“It’s Not That Straightforward”: When Family Support Is Challenging for Mothers Living With Mental Illness

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CITATION
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Objective: Mental health service providers often have limited or problematic understanding of parents’ support needs or experiences and family relationships. Moreover, the impact of family life and relationships for mothers with mental illness, and whether these relationships are experienced as positive or negative, have been largely underinvestigated. This article aims to increase understanding about the complexity of family relationships and support for mothers. Findings may be useful for services when considering family involvement, and for how to better meet the needs of mothers with mental illness and support their recovery. Method: Semistructured interviews were conducted with 8 mothers with mental illness and 11 mental health service providers. This article presents a grounded theory analysis of the complexity of family relationships and support for mothers with mental illness. Results: Family relationships of mothers with mental illness can be complex, potentially difficult, and challenging. Problems in relationships with partners and families, and experiences of abuse, can have harmful consequences on parenting, on mothers’ and children’s well-being, and on the support mothers receive. Conclusions and Implications for Practice: This project highlights a need to recognize and work with positive aspects and difficulties in family relationships as part of mental health service provision. Policies can be reviewed to increase the likelihood that mental health care will combine family-sensitive practice with practice that acknowledges difficult family relationships and experiences of family violence in order to maximize support to mothers with mental illness and their children.

Keywords: mothers with mental illness, family relationships, family support, intimate partner violence, family violence

Parents with mental illness experience many challenges. Although their support needs can be high, they are often not well understood or met by services and families (Dolman, Jones, & Howard, 2013; Nicholson, Sweeney, & Geller, 1998). Mental health service providers often have limited understanding of parents’ experiences, relationships, and support needs (Diaz-Caneda & Johnson, 2004). Furthermore, mothers’ experiences of family relationships have been underinvestigated (Nicholson & Deveney, 2009; Nicholson et al., 1998). Understanding the level and quality of support mothers living with mental illness receive from families, and the complexities of these relationships, is critical for delivering appropriate support, treatment, and rehabilitation services. In this article, family can refer to partners, ex-partners, siblings, parents, and other extended-family members.

The provision of family-sensitive mental health services and family interventions continues to increase (Leggatt & Cavill, 2012). The needs of families in which a parent has a mental illness are also increasingly addressed through various family-specific interventions (Beardslee, Solantaus, Morgan, Gladstone, & Kowalenko, 2012). Family psychoeducation, for example, is an evidence-based practice that has been shown to facilitate recovery of persons living with mental illness and reduce relapse rates (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009). Core principles of effective family psychoeducation have been found to include emotional support, knowledge of resources for times of crisis, and problem-solving skills development. Family psychoeducation has traditionally focused on individuals with mental illness and the family members who care for them (SAMHSA, 2009). However, family psychoeducation approaches may require further development to address the situation in which people with mental illness are themselves caregivers. The increase in focus on, and inclusion of families in, mental health care may be welcome, and can be important in meeting the needs of parents with mental illness and their children (Friesen, Katz-
Leavy, & Nicholson, 2011). However, if some of the challenging aspects of family relationships are not appreciated, such practice can inadvertently contribute to problems.

Complexities of Family Relationships Within the Context of Mental Illness

Family members can be experienced as positive resources by mothers, but also as potential stressors. Consequently, relationships can be strained or complex (Nicholson, Biebel, Hinden, Henry, & Stier, 2001; Savvidou, Bozikas, Hatziegelekis, & Karavatos, 2003). This can be true for mothers in general, and can be even more challenging for those with a mental illness. Research indicates that mothers’ mental illnesses may impact negatively on relationships, potentially contributing to relationship difficulties and separations (e.g., Nicholson et al., 1998). For example, symptoms of mental illness (e.g., disordered thinking, hearing voices) and frequent hospital admissions can strain relationships and contribute to difficulties in maintaining support networks with families (Nicholson et al., 1998; Short, 2008). The effects of having a mental illness and medication side effects (e.g., drowsiness) can negatively impact upon mothers’ ability to engage with their children (Diaz-Caneja & Johnson, 2004). Mothers with mental illness may experience difficulties with partners or family members who lack understanding about mental illness and its impact, feel uncomfortable about the diagnosis, or blame or feel judgmental toward the mother (Nicholson et al., 1998; Savvidou et al., 2003). Similar to mothers in the general population, although often a major source of support, some family members can be experienced as undermining mothers’ parenting and as overstepping boundaries (Nicholson et al., 1998; Savvidou et al., 2003). This form of support can be a source of conflict and contribute to low self-esteem, poor parenting experiences, and feelings of disempowerment (Nicholson et al., 1998). Mothers living with mental illness are more likely than those without mental illness to be single or have family members who also have mental health problems or problematic substance use, which can impact on relationships (Howard & Hunt, 2008; Nicholson et al., 1998).

Violence Against Women With Mental Illness and Its Impact

Research has consistently indicated high levels of violence against women, in general, and those with mental illness, specifically. Around the world, between 10% and 69% of women are physically assaulted by a male partner at some point in their lives (VicHealth, 2011). Australian population-based studies indicate that more than one third of women have experienced physical and/or sexual assault since the age of 15, usually by a current or former intimate partner or male relative (VicHealth, 2011). Approximately one quarter of people aged 12 to 20 years have witnessed physical violence against their mother or stepmother; up to 1 in 3 girls experience unwanted sexual behavior by the age of 15 (VicHealth, 2011).

Abuse has been found to be related to higher rates of posttraumatic stress disorder and a range of other health and mental conditions, including depression, substance use, and psychotic disorders (e.g., Cashmore & Shacket, 2013; Jaffe, Cranston, & Shadlow, 2012). In Victoria, intimate-partner violence is the leading contributor to death, disability, and illness in women aged 15 to 44 (VicHealth, 2011). Experiences of abuse in childhood and adulthood can impact negatively on women’s mental health, parenting experiences, confidence, and on the mother–child relationship (e.g., Cashmore & Shacket, 2013; Jaffe et al., 2012; Warshaw, Brashler, & Gil, 2009). Having a mental illness can make women more vulnerable to further experiences of abuse (Howard, 2012).

Not surprisingly, then, research demonstrates that women who have a mental illness and use mental health services have commonly experienced higher rates of violence across the life span than other women (e.g., Fernbacher, 2008; Howard, 2012; McPherson, Delva, & Cranford, 2007; Warshaw et al., 2009). However, there is a lack of research investigating the impact of family violence on women with mental illness who are mothers (McPherson et al., 2007; Perera, 2012).

Given that most violence against women is perpetrated by partners, ex-partners, and family members, and other adverse events are commonly experienced in a family context, it follows that family relationships are frequently complex. However, past or present abuse and other interpersonal difficulties frequently remain unknown to mental health professionals, and even when disclosed, these experiences rarely form part of treatment planning (Howard, 2012; Rose et al., 2011).

Addressing the Gaps

Researchers and policymakers have called for gaps in knowledge about support for mothers to be addressed. Increasing this knowledge may contribute toward services being more sensitive to challenges mothers may face, including family life and relationships (Dolman et al., 2013; Nicholson & Deveney, 2009). Findings from mothers and mental health service providers presented in this article focus on the complexity of family relationships and associated challenges, and with the level and quality of family support they receive. This increased understanding about complexity within family relationships can be helpful when considering how to meet the needs of women with mental illness, how to support their recovery more effectively, and the level of family involvement in the treatment and support of mothers.

Method

A qualitative grounded theory approach was used to generate rich, in-depth, and complex informative data. Data was gathered through semistructured interviews with mothers and mental health service providers, about the family and mental health support experiences of mothers with mental illness. This approach was chosen for its efficacy in exploring complex phenomena, and building theories and understanding about areas previously underexplored (Charmaz, 2006). Grounded theory allows for knowledge to be gained about complex subjective experiences and how people understand their experiences. The sample size of research employing grounded theory is traditionally small, at approximately 10 participants (Charmaz, 2006). Nineteen participants was deemed appropriate for the scope of research and provided a large amount of rich data, which allowed for the domains of interest to be covered in depth.
Setting and Sample

This study was undertaken at an adult public mental health service in the northern area of Melbourne, Australia, which is characterized by economic disadvantage. Staff members from the service were eligible to participate, with 11 opting to do so. Mothers were eligible to participate if they had (a) a diagnosis of mental illness, (b) an episode of acute mental illness in the last 5 years, (c) at least one child under 10 years of age, and (d) if they were not currently experiencing an acute episode of mental illness.

Eight mothers who participated were from various cultural backgrounds (including Aboriginal Australian and European) and of ages ranging between 26 and 44 years, with a mean age of 34 years. Five had a diagnosis of schizophrenia, two had major depressive disorder with psychotic symptoms, and one had bipolar affective disorder. Three were diagnosed with more than one disorder (e.g., also with posttraumatic stress disorder). They had a total of 20 children, with an average of 2.5 children. Their children ranged from 1 to 24 years, with 13 being under the age of 10 years. Seven mothers lived with their dependent children, with one mother living with her own children as well as her grandchildren. One had three children living with her, having lost custody of two other children to her ex-partner. One reported losing custody of her only child and lived alone.

Of the 11 mental health service providers, six were social workers, two were psychiatric nurses, two were medical officers, and one was a parent peer leader. Nine were female and two were male, with the majority having at least 10 years’ experience working in various mental health settings.

Data Collection

Ethics approval was obtained from the appropriate research ethics committees, and established ethical guidelines were followed. The semistructured interview schedule was designed to elicit information about various aspects of mothers’ experiences, challenges, family relationships, and level and type of supports received from services and families. Interviews were conducted and transcribed by the first author, who had postgraduate training and experience working with people living with a mental illness. Interview questions included, “What aspects of family support, if any, have been helpful?” and “What aspects of family support, if any, have been unhelpful?” Prompts to elicit further details in response to what participants said were developed and used during the interviews, when appropriate. Direct questions about abuse were not included in the interview schedule to allow women to speak about their support needs and experiences within their own terms of reference. However, as with other topics the participants spoke about, comments made by participants were followed up on, when and to the extent that it seemed appropriate.

At their request, seven mothers were interviewed at their mental health service and one was interviewed at a family support service. Eight of the 11 mental health service providers preferred to be interviewed at their workplace, with the remainder opting to be interviewed at a café. Interviews lasted approximately one hour and were audiotaped, with participants’ permission. Mothers were reimbursed for travel costs and were given a $20 voucher for their participation.

Data Analysis

The interviews were analyzed using coding and analysis methods consistent with constructivist grounded theory, which is particularly useful when researching underresearched areas, subjective experiences, and how people construct their views and actions (Charmaz, 2006). The transcription and analysis took place from the first interview. The significant and frequent initial codes were organized into basic categories (e.g., experiences of family relationships) and subcategories (e.g., difficult and positive aspects of those experiences). Each transcript and category was read numerous times, with coding and analysis further developed at these points. The research team met to review the material and the developing analysis. Several techniques were employed in order to develop rich and in-depth understanding of the issues and the material, including ongoing coding and analysis to identify and explore relationships between categories and concepts; memo and journal writing; ongoing review of the literature; and seeking specific experiences and viewpoints during interviews. Maintaining familiarity with relevant aspects of policy and practice, such as workforce initiatives, mental health policy documents, and developments in the field was also employed.

Results and Discussion

The results presented here focus on challenges that some mothers experience with families to assist in understanding potential difficulties mothers face. It is important to note, however, that all participants also discussed positive experiences related to families and how positive family relationships help mothers in various ways (Perera, 2012). All but one mother reported not having enough and needing more family contact and support. Consistent with Nicholson et al. (1998), mothers and the majority of mental health service providers identified that mothers often have limited and problematic family support, and frequently do not receive the amount or type of support they want from partners or family members.

Challenges in Relationships

Participants spoke about various strained or broken relationships with partners, ex-partners, or family members. One such example was a mother who spoke about “going through a hard time” with her partner, and although she described him as “patient” about the impact of her illness, she discussed how her “low days” were becoming “a bit too much” for him. Other mothers described similar experiences. Some mental health service providers reported that difficulties associated with relating to someone who has mental illness may be one reason why many mothers with mental illness are frequently single. All mothers discussed that at least one relationship with a former partner was problematic. Examples of relationship difficulties include ex-partners who were abusive, or who were continuously in trouble with the law, with some having been in jail. Some mothers discontinued contact with former partners for such reasons.

Several family members, including parents and siblings of mothers, were described as “unreliable,” “inconsistent,” or “unstable.” Some were reported to be unable to recognize or cater to a mother’s needs on an everyday basis or in times of crisis. Some
mothers articulated that these family members contributed to them becoming more distressed or unwell, and, as a result, some reported that they limited or ended contact with them. One such example included a mother who did not want to turn to her family for help and said, “They make matters worse for me in my head.” Other mothers and mental health service providers spoke about family members themselves choosing to end contact with mothers because of the mental illness or difficulties associated with relating to or caring for their family member. It was identified that such loss of contact has an impact on the mental health of mothers, with one stating that family members “have cut contact from me and that really makes me upset . . . and keeps me awake all night because I keep thinking about it.”

Unhelpful or Negative Attitudes and Beliefs or a Lack of Understanding About Mental Illness

In keeping with previous research (e.g., Savvidou et al., 2003), several participants reported that some partners or family members appear to hold unhelpful or negative attitudes and beliefs about mental illness. Beliefs discussed as unhelpful include that “anyone with schizophrenia shouldn’t have kids” and that mothers with mental illness are “bad mothers.” One mother stated that as a result of her own mother’s negative attitudes about her diagnosis, “she doesn’t help . . . and she won’t even come over and see the kids.” Mothers and mental health service providers mentioned that some family members regarded mothers who were unable to do everyday tasks as “just being lazy” or “not looking after their kids properly.” Mental health service providers also discussed that service providers often have difficulty engaging with partners and family members because of their negative attitudes about mental illness.

Some mothers and mental health service providers expressed the view that, in some situations, it might be best to limit contact with family members who were not supportive, as those relationships can be detrimental to the well-being of mothers.

“Too Much Support”: Families Who Are Experienced as Undermining the Parenting Role of Mothers

A number of participants discussed the provision of too much support by family members. Several suggested that family members are often the main support in the lives of people with mental illness, including those who are mothers, but that some family members may “take control” or “take over” at times. Women experience this as undermining their parenting role and mental health. One participant described her own mother as “taking over” her role as a mother, and that she subsequently felt “out of place, left out,” and unable to parent her child when her own mother interacts with her child. These situations were described as stressful and difficult, and as contributing to mothers’ mental health difficulties and lowered self-esteem and confidence, including in relation to parenting.

Service providers suggested that family members may provide too much support because they may inadvertently impose their own parenting style or view the mother as incapable of parenting because of mental illness. These findings are consistent with previous research demonstrating that family support can sometimes be experienced as undermining the parenting role (Nicholson et al., 1998, 2001). Desired and required levels of involvement were seen as a complicated issue by several participants, and as potentially leading to conflict and other difficulties. It was common for mothers to seek high levels of involvement and support from family members, such as their own parents (particularly with caring for their children), at times when they were feeling unwell. However, during other times, this level of involvement was not necessarily desired or required. Family members may understandably find it difficult to see their loved ones live with mental illness and endeavor to meet mothers’ needs in various ways. This can result in tension and differing views about the right balance between support and control.

Partners and Family Members Who Have Mental Health Difficulties or Problematic Substance Use

The majority of mothers reported having at least one present or past partner or family member with a mental health or substance use problem. Mothers discussed this as being problematic and challenging. These issues may be further complicated by the fact that some mothers themselves may have past or current substance use problems. One spoke about having an ex-partner who had a mental illness, and stated that he “had a psychotic illness and made me stop seeing all my friends; I lost everyone who was close to me.” Another said that she “ended up having a speed-induced psychosis,” because of her partner’s history of using amphetamines and “pressuring” her to use as well. Three mothers also spoke about other family members who had problems or were unwell themselves. One mental health service provider reported that a family member “spent all of the family resources on gambling and there was no food and this mother was struggling to hold it together.” These findings are consistent with the literature indicating that mothers living with mental illness are more likely to have partners and family members who also have mental health difficulties or problematic substance use (e.g., Howard & Hunt, 2008). These factors may contribute toward making it difficult for mothers and their children to receive effective support from those partners and family members. Furthermore, this may also trigger the involvement of child protection services, which adds to the complexity of family relationships.

Abuse and Trauma in Childhood and Adulthood

Despite the fact that direct questions about abuse were not part of the interview schedule, seven of the eight mothers disclosed having experienced violence from one or more family member or partner. The majority of the service providers also reported that mothers they work with have almost always had one or more experiences of abuse during childhood, adolescence, or adulthood. They stated that the abuse most often involved previous or current partners or family members. This is in keeping with research indicating high rates of violence experienced by women and mothers with mental illness, and links between violence and subsequent mental health problems (Howard, 2012).

The majority of mothers spoke about one or more family members who had been abusive toward them during their childhood or adolescence. One referred to her sister as “controlling and quite abusive.” Another said that “it was very abusive when I was living with my dad . . . and his partner was very abusive toward me both
physically and verbally... they took my money and everything.” Another spoke about her father playing “mind games” with her, and she would find herself being controlled in various ways, which she referred to as “emotional torture.” One mother said, “I don’t want to think about the child abuse or sexual abuse; I just want to forget and block all of that out.”

More than half of the mothers disclosed that they had been abused by one or more male partners or other male family members as an adult. One spoke about a previous male partner who had been verbally abusive and threatened to kill her and her child on numerous occasions. Three spoke about at least one previous partner who had been controlling and physically abusive—some controlled the number of friends and supports mothers were allowed to have. One stated that she had felt used by her physically abusive ex-partner and manipulated by him into having children. One mother said, “I felt like a prisoner when I was with him and now I’m free.” One mother spoke about being abused by more than three family members, without specifying the types of abuse. The majority of mothers who mentioned they experienced abuse during adulthood also reported experiencing abuse as a child. This is consistent with research indicating that women who experience abuse in childhood are more likely to also experience abuse in adulthood.

Participants spoke about abusive family members, particularly partners, being damaging in a range of ways, particularly in relation to the negative effects they can have on parenting, mental health, and children. One mother said that her ex-partner “would try and interfere with my bond, and stop me from clapping and praising my child... it was really destructive and he wouldn’t even let me breastfeeding.” Others reported that their previous partners were critical of their parenting, which eroded their confidence and caused them to doubt their parenting ability. As a result, some mothers reported that they distanced themselves from their children, which had an impact on the mother–child relationship, and on the well-being of mothers and their children. Some mothers also disclosed that these experiences made them more vulnerable to substance use. These findings are consistent with previous research demonstrating that family violence has detrimental effects on women’s mental and physical health, making parenting more difficult and potentially affecting women’s bonds with their children (Howard, 2012). In keeping with previous research, two mothers also spoke about how partners used their mental illness against them to create the view that they are “bad parents” (e.g., Fernbacher, 2008). One mother reported, “There were a lot of lies, he told them I was sick and living in my car with my son and living on McDonald’s and just all this malicious stuff.”

Research Considerations

Although this article provides in-depth knowledge about family relationships and support of mothers with mental illness, the sample size is small and is not necessarily generalizable. Mothers were recruited from an area characterized by economic disadvantage and underresourced support services. The findings may not be generalizable to mothers with different characteristics, including socioeconomic circumstances. It is also important to note that this study did not elicit the perspectives of families; future research including this perspective would be beneficial.

Conclusions and Implications for Practice

Although there are undoubtedly positive experiences of family relationships, which were discussed by all participants, family relationships of mothers with mental illness can also be complex, difficult, and challenging. The findings of this study corroborate other studies. Support from families and partners that is experienced as problematic, and difficult or abusive relationships, can have harmful consequences on women’s mental health, mothering, and parenting confidence. The intricacies of family relationships have implications for the type, quality, and level of support that mothers receive from families, which can mean that they do not receive the support they need.

Service providers need to take into account the history of family relationships when considering how and if family members could be involved in supporting a mother and her children. Although a child- and family-focused approach is recommended and is frequently beneficial, the challenges of family relationships that include abuse and other difficulties need to be carefully considered. Treatment and services for mothers with mental illness aiming to strengthen family interactions and relationships need to take account of the range of potential problems. The balance between “not enough,” “enough,” and “too much” support, and the type of support desired, need careful consideration. There is a need for thoughtful family relationship assessments that may be implemented as part of collaborative care planning for mothers and their children, and relationships and care plans need to be revisited over time. Plans specifying ongoing support that mothers want from family members can be designed to include more active involvement and support for times of exacerbated difficulties or hospital admission. Such plans can provide reassurance and a desired and appropriate level of self-determination for mothers and children.

Professionals need education and supervision in a range of areas. These include how to work with parents, families, and children using strengths-based approaches, and how to work with family members who may be experienced as challenging. Furthermore, they need to be up-skilled on how to assist families to enhance communication and relationships, and balancing potentially competing needs and wishes of family members. It is recommended that sensitive psychoeducation be available to partners and family members that encourages constructive support and communication styles, increases coping skills of families, and provides information about mental health and services. Our findings suggest that family psychoeducation approaches need to take into account that many adults living with mental illness are themselves parents (SAMHSA, 2009). This type of psychoeducation could contribute toward shifting potentially negative attitudes held by families, particularly those related to parenting. Such education could also include a focus on respectful relationships and, only if safe to do so and in consultation with the mother, the impact of past abuse and other adverse experiences and how these can be addressed could be discussed by skilled staff.

Workforce development should include skills development in recognizing and working with family violence, including in the context of mental illness and parenting. Mental health service providers need to be supported in balancing a family-sensitive approach with the reality of challenging family relationships. Access to consultation and supervision to continue to develop expertise in these areas is paramount. It is recommended that mental
health service providers develop collaborative relationships with service providers who work in the areas of family violence, sexual abuse, and child protection. Although substantial improvement has been made to policy and service development in Australia and elsewhere, including family-sensitive practice and working with trauma and abuse, this project highlights the need to recognize and work with complexity. This needs to include taking into consideration positive aspects and difficulties in family relationships as part of mental health care. Policy and practice guidelines must reflect these complexities in order to guide practice. Finding a balance between family involvement and due recognition of the complexities of family relationships will go some way toward ensuring that the needs of mothers living with mental illness are better recognized and attended to. This, in turn, will assist in protecting and supporting mothers, children, and families.

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