# Motherhood and mental distress: Personal stories of mothers who have been admitted for mental health treatment

## Introduction

This paper aims to contribute to our knowledge of mothers with a mental illness diagnosis and their experiences of admission for mental health treatment. The personal stories are closely related to dominant Discourses of good motherhood defined in terms of presence, caregiving and self-sacrifice (Choi et al., 2005). This study utilizes a narrative approach that focuses on the participants' personal stories and analyzes these stories thematically. Our study describes the mental health service user (MHSU) experience with the support system and provides important clues about admission to mental health services in this group of individuals. In this context, the support system refers to the statutory mental health services and child welfare services rather than community support networks, such as family and friends. The ten interviews of mothers included in this study are part of a larger research project on MHSU involvement, which included 30 individual interviews with MHSUs of three community mental health centers (CMHC) in Norway. User involvement is a legal right in Norway and can be seen as a means of ensuring the protection of MHSU care and treatment. A central part of user involvement is connected to admissions and opportunities to express these treatment wants and needs.

Little research concerning mothers' experiences with admission to CMHCs has been conducted in Norway. Personal stories can yield important clues regarding the aspects of municipal support for mothers diagnosed with mental illnesses that increase opportunities for recovery from the difficulties and suffering that mental distress can produce. The health care system focuses on the mothers' illnesses, and they become invisible as women (Chernomas et al., 2000) and mothers. Personal stories provide a nonmedical perspective and present how women make sense of being both mothers and MHSUs given prevailing norms of good mothering.

The mothers' personal stories of being admitted for mental health treatment can be understood as strongly related to dominant Discourses. The use of the upper case allows differentiation between discourse as talk and Discourse as a body of knowledge. This distinction is an analytic one, which arises from the researcher actively tracing the genealogy of talk (discourse) to a specific body of knowledge (Discourse) (White 1997: 52-53). The 'ideal' mother is one who mothers naturally, who is always and immediately present to care for her children and who does this mothering selflessly (Choi et al., 2005). According to Sevón (2011), these Discourses of good mothering are recognized by most Western women regardless of their nationality, ethnicity, class, age or sexual orientation.

First, we describe previous research on mothers who have been diagnosed with mental illnesses and then present research on dominant Discourses of motherhood. We describe the data and methods with a focus on personal stories. Then, the participants are presented. Next, we analyze the personal stories thematically. We find these themes to be about mothering in relation to being admitted. The results indicate how mothering by women diagnosed with mental illnesses is created within the Discourses of good motherhood. After a discussion, we offer suggestions for improved clinical practice.

**Research on mothers who have a diagnosis of mental illness**

Women diagnosed with mental illness often need help to reach their potential as mothers; therefore, research about and with these women is warranted (David et al., 2011). Studies indicate that mothers with mental illness diagnoses report various positive consequences of motherhood, including increased motivation to seek mental health treatment and enhanced ability to address their psychiatric concerns (David et al., 2011). Research also indicates that these mothers want greater recognition of and support for their roles as parents (David et al., 2011). Blegen et al. (2010) conducted a literature review of 19 studies, including quantitative, qualitative and mixed-methods research, examining mothers with mental illness diagnoses. The authors identify the following three themes in motherhood experiences among the women in these studies:

*the vulnerability of mothers with mental health problems, the fear of being perceived as not good enough as a mother,* and *concern that the children might develop mental health problems.* Blegen et al. conclude that the reviewed studies generally view mothers within the dominant medical Discourse 'in which the mothers' own voice remained silent' (2010: 527).

According to Dolman et al. (2013), qualitative research on mothers with mental illness diagnoses has focused on psychopathology and potential harm to children rather than the experiences and attitudes of these women. The authors performed a systematic review of 23 qualitative research studies on motherhood and mental distress and identified the following nine themes of experiences of motherhood and concurrent mental illness: *stigma, guilt, custody loss, concern over effect on the child, isolation, coping with dual identities, centrality of motherhood, problems with service provision* and *positive aspects of service provision.* As the authors conclude, "research into possible interventions such as preconception counseling, parenting programs and peer support is needed" (Dolman et al., 2013: 44I) because these women have particular needs that must be considered by healthcare professionals.

It is not known how many mothers seek help from CMHCs in Norway today. Nevertheless, we consider research that highlights the specific strengths and needs of these mothers to

promote effective parenting and thereby improve outcomes for both the mothers and their children (David et al. 2011).

**The dominant Discourse on good motherhood**

The Discourse on "good mothering" in relation to illness is reflected in several studies (Montgomery et al., 2006, Malacrida 2009, Power et al., 2011). This discourse may affect how mothers interpret their lives (Sevón, 2011). As mothers, they are typically considered responsible for the health and well-being of their children, and they are judged publically on their perceived mothering skills (Malacrida, 2009; Power et al., 2011). The ideal mother "centers her life around her children to the point of self-sacrifice" (Stephens and Breheny, 2013: 24). These aspects of the Discourse on good motherhood are, according to Stephens and Breheny (2013), historical, political and legal creations that inform personal mother-child relationships in our society. This Discourse provides one idea against which women compare themselves as mothers (Ussher, 1989). Research on mothers with mental illness focuses on maternal characteristics (Montgomery et al., 2006: 21). This focus has led to a neglect of "other contextual variables of mothering" (Montgomery et al., 2006: 21). Over the past decade, scholars have worked to understand the dynamics of motherhood in a broader sense, constructing a more complex understanding of motherhood and motherhood Discourses that both shape and are being shaped by different practices and experiences

(Kawash, 2011). We hope that our research contributes to a more complex understanding of motherhood and mental distress.

**Data and method**

The ten interviews analyzed in this study are part of a larger research project that includes 30 MHSUs at three CMHCs in Norway. The project was approved by the Regional Ethics Committee in 2011. A CMHC is an independent, professional entity that is responsible for a significant part of the general psychiatric services within a geographic catchment area. The MHSUs had experienced considerable changes in their lives because of mental distress, and most of them had been admitted to a psychiatric hospital several times (Klausen et al., 2013). The participants were recruited through a local manager at each center. Information letters were distributed, and individuals who were interested in participating in the study signed letters of consent. The MHSUs could bring a companion if they wished, and some MHSUs brought their contact person from the center. A thematic interview guide was used based on feedback from a pilot interview with a MHSU from a mental health organization. Most of the interviews were approximately 45–60 minutes long. Interviews were digitally recorded, and the sound files were transcribed verbatim. The following transcription conventions were used: an ellipsis … indicates a 1- to 3-second pause; brackets containing an ellipsis […] indicate parts that have been removed; parentheses ( ) provide descriptions of sounds or

phrases from the respondent; and brackets [ ] represent interviewer comments. The stories have been transformed into coherent narratives based on the interviews. This process involves the construction of a comprehensive, condensed narration. Comments or questions from the interviewer has been omitted to improve the coherence of the stories. There were 12 men and 18 women among the participants, and 10 of these women were mothers between 31 and 70 years old. Of the mothers, only Ruth was admitted involuntarily at the time of the interview. The main condition for involuntary admission is a serious mental disorder. The patient must also meet one of two additional conditions: the condition will worsen without treatment and/or the patient might pose a danger to themselves or others (The Directorate for Health, 2008). In Ruth's case, the dangerousness criterion was not involved. The other mothers were either voluntarily admitted or accessed various services under the auspices of the CMHC.

This study employed a narrative approach. Stories are produced, distributed and circulated in society (Gubrium, 2005). Understanding how stories relate to particular social contexts requires an understanding of what those contexts do with words. The same story can have different meanings in different settings. The social consequences of narratives must be understood in relation to what is at stake in the context of storytelling (Gubrium, 2005). In this study, the narrative approach relied on a thematic

analysis of the interviews, which was inspired by the work of Riessman (2008). Telling personal stories opens opportunities to change the past, present and future by virtue of what the storytellers might want to emphasize in the here and now. We define the personal stories within our research as topical life stories (Berteaux, 1981) because they focus on a limited period of these women's lives. Moreover, we draw on Denzin's (1989: 37) definition of a narrative, 'a story that tells a sequence of events that are significant for the *narrator* and his or her *audience*'.

These personal stories are understood and analyzed in relation to the dominant Discourse on good motherhood. Dominant Discourses are blueprints that offer "a way of identifying what is assumed to be a normative experience" (Andrews, 2004: 1). We view the Discourse on motherhood as inevitably woven into personal stories of the lived experiences of mothering. Traditions, cultural norms and values related to good motherhood are, to a certain extent, conditional on what is told, why and how (Wiest, 2013). We agree with Stephens and Breheny (2013) that personal stories about experiences of mothering are shaped to fit with or to justify contradictions within these dominant Discourses on good motherhood. Note that we do not view the female participants as carriers of a dominant discourse on good motherhood. Rather, we consider the interview situations as social contexts in which both the interviewer and interviewee draw upon the Discourse as a "culturally shared stock of knowledge"

(Mishler, 1999: 10) of what defines good mothering to understand the topics of conversation.

*The participants*

Table 1 presents the ten mothers in our study. The mothers have been given pseudonyms to protect their identities. The characteristics included in the table are the mother's age, number of children and whether they were ever in contact with Child Welfare Services after their first admission. We also include their age at the first admission and the reasons they provided for their first contact with mental health services.

Table 1 gives an impression of the participants in the study, and it also helps the reader as he or she reads the different excerpts from the ten mothers to identify which one is telling her story.

*Thematic analysis*

There are different expressions of thematic analysis from within a broad theoretical framework, and one of several benefits of thematic analysis is its flexibility (Braun and Clarke, 2006). According to Riessman (2008: 54), a thematic approach is "suited to a wide range of narrative texts". Considering the mothers' personal stories within a

narrative approach led us to a thematic analysis in which attention was focused on what was said rather than how it was said.

Inspired by Riessman (2008), we performed an experience-oriented thematic analysis. We worked with a single interview at a time, isolating and ordering relevant episodes into many different themes. After having done this with all 10 interviews, we sharpened our focus and attempted to identify common themes for all of the interviews; particular cases were chosen to illustrate certain patterns in range and variation. A theme "captures something important about the data …and represents some level of patterned response or meaning within the data set" (Braun and Clarke, 2006: 82). Using an experience-oriented thematic approach meant that we did not try to fit the data into a preexisting coding frame or any analytical preconceptions. The analysis was, so to speak, driven by the data, the personal stories of the participants and the experiences they focused on in their storytelling.

We present excerpts that are followed with interpretation, theoretical formulation and references to prior theory (Braun and Clarke, 2006: 82). Thus, the analysis is not a linear process; it is a more recursive process (Braun and Clarke, 2006). We moved between the two styles throughout the analysis. This process was central to attempting to understand the personal stories and their complexities of meanings. After having

identified four main themes that described the complex relationship between being a mother and being an MHSU, it was interesting to examine the ways in which these maternal experiences correlated with the dominant Discourse on good motherhood defined by presence, caregiving and self-sacrifice.

**Findings**

During the interviews, it became clear that the women considered their admissions turning points (i.e., significant life experiences). Turning points are episodes during which someone undergoes a change (McLean and Pratt, 2006). These stories are the points at which one comes to understand something new about oneself or faces decisions about different life paths (McLean and Pratt, 2006). Their admissions were points at which these women transitioned from being mothers and members of the community to also becoming MHSUs. Four themes were derived from the analyses, which sought to provide descriptive accounts of the richness, breadth and complexity of participant experiences of being mothers diagnosed with mental illnesses (Tjoflåt and Ramvi, 2013). The following themes were identified: 1. Being able to put oneself in the child's shoes; 2. Being emotionally affected by the admission; 3. Being open with the children about the admission; and 4. Being an emotionally available and present mother.

*Theme 1: Being able to put oneself in the child's shoes*

In their interviews, the women spoke about their ability to identify with the challenges their children face in having a parent diagnosed with a mental illness. The mothers expressed worry about what troubled their children, and they emphasized their need as mothers to minimize the burden of their distress on their children. Women value being good mothers (Tardy, 2000), and being able to put oneself in the child's shoes is one value for these women within the Discourse on good motherhood. One example of this theme is found in an excerpt from Ruth's story. Ruth's children live with her for two weeks a month. She reported that they worried a great deal when she was admitted some years ago:

> I have three kids. I've talked a lot with them. They are so big that I have talked a lot with them about things that have happened to me before, and also the suicide attempt I had during a previous coerced admission, so this time I prayed that no one should know that I was involuntarily hospitalized. They were asked to say outwardly that I was voluntarily admitted, so my kids would not be terrified. But I have talked with my kids afterwards, especially my oldest daughter, and she told me she had a suspicion that I was forcibly committed, but this time they could meet me. And then they became very calm. Previously it has…I have been denied contact with my

> kids, and they became very frightened of it. They knew nothing about what happened, and they did not know what shape I was in.

Ruth expressed unease regarding the effect of her admission on her children. Ruth has been open with her children and has told the children about her earlier admissions. This disclosure worried her children, and when she was admitted this time, she wanted to protect her children by saying that she was voluntarily admitted. She also says that her children became frightened when they were unable maintain contact with her while she was being treated. She wants to protect her children, but she knows that hiding the truth from them will only make things worse. She understands this fact and acts accordingly. She speaks with her oldest child, and the children are able to see her during her treatment. Ruth believes that this contact is good for her children and that being able to see her keeps them calm.

Another excerpt that highlighted the same theme came from Ellinor's story. Ellinor had been depressed for years, and the children never knew what they would find when they came home from school. She had been through many admissions. When we met, both Ellinor and her daughter had been admitted in the same ward. Ellinor said that her children have had a tough life because of her:

> They've probably had it tough. And I think that is reflected today, in my daughter. It is. It is coming. So they've had enough, they've had a burden, where they've had…a mother who has been on and off, and they never knew how they would be treated when they came home. True, "is she screaming? What is she doing?" So I think it probably has been pretty tough for them. Although we have not been talking about these things. I think so. This winter I learned in retrospect, I learned in fact just before last summer, she [her daughter] tried to kill herself twice. So how much she knows and how much she snatched up, she has probably heard me say that I want to die. I think so.

Ellinor had tried to protect her children by not talking about her distress at home. Still, she was worried. When Ellinor says that she has learned her lessons in retrospect, it is likely that she realizes her impact on the children. She says that her daughter has probably heard her talking about wanting to die and notes that her daughter has also been admitted for mental health treatment. Ellinor blames herself, and one interpretation of this excerpt is that silence in the family is like a Gordian knot, that is, a problem that is insoluble on its own terms. Silence was not protecting the children but exposing them to her mental distress. When Ellinor notes this effect during the interview, she is able to put herself in her children's shoes. The excerpts above provide

examples of women attempting to maintain silence about their distress to protect their children, but these children had grown frightened of the silence. The material collected during our study indicates that being able to put oneself in the child's shoes was a shared need expressed by all ten mothers.

*Theme 2: Being emotionally affected by the admission*

An important value among mothers is being able to take care of their children (Power et al., 2011). This value is underlined by stories of the emotional impact of their admissions. The ripple effects of admissions can be serious; the greatest fear might be losing custody. In their personal stories, the women described setting aside their own needs for their children's sake. Today, mothers must find ways to merge societal expectations that they are good mothers with accomplishing their roles as members of society (Tardy, 2000). Our participants told stories about feeling expected to be good mothers and fulfill their roles in society while struggling with their mental distress. Karin talked about restraining herself in meetings with child welfare; she could not tell them how bad she really felt. All they would do is have her admitted, and she was afraid of being away from her son:

> I feel like with child welfare authorities that they really…like follow me with their eyes, how I am, how I seem to be…if I have a bad or good day,

> so I try - yes, to feel good. When I meet them. Afterwards I am totally exhausted.

Karin felt compelled to keep her mental distress hidden in the presence of Child Welfare Services because she was afraid she would lose custody of her son. She describes being in an anxious state whenever she is in contact with the support system. The fear of losing custody, through voluntary relinquishment or by coercion, was described by several participants as related to deep anxiety. Hiding the mental distress that these mothers struggled with became a coping strategy to protect their children. In terms of being a mother who sacrifices everything for her child, Bemiller (2010) emphasizes that mothering is about fulfilling the child's needs and that a mother does everything for her children, including always being present.

Rigmor spoke about hiding from the support system and the community for many years, sacrificing her own needs and health challenges for fear of being admitted. She preferred to hide herself in her apartment and not go anywhere. If no one saw her, then no one could say she was mentally distressed. She talked about would happen with her while she was hiding from everyone:

> Then, you become so withdrawn, and you stop talking eventually. You hide yourself, and when you come out and are able to talk, you talk too much again. It goes in circles. Because you are sitting and hiding so much inside of you. You can say that I am terrified of the winter darkness. It's like a big wolf that shall come and take you away.…I'm so scared of windows, large windows. You feel that you are being watched all the time.

Being emotionally affected by the admission is described as exhausting by the mothers in this study. Rigmor uses metaphors such as "winter darkness" and "wolf" when she describes hiding from the healthcare professionals. These terms are both metaphors for loneliness and are often used as symbols of fear, aggressiveness or hostility. Several mothers spoke about attempting to protect their children from contact with mental health services or Child Welfare Services. The mothers claimed that these worries had exacerbated their fear and anxiety. Protection was part of a negative spiral for several of these mothers. All of the participants told stories about waiting too long to ask for help in their efforts to protect their children.

*Theme 3: Being open with children about the admission*

Our participants emphasized the importance of speaking with children about mental illness diagnoses, and hiding distress from the family was not considered responsible. It

was important for our participants to be present mothers, that is, providing caregiving and being responsible. When the women talked about their admissions as turning points in their lives, they were concerned about how they would be perceived by others (Brown, 2013). Marianne's story addressed how her three children were affected by her mental distress. She wanted the mental health professionals to talk with her children about what was going on. I asked her whether she had missed her children while she was admitted.

> Yes, of course I did, but I just thought that they needed to speak. As much as I have to go to a psychiatrist or a psychologist and chat, the kids have to be allowed to go…they've got so many thoughts in their heads, and I was not able to talk like that with them. I had enough with myself. So Elise, the community clinic nurse here at our home - she has been fantastic for them. She had them in conversation until she somehow thought that (pause) that things looked alright.

Marianne emphasizes her children's need to be listened to by professionals. The children also needed to tell their own stories of their mother's admission; to talk about their experiences, and Marianne felt unable to speak with them about these things. Thus, although she was open with them about her mental distress, she

thought they needed more support. Taking good care of the children is inextricably tied to women's self-worth (Tardy, 2000). Motherhood is a social role that carries momentous moral weight (Malacrida, 2009).

Another excerpt that spoke on the same theme came from Elena, whose 17-year-old son came to visit at the CMHC. As she indicates, she wanted peace while she was admitted, but her son was in town and wanted to visit her:

> I did not say no. They [the professionals working at the center] only explain; they the other patients that "there will be a boy and…" I'll show off the ward and YES. All agreed and no one…Yes, for me it was cozy. But he was scared of it; he said, "typical institution, it is like a prison and…" but you know young people today (laughs). I [also] have a girl who is 20 and one boy who is 15 (uh). I pull myself away. I pull myself away from the entire contact that - (pause) can make me uneasy because of that. I hear them on the phone, so I do not - I'm so sad. It evokes emotions that hurt.

Even though it was difficult to have contact with the children while she was admitted, Elena wanted her son to visit her. She did not hide her mental distress but let her son talk to the professionals at the center about her diagnosis and her admission. The

mothers expressed a need to protect their children from their mental distress but they also wanted them to know what was happening. When they felt they could not talk with their children about their distress, they sought help from professionals at the CMHC.

*Theme 4: Being an emotionally available and present mother*

The mothers in our study felt that their admissions, rather than their mental distress, had interrupted their lives. They were aware that they needed help, but they did not feel that they belonged in mental health services. They were placed in an environment that was foreign while they needed to be physically present and emotionally available for their children. Emotional availability refers to 'the capacity of a dyad to share an emotional connection and to enjoy a mutually fulfilling and healthy relationship' (Biringen and Easterbrooks, 2012: 1).

Being an MHSU created fear, anxiety and feelings of unfamiliarity for all participants. The ripple effects of the admissions had caused major changes in their lives. Being physically separated from their children during treatment made them feel like they were in a strange place. The following was Karin's response when I asked what would be a good treatment for her:

> That's EXACTLY what I am so unsure of, and do I want, do I want to be treated anymore. Am I really patient material? I try living as normally as possible so

> that no ... yes, as I said, especially for his [her son] sake ... yes. Or for the both of us. So I often think that this [her mental distress] is something that will never go away. That I just have to live with it. I have gone to a psychologist for several years and ... Okay, now you sit there and talk and then you go back home and I'm talking with the psychiatric nurse ... but I'm maybe a little, that I am a little scared, let's say I have it pretty bad, but I do not say it…because of him [her son] and I try to be stronger than I am, maybe.

Karin reflects on her situation and the mental distress she is experiencing as an ongoing challenge. She prefers to be a present mother for her son to being admitted for treatment. She struggles with her distress at home, but she is taking care of her son while she struggles. In the interview with Ruth, she explained that she spent her days in the ward while her children were at school but was able to spend time with them at home in the afternoons and evenings. For Ruth, this reflected that the professionals in the acute ward understood her needs and were able to accommodate them so that she was able to remain a present mother to her children despite her mental distress. In all the mothers' stories, the Discourses of good motherhood were evident and there was a need or desire to distance themselves from mental health services if they feared losing custody or involuntary admission. When these women were *not* treated as mothers first

and patients second, they would reject help from any mental health service that did not recognize them as primarily caretakers.

**Discussion**

This paper aims to contribute to our knowledge of mothers diagnosed with mental illness and their experiences with mental health treatment. The participants told personal stories that are interwoven with the Discourse of good motherhood, especially the values of presence, caregiving and self-sacrifice (Choi et al., 2005). These women's stories indicated that they perceived themselves primarily as their children's caretakers (not as MHSUs) and that they understood their distress as natural responses to life strains. In the subsequent discussion, we will examine presence, caregiving and self-sacrifice in relation to the four themes described above.

The importance of presence was underlined in the stories that emphasized the significance of being a mother who wants her children to be involved in their treatment. These women expressed feelings of not belonging to a system that did not view them primarily as mothers. Caregiving is strongly visible in all four themes: attempting to protect their children, setting their own needs aside, waiting as long as possible to contact the support system and wanting the children and family to be able to be more involved in the treatment. Self-sacrifice was evident in the themes of being able to put oneself in the child's shoes and the emotional impact of being admitted. These mothers

told stories within the good motherhood Discourse, that is, they might need help but are not unfit to mother.

How motherhood is experienced depends on the context within which it occurs, and these mothers insisted on motherhood as a relational process rather than an internal process (Cowdery and Knudson- Martin, 2005). The women in our study illustrate the need for new, flexible definitions of mothers that represent a diversity of experiences (Bemiller, 2010). The meaning of mothering must be understood within the mothers' lived contexts (Montgomery 2005). Good motherhood can become translated into practices through which the participants see themselves within a recovery frame; keeping close to their children is linked to a sense of being normal, secure and responsible (Montgomery, 2005). When Ruth could stay at home while she was under coerced treatment and her children were at home with her, she felt that she was participating in her own treatment and that the professionals were taking her motherhood seriously. The mothers looked at their total life situations, not through a clinical lens or from a medical perspective. They made meaning of their experiences within culturally available discourses and drew on existing stories to tell their own. The mothers in our study call for open dialogue with professionals in which losing custody of children and involuntary treatment are not the main topics of discussion.

Admission for treatment and disruption of motherhood are characteristic of a traditional style of psychiatric treatment with an individual patient approach. Being separated from their children during treatment caused loss and grief and exacerbated the mothers' mental distress. Additionally, these mothers seldom had the necessary support to prove that they were adequate mothers (Diaz-Caneja and Johnsen, 2004). According to Alegria et al. (2010), changes are required to develop and implement mental health services that better match diverse families' unique needs.

*Implications for practice*

The primary issue is to create social environments in municipalities that support mothers with mental illness diagnoses. Their roles as present mothers and caregivers should be discussed during the admission process. A contextualizing of the treatment is needed (Chernomas et al., 2000). The first meeting between the mental health professional and mother must establish these women as mothers and create an environment in which they can continue to be caretakers within the context of having been admitted for mental health services. The dominant Discourse on good motherhood naturally affects mothers with a diagnosis of mental illness. The professionals involved should promote holistic teamwork that includes inpatient, outpatient and community mental health services, child services, and social services (Krumm et al., 2013). The social support system should be open to designing plans in partnership with these

women to ensure satisfactory user involvement in treatment. Plans can also include roles for members of community support networks, such as family and friends. Different needs and contexts affect the interpersonal dimension of mental health care (Alegria et al., 2010) and underline the necessity of mental health services and social support systems that focus on the personal and social aspects of both motherhood and mental distress. The mother's experience-based knowledge of her children and family is central during admission, and it is important to identify the family as a part of the overall clinical picture.

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