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Title: Adult Children of Parents with Mental Illness: Dehumanization of a Parent**.** "She wasn't the wreck in those years that she was to become later"

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Adult Children of Parents with Mental Illness: Dehumanization of a Parent

"She wasn't the wreck in those years that she was to become later"

Abstract

Children who have lived with parental mental illness experience long standing reduced health and social outcomes, alongside ongoing personal distress. While there has been some dialogue regarding interventions to support children who are living with parental mental illness, there remains a paucity of knowledge regarding adult children's experiences and potential needs. Given this, the aim of this study was to establish parenting narratives of adult children who had experienced childhood parental mental illness. This included their experiences of being parented alongside their own subsequent parenting roles. Three men and 10 women, ranging from 30 - 78 years old, met individually with a researcher to tell their stories. Narratives were thematically analysed to establish themes. The findings of the study demonstrated that individuals who have lived with childhood parental mental illness dehumanized their parent with mental illness. The authors argue that all mental health services should be underpinned with a whole of family assessment and care philosophy. There is also a need for all mental health services to consider how policies and procedures may inadvertently dehumanize clients who are parents, which could contribute to familial dehumanization. This could prevent the dehumanization of parents who experience mental illness to preserve parental and child relationships.

Background

There is consensus within the literature that children of parents with a mental illness are at risk of developing their own mental health concerns, and reduced social engagement and functioning (Afzelius et al. 2016; Grant et al. 2016; Reupert et al. 2015; Vigano et al. 2017). Children's quality of daily lives in terms of emotional health, social and economic wellbeing, family context and experiences, self-esteem and self-actualisation are also thought to be negatively affected (Bee et al. 2013). Ranning et al. (2016) specifically highlighted that parental mental illness affects children's family composition and living arrangements. They noted fewer children living within two parent families, particularly when a parent was diagnosed with schizophrenia, possibly reducing available supports for these children. Ranning's et al. (2016) work is important to consider in the context of work by Bee et al.

(2013), who highlighted that children of parents with mental illness feel isolated from others in their peer group. The possible changes in family structure and feelings of isolation from peers could increase children's distress when living with a parent with mental illness.

Interventions for children experiencing parental mental illness are primarily aimed at reducing perceived negative health and social effects, and increasing resilience; for example: child psychoeducation (Reupert et al. 2012; Woolderink et al. 2010;) and peer support programmes (Foster et al. 2014). Yet, health service staff continue to feel concerned about their role in supporting children and families experiencing parental mental illness (Laletas et al. 2017). Additionally, whole of family interventions within adult mental health services remain limited (Pfeiffenberger et al. 2016; Reupert & Maybery 2014; Van Loon et al. 2015 despite the notion that positive familial relationships are positioned as critical for recovery for both individuals with mental illness and their families (Wyder & Bland 2014).

Quantitative studies found correlations with adults who experienced childhood parental mental illness and early onset psychosis; bipolar disorder and substance misuse (Choi et al. 2017; Post et al. 2016; Reed et al. 2017). While there is a paucity of qualitative studies with a focus on adults who experienced childhood parental mental illness, current knowledge suggests there may be similarities with study findings involving children. Relational worries, for example, are not unique to the childhood period but are also reported by adults who have lived with a parent with mental illness during childhood (Foster 2010; Petrowski & Stein 2016; XXXX et al. 2016).

There remains a paucity of qualitative research which focuses on adult experiences of childhood parental mental illness. The study sought to establish parenting narratives of adults who had lived with parental mental illness as children. Narratives included being parented by a person who experienced mental illness alongside their own subsequent parenting role. It is important to consider the longer-term experiences of childhood parental mental illness to identify possible stressors, protective and resilience factors alongside potential drivers for whole of family recovery.

Methods

Design

A narrative approach was used to explore participants experiences. The use of narratives had the potential to generate accounts of one's life and an individual's perceptions of their

experiences. Fundamentally, narratives can help to establish meaning (Sandelowski 1991). They can encourage emotional expression which in turn can generate a deep understanding and further conceptualisation of participant' experiences (Fioretti & Smorti 2015; Romano & Cuenca 2013). Furthermore, there is also a growing use of narratives to generate lived experience perspectives and recovery models for people with mental illness and their families (Tondora et al. 2014).

Study context

The study took place in a metropolitan city situated on the eastern side of Australia.

Participants

The study procedures were in keeping with ethical approval provided by the approving Human Research Ethics Committee. Potential participants were invited to take part in the study via newspaper articles, posters in community centres and a radio show. They were asked to make direct contact with the lead researcher by telephone or email to express their interest in participating in the study. Potential participants were asked several screening questions in line with the inclusion criteria, to ensure suitability for the study. The inclusion criteria asked that participants: be over 18 years of age; English speaking; have lived with a parent with mental illness during childhood; have a parent with a diagnosis of schizophrenia, psychosis or mood disorder who was hospitalised for mental health during the participant's childhood and be a parent themselves. Study information and consent forms were provided to potential participants. Once they had time to consider their role in the study to provide informed consent, a one to one meeting was arranged between the lead researcher and each individual participant. Meetings took place in a private room on a university campus or community centre. Each meeting lasted between one hour and 90 minutes. The average meeting was one hour and 15 minutes.

A previously published partnership approach between the researcher and participant provided space and time to generate narratives (xxxx et al. 2016). Participants constructed narratives of their experiences of living with childhood parental mental illness and their own parenting roles. Two main questions were asked during the meeting: "tell me about your experiences of being parented by a person with mental illness" and "tell me about your own parenting experiences?" Interspersing questions and clarification helped to seek depth to participants'

experiences. All meetings were digitally recorded and transcribed into written text. All transcripts were de-identified. Pseudonyms are used in reporting study findings.

Ten women and three men aged between 30 to 78 years old with an average of 54 years of age engaged as study participants. Seven participants had a parent who had been diagnosed with schizophrenia, and two reported a parental diagnosis of psychosis. The remaining four participants reported their parents had a mood disorder, including severe and ongoing depression. Parental diagnosis of mental illness was determined from the participants' own knowledge.

Analysis

All transcripts were reviewed initially. There was a two-staged approach to data analysis. Initially, main concepts and themes were noted, prior to establishing sub themes. This is in keeping with analytical approaches for qualitative studies (Green 2014). Further, themes and sub themes were highlighted for differing life stages: childhood; teenager years; young adulthood; adulthood followed by those from participants' own parenting. The two-staged analytical approach allowed conceptualisation of longer term experiences for those who had lived with childhood parental mental illness.

Findings

Five themes were generated from the narratives: living with fear and mistrust; navigating stigma; loss of self; dehumanization of a parent and parenting journeys. Three of the themes from the study findings have been published previously: living with fear and mistrust (xxxx et al. 2015a); navigating stigma (xxxx et al. 2015b) and loss of self (xxxx et al. 2016). Dehumanization of the parent by the adult child is presented in this paper.

Dehumanization of a parent with mental illness

She wasn't the wreck in those years that she was to become later

The dehumanization process of parents with mental illness by children had different presentations. Firstly, the humanistic characteristics of the parent or their parenting roles were perceived as being diminished in some way, meaning that they were viewed by participants as having less value in society. Secondly, individual parents were reduced to illness

symptoms with loss of the person. Participants perceived that the parental illness and / or symptoms had become part of their parent's character or the person.

The narratives show how the mothering role was conceptualized within the concept of illness with the loss of the mother as a person. Kate summarised stating

> *I remember as a child - shame if she wasn't ill, I think she would have been such a wonderful mother.*

Through her narrative Kate made reference to her mother showing high levels of love to her as a child. Yet, Kate also noted that her mother could have undertaken improved mothering had she not experienced mental illness. David also highlighted

> *I think that's a story of feeling let down and not cared for and like Mum hadn't done her job. It's a different feeling about her compared to Dad. You feel a bit cheated because you've drawn the raw straw - short straw, or raw prawn. So you're resentful. It's a bit of a bloody lousy hand that we've been dealt.*

A similar positioning was noted in Edward's narrative, where the value of the person with mental illness, as a parent is diminished.

> *To a degree she wasn't really a parent. She was more like a housekeeper, because she wasn't there to be a good role model.*

Kate, David and Edward compared their mother to a social norm or societal expectation of a parent. In doing so, they framed their mothers in terms of a deficit framework - what they had not achieved as mothers with illness as opposed to a humanistic or personhood positioning. Maria drew further attention to this when stating

> *probably now as I've grown up I've gotten to know my mum a bit more. I didn't really know my mum as a person, I just knew her as a sick lady.*

Alternatively, symptoms or manifestations of mental illness were conceptualized by participants as fundamental characteristics of the parent. Sarah recalled

> *I remember barging in front of the police, in front of Mum and Dad to stop the police to say just don't believe a word that she says. I was so grateful to the police that did listen to me and did take everything that*

she said in the appropriate context. That it is all made up. That not one word is true. That it is very attention seeking sort of behaviour.......The same issues as other adolescents face. We wanted new clothes and our clothes ironed. We wanted the kitchen clean so we would actually do it ourselves. If it was a birthday party being organized which very, very rarely happened. If Mum had overdosed, instead of cancelling it at that time, we'd get money out of her purse and go down to the little shop and buy some soft drink and buy some chips and just shove her in the bedroom and have the party anyway.

Further into her narrative, Sarah conveyed that even when her mother engaged in possible life threatening behaviours, Sarah strived to live her life as normal. She described an incident when she had had a holiday booked. She was expecting to leave for her holidays at the time when her mother engaged in further suicidal behaviours. Sarah revealed that despite the possible pending death of her mother, she decided against rescheduling her holiday. Instead Sarah made preparations to delay a likely funeral until after her return, further demonstrating parental dehumanization from an adult child perspective.

Edward's account provided a deeper understanding of how a parent is positioned within an illness construct

she can be a loving, caring mother, well intentioned, all the rest of it. But then on the flip coin you can get this little delusional section of her life that - it's a beautiful day, it's wonderful - but you know he drugged my - he's taken this or he has done this or someone has done something. It's a delusional part of their persona that believes something has happened, something has been done…..That part, unfortunately, always seems to override - or especially when I was younger - would always override the rational, normal personality that she had. It was a lot more dominant. Those sort of Dr Jekyll and Mr Hyde sort of things, where you can have all the best intentions and then - but these thoughts just sort of slide in and these thoughts are completely 90 degrees from where she would be and go off to ridiculous theories that made absolutely no sense, would just sort of jump in…..They didn't have a schizophrenic mother.

Additionally, Peter, another participant, encapsulated the notion of dehumanization when he highlighted

> *severe depression is what I would term it. That happy person, that very beautiful person that I have in my memory as my mum as a child was no longer there. It was like the shop was open but no one was behind the counter.*

Maria describes her mother as schizophrenic, in essence, omitting her mother's personal or humanistic characteristics.

> *It was before I was born. She was 19 when she had her first nervous breakdown, and she was 22 when she had me. She was schizophrenic from before I was born.*

Additionally, David referred to his mother stating

> *she wasn't the wreck in those years that she was to become later.*

There are other examples in the narratives of adult children describing their parents. Margaret noted her mum as a *"zombie"*, while Maria stated her mother's comments were getting *"wackier and wackier"*. Maria's text contextualised her use of this term.

> *I remember saying to her, you need to start telling the doctor because you probably know that they just come out all wacky comments here and there and you're just like where did that come from? They were getting wackier and wackier and I said, do you tell your doctor this?*

Discussion

For the purposes of this text, dehumanization refers to a feeling, perception or verbal conceptualisation that someone is less of a person or offers less worth or value to society (Haslam 2006). Haslam (2006) developed a model of dehumanization which encapsulated two main forms. He argued that there are "two distinct senses of humanness: characteristics that are uniquely human and those that constitute human nature" (p. 252). The process of dehumanization resulted in people becoming represented in the perceptions of others, as either animals or "mechanistic" (p. 252). Bastian and Haslam (2011) further developed their concept of dehumanization, when they highlighted identity and status as central elements of personhood. In the context of this study, participants altered their perceptions of the parent's

identity and instead positioned their parent within an illness construct. Adult children made many references to their parents as having become the illness in some way. Given this, it seems likely that there is a process of parent dehumanization in some families experiencing parental mental illness.

The notion of dehumanization within the parent and child relationship is complex. Dehumanization enables violence and aggression to others (Haslam et al. 2007). The work of McEwan and Friedman (2016) noted positive correlations between risks of violence towards children and acute mental illness for some, but not all parents. The view of Haslam et al. (2007) that dehumanization of self and / or others enables violence, leads to the assumption that parents also experience dehumanization. Haslam's et al. (2007) position added further complexity to parent and child relationships and supports the need for familial based interventions when engaging with parents with mental illness.

Gwinn et al. (2013) claimed that power can result in dehumanization of others without power. This is important to consider with reference to parental mental illness. Some parents with mental illness, albeit not all, may have experienced mental health hospitalization. A person's admission to hospital may have been facilitated by police, which can generate not only significant distress for the person and their families, but make the person who requires mental health care and treatment "feel like a criminal" (Riley et al. 2011, p. 164). They may have been detained in hospital against their will, possibly resulting in fear and loss (Seed et al. 2016). A feeling of disempowerment for the person experiencing mental illness was a major finding in the work of Seed et al. (2016) who referred to a power differentiation with health professionals. Haque and Waytz (2012) noted that procedures during hospital admission can enhance the dehumanization of people. They argued that dehumanization of people in hospital is widespread, as doctors make attempts to cope with the emotional challenges of their roles. This same phenomenon may account for some degree of the child's and adult child's dehumanization of their parents. Adult children of parents with mental illness can feel an altered sense of self, fearing that they themselves become lost (xxxx et al. 2016). In light of the work by Haque and Waytz (2012), dehumanization of the parent may be an attempt to further preserve their sense of self and cope with the ongoing and unpredictable emotional distress, in the same way medical staff do. Children and adults of parents with mental illness worry about the changing nature of the child and parent relationship (Foster 2010; Petrowski & Stein 2016; XXXX et al. 2016). Dehumanization by the child towards their parent with

mental illness may be a result of worry which may ultimately reduce their personal distress, as this process may generate emotional distance between the parent and child.

Further, previously published findings from this study have illustrated that adult children of parents with mental illness experience community, self and intra-familial stigma (XXXX et al. 2015). The daily stigma experienced by people with mental illness can be so intense that Charles et al. (2017) conceptualized stigma as microaggression. Negative perceptions which others hold about a person can influence how the person views themselves, resulting in non-disclosure of mental illness and limiting help seeking behaviours (Matsea 2017). Individuals experiencing mental illness, may attempt to cope with stigma by keeping secrets (Hunter et al. 2017). This response may alter the emotional connectivity with their families, further contributing to intra-familial dehumanization, particularly for people diagnosed with schizophrenia which is associated with increased social stigma (Berna et al. 2017). Yet stigma is not unique to individuals with mental illness, but is a common experience for their families (Banerjee & Dixit 2017). Negative social stigmas associated with mental illness can negatively influence a child's wellbeing (Kaushik et al. 2017). Given this, the dehumanization process may be generated by a child's desire to distance themselves from their parent in response to stigmas associated with mental illness.

Conclusions

The process of intra-familial dehumanization can influence longer term emotional connectivity between parent and child / adult child. This paper has further demonstrated the complexity of the parent and child / adult child relationship and dynamics when a parent experiences mental illness. Interventions to support whole families with a parent with mental illness are required in all mental health services to foster parental and child relationships. While there has been increasing discourse about familial care, implementation within mental health care remains limited. Yet a core philosophy of familial assessment and interventions for mental health services may reduce the likelihood of dehumanization. Psycho-education for children and families experiencing parental mental illness is paramount to limit dehumanization. Additionally, there is a need for all mental health services to review policies, procedures and practice to limit dehumanization of a parent where possible, as this may further contribute to dehumanization within the parent and child relationship.

Relevance for Clinical Practice

It is important that nurses working in mental health services have a greater knowledge of the dehumanization process between children and parents with mental illness. The study findings reinforced a need for a whole of family approach, to facilitate strategies promoting positive communications between children and parents. This is applicable for all mental health services. This could reduce the risks of, and actual dehumanization processes within families, thus preserving unique relationships between parents experiencing mental illness and their children.

Limitations of the study

Adult children who participated in this study had not received counselling or mental health treatments themselves. Given this, parental dehumanization may be a predominant feature for participants in this study, as the adult children may not have been able to reconceptualise their own experiences. Nevertheless, the study does demonstrate the need for dialogue regarding parental experiences of mental illness to prevent or to lessen the intensity of intra-familial dehumanization where possible.

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