children and possibly also their attachment relationships with the children.

The socio-economic context of participants in the study should be considered as an important backdrop to the findings. The support system of the mothers with HIV associated psychosis appeared to mitigate attachment risk factors. Specifically, having a higher number of people providing emotional support for the mother was associated with more secure attachment relationships, suggesting an important avenue for future interventions (Chapter 4). It may also be beneficial to study the attachment relationships of children from mothers with HIV associated psychosis with their surrogate caregivers (e.g., grandmothers) as it may provide insight into the possible buffering effects of the support network. In addition to the

positive effects on attachment security, the support figures helped the mothers to cope with the illness and importantly relieved the mothers of their caregiving responsibilities. The role was confirmed by the support figures themselves, but they reported that the mothers' illnesses, additional stressors and poor support networks made helping difficult. Having hope and good support networks made it easier, but in order to help and provide better support they need information and psycho-education (Chapter 5).

There were however socio-economic risk factors inherent to the population that according to the meta-analysis by Cyr, Euser, Bakermans-Kranenburg and Van IJzendoorn (2010) also play an important role in attachment disorganization. All the mothers from the sample resided in poverty stricken and high crime neighbourhoods which made it difficult to study HIV and psychosis in isolation from the confounding socio-economic factors having an effect on the attachment relationship. Furthermore, findings cannot be generalized to all populations as this was a homogenous group with similar demographic characteristics, namely indigenous South African women from low incomes, low education and high rates of unemployment.

Comparing the attachment statuses of our sample with other normal and high risk samples indicated a significantly higher distribution of disorganized attachment for dyads from our study (Chapter 4). It is unclear what proportion of the effect is attributed by the HIV. The absence of a demographically similar control group without HIV or psychosis would have opened up the possibility of measuring the effect of HIV versus no-HIV on attachment, making it possible to determine the impact of the socio-economic context. Although the disorganized attachment classification was significantly more prevalent compared to other studies, the number of dyads classified as secure was not significantly lower than normative populations worldwide. Future research may be focused on the factors facilitating resilience in these dyads despite the high risk context in which they live.

Attachment research has been neglected in South Africa where children grow up in contexts with multiple risk factors for healthy attachments. This is the first study to investigate the attachment relationships of preschool aged children in this country.

Implications of the study

Theoretical implications

For children raised by mothers with these diagnoses, the risk of being exposed to adversities such as maltreatment, neglect, and dangerous contexts are high. Mothers' symptom experiences heighten the odds for unpredictable and frightening behaviour and impair their caregiver abilities. A disproportionate number of mothers diagnosed with HIV have less favourable socio-economic advantages (Shisana et al., 2012) and therefore have to deal with both the illness as well as other stressors such as poverty. Children from mothers with HIV and HIV associated psychosis had a significantly higher distribution of disorganized attachment compared to children from other normal and high-risk studies. Current theoretical models do not take into consideration the role of HIV in the development of disorganized attachment.

There was no difference in the distribution of attachment between dyads in which the mother had a diagnosis of HIV associated psychosis compared to HIV only (Chapter 4). This was surprising because children reared by mothers with psychosis were burdened with additional distress and anxiety due to the mothers' erratic behaviour as well as more impaired parenting (Chapter 2, 3 & 4). Theoretical assumptions about the aetiology of disorganized attachment were thus challenged in this study. If the children from the psychosis group were more exposed to "fright without solution" situations (Main & Hesse, 2000) compared to the HIV only group, they should have been significantly more disorganized in their attachment statuses. It should however be taken into account that the severity and duration of the

mothers' symptoms were unknown and that it may have played a role in the attachment relationship as children's exposure to the mothers' frightening behaviours may have been limited. The effect of individual concomitants of disorganized attachment may vary depending on the accumulation of risks. In a dyad with a high-risk profile such as seen in our study, the addition of psychosis may not have a significant effect on the attachment status.

The role of the support network needs to be taken into account. A higher number of support figures providing emotional support predicted more secure attachment relationships in the psychosis group (Chapter 4). The support figures additionally reported completely taking over the caregiving responsibilities when the mothers' illnesses impaired their caregiving capacities (Chapter 5). The combination of support figures attending to the emotional needs of the mothers as well as the overall caregiving of the children may have a buffering effect on the adverse effects of psychosis on attachment. Comparing the distribution of securely classified dyads of our sample to other normal and high risk studies no significant differences were found. This challenged the conventional knowledge that attachment security is jeopardized when children are raised by mothers where multiple risk factors are present.

Current attachment literature identifies risk factors for attachment security, but does not specify the duration that the child needs to be exposed to each risk factor (Cyr et al., 2010; Van IJzendoorn, Schuengel & Bakermans-Kranenburg, 1999). These mothers and children lived in collectivistic cultures where families live in close proximity, defined by social relatedness (Valchev et al., 2012) and monitoring and preventative measures by support figures can take place relatively early especially in an illness where the symptoms are as overt as psychosis (De Ronchi et al., 2006). The exposure of the child to the mother's psychotic symptoms may be minimized by timely actions of the support network. The mere

presence of a risk factor may not be predictive of attachment security as it has been measured in previous studies, but the duration and severity of the exposure has to be taken into consideration in future studies.

Implications for practice

Results from our systematic review as well as interview data gathered from the support figures indicated that there is limited knowledge about the comorbid psychiatric illnesses associated with HIV, especially HIV related psychosis. Awareness needs to be created about the illness amongst community members as well as health care providers so that affected people can be treated sooner. This will reduce the traumatic experiences for the affected mothers and limit the child's exposure to potential harm in the mother's presence. Psycho-education for support figures plays an important role in order for them to understand the illness as well as the appropriate ways of supporting mothers based on the needs identified in this study. Examples of needs include how to deal with aggression from the mother, how to communicate about the illness, caring for the mothers' children, and how to utilise additional support figures

Support figures' caregiving burden can be relieved by focussing on important aspects identified by themselves. The support figures' own support networks need to be strengthened as this is a valuable resource for them. Stigmatisation often isolates and alienates support figures from other community members, depriving them from a vital support lifeline. Spirituality and religion helped supporters to cope with the demands of caring and religious groups became a place of refuge where they seek comfort. Organized supporting communities such as churches and religious groups must be empowered through education about the illness so that caregivers of mothers with psychosis can receive appropriate support, as these groups create hope and it is a place where supporters feel comfortable to ask for help.

Emotional support for mothers with psychosis may benefit both the mothers as well as their children. This was the only variable measured in our study that was significantly associated with attachment security for the children. Support figures need to be guided to focus their attention on the emotional needs of mothers with psychosis and in turn their caregiving responsibilities will also be eased as the mothers will have healthier relationships with their children which lessens the needs for support figures to play a parenting role. Once the mothers have been stabilised and treated, their children can develop secure attachments and they are more capable of caring for them, which reduces the need for alternative rearing arrangements such as foster care.

Spouses and professional support figures were identified as the least salient part of the support network for both groups of mothers but in particular for the mothers with HIV and psychosis (Chapter 3). This is unsettling as many of the spouses are also the fathers of the affected mothers' children. They need to be encouraged to play a bigger role in the children's lives as supportive co-parenting was found by Brown, Schoppe-Sullivan, Mangelsdorf, and Neff (2010) to predict more secure father-infant attachment and additionally, in boys more secure father-infant and mother-infant attachment relationships. Professional support figures are equipped with knowledge about the symptoms and course of the illness as well as possible treatments and interventions and should collaborate with other supporters in the mothers lives as they will fulfil the needs expressed for psycho-education. Professional supporters can emphasize the value of emotional support from family members in order to promote attachment security in the children. Despite the high risk context in which parenting takes place for children from mothers with HIV and psychosis, the number of secure attachment relationships was similar to normal populations. Future research focussing on the resilience of these families may provide valuable insights that can be used in interventions to promote healthy parenting.

General conclusion

Mothers with HIV with or without psychosis face a number of challenges and needs with regard to caregiving, especially in a context where other socio-economic adversities co-exist. The challenges extend to their ability to be effective caregivers because of dysfunction caused by their illnesses; therefore support is crucial especially for their caregiving abilities. Children growing up in these homes are exposed to a number of risks for healthy development and are more at risk of developing disordered attachment relationships with their mothers compared to children from other normal and at risk populations

The role of support figures becomes very important in supporting the mothers with dealing with their illness but also in taking care of the mothers' children and protecting them from harm. Especially emotional support plays an important role as it may buffer against attachment insecurity. Until now, female relatives play a predominant role and they need to be empowered with psycho-education and a focus on their own support networks. Spouses and professional supporters play a lesser role and should be encouraged to become involved.

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