Mothers With Mental Illness: II. Family Relationships and the Context of Parenting

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Objective: **This study explores the experiences of mothers with mental illness regarding their family relationships.** ***Methods:*** **Six focus groups of mothers with mental illness and five focus groups of case managers met to discuss problems facing mothers with mental illness and to recommend solutions. Focus groups were audiotaped, and transcripts were coded and analyzed qualitatively to describe ways in which husbands and partners, grandparents, and other family members contribute to the context of parenting for mothers with mental illness.** ***Results:*** **Mothers with mental illness and case managers described a range of relationships and attitudes of family members and provided examples of the ways in which family members contribute both positively and negatively to parenting.** ***Conclusions:*** **Although family members may seem to be natural supports for mothers with mental illness, their involvement in the context of parenting may not be entirely positive. The contributions of family members to the context of parenting for mothers with mental illness must be considered by treatment providers if unintentional negative outcomes are to be avoided. (*Psychiatric Services* 49:643–649, 1998)**

Research on the relationships between adults with mental illness and their family members has focused primarily on the burden to families of caring for an adult with significant impairments and needs (1,2). Attention has only recently been brought to the fact that increasing numbers of adults with mental illness may be in the position of caring for others (3).

Women with mental illness are bearing children and raising them (4–10), and their parenting careers are markedly shaped by the attitudes and behavior of significant others (5,7,11,12). Researchers have suggested the need to understand the extent to which social supports, and specifically family supports, contribute to the context of parenting and the relationship between mental illness and motherhood (5,7). There has been limited research on the secondary, often hidden, burden to family members of caring for the children of mothers with mental illness who are themselves unable to provide this care (13).

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Research on the family relationships of mothers with mental illness has lagged behind research examining how the family context affects outcomes for children of these mothers. Researchers studying the multiple sources of risk to children whose mothers have mental illness have concluded that the family context may be more significant than biological vulnerability in accounting for children's outcomes (14–17). The emotional states of children may be greatly influenced by the family constellation and the presence of "well" adult alternatives to the mother with mental illness (18,19).

Researchers and clinicians have noted that although personal relationships are important to women with mental illness (10), they often have difficulty establishing support networks and maintaining family relationships (9,10,20). Relationships can be both a buffer against stress and a source of competence, especially if women are able to give to others in return (10). Ritsher and colleagues (10) reported that women with mental illness maintained some mutual relationships despite the negative impact of their illness on their ability to participate fully in these relationships. Fifty-five percent of the women in their study had at least one family member who was supportive, and 61 percent felt that they were a fully accepted member of their family.

Women with mental illness who are vulnerable to relationship diffi-

culties are likely to have problems in dating and marital relationships (10). Indeed, fewer than 48 percent of the women in the study by Ritsher and colleagues (10) had romantic partners. Marriage rates are lower and divorce rates higher for women and men with mental illness (21,22). Women with mental illness who choose romantic partners of the same gender receive little support. Nineteen percent of the women in the study by Ritsher and colleagues (10) indicated they were gay or bisexual, and the vast majority of those women—79 percent—said they had no one in whom to confide about relationship issues.

Women with mental illness who are mothers are significantly more likely to have been married at some time in their lives than are those who are not mothers (4), although many mothers have experienced divorce. Spouses of women with schizophrenia have high rates of psychiatric disorder themselves (9). Women with schizophrenia are less likely than women with no psychiatric diagnosis to be married or living with a partner when their children are born, and these children are more likely to be raised by someone else (8,9). Mothers with schizophrenia-spectrum disorders are less likely than mothers without major psychiatric impairment to have someone helping them raise their children, although the percentages of mothers with and without serious mental illness who are raising children alone are not significantly different (8). Mothers with serious mental illness who are caring for minor children, however, have significantly better immediate and extended social networks than do women with mental illness who are not current caretakers (4).

Of significant interest are the experiences of mothers of diverse ethnic and racial backgrounds, specifically regarding their networks of family support and patterns of caregiving. In a sample of women who were receiving case management services from a state mental health authority, mothers with mental illness who were caring for minor children were significantly more likely to be non-Caucasian (4). In the evaluation of the Ohio site of the Robert Wood Johnson Program for the Chronically Mentally Ill, parents were more likely to be female and African American and were more likely to have been married than were nonparents (13). Children of African-American women with mental illness were less likely to be living with a father and more likely to be living with a grandmother, in foster care, or adopted.

This study also examined the hidden burden to family members of caring for the minor children of parents with mental illness. Significant relationships were found between family members' helping the parent with child care and their helping with other activities of daily living such as housework, meal preparation, and transportation.

Focus groups were conducted to provide opportunities for mothers with mental illness and for case managers to describe mothers' experiences in great detail.

The quality or nature of family relationships is just as important as the number or extent of these relationships (7). In a sample of mothers with mental illness who were interviewed while hospitalized, social support networks were smaller than those of well mothers, were composed primarily of relatives, and contained persons whose contributions to support were negative as well as those whose contributions were positive (23). Seventy percent of the mothers reported that their lives were made difficult by at least one member of their network. The women who were made most profoundly vulnerable by deficits in social supports were single mothers who, when hospitalized, relied on relatives for child care. Again, racial differences in marital status may have influenced family supports for mothers with mental illness. A greater number of African-American mothers were single (23), but fathers overall provided child care most frequently for married mothers who were hospitalized. Thus foster care was used more frequently for children of mothers who were not currently married and was used disproportionately for children of African-American mothers.

In the current study, we provided opportunities for mothers with mental illness and case managers employed by the Massachusetts Department of Mental Health to describe mothers' experiences in great detail. Focus groups were conducted to allow participants to share their perspectives fully in a nonthreatening atmosphere. Although our emphasis was on mothers' perspectives, key informants—including consumers, researchers, service providers, and policy makers—recommended that case managers also be involved in the research, as they are the service providers perceived to have the greatest current knowledge of the day-to-day lives of mothers with mental illness and their families.

Qualitative methods were most appropriate to this research because so few relevant previous studies were found, and none of the previously used methods allowed a complete description of the complex family relationships we wanted to examine. The use of existing theoretical frameworks at this stage in the development of knowledge about the experiences of mothers with mental illness would potentially have limited the breadth and depth of findings from this exploratory study (24). Our goals were to elaborate the full range of variables, and nuances in relationships among them, as they relate to the experiences of mothers with mental

illness and their families and to develop a thoroughly grounded foundation for theory building, rather than to test existing theory (25).

The purpose of the study was to explore the experiences of mothers with mental illness regarding their family relationships and social supports by turning to mothers as the major source of information. Six focus groups of mothers with mental illness and five focus groups of case managers were conducted in different locations across Massachusetts in the spring and summer of 1994. Two discussion questions were posed to mothers and case managers: what are the problems facing mothers with mental illness, and what are some solutions or recommendations you would make? Focus groups were audiotaped, and transcripts were coded and analyzed to describe the ways in which husbands or partners, grandparents, and other family members contribute to the context of parenting for mothers with mental illness.

Methods

Recruitment of study participants

Details of the recruitment process are provided in the companion paper by Nicholson and colleagues in this issue (26). Briefly, 100 mothers were randomly identified from active case management rosters in six area offices of the Massachusetts Department of Mental Health. Clients who receive case management services are persons with serious, long-term mental illnesses that keep them from meeting the requirements of daily living, including self-care and obtaining shelter, food, and clothing; persons who have had at least two psychiatric hospitalizations in the past year; and homeless persons with mental illness.

Mothers recruited for this study had a diagnosis of severe mental illness, were between the ages of 19 and 59, were regularly involved with a biological child under the age of 13, and were English speaking. Of the 89 mothers invited by case managers to participate, 42 ultimately attended focus groups.

Fifty-five case managers who were currently providing services to clients who were mothers or who had provided services to mothers in the past were randomly recruited for focus groups held in five area offices of the department of mental health. Most case managers were college educated (84 percent), and the majority (66 percent) had ten or fewer years of experience as case managers.

Focus-group procedures

Forty interviews with key informants—consumers, researchers, service providers, and policy makers—and a pilot focus group of mothers informed the development of the study procedures. Five of the six focus groups for mothers were held in psychosocial rehabilitation clubhouses; the sixth took place in an area office of the department of mental health. Mothers' focus groups had an average of seven participants, and the groups ranged in size from three to ten participants. Case managers' focus groups had an average of 11 participants, with a range from six to 14 participants.

After signing informed consent forms and completing background questionnaires, focus-group participants responded to the two study questions on the challenges facing mothers with mental illness, and recommended solutions. Participants were encouraged to brainstorm a list of experiences, issues, and recommendations. The group coleaders, who identified themselves as independent researchers not affiliated with services the mothers were receiving, recorded ideas and summarized group discussion. The research staff met to debrief after each session.

The focus groups were audiotaped, and the tapes were transcribed by a research assistant who had attended the groups. Transcripts were compared with tapes for accuracy. Brainstormed items were checked against complete group transcripts to ensure they were valid representations of the group discussions.

Analysis of qualitative data

Brainstormed items were coded by group coleaders and research assistants using several broad content domains suggested by the literature as a provisional starting list for coding (27,28). The researchers coded 466 items that were generated by the six focus groups of mothers, and 572 items from the five groups of case managers. An interrater reliability level of at least 90 percent was achieved by three researchers who independently coded random items from each focus group. Additional coding categories were suggested by items identified by focus-group participants, and the categories were refined as the focus groups progressed until no new coding categories emerged. The coded items were grouped by themes as patterns among items became apparent.

For this study on family relationships and the parenting context of mothers with mental illness, data were drawn from two thematic categories—relationship with husband or partner and relationships with grandparents and other family members. The range of mothers' family relationships and the attitudes of family members toward mothers with mental illness are described below. Quotes from mothers and case managers are used to provide specific examples of the ways in which relationships with husbands and partners and relationships with grandparents and other family members contribute both positively and negatively to the act and context of parenting.

Results

Characteristics of mothers

Details of the mothers' characteristics are presented in the companion paper in this issue (26). Briefly, the 42 mothers in the focus groups were an average of 35 years old. Most were Caucasian (83 percent). They tended to be currently married or living with a partner (45 percent) or previously married (48 percent). The majority (62 percent) were recipients of Supplemental Security Income or Social Security Disability Insurance. Most lived in their own homes or apartments (81 percent). Most mothers (55 percent) reported having a diagnosis of an affective disorder such as major depression and bipolar disorder. Mothers rated themselves as

functioning between fair and good on a continuum from poor to excellent.

The mothers who participated in the focus groups had a total of 93 children. The average number of children per family was 2.2, with a range from one to six children. Thirty-eight of the children (44 percent) lived with their mothers or mothers and partners. Eighteen (21 percent) lived with their fathers, without their mothers. Ten (12 percent) lived with relatives, and ten (12 percent) were adopted. Six children (7 percent) were in foster care. Five children (6 percent) were old enough to be living independently.

Eighteen of the mothers (43 percent) were currently living with their children. These mothers identified significant sources of daily support for child care, including spouses (56 percent), day care centers (39 percent), and grandparents (14 percent). The 18 mothers currently living with their children provided 25 responses to the question of who cares for their children when they are hospitalized. Grandparents and other relatives most frequently provided care; this source of care was mentioned by nine mothers and in 36 percent of the responses. Seven mothers (28 percent) designated foster care, six mothers (24 percent) indicated fathers, and nine mothers (12 percent) stated that friends or others routinely provide child care.

Family relationships and attitudes of family members

Family members include husbands or partners of either gender, grandparents, and other extended family members. Husbands or partners may or may not be the biological fathers of children in the home, they may live with mothers or not, and they may participate in child care to varying degrees. Some mothers who were divorced reported that their former spouses had legal custody of their children. Men may be involved in families as stepparents. Women may be dependent on their partners for day-to-day resources and, if children are living with foster parents or other family members, for support in maintaining relationships with children, such as transportation to visits.

Mothers and their children may be residing with grandparents—the mothers' parents—who provide care for children routinely or as needed while mothers cope with daily stresses or when they require hospitalization. Mothers may live apart from grandparents, who provide help in emergency situations. Mothers may live apart from children, who reside in a more permanent way with their grandparents. Extended family members may be temporary caregivers or designated guardians for children of mothers with mental illness.

Family members may reinforce the "sick role" for mothers with mental illness and neglect to consult them or to consider their wishes in making decisions about children.

Mothers and case managers explained that family members may vary considerably in knowledge and attitudes and may not understand or be comfortable with mental illness. One mother said of her former husband, "He'd say, 'Snap out of it. You can, you know, pull your boot straps up.'"

Family members who do not understand mental illness may be angry and resentful toward mothers with mental illness, blaming them for problems that arise. One mother said, "The family talks, and a lot of the family members are ignorant about mental illness. Their ignorance speaks a lot of malicious stuff, and my children have to listen to that about their mother." A case manager said, "The family members are just frustrated, and so they back off. They're very negative toward her [the mother]. Of course, they're not necessarily horrible people."

Mothers described judgmental family members who were condemning or lacking in forgiveness. "If you say a little thing, they're so quick to jump to the conclusion that you're defective mentally. A lot of judgments are made, a lot of accusations," said one mother.

Family members may reinforce the "sick role" for mothers with mental illness and neglect to consult them or to consider their wishes in making decisions about children. Both mothers and case managers described women who feel dominated by family members in this way. One mother said, "I am 34 years old. I can make my own decision. I don't need to be babysat. But to my father I'm still a baby no matter how old I get." A case manager said, "If the mother is set in the role of being the sick one in the family and family members reinforce that, then they don't let her consult. Her role is the issue."

Husbands and partners

Husbands or partners may be perceived by mothers and case managers as resources or hindrances, as supportive or undermining. Some are described as helpful with daily parenting tasks or in emergencies, when mothers are hospitalized. One mother said, "If I didn't have a supportive husband, I wouldn't even have my children. I'd probably be dead, you know." Another mother said, "My husband does laundry, does dishes, babysits."

On the other hand, husbands and partners may be described as passively or actively undermining of mothers' efforts to cope with mental illness and the activities of parenting. A mother said, "My partner was awful. When I came out of the hospital, he didn't want me to take the medications. My kids are kind of afraid of me because of what he's told them—that I'm a psycho, that I don't belong in the house, that I have no business having kids." A case manager said, "I have a father who

threatens my mentally ill client with 'if you go in the hospital one more time I'm going to have DSS [social services] take the children.'"

Husbands or partners may make situations worse by having unrealistic expectations for mothers or children or by depleting women's energy or other resources. One mother said, "When our daughter came along, he got a little more picky, like he wanted the house cleaned more and he wanted this just so." Another mother said, "I had a car then, but once my husband stole my car, I didn't have a ride to see the kids. I had to depend on him."

Women described husbands or partners who were abusive to them or their children, who may be abusing substances, or who may have a diagnosis of a mental illness themselves. These men may pass the point of undermining women's efforts to parent their children to the point of being threatening. One mother said, "He just scares me and frightens me every now and then. He's just so mean." A case manager said, "I had a situation where the mother and father had a fight, and the child tried to protect the mother and called the police."

Unfortunately, according to case managers, mothers may need "well" husbands or partners to justify retaining custody of their children to child welfare agencies. Or custody may be awarded to well partners, who do not have a diagnosis of mental illness but are less able caregivers. Former husbands or partners with custody of children may be supportive of the mother's participation in children's lives or may withhold contact.

One case manager said, "I have a client who's married, and her husband threw her out the last time she was hospitalized and refused to let her see the children or anything. She figured she would never get to see her kids if she didn't go back with him. She felt she had no other choice." Another case manager said, "The court would prefer to send the children back to the father who has physically abused the children versus sending them back to the mother who has a mental illness." A mother said, "My in-laws tried to talk my husband into taking my son away from me during my hospitalizations."

Conversely, mothers may be held responsible for their inability to protect their children from exposure to domestic violence or actual mistreatment by husbands or partners. The presence of a man in the home may, therefore, negatively influence the amount of contact a mother is allowed with her children by the court if the man is viewed as a negative influence in the home. A mother said, "I have a live-in boyfriend. I guess this boyfriend had a reputation for being abusive. I was not capable of protecting my children from him or from anybody else." A case manager said, "A client lost her children because of the fact that her boyfriend is an alleged sexual abuser. So the court system was, in effect, trying to protect the children, but it has denied the mother access because of the alleged criminal history of the boyfriend."

Grandparents and other family members

Grandparents may be viewed by mothers and case managers as extremely helpful or quite undermining. They may pitch in when mothers are feeling overwhelmed or may be perceived as overstepping boundaries and interfering with or indulging children. One mother said, "Whenever I go into the hospital, then my daughter goes and spends time with my parents, so that's really good, and that's just like a second home for her." A case manager said, "It's confusing for the child if the mom tries to set limits and the grandmother would come in and tell the child, subtly, that the mother didn't know what she was doing and that she—the grandmother—was the better parent."

Mothers may be stressed by their parents' expectations for the care of their children. One mother said, "My mom feels that I should do everything that my children want me to do. I tried lying down the other day in the afternoon, and my mother insisted that I get up and take my kids swimming because they wanted to go."

Grandparents may have been dysfunctional parents themselves, and as a result mothers may not fully trust the child care provided by grandparents. One mother said, "Because they [the grandparents] are alcoholics in denial, they will speak badly of me and it's so easy for them to find what's wrong with somebody else, but they can't see what's wrong with themselves."

Grandparents may feel "stuck" with their grandchildren and may be stressed by the burden of caregiving. Mothers and case managers described grandparents as feeling responsible or overwhelmed at times. "Well, she is getting kind of old. She babysits all the other grandkids. I think it's too much for her," one mother said. A case manager said, "I have a grandmother who gets stuck with the grandchildren because her own children are very irresponsible. She's having a hard enough time just making it through her day, and she is just totally overwhelmed."

Mothers may feel relieved by or jealous of their children's relationships with grandparents or other family caregivers. Conflict may arise if the caregiver is a relative the mother doesn't like. There may be feelings of competitiveness, as family members struggle to prove "who's the better mother." Conflicts may be exacerbated by custody disputes or efforts by the mother to regain custody.

One mother said, "My daughter favors her [the grandmother] more than me because when I used to be in the hospital for weeks, my mother took care of her, so I think that she's really attached with my mother; she's very close. It makes me a little upset, because I'm her mother." Another mother said, "I was getting along with her [her cousin] until she adopted my son. And now she and I don't even speak. She doesn't send me pictures. She doesn't send me letters. She knows I can't stand her having my son."

Mothers from minority groups who are not living in communities with others who share their culture or ethnicity described feeling isolated and bereft of family support. Women may be living far away from

extended family members who might be resources in childrearing. One case manager said, "I have a client who doesn't have her family here, and she's never connected with people here in the United States. She doesn't know where to get the help, and because of that she had a breakdown about five years ago."

Discussion

Mothers with mental illness may have difficulty in family relationships because of family members' attitudes about mental illness. Stigma and ignorance about mental illness, treatment, and recovery influence family members' behavior toward mothers and children.

The responses of family members to mothers' efforts at parenting and to their illnesses contribute to well-being and outcomes for both mothers and children. Mothers and case managers in this study provided documentation of both passive and active support and undermining by family members. Depression may emerge when relationships with intimate others are unsupportive (29). Family members who do not believe in mental illness or treatment want mothers simply to "get a grip" on their illnesses and take care of things at home. Mothers may come to view themselves as inadequate; reinforcement of this view by family members may exacerbate depression (30).

Active abuse of mothers with mental illness by husbands or partners may well be common. Clinicians and researchers are becoming increasingly aware of the extent to which women with serious mental illness have been victims of trauma (10,31). The negative effect for women of being victimized by husbands or partners, and the negative impact on children of witnessing abuse, are obvious. Less well understood are the ways in which childhood trauma, perhaps perpetrated by the women's parents or other family members, reverberates through the lives and parenting careers of mothers with mental illness. The repercussions of childhood trauma may be most clearly revealed in situations in which parents who were abusive to mothers are awarded custody of their grandchildren. These arrangements are particularly problematic because family members are often the first choice when children require out-of-home placements (13). These situations cause conflict and worry for mothers in their relationships with family members and may cause intermittent worsening of the symptoms of mental illness.

Grandparents or other family members, however, may provide welcome respite for mothers with mental illness. The secondary or "hidden" burden to grandparents or other family members who care for the children of mothers with mental illness must be identified and addressed. Although many grandparents and family members may be willing and able to shoulder all or part of the burden of raising children, these situations are rarely without conflict or stress.

Efforts should be made to provide clear and structured support to grandparents and family members who are providing care and to enhance their relationships with mothers who may be feeling angry, jealous, resentful, or simply helpless. Mothers with mental illness may require assistance in developing positive ways to relate to family caregivers. Children may need support in coping with loyalty issues in family relationships. Interventions to address both of these situations should be explicit parts of the therapeutic contract with mothers.

The experiences of women of color or with diverse cultural roots may be negatively influenced by isolation from others with common backgrounds or enhanced by the support and care given by families who share race or ethnicity. Membership in a particular racial or ethnic group may be a protective factor in the lives of mothers with mental illness and their children. Expectations for women regarding motherhood and natural networks of support in particular cultures may mitigate the effects of mothers' mental illness. Providers who work with mothers with mental illness need to understand these contextual issues.

Family members' attitudes and behavior may support access to or serve as barriers to services for mothers with mental illness and their children. Family members may provide concrete support, such as transportation or babysitting, while mothers attend treatment appointments. Or, as one mother described, husbands may flush medications down the toilet. Clinicians and rehabilitation specialists must understand the roles family members play in supporting the achievement of mothers' treatment goals or in thwarting their efforts to recover and to parent. Knowledge of family resources and supports is essential in assisting mothers to develop plans for child care when hospitalizations are required.

It cannot be stressed enough that working with the whole family has a greater impact than working with only one part of the family. The extent to which the family is overlooked is indicated by the high frequency with which providers of mental health services to adult women do not know if their client has ever had a child (3).

Conclusions

Mothers with mental illness and case managers agree that in general supportive husbands and partners and other family members are an asset, and the lack of family support is a liability. Relationships between mothers with mental illness and family members are quite complex. It is important to note that mothers and case managers describe many situations in which husbands or partners and family members provide essential support in the lives of women with mental illness and their children. A lack of family supports, in combination with other contextual factors such as poverty, puts mothers and children at far greater risk of poor outcomes.

However, mothers with mental illness may be dependent, for a variety of reasons, on partners or family members who undermine their efforts at recovery or parenting and who are less than able caregivers themselves. Difficult situations may unknowingly be created by agencies or courts when decision makers are blinded by the diagnosis of mental

illness and mothers' strengths are ignored. Although family members may seem to be natural supports, their involvement may not be entirely positive and, in some instances, not even desirable. Treatment providers must make the effort to understand the subtle aspects of relationships between mothers and their partners or family members, rather than to rely on commonly shared assumptions about the virtue of family support.

Treatment providers must support mothers in developing and maintaining the most positive family relationships possible. If the attitudes and behavior of family members and their contributions to the context of parenting for mothers with mental illness are not considered, outcomes for mothers, their children, and families may be jeopardized.

To be of service to a mother with mental illness, a provider must know that the client is a mother, must identify her strengths and weaknesses as a mother, must ascertain what her natural supports do and do not do both psychologically and practically, must learn what her hopes and expectations are for herself as a mother and for her children, and must determine what services she needs as a mother. How to start? Listen to the mothers. Our research indicates they have much to tell us.♦

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