



MONASH University

***Mothering with mental illness:
A constructivist grounded theory study of gender, identity and
connectedness in personal recovery***

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Abstract

Mothering is a challenging endeavour; universally recognised as a role and experience that is fulfilling, meaningful, and validating, it can also be relentless, stressful and expensive. The social construction of gender is nowhere more profound than in the realm of mothering, where stereotypes abound, shaping expectations and undermining parenting capacity and confidence.

Mothering with mental illness adds another dimension of difficulty, with impacts on the social, emotional and economic resources available to support parenting. While the mental health service system has begun to embrace personal recovery from mental illness as a primary outcome, mothering is rarely considered by services. Developing a positive identity and experiencing strong connectedness have both been found to be significant processes of personal recovery and significant to the process of effective parenting. Little is known however, about how mothers with mental illness experience identity and connectedness, and what influences these processes.

This thesis is situated within a social constructivist framework, informed by the social model of health and feminist theory. Twenty one in-depth interviews were conducted with 17 mothers with mental illness living in rural settings. Their thoughts, feelings and experiences relating to mothering, mental illness, identity, connectedness and personal recovery were gathered and analysed utilising constructivist grounded theory methodology.

The results of this thesis include four publications (chapters 3, 5, 6 and 7); a literature review and publications focusing upon identity, connectedness and

personal recovery. A review of the literature (Hine, Maybery and Goodyear, 2016; Chapter 3) found that identity is rarely defined in relation to mothering with mental illness, although the significance of the mothering role was consistently highlighted as being under continual threat from the illness and effects of treatment, and also from discrimination and from the impact of social and economic determinants such as poverty and gendered violence.

From interview data, the second publication (Chapter 5) highlights key dimensions of personal recovery as 'managing distress,' 'making a change,' and 'feeling better.' Personal recovery was an irrelevant concept for many mothers. Instead, women spoke of persisting through the hardships and demands of mothering and managing mental illness, in the context of scarce resources.

The third publication (Ch 6) illuminated the crucial elements associated with development of personal and social identity for mothers with mental illness. Women defined their identity in diverse ways. Identities could be perceived as positive and socially valued, or devalued when they felt judged by others or viewed themselves as incompetent. Other themes accentuated the parenting role and highlighted a sense of alienation permeating social identity. In 'Speaking out' women had attained acceptance of their 'difference' and had chosen to embrace and use it to challenge prevailing views associated with mental illness.

A sense of connectedness was found to be critical in the fourth paper (Chapter 7), for a woman's capacity for recovery from the devastating effects of relational trauma, and subsequent psychiatric diagnosis. As one's identity is forged within the context of interpersonal relationships, connectedness was found to be a prerequisite for the development of a positive identity.

The findings together, constitute a substantive theory, reconceptualising personal recovery for mothers with mental illness, enunciated in Chapter 8. Services miss opportunities to promote connectedness if they do not prioritise it as a service outcome, and embrace a non-judgemental, strength-based approach. Facilitating healthy, respectful relationships with rural mothers who have mental illness can assist in strengthening personal and social identity, particularly associated with the parenting role. This may also build confidence and capacity for pursuit of other recovery endeavours that will foster wellbeing for rural mothers and their families.

Declaration

This thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

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Publications during enrolment

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Thesis including published works declaration

I hereby declare that this thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

This thesis includes one original paper published in peer reviewed journals and three unpublished publications. The core theme of the thesis is mothering with mental illness and personal recovery. The ideas, development and writing up of all the papers in the thesis were the principal responsibility of myself, the student, working within the School of Rural Health, under the supervision of Professor Darryl Maybery and Dr Melinda Goodyear.

The inclusion of co-authors reflects the fact that the work came from active collaboration between researchers and acknowledges input into team-based research.

In the case of chapters 3, 5, 6 and 7, my contribution to the work involved the following:

Thesis Chapter	Publication Title	Status (published, in press, accepted or returned for revision)	Nature and % of student contribution	Co-author name(s) Nature and % of Co-author's contribution*	Co-author(s), Monash student Y/N*
e.g. 2	Waveforms in systemic arteries	Accepted	60%. Concept and collecting data and writing first draft	1) Albert Einstein, input into manuscript 25% 2) Marie Curie, Data analysis, input into manuscript 15%	Yes No
3	Identity in personal recovery for mothers with a mental illness: A literature review	Published	55%	1) Darryl Maybery 2) Melinda Goodyear	N N
5	Resourcefulness and resilience: The experience of personal recovery for mothers with mental illness	Accepted for publication	70%	1) Melinda Goodyear 2) Darryl Maybery	N N
6	Identity in personal recovery for mothers with mental illness	Submitted	70%	1) Darryl Maybery 2) Melinda Goodyear	N N
7	Challenges of connectedness in personal recovery for mothers with mental illness	Accepted for publication	65%	1) Darryl Maybery 2) Melinda Goodyear	N N

I have not renumbered sections of submitted or published papers in order to generate a consistent presentation within the thesis.

Student signature:



Date: 24 March 2017

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the student's and co-authors' contributions to this work. In instances where I am not the responsible author I have consulted with the responsible author to agree on the respective contributions of the authors.

Main Supervisor signature:



Date: 24 March 2017

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As personal recovery is described as a journey, so it is with undertaking a PhD. Although it differs somewhat in that there is an official end point at submission, in some ways it may be understood as being ongoing, the re-conceptualising and reflecting continuing into the foreseeable distance. One would flounder without the benefits of a supportive environment. Financial support is fundamental and I would like to acknowledge Monash and the federal Government for recognising me as a worthy recipient of the Australian Postgraduate Award.

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Definitions of key terms and concepts

Mental Health Problems and Mental Illness

The Victorian Mental Health Act (2014) defines mental illness as “a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory” (State Government of Victoria, 2014, Section 4). Clinical mental health services in Australia utilise the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (American Psychiatric Association, 2013) as a guide for identification of symptoms indicating mental illnesses and mental health disorders.

Population health researchers (VicHealth, 2005) have developed a broad definition which is congruent with a social model of health: “Mental health problems and mental illness refer to a range of cognitive, emotional and behavioural disorders that interfere with the lives and productivity of individuals” (VicHealth, 2005a, p. 1).

The literature concerned with parenting with mental illness frequently refers to ‘serious’ or ‘severe’ mental illness to distinguish mental illness of an enduring and disabling nature from mental illnesses that are short term and reactive. In general the terms serious or severe mental illness allude to what is commonly referred to as low prevalence disorders (schizophrenia, bipolar disorder, major depression, personality disorders) rather than the high prevalence disorders of anxiety and depression (see for example (Barrow, Alexander, McKinney et al., 2014; Diaz-Caneja & Johnson, 2004; Montgomery, 2005).

Gender

United Nations Division for the Advancement of Women states:

“The term gender refers to the economic, social, political and cultural attributes and opportunities associated with being male and female. In most societies, men and women differ in the activities they undertake, in access

and control of resources, and in participation in decision making. In most societies women as a group have less access than men to resources, opportunities and decision making” (1995, cited in Judd, Armstrong & Kulkarni, 2009, p. 105).

Clinical recovery from mental illness

Emphasises “the invariant importance of symptomatology, social functioning, relapse prevention and risk management” (Slade, 2010, p. 2).

Personal recovery in mental illness

“A deeply personal, unique process of changing one’s attitudes, values, feelings, goals skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness” (Anthony, 1993, p. 13).

Identity

A multifaceted concept, “manifestations of identity exist at three levels of analysis; the subjectivity of the individual, behaviour patterns specific to the person and the individual’s membership in societal groups” (Côté, 2006, p. 8).

Personal identity

Ontorato and Turner (2004, p. 259) define personal identity according to self-categorisation theory, as “‘me’ versus ‘not me’ categorisations - all the attributes that come to the fore when the perceiver makes interpersonal comparisons with other in-group members”.

Social Identity

“Social identity... refers to ‘us’ versus ‘them’ categorisations - all the attributes that come to the fore when the perceiver compares his or her group (as a collective) to a psychologically relevant group” (Ontorato & Turner, 2004, p. 259).

Mothering

“The process of caring for children as their mother, or of caring for people in the way that a mother does” (Cambridge University, 2015).

Mothering identity

A socially constructed role (Hays, 1996) defined by cultural norms that contributes to shaping how an individual views and identifies themselves. Mothering identity emerges when a mother begins to undertake the tasks generally associated with mothering (Mayes, Llewellyn & McConnell, 2011) and is enhanced when the woman feels competent in doing so (Mercer, 1981; 1985).

Connectedness

An individual’s various caring and supportive relationships. Connectedness “...is considered an attribute of the self that reflects cognitions of enduring interpersonal closeness with the social world in total” (Lee, Draper and Sujin, 2001, p. 310).

Hagerty, Lynch-Sauer, Patusky, and Bouwsema (1993) describe the range of circumstances under which connectedness may occur, “when a person is actively involved with another person, object, group, or environment, and that involvement promotes a sense of comfort, wellbeing, and anxiety-reduction” (p. 293).

Connectedness to self (emotional connectedness)

Closely related to the theory of attachment (Bowlby, 1979). The process of coherently interpreting, regulating and communicating internal emotions, this is facilitated by experience of a secure attachment in infancy with an available, emotionally attuned adult.

“Thus, many of the most intense of all human emotions arise during the formation, the maintenance, the disruption, and the renewal of affectional bonds – which for that reason are sometimes called emotional bonds.” (Bowlby, 1979, p. 69).

Phares (1993) emphasised the personal satisfaction resulting from intimate human relationships as being crucial, referring to “emotional connectedness as one of the potential benefits that fathers, mothers, and children could gain from being in a family” (Phares, 1993, as cited in Townsend & McWhirter, 2005, p. 193) Conversely,

“The loneliness of emotional isolation appears in the absence of a close emotional attachment and can only be remedied by the integration of another emotional attachment or the reintegration of the one that had been lost. Those experiencing this form of loneliness are apt to experience a sense of utter aloneness, whether or not the companionship of others is in fact accessible” (Weiss, 1975, p. 1242).

Connectedness to community (social connectedness and belongingness)

Timpone, 1998 referred to social connectedness as “the level of an individual’s integration into his or her social milieu and the fullness of the resulting associative networks” (p. 59). Belongingness is a sense of being an integral part of a social system or environment, derived from personal experience of being involved and connected (Hagerty et al., 1992).

Wilczyńska, Januszek and Bargiel-Matusiewicz (2015) observe that:

“People need a few close relationships for their well-being. Moreover, the quality of relations is more important than quantity. Humans avoid permanent separation (divorce, death) and they hold to relations with present partners (even when the costs of staying in the relationship are greater than leaving) or replace their relations with other ones” (p. 73).

Connectedness to meaning in life

Kearney (1998) developed the concept of empowered connectedness and defined it as an individual experiencing “a sense of having a safe place within a community and a meaningful role to play” (p. 508).

Chapter 1: Introduction

“Being a mother is an attitude, not a biological relation.”

Robert A. Heinlein

“Being a mom has made me so tired. And so happy.”

Tina Fey

“Children are knives, my mother once said. They don’t mean to, but they cut. And yet we cling to them, don’t we, we clasp them until the blood flows.”

Joanne Harris

“Perhaps it takes courage to raise children...”

John Steinbeck

“To be ill adjusted to a deranged world is not a breakdown.”

Jeanette Winterson

“I will be stronger than my sadness.”

Jasmine Warga

“If you trade your authenticity for safety, you may experience the following: anxiety, depression, eating disorders, addiction, rage, blame, resentment, and inexplicable grief.”

Brené Brown

“Anyone who has actually been that sad can tell you that there's nothing beautiful or literary or mysterious about depression.”

Jasmine Warga

“But pain's like water. It finds a way to push through any seal. There's no way to stop it. Sometimes you have to let yourself sink inside of it before you can learn how to swim to the surface.”

Katie Kacvinsky

1.1 Background

The experiences, strengths, challenges and outcomes of mothering with mental illness are becoming increasingly illuminated through an emerging research focus internationally. Studies emphasise the central role that mothering plays in the lives of women with mental illness and the joy, hope, meaning and purpose that being a parent engenders (Diaz-Caneja & Johnson, 2004; Montgomery, Tompkins, Forchuk, & French, 2006). However it is also recognised that mothers with mental illness may confront a myriad of complex challenges emanating from the illness and associated symptoms, effects of medication, social isolation, and lack of support, stigma and discrimination (Hinshaw, 2005). A range of socio-economic factors (Reupert, Maybery, & Kowalenko, 2012) such as poverty (Luciano, Nicholson & O'Meara, 2014), homelessness, unemployment, limited educational attainment and the ever-present threat of losing custody of their children (Ackerson, 2003; Bassett, Lampe, & Lloyd, 1999; Mowbray, Oyserman, Bybee, & MacFarlane, 2002; Mowbray, Bybee, Hollingsworth, Goodkind, & Oyserman, 2005; Thomas & Kalucy, 2002) present further layers of adversity.

The mental illness and personal recovery experience in conjunction with the mothering journey are often construed in the literature as two parallel processes, although they can occur simultaneously for many women. Connectedness theory considers the psychological dysfunction of loneliness and disconnection that often manifest in (or precipitate) mental illness. In addition, connectedness theory illuminates the substantial benefits of robust connectedness for other social and psychological processes. Identity as a multi-faceted construct is far more complex than the motherhood/psychiatric illness dichotomy that is often presented. The

confluence of mothering, identity, connectedness and personal recovery in mental illness, has not previously been deeply and purposefully investigated.

The overall aim of this thesis is to bridge this fundamental gap and increase understanding of how recovery manifests *within* the family context where the social construction of mothering as resource intensive and all consuming (Hays, 1996), can take precedence over addressing the needs of the mother. This thesis presents a substantive theory: Reconceptualising personal recovery for mothers with mental illness.

Chapter one introduces the background to the thesis including the origins of the conceptual framework from which this research stems. The social and cultural assumptions of mothering are explicitly explored, with an overlaying gendered lens. What is known about the experience of mothering with mental illness will then be outlined, prior to an examination of the CHIME personal recovery conceptual framework. This section commences with an introduction to the principles and assumptions surrounding personal recovery from mental illness. Each of the CHIME categories will be outlined, with emphasis on the processes of identity and connectedness upon which this investigation focuses.

Questions of reflexivity are addressed through an overt examination of the experiences and assumptions I bring as a researcher and how they influence my epistemological standpoint and more broadly, my ontological framework, in the section 'Mental illness, mothering and Me'. Finally, an overview of the thesis structure and content will be presented.

1.2 Mothering ideologies

Most women become mothers, with national statistics demonstrating that just 16% of Australian women remain childless into their 40s (Australian Bureau of Statistics, 2008). Nicholson, Biebel, Katz-Leavy, and Williams (2004) estimate that

in the USA approximately 65% of women who experience mental illness in their lifetime are parents, and UK researchers have determined that one in four children have a mother with a mental illness (Parker, et al., 2008), while an estimated 23% of children in Australia have a parent with a mental illness (Maybery, Reupert, Patrick, Goodyear & Crase, 2009).

The processes of birthing and childrearing signify profound and irreversible change necessitating major adjustment in one's social, economic, physical and psychological realms of existence (Maushaut, 1997; Mercer, 2004). Hays (1996) has described the ways in which the ideals of mothering are socially constructed and vary in relation to role and activities according to variables including historical context, culture, social stratification, economic resources available and personal preference. However there are universal elements of the mothering experience that constitute normative social, biological and psychological processes (Mercer, 2004). Oberman and Josselson, (1996) observe that

“Motherhood encompasses a magnitude of experience; it is complex and full of contradictions” (p. 343).

Women from a range of cultures and backgrounds share the love, pride and joy they experience as a parent, along with the agony of sleeplessness in new parenting, social isolation, difficulties in adjusting to the role when it is new, and frustrations in managing all manner of behavioural and emotional issues (Oberman & Josselson, 1996). The role of mother is constantly evolving as the child develops and so a sense of the unknown and a continually shifting landscape is an ongoing theme (Mercer, 2004; Smith, 2010).

The assumption that nurturing children to adulthood is a female role due to the biological imperatives of pregnancy, birth and lactation, has been present for

millenia (Chodorow, 1978). Challenges to this assumption, and the revelation that it emerges due to social and political conditioning rather than being the 'natural' state of gender relations, have arisen and intensified in the 20th century (Chodorow, 1978; Gergen, 1990) and continue to be fiercely debated. The foundations of political, economic and social institutions of nations around the globe continue to be based on the assumption that women will care for children in an unpaid capacity (Hays, 1996; Krane & Davis, 2000).

Feminist theorists have argued that the contemporary Western ideology of mothering is grounded in patriarchal systems of oppression that devalue the role of mother, while embedding social structures to ensure that child rearing is predominantly a female responsibility (Hays, 1996; Krane & Davis, 2000). Hays (1996) purports that a model of 'intensive mothering' evolved as the dominant ideological framework in Western cultures during the latter part of the 20th century and that this is characterised by "child-centred, expert-guided, emotionally absorbing, labour-intensive and financially expensive child-rearing" (p.64).

Furthermore, Hays claims that:

"The ideology of intensive mothering serves men in that women's commitment to this socially devalued task helps to maintain their subordinate position in society as a whole. Child rearing ideologies have also helped to maintain the privileged position of those who are native-born, those who are white, and those who are members of the middle and upper classes" (p.163).

Hays demonstrates the pervasiveness of this ideology for women from a range of backgrounds through her interviews with them. While women with mental illness were not included within Hays' (1996) interview sample, other researchers

(e.g. Seeman, 2010; Krane & Davis, 2000) have argued that within a broader cultural context these women are similarly subjected to these dominant expectations through relationships within their families and through systemic mechanisms of surveillance (Davies & Allen, 2005) such as visits to maternal and child health nurses (Small, Taft & Brown, 2011), child protection frameworks (Bournnell, 2012), media representations of parenting (Venkatarmaran & Ackerson, 2008), and mental health service risk assessment processes.

1.2.1 Mothering and identity

Mothering identity is thought to emerge through beginning to perform 'mothering work', either during pregnancy or immediately after the birth (Mayes, Llewellyn & McConnell, 2011). Furthermore, "maternal identity is characterised by the mother's sense of harmony, confidence, satisfaction in the maternal role, and attachment to her infant (Mercer, 2004, p. 227). According to Mercer (1981, 1985) a woman becomes a mother when she feels competent at undertaking the core responsibilities of the role and feels comfortable with the identity, embedding it autonomously. A sense of congruence and confidence consolidates the transition to a mothering identity as others acknowledge her in the role, and she accepts that the change is permanent (Mercer, 1981; 1985).

Occupational role and competence have been measured to explore mothering identity in a study with a cohort of homeless adolescent mothers (Levin & Helfrich, 2011). Occupational concepts were used to assess the fit between particular aspects of individuals' identity and the tasks or activities they undertook as part of that role. These latter perspectives frame mothering identity as intrinsically linked to the relationship with the baby, perceived competence in undertaking mothering activities and the inter-subjectivity that emerges within the relationship with the infant. This

raises tensions for feminist theorists who have long fought for women's right to an autonomous identity (e.g. de Beauvoir, 1953). However, also contested is the value attributed to independence in identity as a predominantly masculine construct, compared to the inter-dependence which may more accurately reflect the realities and in many cases, the preferences of women surrounding their relationships and social identities (Townsend & McWhirter, 2005).

The experiences of the process of establishing a mothering identity for women who may be marginalised in mainstream discourse, may challenge dominant assumptions regarding how this occurs. Key issues influencing attainment of a mothering identity identified by a cohort of women with intellectual disabilities were not internally driven, but resulted from external factors. These included discrimination and stigma relating to presumed parenting capacity (from family, community and service providers), the potential for social isolation, fear of losing custody of their child and socio-economic vulnerabilities such as poverty and housing issues exacerbating the challenges of child rearing (Mayes, Llewellyn & McConnell, 2011). Chapter 3 of this thesis outlines how these difficulties have been identified as parallel themes for mothers with mental illness.

1.2.2 Mothering with mental illness

Researchers have observed that much of the initial research around mothering with mental illness originated from a child and harm mitigation perspective (Ackerson, 2003; Bournnell, 2012). However more recent inquiry has focused on the subjective experiences of mothers themselves (for example Seeman, 2010 and Montgomery et al., 2005). The ways in which the mental health service system can support parents is a common theme, with mothers who have a mental illness speaking about the positive and negative dimensions of their experiences (Bournnell,

2012). Women define their needs as largely relationship based and refer to the need for continuity in care (Dolman, Jones & Howard, 2013; Nicholson, 2010) as well as system modifications in policy and practice that see mental health service providers proactively address issues of parenting, and sexual and reproductive health more broadly, not as an add on, but as an integral part of their core business (Seeman, 2010).

The subjective experiences of mothers with mental illness was investigated by Montgomery (et al., 2005) who found that mothers frequently choose not to access much needed services due to their fear of being judged and perceived as inadequate as mothers. Their desire to "keep close" to their children and to be identified as 'mother' rather than 'consumer' of mental health services, at times led the participants to neglect their own mental health and parenting support needs. Perceptions and experiences of stigma and a persistent fear of having children removed by authorities are recurrent themes in the literature for mothers with mental illness (Barrow et al., 2014; Bassett et al., 1999; Chernomas, Clarke & Chisholm, 2000; McGrath, Peters, Wieck, & Wittkowski, 2013; Sands, 1995).

Davies and Allen (2005) highlight a two way interaction between the parenting role and a woman's mental health, in that "being forced to relinquish the role of mother, even temporarily because of illness, can cause women to feel a failure and make them vulnerable to experiencing depression and anxiety" (p.369). The theme of motherhood interrupted is also explored by Vallido and colleagues (2010) who included a small number of women with mental illness amongst a sample of mothers who have had their parenting role disrupted by different types of illness. The issues faced by women who have had their mothering role interrupted were similar, particularly in relation to experiencing an unsupportive and dismissive healthcare

response to their emotional distress and guilt around not being able to care for their children whilst in hospital and recovering from illness. Similarly, as seen in women with conditions such as HIV/AIDS, stigmatising and discriminatory behaviour was perceived to impact on the support that women with mental illness felt was provided by healthcare professionals and others in the community around legitimacy as a parent.

Losing custody of their children is frequently cited as one of the most pervasive fears for mothers with mental illness and this is justified, as research demonstrates that they are at increased risk of this outcome (Bassett et al., 1999; Chernomas et al., 2000; Davies & Allen, 2007; Dolman et al., 2013). A complex interplay of factors reduce mothers' access to sources of support while simultaneously placing their parenting under increasing surveillance and stress (Montgomery, 2005). Krane and Davis (2000) argue for greater tolerance of diversity and ambiguity in child protection assessment. They claim that the current child protection risk assessment systems magnify the personal biases and attitudes of practitioners who are grappling with increased complexity, reduced resources and insufficient time for reflective practice.

Risk assessment trends in child protection potentially entrench oppressive relations of gender, culture and class (Boursonell, 2012; Seeman, 2010). Determinations of risk are culturally constructed and white middle class assumptions around the expectations of mothering prevail, resulting in adverse outcomes for ethnic minorities and other marginalised parents. System pressures and lack of resources mean that individual practitioners have less time to get to know families in-depth and make detailed assessment using their professional knowledge and skills,

which results in the most thorough and rigorous decision making outcomes (Krane & Davis, 2000).

1.2.3 Identity and mothering with mental illness

The focus of the first publication within this PhD investigates the scope and construction of 'identity' within literature on mothering with mental illness.

Relationships with children and partners, are at the centre of the parenting role and are also a critical component of identity, thereby identity and connectedness are intertwined. Dolman and colleagues (2013) found in a review of qualitative literature pertaining to mothering with severe mental illness, "identity issues were referred to in the majority of papers" (p.183). For mothers with mental illness living in rural communities, researchers have found that developing a positive sense of identity that includes but is not solely defined by their psychiatric diagnosis and mental health service consumer status can be particularly difficult. Due to increased visibility, women felt they were constantly "being observed and negatively judged (Cremers, Cogan, & Twamley, 2014, p. 100) in one Irish study.

Women with mental illness frequently report the primacy of their mothering role in defining their self-identity (Montgomery, 2005). This identity can be compromised by periods of illness that interrupt their parenting functionality and undermine their confidence (Ackerman, 2003; Diaz-Caneja & Johnson, 2000; Cremers et al., 2014; Mowbray et al., 2001). Mothering identity is also undermined by a lack of recognition afforded to the parenting role and a dearth of support for managing parenting issues in interactions with mental health services (Chernomas, Clarke, & Chisholm, 2000).

1.3 Mental illness in Australia

Mental illness is common, with the most recent estimates suggesting that in any given year, 20% of the population will have a psychiatric diagnosis. Across the

lifespan 45.5% of Australians will experience a mental health problem at some point in their lives (Australian Bureau of Statistics, 2008). The Australian Federal Government defines mental illness as “a clinically diagnosable disorder that significantly interferes with an individual’s cognitive, emotional or social abilities” (Australian Government Department of Health and Ageing 2009). Furthermore, a collective of Australian state governments recognises:

“The risk of developing a mental illness is higher when a person is socially excluded and isolated or experiences poverty, neglect, abuse or trauma; misuses drugs or alcohol; is in poor physical health; or has a physical or intellectual disability.” (Council of Australian Governments, 2012, p. 10).

Approximately 1.9 million Australians received mental health related services in 2010-11 (Australian Institute of Health and Welfare, 2013). People in the 35-44 year age group had the highest rate of service contact per 1000 people. This is an age range comprising people who are commonly in the active parenting phase of life as the median age for women giving birth to their first child in 2010 was 30.7 years (Australian Bureau of Statistics, 2010).

In relation to location and cultural background, “when population size is considered, patients who live in inner regional areas accessed services at the highest rate per 1,000 population followed by those living in remote areas” (Australian Institute of Health and Welfare, 2013, p. 5). Indigenous people accessed services at 2.9 times the rate of non-Indigenous people (Australian Institute of Health and Welfare, 2011), and National statistics indicate that almost a third of Aboriginal adults reported having experienced high or very high levels of psychological distress (Australian Bureau of Statistics, 2008).

Across the state of Victoria, there are a total of 22 mental health service regions providing both inpatient and community clinical treatment services. Of these, 8 are located in rural regions while 14 are metropolitan based. In South Australia, a range of mental health services are provided to residents through community health services and hospitals (Government of South Australia, 2012). Both states are in the process of implementing mental health reforms to ensure compliance with national standards that have emphasised recovery outcomes and an increased focus on the active engagement and support of families and carers (Australian Government Department of Health, 2016). Participants of this study lived in rural locations across Victoria and South Australia.

1.4 Personal recovery

1.4.1 The evolution of personal recovery

Definitions and understanding of personal (as opposed to clinical) recovery evolved from consumer and carer advocacy movements established in the 1980s (Anthony, 1993). Clinical recovery is defined by mental health professionals, characterised by a reduction or remission of symptoms of mental illness, and has been the predominant treatment goal of mental health service systems to date (Lieberman, Kopelowicz, Ventura, & Gutkind, 2002; Slade, 2009). As recently as 1994, clinical recovery was strongly endorsed as the principal outcome of treatment:

“The universal criteria for recovery is defined as no current signs and symptoms of any mental illness, no current medications, working, relating well to family and friends, integrated into the community, and behaving in such a way as to not being able to detect having ever been hospitalized for any kind of psychiatric problem” (Harding & Zahniser, 1994, p. 140).

However consumers of mental health services demanded recognition of their lived experience that recovery is broader and more complex than this narrow medical construction (Deegan, 1996). Emerging, at a time when psychiatry claimed that recovery from “severe” disorders like schizophrenia and major depression was rare (Bellack, 2006; Davidson, Harding & Spaniol, 2005), the establishment of the personal recovery movement was a powerful statement made possible by the solidarity of those with lived experience, who asserted their rights to name and define their journey. Advocates of personal recovery have developed alternative definitions that give prominence to more holistic elements including living “a satisfying, hopeful and contributing life” (Anthony, 1993, p. 13), developing “a sense of integrity and purpose” (Deegan, 1988, p. 15), and building “connection, safety, hope, and acknowledgment of (one’s) spiritual self” (Long, 1994, p.4). Implicit within these definitions, is the assertion that recovery can and does occur even if psychiatric symptoms persist. Since the 1980’s, personal recovery theory has been influential in the Australian mental health sector to such an extent that it is now the guiding principal informing national mental health services policy and practice (Commonwealth of Australia, 2010, 2013). Advocacy for the development and implementation of service systems based on promoting personal recovery, has seen these principles and values also translated into national mental health policy in the United Kingdom (HM Government, 2011; Slade, 2014) and elsewhere across Europe and internationally (Goodyear, Hill, Allchin, McCormick, Hine, Cuff et al., 2015). Mental illness recovery research has been strengthened and expanded to now encompass personal recovery as an evidence based construct (Leamy et al., 2011).

Personal recovery embraces a strength based approach rather than the individual deficit paradigm that is emphasised within a traditional medical model

(Tew, Ramon, Slade, Bird, Melton & Le Boutillier, 2011). However personal recovery literature has also been criticised for articulating too strong a focus on individual attributes and actions, without adequate acknowledgement of the role and influence of political and social structures in limiting or enabling one's recovery (Morrow, Jamer, & Weisser, 2011). Onken, Craig, Ridgway, Ralph, and Cook (2007) advocate for a dual approach that includes supporting the individual while simultaneously addressing the social environment. In regards to connectedness this would include creating "social inclusion and meaningful roles that the person with the psychiatric disability is able to inhabit, along with building inclusive communities" (p. 3).

Read, Mosher and Bentall (2004) are critical of the dominant biological paradigm of mental illness etiology that sees chemical treatment as the primary response. The authors reframe psychiatric symptoms as the consequences of life events – particularly trauma. Furthermore, they argue for a mental health system grounded in humanistic rather than medical roots, supporting people to make meaning and sense of their experiences without labeling behaviour as maladaptive and in need of modification to 'fit' dominant social systems.

This approach is also supported by feminist theorists who advocate for recovery to be viewed through a social justice lens (Morrow et al., 2011). This would lead to increased acknowledgement of issues such as power and privilege and how they operate within mental health service systems. In this context, reforming social policy to address common systemic barriers that impede recovery such as poverty and homelessness (Australian Women's Health Network, 2012) would be viewed as legitimate recovery activities. Practices to follow might then accentuate "the multiple meanings of recovery (political, individual, cultural, etc.) and the ways in which these

meanings play out in an inter-sectorial way with all aspects of a person's identity (gender, race, ethnicity, culture, etc.)" (Morrow et al., 2011, p. 17).

1.5 CHIME Conceptual Framework for Personal Recovery

1.5.1 Overview of the CHIME Framework

The CHIME framework (Leamy et al., 2001) from which this thesis emerges has recently been developed in response to an identified need to create empirical measures that can describe and quantify progress in the key dimensions of personal recovery. Subsequent sections explore the CHIME framework in greater detail, and then investigate the core components of Identity and Connectedness.

The personal recovery conceptual framework was developed following a systematic review and narrative synthesis of 87 studies (Leamy et al., 2011). The CHIME approach represents the first attempt to quantify and synthesize data from existing research on personal recovery to bring conceptual clarity. The authors of the CHIME framework though have recommended the resultant empirical conceptual framework be validated with diverse cohorts (Bird, Leamy, Tew, Le Boutillier, Williams, & Slade, 2014; Leamy et al., 2011). The common characteristics of the recovery journey were documented and tallied (Table 1), while recovery processes were identified and assigned to five categories which emerged during data analysis (Table 2). The first table depicts the individual and transformative nature of the recovery journey, and is reminiscent of a description of the process articulated by Deegan (1988):

"Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again" (p.15).

TABLE 1: Characteristics of the recovery journey (Taken from Leamy et al., 2011, p. 448)	
Characteristics	Number (%) of 87 studies identifying the characteristics
Recovery is an active process	44 (50)
Individual and unique process	25 (29)
Non-linear process	21 (24)
Recovery as a journey	17 (20)
Recovery as stages or phases	15 (17)
Recovery as a struggle	14 (16)
Multidimensional process	13 (15)
Recovery is a gradual process	13 (15)
Recovery as a life-changing experience	11 (13)
Recovery without cure	9 (10)
Recovery is aided by supportive and healing environment	6 (7)
Recovery can occur without professional Intervention	6 (7)
Trial and error process	6 (7)

The degree to which the findings in Table 1 regarding the characteristics of the recovery process have relevance for rural mothers with mental illness, and their experiences and perspectives on personal recovery more broadly were explored in the data collection phase. The second table informed the basis of investigation surrounding women’s experiences of identity development and connectedness, in response to Leamy and colleague’s (2011) invitation for researchers to conduct “research involving more diverse samples of people from different ethnic and cultural backgrounds, at differing stages of recovery and experiencing different types of mental illness (p. 450).

TABLE 2: Recovery processes

(Taken from Leamy et al., 2011, p. 448)

Recovery processes	Number (%) of 87 studies identifying the processes
<u>Category 1: Connectedness</u>	75 (86)
Peer support and support groups	39 (45)
Relationships	33 (38)
Support from others	53 (61)
Being part of the community	35 (40)
<u>Category 2: Hope and optimism about the future</u>	69 (79)
Belief in possibility of recovery	30 (34)
Motivation to change	15 (17)
Hope-inspiring relationships	12 (14)
Positive thinking and valuing success	10 (11)
Having dreams and aspirations	7 (8)
<u>Category 3: Identity</u>	65 (75)
Dimensions of identity	8 (9)
Rebuilding/redefining positive sense of identity	57 (66)
Overcoming stigma	40 (46)
<u>Category 4: Meaning in life</u>	59 (66)
Meaning of mental illness experiences	30 (34)
Spirituality	6 (41)
Quality of life	57 (65)
Meaningful life and social roles	40 (46)
Meaningful life and social goals	15 (17)
Rebuilding life	19 (22)
<u>Category 5: Empowerment</u>	79 (91)
Personal responsibility	79 (91)
Control over life	78 (90)
Focusing upon strengths	14 (16)

Although the structure the CHIME framework provides is one of its key benefits, the categories are not discreet and there is overlap between categories. For example “overcoming stigma” (in Identity) may contribute towards “being part of the community” (under the Connectedness category), just as “support from others” potentially promotes “Redefining a positive sense of identity”. Each of the CHIME processes are significant, as demonstrated by the abundant references to them within the personal recovery literature. All five will now each be briefly summarised,

drawing on this and other literature, before the categories of identity and connectedness are examined in greater detail as they pertain to the current study.

1.5.2 Connectedness

Connectedness within the CHIME framework is strongly associated with peer relationships and support groups. Peers tend to be defined as other people with a mental illness who have also embarked on a personal recovery journey. Reference to relationships is very broad and may capture families (either of origin or of procreation), but may also be extended to incorporate friendships as well as relationships with service providers, especially mental health professionals (Slade, 2009).

The mothering role may be particularly significant to sub-sections of relationships, support from others and being part of the community. Parenting offers opportunities for the development of unique and intimate relationships with partners, co-parents and of course children. The parenting role potentially offers further scope for social connection within one's local community with other parents, through children's education settings and friendship networks, however overcoming stigma is a pre-requisite (Dolman et al., 2013). These community relationships, along with family relationships, may also be complex and problematic for some mothers with mental illness (Perera, Short, & Fernbacher, 2014).

1.5.3 Hope and optimism about the future

Hope has been a pivotal concept within the recovery discourse since its inception (see Deegan, 1996). Within CHIME, hope and optimism about the future are often cited as crucial at the beginning of the recovery journey (Bird et al., 2014; Schrank, Bird, Rudnick, & Slade, 2012), as one moves past the initial phase of being "overwhelmed by the disability" (Spaniol, Wewiorski, Gagne, & Anthony, 2002, p.

328). Hope is defined as “a primary future orientated expectation...of attaining personally valued goals which will give meaning, are subjectively considered possible and depend on personal activity or characteristics (e.g. resilience and courage) and/or external factors (e.g. resource availability)” (Schrank, Bird, Rudnick & Slade, 2012, p. 555). Research conducted with mothers with mental illness have found that being a parent assists in generating hope in relation to the forming of aspirational goals for one’s children and family (Maybery, Reupert & Goodyear, 2013).

1.5.4 Identity

Identity in personal recovery is not well defined, and may incorporate elements of personal and social identity (Slade, 2009; refer also to Definitions of key terms and concepts p.16). This category is commonly described as a process of transforming a sense of self which is dominated by illness and deficit to one that is strength based, and encompassing of a broader range of characteristics and roles. Overcoming stigma, including self-stigma, is a key component of this process, and while some people with mental illness emphasise a return to an identity held prior to the onset of illness, for many it is about redefining a new sense of self beyond the illness (Bird et al., 2014). Tew (et al., 2011) emphasises an increased sense of agency and competence as being critical to this transformation.

The mothering with mental illness literature that reports the subjective experiences of women, reflects their perception of a dichotomy between a mothering identity and a mental illness identity that remain mutually exclusive. Identity as a social, psychological and philosophical construct is vastly broader, encompassing everything “about me”.

1.5.5 Meaning in life

Meaning in life grows within the nourishing environment created through the culmination of hope and optimism combined with consolidation of role and purpose. Emerging from the positive psychology field, Slade refers to the theory of Authentic Happiness (Seligman, Rashid, & Parks, 2006) and lists a meaningful life as one of four types of 'good life'. The Meaningful Life consists of "using your character strengths to belong to and serve something that you believe is larger than just your self" (Slade, 2010, p. 5). Within the CHIME framework meaning in life also includes spirituality (Leamy et al., 2011), attaining valued social roles and coming to an understanding of the mental illness experience (Bird et al., 2014). The structure, responsibility, love and connection of parenting roles have consistently been found to enhance meaning in life (Carpenter-Song, Holcombe, Torrey, & Hipolito, 2014; Diaz-Caneja & Johnson, 2004). The connectedness literature also refers to one dimension of this concept being connectedness to broader life meaning and purpose (Townsend & McWhirter, 2005).

1.5.6 Empowerment

The process of attaining Empowerment is described within the CHIME framework as predominantly individually driven as indicated by the sub-categories of personal responsibility, control over life and focusing on strengths. Empowerment is not defined by Leamy et al. (2011), however participant quotes from the subsequent validation study by Bird and colleagues (2014) suggest that enjoying a more equal relationship with mental health professionals and making informed treatment choices is an important part of empowerment in recovery.

Feminist literature speaks to agency as a core concept and emancipatory task for women in defining themselves beyond narrow and oppressive gender based

stereotypes (Butler, 1990). Foucault's (1977; 1988) writing on the politics of social control, surveillance, and sanctions for deviance have been adopted by some feminists to aid understanding of the social and political mechanisms by which women are subjugated, objectified, and marginalised (Ussher, 1991). Ussher (1991) argues that this contributes towards explaining why such a disproportionately high number of women are diagnosed with depression or personality disorders when they fail to find satisfaction and fulfillment within the narrow roles defined by gender stereotypes.

1.6 Rationale for selection of Identity and Connectedness

The components of connectedness and identity were found by Leamy et al. (2011) to be commonly reported in the literature. In addition, research on mothering with mental illness suggests that identity and connectedness are very important conceptually to the mental health and wellbeing of women who are mothers (Blegen, Hummelvoll, & Severinsson, 2012; Chernomas, Clarke, & Chisholm, 2000; Dolman, Jones, & Howard, 2013). The ways in which mental illness and its effects (including but not limited to psychiatric symptoms, medication, stigma, economic disadvantage and social isolation) impact women's competence and confidence in mothering has been well documented, and have clear implications for the development of a 'positive' identity.

Similarly, relationships with others and connectedness to family and community have been consistently highlighted as key recovery factors for mothers with mental illness (for example, Montgomery et al., 2006; Nicholson, Sweeney & Geller, 1998; Perera Short & Fernbacher, 2014). Within the fields of social and self-psychology, the inter-relatedness of identity and connectedness is recognised,

however the relevance for the experience of mothering in mental illness, has been less well documented.

Identity and connectedness are the most commonly reported categories in the personal recovery literature after Empowerment (Leamy et al., 2011). While empowerment is vital in promoting recovery, women have reported the ways in which their relationships with others have supported them to feel either empowered or disempowered (Nicholson, Sweeney, & Geller, 1998; Perera et al., 2015). A positive identity and healthy connectedness may thereby be viewed as preceding the attainment of a sense of empowerment as underlying protective factors. As will be further enunciated in Chapters 4 and 7, research conducted within the field of self-psychology indicates that identity and connectedness are intimately related, and that a sense of self emerges in the context of social interactions (Lee & Robbins, 1998). For this reason also, considering identity and connectedness together and exploring how they inter-relate within this set of studies makes conceptual sense.

Furthermore, my professional social work experience in clinical mental health and women's health promotion lead me to conclude that identity and connectedness are extremely influential social and psychological processes for women's mental health. Women's behaviour and appearance are monitored from a young age (Ford, 2016; Wolf, 1990) with profound implications for development of a positive identity. For girls and young women, body shape and size, grooming, sexuality and sexual behaviour, emotional expression and communication style, interests and ambitions all closely scrutinised and assessed from infancy (Ford, 2016). Gender bias is ubiquitous and has been shown to be prevalent within families, education settings, employment and politics. It is pervasive in determining how men and boys see girls and women, but also through social conditioning, in the ways that girls and women

view and censor themselves (Fredrickson & Roberts, 1997). All of these factors impact on women's personal and social identities. Internalising problems such as depression, self-harm and anxiety, which are more prevalent in women than men, may be one result of the gendered construction of emotional expression (Rosenfeld, 2012).

Connectedness can be tumultuous for the substantial number of women who experience the traumatic effects of physical and/or sexual violence, which is estimated to be a quarter to a third of the adult female population (VicHealth, 2004). Connection to self, significant others and broader meaning in life can be difficult when women have been historically restricted in terms of their ambitions, opportunities and identities. Attainment of vigorous connectedness relies on relationships that are healthy and reciprocal, and this is not always accessible for many women. So identity and connectedness were chosen as the focus for this thesis, as they are social and psychological processes that, in addition to being identified as significant to recovery, have also been highlighted as important to the mental health of women more generally. In motherhood, both identity and connectedness dramatically alter as women adjust to the maternal role and establish an intimate relationship with their infant and re-negotiate their relationship with significant others, perhaps including their partner or their own parents (Mercer, 2004).

Complex relationships between the two concepts were expected. The possibility of examining them deeply with the potential of beginning to unravel these complexities and deepen understanding in the context of mothering with mental illness, presented an intriguing challenge that I could not resist.

Until recently, research on personal recovery and that conducted around parenting with mental illness had remained disparate (Maybery et al., 2015; Nicholson, 2014). The set of studies that comprise this thesis will contribute towards bridging this gap by exploring selected components of the Leamy (et al., 2011) personal recovery conceptual framework to a specific population group; mothers with mental illness who are living in rural contexts.

1.7 Mental illness, mothering and me

Within constructivist and feminist research methodologies, the researcher is commonly embodied and visible in the processes of data collection and analysis, overtly conscious of their own subjectivity so that "understanding of respondents' meanings emerges from a particular viewpoint and the vocabulary that we invoke to make sense of them" (Charmaz, 2008, p.90). I present this section to overtly acknowledge what I deem to be the significant elements of my own subjectivity. I arrived at the data collection process for this study as a woman in my early 40's, living rurally, from an English speaking background and mother to four children. I envisaged sharing some characteristics with participants in the research undertaken. This, I perceived as a positive, as commonalities in relation to social location may support the development of trust and rapport, creating a safe and supportive space for women to speak more openly of their experiences of mental illness, motherhood and recovery (Ramazanoglu & Holland, 2002).

My subjectivity, including professional social work experience in mental health and women's health promotion fields also shaped the data analysis process. A particular language and understanding emanating from my professional background, was brought to the process of social construction of meaning. This gender, diversity

and equity lens was applied to descriptions of the social and psychological phenomena, being imparted by mothers with mental illness.

As a critical study, a social justice lens was fundamental to my selection of this cohort and examination of the issues surrounding gender and oppression. A core intention of critical research is to overt implicit assumptions that are perpetuated within social systems, to question and seek to explain them, in the context of recognising who in society has dominant power and voice, and who may be marginalised or even silenced (Mazzei, 2007). Critical research is undertaken with a view to making changes in the way phenomena are understood and inequalities are reproduced (Wilkinson, 1997). Rather than being a flaw in the research methodology, this overt acknowledgement of the researcher's subjectivity is thought to build trustworthiness into the process (Harding, 1993).

Issues of power within the interview procedures also need to be overt in critical studies, and even in social constructivism, as it is ultimately researchers who “name the researched in a number of ways, by deciding how to interpret and then to represent individuals and groups” (Thien, 2005, p.79). Participants, and particularly women living in rural communities are accustomed to censoring their responses, particularly relating to how they define their personal and social identities (Bennett, 2005). Indeed, there are heavy social sanctions for non-conformity to ideologies regarding rural constructions of femininity (Dempsey, 1992). Even so, interviews conducted with thoughtful consideration as to how to acknowledge and reduce power differentials, provide opportunities for rural women to “speak for themselves, resist assumptions” (Bennett, 2005, p. 72) and the reflective processes required for participation in qualitative interviewing can create a space for women to consider and articulate their own self-identity. Haraway (1997) advocates a role for feminist

researchers in challenging or changing the dominant stories, as a valid mechanism for deepening inquiry and allowing for consciousness raising. She critiques the claim of an objective disembodied (white, European male) 'modest witness' which proliferates in historical re-telling of the history of scientific endeavour.

The 'taken for granted' assumptions regarding experiences pertaining to the research questions may often remain unspoken. This is a particular risk if research participants believe the interviewer shares experiences, perspectives or characteristics. Key issues may be overlooked as the speaker assumes the researcher already 'knows' these things. Feminist researchers have highlighted that "who is listening, as well as who is speaking, becomes an essential consideration, as through this relationship a narrative account is produced interactively, depending not only on the questions of the interviewer and the experiences of the narrator, but also on the 'social location' of both" (McClellan Taylor, Gilligan & Sullivan, 1997, p. 234).

However connection and trust involves more than simply sharing some characteristics, and relates to one's foundation attitudes, values and practice as a researcher, that together combine to form a particular stance. To more fully appreciate and understand the stance I practiced in the interactions with women participating in this study, additional details about my background and how experiences and circumstances have influenced my ontological position and epistemology, may be useful, and so are described here.

I believe I was born with innate curiosity and a strong sense of justice and equity. These have always permeated my world view, my compassion and empathy grew from this fertile place, nurtured by my gentle, thoughtful and supportive parents. As my father worked within the psychiatric setting, visits to his workplace during the 1980s often involved observing adults in heavily medicated states, wandering around

in the grounds of the psychiatric facility. As a child I was both fascinated and terrified by the vacant stares and mechanical movement of these people.

I still remember in my early teens picking up a brochure from my Dad's office, featuring the Cunningham Dax collection and a particular image and prose created by a woman (who was not acknowledged in the publication) with a diagnosis of schizophrenia who talked about her "fragile eggshell life". I was drawn towards stories of mental anguish, and was enthralled whilst studying Sylvia Plath's 'The Bell Jar' in year 12 English Literature class. By this time I was experiencing my own difficulties, feeling alienated from my peers and being subjected to social exclusion by the 'popular girls' who did not appreciate me speaking out about some of the injustices I saw. I learned to keep my mouth shut for a time, and hoped they wouldn't notice me.

In reflecting on my final years at secondary school I would now say I was depressed. I was often teary, felt alone and different and had persistent suicidal ideation. I never told anyone. I remember one Christmas day, sitting alone in my grandparents' lounge room, listening to the laughter of my relatives in the next room, with tears streaming down my face thinking "what's wrong with me?" No one is meant to be sad on Christmas Day. Two weeks prior to final exams, I received a phone call from a friend to notify me that a close mutual friend of ours who had left school earlier in the year, had suicided. There is no English word to describe my shock – I thought / was the only one who felt that way. My anger and guilt overwhelmed me and I was extremely hostile with the social worker in the debriefing session that the school arranged for us. There was one single group discussion, and that was the extent of the support offered to me by the school and my family. However being involved in writing a eulogy printed in the local newspaper and

attending the funeral did assist in processing the grief. It was through connecting around our mutual relationship with this friend, that I met my husband-to-be and we supported one another through this and other tragedies.

After leaving school things improved. I took a gap year and my father arranged for me to work as a cleaner at the psychiatric facility where he was human resources manager. This was a wonderful opportunity to sample the mental health sector. I observed the roles of all of the medical, nursing and allied health professionals and selected social work as the discipline most closely aligned to my interests and values. I was stunned that people stayed in the 'acute' ward for 6 months or more. I was horrified that staff allowed one talented artist to leave her paintings outside in all kinds of weather, to be destroyed. I thought they should be framed in a gallery. I drank strong Turkish coffee at lunch time with the predominantly Greek and Italian middle aged women who I worked with, and I learned how to crochet as this is how they spent their breaks.

Commencing university the following year, my undergraduate social work electives reflect my ongoing passions – I chose mental health, a unit on working with Aboriginal people, and women's issues. At the beginning of my final year I became pregnant and apart from delaying my final placement, was supported to be able to complete my degree with my cohort. My last written assignment was in the mental health subject, and in between breastfeeding, nappy changing and snatching short bursts of sleep, I wrote a critical essay deconstructing the medicalisation of post-natal depression, a condition that I believed could easily be explained by the mammoth task of simultaneous physical, psychological and social adjustment that having a baby entails. At that point, I was not even cognisant of the additional impact of unresolved trauma upon many first time Mums. My lecturer, a psychiatrist by

training, was also encountering mothering for the very first time, and agreed with my arguments.

So I was a new Mum at the same time I became qualified as a social worker. Although concerned that I wouldn't know how to care for a tiny infant, my greatest fear during pregnancy was - what if I don't immediately love my child? For me, fortunately this was not an issue and I instantly 'bonded' with my daughter and those early weeks were blissful as we transitioned from being a couple to a family (or so they seem now in recalling them 20 years later!).

In initial social work roles in foster care, youth work and child protection, I encountered parents struggling with difficult and complex issues, often with mental illness in the mix of challenges. I then had a second child, and once he was 6 months old, became employed for 5 years in psychiatric disability support and rehabilitation, co-facilitating the organisation's first 30 week Boston University Psycho-social recovery group program. I read John Watkins (1998) 'Hearing voices: a common human experience'. I sought out opportunities to work with people who may hold diverse world views which resulted in me building strong collaborative and personal relationships with people within local Aboriginal communities which have been sustained and strengthened over time. Supporting young people facing homophobic attitudes as they negotiated alternative (to the heterosexual norms) sexual identities was another privilege that further expanded my understanding of the ways in which society constructs 'otherness'. Community development was a strong interest, and I facilitated a community radio program, art exhibitions and other events in collaboration with service users, all designed to reduce mental illness stigma in our rural communities.

At this time, I became aware that my younger cousin was facing difficulties in caring for her new daughter. At 11 months of age, this little girl was about to be placed with her second foster carer, a distance from my cousin that would mean less frequent access visits, and a reduced likelihood of reunification. I hadn't known child protection was involved, as my cousin had carefully concealed this from me, arranging occasional visits with me that were carefully planned to coincide with her access visits with her daughter. She did a convincing job of pretending everything was 'normal', telling me what I expected to hear. With her permission, I got in contact with child protection and learned that my cousin had significant mental health issues, limited family support and that she had not had custody of her baby for the last 8 months.

She asked me to care for her daughter and I agreed. Although every effort was made to achieve reunification, this was not possible, and as this child grew older, the damage of switching to different homes was becoming increasingly apparent. At the age of 3 and a half she came to permanently live in my family, enriching our lives immeasurably. I bore witness to the ongoing grief and anguish of this outcome on my cousin. I was torn, but had to be consciously child focussed in order to make sound decisions that would not only keep this little girl safe but also enable her to thrive.

My next professional role was a women's health promotion position, where I engaged in advocacy and policy development, designed and delivered professional development training and worked at a systemic level to redress gender based inequality and oppression. With a priority of mental health promotion, working towards prevention of violence against women was the focus of much of this work.

The powerful stories shared by courageous women of survival and struggle in the context of family violence at public events we organised, have stayed with me.

In my own home, my husband's heavy moods and pessimism were wearing me down, and I initiated a separation. In March 2008, whilst still in the process of negotiating living arrangements, just two weeks after I had voiced my desire for a separation, he suicided, leaving me instead, along with our three beautiful children.

My mothering role had been at the forefront of my identity for 11 years. My professional identity was also significant, but now I was also a widow. The grief was overwhelming. An avid journal writer in my teens, I again turned to writing and composed a number of poems that capture the emotional turmoil of this time; the process of creative expression was incredibly therapeutic.

I found out what connectedness really means when people I hardly knew were so supportive and comforting, while people I had thought were close friends were conspicuous by their absence. There was a lot of blame and cruelty as relatives dealt with their own emotions in various unhelpful ways.

A close colleague recognised my post-traumatic reaction when I disclosed flashbacks of finding my husband, and promptly linked me up with an extraordinary counsellor who listened, sat with my pain, respected my needs, corrected my misconceptions and always put me together again emotionally, before the end of the session. This experience of receiving high quality psychological support, has transformed me into an avid 'help seeker' and I no longer have any hesitation in accessing support services to address the social or emotional issues my family at times encounter.

The first 12 months following my husband's death were the worst, and the month of the anniversary each year raises powerful feelings of sadness and regret.

In the first 6 months I heard a voice and it repeated one message, “you’re dead at the core”. I didn’t tell anyone at the time, and I wasn’t distressed by this. Somehow, intuitively I knew that the voice was telling me that a fundamental part of me was empty and deplete, and it would take time and effort for me to regenerate. This was of course years prior to Dr Eleanor Longden’s 2013 TED Talk on ‘The voices in my head’, but when I eventually did, it had great resonance for me.

I grieved healthily and openly and encouraged my children to do the same. I know that they found it difficult to see and hear me cry, but they also knew the reason, and had lots of support from the extended family, at school and in our community. They are now compassionate, resilient young people with diverse skills and strengths and it is delightful to be seeing them blossoming and forging their own paths in the world.

Our family now also includes my current partner, who is Aboriginal, and our son, my youngest who is now 5. He is the connective force that makes our family work. His birth had a profound impact on each of us, bringing life and joy where death and absence had dominated. As a mother, my confidence and competence was strong with my fourth child, and yet still there were occasions when my son’s 3 year old raging tantrums would completely deplete my substantial parenting resources and the unexpected thought would strike me ‘I don’t know what to do’. What I did know though, was that this moment of helplessness would pass, as would many other mothering moments imbued with anger, laughter, sadness, elation, hope, fear, worry and anticipation. And above all, each of these motherly emotions would be saturated in love.

So as women have been reflecting during the intensive interviews on their views of what factors have contributed towards them developing mental illness and

supporting their personal recovery, in a parallel process I've reflected on how I have managed to avoid descending into that dark place, despite being on the cusp a number of times. This thinking always leads me back to the social determinants of health. I have had the benefit of a healthy early life, strong connection to my nuclear and extended family, stable housing, economic security, a sound education, I've not had to contend with racism or homophobia, and have had ready access to transport and healthcare. Most of the women who participated in this study have not been as fortunate, however regardless of this, they too have rich stories of endurance and survival. And of course this is not the whole picture, as many people have far more trauma in their lives with significantly fewer resources and yet still manage to escape developing major mental illness.

I do not have a mental illness. I have experienced mental distress. Had I arrived at a mental health intake desk in a state of distress, perhaps this would be different. I question the usefulness of diagnostic medical labels and I believe in the power of the personal story. I am a Mum. I live rurally. These things I bring to the research arena. These experiences have undoubtedly shaped the research process, just as they shape my life. Does that make the research less objective, more subjective? Yes, absolutely. Does this therefore mean the data analysis and findings are less credible, reliable, trustworthy or valid?

Qualitative research methodologies would indicate that this is dependent on what mechanisms were put in place to promote critical reflection and avoid the enmeshing of women's accounts in the data, with the researchers' own experiences and views. Details of the quality appraisal and reflexivity systems embedded within the research methods, appear in chapter 2 (p.75).

1.8 Thesis overview

As a PhD including publication, this thesis contains four published (or in press) articles, with linking chapters to provide a coherent narrative. The overarching aim of this thesis is to explore two distinct components of the processes described within the CHIME framework, for a particular population group. Factors associated with 1) Identity formation and 2) Connectedness were investigated for mothers with mental illness who live in rural settings. Figure 1 sets out the chronological and structural framework within which the studies took place.

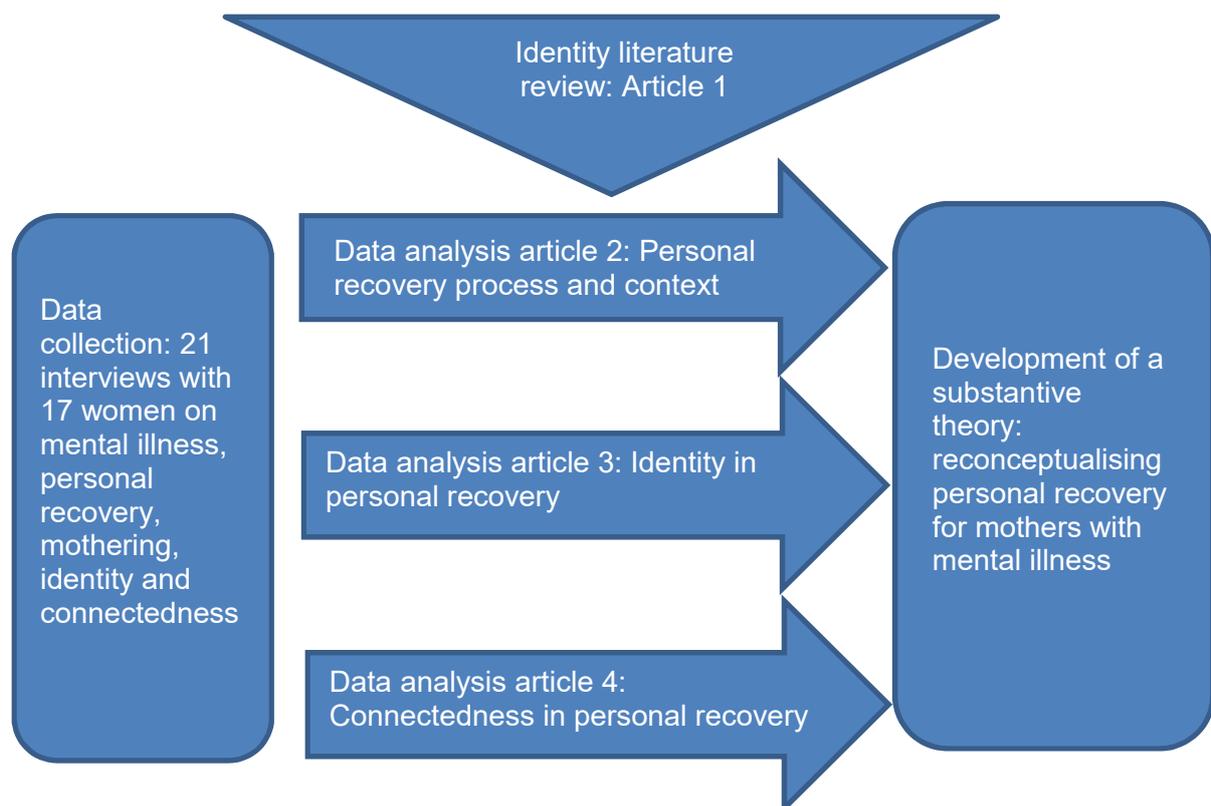


Figure 1: Research structure and sequencing.

Chapter 2 sets out the underpinning conceptual framework along with a detailed account of the CGT methodological approach of the thesis. Chapter 3 comprises Article 1: 'Identity in recovery for mothers with a mental illness: A

Literature Review', while Chapter 4 examines the literature on connectedness and mothering with mental illness.

Chapter 5, 6 and 7 present the three studies emanating from the 21 intensive interviews with 17 participants who were all mothers with mental illness, living in rural settings. Article 2 (Chapter 5) is entitled 'Resourcefulness and Resilience: The experience of personal recovery for mothers with a mental illness'. 'Identity in personal recovery for mothers with a mental illness' follows this (Chapter 6), while the final published article is 'Challenges of connectedness in personal recovery for mothers with mental illness' (Chapter 7).

Chapter 8 is the concluding chapter. This final chapter outlines what this PhD thesis adds to the existing literature, summarises the main research findings, presenting a reconceptualization of the personal recovery process for mothers with mental illness. An evaluation of the overall research process including the limitations, and recommendations for further research and for policy and practice conclude the thesis.

This introductory chapter has acquainted the reader to the background of the thesis including the underpinning concepts and foundational assumptions. Chapter 2 aims to orientate the research within a conceptual framework, as well as examining in detail the methodological approach underpinning the methods and processes undertaken.

Chapter 2: **Conceptual framework and methodology**

“Feminist research *disrupts* traditional ways of knowing to create rich new meanings” (Hesse-Biber, 2012, p. 3).

2.1 Introduction

All qualitative research emerges from prior knowledge systems; from assumptions regarding what constitutes knowledge, and the ways in which knowledge is produced and transmitted (Green & Thorogood, 2014). Theoretical frameworks influence the research questions and shape the methodology, and subsequently new theory may be generated through the research process, revising or expanding previous theoretical notions (Sandelowski, 1993; Charmaz, 2014).

This chapter provides details of the conceptual framework underpinning the research as well as the methodology informing the research processes. A rationale for the decisions made around methodology and conceptual framework selections are also briefly discussed, and are derived from a unique ontological perspective, shaped by my personal and professional background and experiences, as outlined in the previous chapter.

2.2 Conceptual framework

2.2.1 Theoretical approaches underpinning the thesis

This thesis is embedded within an approach that is both critical and social constructivist, informed by two theoretical models that are complementary; the social model of health and critical feminist theory, drawing on feminist social psychologies (Wilkinson, 1997). Social constructivism is based on the premise that all meaning is constructed. Rather than one objective and knowable ‘truth’, there are multiple social realities that are influenced by individual perspectives based on one’s unique life histories and shaped by race, class, age, gender, sexuality and disability (Charmaz, 2014; Denzin & Lincoln, 1998)

Critical theory is also grounded in the assumption that political and social conditions are constructed. However critical theory goes beyond the exploration of social construction, to explain the production and reproduction of power and oppression, with the explicit aim of creating change (Gladstone, 2016).

While feminism and the social model of health inform the gender and equity paradigm that is embodied within this proposal, constructivist grounded theory methodology was employed to guide the overall research design and methodological processes (see research methodology section for more detail, p. 61). These approaches are outlined below.

2.2.2 The social model of health

The social model of health broadly informs the research, as a theoretical approach that describes the ways in which individual health outcomes are influenced by a range of socio-economic and environmental factors over which they have limited control (Wilkinson & Marmot, 2003; Dahlgren & Whitehead, 1991). The social determinants model is a useful approach to aid understanding of health inequalities both between different countries and across different population groups within individual nations (Pickett & Wilkinson, 2009).

The social model of health was selected because it advocates a redirecting of resources towards those most in need, and provides a framework for conceptualising health outcomes at the macro level, enabling the identification of vulnerable population groups and explaining how this occurs within nations and between countries. Examples of social determinants include early life experiences, access to housing, employment and education and exposure to discrimination and violence. Characteristics such as gender, age and ethnicity also have a bearing on health outcomes across large populations (Wilkinson and Marmot, 2003).

Researchers from the Victorian Health Promotion Foundation have identified three key social determinants of mental health as being freedom from discrimination, freedom from violence and social inclusion (VicHealth, 2005a; 2005b; 2005c; 2006). Social exclusion can begin early in life, for example as a result of bullying at school, or can result from life events in adulthood such as homelessness. However on a broader level:

"Social exclusion also results from racism, discrimination, stigmatization, hostility and unemployment. These processes prevent people from participating in education or training, and gaining access to services and citizenship activities. They are socially and psychologically damaging, materially costly, and harmful to health. People who live in, or have left, institutions, such as prisons, children's homes and psychiatric hospitals, are particularly vulnerable" (Wilkinson & Marmot, 2003, p. 16).

Other social determinants that have been recognised as influencing personal recovery are the social gradient, stress, early life trauma or disadvantage, work and "structural barriers such as racism, sexism and homophobia... these factors help perpetuate systemic discrimination" (Morrow et al., 2011, p. 2).

Researchers concerned with parenting with mental illness have begun to consider a broader social determinants approach that takes account of the social, economic and political factors that impact on the resources that women with mental illness have at their disposal to support their own health and wellbeing and that of their children:

"Overall, within a prevention approach where a range of determinants of mental health interact, services need to focus on increasing the positive determinants

impacting on the child and family wellbeing ...while at the same time reducing risk factors for poor outcomes for the child and family” (Reupert, Maybery, & Kowalenko, 2012, p. 9).

2.2.3 Gender as a determinant of health

One of the most powerful and dynamic of the social determinants is gender. Gender inequalities dictate the construction of social rules that place women in a disadvantaged position (World Health Organisation, 2005). Through social conditioning, gender influences the social, political and cultural norms that underpin attitudes and values of individuals, governments and institutions. These in turn, "exert deep and powerful influence" (VicHealth, 2014) on decisions regarding social structures and the distribution of resources at the individual, family, community, national and international level.

Selection of the study cohort (rural mothers with mental illness) is reflective of the gender and equity lens underpinning this thesis, and an awareness of the disadvantaged position of women with mental illness in Australian society, both economically and politically. According to Tew (et al.,2011) “there is an urgent need for...research on how women negotiate potentially oppressive gender stereotypes within their recovery journeys – potentially drawing upon a broader context of feminist research and practice, both within social work and more widely” (p. 7).

Gender is recognised as influencing both daily living conditions and long term health outcomes. Biological factors such as hormone levels and genetic inheritance also affect mental health outcomes, but as the third realm of influence in the bio-psycho-social approach, the social determinants have received significantly less focus and acknowledgement in mental health recovery literature (Read, Mosher & Bentall, 2004; Morrow et al., 2011).

Discrimination against women is deeply embedded in culture and can therefore be subtle and remain unchallenged. Traditional social norms limit women's capacity by "valuing them principally for their sexuality and child-bearing ability" (Bolton, Main & Rugkhla, 2009, p.4). Fine and Addelston (1997) highlight that within the discipline of psychology, "psychological difference has been invented and then appropriated to justify exclusion (of social and political institutions), and to occlude questions of gendered power" (p. 68).

Important determinants of mental health for women include experience of violence in childhood and adulthood, and resultant trauma that can lead to homelessness and substance abuse (Australian Women's Health Network, 2012; Morrow, 2002). Gender shapes women's experience of violence and discrimination, their income level, the type of employment they undertake, housing access and options, their experience of infancy and early life, transport options and aspects of the built environment in which they live (Australian Human Rights Commission, 2014). Vulnerability to mental illness is heightened as risk factors increase and protective factors diminish. For women with mental illness, these factors subsequently influence their access to mental health services and alternative treatment options, social support, safe and secure housing, vocational opportunities, and other resources that can facilitate recovery.

The experience of mental illness is gendered in relation to proportionate representation of men and women in prevalence figures for different diagnostic categories (World Health Organisation, 2005; Read, Mosher & Bentall, 2004). Prescribing of medications and access to other treatments are also indicative of gendered assumptions operating at an individual practitioner level and also at systematic and cultural levels (Bolten, Main & Rugkhla, 2009). As Read and

colleagues (2004) argue, the gender and diversity blindness that afflicts psychiatry as a profession, may make women more susceptible to being diagnosed with a mental illness. For women whose behaviour is deemed to be outside the boundaries of gender norms constituting appropriate expressions of 'femininity', the risk of diagnosis may be even higher (Bushy, 2008; Chesler, 1972; Ussher, 1991). Residual historic cultural assumptions prevail around mental illness as evidence of deviance (Savvidou, Bozikas, Hatzigeleki & Karavatos, 2003). These are the underlying stigmatising attitudes that mothers with mental illness are thought to confront constantly.

The gender and equity lens is embodied within the research process, the authors' subjectivity being recognised as influential in shaping the overall design, inclusion and exclusion criteria and the emphasis on collecting accounts of women's voices (Harding, 1993). Feminist research methods are diverse and have been developed for application across the spectrum of quantitative and qualitative paradigms (Reinharz & Davidman, 1992). These methodologies are apt as they encompass an approach grounded in the feminist movement that describe and critique dominant social and political relationships, highlighting the perspectives of marginalized women that are often silenced in the authoritative discourse surrounding the social and political sciences (Ramazanoglu & Holland, 2002).

2.2.4 Feminist research approaches

Feminist approaches to research represent one strand of the women's movement concerned with gaining gender equality and liberation from the dominant patriarchal social and political structures (Wilkinson, 1997). Feminist theories reveal traditional positivist scientific models to be value laden rather than objective as often claimed (Ramazanoglu & Holland, 2002), as all knowledge is grounded within

complex interactions that are socially constructed and dependent on the subjectivity of the researcher. This viewpoint is consistent and validated by the foundational assumptions of constructivist grounded theory (refer to table 4).

In the tradition of social constructivist thought, feminist standpoint theorists claim that knowledge is socially situated, that women and other groups who are disempowered have a unique vantage point that enables them to question, compare and reflect on the circumstances of their lives and that research concerned with power relations should begin with the lives of those who are marginalised (Harding, 1993; Maynard & Purvis, 1994). Furthermore, Olesen (2011) asserts that the development of a range of feminist research methodologies has positioned “feminist qualitative researchers to address enduring and emergent questions of gendered social justice” (p. 129).

While the social model of health and feminist standpoint theory provide a lens through which the phenomena and research questions have emerged and been framed in this thesis, assumptions and prior knowledge were “set aside” (Sandelowski, 1993, p. 215) during data collection and analysis, to ensure the research was grounded in the data. The specific reflexive strategies employed to facilitate this bracketing of personal knowledge and belief systems, are articulated in the section on trustworthiness of the methods, beginning on page 73.

The research methodology and methods were informed by a constructivist grounded theory approach (Charmaz, 2014). The research methodology and procedures will be detailed in the following section.

2.3 Methodology

2.3.1 Introduction

Three of the four publications in this thesis are informed by qualitative methodologies. The fourth a systematic review of the literature. Qualitative methodological frameworks for the interviews have been selected on the basis of efficacy and in gathering data to generate a conceptual understanding of the phenomena under investigation. This chapter will begin with an outline of the methodological processes which were employed to conduct the literature review (Article 1: Chapter 3). Constructivist grounded theory will be summarised and the methods for gathering and analysing data from participants explained. A rationale for the selection of this particular methodological framework will also be provided, along with the mechanisms for ensuring trustworthiness that were embedded in the processes.

2.3.2 Iterative review methodology

The literature review on identity in personal recovery was undertaken utilising an iterative review process (Whittemore & Knafl, 2005), including critical analysis (Montgomery, 2006) of the emergent data. One strength of iterative review methodology is that it employs systematic search processes to identify relevant articles which can be theoretical as well as empirical and from both quantitative and qualitative paradigms. This enables a broader examination of the literature than traditional more restrictive forms of systematic searching.

The analysis process developed by Whittemore and Knafl (2005) draws on qualitative methodology and has added rigor compared to iterative processes previously utilised. This technique involves the development of a matrix that is informed by the research aim and questions. Constant comparative analysis of content drawn from the articles is facilitated by this method.

Table 3 provides an example of how this process was employed in the analysis phase within the systematic review. Following completion of the identity literature review, constructivist grounded theory methodology was employed for gathering and analysing participant data in the remaining studies.

TABLE 3: Example of literature analysis matrix for identity in personal recovery for mothers with mental illness

Paper	How is the concept of identity constructed and defined?	How does MI impact on mothering identity?	How does motherhood either support or hinder the development of positive identity?	How does identity regarding motherhood impact on recovery?	Summary (In/Out)
Blegen, Hummelvoll & Severinsson (2012)	Existential experience of motherhood while having a mental illness Explores self-identity and social identity: "characterised by inner and interpersonal dialogue" "need to be recognised as mothers" p. 422.	"...struggling to manage to be the mother 'one wants to be', and struggling 'to be present' in the caring relationship with the child and being 'recognised' as a mother" (p423). Trying to not drag child down with her Disempowered re parenting by the illness "I am afraid to be told I am not good enough" (as a mother). Obligated to prioritise their mental illness in the treatment setting p 422. Rejection. Denial or lack of acknowledgement of mothering role by others (professionals and community members).	"The children's need for them as mothers gave them the hope and courage to fight against the mental illness..." (p 423).	"The courage to be involves daring to affirm one's inner self, irrespective of all threat. The threat is expressed...in accordance with our wishes and abilities." p 424	In

2.3.3 Constructivist grounded theory

Constructivist grounded theory (CGT) provides a rigorous and systematic process for the gathering and analysis of rich descriptive qualitative data (Charmaz, 2014). Grounded theory is one of a suite of general inductive approaches to the analysis of qualitative data (Thomas, 2003) that enables “research findings to emerge from the frequent, dominant or significant themes inherent in the raw data” (Thomas, 2003, p. 2). The advantage of CGT over other inductive methods, is that it offers a detailed and instructive process for gathering and analysing qualitative data and can accommodate the use of abductive reasoning to propel the researcher towards the development of theory (Charmaz, 2014).

Grounded theory procedures can be utilised to generate theory related to psychological or sociological processes, making them useful techniques to investigate and explain the experience of personal recovery from mental illness. Although grounded theory methods are designed to generate theory, they are also frequently used to guide the collection and analysis of qualitative data within research projects that do not necessarily result in theory formulation (Charmaz, 2008).

As opposed to positivist methods that commence the research process with the aim of testing a specific predetermined hypothesis, CGT begins with a broad question regarding social or psychological processes. Researchers utilising a CGT approach “bring an open mind to what is happening, so that we can learn about the worlds and people we study. Grounded theory leads us to attend to what we hear, see and sense while gathering data” (Charmaz, 2014, p. 3). Congruent with feminist approaches to research, CGT challenges the objectivity claims of positivist methods, instead advocating for transparency in acknowledgement of the values, perspectives, experiences and biases of the researcher which all influence the research decisions, processes and outcomes (Charmaz, 2014; Flood, 2003). This represents one departure of CGT from the classic methodological

approach of grounded theory articulated by Glaser and Strauss (1967). CGT emerged in the 1990's led by Charmaz (2000) and others (e.g. Bryant, 2002. Clarke, 2003) in response to the epistemological assumption that if “social reality is multiple, processual, and constructed, then we must take the researcher’s position, privilege, perspective and interactions into account as an inherent part of the research reality” (Charmaz, 2014, p. 13). Other differences between objectivist and constructivist grounded theory assumptions are summarised in Table 4.

TABLE 4: Grounded theory, contrasting foundational assumptions (Taken from Charmaz, 2009)	
Objectivist <-----> Constructivist	
Assumes an external reality	Assumes multiple realities
Assumes 'discovery' of data through the consistent and rigorous application of the model	Assumes mutual construction of data through interaction with it
Assumes conceptualisation emerge from data	Assumes researcher constructs categories
Views representation of data as unproblematic	Assumes the observer's values, priorities, positions, and actions affect views.

According to CGT methods, once the research question and parameters have been established, a small sample of participants are recruited, with analysis beginning and continuing alongside the data collection phase (see Figure 2). As initial (referred to as substantive) and then focused (theoretical) coding techniques reveal the emergence of categories, purposive sampling is used so that new participants with particular sought after characteristics may be recruited, or existing participants may be re-interviewed to further extrapolate meanings of statements and actions (Charmaz, 2014). Rather than seeking a random or representative sample, CGT utilises purposive sampling techniques to explore a social or psychological process in depth and enable the generation of theory from descriptive accounts provided by participants based on their experiences.

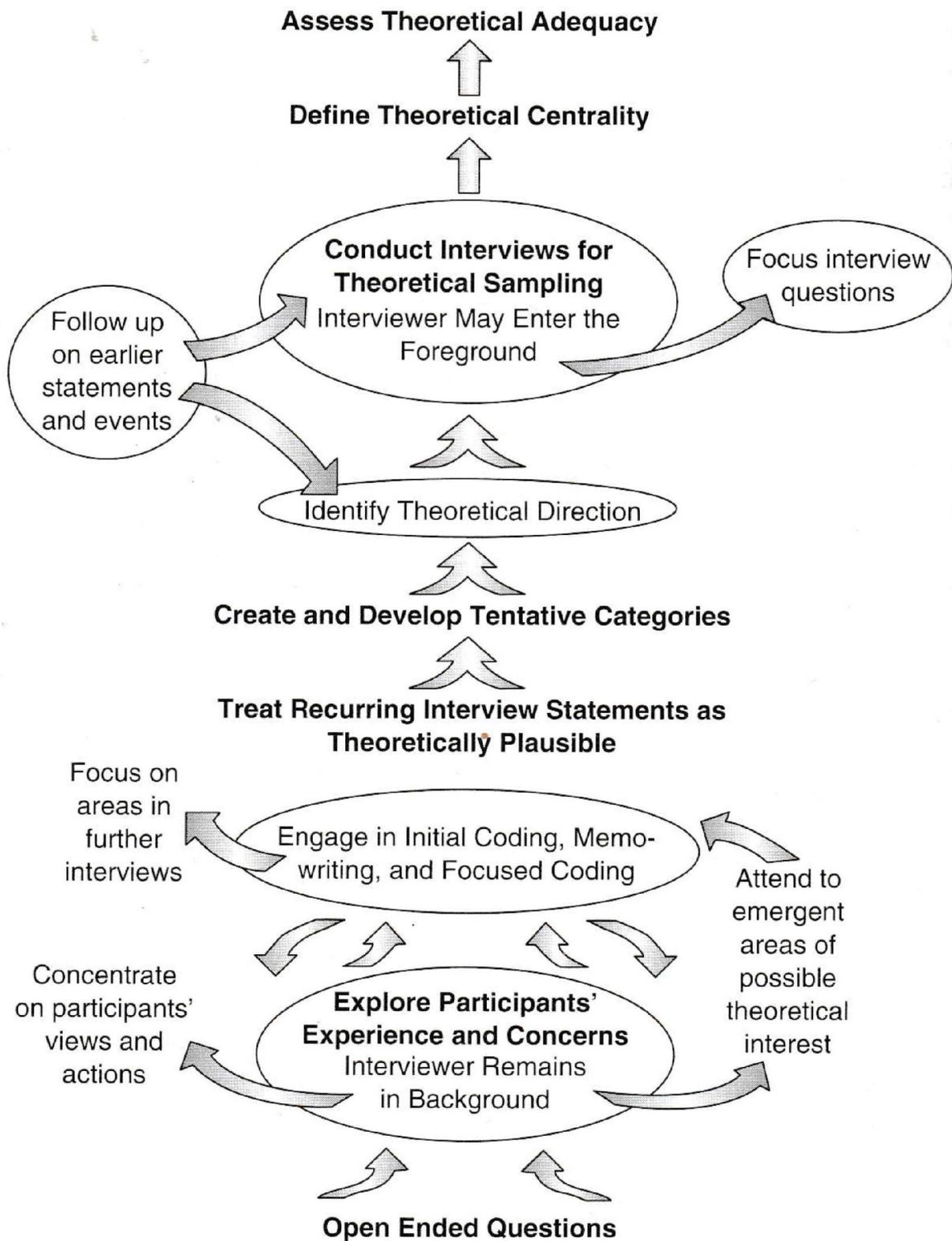


Figure 2: Interviewing in grounded theory studies (Charmaz, 2014, p. 88).

Grounded theory by definition necessitates critical reflection throughout the research process, and provides specific tools such as memo writing and journaling to facilitate its

implementation. Critical reflection is also an essential element of feminist-informed research, and thus another demonstration of the complementary relationship between feminist theory and CGT (Wuest, 1995).

The researcher is embodied and visible in the processes of data collection and analysis, overtly conscious of their own subjectivity so that "understanding of respondents' meanings emerges from a particular viewpoint and the vocabulary that we invoke to make sense of them" (Charmaz, 2008, p.90). As a woman in my early 40's, living rurally, from an English-speaking background and mother to four children, I shared some characteristics with participants in the research undertaken (as described in Chapter 1). Commonalities in relation to social location supported the rapid development of trust and rapport, creating a safe and supportive space for women to speak more openly of their experiences of mental illness, motherhood and recovery (Ramazanoglu & Holland, 2002).

My subjectivity, including personal background and professional social work experience in mental health and women's health promotion fields shaped the data analysis process, bringing a particular language and understanding regarding the interactions of the social phenomena being imparted by mothers with mental illness. Rather than being a flaw in the research methodology, this overt acknowledgement of the researcher's subjectivity is thought to build trustworthiness into the process (Harding, 1993).

With the alignments discussed above, the methods of grounded theory are a good fit with standpoints that bring a critical lens to the research process such as equity or feminist frameworks (Wuest, 1995). One feature that distinguishes grounded theory from other qualitative research methods is that the data collection and analysis occur concurrently. The researcher is immersed in analysing data as it emerges through a series of strategies including multiple layers of coding, developing conceptual categories and a process called memo writing which involves dissecting the categories through detailed

reflective writing that supports identification of patterns and enables comparisons between data from the same person or that gathered from different sources (Charmaz, 2008).

Rather than asking each participant identical questions at interview, grounded theory advocates the researcher rely on their skill and practice wisdom to ascertain when to ask further questions in order to gather additional detail about themes that emerge during the interview. As codes emerge in subsequent interviews, previous participants may be re-interviewed to establish if the emerging theory is consistently represented. Appendix 1 lists all research questions posed, and was compiled from the interview transcripts.

One example of the departure of constructivist GT from its objectivist origins is in relation to the advised sequencing of the literature review. Traditional grounded theory methodology determines that literature reviews should be undertaken after data collection and analysis. It is a strategic decision intended to ensure that researchers arrive at their own data fresh, without prejudice or influence from previous studies (Glaser, 1992) and to preserve the inductive approach. However this sequencing is not required for undertaking constructivist grounded theory as the background research and theoretical context investigated would simply add to the unique subjectivity of the researcher. As all experiences in the social world influence the perspectives, language, assumptions and biases a researcher brings to each project (Charmaz, 2014), it would be exceedingly ineffectual to refrain from reviewing literature as just one of infinite potential influences. Glaser (1992) has subsequently acknowledged that tertiary research assessment requirements often dictate that literature search and review processes be the initial research activities.

2.4 Rationale for the approach

Constructivist grounded theory as a general methodology “can adopt any epistemological perspective appropriate to the data and the ontological stance of the researcher” (Bryant & Charmaz, 2007). Therefore CGT methods and tools are congruent

with and beneficial for implementation of the critically reflective processes in which a feminist approach is grounded. The methodology aligns well with the aims of this study, which are exploratory in nature and aimed at creating conceptual explanation from the descriptions and experiences of mothers who have a mental illness around their experience of personal recovery.

The literature on personal recovery and on mothering with mental illness highlights an urgent need to explore the gendered experiences of women, particularly around oppressive stereotypes and structural disadvantage that may impede the processes of personal recovery. Qualitative methods that acknowledge the subjectivity of the researcher and the participants, have been identified as useful in amplifying the voice of marginalised women, through creating a supportive and unrestricted space for women to share their experiences (Ramaloglou & Holland, 2002).

Through gendered conditioning, women have different ways of knowing and being that are not necessarily suited to male-dominated quantitative approaches (Steen, 1996). Women's voices have long been ignored or discounted across all societies, and this is also the case in the mental health sector (Read, Mosher & Bentall, 2004; Ussher, 1991). As an approach that enables the collection of rich descriptive data and comprises detailed guidance for the analysis of this data, CGT is thought to be highly compatible with the aims of this study.

2.5 Methods

2.5.1 Data collection

For the literature review, the data collection methods involved preliminary scoping followed by a systematic search of the peer reviewed literature. The initial scoping was carried out through consulting with experts in the field, resulting in the location of 25 relevant articles addressing identity and mothering with mental illness. From these, key words were extracted and tallied and then used to conduct the systematic search of 5

databases being PsycINFO, Scopus, Cochrane, CINAHL and Google Scholar. The search terms used were mother*, parent*, identity, mental illness and recovery or synonyms in various combinations.

For studies 2-4 (Chapters 5-7), gathering data involved utilising constructivist ground theory methods. Semi-structured intensive individual interviews were conducted with 17 women who were mothers of at least one child under the age of 18 years. Four women were interviewed twice over the 11 month data collection phase from July 2015 to June 2016, consistent with theoretical sampling techniques. These participants were invited to participate in a second interview due to specific characteristics they possessed, that meant they were able to provide data that could increase understanding of phenomena relating to emerging codes.

To illustrate how a second interview occurred in practice, the following example is provided. One participant indicated in the first interview that she had extensive connections to many other women within her community who also she knew had also experienced mental health difficulties. She had not formed these relationships through a mental health service, but had initiated private conversations that necessitated at least partial disclosure of her own mental health challenges. As the social and psychological processes that enabled or inhibited disclosure became an important component of the connectedness category, it was necessary to more fully explore the factors that had enabled this participant to feel sufficiently safe or confident to disclose her psychiatric diagnosis. This supported increased understanding of the properties of this particular category.

Participants were recruited through either social or mainstream media (twitter and local newspaper articles) or through engagement with clinical and community managed mental health services located in rural Victoria and South Australia. After gaining ethical approval from the Human Research Ethics Committees of Monash University, South West

Healthcare, and Ballarat Health Service, the researcher attended business meetings to inform practitioners and clinicians of the study details. This included dissemination of a research information sheet and plain language statement.

Promotional fliers were also distributed to the services, placed in waiting rooms and included in consumer newsletters. Once they expressed an interest either to their clinician or mental health worker, or directly to the researcher, a face to face screening appointment was arranged, to provide the prospective participant with a Participant Information and Consent Form (PICF, see Appendix 2). Demographics were sought on age, number and age of children, cultural background, income bracket, employment status, relationship status, and living arrangements including a residential address so that rural category could be determined (see Appendix 3).

The majority of the interviews were conducted face to face, with the exception of four interviews which were conducted via telephone due to geographic distance and participant availability. Interviews were held in consulting rooms within public buildings that were convenient to participants, with a degree of privacy, for example community health centres or libraries. Each interview was audio recorded to ensure accuracy, and subsequently transcribed verbatim for analysis. Member checking ensured participants were provided with a copy of the transcript of their interview, and afforded the opportunity to make alterations, additions or clarifications. One participant made some minor changes and additions through this process.

2.4.2 Data analysis

This PhD thesis is unusual in that it has made use of deductive, inductive and abductive reasoning at different points of the research. In the initial study, a literature review, the research question emerged from a pre-existing conceptual framework. The empirical foundations of the CHIME approach were tested within a particular literature field; that of mothering with mental illness, to ascertain its relevance and fit. As described

earlier in this chapter, and also within Chapter 3, the data analysis process was guided by Whitemore and Knaf's (2005) integrative review approach.

Data analysis for the remaining three studies was emergent, codes and eventually categories, being constructed directly from the participant interview data (Charmaz, 2014). This inductive process necessitated the researcher becoming deeply immersed in the data, sorting and resorting pieces of data into codes in ways that provided meaning and explained the social and psychological phenomenon under investigation.

In preparation of the final chapter of the thesis, a more conceptual method was needed in order to construct meaning associated with personal recovery in mental illness for women who are mothers. In order to compare and contrast examples and accounts from all three studies (personal recovery, identity and connectedness), a more abductive approach was employed. This creative and innovative style of reasoning allows for leaps in understanding, and makes possible the development of new theory that can then be refined and tested (Charmaz, 2014). This approach is apt for research exploring undiscovered domains.

However Lipscomb (2012) cautions against using abduction in isolation from other reasoning techniques, as it can lead to erroneous conclusions. Furthermore, he argues that utilising abduction to develop qualitative research findings is problematic:

“...if abduction describes the inferential process whereby qualitative researchers identify the themes, codes and categories in analysis that thereafter become ‘findings’, then these findings are necessarily insecure or fragile. It is not suggested that abduction is the only process involved in qualitative data analysis and, importantly, abduction’s part in this process is asserted rather than demonstrated. Nonetheless, if abduction is granted even a potential role in analysis then this cannot but problematize the action guiding nature of qualitative research” (p. 246).

Within the current thesis the risk of the abductive process resulting in erroneous outcomes was mitigated by two factors. Primarily, abductive reasoning was supplemented by inductive analysis. Where the use of conceptual processing tools such as memos and mind maps were employed, the resulting theoretical ideas were then rigorously tested, through seeking validating evidence of them within the data, keeping the analysis grounded in the data (Charmaz, 2014). Where insufficient data existed to thoroughly explore emerging codes and later, categories, purposive sampling was adopted. Participants with characteristics enabling them to offer deeper insights were re-interviewed, and additional questions and prompts were included in the interview schedule to increase the depth of participant accounts on specific concepts.

2.4.3 Beyond analysis to theorising

An advantage of the CGT methodology is that it enables the researcher to work with the data in increasingly abstract ways toward abduction and the development of substantive theory. This thesis commenced with deductive reasoning, examining the experience of identity in personal recovery for women who are mothers with mental illness through a literature review. An existing personal recovery conceptual framework (Leamy et al., 2011) was the starting point, and the initial study investigated how this framework applied in the context of previous published research with this particular cohort.

During the data collection and analysis process for studies 2-4, inductive reasoning was prominent and the results of these three studies emerge from the data. The close initial line by line coding ensured that the analysis began and returned to the data multiple times. The researcher became immersed in the data, and as analysis proceeded to focused coding, any decisions made about relationships between codes, and around defining the properties of codes, were checked continuously against the raw data.

“Inductive theorising opens the possibility of novel understandings, and, increasingly, researchers acknowledge that:

- 1) their observations include how they see and define the observed phenomenon;
- 2) they move between creating inductive categories and making deductions about them, and;
- 3) explicitly invoke abductive reasoning” (Charmaz, 2014, p. 243).

It was only after the individual concepts of personal recovery, identity and connectedness had been thoroughly examined and articulated in the respective articles, that abduction was invoked to support theoretical development associated with the phenomenon in its entirety. During abductive reasoning, the pieces of the puzzle were considered holistically, and new interpretations of the overall meaning constructed. Chapter 8 contains details of the process and outcomes of the abductive reasoning phase, and contrary to Lipscomb (2012), Raholm (2010) states that

“abduction should be strongly emphasised in research as it serves as a “first stage” of scientific inquiries to have a creative insight of linking between raw data and suggesting a new understanding of the phenomenon (Johnson, 2000)” (p. 265).

2.5 Quality appraisal: trustworthiness of the methods

Guiding principles for appraising the trustworthiness of qualitative literature have been developed specifically for use in the allied health field (Curtin & Fossey, 2007; Anastas, 2004). Although CGT methodology contains very specific and rigorous quality mechanisms, broader themes in distinguishing quality within qualitative research have also been articulated and overlap with CGT processes. Examples of these are the inclusion of a clear research question and thick description of the research process; investigation and relevant use of prior theory and previous research via conducting a comprehensive literature search; the use of triangulation techniques either in the adoption of multiple data collection sources or the inclusion of more than one researcher in the analysis phase to confirm consistency; inclusion of a description of the relationship between researcher and research participants to clarify and acknowledge any inherent bias; tools such as member

checking to substantiate the reliability of the data collection and analysis (Curtin & Fossey, 2007; Anastas, 2004).

These principles were incorporated into the research design, to ensure quality and rigor in data production and analysis. Closely following the CGT methodology meant that the rigor that has been developed by successive grounded theory pioneers (including Glaser & Strauss, 1967; Strauss & Corbin, 1990; Clarke, 2006; Charmaz, 2014) could be utilised to full benefit.

To address trustworthiness, detailed description of the research question is contained within this thesis and included in published articles. The literature review ensured comprehensive incorporation of prior theory and research, and PhD supervisory structures and involvement of multiple researchers and authors in each study increased reliability and consistency. Member checking of interview transcripts was employed as well as consultation with field experts regarding the development and interpretation of conceptual findings.

The qualitative research process was intentionally permeated with mechanisms to overt bias originating from the researchers' prior knowledge and experiences. As a social worker, reflective practice is an approach I learned in undergraduate studies some 20 years ago, and is a fundamental activity I advocate and I have proficiently undertaken throughout my career in various direct practice, supervision, service development and workforce capacity building roles. Three specific reflexive activities were built into the research design for this study. A research journal was kept to capture data analysis processes and foster critical reflection. Interview techniques and inter-personal relationship skills enabled active listening, a safe environment whereby women felt comfortable to challenge or disagree with my interpretations. Thirdly, the research team established a

space for regular review, vibrant discussion, the expression of diverse perspectives, and testing reliability through discussion of multiple coding of data excerpts.

2.5.1 Research journal

As stated above, a research journal was kept throughout the data collection and analysis process. The journal recorded evolving thinking about the meanings being constructed through the data, as well as what was not being captured, and how the gaps may be filled through purposive sampling. Early entries demonstrate reflection on my personal views and values pertaining to religion, and reveal the potential for this bias to influence findings associated with religious identity for women and the role of spiritual beliefs in personal recovery:

6/7/2015 Reflecting on the interview with P1 on Friday. P1 said "God Bless" frequently, and she has also written "God bless this study" on her consent form which I received in the mail today. I had not expected that the challenge to my own subjectivity, perspective etc. would emanate from religious beliefs that I don't share and have trouble relating to! I wonder what it is about religion that attracts people with mental illness? It may be related to the generation of hope for the future; a future which may extend beyond life itself.

Having openly acknowledged my potential prejudice surrounding this issue, I was better prepared to delve into exploring the meaning of both religion and spirituality for future participants when this phenomena was subsequently raised. I was aware of my own responses and more adept and putting them to the side to enable me to authentically hear women's own accounts of how religion and spiritual beliefs influenced their experiences of identity and connectedness. This intention was evident in the subsequent interview questions that were posed to participants 12 and 13 around the role of religion in identity and connectedness to the church community in their experiences of recovery. For example:

RH: Has your spirituality or you're religion influenced the way you see yourself?

P13: Yeah I guess – I guess we’re all sinners in the world, I believe that, we all do wrong, so through Jesus we’ve been forgiven. So I guess that helps me that, I don’t have to be perfect because I can’t be perfect and then for me it’s really important that Jesus died for us and that we can go to heaven but that gives me that faith I guess. I know that whatever happens in this life I’ve got an afterlife in heaven. So I guess that helps, it’s a reassurance.

Another example of the use of the reflective journal was in developing deepening understanding of the concept of “multiple social realities”.

5/02/2016 I am coming to understand the post-modern deconstruction of binary oppositions in relation to empirical thinking. I recall Kathy Charmaz critiques the assumption that inconsistencies in participant accounts mean that the participant is unreliable or dishonest. The researcher’s job is to sort through the inconsistencies and establish the circumstances or conditions under which both accounts would or could be ‘true’ for that person.

The first time I interviewed P7 she was overwhelmed by emotion, continually referring to a new intimate relationship that had “opened her eyes” to what is important in life. Her perspective on her decision making, her priorities had been totally revised and altered, so that she was now able to see how her behaviour and choices impacted on her children. She was adamant that she was now dedicated to focussing on her children’s needs and putting all else on hold for the critical formative time while they are young. At this interview she was experiencing and conveying the intensity of a new connection, and was meeting me for the first time, admittedly anxious and brimming with emotion and sincerity. Two of her children were at child care and the baby was asleep so she had quiet time to consider my questions and reflect on her responses.

A couple of months later, I met her again. This time, 2 of her children were present. The atmosphere was chaotic, interruptions were frequent. She disclosed that the relationship that had been so central to the personal transformation she described last time had ended. Little by little she indicated through the interview that she had withdrawn from the relationship and the person had subsequently moved away. She intimated that her ending relationships was a recurring pattern beginning from childhood. She stated that she doesn't really have any connections, no one she trusts, no one she feels that she is "like". Her discussion regarding the children was at times quite harsh, lacking the empathy she had displayed on the first occasion. Her language was raw, and she was much more forthright, displaying bravado, portraying a tough "who gives a fuck" persona.

I left that second interview somewhat confused. Which version of this Mum was the 'right' one, the 'real' one? Which was the 'truth'? I was so caught up in the contradiction that I was initially unable to see the possibility that they could both be real. This speaks to the interplay between identity and connectedness. The first time I met P7, she was in the midst of an intimate connection. Her perspective was shaped by this connection, by a positive energy associated with feeling loved and cared for, a sense of meaning and belonging. Social connection and the support it brought assisted in her feeling competent as a mother, and content with this as her primary role. She was motivated to fulfil the requirements of this role to her capacity.

On the second occasion, P7 appeared to be totally isolated, disconnected. This undoubtedly compromised her parenting ability through eroding her self-esteem, support, meaning and direction. Without another adult – a compassionate one at least - to witness her challenges and her efforts, the daily unrelenting stresses of

parenting became overwhelming and she frequently blamed the children for “doing my head in”.

What to make of this? Healthy respectful human connections support positive identity. Positive identity (especially mothering identity but could be in another role, vocation seems important too) supports improved parenting skills, competence, and confidence, which results in more parenting success and this becomes a positive feedback cycle.

I will have a look at comparisons between data for each of the women I conduct second interviews. I will remember that “all is data”, context is critical, and that there are multiple social realities!

My use of journaling throughout the interviews, analysis and write up assisted in clarifying personal values and assumptions and supported conceptual thinking. Additionally, it was a platform for rigorous monitoring of the research process, keeping the study methods and procedures accountable to the constructivist grounded theory foundations.

2.5.2 Reflective interviewing and active listening

As a senior social worker within a clinical mental health setting, my practice skills including vast experience in inter-personal communication and employment of a strength based approach, assisted in the development of rapport and trust early in the interview process. In some cases trust was established even earlier, prior to the interview in the engagement and informed consent stages. This is evidenced by the significant disclosures made by participants such as family financial arrangements, conflict with partners, experiences of sexual and physical abuse, and examples of difficulty in coping with parenting stress.

Interview processes and structures were attended to, to ensure that the interviews were intensive, “open-ended yet directed, shaped yet emergent and paced yet

unrestricted” (Charmaz, 2014, p. 85). General statements were interrogated to explore their meaning at a deeper level and participants had opportunities to recount, explain, justify and re-interpret their past and present thoughts, actions and emotions. At times and with some participants a smile and a nod of encouragement was sufficient to encourage elaboration, but women who were perhaps less accustomed to expressing themselves verbally would sometimes appear to be at a loss to explain their meaning. At these times, as the researcher I would paraphrase or use an example of my own to check if I had accurately interpreted their words. The fact that they sometimes disagreed with my questions or statements suggests that they were comfortable to more fully explain themselves and that they did not feel judged or pressured to conform or agree.

An example of this occurred in the interview with P2. In describing the ways in which adjustment to motherhood had impacted on P2’s sense of competence and independence, she was illustrating the difficulty she experienced in completing what she saw as basic tasks such as keeping the house clean, with two young children. Thinking that perhaps she was feeling devalued in her relationship and her domestic work had gone unacknowledged by her partner, I stated:

RH: What was, what were the most difficult aspects of (adjusting to motherhood)?

P2: Because I felt that I was able to achieve so much at work, then I was unable to achieve the most basic things with having a child such as cooking, cleaning, the basics. Yeah. Those two very very basic things.

RH: Yeah. I’ve always said that myself, no one says “gee you’ve vacuumed that lounge room really well today” (laughing). It’s a different reward system isn’t it.

P2: That’s right it just. Yeah. It’s not a nice feeling when you just feel like you can’t even do those things.

RH: Yeah. So your sense of competence was sort of undermined.

P2: Yeah definitely. Undermined was a definite feeling.

Thirty seconds later in the interview, she clarified that it was not so much the external recognition of her domestic role that was the cause of her feeling devalued, but her own perceptions:

RH: What sort of things does (your husband) say that you do well or see that you do well?

P2: Oh well, for example if, just simply if I've cleaned up, you just made the comment about the vacuuming, he *will* comment if I've cleaned up the lounge room or if I've had time to you know, clean up a bomb site or an area of the house. He will comment and say that I've done a good job. So that's good.

In this way, my misconception that P2 may have been feeling dissatisfied, devalued and incompetent as a result of the lack of external acknowledgement she received from her partner, the established rapport enabled her to correct me in relation to the verbal recognition she does receive. Her feelings of incompetence perhaps stemmed more from her own assumptions relating the value of what is socially represented as 'women's work' in the home.

2.5.3 Reflexive functions of the research team

Fortnightly supervision sessions either in person, or more often via video conference, enabled the research team to gather and monitor the progress of studies, provide feedback on memos, and other writing, engage in discussion about emerging themes, deepen awareness of the methodological approach and workshop solutions to any difficulties or obstacles that arose.

An agenda was prepared for each session, and notes recording discussion, decisions, tasks to be undertaken, and upcoming sessions, were circulated within a day of the session. Informal discussions over the telephone or via email took place in addition to this structured fortnightly contact, as needed. Supervisors undertook initial coding of the first 6 interviews in addition to myself, ensuring a high level of competence in the technique had been attained. Two to three times a year Monash University hosted forums

for all PhD students and supervisors, researching within the FaPMI/COPMI (families where a parent has a mental illness/children of parents with mental illness) field. Expert practitioners also attended these forums on occasion, providing an opportunity to present emerging findings to experts in the field and receive informed feedback on data analysis as it progressed. Presenting to conferences attended by international research experts also propelled conceptual contemplation in multiple directions.

2.6 Conclusions

The research topic, processes and constructions of meaning that constitute the findings herein all emanate from a particular and unique set of assumptions and principles that were shaped by the conceptual framework selected to inform the study. Central to this is the researcher's role in determining both the conceptual and methodological approach. The critical and constructivist underpinning foundations enable the development of new theoretical understandings and explanations of the experience of personal recovery, highlighting identity and connectedness in the context of mothering with a mental illness in a rural environment.

Preface to Chapter 3

Chapter 3 is a paper that has been published in the *Psychiatric Rehabilitation Journal* (online) in 2016. This chapter details the literature review conducted to explore identity in personal recovery for mothers with a mental illness. The results of a literature review investigating evidence on the scope and construction of identity in personal recovery for women with mental illness are presented herein.

Hine, R., Maybery, D. & Goodyear, M. (In press). Identity in personal recovery for mothers with a mental illness: A literature review. *Psychiatric Rehabilitation Journal*. doi: 10.1037/prj0000215, Accepted for publication 10 October 2016.

Chapter 3:
Identity in recovery for mothers with a mental illness: A Literature Review.

Psychiatric Rehabilitation Journal

Identity in Recovery for Mothers With a Mental Illness: A Literature Review

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Identity in Recovery for Mothers With a Mental Illness: A Literature Review

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Objective: The development of a positive identity beyond the mental illness has been highlighted as an important component of personal recovery. However, the experience of parenting is often overlooked in recovery discourse. This review aims to explore what the literature reveals about the process of developing a positive identity as part of personal recovery and how this may be shaped by the mothering role. **Method:** A systematic literature search of 5 databases resulted in 27 articles being reviewed, with findings extracted and analyzed using constant comparative analysis. Evidence on the construct and scope of identity in recovery for mothers with mental illness was critically analyzed in the context of a personal recovery conceptual framework. **Results:** The findings highlight that identity was rarely overtly defined in this literature, although the importance of motherhood was emphasized. Common barriers to uninterrupted and rewarding motherhood included illness and treatment, self-criticism, unsupportive families, discriminatory attitudes, and challenging relationships with children marred by intense and difficult emotions. The important role that psychiatric services can play but rarely do was a common finding. **Conclusions and Implications for Practice:** Personal recovery from mental illness is more effectively facilitated through supporting mothers to build positive, realistic, and diverse identities that allow them to acknowledge and respond to their mental health needs without fearing the loss of their parenting role or conforming to restrictive gendered stereotypes.

Keywords: mothering, mental illness, personal recovery, identity

Within mental health settings, the movement from clinical to personal constructions of recovery from mental illness has been growing and evolving since the consumer and carer advocacy movements emerged in the 1980s (Anthony, 1993; Deegan, 1996). Tew and colleagues (2012, p. 2) state that “recovery may involve a journey both of personal change and of social (re)engagement.” A systematic review and narrative synthesis (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011) identified five processes associated with personal recovery. Conceptualized as the CHIME framework, these are Connectedness, Hope, and optimism about the future; developing a positive Identity; finding Meaning in life; and Empowerment.

Parenting and Recovery

Although parenting remains largely peripheral within personal recovery discourse (Maybery et al., 2015; Nicholson, 2014), a mothering role can have a positive or negative influence in each of the domains of the CHIME conceptual framework (Leamy et al., 2011; Maybery et al., 2015). In a recent examination of family in recovery models, Maybery et al. (2015) concluded by citing “the

importance of family in sustaining meaningful connections, providing identity and hope” (p. 321). However, psychiatric rehabilitation services have generally been unsuccessful in implementing programs that address the needs of parents, and Cook and Mueser (2014) have identified several workforce barriers. This current review examines how identity as a personal and social construct is defined and constructed and how it relates to recovery from mental illness for women who are mothers living with mental illness.

Identity Defined

Operationalized in numerous social sciences, identity is broadly defined as one’s self-concept. Onorato and Turner (2004) describe, compare, and contrast two influential theories of self: self-schema theory and self-categorization theory. One major differentiation between the two theories is whether “the self is a fluid or stable entity” (Onorato & Turner, 2004, p. 257). Self-categorization theory makes a distinction between personal identity and social identity, recognizing that each can influence the other. Proponents of self-categorization theory argue that self-concept “is conceived as a context-dependent cognitive representation” (Onorato & Turner, 2004, p. 260). Onorato and Turner (2004) define personal identity as

... “me” versus “not me” categorisations—all the attributes that come to the fore when the perceiver makes interpersonal comparisons with other in-group members. Social identity . . . refers to “us” versus “them” categorisations—all the attributes that come to the fore when the perceiver compares his or her group (as a collective) to a psychologically relevant group. (p. 259)

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Studies have demonstrated that personal identity can be inhibited when social identity is salient, as evidenced by increased self-stereotyping during “in-group” situations (Hogg & Turner, 1987; Spears, 2001). Within the current study, self-categorization theory is adopted to inform identity discussions. This is due to its fit with the concept of personal recovery being a transformative process that is fluid and ever changing depending on variables including context.

Identity in Personal Recovery

Although the process of “developing a positive identity” is not specifically defined or described in detail within the CHIME framework (Leamy et al., 2011, p. 448), the understanding that there is a transformation in the self-concept of a person recovering from the “catastrophic and devastating effects” (Anthony, 1993, p. 527) of mental illness to one more positive is conveyed in recovery language. It has been argued that recovery literature emphasizes individual characteristics and processes to aid recovery, without sufficient recognition of the broader social, economic, and political contexts of people’s lives, which can also either support or hinder recovery (Onken, Craig, Ridgway, Ralph, & Cook, 2007).

Identity and Gender

As one of the most dynamic social determinants of health, gender influences women’s experiences of motherhood, mental illness, and recovery. Socioeconomic and political structures along with cultural factors shape identity development, power, and choice. They impact on women’s access to resources and influence the nature of social relations both within families and the broader community. The ways in which gender shapes experiences of personal recovery from mental illness have remained peripheral (Blegen, Hummelvoll, & Severinsson, 2012; Cogan, 1998; Howard & Hunt, 2008), although studies have examined the broader social and economic dimensions of mothering with mental illness (Luciano, Nicholson, & Meara, 2014; Mowbray, Nicholson, & Bellamy, 2003; Nicholson, Sweeney, & Geller, 1998a). The ways in which women construct and communicate their identity is contested and differs according to social location and agency, among other factors (Butler, 1990; McNay, 2004).

This review will examine and critically analyze evidence on the construct and scope of identity in recovery as experienced by mothers with mental illness. It will specifically examine

1. How is the concept of identity constructed and defined by mothers with mental illness?
2. How does mental illness affect the development of identity for such women?
3. How does motherhood affect identity for women with mental illness?
4. How does identity influence personal recovery in mental illness for mothers?

Method

An integrative review of the literature was used (Booth, 2006; Grant & Booth, 2009; Whitemore & Knafel, 2005). This comprised

a systematic search and review of predominantly qualitative studies, followed by constant comparative analysis, to facilitate identification of themes and development of broad conceptual interpretations of the scope and construction of personal and social identity in recovery for mothers with mental illness.

Data Sources

Literature was sourced from peer-reviewed journal articles reporting on original studies accessed via searches of PsycINFO, Scopus, Cochrane, CINAHL, and Google Scholar databases. Initially, Author 1 (Rochelle Helena Hine) identified 25 key papers through consultation with experts in the field. From these, key words were extracted and tallied, and then common key terms were used to conduct the final searches (Gough, 2013; Grant & Booth, 2009). The key words used to conduct the searches were mother*, parent*, identity, mental illness, and recovery or synonyms in various combinations. Additional articles were identified through retrospective reference list checking.

Inclusion and Exclusion Criteria

English language articles from 1980 to mid-2014 reporting on original studies focused on mothers with mental illness and personal recovery concepts were included. Some quantitative or mixed method studies were also included to enable increased breadth and depth (Gough, 2013; Gough, Oliver, & Thomas, 2012). Exclusions were opinion pieces, gray literature, and literature reviews. Papers focused purely on clinical definitions of recovery, reporting on child outcomes of parental mental illness and pertaining to parental mental illness in general, without breakdown of results into mothers and fathers or studies with fathers only, were also excluded.

Screening

Figure 1 highlights titles and abstracts of 1,509 articles that were retrieved, and 1,419 were excluded after review of titles and duplicates. The remaining 90 articles were reviewed in full by Author 1 (Rochelle Helena Hine) with a sample of 10 also reviewed by the other two authors (Darryl John Maybery, Melinda Jane Goodyear). Seven articles were excluded due to being reviews or theoretical papers rather than original studies, and a

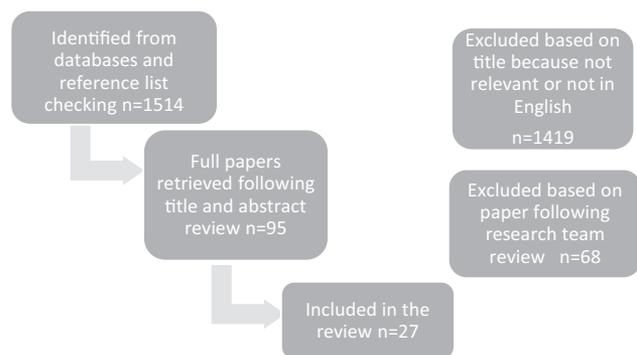


Figure 1. Flowchart showing assessment of eligibility of identified studies.

further 61 articles were excluded because they did not meet the inclusion criteria. A further 5 articles were added through reference list checking of the papers sourced, making a total of 27 articles.

Analysis

The 27 articles summarized in Table 1 were all reviewed by Author 1 (Rochelle Helena Hine), along with one other author (Darryl John Maybery or Melinda Jane Goodyear), with every article reviewed in its entirety by at least two authors. Text pertaining to mothering with mental illness, recovery, and identity were extracted from the articles. These were compiled in a matrix headed by each of the operationalized questions previously listed. Themes that illuminated the findings of studies with cohorts of mothers with mental illness around the fit of identity within the process of personal recovery were grouped. The final step of the analysis involved robust dialogue between all three authors around emerging thematic categories.

Results

This section reports on the review findings in relation to the research questions posed.

Research Question 1: How Is the Concept of Identity Constructed and Defined by Mothers With Mental Illness?

Within the articles selected, the concept of identity was rarely overtly defined, and in 11 of the articles, it was not defined at all. Self-concept was referred to on 58 occasions, often in the context of broad references to recovery. Although not explicit, the remaining 11 papers indicated concepts and phrases associated with personal (7 papers) and/or social identity (8 papers). Mothering identity was at times conceptualized as an occupation (McKay, 2004) or through a capabilities framework (Barrow, Alexander, McKinney, Lawinski, & Pratt, 2014) associated with women's ability to competently perform the tasks and functions commonly associated with that role (Ackerson, 2003).

Identity as self-concept was evident in explorations of experiences of mothering with mental illness (Montgomery, Tompkins, Forchuk, & French, 2006; Sands, 1995), with meanings attributed by the women participants themselves in narrative accounts. Seven papers referred to mothers' sense of self (Carpenter-Song, Holcombe, Torrey, Hipolito, & Peterson, 2014; Heron et al., 2012; McGrath, Peters, Wieck, & Wittkowski, 2013) or self-image (Chernomas, Clarke, & Chisholm, 2000).

The two roles most commonly mentioned as sources of personal or social identity were that of mother or woman with a psychiatric illness. These were frequently described as being in juxtaposition and "in conflict because (the women's) diagnosis seems to foretell their failure to become good mothers" (Savvidou, Bozikas, Hatzigeleki, & Karavatos, 2003). Authors also referred to women's cultural identity, religious affiliations (Carpenter-Song et al., 2014), and work (McKay, 2004) as core components of their self-representation. Women attested to the predominance of their mothering role, attributing a myriad of positive ramifications including a primary source of meaning (Carpenter-Song et al., 2014),

focus (Montgomery, Mossey, Bailey, & Forchuk, 2011; Sands, 1995), purpose (Diaz-Caneja & Johnson, 2004), and worth (Blegen et al., 2012). Diaz-Caneja and Johnson (2004) recognized motherhood as a valued social role that offers women with mental illness the opportunity for increased self-esteem and fulfilment as a woman. The "need to be recognized as mothers" (Blegen et al., 2012, p. 422) was one example of the significance of social identity. Other powerful outcomes of mothering identity included "a source of rich emotional rewards" (Diaz-Caneja & Johnson, 2004, p. 480), a sense of hope and courage (Blegen et al., 2012), and the promise of validation and normalcy in experience of the universality of parenting (Davies & Allen, 2007; Nicholson, Sweeney, & Geller, 1998b; Sands, 1995).

Research Question 2: How Does Mental Illness Affect the Development of Identity for Such Women?

Although mothering was critically important, mothering identity was highlighted as being volatile and unstable, regularly compromised, or disrupted. Typically motherhood was described as being interrupted by illness-related factors including ongoing symptoms and acute episodes (McKay, 2004; Montgomery et al., 2006, 2011; Venkataraman & Atkinson, 2008). Women spoke of their illness preventing them from being fully present and responsive with their children (Basset, Lampe, & Lloyd, 1999). Furthermore, side effects of medication (particularly sedation) impacted on parenting capabilities (refs as they appear). Deteriorating mental health often forced mothers to make a choice between having treatment needs attended to and being active in the parenting role (Heron et al., 2012; Montgomery et al., 2006). The episodic nature of mental illness was also recognized, with extra parenting support being required and welcomed from husbands or partners (Nicholson et al., 1998b) when unwell. However, this was double edged if family members were reluctant to relinquish the primary caring role once the mother had recovered (Nicholson et al., 1998b; Perera, Short, & Fernbacher, 2014), sometimes leading to conflict and the mothering identity being contested (Nicholson et al., 1998b).

Another powerful influence was the degree to which mothers internalized normative cultural expectations surrounding mothering (Savvidou, Bozikas, Hatzigeleki, & Karavatos, 2003; Wilson & Crowe, 2009). The binary of good/bad mother was frequently voiced (Davies & Allen, 2007; Wilson & Crowe, 2009), with women feeling confident and competent to parent satisfactorily when well (Diaz-Caneja & Johnson, 2004) but judged as inadequate when ill (Blegen et al., 2012, p. 423). Associated with this was a range of emotional responses to the impact of their illness upon children, such as disconnection (Montgomery et al., 2011), guilt, worry (Cremers et al., 2014; McKay, 2004), fear, loss (Heron et al., 2012; Khalifeh, Murgatroyd, Freeman, Johnson, & Killaspy, 2009; Nicholson et al., 1998b) frustration, a sense of failure (McGrath et al., 2013), and sadness and regret (Ueno & Kamibeppu, 2008).

Potentially more influential in shaping personal and social identity than the direct impacts of mental illness were the experiences of stigma and prejudice that mothers encountered. Women described their mothering identity as being constantly under threat, as illustrated by one women's observation that "no one seemed happy when I said I was pregnant" (Savvidou et al., 2003, p. 396). As Diaz-Caneja and Johnson (2004) state, "the motherhood of men-

Table 1
Summary of Studies Reviewed on Identity in Personal Recovery for Mothers With Mental Illness

Publication details	Number of participants; number of mothers	Methodology	Diagnosis	Socioeconomic factors	Contact with children
Ackerson (2003) "Coping with the dual demands of severe mental illness and parenting: The parents' perspective." <i>Families in Society</i> .	13 parents; 12 mothers.	Qualitative, individual interviews, partial grounded theory.	Serious and persistent mental illness.	Education: 10 competed high school, 4 college or graduate studies. 3 currently married, 10 separated, widowed, or divorced.	7 had lost custody, 4 regained custody of at least 1 child. Another participant had joint custody. All separated from their children.
Barrow et al. (2014) "Context and opportunity: Multiple perspectives on parenting by women with a severe mental illness." <i>Psychiatric Rehabilitation Journal</i> .	7 mothers, all living in transitional homelessness sheltered apart from their children.	Qualitative, focus groups. Community-Based Participatory Research.	Not reported.	Transitional housing shelter. Single.	All separated from their children.
Bassett et al. (1999) "Parenting: Experiences and feelings of parents with a mental illness." <i>Journal of Mental Health</i> .	Not stated; all participants were mothers.	Qualitative research design, focus groups and individual interviews.	Consumers of psychiatric rehabilitation services.	Not reported.	Not reported.
Blegen et al. (2012) "Experiences of motherhood when suffering from mental illness: A hermeneutic study." <i>International Journal of Mental Health Nursing</i> .	5 participants, Norwegian-speaking mothers of children aged 0–18 years, with mental illness.	Qualitative exploratory design, hermeneutic approach.	Depression, anxiety, personality disorder, eating disorder.	4 living alone with children, 1 with a partner (and children).	All lived with children full time.
Campbell et al. (2012) "The experiences of Australian parents with psychosis: The second Australian national survey of psychosis." <i>Australian and New Zealand Journal of Psychiatry</i> .	1,825 Australians with symptoms or diagnosis of psychosis; 38.1% were parents ($n = 696$; 281 men and 415 women).	Quantitative, national survey delivered via individual interviews at MHS by qualified clinicians.	Psychosis; schizophrenia, schizoaffective disorder, bipolar, mania, depressive psychosis.	Most parents on a pension. 83.4% of mothers lived in own house or rented accommodation.	23% of mothers had children living with them.
Carpenner-Song et al. (2014) "Recovery in a family context: Experiences of mothers with serious mental illnesses." <i>Psychiatric Rehabilitation Journal</i> .	3 African-American mothers with serious mental illness.	Ethnographic observations and informal interviews over 12 months.	Major depressive disorder; PTSD with panic disorder with agoraphobia; depression and bipolar disorder.	11 had general education, 11, some college. One mother employed full time (very low income); other 2 unemployed. All 3 never married and live with all of their minor children.	All are primary single carers for their children.
Chermomas et al. (2000) "Perspectives of women living with schizophrenia." <i>Psychiatric Services</i> .	28 women, 15 mothers.	Qualitative, 5 focus groups. Thematic content analysis.	Self-identified: 18 with schizophrenia, 10 with schizoaffective disorder.	Education: 7 had university degrees, 7 some university, 7 high school graduate, 1 less than high school. Employment: 26 unemployed, 2 retired.	Not reported.

(table continues)

Table 1 (continued)

Publication details	Number of participants; number of mothers	Methodology	Diagnosis	Socioeconomic factors	Contact with children
Cogan (1998) "The consumer as expert: Women with serious mental illness and their relationship-based needs." <i>Psychiatric Rehabilitation Journal</i> .	25 women with serious mental illness, 9 were mothers.	Qualitative structured interviews.	Not reported, all received a Community Rehabilitation and Treatment Service through a community MHS.	Employment: 21 unemployed; 1 working full time. Education: 10 high school or less; 15 some "advanced" education (e.g., college or technical school). Culture: 1 woman was "biracial" (White and Native American) others all "White". 5 were single, never married; 4 married; 5 living with a partner; 2 separated; 9 divorced.	Of the 9 women with children under 18 years of age, 8 did not have custody.
Cremers et al. (2014) "Mental health and parenting in rural areas: An exploration of parental experiences and current needs." <i>Journal of Mental Health</i> .	6, all mothers.	Qualitative, semistructured interviews, interpretative phenomenological analysis.	Two had bipolar; 1 PND; 3 anxiety/depression (undiagnosed); all utilized a MHS.	4 mothers felt "under extreme pressure". 3 lived in towns, 2 in the "countryside" and 1 just outside of a town.	All did 80–90% of parenting, 1 mother had lost custody of her children.
Davies and Allen (2007) "Integrating 'mental illness' and 'motherhood': The positive use of surveillance by health professionals. A qualitative study." <i>International Journal of Nursing Studies</i> .	11 participants, all mothers with mental illness.	Qualitative, postwar feminist theory. Semistructured interviews, constant comparative analysis.	OCD, 2 had bipolar, 4 had depression, 2 had psychosis with PND.	Not reported.	3 have experience of children in care, but are living with children.
Diaz-Caneja and Johnson (2004) "The views and experiences of severely mentally ill mothers: A qualitative study." <i>Social Psychiatry and Psychiatric Epidemiology</i> .	22 mothers with severe mental illness.	Qualitative interview methodology with thematic analysis.	8 with schizophrenia, 10 with bipolar, 4 with severe depression with psychotic symptoms.	1 working part time, 21 on "benefits". 21 living in public housing, 1 in private rental. 3 currently married or living with a partner, 11 previously married but no longer living with a partner, 1 widowed, 7 never married.	11 lived with their children, 11 did not.
Heron et al. (2012). "Information and support needs during recovery from postpartum psychosis." <i>Archives of Women's Mental Health</i> .	5 mothers who experienced postpartum psychosis.	Qualitative semistructured interviews; service user-conducted research model.	Not reported.	Not reported.	Not reported.
Khalifeh et al. (2009) "Home treatment as an alternative to hospital admission for mothers in a mental health crisis: A qualitative study." <i>Psychiatric Services</i> .	18 mothers with mental illness, 5 children.	Qualitative semistructured interviews, thematic analysis.	10 had major depression, 6 had bipolar disorder, 2 had schizophrenia.	Half were single parents, 9 lived alone, 8 with the children's father, 1 with another male. Children lived either with their father or with both parents.	Not reported.

(table continues)

Table 1 (continued)

Publication details	Number of participants; number of mothers	Methodology	Diagnosis	Socioeconomic factors	Contact with children
McGrath et al. (2013) "The process of recovery in women who experienced psychosis following childbirth." <i>BMC Psychiatry</i> .	12 women who had experienced psychosis after childbirth.	Qualitative semistructured interviews, constructivist grounded theory.	11 had postleptal psychosis; 1 had postleptal depression with psychotic features.	Three working full time, 5 working part time, 1 on maternity leave and 3 "house wives". Women were "economically secure". All 12 were White British women living in England or Wales. 1 single, 1 divorced, 10 married or cohabitating.	All have custody of children.
McKay (2004) <i>Mothering occupations: Challenge agency and participation</i> .	5 women, 4 were mothers.	Narrative inquiry using life history. In-depth interviews.	2 had depression; 2 with bipolar disorder.	1 woman was a teacher, other women had volunteer roles, no job or career specified.	2 women experienced custody loss, all children are now adults aged 27 to 52 years.
Montgomery et al. (2005) "Keeping close: Mothering with severe mental illness." <i>Journal of Advanced Nursing</i> .	20 mothers with serious mental illness.	Grounded theory, individual interviews.	3 had schizophrenia, 4 had bipolar, 9 had major depression; 4 not specified.	1 widowed; 3 divorced. Two live alone, 1 with adult son, 1 with a partner. Not reported.	16 of 20 mothers lived with their children.
Montgomery et al. (2011) "Mothers with serious mental illness: Their experience of "hitting bottom." <i>ISRN Nursing</i> .	32 mothers with serious mental illness, from previous studies.	Secondary analysis of qualitative data gathered through grounded theory, individual interviews.	3 had schizophrenia, 4 had bipolar, 9 had major depression, 4 not specified.	Not reported.	22 of 32 mothers lived with their children.
Mowbray et al. (2001) "Life circumstances of mothers with severe mental illness." <i>Psychiatric Rehabilitation Journal</i> .	379 mothers with a serious mental illness.	Quantitative interview in two parts.	Schizophrenia, major affective disorder or bipolar "causing major dysfunction".	40% college or beyond, 25% high school diploma, 35% less than high school. 68.1% living below the poverty line, 11.3% working full time, 10.6% working part time. 60% African American, 29% Caucasian, 8% Hispanic, 3% "other". 29% married, 12.4% living with a partner, 27.7% separated/widowed/divorced, 30.6% never married.	82.2% of children living with mother.
Nicholson et al. (1998b) "Focus on women: Mothers with mental illness: II. Family relationships and the context of parenting." <i>Psychiatric Services</i> .	42 mothers; 55 case managers.	Qualitative; exploratory, focus groups, informed by grounded theory.	Majority affective disorders—major depression and bipolar disorder.	32 had at least high school education. Majority Caucasian. Almost half currently married. Most on social security. 34 lived in their own homes.	38 (of 93 children) lived with their mothers.

(table continues)

Table 1 (continued)

Publication details	Number of participants; number of mothers	Methodology	Diagnosis	Socioeconomic factors	Contact with children
Nicholson et al. (2006) "A comparison of mothers with co-occurring disorders and histories of violence living with or separated from minor children." <i>Journal of Behavioural Health Science and Research</i> .	2,729 women, 2,366 mothers. 1,954 had children younger than 18 years of age.	Surveys administered face to face in participants' chosen location.	DSM-IV Axis I mental disorder and/or Axis II personality disorder. Also a DSM-IV substance use disorder.	Education and income listed as averages comparing women living with all of their children to women who have had children removed.	558 had all children living with them, 1,396 mothers of children under 18 of whom at least 1 was not living with them.
Perera et al. (1998a) "Focus on women: mothers with mental illness: I. The competing demands of parenting and living with mental illness." <i>Psychiatry Services</i> .	42 mothers with serious, long-term mental illness. Also, 55 case managers.	Qualitative, focus group discussions.	Serious mental illness: 55% had either major depression or bipolar disorder.	62% on social security payments. Most were Caucasian, 45% currently married or living with a partner, 48% previously married. 81% lived in their own homes or apartments.	All "regularly involved" with a child under the age of 13 years.
Perera et al. (2014) "It's not that straightforward": When family support is challenging for mothers living with mental illness." <i>Psychiatric Rehabilitation Journal</i> .	8 mothers, 11 mental health service providers.	Semistructured qualitative interviews, constructivist grounded theory.	5 with schizophrenia, 2 major depressive disorder with psychotic symptoms, 1 had bipolar disorder. Episode of acute mental illness in past 5 years.	Low socioeconomic status is mentioned on numerous occasions.	6 lived with all their children, 1 lived with 3 of 5 of her children, 1 mother lost custody of her only child.
Sands (1995) "The parenting experiences of low-income single women with serious mental disorders." <i>Families in Society</i> .	10 mothers with serious mental illness. A comparison group of 8 "day care mothers"—single low-income mothers without a mental illness.	Qualitative, participant observation, informal conversations with staff, semistructured open-ended interviews with mothers.	6 had schizophrenia, 1 schizotypal personality disorder, 1 major depression, 1 bipolar disorder, 1 unknown diagnosis.	6 mothers had at least high school education, 3 less than high school, 1 unknown. 7 women were African American, 3 were White.	Not reported.
Savvidou et al. (2003) "Narratives about their children by mothers hospitalized on a psychiatric unit." <i>Family Processes</i> .	20 mothers with mental illness.	Qualitative, semistructured interviews. Derived from constructivist epistemologies, narrative analysis.	10 with schizophrenia, 1 delusional disorder, 4 bipolar disorder, 3 major depression, 2 borderline personality disorder.	14 had not competed high school. 12 were facing "severe financial problems". 10 women were divorced, 1 was widowed, and 9 were currently married.	13 women were living with their children (7 were not). 7 of the 10 divorced women had lost custody. All living with their children and had custody.
Ueno and Kamibeppu (2008) "Narratives by Japanese mothers with chronic mental illness in the Tokyo metropolitan area." <i>Journal of Nervous and Mental Disease</i> .	20 Japanese mothers with "chronic mental illness."	Qualitative, narrative interviews.	13 with schizophrenia, 7 mood disorders.	14 currently married, 4 previously divorced, 1 widow, 1 never married. Married women lived with partners, remainder lived alone.	

(table continues)

Table 1 (continued)

Publication details	Number of participants; number of mothers	Methodology	Diagnosis	Socioeconomic factors	Contact with children
Venkataraman and Ackerson (2008) Parenting among mothers with bipolar disorder: Strengths, challenges, and service needs." <i>Journal of Family Social Work</i> .	10 mothers with bipolar disorder.	Qualitative, semistructured interviews. Grounded theory.	Bipolar disorder.	All completed high school; half attended college, 2 completed a certificate course, 3 had college or associate degrees. 2 unemployed, 4 in "lower level jobs", 2 in "higher level jobs," 2 students. Seven from lower socioeconomic background. 6 were single parents; 4 never married, 1 divorced, 1 widowed. 1 woman married and living with husband. 3 living with partners.	All were living with their children.
Wilson and Crowe (2009) "Parenting with a diagnosis of bipolar disorder." <i>Journal of Advanced Nursing</i> .	5 parents with bipolar disorder, 4 mothers, 1 father.	Critical discourse analysis of data gathered via interviews, expert text (<i>Diagnostic and Statistical Manual of Mental Disorders</i> , fourth edition) and popular parenting content (media, TV).	Bipolar disorder.	Not reported.	Not reported.

Note. *DSM-IV* = *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition; MHS = Mental Health Service; PTSD = posttraumatic stress disorder; PND = Post-natal depression; OCD = obsessive-compulsive disorder.

tally ill women does not appear to be highly valued in the way that motherhood is in general. Rather, it seems to be viewed by the public and by professionals as inherently problematic” (p. 480).

In almost half of the articles ($n = 11$) women spoke in evocative language about the impact of their experience of custody loss through child protection intervention or family court proceedings after separation (including Barrow et al., 2014; Cogan, 1998; Nicholson et al., 2006). Custody loss had a devastating effect on mothers’ identity and

a deep sense of loss, grief and some anger still haunted the women who had lost children to child and family services. Years later these women were still struggling to process and integrate their experience of being judged an unfit mother. (Chernomas et al., 2000, p. 4)

Another mother declared “to lose your child is a personal holocaust” (Cogan, 1998, p. 153) with potentially lifelong effects (Nicholson et al., 2006).

Socioeconomic and environmental factors combined to limit the efficacy of parenting for many women. A lack of economic resources and social supports led to disadvantage whereas social isolation was also commonly experienced. Nicholson, Sweeney, and Geller (1998a) identified that this was exacerbated for women from minority cultural groups with implications for social identity. For women with partners, family violence was commonly encountered (Cogan, 1998; Nicholson et al., 1998b; Perera et al., 2014), with compounding impacts upon mothering identity when mothers were blamed for failing to protect children from its effects (Nicholson et al., 1998b).

Although many women identified challenges to their parenting identity associated with being isolated from the support of family (Carpenter-Song et al., 2014), for others the family support available could also be destructive, problematic, or complex (Khalifeh et al., 2009; Nicholson et al., 1998b; Perera et al., 2014). Mothers spoke of feeling patronized and treated like a child within the family context (Sands, 1995). Having their autonomy and parenting identity undermined was a theme.

Encountering clinical and community mental health services was an outcome of experiencing mental illness for many women, and this review also illustrated mental health professionals’ positions of power and authority in treatment settings (Davies & Allen, 2007), with opportunities to influence women’s sense of self when they may be at their most vulnerable. Critical to mothering identity was the need for mental health services to address the parenting role as a core component of treatment and recovery (Ackerson, 2003; Barrow et al., 2014; Davies & Allen, 2007; Mowbray et al., 2001). This involved encouraging women to articulate their needs “without fear that this will call her capacity as a parent in to question” (Davies & Allen, 2007, p. 374). It also involved services establishing more family-friendly environments in clinical settings (Davies & Allen, 2007), particularly for mothers of babies to demonstrate recognition of the importance of building confidence and competence in early parenting to consolidate this prevailing identity. Heron et al. (2012) found that “women admitted to (inpatient) units without their baby reported distress and anger about the separation and low confidence about taking over the mothering role on discharge” (p. 159).

Barrow et al. (2014) stated “many public systems that influence their life options do not recognize that a mothering identity—

custodial or not—is central to extremely marginalised women over their lifetime” (p. 6). Services that failed to respond to the needs and priorities of mothers in their mothering role were described as compromising or even jeopardizing recovery for mothers separated from their children (Barrow et al., 2014).

Research Question 3: How Does Motherhood Affect Identity for Women With Mental Illness?

Mothering offered an alternative identity that was more socially valued than an illness identity. To sustain their mothering identity in the face of the significant difficulties described, women used strategies aimed at reducing the threat of being usurped from the mothering role. Mothers spoke of undertaking “impression management activities” (Davies & Allen, 2007, p. 370) to participate in the social construction of identity. This included careful use of language, managing physical appearance, and concealing mental illness to meet social expectations (Carpenter-Song et al., 2014; Cremers et al., 2014; McGrath et al., 2013; Montgomery et al., 2006). Techniques utilized included masking symptoms or emotions, being hypervigilant regarding outward behavior, and diligently conforming to the role of “good” mother. Mothers spoke of forfeiting their own needs (particularly treatment needs) to be present for children.

Montgomery and colleagues (2006, p. 23) highlighted that

Claiming an identity as a “good” mother rested on the moral attributes of altruism and relentless commitment to their children. Placing the children’s needs and interests ahead of their own affirmed them as mothers, while also affording them the opportunity to role model “appearing normal” for the sake of the children. Forsaking their own needs, despite limited resources, was a way to keep close to the children.

Likewise, Carpenter-Song et al. (2014) found that women engaged in behavior to meet the social expectations of their community. This meant disguising symptoms such as anxiety or depression that would be incongruent with a resilient image and imply weakness.

Numerous studies revealed that fear of being judged as an incompetent mother led to avoidance of seeking support when required (Ackerson, 2003; Montgomery et al., 2006). Through isolating themselves, mothers felt that their identity was more secure. However this strategy was counterproductive in the long term because it resulted in increased stress or exacerbation of mental illness symptoms, making this sense of security a temporary state (Montgomery et al., 2006).

Research Question 4: How Does Identity Influence Personal Recovery From Mental Illness for Mothers?

Recovery promoting aspects of a mothering identity were numerous. They included joy and connectedness associated with the relationship with one’s children (Ackerson, 2003; Carpenter-Song et al., 2014); “personal worth and accomplishment” (Mowbray et al., 2001, p. 119); hope and courage “to affirm one’s inner self” (Blegen et al., 2012, p. 424); increased overall global functioning (Campbell et al., 2012); love, meaning, purpose, and support (Chernomas et al., 2000; Montgomery et al., 2006); and “a central incentive to try to recovery and stay well” (Diaz-Caneja & John-

son, 2004, p. 475). Others suggested that “residual sadness for the lost period of early motherhood could co-exist with a sense of survival and an understanding of the positive changes brought about by the experience” (Heron et al., 2012, p. 164).

Heron et al. (2012) found that “for many women, telling their story and hearing others’ stories was a powerful aid to recovery” (p. 158). This reflects the benefits of connectedness based on shared social identity. Other mothers found similar benefits from being given a diagnosis that helped them to feel validated, connected, and hopeful regarding the likelihood of recovery: “it does exist, other people have had it before and there are things that can be done” (McGrath et al., 2013, p. 7). Wilson and Crowe (2009) advocate for work

to promote a sense of identity beyond a diagnosis. With a more rounded sense of self, a parent with (mental illness) is better placed to develop less strenuous self-surveillance strategies and to feel more satisfied and validated for who they are as parents. (p. 883)

An important transition appeared to be overcoming the desire to conceal the illness from others (Cremers et al., 2014; McGrath et al., 2013). Cremers et al. (2014) observed “mothers emphasized the desire to be able to be open about their mental health problems” and viewed this as the “key to wellbeing and recovery” (p. 102). Women in McGrath’s et al. (2013) study described reaching a point where they made a conscious decision not to conform to society’s expectations but instead to honor their authentic self, acknowledge their needs, and invite the support required. This powerful turning point was not reflected in other articles, and the cohort of women who participated in McGrath’s study were financially secure, affording them the luxury of making choices about whether it was conducive to their mental health and recovery to return to the workforce and partake in other social or vocational opportunities expected of them. This underscores the relevance of access to economic resources as a key determinant of mental health outcomes.

Discussion

Mothering and Identity in Personal Recovery

Mothers with mental illness consistently emphasized the importance of their mothering role and relationships with their children. The universal experience of mothering and being recognized as “mother” was seen to boost capacity to develop positive personal and social identities. However threats to undermine this identity emanating from the mental illness itself, and more significantly from the social, economic, and cultural environments in which they lived, made maintaining a positive and secure mothering identity complex and problematic for women with mental illness. Women undertook arduous strategies in attempting to ameliorate the challenges to their identity, often with paradoxical effects on both their identity and their overall personal recovery.

Perhaps unsurprisingly, the literature review unearthed few studies that defined mothering identity in relation to mental health problems. However, the CHIME framework (Leamy et al., 2011, p. 448) has recently emerged to highlight the dimensions of identity, rebuilding/redefining a positive sense of identity, and overcoming stigma as three subthemes of identity in the personal

recovery literature. In subsequent research conducted to test the validity of the CHIME framework with a cohort of mental health consumers (Bird et al., 2014), individuals with mental illness sought recognition of the multiple dimensions of their identity beyond the diagnosis. Having health professionals validate the breadth of one’s identity was found to be recovery promoting for mothers with mental illness. The need for significant others to recognize their mothering role was also important, although this was rarely fulfilled. Women often spoke of their mothering role being ignored, diminished, or challenged by health professionals, family, and other community members.

Rebuilding/redefining a positive sense of identity has been interpreted as either regaining the identity one occupied before the illness or attaining a transformed sense of self that transcends the illness (Bird et al., 2014). The description of this process suggests a gradual progression from negative (illness dominated) to positive (multidimensional and strengths orientated) identity. In the literature, the experience of identity reclamation for mothers with mental illness was described as far more nuanced. Rather than a smooth trajectory from negative to positive, women spoke of their mothering identity as being persistently under threat. A sense of insecurity permeated as a result of feeling under constant scrutiny and being challenged to demonstrate capacity as a “good” mother. Periods of competence and agency in the mothering identity could be abruptly disturbed by not only episodes of illness but by the perceived prejudiced attitudes of others regarding the women’s capacity in the role, with custody loss being the most profound and destructive example. Tapping into the motivational opportunity that a parenting identity offers as an incentive to recover (Dolman, Jones, & Howard, 2013; Evenson, Rhodes, Feigenbaum, & Solly, 2008) and supporting mothers to increase competence and resources to prevent custody loss is a legitimate undertaking for the psychiatric rehabilitation sector.

Stigma was identified as a significant barrier to others recognizing and supporting the mothering role. The fear of stigma led many women to adopt strategies such as masking to avoid detection of their illness and impression management (Wilson & Crowe, 2009), vigilantly monitoring emotions and behavior to conform to the good mother ideal. Reversing internalized negative self-concepts associated with an illness identity is inherently difficult (Corrigan & Watson, 2002; Wisdom et al., 2008), and this was certainly evident for mothers with mental illness in their dedication to defying the “bad mother” label. “Individuals’ self-perceptions and sense of optimism can also be affected by interactions and feedback from others” (Wisdom et al., 2008, p. 490), underscoring the importance of family and mental health professionals demonstrating recognition of and support for a mothering identity.

Implications for Practice

For mothers with mental illness, having their mothering identity recognized and valued appears of utmost importance. Other aspects of the women’s identity, such as their culture, gender, sexuality, beliefs, or vocation, were less prominent in the literature, with the focus on exploring the tensions between mental illness identity and motherhood. Embracing motherhood as a valued social role to be attained and maintained provides women with meaning, hope, normalized social status, love, and support as the

children grow along with connectedness to children, extended family, and community that may not be available otherwise.

The findings offer considerable insights for psychiatric services. First and foremost practitioners need to recognize and respect motherhood and the predominance of the parenting role. They need to find ways to empower mothers by acknowledging and validating the strengths in their parenting capacity at any given time. Facilitating parenting and engagement with children while moving their practices away from the medical model and toward being person and family focused are important steps that can be made. Furthermore, psychiatric rehabilitation practitioners can support the development of a positive mothering identity by adopting strength-based language and practice, recognizing that difficulties in parenting are part of the universal mothering experience and not necessarily due to the mental illness. Supported referrals to child and family services that are qualified to provide unprejudiced parenting education are a psychiatric rehabilitation role that is part of enhancing individual skills to improve competence in the challenging parenting domain (Rossler, 2006). Mental health services can offer peer-facilitated playgroups (Goodyear & Fernbacher, 2013), which foster social identity and connectedness and build confidence and skills that may be transferrable to other life domains. In addition, services need to develop policy frameworks and offer professional development opportunities to build knowledge and skills that will enable provision of practical, nonjudgmental supports that are family focused, build parenting confidence and competence, and foster help-seeking behavior. Evidence-based interventions such as Let's Talk about Children (Solantaus, Paavonen, Toikka, & Punamäki, 2010) are being found to be effective in clinical mental health settings as well as in family services.

Support can be provided to mothers to develop a positive identity by facilitating reflection on the origins of their mothering values and ideologies, counseling women to accurately benchmark their parenting competencies to realistic role models. Encouraging the development of individual and realistic parenting aspirations that better align with women's own needs and capacity and those of their children is also a role that mental health practitioners can assume. Furthermore, women may be validated in choosing to adopt and express alternative identities that reflect their knowledge, roles, beliefs, and aspirations beyond mothering.

For many mothers, psychiatric rehabilitation services are an important source of support and strategies for recovery. Explicitly addressing the parenting role of mothers is one way in which their identity can be supported and enhanced. Mental health services also need to embody a stronger emphasis on the social and environmental factors that contribute to mental distress, holistically implementing the principals and practices of trauma-informed care and supporting women to embrace a broad and multidimensional sense of self that extends beyond the psychiatric diagnosis.

Research Considerations

In terms of future research, this review, although systematically conducted, was limited in its scope with a small number of articles meeting inclusion criteria. Within the CHIME framework, and within the articles reviewed, the concept of identity was not clearly defined or differentiated. Personal identity was often alluded to in relation to how mothers with mental illness described their par-

enting competence, confidence, and fluctuating capacity. Social identity was suggested in discussions around stigma, family support, and the responsiveness of mental health professionals in recognizing the parenting role. Identity was not the primary focus of the majority of these articles, although the analysis demonstrated the concept to be embedded among other themes.

However, this review does expand knowledge on the interrelationship between personal recovery and mothering with mental illness within the domain of "identity." In terms of future research, further exploration of the influences upon identity for mothers with mental illness is warranted, including examination of the ways in which gendered social norms and gender-based violence and discrimination may impact on their sense of self. Further research into how other elements of the CHIME framework apply for women with mental illness who are mothers is also recommended, with a focus on those women who may be further marginalized through minority cultural, sexual, geographical, and socioeconomic status.

Conclusions

One process by which personal recovery is facilitated is through building a positive and multifaceted sense of self. For mothers with mental illness, a positive personal identity that encompasses the parenting role may be promoted through acknowledgment and validation of the critical importance of mothering in times of both illness and wellness. Social identity may be enhanced through reducing the stigmatizing attitudes that can separate mothers with mental illness from other mothers, emphasizing commonalities rather than difference. A key role of psychiatric rehabilitation strategies includes supporting women to conceptualize diverse identities that validate multiple aspects of themselves and challenge prevailing gender norms surrounding illness and motherhood. Defining and critically examining the influences upon identity for women with mental illness who are mothers is vital for promoting personal recovery.

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Preface to Chapter 4

The previous chapter explored the definition, scope and relevance of the concept of identity within the literature on mothering with mental illness. Chapter 4 continues on with examining the literature, this time with a focus of connectedness. As another of the key processes identified within the CHIME personal recovery framework, what the existing literature reveals about the significance of connectedness for mothers with mental illness will now be interrogated.

Chapter 4:

Mothering with mental illness and connectedness: what we already know

4.1 Introduction

Like identity, connectedness has become a core concept in the social sciences, especially within the disciplines of psychology and sociology. Emerging from the pioneering and persuasive work of Bowlby (1969) in understanding the significance of attachment, the influence of connectedness on a range of psychological and interpersonal processes has been increasingly highlighted.

Connectedness is broader than attachment, and occurs subsequent to it. Connectedness relates to the totality of an individual's relationships to self, others, and the social world beyond. According to Lee and Robbins (1995) connectedness emerges in adolescence, and continues throughout adult life. Identified as a fundamental human need (Townsend & McWhirter, 2005), connectedness also influences many other psychological tasks including emotion regulation and identity development, thereby,

“A sense of connectedness is a more pervasive experience that subsequently guides feelings, thoughts, and behaviors, especially in social situations” (Lee and Robbins, 1998, p. 338).

Connectedness is context dependent and varies according to diverse social and cultural environments and the norms found therein. Gendered conditioning is also significant and evident in the ways in which cultural expectations surrounding women and men's respective social roles, and shape responses to their inter-personal relationship choices. The different expectations of women and men within parenting roles is one example of this, with the myth that women are 'naturally' more predisposed to nurturing infants still remaining pervasive today (Chodorow, 1979).

While the issues that might be expected to influence connectedness outcomes for mothers with mental illness (such as trauma, family relationships and economic status) have been convincingly articulated within the literature (see for example Everett & Gallop,

2001; Nicholson & Alberts, 2004; Luciano, Nicholson & Meara, 2014), connectedness as a psychological construct has not been well integrated into this discourse. This chapter aims to explore how the existing research on the various dimensions of connectedness, apply for mothers with mental illness. This discussion commences by defining the construct according to three core dimensions of connectedness: in relation to self, in relation to others and in relation to broader meaning and purpose in life. Subsequent sections summarise the research on the impact of disruptions to connectedness on mental health, in the context of mothers with mental illness. Research pertinent to the relationship between connectedness and identity will be examined, and the concluding section will outline why promoting connectedness is viewed as an ideal launching pad for fostering personal recovery.

4.2 Connectedness defined

Connectedness is a multi-faceted concept that encompasses the breadth of human relationships. In a review of the connectedness literature, Townsend and McWhirter (2005) stated that connectedness as:

“...a psychological construct might be understood as relatedness, which is a key feature in identity development and a factor in mental health and wellbeing”

(Townsend & McWhirter, 2005, p. 193).

They further emphasise that connectedness is defined by the quality, and not quantity of relationships, so the measure of one’s connectedness remains within their own subjective experience. Belongingness is an associated concept of which connectedness is defined as one component (Lee & Robbins, 1995).

While connectedness is now recognised as a social determinant of health at the population level (Wilkinson & Marmot, 2003), and an important factor for promoting mental health and wellbeing in individuals (Riggs & Bright, 1997), this has not always been the case. Historically, within the context of traditional and binary constructions of masculinity and femininity, strong connection to others was seen as problematic, symbolising

dependence and weakness (Granello & Beamish, 1998). Associated predominantly with women's social and economic roles, connectedness was discounted, in preference for the more desirable attributes of autonomy and independence, symbolised by dominant forms of masculinities within the workplace as well as in the domestic sphere.

Challenges to the values and assumptions embedded in such definitions, have emerged from cultural and gendered critiques (Granello & Beamish, 1998). Meaningful connectedness is now acknowledged to be a personal strength and a protective factor in overcoming adversity. Furthermore, Lee and Robins (2000) have demonstrated it is a salient construct for both men and women.

Within the mothering with mental illness literature, women's subjective experiences of social connections to family members, service providers and their communities have been explored. Mothers with mental illness are frequently portrayed as socially isolated and marginalised, often separated from partners (Ackerson, 2003; Campbell et al., 2012) and disconnected from the support of families of origin (Nicholson, Sweeney & Geller, 1998; Perera, Short & Fernbacher, 2014). Connectedness to self and others is impacted negatively by poverty, stigma, including self-stigma (Diaz-Canja & Johnson, 2004; Wilson & Crowe, 2008), the consequences of interpersonal violence and trauma, substance abuse (Campbell et al., 2012), and awareness of being under the surveillance of child protection authorities and the subsequent fear of custody loss (Bournsnel, 2012; Seeman, 2010).

4.2.2 Attachment

Humans have an innate and powerful need to connect to others (Townsend & McWhirter, 2005). Attachment theory has been broadly adopted as an explanatory framework to understand psychological development, stemming from relational experiences forged in infancy. Connectedness experiences throughout the lifespan are thought to be cultivated within the context of early life experiences of attachment (Bowlby, 1969; 1977). In the presence of caregiver attunement, the infant learns through experiencing sensitive parenting responses that their physical and psychological needs will

be consistently met (Bowlby, 1969). This instils a sense of their own intrinsic value and fosters a sense of love and belonging (Ainsworth & Bowlby, 1965), thereby setting up a normative model of healthy connection that underpins expectations for subsequent relationships.

The alternative to secure attachment is anxious-ambivalent, anxious-avoidant or disorganised attachment, which researchers claim result from insensitive or inconsistent caregiver responses (Ainsworth & Bell, 1970). Without a secure attachment base, individuals may be at risk of a multitude of mental health problems. At the extreme end, a profound lack of connectedness has been identified as a risk factor for schizophrenia (Spaniol, Wewiorski, Gagne & Anthony, 2002) and fear of real or imagined abandonment and intolerance of aloneness, profoundly shape relational interactions for those diagnosed with borderline personality disorder (Levy, 2005). Other studies have found disruptions to social connectedness also contribute to higher rates of internalising mental health behaviours such as self-harm and disordered eating (Rosenfield, 2012).

The importance of healthy relationships cannot be overstated. Relationships, and the love, joy and connection they bring, are at the very core of human life (Baumeister & Leary, 1995). They shape many fundamental aspects of life, including physical growth and development, social-emotional competence, cognitive capacity, friendships and intimate partnerships, confidence, self-esteem, values and ethics, education and employment outcomes and health across the lifespan. In short, healthy relationships help us to flourish, while unhealthy, abusive, oppressive or unequal relationships promote poor outcomes.

4.2.3 Feminist critiques of attachment theory

Attachment theory, which developed from the psychoanalytic tradition, forms the foundation of the vast majority of psychological interventions, despite challenges to its basic assumptions. While many psychologists agree that the quality of one's primary relationships as an infant shape subsequent interpersonal interactions and relationships, this notion does not go unchallenged. Alternative views on the predictive significance of

attachment will be explored in this section. Attachment theory must also be contextualised within the social and cultural context in which it arrived. Originally, Bowlby privileged the maternal infant relationship as the primary, and exclusive site of attachment development. Bowlby's research used large samples of orphaned children following the Second World War, and claimed that maternal deprivation accounted for the plethora of mental and physical health difficulties he observed (Birns, 1999). Feminist psychologists have since criticised the exclusive focus on the deficiencies associated with maternal role as the primary source of attachment disorders, and the simultaneous omission of other factors that impact on childhood attachment outcomes. Birns (1999) identifies the various deprivations experienced by these infants, and although many of these conditions were and still are largely provided by mothers, this is not always the case, and neither does it need to be.

Women still shoulder the overwhelming burden of responsibility and blame for the mental health difficulties experienced by their children (Strega, Fleet, Brown et al., 2008). Mothers are under the constant scrutiny and instruction of figures of authority, who are often male (e.g. obstetricians, paediatricians, psychologists) (Krane & Davis, 2000). Single mothers come under the pervae of child protection services most frequently

“Because they are poor and otherwise marginalized, these mothers find it difficult to secure adequate housing, feed their children or live in a safe neighbourhood”

(Strega et al., 2008, p. 706).

However attachment research has also found that maternal stress is closely linked to infant attachment, and in a study conducted by Vaughn (et al., 1979):

“the mothers with the greatest amount of psychosocial stress had the babies who changed from secure to insecure attachment, although the converse did not prove to be true. Vaughn and his colleagues acknowledged the importance of poverty-

related stress as altering attachment classification from secure to insecure” (Birns, 1999, pp. 14-15).

This finding illustrates what feminist researchers have long argued, that women are held by society to be primarily responsible for nurturing children, in a social and cultural context where this work is not highly valued or resourced (Hays, 1996). This Western norm best meets the needs of those in positions of power and privilege: namely white middle class men (Hays, 1996). When women inevitably fail to reach the unattainable expectations of this role, the social sanctions in terms of surveillance, stigma and punishment are monumental. Birns (1999) succinctly summarises the central tenants of the feminist critique of attachment theory:

“Perhaps the most negative effect of considering attachment to form the basis of future mental health is the fact that in blaming mothers and the quality of their care for all the problems of their children, it minimizes the importance of all the other factors that influence how our children grow. I would suggest that poverty, racism, poor schools, access to guns, violence on television and inadequate health care all have profound effects. That every child, or for that matter all of us, thrive on feelings of warmth, love and respect is undoubtedly true. But to think that this depends on mothers and mothers only, or that it all happens in infancy is an extraordinary oversimplification. To attribute the healthy development of children exclusively to the care that mothers provide is to ignore the complexity of the world of infants and children, their resiliency and their potential of growth and development throughout the life cycle” (Birns, 1999, p. 19).

4.3 Connectedness and mental illness

The link between connectedness and mental health has been well established (Townsend & McWhirter, 2005). While robust connectedness to self and others promotes wellbeing, psychological growth and resilience (Riggs & Bright, 1997), disconnection and

social isolation has been associated with a multitude of mental health disorders. It has been observed that “disconnected individuals may see themselves as cut off from the social world despite the fact that they may have nonconflictual relationships with professional colleagues, personal friends and family members” (Townsend & McWhirter, 2005, p. 191). Development of a mental illness is “often is experienced by a person as a profound disconnection from him or herself, from others, from living, learning, and working environments, and from a larger sense of meaning and purpose” (Spaniol, 2002, p. 321).

4.3.2 Connection to self

Connection to self emerges through processes of self-reflection that lead to self-awareness. Curtis (1992) observes that the term ‘self’ has been assigned different meanings, but she emphasises that it is incorrect to use it as a synonym for self-concept, as self-awareness is the more accurate interpretation. This is congruent with the understanding of the self as a process, rather than a structure and fits with self-categorisation theory, in that the self is viewed as a dynamic and fluid entity rather than a static structure. It is the process through which the development of personal identity is facilitated, in an awareness of self as a distinct and unique in relation to others. Personal identity is forged through ascertaining and defining what one is ‘like’, (and not like). A coherent personal identity results through consistency between internal (thoughts and emotions) and external expressions of this self, in behaviour.

Kohut (1984) claims the self is the organising centre of experience. Behaviour is therefore seen as resulting from the three imperatives of grandiosity, idealisation and belongingness. “These three needs together provide the motivation and structure for self-expression” (Lee & Robbins, 1995, p 232).

For mothers with mental illness, connectedness to self may be hampered by powerful emotions that arise as mental illness symptoms, and also as a response to the disconnect between internalised thoughts and values associated with mothering,

compared to behaviour, for example feelings of failure, guilt and regret (Davies and Allen, 2007). This self-stigma arises from internalised assumptions regarding social expectations of the mothering role, that fail to consider the realities of social and economic deprivation experienced by the majority of mothers with mental illness (Seeman, 2015).

4.3.3 Connection to others: mothering and family relationships

“A person struggling to feel connected begins to feel different and distant from other people. He or she may find it hard to accept social roles and responsibilities, leading the person into greater isolation. The person will try to relate with others but will get frustrated or disappointed by the failure of others to understand him or her. The person may begin to fantasize about finding a place where he or she belongs, rejecting more realistic roles and relationships. In the extreme case, the person may distance him or herself from society and lead a solitary life” (Lee & Robbins, 1995, p. 233).

This finding that people who have experienced social rejection will go on to behave in ways that exacerbate their isolation and cumulative disconnection is confirmed by Wilczyńska and colleagues (2015). While the experience of social rejection was found to increase the need for belonging, another effect of exclusion was a blunting of emotion. This manifested as a reduction in emotional expression, with the consequence that others would be repelled rather than engaged in future social interactions, thus continuing the cumulative cycle of rejection. For mothers with mental illness, these research findings are useful in explaining experiences of isolation in parenting.

4.3.4 Community and belonging

Lee and Robbins (1995) propose that belongingness, along with grandiosity and idealisation (Kohut, 1977) is one of three core needs of the self, as the organising centre of experience. Belongingness is associated with a sense of occupying a valued social role. It emerges in relation to others within close social proximity and this could be in the context of family, neighbourhood, cultural group, workplace or within another type of social

connection. Belongingness is argued to be comprised of three parts: companionship, affiliation and connectedness (Lee & Robbins, 1995).

Connectedness within community suggests a perception of having attributes or values in common with others, as well as having something valuable to contribute. Understanding of the particular social norms and rules of the community is often a prerequisite for belongingness, as suggested by the term 'affiliation'. In addition to the inherent psychological benefits that emanate from close reciprocal social relationships, the opportunity to gain social support during times of adversity is another advantage of belongingness.

4.3.5 Connection to life meaning and purpose

Many researchers have found social relationships in and of themselves to contribute significantly to meaning in life (Lambert et al., 2013; Stavrova & Luhmann, 2015). One of the properties of robust connectedness is the provision of a sense of fulfilment in present relationships and a future-orientated perspective that links current roles and activities to broader concepts of meaning and purpose in life. Connectedness to meaning and purpose delivers motivation and drive for undertakings, suggesting interconnectivity to others and pursuit of shared goals and purposes beyond one's individual aspirations. Stavrova and Luhmann (2015) in a longitudinal study found that the relationship between meaning in life and social connectedness is bi-directional. Not only does connectedness provide vigorous meaning in life, but additionally, possessing meaning in life promotes social connection, as those with high measures for life meaning were found to be more likely to have satisfying and supportive intimate relationships.

In qualitative studies, mothers with mental illness have identified one of the core positive aspects of the parenting role, is the meaning it provides (Carpenter-Song et al., 2014). Furthermore women experience increased focus (Montgomery, Mossey, Bailey, & Forchuk, 2011; Sands, 1995) and purpose (Diaz-Caneja & Johnson, 2004) through motherhood. As a socially valued undertaking, motherhood increases women's worth

when the alternative dominant identity may be closely associated with their illness (Blegen, Hummelvoll & Severinsson, 2012).

4.5 Connectedness and identity

The relationship between connectedness and identity is complex and multi-dimensional. A number of theorists claim that identity is formed in the context of interpersonal interactions and enduring relationships (Chodorow, 1978; Gilligan, 1982). Therefore the quality of connectedness to self and others, has the potential to profoundly impact on both personal and social identity as it develops in the adolescent years.

Personal identity pertains to one's self concept, especially in articulating an awareness of *what* one is 'like', while social identity is associated with affiliations and describes who one is 'like' (Ontorato & Turner, 2004). Self-categorisation theory portends that these beliefs about one's self are an evolving process rather than an enduring structure (Ontorato & Turner, 2004). In developing an identity and defining one's 'self' the characterisations pertaining to 'me' are all conceptualised in relation to others.

Connectedness is observed to emerge as a key developmental process in the teen years (Lee & Robbins, 1995), following successful attainment of companionship (in early life) and affiliation (in childhood). This model is offered as an alternative to attachment theory, which is exclusively concerned with the infant and primary caregiver relationship and does not articulate a developmental process of relational development through ages and stages (Kohut, 1984).

Adolescence is salient for the development of identity as young people separate socially, psychologically and often geographically, from their parents. Connectedness enables adults to form relationships with others who are different to themselves and the benefits "include the ability to identify with marital partners, parenthood, and other social roles in life" (Lee & Robbins, 1995, p. 233). Lee, Draper and Lee (2001) go on to suggest that for a small number of people "a lack of belongingness is a persistent and pervasive experience that is psychologically distressing and potentially debilitating (p. 310).

4.6 Connectedness and personal recovery

The multi-dimensional reach of the construct of connectedness makes it a central concept for personal recovery. Importantly for the personal recovery context, Hogg and Frank (1992) found that connectedness to self and others stimulates emotional healing and recovery. Encompassing elements of relationship to self (personal identity), relationship to others (social identity), relationships to broader meaning in life (including hope), and a sense of agency (empowerment), in and of itself, connectedness is connected to and overlaps with, all of the other CHIME categories.

As argued by Price-Robertson and colleagues (2016), recognition of the relational aspects of an individual's existence is the foundation from which recovery work may grow. Examining connectedness as a starting point may have numerous benefits. It can promote, privilege and validate the fundamental importance of the therapeutic relationship as a secure base for all subsequent work. It may increase understanding of an individual's history and factors that have contributed to their mental illness, identifying social and psychological barriers to relationship development such as insecure attachment, trauma and abuse or discrimination. It can identify unexplored potential avenues for the development of relationships with family members or peers who may be able to support other recovery processes. Explicitly and sensitively exploring experiences and assumptions surrounding connectedness may also strengthen existing relationships that may be complex or problematic. For mothers, this includes connectedness within relationships with their children. Connectedness discussions may also form a base from which to explore associated concepts such as identity, allowing an individual to contextualise their relationship to self, and to reflect on the ways in which their relationships with others, may have influenced their self-concept.

4.6 Conclusions

The connectedness literature illuminates the substantial social and psychological benefits of robust connectedness to self, others and to broader meaning in life. Along with

companionship and affiliation, connectedness is conceptualised as one component of the construct of belongingness, which is viewed as a developmental process (Lee & Robbins, 1995).

Low connectedness can result in a sense of interpersonal distance and profound loneliness (Lee, Draper & Lee, 2001). Connectedness can be hampered by low self-esteem, and patterns of social rejection can create expectations of future rejections, leading individuals to present in social contexts in emotional states that are more likely to repel others from engaging with them.

For mothers with mental illness, the relationship difficulties that are frequently reported in the literature illustrate experiences of low connectedness, manifesting as repeated social rejection within families, and in interactions with service providers and the community. The literature suggests that promoting connectedness in mothers with mental illness may be enhanced through individual interventions with an emphasis on developing the therapeutic alliance initially, rather than focussing on addressing symptoms. Working to demonstrate empathy and validate experiences whilst gently challenging negative self-perceptions have been recommended as therapeutic strategies for people assessed to have low connectedness (Lee, Draper & Lee, 2001; Rook, 1984).

Preface to Chapter 5

While Chapter 7 reports on the findings of the fourth study on challenges to connectedness in personal recovery for mothers with mental illness, Chapter 5 will now examine the processes along with the social context within which the personal recovery journey occurs. The following chapter is derived from data collection with 17 women who are mothers with mental illness. The following chapter has been accepted for publication in the *British Journal of Social Work*.

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Chapter 5:

Resourcefulness and Resilience: The experience of personal recovery for mothers with a mental illness

ABSTRACT

Understanding of key characteristics and processes of personal recovery from mental illness is growing. However a paucity of research exists with mothers with mental illness around experiences of personal recovery. An improved understanding of the interplay between illness, parenting and broader social factors may better inform how mental health services respond to the needs of these women.

Using constructivist grounded theory, in-depth interviews were conducted with 17 women who were mothers with a mental illness, residing in Australia. Through constant comparative analysis, initial codes were synthesised and theoretical sampling employed to reach saturation of the categories associated with the construct of personal recovery. For mothers with a mental illness, personal recovery takes place within and is shaped by broader social contexts. Six key dimensions of personal recovery were 'recognising recovery', 'mothering', 'experiencing oppression', 'managing distress,' 'making a change,' and 'feeling better.'

This study found that mothers with mental illness interpret recovery as enduring through difficult times, rather than a process of personal transformation and adjustment which is articulated within personal recovery literature. Wellbeing outcomes for women with children may be more effectively promoted through strategies that address underlying factors such as supporting early mothering, preventing violence against women, addressing trauma, and redressing socio-economic disadvantage and gender disparity.

Key words: Personal recovery; Mental health; Mothering; Trauma-informed care

INTRODUCTION

Personal recovery

As part of multi-disciplinary teams, social workers are advantageously positioned within mental health services to be able to promote recovery from mental illness. Social workers are also employed across a range of family settings including early years, child protection, drug and alcohol services and community health where they may encounter maternal mental health difficulties. Social work training prepares practitioners to provide expertise in family focussed practice (Maybery, Goodyear, O'Hanlon, Cuff & Reupert, 2014), community development approaches (Forde and Lynch, 2015) and understanding of socio-economic and political enablers and barriers to recovery (Bowen and Walton, 2015). Mental health services within Australia and internationally are re-orientating policy and practice from being focussed on such clinical results as reduction or elimination of symptoms, towards more broad and diverse personal recovery outcomes (Commonwealth of Australia, 2013; Tew et al., 2011; Wyder and Bland, 2014). People with lived experience have articulated that recovery is broader and more complex than narrow medical constructions (Deegan, 1996; Slade, 2009). Alternative definitions give prominence to elements including living "a satisfying, hopeful and contributing life" (Anthony, 1993:13), developing "a sense of integrity and purpose" (Deegan, 1988:15), and building "connection, safety, hope, and acknowledgment of (one's) spiritual self" (Long, 1994:4).

Implicit within these definitions is the assertion that recovery can and does occur even when psychiatric symptoms persist. Since the 1980's, personal recovery theory has been influential in the Australian mental health sector to such an extent that it is now the guiding principal informing national mental health services policy and practice (Commonwealth of Australia, 2010, 2013). In 2012, trauma informed care practice guidelines were developed for universal implementation across settings, in recognition of

the high prevalence and profound implications of trauma on individuals and families (Kezelman and Stravropoulos, 2012).

The conceptual base of personal recovery has been considerably strengthened with a systematic review of 87 personal recovery articles by Leamy and colleagues (2011; Shanks, Williams, Leamy, et al., 2013). The key characteristics and processes associated with personal recovery were summarised according to the CHIME personal recovery conceptual framework. The five critical processes are Connectedness, Hope and optimism, Identity, Meaning in life and Empowerment (Leamy, Bird, Le Boutillier, et al., 2011). This framework is being validated with diverse cohorts to test its relevance and application more broadly (Bird, et al., 2014; Shanks, Williams, Leamy, et al., 2013). However personal recovery has rarely been examined from the grounded perspective of mothers and it is unclear from this paper how many of the 87 studies included parents in the participant cohort. Certainly, parenting is not mentioned at all in this paper.

Mothering with mental illness

Only 16% of Australian women remain childless into their 40s (Australian Bureau of Statistics, 2008) and it has been observed that “motherhood, which is often an intensive and lifelong relationship for women, can have a significant impact on women’s identities” (Laney, Hall, Anderson, et al., 2015:127). It is estimated that over 50% of women with mental illness are parents (Maybery, Reupert, Patrick, Goodyear & Crase, 2009; Parker et al., 2008; Vigod et al., 2012) and recognised that the challenges of parenting can impact on mental health (Ackerson, 2003), while mental illness symptoms, treatment and associated difficulties can compromise parenting capacity (Montgomery et al., 2006; Venkataraman and Ackerson, 2008) and impact on all family members (Reupert & Maybery, 2007). However parenting is rarely alluded to in personal recovery discourse.

Conceptually, personal recovery has been founded on an individual perspective, sometimes with reference to others as carers of those in recovery (Wyder and Bland,

2014) but rarely from the perspective of mothers with mental illness caring for children. Mothering is highly gendered (Chodorow, 1978), socially and culturally constructed (Hays, 1996), and at times difficult and demanding (Hays, 1996; Ussher, 1991) for all women. Women with a mental illness face additional parenting challenges emanating from the illness itself including symptoms and treatment (Ackerson, 2003; Blegen, Hummelvoll and Severinsson, 2012; Dolman, Jones and Howard, 2012), socio-economic disadvantage (Luciano, Nicholson and Meara, 2014), difficult family relationships (Nicholson, Sweeney and Geller, 1998; Perera, Short and Fernbacher, 2014), stigma and discrimination from health service providers (Cremers, Cogan and Twamley, 2014; Davies & Allen, 2007), family members (Nicholson, Sweeney, Geller, 1998) and from other sections of the community (Seeman, 2010; Chernomas, Clarke & Chisholm, 2000; Diaz-Caneja and Johnson, 2004). These latter issues at times result in women masking symptoms when they are unwell, to reduce the risk of separation from their children through custody loss (Montgomery, Tompkins, Forchuk, et al., 2006; Venkataraman and Ackerson, 2008). In these circumstances, women's own needs including those associated with facilitating recovery, may be compromised. While knowledge of the experiences and needs of mothers with mental illness is increasing, exploration of these issues within the context of personal recovery is deficient. A primary aim of this study is to examine the concept of personal recovery from the perspective of women with a parenting role. The failure to acknowledge the significance of one's parenting role within the experience of mental illness and recovery has been a criticism of recovery discourse and research generally (Maybery, Reupert, & Goodyear, 2015a; Nicholson, 2014).

Aims

This study explores the ways in which a group of rural mothers with severe and enduring mental illness experienced personal recovery. Specifically, the study investigates how women who are mothers describe the characteristics and processes they have found

to be of significance in their recovery journey, including the factors that facilitate or impede recovery. This particular cohort was selected as rural women are under-represented within mental illness research and it was considered that their needs and experiences may differ due to the rural context.

Methods

Following ethics approval from the relevant University and Health Service Ethics Committees, women were invited to participate in the study via mental health clinicians and through social and local print media. Ten participants had had current or past involvement with a mental health service, while 7 had not. Women were screened for eligibility and informed consent obtained in writing. Eligibility entailed women having at least one child aged under 18 years in their care at least 50% of the time, self-identifying as having a current or past psychiatric diagnosis, and living outside a regional or metropolitan centre. Brief demographic details were gathered and intensive interviews conducted in a health or community setting convenient for participants. Interviews were held between July 2015 and February 2016. They were audio recorded and fully transcribed and conducted by the first author. Three phone interviews were held, and the remaining 17 were conducted face to face. Interviews ranged from 25 to 62 minutes duration, averaging 43 minutes.

The interview schedule was flexible and responsive and included questions about the background to women's experience of mental illness, their experience of motherhood, and their perspectives and experiences of personal recovery. Open ended questions included: Could you give a little bit of background about your mental health difficulties? What does recovery mean to you? What do you think might be the key ingredients or processes for personal recovery from mental illness? How do you feel now, compared to when you first became unwell? How would you describe yourself as a mother? How has becoming a mother changed the way you see yourself?

Data was analysed concurrently with data collection using a constructivist grounded theory approach (Charmaz, 2014), initially through line by line coding whereby every line of data was coded with a gerund that described the social or psychological process occurring. Focussed coding was then undertaken, facilitated by memo writing and mind-mapping (Charmaz, 2014). During this process those codes with “more theoretical reach, direction and centrality” (Charmaz, 2014:141) were raised to categories. The properties of those categories including the circumstances under which they transpired were explored. Emerging ideas about relationships between codes and categories were represented pictorially (Figure 1).

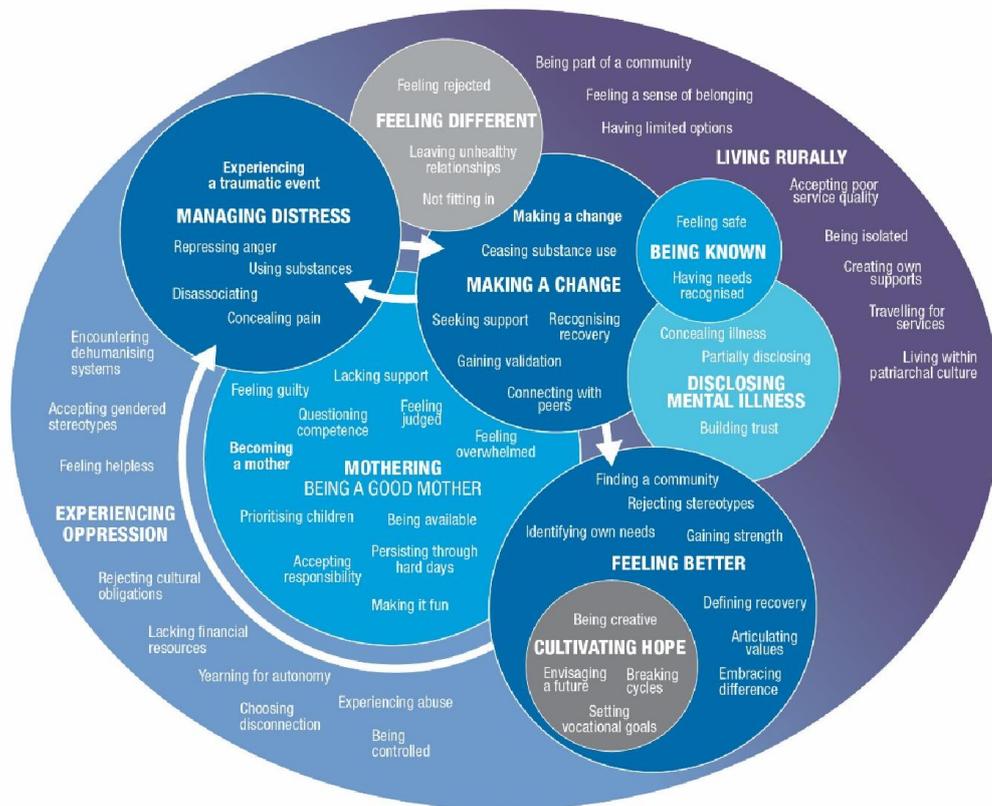


Figure 1: Personal recovery conceptual map

Following the tenth interview, theoretical sampling techniques were undertaken to further examine ambiguous or incomplete elements within the emerging data. An additional 10 interviews were conducted (3 being second interviews with existing participants, 7 with new participants) with a revised and flexible semi-structured interview

schedule to delve deeper into the meaning given by participants to the social and psychological processes pertaining to personal recovery. This was a part of the theoretical sampling process of CGT methodology (Charmaz, 2014). As codes emerge, the researcher purposefully recruits to the study participants who have characteristics that may enable them to provide additional data that deepens understanding of the properties of the emerging codes (and subsequently, the categories). In some cases these were new participants, however existing participants may be asked additional clarifying questions in subsequent interviews to explore an emerging code in greater depth or to investigate previous responses in an effort to expand understanding.

Components of the data were coded by two researchers. Discussion between all 3 authors enabled consolidation of categories and promoted reflexivity and quality and accuracy of coding.

Participants

Twenty interviews were held with 17 women. Women were aged between 23 and 53 years and had an average age of 36.29 (SD= 8.27). Cultural background was described as Australian for 10 participants, Australian/English for 2, and Australian/German for one woman. Two women identified as having Aboriginal heritage, while an additional woman identified as part of the Aboriginal community through being a mother to Aboriginal children. The remaining participant stated that her biological parents were Italian and Finnish, although she had grown up in an adoptive Australian family.

Self-reported diagnoses included bipolar disorder (5), borderline personality disorder (2), anxiety (9), psychosis (2), depression (11), post-natal depression (4) and obsessive compulsive disorder (2). Fourteen women reported having two or more diagnoses. Participants had a total of 37 children, averaging 2.18 children per family. The average age of children was 8.27 with a range from 6 months to 17 years. Eight of those

children were living in out of home care at the time of the interview, however all but one women had at least one dependent child living with them.

Eight participants relied on a Government payment as their primary source of income, while 2 were employed fulltime, 4 were supported by a combination of their partner's wages and their own part time wages, and 2 derived an income from the family farm. The majority (n=9) of women lived with their partner and children, four lived with their children only, one lived alone and two lived with their child and their parents. Nine of the women owned or were buying their home, 5 lived in private rental, and 3 lived in public housing, one of these being transitional housing.

FINDINGS

The following sections detail the categories emerging from the data relating to personal recovery.

Recognising recovery

Of the 17 women interviewed, 7 were familiar with the term personal recovery at the outset of the interview. Those who were familiar had all had a long term relationships with a psychiatric rehabilitation service (which in Australia is a community based organisation which promotes psycho-social recovery and rehabilitation) instead of or in addition to a clinical mental health service (which is more likely to be focused on promoting clinical recovery through medical and psychological therapies). One woman who strongly related to the term stated:

“Recovery to me... is seeing myself beyond the illness. It's about moving forward in life. It's about getting back into study, it's about educating yourself and wearing the illness so that you know you can walk through any door and you know that you're unique inside, that you've got it in yourself, you can help someone else.”

All participants, regardless of their familiarity with 'personal recovery' in mental illness, were able to conceptualise how it might be relevant for them. Concepts associated

with recovery included acceptance, normalcy, validation, emotion regulation, personal insight, gaining understanding, seeking support and making conscious changes.

Acceptance was multi-faceted and included acknowledgement of an underlying problem, a diagnosis, the need to take medication, the need to access services and supports, and acceptance of personal responsibility for initiating change. Being diagnosed and prescribed the correct medication is more closely aligned with clinical recovery outcomes, however one woman described significantly improved cognitive function on commencing medication:

“When I used to think, it was like a freeway, like a fifty lane freeway of thought... all just going at once, and I can’t stop it, I can’t help it. It frustrates me... but with the tablets I am able to just slow it down. I can pick one, and I can have it slowed down even more, and I can concentrate on that line. It makes things a lot clearer, which makes it better.”

Recovery was described as a process that is unique, individual, ongoing and active, requiring conscious effort and commitment, “recovery, can start with a beginning... a realisation that there is something wrong, really wrong, I need to help myself.” One participant regarded recovery as impossible for her, seeing her symptoms as ongoing and persistent barriers to achieving 100% clinical recovery, thereby dismissing other measures of recovery. She also commented that she regarded herself as a ‘normal’ mother, undertaking the same tasks as other mothers with equivalent competence, highlighting that mothering competence and confidence can still occur while mental illness persists.

Women related less to the concept of personal recovery than to the notion of enduring through continuing episodes of mental illness. Along the way and through personal reflection they learned more about themselves and the factors that were likely to place stress upon them. They also developed skills to deflect the negative responses of others and resourcefully sought more helpful sources of support whether that be via on-

line forums, through health services or through developing friendships with like-minded peers. Through hearing the experiences of others, women learned to be less self-critical and to increase self-care activities that they had found to be effective:

“There’s just a lot of healing these days where I just don’t want to get up but I do.

With my boy, he’s got school and I get up with him... And if I go back and lie on the couch and sleep for an hour when he’s gone, sometimes I do that, I need that.”

Mothering

The mothering role was dominant in women’s lives, and they spoke of their love and devotion to their children, in tandem with the values they wished to impart, such as independence, kindness, respect, and a strong work ethic. However for women with limited social and financial resources, the relentless labour of parenting was also apparent, and participants shared their struggles in attempting to provide for their children’s needs, aware that this left them depleted in time, energy, finances and other resources.

Women articulated an understanding of the cultural expectations surrounding mothering, and aspired to meet them, conceding that their own needs were on hold until the children grew older because “that’s what being a mother is about – the kids.” While half of the women spoke of their desire for closer peer relationships with other mothers, their attempts at connection in settings such as new mothers groups often left them feeling as though they didn’t “fit in” and “this divide or wedge got bigger and bigger” due to differences in socio-economic status, cultural background, language or age.

“It’s a bit disappointing because I was looking forward to mothers’ group the whole time I was pregnant. I was absolutely looking forward to it and now it’s a bit of a let-down.”

The demands of mothering influenced opportunities to source resources to promote recovery. However recovery outcomes were also seen to benefit children as women sensed that their wellness would provide security and hope for their children. Their hopes

around the future were centred on being able to manage emotions, symptoms and challenges, with their mental illness diminishing in influence. Women aspired to enjoy more happiness and “just a bit of freedom” rather than being overwhelmed by anxiety, sadness or confusion, “so when the kids come home they can see me on fire and they can see Mum leading a whole healthy life and not tortured by the past.”

Experiencing oppression

The social context of participants’ lives was found to be highly influential for promoting or hindering access to the personal, social and economic resources required to promote recovery from the mental illness and its effects. Oppression took many forms. The most profound was gender-based and manifested as family violence, inequality in intimate relationships, a lack of financial resources, and disempowering interactions with service providers. Although women were not directly asked about their experiences of abuse in this study, 6 participants disclosed childhood sexual abuse, 5 had experienced domestic violence while 7 women provided accounts of gender based discrimination encountered in relationships.

Women spoke of service providers from a range of professional backgrounds (e.g. doctors, midwives, infant health nurses, teachers, child protection staff) stripping them of their dignity and humanity through subjecting them to processes, language and actions that invalidated their own experiences and failed to recognise their individual characteristics or needs. Assessment tools were administered mechanically, devoid of a relational context, leading one woman to observe:

“I think sometimes they need to listen to the individual a bit more. Because the amount of times I’ve filled out the (Edenborough post-natal depression scale)...and a lot of the time I find they just focus on that rather than the individual situation. I find that a little frustrating.”

Some women perceived higher levels of monitoring of their early parenting occurred because of stigma relating to their mental illness. They felt that this scrutiny was aimed at meeting the organisation's risk management frameworks rather than supporting their mental health and the wellbeing of their child:

“they ticked the boxes, (visiting me) 2 or 3 times instead of just the once, and that really annoyed me because I didn't want them to come and visit me... they sit there with a questionnaire and go through it to tick their boxes, how did that actually help me? It didn't help me, I just sat there feeling judged, and every time after they left I cried.”

Another participant pinpointed prejudice in practitioners as a factor that undermined the therapeutic relationship, stating “they try to judge you straight away and they don't even know you. I don't like people like that.” Exasperation was expressed by a different participant with what she perceived as the unrelenting demands of child protection to demonstrate her mothering competence in the context of social isolation, cumulative trauma and poverty.

“I'm sick of jumping through (service system) hoops. I'm over it. If they had just left me in the first place, I would have been OK.”

Sub-standard medical treatment and health service provision – on occasion leading to life threatening medical emergencies - were tolerated, partly as a result of the lack of comparative experiences with which to measure this treatment. Patronising and demeaning responses from doctors were also related:

“I think there's sexism involved, definitely... ‘there there, woman, you're just worrying, you're just a worried mother hen’. That's what he (the doctor) said to me and I went off at that. No, my baby's not eating and losing weight. Don't tell me I'm a mother hen!”

Experiences of gender based oppression were also apparent within intimate relationships. Seeing patriarchal economic and social relations mirrored all around them in their “close knit” “family focused” communities, women had difficulty in identifying and addressing inequality in their own relationships which contributed to their sense of powerlessness and dependence. Distribution of domestic labour was gendered for women who were partnered, and although they appeared to accept their household role, they simultaneously expressed a sense of injustice relating to their lack of freedom and autonomy. One woman claimed that her husband was supportive when she was unwell, in that he didn’t expect her to have domestic tasks completed by a set time. However she later clarified that these tasks remained her sole responsibility to undertake. Another woman expressed conflicted thoughts,

“I would like him to do more around the house, but then I feel the guilt of me being there (and not in paid work, therefore), I should be doing much more of the housework than him... I love my children but I do feel that my life has changed much more than I thought it would.”

Financial stress was also an oppressive force for women reliant on government payments as their primary source of income. Five women had no independent transport and lived in public housing. They struggled to meet fundamental expenses such as food, clothing and education costs for their children. However their resourcefulness and tenacity in managing these circumstances was apparent in the ways they used facilities like public libraries and community houses, sought out on-line forums for anonymous support, and developed reciprocal relationships with friends and neighbours to assist with childcare.

Recovering from trauma, not mental illness

Women most commonly spoke about recovering, not from the symptoms or impact of their illness, but from the events or cumulative traumas that had precipitated the illness diagnosis. Participants in this study identified the mental illness symptoms they

experienced as being a psychological response to manage extreme traumatic distress from past events. For some women, this distress emerged from physical, emotional or sexual abuse in childhood, for others it was the result of a one-off event, for example physical injury, the death of a baby, a traumatic childbirth or the serious injury of a sibling. Narratives of severe distress in childhood that had resulted from abuse and neglect were forthcoming, without the need for specific questioning or prompting. One participant disassociated to manage pain from a pattern of maternal rejection and psychological bullying, "I really space out, it's just a thing I do, a coping mechanism I've been told." Another participant experienced horrific trauma in her childhood resulting from physical and sexual assault. She described using drugs and alcohol and enduring violent relationships in response to the ongoing state of distress she found herself in.

Being "ripped away" from her birth mother, was how one woman described her early life. In her first weeks of life she was placed with an adoptive family who she depicted as caring and responsive, however ineffective in identifying or addressing her particular needs. She described perceptions that she was expected to conform to a set of values and behaviours to which she didn't relate. This led to feelings of alienation and isolation that were later in adulthood labelled as symptomatic of borderline personality disorder.

"There was a certain way you did something, and that wasn't me. And now, for the first time in my life I'm starting to make my own decisions and not worry about what other people think."

Episodes of maternal rejection or emotional abuse were portrayed by 7 participants, with an additional 2 women sharing experiences of being physically abused by their fathers and this being witnessed and tolerated by their mothers. The most common reaction to the immediate distress arising from these encounters was emotional blunting, and for some women this response continued into the present:

“I just thought, have you inbuilt it into me over the years that I just go blank and freeze and can’t think of anything when you look at me a certain way? ... I couldn’t even think what it was I was going to tell her. I hate it.”

Making a change

Participants identified definite turning points where an event or an insight led to them making deliberate choices around their behaviour that would lead to improved mental and physical wellbeing in the longer term. Four women spoke of this being partially instigated by the actions of intimate partners. In 3 cases, women left relationships following escalations of violence in which they perceived their lives to be in danger. In another instance, a controlling partner unexpectedly left the relationship abruptly and permanently. For another 3 women, deciding to leave a culture of drug use which had served as a coping mechanism for years, was a symbol of their raised consciousness about the numbing impact of drug use on their emotions and a re-prioritising of their own health and their motherhood role. On ceasing drug use, one woman related how she was able to see, for the first time, the damage her harsh responses were causing her children. With the aid of a supportive friend, she became aware of her children’s needs as independent from her own, and that these had to come above the demands of adult friends or family. Another woman claimed, that on ceasing of marijuana use she had begun to commit to “recovery full time... and giving up the drugs and even though it’s a crutch I suppose for a lot of stuff, it just took me that little bit longer to grasp it, to wear it, to own it and really to think about my life.” This statement implies a conscious decision to take responsibility for past actions and future decisions.

Another participant attributed acceptance of the need for self-care as being a critical contributing factor to her recovery. Although recognising her own capacity to care for others as being a stable and enduring component of her personal identity, it took recognition and conscious effort to value the effects of care for herself. “Self-care was

something that I had never done particularly well so I had to start doing some of that. So making time for myself, and at first that felt quite selfish.”

Deciding to engage with services was one action women took to instigate change.

Supportive service providers were described as non-judgemental, easy to talk to, practical, flexible and accessible. With supportive service providers, women felt safe to disclose openly their difficulties and challenges and trusted that they would be listened to without prejudice. Having this support enabled women to begin to address the underlying issues associated with their mental illness and to commence building coping and parenting capacity. Communication skills were one of the core indicators that women used to ascertain whether a health professional was supportive, thereby capable of assisting one to make a change. One participant identified the qualities she valued in her support worker as being “really good to talk to, I could talk to her about anything. But she puts her foot down and she sets the rules and the law, I really like the way she does it.”

Feeling better

In this healing phase, women gained strength and a belief in themselves that enabled them to reflect on their experiences, develop personal meaning regarding the mental illness, and identify and access resources to address their needs. For a number of women, social isolation and feeling ‘different’ to others in their family or community was a significant barrier to recovery. Developing friendships or finding a community that shared some characteristic or experience helped to overcome isolation and assisted in rejecting narrow stereotypes and tolerating their ‘difference’. When feeling better, women were able to focus on attending to activities such as work or vocational training that would provide for themselves and their children into the future.

Three participants spoke about coming to an acceptance of aspects of themselves that they had struggled with for years. This could be associated with receiving a formal diagnosis within the context of a supportive therapeutic relationship. One woman described how

“the diagnosis has allowed me to not internalise as much, and realising that ...because (I’ve) had all this trauma and abuse and whatever. No one’s going to be normal after that. So then I felt, I don’t know, validated I guess.”

Another woman felt more stable in her mental health and stronger in her identity after ‘coming out’ as same sex attracted. This woman shared the layers of discrimination she encountered in the rural context:

“If you’re not born and bred in this area you’re not a local. And then if you’re gay as well, oh my God! And then if you’re a single Mum, aw Jesus. And then if you’re a single, professional, gay Mum – oh my God! Can’t cope with that!”

For another participant, unplanned motherhood led initially to a severe exacerbation of her mental illness symptoms which lasted for almost 2 years. She described being completely incapacitated with constant migraines, chronic anxiety and significant depression, requiring continual care from her parents. Despite her parents’ efforts to establish a routine that included exercise, relaxation, connecting her to her baby and self-care, eventually feeling better came about quite suddenly one day when her migraine disappeared and awareness resumed. At this point she “still wasn’t 100% OK, it still took me a while to pick it up. But I’d say that is when I would have come home like a new Mum.”

One component of feeling better was choosing to hope. This occurred when women were able to envisage a brighter future for themselves and their children, even if the present remained bleak.

“You get to a point in life where you go, I can either be in self-destruction mode or I can garden and make it colourful, and that’s what I’ve done.”

Choosing hope was when women decided to embark on the arduous work described by one participant as “dragging yourself up”. Having children, even when they were removed from the mothers’ custody, provided motivation and a rationale for working

towards recovery. Envisioning the children's growth and development allowed women to imagine a future for themselves and their family. Aspiring to enjoy a "normal" life, defined as one not dominated by illness, was voiced on multiple occasions.

Women who had experienced inter-generational disadvantage, poverty and hardship, hoped that with their generation and through their actions and role modelling, cycles of trauma associated with substance use and sexual abuse would be broken. They hoped and believed that life would be easier for their children than it had been for them. Most of the women interviewed talked about hope in the context of wanting positive and healthy futures for their children.

Acceptance of the hard times as well as the more positive days assisted women in coping with the relentless tasks of mothering. One woman conceded "every day is a good day, I have my bits of good and bits of shit." In this context, personal recovery was unfamiliar as a realistic aspiration. Women who were dependent on government pensions and public housing, spoke of hopes for what they deemed to be a 'normal' life. Encompassed within this were normative expectations around the economic resources that make for a satisfying life such as reliable and accessible transport, occasional family holidays, and the possibility of employment once children were old enough to attend school.

DISCUSSION

Personal recovery and mothers

Personal recovery is a concept that is gaining prominence as an outcome goal for the mental health sector. "From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self" (Commonwealth of Australia, 2010). However in this study the majority of the women did not recognise the term 'recovery' nor were they

familiar with the concept in relation to mental illness. For the women in this study, recovery was usually not recognised as a legitimate term to explain their experiences as most did not see themselves as progressing in the key areas encapsulated within the quote above.

Although participants expressed that they could imagine what the term might mean, they nevertheless felt as though the difficulties posed by their ongoing symptoms, financial hardship and parenting challenges persisted, creating barriers to engagement in life, gaining a sense of meaning and purpose and developing a positive sense of self. Women expressed that they did not feel satisfied with their level of enjoyment or engagement in life and their sense of self was often overshadowed by negative interpretations of their deficits rather than abilities. In some cases recovery may be a foreign and intangible term that feels incongruent with the daily struggles of enduring mental illness. This finding echoes a similar result articulated within a Canadian study (Morrow, Jammer and Weisser, 2011) where one participant spoke of “incorporating” life experiences, rather than recovering and “becoming” as opposed to surviving.

However, elements of the CHIME framework were evident in the accounts women provided of their recovery journeys. Connectedness to family, friends and community was a significant facet of feeling better and was important in determining the success of attempts to seek support. Similar to previous findings (Blegen et al., 2012), hope was difficult to sustain in the daily struggles of life, but crucial for providing motivation to persist.

A positive identity was fostered through support for the mothering role and validation of women’s experiences, knowledge and skills. Empowerment resulted from respectful relationships (including with mental health services), learning to more effectively manage emotions and the accomplishment of new skills. Similar to previous findings in studies with cohorts of mothers with mental illness, the mothering role was imbued with deep meaning (Carpenter-Song, Holcombe, Torrey, et al., 2014) and provided a socially

validated purpose (Diaz-Caneja and Johnson, 2004; Chernomos et al., 2000; Montgomery et al., 2006).

For the cohort of this study, feeling better and choosing to hope was where women had moved towards, however most were still living in extremely difficult socioeconomic circumstances that challenged their mental health on a daily basis. Factors such as the relentless burden of single parenting (Sands, 1995), financial hardship (Luciano, Nicholson and Meara, 2014; Nicholson, Sweeney and Geller, 1998; Author's own, 2007), lack of transport, conflictual relationships (Perera et al., 2014; Nicholson et al., 1998), histories of trauma (Perera, Short and Fernbacher, 2014; Nicholson, Finkelstein, Williams, et al., 2006), unemployment and lack of social support (Mowbray, Nicholson and Bellamy, 2003) and social connection had substantial impact. Issues of social isolation, financial difficulty, lack of support and lack of transport were more profound for women who were single mothers. Likewise, child protection involvement was more common for these women and they were also more likely to have had past experiences of family violence or sexual assault. In this context, personal resources to foster recovery for single mothers with mental illness are likely to be scarce, while paradoxically more intensely required to overcome the cumulative traumas that have contributed to the mental illness.

Women's preference for describing their mental illness journey as managing, struggling or persisting, rather than recovering may be indicative of the active parenting life phase they were in, caring for children who were the primary recipients of sparse family resources. Women may attain increased resources to direct towards their own needs once children become independent. Alternatively, women with experiences of serious and cumulative trauma that leads to enduring mental illness may find themselves in circumstances of such vulnerability and disadvantage, that without sustained support, they are unable to obtain opportunities to gain the social and personal resources needed to recover.

Trauma and change

Personal recovery for the mothers in this study is perhaps better understood when two of the themes from interviews are combined. Managing distress and subsequently making a change, provide important indicators of potential intervention points for social work practitioners. As found in previous research (Cutajar, 2010; Victorian Health Promotion Foundation, 2004), the majority of the women interviewed identified traumatic events in their lives that precipitated or accompanied their mental health problem. Many then recounted how experiences of the initial violence or abuse led to successive relationships that contained violence, oppression and substance misuse, intensifying mental illness symptoms. Therefore the illness may actually be understood by women as the beginning of a process of healing, when they can no longer rely on their previous strategies for managing the distress caused by past or current trauma.

Opportunities for intervention were identified by women, as they described previous attempts to seek support, however their encounters with service providers had resulted in an exacerbation of unequal power dynamics that left them feeling dehumanised and in the most severe examples, re-traumatised. A common and significant window of opportunity appeared to be in the peri-natal phase, when women desperately needed information, reassurance, support and referral. While the principals and practices of trauma-informed care are already being employed within mental health services (Muskett, 2014), this study suggests inadequate progress has been achieved on fully implementing this model across the range of health and community sectors that women with mental illness access. Due to the apparent salience of the perinatal period, trauma informed care built on a strength based foundation of practice would also be recommended for midwifery and early parenting services. Women described feeling desperate for support and reassurance while transitioning to parenting. However these needs were rarely fulfilled due to a lack of rapport. Outcomes may have been enhanced through the development of trusting non-

judgemental relationships with midwifery, maternal and child health and mental health professionals, that took account of the women's experiences, knowledge and skills, and promoted their agency and choice. Currently, social work professionals are rarely employed within maternity or early years education settings, however numerous roles for social work are apparent. These include providing training to midwives, nurses and educators on how to support parents with mental illness, offering secondary consultations, establishing early intervention programs and facilitating peers support groups, all of which could improve outcomes for mothers and prevent mental health difficulties in their offspring (Author's own, 2015).

Research considerations

This study was conducted with a small cohort of women who were mothers with mental illness, living in rural locations across Australia. Future research replicating this study with a metropolitan group of women is warranted. Women were not screened for their current wellness, and participants would be expected to articulate their views and experiences differently at different points in time, as recovery is ever-changing. In fact one woman explicitly stated that had she been unwell, her responses would have been considerably divergent. A strength of this study was the diversity in the cohort, however a consideration is the ways in which single mothers (as opposed to those with supportive partners), and those women who had contact with mental health services compared to those who had not, may have had vastly different experiences relating to issues like economic and housing security and fear of custody loss.

Two of the participants identified being of Aboriginal descent, and there are particular historic, cultural and political factors that impact on Indigenous people that shape experiences around mothering and mental illness. However there was insufficient information gathered to enable a separate analysis of this cohort. Investigation of the issues surrounding mental illness within the broader concept of social and emotional

wellbeing, mothering and experiences of recovery and healing with Indigenous women is recommended.

Implications for social work policy, practice and research

This study adds to the understanding of the experiences of mothers with mental illness, specifically associated with personal recovery. One important implication for social work practice is that practitioners and services must work with women to identify and manage past traumas. As noted by Isobel (2016), in the psychiatric setting,

“Understanding the impact of trauma on individuals does not discount their current or future diagnosis, nor alter the course of their care, but rather contextualises them, their diagnosis, their behaviours and their experiences, while informing practice in a way that aids effective treatment and recovery” (590).

Women expressed a desire to disclose, but were deterred by what they perceived as prejudice from service providers. The research also indicates a need to help identify key turning points offering opportunities to build supportive relationships that validate women’s experiences, increase their community connection and support their parenting functioning.

The high rates of violence and sexual assault in this cohort are substantiated by national and international statistics (Australian Bureau of Statistics, 2012; Morrow, 2002; World Health Organisation, 2016) and often precipitate mental illness. These data indicate the need for additional resources to redress gender inequalities and cultural norms surrounding masculinity and femininity which are determinants of violence against women (Victorian Health Promotion Foundation, 2007; World Health Organisation, 2016). A need for mental health promotion and education to challenge stigma was also indicated, with a focus on early years providers and workplaces. Social work policy on early intervention and cross-sector collaboration needs to be extended to reflect the gaps in current service

provision and capitalise on opportunities to have increased impact (Reupert, Maybery, & Morgan, 2015b).

Future research is recommended with mothers who have adult children, to ascertain if personal recovery outcomes vary as children become more autonomous and women enter a new life phase. Research with midwifery and maternal and child health nurses identifying and addressing barriers and enablers to psycho-social aspects of early parenting for women with existing mental illness, and how social work as a discipline can support this fundamental work is also recommended.

CONCLUSION

Recovery outcomes may not be articulated as women's primary goal and may not appear relevant or even possible during early parenting. Social workers employed within mental health services need to embrace and transmit a strength-based, trauma informed approach that is informed by a gendered framework that differentiates the needs and experiences of women who are mothers. For many women it is equally important to focus upon the prior experience of trauma rather than focus on the mental illness. Validating women's knowledge, roles and experiences, is fundamental to establishing the trusting and respectful relationship that is required to address both mental health and parenting needs.

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Preface to Chapter 6

Having examined the experiences of mothers with regard to the personal recovery process and context, this chapter presents the results of data collection with the same cohort, on identity in personal recovery. The paper outlines how the women conceptualised their 'self' and what factors influenced this. Central to identity was the motherhood role, although other dimensions of personal and social identity were also salient. Constructing a sense of self that included an understanding of the mental illness and its origins was important in propelling women towards future hopes of a time when the illness would be less dominant and they could fulfil their broader goals for themselves and their children. This chapter is currently submitted to *Gender and Society*.

Chapter 6:

Article 3: Identity in recovery for mothers with mental illness

Abstract

Developing a 'positive identity' is considered a core component of personal recovery, and mothering offers meaning in life and a valued identity. Few studies have highlighted the factors influencing identity within a personal recovery paradigm for mothers with mental illness. This study explores how mothers describe their identity in relation to recovery, including the factors that influence identity.

Using constructivist grounded theory methodology, in-depth interviews were conducted with 17 women who were mothers and experienced mental illness. Women defined their self-concept broadly, accentuating motherhood, but also including vocational, community and social roles. Analysis revealed six categories: defining self, becoming a mother, being a 'good' mum, feeling different, doing it my way and speaking out. Valuing identity in parenting was found to be linked to recovery. Services may facilitate personal recovery by supporting mothers to enhance a positive self-concept associated with mothering, as well as other diverse attributes and roles.

Key words: Gender; Identity; Mental illness; Motherhood; Personal recovery

Introduction

Personal recovery is a unique journey for those experiencing a mental illness, however common underlying characteristics and processes are now becoming better understood (Leamy, Bird, Le Boutillier, Williams & Slade, 2011). Distinct from clinical recovery, which emphasises a remission of psychiatric symptoms, personal recovery is grounded in the subjectivity of people who have lived experience of mental illness (Jacobson, 2004). Personal recovery is concerned with holistic life functioning and social participation and agency, regardless of the presence of ongoing symptoms (Slade, 2010).

Identity, and particularly the development of a positive sense of self that is less illness dominated and more strength based, is one of the key processes of the CHIME personal recovery framework developed by Leamy and colleagues (2011). Resulting from a systematic review of personal recovery literature, the CHIME framework highlights Connectedness, Hope, Identity, Meaning and Empowerment as core categories that transform in a recovery journey. The significance of redefining and reclaiming a valued identity may comprise “determining the direction of one’s life, grieving for lost opportunities, and yearning for belonging and acceptance” (Wisdom, Bruce, Saedi, Weis & Green, 2008).

The ways in which mothers with mental illness describe their identity and the influences upon it within the process of personal recovery has remained peripheral within recovery discourse. The aim of this study is to explore the ways in which mothers with mental illness describe their identity, and the factors that support or hinder development of a positive identity.

Identity theory

Identity is broadly defined as one’s self concept and is constructed through self-awareness of what and who one is ‘like’ and ‘not like’ (Ontorato & Turner, 2004). Identity is

constructed within one's social and cultural context (Saunderson & Weinreich, 2003) and is therefore related to the construct of connectedness.

Côté defines identity as multifaceted and states that "manifestations of identity exist at three levels of analysis; the subjectivity of the individual, behaviour patterns specific to the person and the individual's membership in societal groups" (Côté, 2006, p. 8). Within psychology, these differentiations have more broadly been separated into two categories: personal and social identity. The capacity for self-awareness and self-reflection is important for the articulation of personal and social identities (Leary & Tangety, 2003).

Personal identity relates to the internal characteristics including attributes and values that one recognises as inherent to one's self concept. Social identity meanwhile, reflects how individuals view themselves as affiliating with and belonging to particular societal groups. Vocational, family, community, political or gender-based categorisations are realms in which social identity may exist.

A fundamental debate in identity theory is whether the self is essentially a stable and enduring entity, or whether it is constantly changing and evolving (Ontorato & Turner, 2004). According to self-schema theory, the core identity constructs of an individual are thought to remain stable over time, although there may be some change in the more peripheral aspects of one's identity (Markus, Crane, Bernstein & Siladi, 1982). Rosenfield (2012) used schemas relating to self-salience, to explain disparities in mental health outcomes across gender, race and class, where a social determinants framework was ineffective in accounting for results that were inconsistent with structural inequality. Rosenfield (2012) cites the gendered socialisation processes that contribute to the social construction of femininity and masculinity, and recognises how these differ in relation to race and culture (Hill Collins, 1990). These underlie the gendered internal self-salience tendencies that predispose white women to experiencing more internalising problems (e.g.

depression) and white men to have a greater prevalence of externalising problems (e.g. aggression).

In contrast, self-categorisation theory is based on the assumption that individuals' identity can and does change and evolve in response to the social and environmental context in which people live, and in response to external and internal processes associated with major life events. Ontorato and Turner (2004) compared the two theories and found evidence to support self-categorisation theory, with two studies demonstrating "the dynamic nature of self" (p. 276) that is context dependent. Self-categorisation is a useful theory to inform exploration of the influences on identity development occurring through recovery from mental illness. Underlying assumptions imply that recovery emerges through social and psychological processes of personal change and development (Leamy et al., 2011). The depth and breadth of self-reflection and change embedded in many of the subjective narratives of those with lived experience in mental illness and recovery suggest that recovery entails a transformation at a deep psychological level, not merely some pruning or enhancement on the margins. It is for this reason that self-categorisation theory relates to this study.

Gender and identity

Identity is a highly contested concept within feminist theory. An overarching theme is that gender based identity is predominantly oppressive. Butler (1990) has problematized the concept of gender identity as the reproduction of the subordination of women, and explored the ways in which it is reproduced through linguistics. She also questions whether identity is a stable and continuous entity, and if it is static, the social regulatory structures that produce this outcome:

'To what extent is 'identity' a normative ideal rather than a descriptive feature of experience? And how do the regulatory practices that govern gender also govern culturally intelligible notions of identity? In other words, the 'coherence' and

'continuity' of 'the person' are not logical or analytic features of personhood, but rather socially instituted and maintained norms of intelligibility.'

Since the 1980's feminist discourse has been critiqued for claiming to represent the interests and experiences of all women, without including the voice of diverse groups. Especially marginalised may be women from low socio-economic backgrounds (McNay, 2004; 24) and Indigenous, black and ethnically diverse women (Hill Collins, 1990). For women from subordinated cultural groups, class and race based discrimination may have an impact akin to or greater than the sexism they face (Hill Collins, 1990; McNay, 2004). Numerous writers (Butler, 1990; McNay, 2004) highlight the lack of heterogeneity of women's experiences, contention around the primary sources of their oppression, and the methods to address this oppression. Also contested are the ways in which women construct and communicate their identity. Women with mental illness may experience a range of the above sources of disadvantage, in addition to the oppressive impact of a psychiatric diagnosis.

Although gender identity can be a source of solidarity amongst women, it is more frequently problematized within feminist debate as a site for the reproduction of existing power differentials and maintenance of patriarchy. Within feminist theory:

"...the reproduction of normative identities cannot be understood simply as a question of positioning within language but as a lived social relation that necessarily involves the negotiation of conflict and tension" (McNay, 2004, p. 185).

For women who are mothers with mental illness, those conflicts and tensions may be the precipitant as well as the result of the psychiatric diagnosis and subsequent treatment and recovery. One method of developing deeper understanding of lived social relations is through amplification of the voices of those women who are marginalised in dominant discourse. This study aims to contribute to this endeavour.

Mental illness and identity

Mental illness has been characterised as a loss of self (Wisdom et al., 2008), as psychiatric symptoms may conceal or distort an individual's skills, knowledge, values and attributes. Social identity can also be disrupted as the illness often manifests in ways that prevent people from continuing in social roles that they had previously occupied and enjoyed (Charmaz, 1995). Individuals have spoken of enduring confusion, grief and regret as they seek to reconstruct a sense of self and reconcile the differences in their identities before, during and after the mental illness experience (Heron, et al., 2012).

Researchers have explored the relationship between psychiatric symptoms and disruptions or incongruence in self-concept (Agnew, 2016; Oyserman, Elmore & Smith, 2012) including models of conceptualising and mitigating the impact of complex trauma on ones' identity and healing (Herman, 1992). In a review of identity and recovery in first person accounts of mental illness, Wisdom and colleagues (2008) found loss of self to be the most prominent focus of narratives, with the illness "often described as taking away...their previously held identity" (p. 491).

Feminist writers have observed that historically, society's response to mental illness in women has resulted in sanctions for deviance and non-conformity to the prevailing cultural expectations (e.g. Ussher, 1991). A focus on social 'integration' and adaptation of the individual, rather than advocacy for social change to create more equal and accessible social environments that foster diversity and inclusion, are evident in critiques of the recovery paradigm (Morrow, Jamer, & Weisser, 2011; Onken, Craig, Ridgway, Ralph & Cook, 2007).

Mothering with a mental illness

International statistical data indicates that an increasing number of women with mental illness are becoming parents (Maybery, Reupert, Patrick, Goodyear & Crase, 2009; Vigod, Seeman, Ray, Anderson, Dennis et al., 2012). Therefore an important undertaking

is to increase understanding of the ways in which women who are mothers experience recovery and how they relate to the concept of identity more broadly (Wisdom et al., 2008). Studies conducted with mothers with mental illness have emphasised the importance of a mothering identity to women in providing meaning and purpose (Montgomery, Tompkins, Forchuk & French, 2006), love and connection (Montgomery et al., 2006), and fulfilment (Blegen, Hummelvoll & Severinsson, 2012).

Researchers have highlighted that parenting stress can compromise mental health (Ackerson, 2003; Mowbray, Bybee, Hollingsworth, Goodkind & Oyserman, 2005; Reupert, Maybery & Kowalenko, 2012), and discovered that mothering confidence and competence can be undermined by the scrutiny and prejudice that can be imposed by over-zealous service providers (Montgomery et al., 2006, Seeman, 2012) and family members (Perera, Short & Fernbacher, 2014), who are often operating within a risk aversion framework.

Shor and Moreh-Kremer (2016) conducted a study with 12 mothers with mental illness in Israel. The results of this study emphasised the strengths for women with mental illness in being able to claim a normative maternal identity, thereby reducing their vulnerability to stigma and alienation. Within this study mothering identity was compared to mental illness identity, without consideration of other potential sources of identity in women's lives. While there may be individual benefits to conforming to gendered norms, if this is through developing a public persona that is incongruent with one's internal value system, and acceptance of oppressed social status, there will also be psychological costs (Ussher, 1991). Critical research aims to reveal and question social inequalities that are embedded within stereotypes (Wilkinson, 1997). This current study adopts a gendered lens to examine the identity experiences of mothers with mental illness, and to investigate multiple identity possibilities including and also beyond, motherhood.

Aim

The aim of the study was to explore how a cohort of Australian women who were mothers with mental illness described their identity, and how this related to personal recovery from mental illness. The research furthermore aimed to explore the factors and processes that mothers with mental illness describe as influencing their identity.

Method

Constructivist grounded theory methods were employed to gather and analyse rich descriptive qualitative data (Charmaz, 2014). Grounded in feminist understandings of gender inequality that can result in and exacerbate the effects of mental illness, the research aimed to amplify the voices of women from a marginalised population group (Van Zoonen, 1994). Congruent with feminist approaches to research, CGT challenges the objectivity claims of positivist methods, instead advocating for transparency in acknowledgement of the values, perspectives, experiences and biases of the researcher which all influence the research decisions, processes and outcomes (Charmaz, 2014). CGT emerged in the 1990's (e.g. Bryant, 2002; Clarke, 2003) in response to the epistemological assumption that if "social reality is multiple, processual, and constructed, then we must take the researcher's position, privilege, perspective and interactions into account as an inherent part of the research reality" (Charmaz, 2014, p. 13).

Procedures

Ethics approval was granted by the relevant health and university committees, and mental health clinicians supported recruitment processes by promoting the study amongst eligible women. Steps were taken to ensure no harm or distress was caused, and that women felt comfortable to end or pause the interview at any time. All interviews were conducted by a researcher who is also an experienced social worker employed as a senior mental health clinician and informed consent was obtained in writing. Local services

guides were developed and distributed to participants in the event that the interviews triggered psychological responses requiring follow up.

Nine women were recruited via clinical mental health services, and the remaining 8 from the general community via social and print media. Interviews were conducted by one researcher (RH), and consistent with CTG procedures, four of these 17 women were interviewed on more than one occasion as part of theoretical sampling. A total of 21 interviews were conducted, the mean duration of interviews was 42 minutes.

Interviews were conducted in person at community venues and were audio recorded and transcribed verbatim. The interview schedule was open ended and flexible, containing questions pertaining to women's experiences of personal and social identity. To set the context, women were asked about their mental illness and recovery journeys. Women were then asked broad questions regarding how they describe themselves, their social roles, personal characteristics, if and how the way they see themselves has changed over time, about their mothering and parenting, how they envisage others see them, and what or who influences how they view themselves in various settings (e.g. work, mothering/family, community).

Data analysis occurred concurrently with data collection, coding and reflection beginning immediately after transcription of the first interview and continuing after each interview. Analysis consisted of initial coding, memo writing, purposive sampling, focused coding, mind-mapping and development of categories (Charmaz, 2014). Fortnightly dynamic discussion amongst the three member research team stimulated analysis and further data collection from participants who were selected on the basis of their capacity to provide additional details to define the properties of emerging categories.

Participants

Participant characteristics are summarised in Table 1. A total of 21 interviews were conducted with 17 women who were all mothers with a psychiatric diagnosis. The women

were a heteronomous group and varied in relation to their living arrangements, socio-economic status and cultural background. Ages ranged from 23 to 53 year, with an average age of 36.29.

Table 1: Participant characteristics

Age & cultural background	No., sex & age of children	Housing type & lives with	Rural setting and ASGC-RA rating	Self-reported diagnosis & did diagnosis occur prior to motherhood?	Income source
38; Irish, French & self identifies as a non-Indigenous member of an Aboriginal community	3 Children aged 10, F 8, M 6, M (All currently in foster care)	Private rental house Lives alone	RA2 Small rural centre on the fringe of a regional city with a population of <35,000	Bipolar, OCD, BPD Yes	Government payment
35; Australian	2 Children aged 2, F 10 months, M Pregnant at time of interview	Own home on farm Lives with husband & 2 children	RA3 Remote farm, more than 50km from a regional city	Anxiety & depression No	Farm income
44, Australian	2 Children aged 13, F 11, M	Own home Lives with 2 children & husband who works interstate	RA3 Rural area on the outskirts of a regional town population <10,000	Anxiety & depression No	Husband's full time income
39, English, Australian	1 Child aged 15, F	Own home Lives with partner & daughter 50% of time (50% with father)	RA2 Rural area outside regional city population <35,000	PND, anxiety & depression No	Own full time wages
39, Biological parents Finnish & Italian, grew up in adopted Australian family	1 Child aged 14, M	Private rental Lives with son	RA2 Rural town population <10,000	BPD & bipolar disorder. No	Government payment & part time wages
40, Australian	1 Child aged 2, M	Public housing Lives with son	RA3 Rural town population <10,000	Drug induced psychosis Yes	Government payment

29, Aboriginal	8 Children aged 15, M 11, F 10, M 8, M 4, M 3, M (youngest 2 in foster care)	Public housing Lives with eldest 4 children	RA3 Rural town population <10,000	Anxiety & depression, paranoia, bi- polar disorder	Government payment
31, Aboriginal	6 Children aged (14, M and 2 others in foster care) 4, M 2, F 8 months, F	Transitional housing Lives with youngest 3 children	RA3 Rural town population <10,000	Anxiety, PTSD	Government payment
43, Australian	1 Child aged 15, M	Own home Lives with husband & son	RA2 Rural town population <2,000	Bipolar Disorder	Government payment
26, Australian (non- identifying Aboriginal heritage)	1 Child aged 6 months, M	Private rental Lives with partner & son	RA2 Remote farm, more than 30km from regional city	Bipolar Disorder	Partner's full time wage
34, Australian	3 Children 9 yo – M 8 yo – M 5 yo – F	Private rental Lives with 3 kids 60% of time (40% with father)	RA3 Rural town population <5,000	PTSD & depression, PND	Government payment
53, Australian	3 Children aged 17, F 16, F 13, M	House on the family owned farm Lives with husband & children	RA3 Remote farm located 50 km from rural town population < 5,000	PND & depression	Farm income, & wages from 3 part time jobs
28, Australian	2 Children aged 5, F 2, M	House on the family owned farm Lives with husband, children & a boarder	RA3 Remote farm located 50 km from rural town population < 5,000	Depression	Part time wages & farm income
44, Australian, English	1 Child aged 9, M	Private rental house Lives with mother & son	RA1 Urban fringe of a city Previous RRMA 1 capital city	Depression & anxiety	Government payment
23, Australian	1 Child aged 10 months, M	Purchasing own home Lives with partner's	RA3 Rural town population <5,000	Depression & anxiety	Full time wages and partners' wages

		daughter aged 4 & son			
45, Australian & German	2 Children aged 14, M 12, M	Purchasing own home Lives with husband & 2 children	RA3 Rural town population <5,000	Anxiety, OCD & depression,	Part time wages & husband's full time wage
26, Caucasian	1 Child aged 14 months, F	Privately owned home Living with parents & daughter (husband working overseas for 8 months)	RA3 Rural town population <2,000	Depression, Anxiety & PND	Husband's full time wage

***Abbreviations**

ASGC-RA: Australian Standard Geographical Classification – Rural Area

OCD: Obsessive compulsive disorder

BPD: Borderline personality disorder

PND: Postnatal depression

PTSD: Post traumatic stress disorder

Results

The study resulted in identification of six categories surrounding the concept of identity. The first finding explores how women describe their self-concept and highlights the important elements of personal and social identity. As mothering was a core component of participants' identity, two categories illuminate the relationship between women's mothering role, their mental illness and their recovery journey. The relationship between an illness identity and a mothering identity is explored in these sections. The category 'feeling different' focuses on the women's experience of lacking a social identity and the implications of this on their personal identity. The final two categories reflect women's recovery progress, and highlight the importance of developing a positive identity for attaining other personal recovery outcomes such as empowerment and meaning in life.

Defining self

In describing their sense of self, all of the participants sought to contextualize their current temporal personal identity within their life histories, and inter-relational experiences, beginning in childhood. Ten women shared accounts of trauma from interpersonal violence occurring within childhood and/or adult relationships, and it is not known whether the remaining women may have also experienced violence but not disclosed. Through articulating key formative events, the women sought to construct identity narratives that provided meaning to explain their current circumstances, including their mental illness diagnosis.

Personal and social identities were described by participants as changing and evolving, while also containing stable components that persisted over time as illustrated by the assertion “I’ve always been this way” (P7). Participants described their identity in relation to their personal attributes, social roles and key relationships. Not all women were able to eloquently describe themselves, however there were exceptions:

“(I’m) a woman, a mother you know, I’m a feminist, I’m an atheist, I’m left wing, very left wing in a lot of ways. I’m very politically minded, I’m very also socially conscious I guess. I do a lot of social activism. I’m bisexual so I’ve done a lot of campaigning for marriage equality and stuff like that. I’m very creative... I do a lot of crafty stuff. I love having kids because it gives you an excuse to colour in... I do a lot of puzzles, I watch probably way too much television and movies, I’m a huge film buff. I love politics as well” (P11).

Moral characteristics such as honesty, independence, generosity and creativity were viewed positively by the women in their self-appraisal, and they validated this through reflecting on how others might see them such as “I think people would describe me as nice and caring” (P13). Recognition of their own resilience was also evident (n=9) in comments such as “...sometimes I look back on what I’ve coped with and I think, wow” (P5).

For other women, there was recognition that attributes that had been characterised as strengths prior to the mental illness experience could also become barriers to the help seeking that may be required to address mental health challenges:

“I would describe myself as very independent. Probably too independent... I like individual sports like running and tennis. I’ve never really played team sports. I like to achieve, like at work I became fairly obsessed with achieving at work. But that was another thing after having the baby. It was very different...” (P2).

The social roles that the women identified embodying were relational, vocational, and community orientated. They included mother, sister, daughter, partner, friend, worker, health professional, student, mental illness advocate or educator, committee member and volunteer. Relationships with others in these spheres contributed to how they viewed themselves, and their personal identity could be particularly susceptible to messages they received from significant others regarding their performance within those roles.

Four women referred to their religious affiliation as being important in defining their moral and ethical framework. Although three women spoke of attending church related activities, they did not view themselves as sharing many characteristics with other members of their church except for their religious beliefs, therefore this was salient for personal rather than social identity.

Cultural identity was discussed by five women, two of whom were of Aboriginal descent (P7 and P8). Cultural disconnection was apparent with one of the women who indicated she knew little of her heritage as her Aboriginal father had died when she was young. Another Aboriginal woman had experienced significant trauma during childhood and in adult life and had lacked opportunities to develop cultural knowledge or connection, stating “I want to know my culture, but I don’t want to *do* my culture” (P8).

Participants articulating devalued personal identities were more likely to be in roles or relationships where they derived little pleasure or fulfilment:

“I have issues with my work and because my boss is bully... when they cut my hours I took it really personally and I couldn't go to work the next day – I just cried” (P16).

Some women has difficulty describing themselves, identifying their strengths and imagining themselves in the future: “at the moment I can't see past tomorrow... I'd really like to enjoy things in my life a little bit more” (P15).

Identity across different domains could manifest in either positive, socially valued ways, or as negative and socially devalued. For example, a mothering identity could be positive if one perceived oneself to be a 'good' mother, and felt a sense of belonging to a mothers' group. Alternatively, a mothering identity could be experienced as negative if one considered herself to be deficient and incompetent, thereby judging herself as a 'bad' mother. Similarly, if a woman held a position of esteem within the community as a committee member in a sporting club, this would foster positive personal and social identity across other domains, whereas a lack of community recognition or a sense of social distance could contribute to a devalued identity reinforcing isolation and social exclusion.

Becoming a mother

“When I gave birth, I felt connected to something bigger and stronger than myself.

I'm not religious, but I'm spiritual. So I felt connected to the bigger scheme of things like connected to other women and the feminine force of the universe” (P11).

Becoming a mother could transform a woman's personal and social identity, fostering a deep sense of connection and meaning. Diversity was apparent in the responses the women had to embodying a mothering role and identity. For some it was an identity they immediately embraced and had always expected. The majority of participants (n=12) had always had aspirations of parenting, and one woman with her partner had been planning the pregnancy for some time, including changing psychiatric medication and

exploring fertility options. Having a baby brought a sense of empowerment and fulfilment for 8 of the participants. For one woman it was an opportunity to exercise her own autonomy and make choices that would not necessarily be endorsed by her own mother;

“I breastfed until 21 months and I loved it. And my mum said ‘don’t you think it’s time you gave it up?’ at six months. And I’m like, hey, I felt something was right” (P5).

However the experience did not always live up to expectations, especially in the early days and weeks.

“I hid it from the maternal and child health nurse that I wasn’t coping and then on the Friday I’d had enough and so I rang (family services worker) and said ‘I need your help’” (P10).

For four women, all of whom had relished the idea of motherhood since childhood, childbirth was accompanied by debilitating post-natal depression when they had thought they were emotionally prepared. This left them with guilt and regret for the aspects of early parenting that they missed.

Experiencing breastfeeding difficulties was a source of significant stress and eroded self-confidence for four women. One woman delayed disclosing her decision to bottle feed to her new parent’s group, fearing social rejection:

“It took me probably two weeks to tell them that I wasn’t breastfeeding, because I was just so anxious about it because everyone else was breastfeeding and I was like, oh they’re going to want to kick me out of the group, yeah they won’t want to talk to me ever again. But once I told them they were really supportive” (P17).

Having responsibility for a child prompted two women to re-assess their social behaviour and temper their anger. They explained how accepting the responsibility associated with caring for an infant had led them to cease drug use, necessitating the severing of social relationships that would undermine this new healthy lifestyle choice. This

assisted in them feeling greater competence in managing emotions, which led to a more positive identity.

Becoming a mother could have positive or negative implications for the women's personal identity. This was partially influenced by the availability of supportive relationships and assistance to adjust to the early parenting phase. How women perceived themselves to be performing in the mothering role profoundly shaped their identity, as did the quality of their relationships with family members and health professionals and the ways in which their inherent value was reflected through interactions within these relationships.

Another factor was whether the women's mental illnesses emerged before or after they became a mother. While 6 women had been given a psychiatric diagnosis prior to becoming a mother, an additional 7 participants expressed the belief that the mental health issues that eventually led to the subsequent diagnosis (after motherhood) had existed for many years, in some cases from childhood or adolescence. In these situations women described the mental illness label as providing an explanation for psychological, cognitive and behavioural events, along with the opportunity for enhanced social identity through developing peer relationships.

Being a 'Good Mum'

A 'Good Mum' was defined as accepting responsibility for one's children, prioritising her children's needs over her own, being present and responsive and "making it fun" (P7); using humour and actively engaging in play. Attending to children's emotional needs and being available was a part of this: "I want to be the person that my kids will come and talk to me when something's going on, you know. Instead of hiding that away" (P7). All of the women interviewed expressed a desire to be identified by others as a 'good mother'. Furthermore, they wanted to embrace this label for themselves, although for three participants reconciling their thoughts and emotions regarding the mothering role with an

ideal self-as-mother was problematic. One woman rationalised that she wasn't a good mother because

“...most of the time I feel like I'm just getting through... it's the extras that play with the mind and question how well you are doing. Am I stimulating them enough? Am I doing the right things for learning at this age?” (P2).

Characteristics of being a 'good' mother ranged from meeting children's basic needs for nutrition, sleep and intellectual stimulation to being physically and emotionally available to children; “a good mother is showing love to their child, their little one, talking to them, validating their feelings... understanding his point of view” (P5). It involved persisting through hard days. Persisting entailed getting up in the mornings despite exhaustion or symptoms of depression, putting “a smile on a lot in front of them and for them” (P7) and for two mothers, remaining in undesirable employment to provide financial stability.

Eight women expressed sadness and regret regarding their own upbringing. Attributing their subsequent mental illness to the cumulative impact of trauma, abuse, neglect and disadvantage, participants felt that if they had been raised in a family with a responsive adult figure attentive to their needs, their lives may have taken a different path. This fuelled a desire to be present and considerate and sensitive to their children's traits, strengths and needs, even within challenging socio-economic circumstances.

“Making sure I do a good job and (my child) gets a good education and just the little things, speaking to him nicely. I've never ever yelled at him, I don't believe in that and I don't like people who smack their children” (P6).

Despite best intentions, there were times when women's stress levels were high and their mental health was compromised. They became aware of how difficult this high expectation of parenting was in such times. For five women, serious physical health conditions such as pneumonia also took a toll. At this time children

“...learnt to become very independent and it was hard to parent them at that time. I didn't have the energy to discipline them and I noticed a lot of things went out the window – just their manners and the way they behaved and stuff – like I just couldn't be a good parent” (P16).

Breaking the pattern of cycles of intergenerational poverty, trauma and substance use were important to women in demonstrating their parenting attributes. They hoped for easier life circumstances for their children and hoped to guide them towards healthy choices:

“It's being able to see beyond their pain and just walk with them and be their friend and guide them and show them this is what Mum and Dad have been through and this is why we don't want you to go down this path” (P1).

Viewing oneself as a good mother therefore had a positive impact on personal identity, while feeling incompetent or guilty had the opposite effect. Women used different measures to assess their parenting capabilities however an increased capacity for self-reflection and self-compassion was associated with greater progress towards recovery.

Feeling 'different'

A sense of disconnection and alienation from peers and family members impeded development of a valued and intact self-concept for a number of women and they related experiences stemming from childhood to illustrate this. For some this was characterised by additional sensitivity, “I was a very clingy needy child” (P16) or by having different needs and abilities than siblings “when we were younger I would clean (my sister's) room or do stuff for her just so I could spend time with her. Because we're very different” (P10). These examples suggest an unmet need for nurturing and connection in childhood. Resulting from this was a fragmented sense of self that was dominated by rejection.

For others it was about possessing a unique skill set or perspective on life, “the way my mind works I've never known anything different...and because of that I got treated

different" (P7). Being able to deflect childhood labels of deviance and learning to embrace their own uniqueness fostered a sense of wellbeing, but was difficult to achieve outside the context of a supportive relationship. Women who felt validated by supportive intimate partners were better able to reflect on their childhood experiences of exclusion and externalise the cause of this experience.

Doing it my way

This category was associated with increased confidence in one's experience and competence in mothering and signified a recovery milestone. Over time, women's self-awareness grew, and they became more insightful as to their own strengths, values and needs. This informed the resources and strategies they accessed to support their mental health and wellbeing. They gradually became proficient at seeking the support they required, whether that involved psychiatric medication, talking therapy, social connection, creating art, returning to study or if it was a viable economic option, taking respite from employment.

A key recovery milestone was reached when women grew in confidence and self-efficacy, enabling them to recognise and confront people in their lives that they saw as exerting disproportionate negative influence. In relation to parenting choices and styles, four women spoke of rejecting the preferred methods of others and asserting themselves. A sense of empowerment emerged when they were able to exert control over their baby's wellbeing. For one woman, ensuring that her own mother was not verbally or physically violent towards her in her infant son's presence was of paramount importance, and she asserted herself around her expectations through threatening to withdraw access to her son.

Another participant reflected on receiving what she defined as a "one size fits all" (P5) approach to parenting and attributed much of her mental anguish to the circumstances of her adoption. Being able to successfully breast feed her baby for 18

months was an empowering experience for this mother, and perhaps the most powerful example of her defying her adoptive mother with great success for the health and wellbeing of herself and her son.

Living on her in-law's rural property, another woman (P2) explained how she withdrew from her husband's parents as a strategy to maintain her independence and to reduce the feelings of inadequacy her mother-in-law instilled. In declining offers of child care from the children's grandmother, this woman sacrificed the potential for respite from her two young children, in the interests of sustaining her need for independence and autonomy.

Self-expression through choosing unusual clothing was how another participant asserted her own style. Creativity was employed to physical represent her mood, and she shared how her curious outfits at times draw smiles from community members, which then made her feel "that little bit happier". On one occasion she related dressing in a pink ball gown with a purple top hat to go to the supermarket:

"I just got up feeling... I'm in a mood today, what can I wear? And I will spend hours because I need to find (the right outfit) and I won't wear something that won't match my personality, if I don't I think that matches my personality for today I won't wear it" (P7).

Speaking out

The category of speaking out included disclosing, becoming a mental health advocate/educator, addressing stigma and challenging stereotypes. Although in speaking out, mental illness became dominant in women's personal identity, it was viewed positively and enabled social identity through peer networks to flourish. Enduring the ups and downs of mental illness was seen as a valuable asset that enabled women to take on an educator role, to connect with others through shared experience and to be knowledgeable in ways that others were not.

“My mental health journey has meant that I’ve got experience in that to be able to connect with people on that level and that’s what I want to be able to do” (P13).

Sometimes the desire to engage in community education stemmed from experiences of discrimination that women believed arose from ignorance.

“I was angry with the way society treated us. And just cast us aside like we were nothing... you can’t necessarily see the pain that we carry with us. It’s soldiers. And that’s what I call it. We’re all soldiers. We’re all in this together...” (P1).

When women began speaking out, they embraced their illness as a core component of self. The illness symptoms, treatments, and ramifications were integrated into their lives and were a part of how they viewed themselves and presented themselves to others:

“...doing the mental illness education was a really big part of my recovery so to go back and give out to the community, our point of view of how we feel, that’s recovery too” (P1).

Participants expressed being selective in how and to whom they disclosed.

Generally there was a correlation between the relative perceived safety of the participant’s social environment and the extent of their disclosing. Women who felt supported and who had a multi-faceted, secure and positive social identity within their community were more likely to fully disclose. Past involvement with child protection was a deterrent that led women to conceal or minimise the impact of their mental illness.

Discussion

The majority of women who participated in this study described multifaceted identities that represented their mothering and familial roles, their employment or vocational occupations, community relationships, hobbies and interests, religious and cultural status as well as the ways in which they defined their political or social values and

attitudes. These descriptions encompass broader dimensions of identity than have previously been reported in studies with this cohort (Authors, 2016).

Also significant were women’s expectations of the future. Impending opportunities and obstacles were related to women’s ideas about their own competence, social status, agency and aspirations. The findings also highlight that identity is inseparable from social connection as participants described the ways in which their sense of self was heavily shaped by interactions with others (Townsend & McWirther, 2005). Figure 1 represents conceptually the ways in which the women described the factors influencing their personal identity.

WHO AM I (RIGHT NOW)?

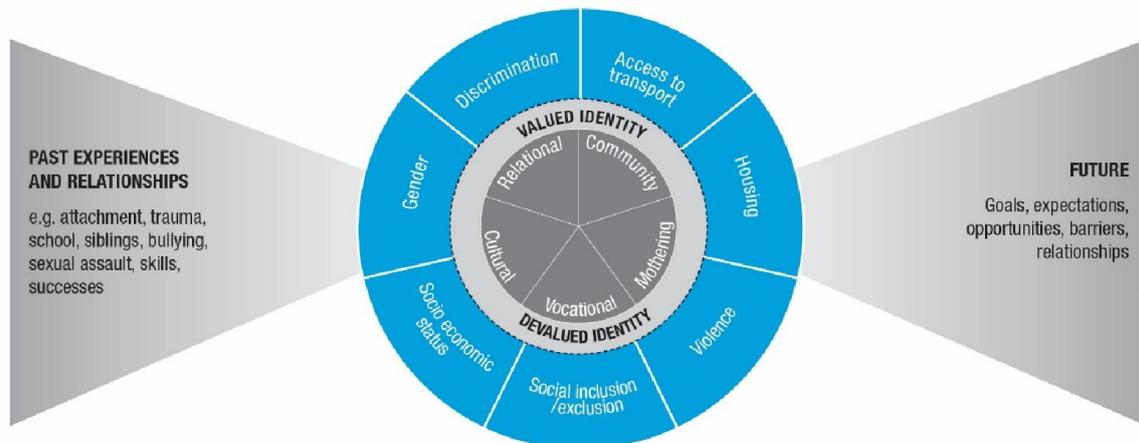


Figure 1: Influences on personal and social identity for mothers with mental illness

The categories of ‘doing it my way’ and ‘speaking out’ were indicators of significant integration of the illness experience into a woman’s personal and social identity. Although

the illness identity was at the forefront in 'speaking out', it was constructed positively, intrinsically linked to meaning in life and empowerment, which are other recovery processes identified by Leamy and colleagues (2011). Women emphasised recovery outcomes attained through being supported to identify their strengths, validate and normalise their challenges and self-reflect on the development of their identity across their life span. Often, however, prejudiced attitudes of others, especially associated with their mothering capacity, undermined women's self-concept.

Mothering identity

Consistent with previous parenting studies (e.g. Montgomery et al., 2006), participants spoke of disconnection from other mothers. This was associated with socio-economics, parenting styles and difficulty infiltrating closed (well-established) social groups. Feeling disconnected, socially isolated and 'different' is a common experience for mothers with mental illness (e.g. Carpenter-Song, Holcombe, Torrey, Hipolito & Peterson, 2014) and is considered a barrier to both sustaining a positive social identity and to recovery (Tan, Gould, Combes & Lehmann, 2014) and wellbeing more generally (Townsend & McWirther, 2005).

Identifying as a 'good' mother was symbolic of women's reflective capacity and internalisation of social and cultural expectations as they related to the morality of parenting and the quality of relationships to children. Narratives reflected how women compared their mothering experiences to archetypes represented in their social environment. This finding echoed Venkataraman and Ackerson's (2008) study on sources of parenting norms in popular culture, the media and parenting literature. Importantly, the signals women perceived from service providers portrayed a deep understanding of how society assesses 'good' mothering, and an intense desire to be viewed as competent. This facet of personal identity was susceptible to women's own internalised self-criticisms, in addition to the censorious messages conveyed by health professions or family members.

Having a psychiatric diagnosis was a core component of identity for some women, however this was not always experienced negatively, as disclosure could also bring meaning, purpose and connection when used to educate, support or advocate around mental illness. For other women, having experienced mental health difficulties was just one relatively insignificant facet of a rich and varied life history. In this study a distinction between positive and negative identity was apparent, however this was not necessarily associated with the extent to which women embraced the illness as part of their personal identity.

Identity, mental illness and trauma

Findings emphasised the importance of identity to recovery, consistent with the CHIME framework (Leamy, et al. 2011). The data also parallels Agnew and colleagues' study that "highlighted the complex and intertwined nature of traumatic experience, personality organization, and self/identity" (2016, p. 8). Crucially important in defining a self-concept within the current study, were women's experiences from the past, including trauma resulting from physical, psychological or sexual abuse, the quality of early life attachments, transience in housing and schooling, relationships with siblings and parents, experiences at school and access to physical and economic resources. These factors, along with the ways in which women conceptualise them have also been previously highlighted (Perera, Short & Fernbacher, 2014; Carpenter-Song et al., 2014; Mowbray CT, Oyserman, Bybee, MacFarlane & Rueda-Riedle, 2001; Morrow, 2002). In this study, these factors shaped the identity journey and the way the women saw themselves in the present.

For some women, having a diagnosis provided meaning and understanding that made sense of their symptomatic experiences. Additionally, this enabled them to connect with a peer network of others who shared similar thoughts, feelings and behaviour and this offered validation. Mental health education and activism constituted a positive

interpretation of lived experience that could simultaneously maintain the mental illness part of identity at the forefront.

Identity and change

Identity is assumed to be fluid and dynamic within self-categorisation theory (Ontorato & Turner, 2004), and while the participant interviews in this study are a snapshot in time, identity was described by participants as flexible, changing and evolving. This was evident in women's descriptions of themselves over time, and the ways in which they connected with others including disconnecting from unhealthy relationships and becoming more discerning or alternatively, learning to trust. However there was also reference to consistent and enduring components of identity associated with preferences and strategies for managing stress and mental health difficulties. Crossley (2000) adopted a narrative approach in investigating the disruptive impact of trauma, identifying the capacity for trauma to unseat previously coherent conceptualisations associated with self. Crossley (2000) found that assumptions regarding one's usual patterns of thoughts, behaviour and emotions are undermined along with one's temporal awareness that ordinarily provides meaning and context. This is congruent with the descriptions of women in this current study in relation to managing distress, in the early period of the illness. For the participants in Crossley's study, narratives become prominent in creating meaning, when customary psychological processes fail under the vast strain of traumatic occurrence.

Not only was it observed that events from women's past shaped their current identity, but their perceptions of their future lives including hopes, plans and aspirations were also influential in defining how they perceived themselves in the present. Identity development appeared to be a non-linear process that was highly permeable to social influence.

Recommendations for research, policy and practice

The findings demonstrate mothering identity to be important for mental illness treatment and recovery. Women primarily related as mothers in articulating their self-concept and strove to be recognised as proficient in this role, highlighting their skills, strengths and underpinning parenting values as critical components of their identity. Therapeutic interventions need to explore mothering relationship to self and others, as “therapeutic understanding that takes into account the deficiencies within diagnostic criteria and acknowledges the diverse nature of self and identity of an individual may improve the therapeutic relationship” (Agnew, 2016). Within such interventions, women need to feel safe and secure to explore their identity ‘journey’ including the interactions and events that have led to their current self-concept.

A strong therapeutic alliance is critical to cultivating a safe space within which women can begin to address the issues that underpin their healing and recovery (Shepherd et al., 2016). Women spoke of the importance of this particularly in the early parenting phase, while adjusting to a new mothering role, and not yet feeling confident in their parenting knowledge and skills. The women who participated in this study indicated that validation of normalcy of parenting challenges can be useful at this time, as well as a more conversational approach that moves beyond the assessment checklists, to the development of an authentic relationship that offered individualised support, rather than reinforcing a sense of being “monitored” and judged.

Elevating the significance of identity and self may reveal areas of intervention that can support more flexible, nuanced and realistic expectations surrounding women’s multiple roles and activities. Identity work, integrating past experiences that may challenge individual’s assumptions regarding their identity (Tan et al., 2014) and reflecting on emotional and behavioural responses, is acknowledged as a core component of the recovery process (Leamy, et al. 2011; Shepherd et al., 2016).

Beyond this, the current research suggests that investigation of identity and self in the context of social and environmental conditions must incorporate critical reflection on the dominant norms that may be oppressive and result in devalued status within various identity domains. Challenging and contextualising these dominant assumptions may be particularly significant for marginalised population groups (e.g. Indigenous, people identifying as GLBTI), who are demonstrated to be at increased risk of developing mental health difficulties (Marmot, 2005).

Discussions at this deeper conceptual level may be perceived as challenging to establish in the midst of psychological distress, and practitioner judgment in ascertaining readiness for such discussions is essential. However avoiding these topics can pathologise individual responses to issues that are associated with layers of structural inequality. Future research should also focus upon overcoming workforce barriers within mental health and family services to engaging in identity work with women who have a mental illness.

Mental health policy needs to recognise and reflect the importance of identity work as a crucial part of practice. A disproportionate focus on medication and risk management within clinical mental health continues to stifle recovery oriented practice that encompasses a holistic view of people including consideration of their diverse and multi-faceted roles and relationships.

Conclusion

The importance of developing and sustaining an identity that is multifaceted and socially valued has been under-acknowledged within mental health services, despite positive identity development being repeatedly identified as a key characteristic of the recovery process. Fostering a positive self-concept, particularly associated with one's parenting role, can assist in facilitating personal recovery in mental illness.

For women who are mothers with mental illness, gendered norms around the mothering role can result in the imposition of unrealistic expectations of women's functioning, particularly if they are living in impoverished social and economic circumstances. Identity work needs to incorporate consideration of the personal level including past experiences, relationships, thoughts, emotions and behaviour, as well as the broader social and societal environmental context.

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Preface to Chapter 7

Identity and connectedness are intertwined as psychological and sociological concepts.

While the significance of cultivating a positive personal and social identity for promoting personal recovery has been highlighted in the previous chapter, the ways in which connectedness as a construct may influence this will now be investigated. This chapter presents the findings of data collection with the same 17 women as the previous two papers, this time focussing on the women's experiences of connectedness and by association, also that of isolation and disconnection.

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Chapter 7:

Connectedness in personal recovery for mothers with mental illness

Abstract

Social connection is a fundamental human need, but challenging for individuals with characteristics that are socially stigmatised. Parenting with mental illness presents obstacles as well as opportunities for connection. This study examined connectedness within a personal recovery paradigm for rural mothers with a mental illness.

In-depth interviews with 17 mothers with a mental illness, utilising constructivist grounded theory resulted in six categories of meaning including 'yearning for connection', 'connecting intensely', 'encountering rejection and exclusion', 'choosing isolation', 'being known' and 'finding peers/helping others'. Women expressed strong desire for connection, but for many, prior experiences of trauma and rejection created barriers to the development of trust, preventing some women from seeking opportunities for connection.

Connectedness to self, significant others and a broader life meaning and purpose can support and expedite personal recovery from mental illness for rural women. However the factors that contribute to the mental illness may also inhibit the development of trust needed to attain social connection. Increasing connectedness in mothers with mental illness is a complex endeavour requiring concerted focus as distinct from other service delivery goals. The perinatal period may be a key time for intervention.

Key words: Connectedness; isolation; mental illness; mothering; personal recovery

Introduction

Connectedness is a fundamental human need (Lee & Robbins, 1995), a social determinant of health (Wilkinson & Marmot, 2003) and a key process involved in personal recovery in mental illness (Leamy, Bird, Le Boutillier, Williams & Slade, 2011). Robust connectedness encompasses distinct social and emotional dimensions of attachment (Weiss, 1973) and when both are present, individuals can proactively seek resources to meet their needs, develop a positive self-image, take social risks and achieve physical,

cognitive, and psychological milestones (Townsend & McWhirter, 2005). In personal recovery, facilitating or rebuilding connectedness to self and others is a role that mental health nurses can and do support.

Background

The earliest social-emotional developmental need for infants is to form a secure attachment to an attuned adult carer. The quality of this relationship profoundly shapes the child's cognitive and emotional development and sets the scene for relationships and social interactions across the lifespan (Bowlby, 1969, 1988; Karen, 1998; Mares, Newman & Warren, 2011). While Bowlby (1977) conceptualised attachment as the "propensity of human beings to make strong affectional bonds to particular others" (p. 201), the connectedness concept is broader, and refers to the quality of relationships to self and others in one's social vicinity. Definitions of connectedness privilege the subjective perception of the quality of the connection rather than the quantity of relationships (Townsend & McWhirter, 2005). Social connection involves trust, reliability and consistency, imbuing a sense of belonging and of being valued, loved and cared for. Lee, Draper and Lee (2001) have defined connectedness as an individual's various caring and supportive relationships and it is "considered an attribute of the self that reflects cognitions of enduring interpersonal closeness with the social world in total" (p. 310).

Connectedness has also been considered to have distinct social and emotional dimensions. Weiss (1973) suggests that a network of people such as peers constitutes a social provision that includes information and advice along with the simple pleasures of sociability. Social connection provides engagement with others while exclusion leads to boredom and loneliness (Weiss, 1973). Emotional relationships provide security for the individual and reduce anxiety and apprehension (Weiss, 1973). A lack of connection however, can have detrimental impacts in all of these domains:

“A person struggling to feel connected begins to feel different and distant from other people. He or she may find it hard to accept social roles and responsibilities, leading the person into greater isolation... the person may distance him or herself from society and lead a solitary life” (Lee & Robbins, 1995, p. 233).

Connectedness and mothering with mental illness

The parent-child relationship “is characterised by the quality of the emotional bond between parent and child and by the degree to which this bond is both mutual and sustained over time” (Lezin, Rolleri, Bean & Taylor, 2004, p.viii). Parenting offers opportunities for the development of unique and intimate (emotional) relationships with partners, co-parents and of course children. The parenting role potentially offers further scope for social connection within one’s local community with other parents, through children’s education settings and friendship networks, however overcoming stigma is a pre-requisite (Dolman, Jones & Howard, 2013).

Women with mental illness describe a sense of connection emanating from their mothering relationship with their children (Ackerson, 2003; Montgomery, Tompkins, Forchuk & French, 2006), intimate partner relationships (Heron et al., 2013; Nicholson, Sweeney & Geller, 1998), and from friendships and extended family relationships which may be consolidated through participation in events such as children’s birthdays or junior sporting pursuits (Maybery et al., 2015). Connectedness may strengthen over time from being known within communities, especially if those communities are intimate such as in rural locations, or within cultural groups. These community relationships, along with family relationships, have been identified as frequently problematic for mothers with mental illness (Perera, Short & Fernbacher, 2014; Nicholson et al., 1998). Dolman and colleagues (2013) found that connectedness was often highlighted in the context of recovery as being an important need, although isolation and loneliness was frequently reported by cohorts of mothers.

Within one systematic review of the personal recovery literature, connectedness was found to be one of five processes with high “proximal relevance to clinical research and practice” (Leamy et al., 2011, p. 449) associated with personal recovery. This study lead to the development of a personal recovery conceptual framework, highlighting Connectedness, Hope, Identity, Meaning and Empowerment, to form the acronym ‘CHIME’. The personal recovery literature described connectedness as including peer and other support groups, relationships, support from others and being part of the community (Leamy, et al., 2011). Reference to relationships is very broad and may capture families (either of origin or of procreation), but may also be extended to incorporate friendships as well as relationships with service providers, especially mental health professionals (Slade, 2009).

Rural communities are incredibly diverse in relation to characteristics such as culture, employment, population density, infrastructure, industry (Hastings & McClearn, 2002; Smalley & Warren, 2012; Wainer & Chesters, 2000) and include a complex mix of factors that promote mental health as well as challenge it (Wainer & Chesters, 2000). Supportive communities, natural assets and lower levels of stress have been cited as characteristics of rural environments that promote mental health and wellbeing (Wainer & Chesters, 2000). However, women living in rural areas often lack childcare support, and experience higher rates of abuse, economic hardship and social isolation (Bushy, 1998; Smalley et al., 2010), all of which constitute risk factors for the development of mental health problems. Family violence literature identifies rural women as a particularly vulnerable population due to the distance from services (including Police), higher levels of gun ownership, lack of transport (Wainer & Chesters, 2000) and cultures of rural communities where traditional gender stereotypes can prevail (Hastings & McClearn, 2002), which can harbor violence supporting attitudes and behaviour (Flood & Pease, 2009).

One study conducted with a cohort of mothers with mental health problems in rural Ireland (Cremers, Cogan & Twamley, 2014), identified that the women felt more visible in the rural context than they may have been in a metropolitan setting. As a result they perceived themselves to be perpetually observed and judged within their families and communities. One of the findings was that parents articulated a need for inclusion, despite the social barriers encountered, and additionally, they desired a more equal relationship with mental health practitioners (Cremers et al., 2014).

How mothers with mental illness living in a rural environment describe their thoughts, feelings and experiences around social connection as a recovery process, has not been investigated previously (Tew et al., 2011). This study aimed to explore the factors mothers with mental illness described as supporting or hindering their connectedness to others. A further aim was the identification of strategies to strengthen social connection for mothers with a mental illness living in rural communities.

Method

Women were recruited via newspapers, social media and from regional mental health clinician referrals. Participants were screened and deemed eligible if they self-reported having a psychiatric diagnosis, had at least 50% custody of one or more children under the age of 18 years, and lived rurally. Informed written consent was obtained.

Through employing constructivist grounded theory (CGT) methods (Charmaz, 2014), in-depth interviews were analysed using constant comparative analysis (refer to Table 1). Data collection occurred simultaneously with data analysis, the researchers' analytical induction being grounded in the data with the co-construction of meaning drawn directly from women's accounts. Grounds were assigned through undertaking initial line-by-line coding "to bring the researcher into the data, interact with them, and study each fragment of them" (Charmaz, 2014, p. 120).

Table 1: Example of data analysis coding.

Initial code	Category	Transcript
Expressing ambivalence around connection	Yearning for connection	<p>P7: I don't really like talking to people. But then I do, I love talking to people, actually I won't shut up. I used to not talk at all, but you get me to talk and then I won't shut up...I do want to connect with people.</p>
Avoiding rejection		<p>Q: You do talk a lot, but yeah, what stops you-?</p> <p>P7: I do. I guess a life time of put downs.</p>
Fearing rejection		<p>Q: So you're worried about that will happen again?</p>
Experiencing false friendship		<p>P7: Scared, yeah fear of getting rejected. I don't, like, some days I don't have a fear in the world, well unless it comes to my kids, but about talking to people, saying what I want to say and not worrying about what other people will have to say...Yeah, the</p>
Reading body language	Encountering social rejection	<p>father, one of – and my mum, as well, I guess and a lot then through actual life and meeting some people, it's like they'll say hi, and they'll talk to you as friends, and they'll</p>

<p>Recognising duplicity</p> <p>Valuing honesty</p>		<p>be okay and everything, but you can tell, you can see by the way they look at you, the movements in their body when you stand next to them, and it's – you know, just because someone says hi and talks to you doesn't mean they're friends.... I don't like people being dishonest, I really don't, and a lot of shit's happened lately.</p>
<p>Losing friendship network</p>	<p>Choosing isolation</p>	<p>Q: Sort of among your friendship network?</p> <p>P7: Yeah. I kind of knew I lost everyone, except for one anyway, because they all stuck with her. Their loss not mine.</p>

All interviews were coded by author 1 with a selection of interviews also coded by the other 2 researchers (authors 2 and 3). Memo writing and mind maps in conjunction with a research journal and regular research team discussions were used to synthesise data and allow for sorting and comparison between data and emerging codes.

Following completion of the 10th interview, theoretical sampling was employed consistent with CGT methods (Charmaz, 2014). Women who had characteristics and experiences that could further enunciate the emerging codes and address unanswered questions regarding the properties of these codes were recruited and memo writing was

utilised as a tool to prompt analysis of where data may be incomplete, illuminating participant characteristics and topics to explore through expanding the interview schedule.

Focused coding followed initial coding and led to the co-construction of categories, through sorting and re-sorting pieces of data collected from the interviews. Robust and regular discussion between the research team members facilitated this process along with the sharing of mind maps depicting increasingly conceptual understandings of the phenomena.

Participant characteristics

A total of 21 interviews were conducted with 17 women. The mean age of participants was 36.29 with a range of 23 to 53 years. The women lived in a range of rural settings, from remote farms, to small townships with populations of less than 5000 residents, to locations on the fringe of larger regional centres. All participants were mothers with a total of 37 children aged between 6 months to 17 years averaging 8.27 years. Government payments were the primary income source for 8 women. Four participants lived on their partner's wages as well as their own part time wages, and the family owned farm was the source of income for 2 women while another 2 participants worked fulltime. One woman lived alone when her children were not in her care, most women (n=9) lived with their partner and children. Two women lived with their own parents and their children, while four lived with their children only.

Ten women identified as being Australian, and other cultural backgrounds were Australian Aboriginal (2), Australian/English (2), Italian/Finnish (1) and Australian/German. The majority of women (n=14) had more than one psychiatric diagnosis, and diagnoses included anxiety (9), depression (11), bipolar disorder (5), borderline personality disorder (2), psychosis (2), post-natal depression (4) and obsessive compulsive disorder (2).

Results

Yearning for connection

The need to make meaningful connections to others was of fundamental importance for participants. One woman spoke about the efforts she made as a child to connect with her twin sister, “I would clean her room or do stuff for her just so I could spend time with her because we’re very different” (P10). This sentiment was also echoed by women who eagerly anticipated motherhood, relishing the idea of love and connection to their baby: “I always wanted to be a mum... and have a lot of kids” (P7). The reality of the early days of parenting however, resulted in a number of women realising how emotionally unprepared they were, feeling surprised and saddened when they didn’t instantly “bond”, one woman revealing “I was really surprised actually. It was the opposite to how I thought it was going to be” (P16)

New mothers’ groups were available to the majority of the women interviewed, but they did not always provide the expected connection to other mothers. An example of this was a decision that the new Mums’ group go out to lunch and a gym class on a weekly basis, activities that were often out of financial reach for this participant who felt:

“It’s a bit disappointing though because I was looking forward to Mums’ group the whole time I was pregnant. I was absolutely looking forward to it and now it’s a bit of a let-down” (P10).

A variety of mother’s group experiences were voiced, from a sense of exclusion and disconnection, feeling “really out of place and I couldn’t relate to the girls” (P14) to support, relief and belonging when fears associated with being judged were unfounded. Across a range of accounts was a need for social acceptance and connection.

Two participants expressed holding high expectations about relationships that continually failed to be attained. They described relationships with various family members and friends where the endeavour to keep in contact was always assumed by them.

“...when I relapsed it sort of made me realise how actually isolated we are. Because with a few of my friends I actually visit them and initiate catching up. So we don't really have many visitors at all. And you know if you're in a bad situation or you've had no sleep with a baby and your partner's at work, you don't necessarily have anyone to call on which can make it a bit harder” (P10).

Four participants spoke of their primary social connections being with mental health services, either staff or other consumers. In this instance they chose a primary social identity associated with their mental illness, and related to others primarily through this shared experience, rather than any other potential connecting factor, as “we all just get validated every time we see each other” (P5).

Making healthy and sustainable social connections appeared to be a difficult undertaking for this cohort of mothers, despite their desire for closeness and belonging. As the majority of the participants (65%) were not in paid employment or education, they lacked normative opportunities to connect with peers in a vocational context. Some women identified that the social groups they felt comfortable within and have a longevity with were not necessarily healthy and respectful, for example those focused on alcohol or drug use, yet women were often unable to build connections elsewhere.

Connecting intensely

Participants related powerful narratives of connection to aspects of themselves, to their children, partners, their own parents or to service providers who had been influential in their lives. One woman stated “having a baby is the best thing to happen to us. It really joined our family... I love the idea of being pregnant and I love the idea of having my own little family” (P15). Implicit within this statement is deep connection to the ‘mother’ and ‘family’ components of her own social identity, as well as direct connection with family members. Having previously experienced an emotionally abusive relationship, another

woman credited her husband with highly developed communication skills and emotional intelligence:

“He is very supportive – just amazing. Sometimes it gets really hard on him but he claims that he doesn’t really understand because he doesn’t but whenever I’ve suffered a bout of depression he’s always been there for me and helped me through it” (P16).

Profound connection to her baby led another participant to share “no matter how bad I got it was never a struggle to look after (my baby)” (P10). The predominance of her son’s wellbeing was also the overwhelming purpose of another single mother who explained how his arrival caused her to make significant changes around her drug use and other risk taking behaviour because “he’s cute and just great to wake up to, he’s a really good baby” (P6).

For women who lacked social connection to family or friends, support workers or health professionals were sometimes described in terms of endearment. Three women used the term “love” to show their esteem for a health practitioner. “I love (family services worker)... she’s really good, non-judgemental, she’s helped me as much as she can. I’d highly recommend her, she would be a good person” (P10). Another woman attempted to articulate what it was that she so “loved” about the relationships she had with a support worker. It seemed that she was responding to a non-judgemental attitude, honest feedback and firm values and boundaries, characteristics she had not experienced in her own family of origin or any other social context.

“I don’t know what it is about her but I love her... it’s really easy to talk to her... she comes over and sits there and... she laughs... she is the type of person I would want as my Mum, she’s hard footed, she’s hard headed, but she’s really good to talk, I could talk to her about anything. But she puts her foot down and she sets the rules and the law... I really like the way she does it” (P7).

A small number of women depicted a range of relationships that fulfilled their need for belonging and social identity. Supportive workplaces, sporting clubs, book clubs, on-line parenting forums, social media and tertiary education settings were all environments where women found themselves to be encouraged, challenged and befriended. When women felt supported, they were more likely to test out partial disclosure of their mental illness experience, and if others responded positively or also shared their own experiences, then a deeper bond could be forged. The knowledge of others' understanding, meant that need for connection could be anticipated and acted upon:

“I just remember out of the blue she just walked up and gave me a hug one day because she knew I needed one without saying anything. And that was just perfect” (P13).

Women who spoke of initiating social interactions and having these reciprocated were more likely to have experienced strong relationships with either a parent or siblings during childhood that extended into adult life as a source of emotional support. Participant 13 recalled, “...we used to get together for sibling dinners or for birthdays. So that sort of strengthened our relationship”.

Encountering rejection and exclusion

From an early age, many women recalled situations at home and school that reinforced negative perceptions regarding their sense of self.

“I can't remember anything ever being good with dad, I used to do everything with him I'd go fishing and camping and things like that but no matter what I did it was never good enough” (P14).

Parental rejection in the form of verbal put downs, a lack of warmth, physical abuse, and public shaming all took a psychological toll, imparting destructive messages about

participants' intrinsic value, undermining their self-esteem and confidence to establish relationships outside the family:

“It does make you feel like you're the only person, it does make you feel like you're out of it, you know, because not a lot of people like to talk about stuff like that... and I acted differently. I tried to, as hard as I could, because I wanted people to like me. I thought I was too different, and a lot of the comments I'd ever got from other people were negative” (P7).

Facing rejection created barriers to trust that were exigent to overcome. A desire to connect could be stifled by the fear of having social rejection reinforced yet again:

Participant 7 (P7): I don't really like talking to people. But then I do, I love talking to people, actually I won't shut up. I used to not talk at all, but you get me to talk and then I won't shut up... I do want to connect with people.

Interviewer (I): What stops you-?

P7: I guess a life time of put downs.

I: So you're worried about that will happen again?

P7: Scared, yeah fear of getting rejected. I don't, like, some days I don't have a fear in the world, well unless it comes to my kids, but about talking to people, saying what I want to say and not worrying about what other people have to say.

Women also spoke of school environments that were equally perilous, particularly for students who struggled academically. “My first teacher was a really bad bully... and I just hated school. So I had the anxiety of going to school and then the anxiety of coming

home” (P16). Having no safe place left participants in a constant state of anxious arousal that was uncondusive to social and emotional development.

Choosing isolation

As a result of experiencing and subsequently acting to avoid rejection, violence or oppression, a number of women chose to isolate themselves and became guarded and aloof in social contexts. Eight women (47%) claimed to be happier to be alone rather than risking encountering further relationships based on exploitation. This decision could be a transitional phase that created a temporary void that they maintained until they could feel secure that a relationship would be emotionally safe and supportive to both themselves and their children.

One woman explained “I don’t choose to put myself in situations anymore around alcohol or dope, it just doesn’t sit right” (P1), while another imagined the implications for her child of another violent relationship:

“I’m not having a baby to someone who’s going to bash me. I don’t want to be bashed in front of my kid” (P6).

For another woman, choosing to be alone had resulted in time for reflection on past exploitation, and led to the realisation that “I am a strong person. I’m quite happy to be by myself, I don’t need people around me to make me happy and I’ve learnt you can tell when people are genuine and when they’re not. I’ve learnt how to kind of judge people a bit more” (P14).

In this phase of choosing isolation, women were unlikely to seek support from services, and articulated a sense of frustration with health practitioners they had encountered in the past, who they had found to be judgemental or unhelpful. Five participants shared accounts of being dismissed by health professionals when they had sought assistance for serious health concerns, and this resulted in a reluctance to seek help for mental health or parenting difficulties. For one woman “it took nine health

professionals to take some of the stuff seriously with my daughter's allergies, and other health issues I've had" (P11) while another woman shared "I bled internally for two days and the hospital wouldn't admit me" (P16). A third participant shared her experiences with a particularly insensitive midwife in the days after giving birth:

"...she'd just walk into the room and take (my baby); wouldn't talk to me or show me what to do, and I'd been standing over in the corner in tears... to the point where I didn't want to call anyone for help. I was just really freaking out about it" (P17).

Being known

The rural context meant that women were more likely to be known in their communities, and this had both positive and negative ramifications. Nine of the participants had lived in the same community for the majority of their lives, since childhood. Being known at times made women feel as though they were under the surveillance of family, the service system and the broader community if they were known primarily as a mother with mental illness. Practitioners within child protection settings were described as harbouring ignorant or prejudiced views regarding mental illness and the potential for recovery. For one participant (P1), this was highlighted when she was considered well enough to have her treatment ceased at mental health services. Rather than celebrating her recovery, child protection staff expressed grave concerns that without ongoing clinical mental health treatment she would be unable to demonstrate her mental health stability to the extent required to have her children returned to her care.

However, within the acute inpatient unit, being known enabled this same woman to receive privileges not afforded everyone hospitalised. Staff knew from experience that she needed solitude and rest, and so she was allowed to sleep and use her preferred symbolic healing materials such as candles and incense that would not usually be permitted.

For another woman (P3), being known was strongly associated with trust and feeling safe. At a time when her life was unravelling with multiple stressors, she confided in

and was nurtured by a nurse who she had a long term relationship with. The significance of this relationship only became apparent when she was allocated a doctor who she did not know. While in excruciating pain, she was “interrogated” by the doctor and then a drug and alcohol counsellor, who instead of supporting her with alternative strategies and supports, threatened to remove her children when she was unable to name an appropriate friend or family member to care for them.

For another woman, having a mother with a high profile identity put her under the microscope and she felt “pressured into being good enough and I was always in the public eye and... everyone knew who I was and I guess that kind of played on a bit. My mum, she always expected a lot of us and if something didn’t go right then we’d cop it” (P15).

As a contrast, Participant 2 was not known within the community in which she experienced anxiety and depression post childbirth. While she credits a new parents’ group as being a great support, she had not disclosed her experiences of mental illness, stating that this as being due to a concern of frightening them. Describing herself as being a very private and independent person, having a diagnosis was inconsistent with the social identity she was fostering and the risk of alienation too high at a time when her connections to others were limited and fragile.

Finding peers, helping others

A number of women (n=7) stated that they had moved into a more confident phase when they were no longer as concerned about what others thought of them and had begun to be more open in disclosing their experiences of mental illness. Some women described reaching a point where they could embrace their ‘difference’ to encompass a unique and valued sense of self and felt validated in using this experience as a source of connection to others.

“I’ve done a bit of work lately on my values and talking about that with someone and being connected was certainly a big part of (that). For myself I value being connected with people and also for myself I value helping people. And I guess for me, my mental health journey has meant that I’ve got experience in that to be able to connect with people on that level and that’s what I want to be able to do” (P13).

Social media made this easier as information de-stigmatising mental illness could be shared, without the necessity of divulging personal details of their own experience. One woman felt that her role as a mental illness educator and advocate had been crucial in her recovery:

“I could give my time to mental illness education, and try and break stigma and just get the message out there that we’re not all crazies... part of my journey too is to drop the labels people give us, that to me is the most important thing in my recovery” (P1).

Developing friendships within mental health services meant that the shared history of a psychiatric diagnosis was a given, which reduced the likelihood of social rejection and liberated conversations around the difficulties associated with experiencing distorted thoughts or feelings. One woman expressed a preference for these relationships because “I do have some friends from (a mental health service) that are just the best, we all just get validated every time we see each other. And we ring each other. I do have other friends, but they just don’t get it” (P5).

Discussion

The results of this study confirm that connectedness is difficult and complex for many mothers with mental illness. Early life experiences of social rejection did not diminish but intensified a yearning for connection, although this was difficult to accomplish for many women who had histories of childhood trauma. Previous studies with similar cohorts have

also found relationships to be challenging (Nicholson, et al., 1998; Perera et al., 2014, Montgomery et al., 2006).

The very same socio-economic circumstances and/or traumatic life events that lead many women to develop mental distress and subsequently be diagnosed with a mental illness, often compounded their perception of their own 'difference', social distance, isolation and loneliness. In these circumstances, where rejection and emotional abuse had been recurring themes in women's lives, building the courage to trust another individual or engage in a group process was overwhelming. Women often chose the relative safety of isolation in preference to the unpredictability of attempting to connect to others. While a small number of women demonstrated strong connections to significant others, the majority of participants portrayed a lack of closeness and belongingness.

This phenomenon has been identified and described in previous research. Lee and Robbins (1998) argue that individuals tend to behave in ways that reinforce their 'world view' relating to social interactions and relationships. Those who are socially disconnected will appear to be more aloof in group situations:

"Women with low connectedness may therefore choose not to identify with a new social group, preferring to confirm their lack of belonging in life. For these women, social identification requires a degree of interpersonal trust that may be unacceptably high. This view is supported by Rotenberg's (1994) research on the lack of interpersonal trust exhibited by lonely people" (Lee & Robbins, 1998, p. 343).

This is an important finding in relation to the efficacy of group interventions such as therapeutic, parenting or peer support groups.

In contrast, individuals with strong connection are more likely to seek out additional social opportunities which confirm and reinforce their previous social experiences. Even though their need for belongingness is already satisfied, they are still highly motivated to

socially connect in new social environments (Lee & Robbins, 1998). This was also apparent in the current study, circumstances where women described having had positive childhood experiences of being parented, and possessed ample economic resources to support their recovery.

Women within this study who had numerous supportive relationships were more likely to embrace the illness component of their identity and sought to educate others through participating in formal mental illness education programs or disclosing more fully in their social interactions. Kemper has suggested that social relations serve as a mediator that allows individuals to adapt to their environments (1993). In this study, women who reported long-established emotionally supportive relationships (e.g. with their own parents or siblings) were able to describe proactive help seeking behaviour and reaching recovery milestones such as acceptance and disclosure of the illness, experiencing a more rapid return to vocational activities.

Previous research with mothers with mental illness have investigated women's accounts of the quantity and quality of their inter-personal relationships, but not their connectedness as determined by narrative accounts relating to experiences of social identity. This study highlights the barriers and enablers to connectedness for this cohort and identifies key intervention points at which women may be ripe for change. Also illuminated is the crucial importance of the therapeutic alliance in mental health service provision, and also in the early childhood setting. As Small, Taft and Brown (2001) found:

“First time mothers’ groups – offered by most maternal and child health services in Victoria – were highly valued by many mothers, but others said they didn’t go because their baby was too unsettled, they didn’t like groups, or they worried about being judged by other mothers or by their maternal and child health nurse” (p. 4).

Likewise, the majority of participants in the current study criticised maternal and child health programs for too narrow a focus on the development of the baby, with scant

attention to maternal health except as a means to the baby's wellbeing, rather than a valid and viable outcome in itself. They highlighted the perinatal period as a phase during which they were ripe for help seeking, however what most women encountered were what they perceived to be judgemental and patronising practitioners. This life phase has previously been highlighted as a significant intervention point (Heron et al., 2012; McGrath, Peters, Wieck & Wittkowski, 2013; Mowbray, Oyserman, Zemencuk & Ross, 1995). Women described the impacts of barriers to connection with service providers as including feeling as though they were under surveillance (Montgomery et al., 2006), being repelled from further help seeking efforts, struggling in isolation, experiencing more severe illness symptoms, and taking longer to recover.

When practitioners displayed acceptance and empathy, rapport was established and women used powerful language to describe the connections forged illustrated by three women stating they "loved" their service provider. The characteristics most appreciated were reliability, trust and understanding, qualities they may not have often encountered in their interpersonal relationships previously. The security provided by this style of relationship permitted women to more fully disclose their difficulties and obtain the support and reassurance required.

Previous studies have identified that mothers express regret and guilt associated with the impact of their mental illness on their connection to their children (e.g. Ackerson, 2003; Blegen, Hummelvoll & Severinsson, 2012). Although particular parenting challenges were mentioned, the data from this current study did not reveal this as a strong finding, and in fact relationships with children were described in overwhelmingly positive terms that conveyed mothers' experience of these relationships as robust and reciprocal connections.

Rurality

In relation to connectedness, negative as well as positive consequences may be apparent in the rural context, even when social connections are strong. While having

others to turn to in times of need is perceived as a protective factor, it has been suggested that rural women carry a significant burden of community social obligations and this can create stress and illness (Parr, Philo & Burns, 2004). Women may feel “at risk” (Parr et al., 2004, p. 412) of being obligated to provide help to vulnerable community members. Being well known can result in community expectations regarding behaviour that may be difficult to maintain. For one woman this was the result of her mother having a high public profile, for others it was around life-long relationships with peers, and how reactions to partial disclosures had disrupted friendships.

Within this study, some women spoke of the recovery benefits they obtained from being able to support others or make positive social change through community education roles. Cremers and colleagues (2014) also found that reaching a point where parents felt safe to disclose their psychiatric diagnosis or helping others by revealing their authentic selves was health promoting.

Conclusion

This study supported the notion that connectedness in adulthood is strongly influenced by an individual’s initial attachment relationship. In the realm of mental illness and recovery, subsequent childhood relationships and early experiences of trauma if not redressed, can present powerful barriers to the development of trust and connection, and permeate inter-generational outcomes. However robust connectedness can expedite personal recovery from mental illness and provide resources to build capacity to overcome adversity. Creating safe opportunities for mothers to experience the benefits of connectedness can overcome previous experience and promote recovery. However this must be recognised as a discreet and complex intervention that requires prioritising alongside other treatment goals. The risk of failure to address connectedness in early parenting for mothers with mental illness is that the cycle of inter-generational mental distress may repeat again.

Relevance for clinical practice

The parenting role introduces mothers with mental illness to a vast array of service providers, from midwifery, early years, education, mental health and family services sectors. Each encounter is an opportunity to cultivate a positive social interaction which can begin to challenge or dislodge previous patterns of social rejection and exclusion. This study highlights that all service providers need to recognise that motherhood can play a crucial role in developing important social and emotional connections post-partum, that they need to develop interpersonal skills and knowledge of parenting and mothering that enable them to develop authentic trusting relationships with women that foster the most basic positive emotional responses that result from feeling valued, heard, and cared for.

Further to this skill development, Price-Robertson and colleagues (2016) have suggested the adoption of a relational model to facilitate recovery, with connectedness as a fundamental underpinning of the recovery processes. The current findings support such an approach. The significance of the therapeutic alliance with such a relational model can be lost in the myriad of policy and practice priorities in the clinical environment. In particular, it is critical that mental health service systems foster connectedness as distinct and valid intervention goals.

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Preface to Chapter 8

Previous chapters have enabled a detailed examination of the literature surrounding identity and connectedness in personal recovery for mothers with mental illness. The findings from research with a cohort of rural mothers with mental illness around these concepts has been enunciated. This final chapter presents a construction of the broader meaning of the research including overall outcomes and implications for practice.

Chapter 8:

Reconceptualising identity and connectedness in personal recovery for mothers with mental illness: Developing a substantive theory of mothering, identity and connectedness in personal recovery.

“Theories enter qualitative research as the assumptions that underpin expectations, methods, and analyses; they exit research in the form of findings and suggested implications” (Giacomini, 2010, p. 127).

8.1 Introduction

This final chapter commences by placing this study within the broader personal recovery paradigm, and reflecting on what this research adds to the wider evidence base. The main findings are summarised, including presentation of a conceptual map and substantive theory emanating from the research. This theory redefines the personal recovery process, and places the dimensions of forming a positive identity and increasing connectedness within a broader framework that takes account of the impacts of trauma and social and economic disadvantage. Following these sections, the limitations and strengths of the research methods and processes will be analysed. Recommendations for policy, practice and research will conclude the thesis.

Women who are mothers with mental illness are a marginalised population in society, within frameworks of personal recovery, and in health more broadly. Gender impacts on an individual’s health and wellbeing through influencing access to the resources that are required to attain and maintain health. Mothering adds another dimension as a social and psychological role with profound implications for conceptualisations of self and for experiences of connectedness to self, to others and to broader meaning in life.

A central role of feminist research is to amplify the voices of women whose voices are suppressed within dominant discourse (Van Zoonen, 1994). This thesis provides deeper understanding of the experiences of rural mothers who have a mental illness. In particular, women’s perspectives and experiences surrounding identity and connectedness

within the paradigm of personal recovery, have been gathered, explored and to some extent, explained.

8.2 What this research adds

The research that comprises this thesis emerged from curiosity regarding the fit of the CHIME conceptual framework for personal recovery (Leamy et al., 2011) to one of many diverse populations of people who experience mental illness. The aim of this research at the outset was to explore two distinct components of the processes described within the framework (Leamy et al., 2011), identity and connectedness, for mothers with mental illness living in a rural context. The perspectives of women who were mothers with a psychiatric diagnosis living in rural locations were gathered, with extensive data extrapolated using constructivist ground theory methodology, pertaining to mothering, mental illness experiences, the significant influencing factors on identity development and connectedness, and the relevance of these processes in promoting recovery.

Twenty-one in-depth interviews were conducted with 17 women, representing a heterogeneous cohort. The women embodied a diverse range of characteristics across the domains of age, cultural background, marital status, diagnostic criteria, income, educational attainment and housing circumstances. Each woman's mental illness narrative was unique and varied. The ways in which they understood and related to the recovery term also differed, however overall, the term did not have great resonance for participants.

The study resulted in the development of a new conceptualisation of the recovery process for rural mothers. Key findings surrounding the factors that support or hinder connectedness and positive personal and social identity were identified, and the relationship and intersection of identity and connectedness was explained for this population. The study revealed key intervention points for work with women with mental illness who are mothers, and highlighted the crucial importance of the therapeutic relationship in facilitating connectedness. Connectedness was established as a prerequisite for developing positive identity.

8.3 Main findings

The main findings to emerge from this research were reported in the published studies presented in previous chapters. To summarise, the findings were:

- Chapter 3: Identity is rarely defined within the literature pertaining to mothering with mental illness, although the concept is frequently alluded to through women's accounts of the importance they attribute to motherhood and other socially valued roles (Hine, Maybery & Goodyear, 2016).
- Chapter 5: Outside of extended experience within mental health settings, the term 'recovery' itself with an associated metamorphosis, does not resonate with rural mothers with mental illness. They are more likely to portray their experiences as enduring or managing motherhood in tandem with mental illness (Hine, Goodyear & Maybery, in press).
- Chapter 5: Mental illness symptoms and episodes are often conceptualised as first attempts towards managing the distress emanating from previous trauma.
- Chapter 5: Unresolved trauma along with profound socio-economic disadvantage create persistent barriers to living a "satisfying and contributing life". Normative expectations such as stable housing, reliable transport and family holidays are forfeited due to sparse economic resources, creating constant stressors that continually challenge mental health and well-being.
- Chapter 5: Mothers express a desire to break trans-generational cycles of mental illness and poverty, and hold out hope that circumstances will be easier for their children.
- Chapter 6: Identity develops in the context of social relationships and early interpretations/representations of one's attributes. Formative messages about value

and worth are difficult to shift without sustained connectedness within a healthy respectful relationship with a partner or significant other.

- Chapter 6: Women may recognise social roles within various domains such as relational (e.g. mother, partner, sister), vocational (e.g. employee, student, health professional), cultural (Elder, healer) or within the community (volunteer, “giver”, sportsperson). Each of these could be considered positive and socially valued, or negative and socially devalued, with implications for social and personal identity, depending on the perceived competence and autonomy in the role. For instance, self-identifying as either a “good” or “bad” mother.
- Chapter 7: Some of the mothers with mental illness in this study reported having lacked the receipt of parental warmth in their own childhood years, and the negative effects of this were compounded by patterns of social rejection endured at school and in rural communities during adulthood.
- Chapter 7: Connectedness is challenging to achieve in the context of trauma and social disadvantage. The very risk factors that contribute to the mental illness diagnosis also contribute to increased experience of discrimination and result in social distancing behaviour.
- Chapter 7: Women articulated a strong desire to connect to service providers to gain support and resources during the perinatal phase, however overwhelmingly they described encounters where they felt patronised and judged, that served to further alienate and marginalise them.

Although personal recovery is being embraced by mental health services internationally as an underpinning framework, outcome goal and set of practice principles, mothers with mental illness did not immediately relate to the term in describing their experiences of their journey with their mental illness. Normative understandings of the term recovery in the context of injury or illness are incongruent with how rural mothers experience the

tumultuous journey of living and parenting in the context of mental illness. Persisting or managing were terms the women found to be more accurate and relatable.

Figure 3 summarises a conceptual map developed using inductive and abductive reasoning from the data gathered from 17 women regarding how identity and connectedness might be understood within personal recovery for rural mothers with mental illness. A substantive theory reconceptualising personal recovery for rural mothers, sits alongside the map and is detailed in the section that follows.

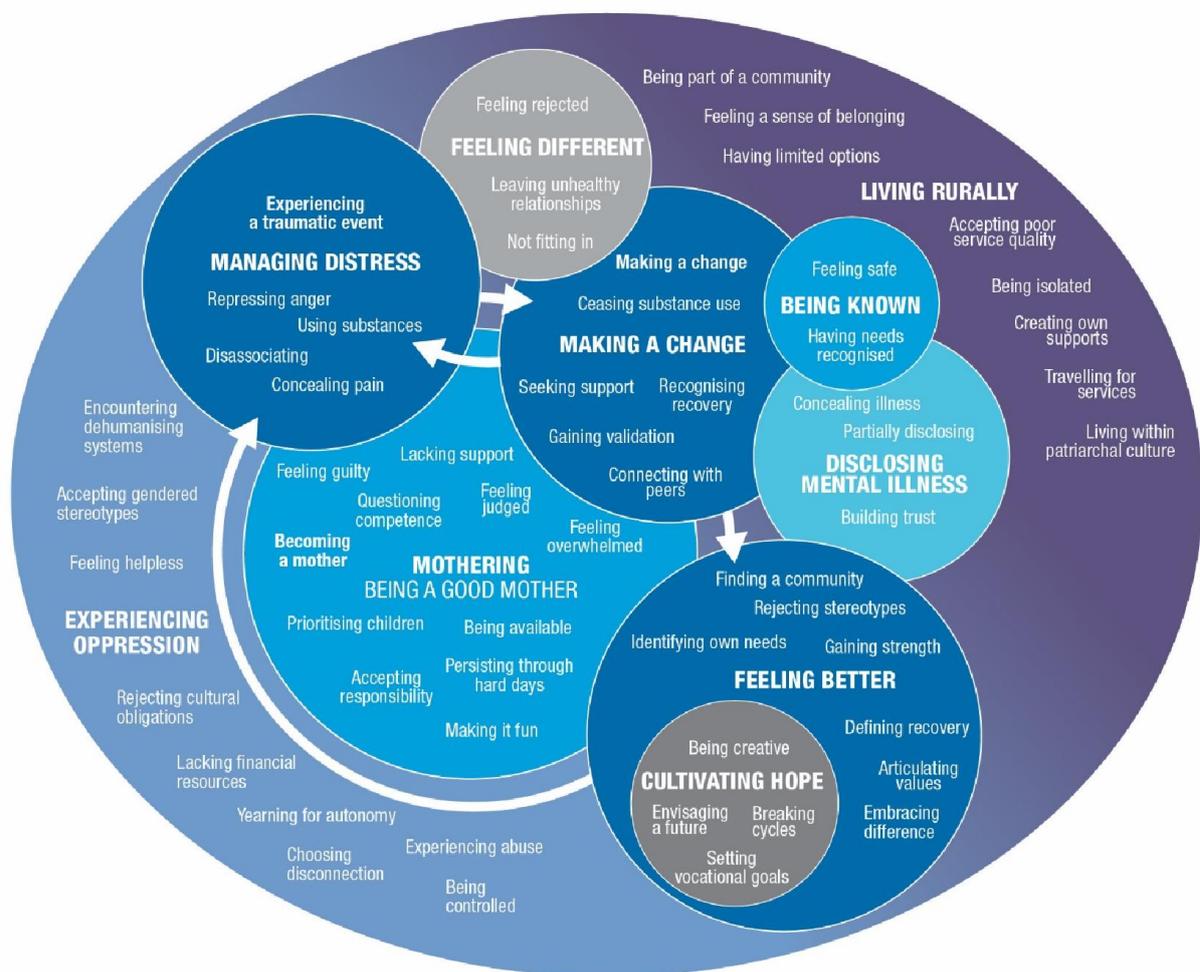


Figure 3: Conceptual map of Identity and Connectedness in Personal Recovery for rural mothers with Mental Illness.

8.4 Redefining the personal recovery experience of mothers with mental illness: Presenting a substantive theory

9.4.1 Introduction

Figure 3, published in Article 2 (Chapter 4), highlights a redefinition of the personal recovery experience giving a greater understanding through “the theorist’s interpretation of the studied phenomenon” (Charmaz, 2014, p.230).

The women who participated in this study, shared different interpretations of the term personal recovery, however it was not usually a prominent process in their lives. Women more commonly described themselves as persisting through the multiple challenges presented by their life circumstances. These challenges came from different domains and comprised of:

1. The mothering role: responding to the constant demands of parenting and managing the expectations of self and others pertaining to functioning in this role, often in disadvantaged financial circumstances;
2. Managing distress that could be recurring and was described as being grounded in earlier life experiences of adversity and/or trauma;
3. Disconnecting from abusive or oppressive relationships in order to be capable of reflecting on the needs of self and children;
4. Establishing connections to family, peers or services that were based in respect and authenticity, and could promote wellbeing outcomes;
5. Finding meaning within the mental illness experience, gaining insight into one’s attributes and accepting unique characteristics, using experiences and strengths in purposeful ways to educate, support and advocate, either informally or within vocational roles.

In addition, the interviews with mothers in this study highlighted that during the process of personal recovery from mental illness, the women experienced three phases: ‘managing distress’, ‘making a change’ and finally, ‘feeling better’. These processes occur

in a context shaped by the social and cultural constructions of mothering and living rurally, both overshadowed by oppression.

This study confirms previous findings that personal recovery necessitates transformations in personal and social identity, which occur within the struggle of enduring multiple challenges, and also within the context of social interactions and experiences of connectedness. Social and psychological processes associated with identity and connectedness occurred alongside, and facilitated the recovery process. The following section discusses the three phases of personal recovery, according to the domains of mothering, identity and connectedness.

8.4.2 Managing Distress

The category of “managing distress”, as shown in Figure 3, is where the recovery journey commences for mothers, and this category is also where the theoretical discussion begins. An important temporal consideration is that women can remain in a state of managing distress for a relatively short time, or for extensive periods. Women who experience cumulative trauma and lack the personal, social and economic resources to find alternative strategies to overcome this distress, may live large components of their lives in this state. During the initial managing distress phase, women are trying, usually unsuccessfully, to fit in, to connect with others, to articulate a coherent sense of self and to manage their mental illness symptoms by whatever coping methods seem to be effective in the short term. These may include disassociating under circumstances of elevated distress, emotional distancing from children and others, using substances, or isolating self from others.

Mothering

Mothering roles and responsibilities are challenging during this phase. This is due to acute stress associated with managing the demands of parenting, especially in the early parenting phase when sleep deprivation depletes energy, and physical, social and emotional adjustment simultaneously occur. Women describe difficulty bonding with

babies and attuning to their children's needs and as a result, they feel incompetent in the role and think of themselves as a "bad mother" if they do not have the required level of knowledge or if they are not enjoying the role as they expected that they 'should'.

Women's guilt and fear associated with what they perceive as low functioning in the parenting role, lead them to marginalise themselves, avoid contact with other mothers who appear to be 'coping', and to remain silent about the challenges they face. This was due to fear of being judged, or in the extreme, to avoid custody loss.

Identity

Women's personal identity is shaped by what they perceive as their deficits, an example being P7 stating "I'm not the smartest person in the room". In relation to social identity, alienation is profound, the belief that no one is *like* me, and therefore they won't understand me, and their advice or suggestions will not work for me. This leads to a sense of helplessness and hopelessness and is a counteractive to help seeking (in the connectedness realm). Examples of self-talk influences on identity in this phase include: "I can't manage" (P2), "I'm a bad mother" (P16), and "my children would be better off without me" (P11). The overwhelming sense of women's perceived difference from others is encapsulated in the code 'feeling different' as shown in figure 3. Within the managing distress phase, feeling different is overwhelmingly construed as being a negative and isolating psychological experience.

Connectedness

Negative self-beliefs are reinforced by the verbally and emotionally abusive interactions that occur in unhealthy relationships with family (of origin) members or current partners. Although women were not directly questioned about their experiences of abuse, 10 women disclosed having been subjected to emotional, physical and/or sexual assault in childhood or as adults within intimate relationships.

Although some women test out selective and partial disclosure in this phase, the judgmental reactions of others usually provide a disincentive to continuing along this path.

Some women attended parenting groups, usually with the result of increasing their sense of disconnection as their sense of difference was enhanced. Being older or younger than the majority of group members, and in different socio-economic brackets were mentioned. Other women were unable to attend such groups due to transport or financial barriers or social anxiety.

Women may be estranged from their own mothers, sisters or aunts, and often do not trust in the advice being provided by family as they state that they have different parenting values (P6, P7). Therefore, on the whole, women struggled in isolation and later felt guilty about the implications for their children's development.

Summary

In the absence of connectedness, and in the context of ongoing surveillance by child protection authorities or maternal and infant nurses, combined with impoverished financial circumstances, some women remain in a state of perpetually managing distress as they struggle to deal with each and every adversity as it arrives. Without adequate support and resources, it is not possible to develop proactive coping strategies. The exception is women who have secure socio economic situations with partners who are capable of providing emotional as well as practical support. These women are likely to move on from 'managing distress' more rapidly.

The finding that the first stage of recovery from mental illness was 'managing distress' has also been discovered by Tan (2012) in investigating recovery experiences in people with first episodes of psychosis. Nicholson and Albert (2005) also identified that mothers with mental illness who had experienced childhood trauma described psychiatric symptoms manifesting at times as coping strategies, although they conceded that these might be construed as maladaptive and manipulative by service providers.

8.4.3 Making a Change

When women become aware that their existing coping strategies (e.g. substance use, aggressive behaviour, dis-association, isolation) are no longer effectively managing

the distress, they seek to make a fundamental change to their behaviour, to find another way to alleviate their psychological distress. Sometimes this is precipitated by a health crisis, or a life threatening situation, such as a serious physical assault from a partner:

“That’s why I left... I thought, I’m not having a baby to someone who’s going to bash me. I don’t want to be bashed in front of my kid” (P6).

The change could mean leaving a violent partner, engaging with a service, or deciding to cease substance use. This stage is characterised by a pause, and accompanied by increased insight into the likely trajectory of continuing along the current path. Consistent with theory of change (Prochaska et al., 1994), women could cycle through levels of commitment to and readiness for making a change several times before they were able to succeed in instigating the planned action. This is indicated by the arrows in figure 3.

Mothering

In the phase of ‘making a change’, mothering comes to the fore, in the reflective process of reassessing life priorities and goals. Women consider the needs of their children and assess their own capacity. One mother pinpointed the moment she decided to leave her husband:

“...the day my husband laid a finger on me was the day I left my husband. Because it made it clear to me, there’s your line and he’s crossed it and I’m leaving because they (my children) are not having the same childhood that I had” (P11).

Seeking help with their mental health needs and/or parenting from service providers could occur in this phase. Validation of the inherent difficulty of parenting could assist in building confidence in one’s competence and this can lead to greater enjoyment of the mothering role. P17 had avoided disclosing her decision to cease breastfeeding amongst peers, fearing that others would judge her as a ‘bad mother’ as breastfeeding is associated with promoting health in infancy and the decision was in conflict with her own values, as well as being different to what all of the other mothers in her group were doing.

When P17 decided she could no longer conceal her bottle feeding, she found her peer group to be understanding and supportive. This assisted her to feel more confident and less self-critical about her mothering choices and capabilities.

Sometimes the reflective process leads to decisions like commencing work or study, and women found that attainment of a vocational role could support improved esteem in the mothering role. Women (e.g. P14, P17) described their experience that having time apart from children and being recognised and validated as an individual with distinct meaning and purpose which employment can provide, enabled greater appreciation for and attunement to the needs of children when reunited at the end of the day. Gaining education and employment also provides hope as it is a pathway to improved financial security.

Identity

The possibility of re-evaluation of personal identity comes into focus in 'making a change', with aspects of self previously viewed as primarily negative being challenged. For example "I am selfish" may be replaced with "I am independent" or "I am disorganised" may become "I am creative". Increased confidence in one's mothering capacity also created the possibility of identifying as a 'good Mum'.

Part of this identity transformation might include increased awareness and articulation of core values that may have been subverted through oppressive relationships. This is particularly relevant to the assertion of parenting values, and the ability to cultivate increased congruence between values and behaviour, especially if leaving a violent partner and thereby having increased control over decisions. 'Making a Change', following the gradual or sudden gaining of insight at the time of transition to motherhood has been found in studies with women in recovery from problematic drug or alcohol use (Kearney, 1998).

Connectedness

In this phase, women often withdraw from others, allowing space for reflection on their core values, attributes and experiences. They chose isolation rather than continuing in dysfunctional relationships, although testing out help seeking with service providers was a feature of this stage, and could assist in the reflective process.

Being known in small rural communities could manifest in positive and negative ways, increasing intimacy and a sense of security, or being experienced negatively, as surveillance and scrutiny. Peer support can be powerful in this phase, as women's views on the nature of their own 'difference' are challenged through meeting people who may have shared experiences or made similar changes. This can potentially enhance their social identity through validation of trauma, oppression or mental illness experiences and also through acknowledgement of the scale of the impact of these experiences.

Summary

Similar to previous studies associated with women's recovery from anorexia nervosa, a critical recovery task was "distancing self from unsupportive others and rebelling against expectations of others" (Beresin, Gordon & Herzog, 1989). Two key elements are apparent here. While "distancing self" is related to connectedness, "rebelling against expectations of others" is associated with identity; and suggests a process of reflection on ones' values, along with behavioural change to implement them.

Within the current research, sometimes women might begin to explore new relationships with peers or service providers, however more often women described narratives of cumulative social rejections, leading them to choose to isolate until they were certain that new relationships would not also become unfulfilling and abusive. As an example, P14 stated that through reflecting on relationships that she experienced as unsatisfying, she had learnt "... I don't need a man and I don't need other people to make me feel happy". While far from content in her current circumstances, she was prepared to

wait for a relationship that embodied equality and respect, rather than seeking connection or intimacy with anyone who was incapable of demonstrating these characteristics.

'Being known' was an important component of this phase, as women who had lived in the same rural community for the majority of their lives could experience complex barriers in attempting to transform their social identity or levels of connectedness. The expectations of others associated with their enduring social roles and relationships could be difficult to shift and stifled women's movement. Dempsey (1992) has also observed a key dynamic of rural communities is the promotion of stability and continuity. Indeed, there are heavy social sanctions for non-conformity to ideologies regarding rural constructions of femininity (Dempsey, 1992).

8.4.4 Feeling Better

In the final phase, characterised by 'feeling better' (refer to figure 3) women begin to more fully disclose their illness experience, accepting and embracing their 'difference' and using their lived experience to connect with others in authentic ways. A feature of this phase is cultivating hope, and developing a belief that life will be easier and more enjoyable in the future, not due to a lack of adversity, but due to their increased capacity to manage difficulties as they arrive.

Mothering

Security and competence in the mothering role is a feature of this phase. Although constantly evolving, women express joy and satisfaction as well as frustration and humour in describing their relationships with their children and the knowledge they have gained through a range of parenting experiences, "I think I'm a good mum now. I actually have a lot of confidence in that." Women demonstrate a greater level of understanding that difficulty and emotional breadth and depth is a universal experience of parenting, not a sign of incompetence.

They hold out hope that inter-generational cycles of hardship and mental distress will be broken. They hope that their efforts to address and resolve their own mental health

challenges will mean that their children will not experience the depth of mental distress, despair and difficulty that they themselves have endured.

Identity

The mental illness experience is more fully integrated into a coherent sense of self. A narrative that provides meaning about what happened psychologically and why, allows women to conceptualise their experiences not as 'normal', but as understandable, given the context of their circumstances. As a result, women have increased confidence in the validity of their experience, and can depict how their unique attributes have influenced but also been shaped by these experiences of distress. They can confidently name the different aspects of their personal identity and recognise those with whom they share a social identity.

Connectedness

Connecting intensely occurs when women encounter loving, respectful and supportive relationships, especially when this occurs for the first time and is therefore unexpected. Women feel more comfortable to use their lived experience of mental illness to connect with other, to forge deeper and more authentic relationships. They become more aware of what they need to maintain their mental health, and are less hesitant about asking for it from partners, other family members, peers, friends or service providers.

Summary

Women's social identity and social connectedness may coincide when they choose vocational occupations that involve disclosing their illness experience, as a mental illness advocate or educator. As this experience and the meaning drawn from it come to the fore, rather than being concealed as a source of guilt and shame, women gain strength and fulfilment in using their experience for a distinct purpose, to help others.

In Tan's (2012) study, deriving meaning from the disordered thinking that is the hallmark of psychosis was found to take time. This can perhaps be considered a parallel process to

'reframing meaning' in the category of 'feeling better'. Developing an understanding of the meaning of the illness experience was significant.

For some women, learning about the ways that trauma effects the brain was helpful for them in conceptualising what had happened to them personally. This assisted them to understanding their experience in relation to broader psychological knowledge and phenomena. This is demonstrated by the response of one participant when people ask her why she holds onto negative memories "...because its trauma and I don't think people understand what trauma does and that's what I'm learning because of the counselling I'm doing."

Feeling better did not mean women ceased to experience "bad days" or that they couldn't become unwell again. Feeling better coincided with a greater sense of perspective in the knowledge that difficult phases would pass, and that there were actions women could take to improve their mental state so they felt more empowered to manage their mental health during future difficult times.

8.5 Identity and connectedness in personal recovery

Identity and connectedness are closely entwined at the location where the social and psychological intersect. There is significant overlap between social and personal identity and social and personal (or self) connectedness and they are dynamic and interactive constructs. Within these PhD studies, personal identity was forged in early life experiences of social interactions. The quality of women's early attachment relationships shaped their subsequent personal and social identities in that they took their interpretation of their own value the verbal and non-verbal cues others gave them from their earliest life. Women then based their own self and relationship knowledge on these and they became foundational identity assumptions e.g. I am/am not loved, lovable, fun, valued, annoying, helpful, clever, sporty, like you, different etc. Always complex and multi-dimensional, whether these were overwhelmingly (dominantly) perceived as positive or negative

appeared to guide their future relationships thereby reinforcing (usually) or challenging (sometimes) how they viewed themselves and their intrinsic worth.

Therefore, by the time a mother is recovering from mental illness, these assumptions and patterns are deeply ingrained. But becoming a mother is a potentially transformative psychological event. In motherhood, an internal and external transition occurs of a physiological, social and emotional nature. Personal as well as social identity can be significantly altered through becoming a mother.

Too often though, the pervading identity grounded in disconnectedness shaped the women's behaviour in ways that continued to alienate her. It takes a very compassionate and insightful practitioner to be able to create authentic connection that goes beyond "unconflictual relationships" (Townsend & McWhirter, 2005), to the building of acceptance and trust, demonstrating to women that she is valuable for her self. This echoes Rogers' (1951) emphasis on unconditional positive regard as the essential foundation for client-centred therapeutic work. The women who participated in this research described themselves as adept at sensing who they can and cannot trust.

8.6 The experience of identity in personal recovery and the CHIME Framework

One of the struggles women experienced in attempting to define who they were, and who and what they were like (or not like), was differentiating that which had been named 'illness' from what they believed to be their core traits, parts of their constant and enduring personality. P1 shared that a friend has commented "but you're still high" and she responded "no, I get very excited." It can be difficult for people to draw the line between a vivacious personality and symptoms of bi-polar.

Similarly, P2 defined herself as a high achiever throughout her life, this had enabled her to excel in her career and feel driven and satisfied prior to becoming a mother. After the birth of her first child, her high expectations for herself were sustained and transferred to the mothering occupation, however she no longer had an accurate measure of her performance and progress, being isolated from peers in a new environment with a new

role. Her assumptions were that she was incompetent, compared to an arbitrary measure of how she thought she should be performing – not only completing all the “basics” of feeding and changing a new baby, but also accurately anticipating, assessing and fulfilling all developmental needs and enjoying the entire experience. In this context, P2 found it difficult to accept that her feelings of being overwhelmed and out of control were associated with anxiety, as they could also be construed as an extension of her usual tendency to aim high and constantly monitor her own performance. It is difficult to disentangle which is the illness and which are the usual traits of a high achiever.

P7 defined herself as “different” to the rest of her family and from everyone else she knew. She felt uncared for and misunderstood from an early age. While she expressed belief in her own athletic and intellectual capacity, she explained the cumulative abuses and associated trauma that had led to her psychiatric disorder and stifled her potential. The extent of this impact was evident in her inability to imagine a future or articulate her goals. The entirety of P7s loss of self (or lack of self), sadness and inconsistency in parenting, attending counselling sessions or going to boxing classes, could be explained by the profound and intergenerational experiences of violence and poverty. Identity was entrenched deep within layers of trauma and inseparable from it. P7 rejected any comparison to other, differentiating herself from all family (the source of the trauma), distancing herself from other women, from her culture, from other people who had experienced mental illness. She saw herself as completely alone and disconnected. Her mental illness symptoms were constructed as a manifestation of sustained mental distress that could no longer be contained but continued to interrupt functioning. Substances had been used as a tool to manage the distress, although the effects also exacerbated anxiety. A physical outlet in the form of boxing training had been temporarily successful in alleviating symptoms and building confidence, however P7 had not been able to sustain this activity in the context of mounting child care debts.

P6 defined herself according to what she was not. She differentiated her parenting style and values from her own mother who had been harsh, both physically and emotionally, and from others in her peer group who advocated smacking toddlers. In prioritising the needs of her son, she was ambivalent about whether to begin a short course or to find a job, or to maintain her full time parenting role. While wanting to role model the attributes she valued such as hard work and responsibility, she did not want to forfeit her mothering role, and strongly believed that if her son spent more time with others, he may be more influenced by their values, and she would lose her exclusive control over his moral development, as a single mother.

All of these examples speak to identity, and call into question the process articulated within the CHIME Framework of moving from a negative (illness dominated) identity to a positive (broader, less illness dominated) sense of self. If the illness symptoms are part of or an extension of the normative characteristics of a woman, it can be complex and even undesirable for her to disassociate from or reduce the impact of these core identity attributes. If these characteristics have been valuable in the past, and have enabled her to survive through devastating experiences, why should the recovery aim be to diminish their dominance? Women within this study spoke of coming to an understanding of self, acceptance of those aspects that defined them as “different” and ways that they could cultivate and reflect on the meaning of this ‘difference’, eventually using it to connect to, educate or support others.

These findings indicate that there are fundamental flaws with the way that identity is articulated within the CHIME Framework. As evidenced above, primarily it is oversimplistic to purport that personal recovery in the identity domain involves a transformation from a negative (illness dominated) identity to a more positive one (Bird et al., 2014; Slade, 2009), that is strength based and broad.

Identity is a multi-faceted concept and the development of personal and social identity is a complex process that begins at birth and takes place within the relational context of one's social environment. The CHIME Framework and personal recovery discourse more broadly would appear to be detached from the substantial body of social, psychology and philosophy literature associated with identity. Slade (2009) refers to the differing conceptualisations of personal, social and enduring (philosophical) identity, across those three disciplines and combines these to define identity as comprising

“those persistent characteristics which make us unique and by which we are connected to the rest of the world” (p. 368).

However the framework he proposes overlooks the critical significance of interpersonal relationships and the need for robust connectedness to facilitate positive identity. An important finding confirmed by this research is recognition of how rare such relationships may be for those who have a psychiatric diagnosis that trauma is often part of the “meaning” of the experience. Participants articulated that the same traumatic experience that may precipitate mental distress, may also create subsequent obstacles to the development of trust. Trust however is required to develop and maintain connectedness; which is essential to developing a positive identity. Furthermore, the domain of ‘taking personal responsibility’ lacks understanding of social, political and economic disadvantage that dictate (and restrict) access to essential resources required for recovery, including resources that facilitate identity formation and connectedness.

As a result, identity as a concept and identity rebuilding or redefinition as processes, remain under-developed. Identity formation is presented as an individual undertaking, separate from social interactions and relationships and with insufficient consideration of the interplay of dynamics such as gender, race, socio-economic status, or sexuality. Furthermore, the broader impacts of the social determinants of health over

which individuals have limited control are not adequately addressed within the descriptions of identity transformation.

The particular recovery processes within the category of identity are listed as: dimensions of identity, rebuilding/redefining positive sense of identity and overcoming stigma (Leamy et al., 2011). These processes are focussed on the illness itself as being the primary basis for the negative identity, failing to account for traumatic experiences that are well known to frequently precipitate mental distress and subsequent psychiatric diagnosis (Morrow, 2002; VicHealth, 2004). Effects of trauma upon one's sense of self are profound and well documented (Everett, & Gallop, 2000) however they are under-represented as key factors within personal recovery discourse. This is despite the development and introduction of national practice guidelines for trauma informed care (TIC) (Kezelman & Stavropoulos, 2012) across various settings, including mental health.

“TIC emerged from recognition that mental health services often provide care for survivors of trauma without addressing trauma, and often without even being aware that trauma has occurred. TIC is based on significant research demonstrating the wide reaching effects of trauma on individuals, including their mental health and their responses to services and treatment” (Isobel, 2016, p. 589).

In emphasising the reduction in domination of one's illness identity, the CHIME framework fails to address the growing number of lived experience experts who gain strength and empowerment through embracing their illness identity and using it to educate and advocate in the peer workforce. In using personal experience of mental illness as the foundation of one's vocational knowledge to inform employment tasks and processes, the illness experience is central to ones' identity. A transition from negative conceptualisations of the illness as a burden and a barrier, to positive perceptions of it as a source of knowledge is apparent, however the illness part does not necessarily become less dominant. There are many issues pertaining to power and hierarchy concerned with the

introduction of lived experience experts into the mental health system, however it is outside the scope of this thesis to explore these in detail. Systemic developments such as supportive structures with clear role definitions and career pathways are required to further enhance the potential benefits of having people with lived experience as an integral part of mental health service systems.

As the CHIME Framework evolved from a systematic review of the personal recovery literature, these problems reveal a gaping hole in the existing literature. Although the intention of the CHIME study was to summarise the existing literature in a meaningful way, there may be shortcomings of a methodology that resulted in development of a framework that essentially consolidates and then reflects what has come before, rather than applying critical analysis to identify the missing components and enable expansion beyond this.

8.8 Evaluation of the research

“In critical and liberatory theory and practice, there is always a tension between respecting people’s subjectivity and arguing that their subjectivity emerges from problematic social conditions” (Chodorow, 1999, xvi).

8.8.1 Self evaluation

The strengths of this study lie in the successful recruitment of a diverse range of women, including some who would not usually be represented in research. The researcher’s existing professional networks, persistence, dual recruitment methods and capacity for relationship building, assisted in creating a safe space for the participation of a small number of women who had not previously taken part in research and who were largely disconnected from family, social networks and service providers.

The sample size of 17 was appropriate to the research question and the methodology, allowing for theoretical generalisation. However the generalisability of findings are limited to a particular location in time and geography and therefore applying

the findings to other populations of rural women across different cultures may not be appropriate.

CGT methodology was apt for addressing the research topic and was advantageous in containing detailed instructions for developing procedures within the research that would allow for rigour and transparency. Fidelity to the CGT methods was enhanced through the quality processes adopted, and through frequent reference to the guiding methodology (Charmaz, 2014) throughout the duration of the study.

In the co-construction of understandings between researcher and those researched, a power imbalance is always apparent. Whether the participants of this study would necessarily agree with all of the findings and recognise their narrative within the emerging theorising is unclear. The feminist lens guiding the research was overt and transparent. However women who participated may not share this view of their experiences and relationships or this interpretation of the rural communities within which they reside. The research findings reflect a particular time, location, culture and critical construction. They are valid as an in-depth exploration of the phenomena under investigation, but exist as one of many possible multiple social realities.

8.8.2 Addendum: Response to Examiners' Comments

This sub-section has been added post examination, in order to address the valid and insightful recommendations of the two Examiners. Two issues are briefly addressed within this section. The first is a summary of the limitations of the research, and the impact of these limitations on the findings. The second issue takes the Examiners' suggested expansions to the discussion of connectedness in relation to attachment theory, and in acknowledgement of the opportunities presented by technology based interventions.

This research is limited primarily by the small sample, and the amount of time spent interviewing each participant (which was a mean of 42 minutes). While some women were interviewed twice, the majority were interviewed only once and there was a broad range of

topics being explored. Additional time dedicated to data collection with the opportunity to interview and observe women on multiple occasions would have resulted in a more rigorous process and greater capacity to dissect and clarify meaning participant attributed to the psychological and social processes they described. The two methods of recruitment (through mental health clinicians and through media and social media platforms) resulted in a large range of mental illness experiences in terms of duration, acuity and recovery.

Comparing the experiences of those women (mothers) requiring long periods of clinical case management with those who had a brief situational crisis that resulted in a diagnosis of anxiety or depression may be somewhat inadequate. While many commonalities were evident as illustrated by the conceptual map, the issues associated with oppression and trauma were variable and the oppression arising from social and personal stigma associated with poverty and racism, before mental illness was diagnosed. These were the main limitations of the studies. Fidelity to the CGT methodology and embedding mechanisms that prompted critical reflection reduced the number and significance of the impact of limitations.

The construct of connectedness was found to be important, and the concluding sentences of Chapter 7 presented recommendations for practice, including trauma informed care and a re-prioritising of connectedness as a prerequisite for identity work. Emerging evidence around the efficacy of technologically based interventions and the advantages and disadvantages of utilising them to deliver interventions in the social work field have been synthesised (Ramsey & Montgomery, 2014). Research suggests that when used with comprehensive planning around purpose and intent, in some circumstances these may be a sound and helpful mode for isolated mothers, particularly those in rural areas, to be able to connect with both peers and service providers.

Connectedness is thought to be a crucial component of social and psychological development during adolescence (Lee & Robbins, 1995). Connectedness outcomes are

related to early life experiences (Bowlby, 1977), and barriers to the establishment of robust connectedness to self and others could be expected to progress from insecure attachment types (Ainsworth & Bell, 1970). Building supportive opportunities for mothers to experience connectedness are important interventions that have the potential to break trans-generational patterns of mental distress. A discreet focus on increasing the connectedness of mothers (or ideally, pre-natal women), may assist in building their capacity to connect with their partners, their babies and with themselves in the mothering role. Being capable of cultivating a consistently attuned response to the baby's needs is known to build secure attachment and may also increase connectedness. Experiencing success in early mothering may also be crucial to fostering a positive and confident mothering identity. The relationship between maternal connectedness (particularly for mothers with mental illness) and infant mental health outcomes warrants additional investigation.

8.9 Recommendations for future research, policy and practice

8.9.1 Introduction

The detailed analysis of the many and varied impediments may suggest that it is difficult to remain optimistic about the recovery prospects of mothers with mental illness in rural areas. However the tenacity, resilience, resourcefulness, and humour displayed by the women who participated in the studies also has to be highlighted and celebrated. Throughout lives punctuated by trauma and socio-economic struggles, women displayed profound endurance and creativity. If there were no supports locally available they went on-line. If there were no family members who could understand and support them, they created their own networks with neighbours, peers or in cyberspace. Women educated themselves on parenting through questioning health professionals or reading books. They reflected deeply on their core beliefs and attributes to counteract negative identity messages they carried from early life. They undertook the emotional toil of re-framing their identity in ways that made a better fit with their core values and life experiences.

Sometimes this important work was done in partnership with health professionals, but often women embarked on these winding pathways alone.

The data provided by participants draws attention to prime opportunities for service providers to intervene in assisting to build parenting competence and confidence, reframing identity, building connectedness, and working proactively to prevent further distress to mothers and their children and families. These research findings, have led to recommendations for improving policies and practices within mental health services as well as other health, education, community and family sectors so that service providers may offer more effective support and promote opportunities for personal recovery for these women along with their children and families.

8.9.2 Redressing (not reproducing) inequalities

These findings suggest that holding people with mental illness responsible for their lack of progress towards externally derived outcome measures is likely to be ineffective and unjust. The obstacles to recovery for mothers with mental illness are not easily addressed without broad and systematic structural change to the political and economic infrastructure of Western society.

The socio-economic barriers to personal recovery have been identified by others (e.g. Morrow, 2002; Tew et al., 2011). These conditions underlie the rationale for the ‘Unrecovery’ movement (2016), recognising that a focus on individual responsibility for personal recovery negates the profound impact of the social determinants of health, and the social and political structural failures in producing more equitable economic conditions across populations.

Reupert, Maybery and Nicholson (2015), cite Tanner (2000) who argues for a focus on generating sustainable changes to social structures rather than individuals, as “the inequalities of women, unrealistic expectations of motherhood, stigma and shame, and the fear of involvement of statutory bodies constitute the main problems of such families, rather than the parents’ mental illness” (as cited in Reupert, Maybery & Nicholson, 2015, p.

10). Furthermore, Seeman (2015) notes that in Scandinavian nations, difficulties in parenting or whilst parenting, are constituted as part of normative child-rearing experiences, and so all parents are proactively encouraged to adopt help seeking behaviour through universal assessment and screening processes. In this way the shame of disclosing difficulties in parenting and the profound fear of custody loss as a sanction for this are removed.

A concept of relational recovery has been proposed by Price-Robertson, Obradovic and Morgan (2016), in recognition of the observation that individuals who have a mental illness have multiple social connections and roles. The relational model constitutes an attempt to emphasise the critical role of these inter-personal relationships, in addition to addressing the social determinants of mental health, in fostering recovery outcomes. The authors argue:

“...that while interpersonal relationships are currently recognised as a component of the recovery process, they can more accurately be seen as suffusing all aspects of recovery, including experiences like hope, identity and empowerment...” (p. 2).

8.9.3 Focusing on connection

The significance of the therapeutic alliance in the mental health field as well as other health and community sectors has been highlighted elsewhere (for example Castonguay, Goldfried, Wiser et al., 1996; Fox, 2002; Lambert & Barley, 2001). It is critical to retain and strengthen a focus on developing a strong rapport and a foundation of trust in work with people who have experienced trauma, especially in the context of interpersonal violence (Isobel, 2016). This can take time, and be in competition as an outcome with other organisational and treatment imperatives. Kavanah (2002) and Maidment (2006) have both observed the elevation of the primacy of maintaining professional boundaries and therapeutic distance, which has resulted in a diminishing in recognition of the crucial role of the therapeutic alliance.

Women demonstrated the importance of a non-judgemental approach in encouraging them to disclose their difficulties and seek support from service providers. As parental mental illness has appropriately been emphasised as a risk factor for children, service providers may feel conflicted about their responsibilities to their adult clients as well as to the children in their care, especially when the needs of parent and child appear to be divergent (Cousins, 2004; Maddocks, 2010). Sitting with discomfort while identifying the needs of each member of the family and working in partnership with other services to address those needs is challenging but necessary (Cousins, 2004).

Outcomes for children can be enhanced through strength based work with parents (Solantaus, Paavonen, Toikka & Punamaki, 2010). The findings from this research calls for a renewed focus on building relationships with mothers with mental illness through strategies including deep listening, validating experiences, providing psycho-education especially surrounding the impacts of trauma and exhibiting an understanding of the ways in which social and economic disadvantage exert influence over health outcomes beyond an individual's control.

Recognition that motherhood is a demanding and challenging endeavour needs to be communicated to women (Seeman, 2015), and practitioners' self-disclosure regarding their own parenting difficulties can go a long way towards establishing a more authentic therapeutic relationship. Similarly, promoting help seeking for parents and the establishment of safe and respectful peer groups interventions such as supported playgroups (Goodyear & Fernbacher, 2012) can assist in normalising and validating parenting challenges.

8.9.4 Supporting parenting and mental health in the early years

The accounts provided by the participants of this study identified the perinatal period as a prime opportunity to work on supporting the development of a positive identity during the transition to early parenting. Although women described themselves as needing support and assistance at this time, their encounters with health professionals or indeed

with other mothers were not always positive. Compounding this was negative and socially rejecting experiences in group contexts.

In Australia the vast majority of antenatal education and post birth support is offered in a group context and the connectedness literature suggests that this is not the most effective format for those with low connectedness. Rook (1984) found that it is those who are the least lonely and isolated who benefit the most from groups. Individual therapeutic and educative sessions with one consistent practitioner would be likely to provide the greatest benefit to women with mental illness during their pregnancy. The majority of participants within this study expressed feeling unprepared for mothering, and their expectations of the experience had not been met. Instead, they struggled to cope in isolation, feeling inadequate and guilty. These emotions are recognised as part of the normative transition to becoming a mother (Mercer, 2004). Resolving or reconciling the incongruence between the 'ideal self' as mother, that women may have developed during pregnancy as they anticipated the birth of their child, with the 'self-image', which is a "representation of a consistent self in the present" (Mercer, 2004, p. 227). When women are socially isolated from peers and lack supportive relationships with older women, such as their own mother, the opportunities for validation of this experience is absent. Small, Taft and Brown (2011), reviewed a program which included "mother-to-mother support based on the principle of non-professional befriending" (p. 4). This model of one to one mentoring and social connection has the potential to enhance identity while explicitly addressing connectedness.

The many benefits of a mental health peer workforce in facilitating recovery orientated practice are beginning to be more fully understood in Victoria, and other jurisdictions where peer worker positions are being introduced. A discreet focus on employing parents with mental illness and matching them with parents utilising mental health services would expand the positive outcomes of this initiative. This service model

could also be implemented in a broad range of settings and environments mothers with mental illness may frequent, such as kindergartens, child care, maternal and child health services (Small, Taft & Brown, 2011), primary schools, family services and alcohol and drug services.

During early parenting, mothering experience and confidence can be low at the same time as emotional and physical resources may be depleted. This is identified as a crucial period for intensive intervention that could potentially be transformative in relation to mental health outcomes for both mother and child.

8.10 Further research

This study has explored the relationship between identity and connectedness within the context of personal recovery for a cohort of mothers who resided in rural locations. Whilst this thesis contributes towards increased understanding of the constructs of identity and connectedness as they relate to mothering with mental illness, many questions remain. Future research endeavours in this domain include how the service system can provide improvements to the ways in which we support the transition to motherhood for women with existing mental illness. As women identified the perinatal phase as a crucial time when they were seeking engagement, research projects that evaluate new models of care during this phase are key. Sectors that might participate in such research could include midwifery, maternal and infant services, perinatal mental health and adult inpatient and community mental health services. The ways in which these respective services can collaborate to cohesively meet the needs of the mother, infant and other family members would be important to ascertain.

Other research areas include exploring differences in identity and connectedness within different cultural environments, and illuminating efficacious strategies to overcoming barriers to connectedness. Barriers and enablers to integrating trauma-informed practice across a range of services and sectors also need to be investigated.

8.11 Conclusion

The findings from this thesis facilitate increased understanding of the ways in which mothers with a mental illness living in rural locations relate to the concept of personal recovery. Furthermore, the studies have examined experiences of mental illness, motherhood, identity and connectedness within this cohort and the factors that either hinder or support a positive identity and strong connectedness. The development of a substantive theory that provides abstract understanding of the meanings of women's account and associated recommendations, enables service providers and families to reconceptualise the ways in which systems and communities identify and address the needs of rural mothers with mental illness, to promote their mental health and wellbeing through the parenting phase of their lives and beyond. Improving service system responses to rural mothers with mental illness, along with the creation of more inclusive community, social and economic environments will allow mothers to access the resources that they need to promote recovery. Furthermore it will allow their children to:

“...see me on fire and they can see Mum leading a whole healthy life and not tortured by the past.”

Then perhaps women's hopes for themselves, their children and future generations can be realised.

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APPENDICES

INTERVIEW QUESTIONS

Taken from interview transcripts

Interview question	Asked in interviews
<u>Background to mental illness</u>	
What came first for you; motherhood or mental illness?	4, 5, 7, 9, 14
Could you give me a little bit of background about your mental health difficulties?	2, 3, 10
What were your warning signs that things were not quite right? Who noticed?	2, 10
I was just wondering what “spinning out” was like?	3
What do you mean by “not coping”?	10
In what ways did experiencing adversity make you a stronger person?	3, 8
When did you actually get the, like the label of having borderline, or bipolar?	5
Do those (diagnostic) labels mean much to you?	5
Did you have any mental health concerns or problems before you became a mother?	6
Do you feel like those community attitudes and misunderstandings of mental illness are starting to change? Have you seen them change over your time?	1, 9
Did your mum have a mental illness?	14, 6, 7
Tell me about your childhood...	13
Did you have a caring role with your brothers and sisters?	11, 12
<u>Recovery</u>	
Have you heard of the term ‘personal recovery’ in relation to mental illness?	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 14
What does recovery mean to you?	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 14
What do you think might be the key ingredients/steps/processes for personal recovery from mental illness?	3, 4, 9, 14
What would recovery look like to you? What would it mean to be recovered?	9, 14
What sort of things do you feel you’d be able to do when you feel you are recovered?	9
Do you feel that you are on a recovery journey?	8
How have you been going on your recovery journey?	6
Do you tell people about your MI?	4, 7, 8, 9, 10
Can you explain a little bit more about that anger?	1, 7, 8
Why is it that you don’t use the anxiety strategies taught?	2
How do you feel now, compared to when you first became unwell?	2
What strategies help you manage day to day with the young children/teen and life stressors?	2, 10
What was the right path for you? What were the things that were really important then?	2
What was it about the talking that helped?	2
Do you feel any hesitation about telling people (about MI) or worrying about that?	4, 9
Giving yourself permission (to rest or self-care), is that a part of recovery do you think?	5
What do you feel like you’re recovering from?	6, 7
How do you manage that huge change?	6, 8
Was there something that happened that’s brought about this change?	8

What does a 'normal life' look like for you?	9
Is goal setting for yourself something that's important?	9
Do you plan to go back to work?	10
Do you have some good days as well? What are some of the good bits?	12
Motherhood	
What is a 'good' mother? How would you define the characteristics of a good mother?	2, 5
How did your main roles change once you had a baby?	2
What were the most difficult aspects of leaving work to be a full time Mum?	2
What sort of a mum was your mum, what was she like?	13
Are there other people in your life, like even not people you necessarily know, on television or in society that would be a role model for you around what good mothering looks like?	2, 4, 14
Did you always want and/or expect that you would become a mother?	11, 12, 14
What would your husband say about how you are as a mother and what are your strengths?	2
What does being a mum mean to you?	1, 4
What sort of mother are you?	3, 5, 6, 7, 8, 9, 10
How would you describe yourself as a mother? What sort of mother are you?	2, 3, 14
Who do you compare your mothering to?	1, 3, 5, 6, 7, 9
How did you learn your mothering style or the skills?	1, 3, 5, 6, 7, 9, 10
Where do your ideas or those benchmarks about mothering come from for you?	2, 4, 14
Have you felt guilty about time missed when your son was a baby?	9
What was it like, becoming a mother?	5, 6, 8, 9, 10, 12, 14
Did you feel comfortable in the mothering role right from birth or did it take some time to adjust?	11, 14
What was it like when you found out you were pregnant?	13, 14
What's some of the good things about being a Mum?	6
What are the most difficult things about being a parent that you've found?	9
Has becoming a mother changed the way you see yourself?	6
Could you describe the relationship you have with your kids?	7
Have DHS been involved long?	7
How easy or difficult is it to hide your emotions from your kids?	8
What skills or strengths do you have as a mother?	8
Is it important to be honest and clear with your son about your mental illness and the limitations of it?	9
When did you feel competent as a mother?	9
Have others reinforced your skills and strengths as a mum?	9
How do your adolescent son's mood swings impact on your mood swings?	9
How do you manage parenting challenges?	9
Who were your supports when you first became a mother?	14
Do you have any other, older kids? How old?	12
Do you remember much about when your first child was born?	11, 12
What was the birth like?	13
How do you bring your fun attitude to parenting?	11
How does your childhood effect the way you parent now?	12
Identity	
How would you describe yourself to someone who maybe doesn't know you?	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 14

Have you always been like that?	3
What sort of things are important to your sense of self across your lifespan?	2
What were your main roles in life at that time?	2, 3
What roles define you?	4
How does that influence how you see yourself more broadly?	3, 9
Who are the people that influence the way you see yourself and who are the people that are really important to you?	4
How would your child describe you?	4
How would your friend describe you, do you think? What sort of things would she say about you?	13
What other things define your sense of self?	1, 5
What are the important things to you in life?	6
Is there anything else that you think, like, that's important in identity in recovery?	4
I wonder how you see that you've changed over time. Like how would you have described yourself earlier on when you first had the mental illness?	1
How do you see yourself now?	8
Are you still Christian now?	12
What are your strengths or interests as a person?	9, 12
Has the way you see yourself and your valuing of your independence changed over time?	2, 9
How does the work you do with your psychologist influence your identity?	2
Do you have some activities or times where you're not with the kids or hobbies you can do that are just for you?	2
Was the work around your sense of self helpful or hindering?	3
Did you always know you were adopted?	5
Is your relationship (with your Mum) changing along with your identity and your confidence in your identity?	5
Did you work before you became a mother?	6
Do you think how you see yourself and your sense of self is important for your recovery?	6, 7, 9
How are you "different"?	7, 11
Has your family of origin influenced how you see yourself now?	7
Have there been any people or services that have helped you to discover that about yourself? And to bring out all the positives?	8
How does your Aboriginal identity influence how you see yourself? Is it about culture, language?	8
How did the psychiatric diagnosis change the way you see yourself?	11, 14
How did (cruel treatment by mother/grandmother) make you feel about yourself?	12, 13
Who are you like?	12
Have you always been like that?	12
Who do you think you'll be in 10 years?	12, 13
What was it that made you choose to do aged care rather than a different course? Do you like spending time with older people?	13
What are you really passionate about? What gets you really excited?	11, 13
Is having fun/making people laugh part of your role on Earth?	11
<u>Connectedness</u>	
Are there any other people or groups who are really important to you staying connected?	1, 10
Did you have other supportive people like when he was first born?	13

What/who are your main connections?	4, 7, 8, 9, 10, 14
Who are the people who are your supports or who you're close to?	3, 2, 5, 6
Do you have much in common with her, like do you feel like you are similar in the way you parent?	13
Did you grow up in the same area where you live now?	3, 4, 6, 7, 9
How long have you lived in your current home? What's it like?	10
Was your partner supportive during your illness?	4, 10, 12
Were your parents supportive?	9, 13
Was that relationship abusive?	7, 8
What sort of relationship do you have now with your siblings?	11
Do you have a strong connection to other people who've experienced mental illness as well?	1, 11
How do your connections, you know, identifying strongly with the local Aboriginal culture? Does that change how you feel as a mum or how you feel about yourself?	1
What are your concerns about sharing your mental illness diagnosis with that group?	2
Are you like are you involved in the gay community locally now? Or on social media or anything like that?	4
Do you have relationships with people that go back to childhood?	6
Do you feel like you are known in the place where you live? Is it important or helpful to be known?	6, 7, 8, 9
Was/is part of your recovery about relationships?	6
Do you feel connected to the other Mums that go to that playgroup?	6
Are you looking for something beyond (mothering role) to give you something as well and connection with other people?	6
Can you tell me about the family you grew up with? Mum, Dad, siblings etc...	7, 9, 14
Who gives you hope?	7
Did you feel an immediate connection to your baby?	9
Have you found other creative people to connect to?	11
Are you close to your family?	10
Do your friends know that you have a mental illness? How open are you about disclosing MH difficulties?	10, 14
What is the barrier to connection/ in your mother's group?	10, 11
Did you see a M&CH nurse?	14
Did you know any other young mums?	12
Was there a time where you sort of had no one?	13
<u>Services</u>	
How did the service system support your recovery?	4, 7, 8, 9
What could the service system have done to make that a better experience and more appropriate support peer group?	4, 5, 10
As a mother, what do you think are important things that mental health services or other support services can do to support the way you feel about yourself and to support your connections and your recovery?	1, 2
What was seeking support for your mental health difficulties like? Was it hard to ask for help?	2, 8
What was it that made you change your mind and link in with the support services?	10
How do you feel mental health service providers acknowledged your mothering role and your identity?	2, 9, 10
Do you feel you were treated differently because of your mental illness?	11

When you were working with mental health service providers, was any of that work around your identity or your sense of self?	3
Did you have any other supports that were understanding of your mental health?	5
Does (your child's) school know about your mental illness?	5, 7, 9
Do the child and family (M&CH) services know about your mental illness?	8, 9, 10, 14
What does your mental health clinician/support worker etc do that's really helpful?	6, 7, 9
Do you talk to your mental health clinician about your parenting? How does MHS address your parenting needs?	6, 10
What does (the facilitator/worker) do that's really good, how does s/he support people and bring them together?	6, 13
What do you think were the barriers to you connecting with health professionals?	14
How did you find the on-line support group?	14
Do you think they treated you differently because they knew you had a diagnosis?	14
<u>Rural context</u>	
Do you think there's other things that happen in the rural environment that are different or important for mothers with mental illness?	1, 7, 9, 10
Do you think that you're more visible and more known by the health services and the rural community as well? Have you experienced stigma?	1, 9
Do you prefer to live in the rural areas or in the city?	8
Did you have a bit of land where you lived, you had a horse?	13
<u>Concluding questions, summary</u>	
What are your hopes and aspirations for the future with recovery and your ongoing mothering role?	1, 2, 3, 5, 6, 8, 9, 10, 14
Do you think there's anything else that I haven't asked that's been important for your recovery or around your identity?	6, 8, 10, 14

PARTICIPANT INFORMATION SHEET AND CONSENT FORM (PICF)

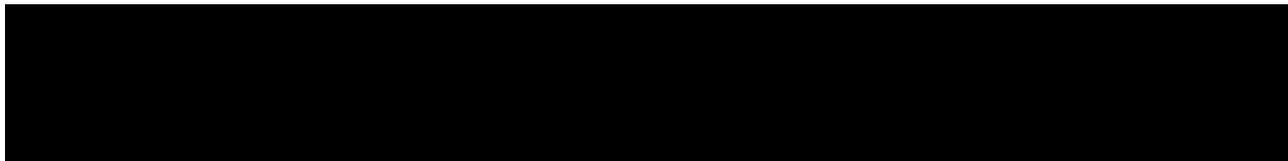
Participant Information Sheet/Consent Form: Consumers with mental health difficulties

Ballarat Mental Health Service

Mothering with mental illness in a rural context: Gender, Identity and Connectedness in Personal Recovery

This information sheet is for you to keep.

My name is Rochelle Hine and I am currently studying a PhD at Monash University. I would like to invite you to participate in this research. Please read this Explanatory Statement in full before deciding whether or not to participate. If you would like further information regarding any aspect of this project, you are encouraged to contact the researchers via the phone numbers or email addresses listed below.



Introduction

You are invited to take part in this research project, exploring experiences surrounding personal recovery from mental illness and how the mothering role may influence your identity and connectedness.

This Participant Information Sheet/Consent Form tells you about the research project. It explains the activities involved. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Ask questions about anything that you don't understand or want to know more about. Before deciding whether or not to take part, you might want to talk about it with a relative, friend or your local doctor.

Participation in this research is voluntary. If you don't wish to take part, you don't have to. You will receive the best possible care whether or not you take part.

If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:

- Understand what you have read
- Consent to take part in the research project
- Consent to participate in an interview as described
- Consent to the use of your personal information and your responses to interview questions, as described.

You will be given a copy of this Participant Information and Consent Form to keep.

2 What is the purpose of this research?

The aim of the research is to find out more about the experiences of mothers with mental illness who live in rural areas. While there is an increasing understanding of the needs of parents with mental illness generally, very little research has been carried out in rural areas. By understanding what supports or hinders recovery for mothers with mental illness, it is hoped that rural services to mothers, children and families can be improved.

The results of this research will be used by the researcher Rochelle Hine to obtain a Doctor of Philosophy (PhD) degree.

3 What does participation in this research involve?

Individual interviews will be conducted with up to 20 women. Each participant will be asked to share some information about themselves such as age, where they live, the age of their children and about their mothering role. Participants will then be asked to take part in an interview that will take approximately one hour. In the interview you will be asked questions about your mental health problems, your mothering, how you see yourself (your identity), and about your relationships and connections (connectedness) with others.

This interview will take place at a convenient and private community location that suits the participant, such as a mental health service or their children's school. The interviews will be audio recorded to ensure accuracy.

The research will be monitored and supervised by two very experienced researchers employed by Monash University. This research project has been designed to make sure the researchers interpret the results in a fair and appropriate way and avoids study doctors or participants jumping to conclusions.

There are no costs associated with participating in this research project, we will pay you a total of \$25 to participate in an interview. Payments will be in the form of a gift voucher and not cash.

4 Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project. If you do decide to take part, you will be given this Participant Information and Consent Form to sign and you will be given a copy to keep. You have the right to withdraw from participation at any stage, along with the possibility to withdraw any data that has been collected from an interview with you as long as this occurs before it has been de-identified and analysed.

To withdraw you will need to notify the researcher either verbally or in writing. Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your routine treatment, your relationship with those treating you or your relationship with Ballarat Mental Health Service.

5 What are the possible benefits of taking part?

There is no guarantee that you will receive any personal benefit, however many people enjoy participating in research interviews, and people with mental illness have talked about the benefits of sharing their experiences of recovery. By participating in this research, you will be assisting in improving understanding about the experiences of rural-living mothers with mental illness, and what can support them in recovery. The factors found to support mothers will be communicated to service providers, to assist in delivering more effective services in the future.

6 What are the possible risks and disadvantages of taking part?

The risks of participation are minimal but may include the inconvenience of attending an interview as an interruption to your day. Talking about mothering and mental illness experiences may be difficult and emotional, and some of the discussion may produce feelings of discomfort or even be distressing. At any time, the interview can be paused or stopped if an intolerable level of discomfort occurs. Any information that you provide regarding risks to your own safety or the safety of your children could be released in accordance with legal obligations/ethical duty of care requirements.

Services on offer if adversely affected: A Family Services Guide has been developed specifically for Families where a Parent has a mental illness in recognition of the extra challenges that are sometimes encountered. Support to contact any of these services could be arranged if required.

- **How can I access my information?**

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to access the information collected and stored by the researchers about you. You also have the right to request that any information, with which you disagree, be corrected. Please contact one of the researchers named at the end of this document if you would like to access your information.

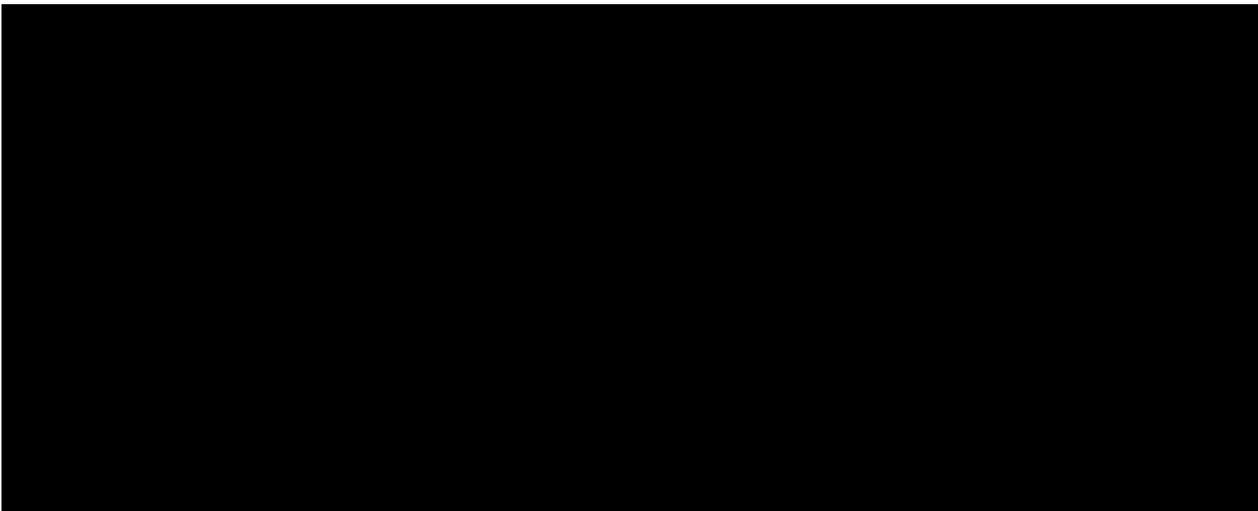
- **Is this research project approved?**

The ethical aspects of this research project have been approved by the Monash University and Ballarat Human Research Ethics Committees.

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research* (2007) produced by the National Health and Medical Research Council of Australia. This statement has been developed to protect the interests of people who agree to participate in human research studies.

Complaints

Should you have any concerns or complaints about the conduct of the project, you are welcome to contact the Executive Officer, Monash University Human Research Ethics (MUHREC):



PARTICIPANT CHARACTERISTICS

	Age & cultural background	No., sex & age of children	Housing & lives with	Location & rural rating	Self-reported diagnosis	Income source or bracket	Interviewed; recruited via
1	38; Irish and French and Gunditjmara Aboriginal community	10yo – F 8yo – M 6yo – M (All in foster care)	Private rental, 3 br house, Lives alone	Dennington, RA2 Previous RRMA 4, small rural centre	Bipolar, OCD, BPD.	DSP, \$782.20 per fortnight	11am, 3/7/2015 33 min, 46 sec -General community, word of mouth
2	35; Australian	2yo – F 10mth – M Currently pregnant	Own home on farm, with husband and 2 children	Tatyoon, RA3 Previous RRMA 5 other rural area	Anxiety & depression	Farm income.	10:30am, 14/7/2015 24 min, 27 sec -Twitter
3	44, Australian	13yo – F 11yo - M	Own home, with husband and 2 children	Bolwarra, RA3 Previous RRMA 5 other rural area	Anxiety & depression	Husband's income, \$200,000 PA	11:30am, 15/7/2015 47min, 26 sec Newspaper article, Portland Observer
4	39, English, Australian	15yo - F	Own home, partner and daughter 50% of time	Allansford, RA2 Previous RRMA 5 other rural area	PND, anxiety & depression	Wages, \$65,000 PA	11am, 9/9/2015 29 min, 56 sec Mental Health Services
5	39, Parents Finnish & Italian, grew up in Lutheran Australian family (adopted)	14yo – M	Private rental, with son	Hamilton, RA2 Previous RRMA 5 other rural area	Borderline personality disorder & bipolar disorder.	Centrelink + part time wages	11am, 5/10/2015 41 minutes, 22 sec Mental Health Services
6	40, Australian	2yo- M	Public housing, with son	Portland, RA3 Previous RRMA 4, small rural centre	Drug induced psychosis	DSP, \$782.20 per fortnight	10:30am, 8/10/2015 25 min, 36 sec Mental Health Services Re-interviewed 6/2/2016 49 min, 53 sec
7	29, Aboriginal	15yo – M 11yo – F 10yo – M 8yo – M 4yo –M 3yo – M (youngest 2 in foster care)	Public housing, with eldest 4 children	Portland RA3 Previous RRMA 4, small rural centre	Anxiety and depression, paranoia, bi-polar	Newstart, Family tax benefit Centrelink	11am, 23/10/2015 53 minutes, 08 sec SWH MHS Re-interviewed 14/01/2016 53 min 45 sec SWH MHS
8	31, Aboriginal	4yo – M 2yo – F 8 mths – F	Transitional housing	Portland, RA3	Anxiety, PTSD	Centrelink, parenting payment	10:30am, 30/10/2015 38 min, 59 sec

		+ 3 others in care 14yo – M	with 3 children	Previous RRMA 4, small rural centre			SWH MHS Re-interviewed 27/01/2016: 43 min
9	43, Australian	15 yo - M	Own home, with husband & son	Cobden, RA2 Previous RRMA 5 other rural area	Bipolar Disorder	DSP	2:30pm, 30/10/2015 28 min, 27 sec Mental Health Services
10	26, Australian (non-identifying Aboriginal heritage)	6 month - M	Private rental, partner & son	Garvoc, RA2 Previous RRMA 5 other rural area	Bipolar Disorder	Partner's wage as a farm worker	1:00pm 11/11/2015 38 min, 59 sec SWH Mental Health Services
11	34, Australian	9 yo – M 8 yo – M 5 yo – F	Private rental, with 3 kids 60% of time (40% with their father)	Loxton, RA3 Previous RRMA 5 other rural area	PTSD & depression, PND	Centrelink	9am, 11/2/2016 55 min, 27 sec Social media
12	53, Australian	17 yo – F 16 yo – F 13 yo – M	House on the family owned farm with husband and 3 kids	Meribah, RA3 Previous RRMA 7 other remote	PND, depression	Farm income, plus wages from 3 part time jobs	4:15pm 11/2/2016 51 min, 10 sec Social media
13	28, Australian	5 yo – F 2 yo – M	House on the family owned farm with husband, 2 kids & boarder	Taplan, RA3 Outer regional Previous RRMA 5 other rural area	Depression	Wages as a private OT	9:15am, 12/2/2016, 43min, 55 sec Social media Second interview 12:45pm 1/6/2016 phone 19min, 54 sec
14	44, Australian, English	9 yo – M	Private rental house with mother and son	Diggers Rest, RA1, inner city Previous RRMA 1 capital city	Depression & anxiety	DSP	4pm, 18/2/2016, 39 min, 38 sec FaPMI Mental Health Service
15	23, Australian	10 mth old – M	Buying own home with fiancé, fiancé's daughter aged 4 and son	Loxton North, RA3 Outer regional Previous RRMA 5 other rural area	Depression & anxiety	Wages as a full time child care worker	3pm, 22/2/2016, 43 min, 10 sec Social media
16	45, Australian, German	14 yo – M 12 yo – M	Buying own home with husband and 2 sons	Loxton, RA3 Outer regional Previous RRMA 5 other rural area	Anxiety, OCD, depression,	Wages as part time supermarket worker + husband's wage	2pm, 24/2/2016, 1hr, 1 min, 1 sec Social media

17	26, Caucasian, Anglican	14 mth old – F	Living with parents and daughter (husband away for 8 months	Coleraine, RA3 Previous RRMA 5 other rural area	Depression, Anxiety, PND	Husband's full time wage	2pm, 25/2/2016, 45 min 14 sec PEHP Mental Health Service
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