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“STANDING ON THE FRONT LINES AND DOWN IN THE TRENCHES WITH HER”: AN EXPLORATION OF THE DIALECTICAL TENSIONS AND COMPETING GOALS OF ADULT CHILDREN OF MENTALLY ILL PARENTS

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“STANDING ON THE FRONT LINES AND DOWN IN THE TRENCHES WITH HER”: AN EXPLORATION OF THE DIALECTICAL TENSIONS AND COMPETING GOALS OF ADULT CHILDREN OF MENTALLY ILL PARENTS

DISSERTATION

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the College of Communication and Information at the University of Kentucky

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ABSTRACT OF DISSERTATION

“STANDING ON THE FRONT LINES AND DOWN IN THE TRENCHES WITH HER”: AN EXPLORATION OF THE DIALECTICAL TENSIONS AND COMPETING GOALS OF ADULT CHILDREN OF MENTALLY ILL PARENTS

Mental illness is a pervasive health epidemic in the United States and worldwide, and available data suggest that mentally ill adults are statistically more likely to be parents than non-parents. The prevalence and continued growth of parental mental illness means that millions of children in the United States have a parent with some form of mental health issues.

This dissertation contributes to and extends existing literature on children of mentally ill parents by exploring 15 adult children’s subjective perspectives on how they navigate the tension-wrought experience of having a mentally ill parent, and how this has implications for the management of their identity, relational, and instrumental goals. Examined through the lens of relational dialectics theory (Baxter & Montgomery, 1996) and a multiple goals perspective, analysis revealed that adult children of mentally ill parents confront conflicting, contradictory forces in making sense of their parent’s illness and the role that it plays in their lives. Specifically, adult children reported feeling a strong sense of interdependence with their parent and a desire to have a closer relationship with them, but simultaneously expressed a strong need and desire for disconnection and maintenance of a life separate from their parent’s challenges. Additionally, adult children noted conflicting goals with regard to privacy management about their parent’s illness, acknowledging that an underlying, but pervasive societal stigma surrounding mental health keeps them from freely disclosing to others about their parent’s illness, but indicating that a certain strategic degree of openness was required in order to meet certain instrumental and relational goals. Finally, participants revealed many fears and anxieties that they had about the future as a result of the unstable nature of their parent’s mental illness, while at the same time expressing a sense of acceptance and stability with the predictably unpredictable nature of their lives.

After presenting an analysis of the data, the implications of the findings for children of mentally ill parents are explored, including, but not limited to, how the results of this exploratory study could be integrated into therapeutic and support interventions for
families of those struggling with mental health issues. Finally, the limitations of the study are addressed.

KEYWORDS: mental illness, parent, adult child, goals, dialectical tensions

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June 5, 2019
Date
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To my husband and biggest supporter, Jesse, and my sunshine, Henry Paul
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Chapter One: Introduction

Historical perspectives and policies on mental health

Attempts to address questions about “normality” in human behavior long predate the establishment of psychiatry (Porter, 2002). During the classical period, deviant behavior was widely attributed to supernatural forces and understood as the product of godly disfavor or displeasure. Hippocrates and other Greek physicians rejected these superstitious beliefs and instead argued that both mental and physical ailments were the result of an imbalance of the four humors—essential bodily fluids—and were among the first to explain illnesses of the mind as a medical phenomenon. The Middle Ages saw a return to the supernatural belief that mental illness was caused by diabolical forces and the result of demonic possession. Foucault (1965) suggests that the rhetoric of “madness” was a product of The Enlightenment, when distinctions between reason and insanity created a clear social divide wherein deviance from societal norms was penalized by confinement. Disillusioned by the medicalization of the mind that dominated modern approaches to treating deviant behavior, Foucault argued that mental illness was a cultural construct and relegated “the language of psychiatry” to “a monologue by reason about madness.”

The notion of detaining the mentally ill began long before institutionalization was popularized during the Age of Reason. Historically, in Western society, the regulation and control of those regarded as mad rested solely with the family, and from the classical period through most of the Middle Ages, their care was considered a “domestic responsibility” (Porter, 2002, p. 90). For instance, Plato’s The Laws, states “if a man is mad he shall not be at large in the city, but his family shall keep him in any way they
can” (as cited by Porter, p. 89). It was not until the latter half of the Middle Ages that the confinement and care of the mentally disturbed began to move away from the home as religious houses were established under the guise of healing. Novella (2010) contends that it was during the 17th and 18th centuries that asylums became regarded as “the symbol of an enlightened and progressive civilization” and reflected a widespread belief in “the essential role of isolating the patient from the community in the work of recovery” (p. 413-414). In other words, the institutionalization of the mentally ill that represented the dominant view for nearly three centuries (from the mid 17th century to the mid 20th century) was reflective of the notion that institutions performed both protective and therapeutic functions. In this perspective, institutions protected society from its undesirables by confining and isolating them, removed the burden of care from their family members who were seen to be ill equipped to manage them, and provided a curative environment with access to necessary treatments for the maladies that were believed to be the cause the deviant behavior.

Grob (1994) suggests that early Colonial America saw a brief period of return to community and family care for mentally ill individuals, but shifted back to a system of institutionalization in the 18th and 19th centuries, where it remained the dominant approach until the mid 20th century. Although the creation of asylums was born out of the idea that mental disorders were curable if treated early and vigorously, practice quickly and sharply diverged from well-intended theory. Overrun and underfunded, the condition of asylums declined and became more custodial than curative in nature. Appalled by the abysmal conditions of these asylums, lobbyists like Dorothea Dix worked to convince the
United States government to regulate and oversee humane treatment for the mentally ill by funding state-run facilities.

Although the government-funded inpatient model of care for mental health enabled greater access to treatment, over time, these facilities experienced an unanticipated influx of patients and suffered from a lack of resources, both in funding and personnel, and as a result, the level of care experienced a progressive decline. Grob (1994) notes that these problems were pervasive, noting that “virtually every urban area in the 19th century faced similar dilemmas” (p. 53). Scandalizing exposes of the inhumane treatment and deplorable conditions of these facilities, such as Nellie Bly’s in 1887 and Clifford Beers’ in 1907, would incite temporary public outrage and act as an impetus for a spike in funding and improved conditions and services for mental institutions. However, their effect was fleeting, and issues with these facilities persisted through the 20th century where “practice deviated sharply from the ideal” (p. 82).

Following World War II, the national and global conversation about mental health started to shift. For over a century, “the mental hospital had become the foundation on which mental health policy rested” in America (Grob, 1994, p. 53), but this was not a system that was sustainable. The Great Depression of the 1930s and World War II “had a devastating impact” on mental institutions (p. 169), and combined with the fact that many who were institutionalized were chronically ill, by 1955, the total inpatient population peaked at approximately 559,000. Thus began the process of deinstitutionalization that characterized the postwar period. Social legislation and pharmacological advancements in the three decades following the end of World War II reflected “a remarkable wave of optimism regarding many social and health issues, including psychiatric problems...[and]
genuine concern seemed to overcome the bulwark of stigma, apathy, and denial” (Sabshin, 2008, p. XV).

Sabshin (2008) suggests that this response was due in part to the high amount of “psychiatric casualties” that had served in the war. Grob (1994) echoes this argument and contends “war-related experiences led to innovative models of psychiatric practice that subsequently became the basis for postwar efforts to create a new mental health system” (p. 192). For instance, the National Institute of Mental Health (NIMH) was established in 1949 and “became a driving force for a scientific psychiatry” (Sabshin, p. 11). Moreover, the development of psychotropic drugs like Lithium and Thorazine and a new emphasis on psychotherapies set the stage for and enabled mass deinstitutionalization by permitting patients to gain functional control over previously debilitating symptoms.

In the years following deinstitutionalization, Americans had to decide who or what was responsible for taking care of their mentally ill population. In an effort to address this question, Congress passed the Mental Retardation and Community Mental Health Centers Construction Act of 1963, which designated millions of dollars in grants to state, local, and private entities focused on developing community-oriented services for the mentally ill. The underlying hope was that given advancements in outpatient treatments, communities should provide facilities and services that emphasize comprehensive preventative and rehabilitative mental health care, encouraging and enabling the reintegration of the previously institutionalized into society, and move away from the more traditional models of custodial care that had dominated in the centuries before. However, as Grob (1994) notes, the passage of this legislation reflected overly optimistic beliefs that were inconsistent with the situational realities of many of the
chronically mentally ill. Specifically, he notes this type of policy was based on the assumptions that (a) the mentally ill had a home, (b) they had a sympathetic family who were willing caretakers, (c) family dynamics would facilitate and not inhibit successful rehabilitation and adherence to treatment, and (d) the responsibilities of caregiving would not be excessively burdensome to family members. Research in the decades since has found these presumptions to be fallible and unfounded, and these misguided—however arguably well-intentioned—policies have had profound implications for families of mentally ill individuals.

Deinstitutionalization brought both positive and negative changes to mental health care in this country. On the positive side, there is longitudinal empirical support that significant numbers of chronically mentally ill individuals who are provided with and utilize a variety of comprehensive community-based services concurrently can be successful, functional members of society. Studies especially point to the success of programs that go beyond the promotion of adherence to medications and psychotherapy to also emphasize empowerment, self-efficacy, and even the provision of occupational support and vocational rehabilitation (Leete, 1987; Rosenfield, 1992). Additionally, deinstitutionalization ultimately lead to the development of organizations like the National Alliance for Mental Illness (NAMI) and the Brain and Behavior Research Foundation (previously the National Alliance for Research on Schizophrenia and Depression, or NARSAD), which have helped to fund advancements in pharmacology and advocate for the mentally ill. However, at the same time, it is also important to acknowledge the dramatic social changes that resulted from deinstitutionalization. A consequence that is of particular interest to the present study is the fact that the
deinstitutionalization of mental health care in America dramatically shifted the burden of care from facilities to families. The social impact of this national change in policy and perspective cannot be understated and forms the contextual basis for the current study.

As previous research demonstrates, “families, rather than institutions, have become the major providers of the long-term care necessary for those individuals with serious and persistent mental illnesses” (Doornbos, 2002, p. 39). Research on family and mental health consistently reveals that even if they are not providing primary caregiving responsibilities, “families play a crucial role in the rehabilitation of their relatives with psychiatric disabilities” (Provencher, Perreault, St-Onge, & Rousseau, 2003, p. 592). But this responsibility carries with it specific stresses and challenges. Lefley (1997) identifies family members of mentally ill individuals as an “at-risk population whose quantitative problems may equal or even outweigh those of the person around whom they revolve” (p. 27). For instance, relatives of mentally ill persons, especially those providing some level of care to their family member, consistently report higher than average levels of emotional and psychological distress like fear, anxiety, depression, insomnia, emotional drain (Marsh, Appleby, Dickens, Owens, & Young, 1993), and family caregivers of the mentally ill are two to three times more likely to report distress than the general population (Oldridge & Hughes, 1992; Winefield & Harvey, 1993). Research on objective burden reveals that family caregivers’ lives may be significantly disrupted by their mentally ill relative (Provencher, et al., 2003) and that many feel overwhelmed, uninformed, and under-supported in their role (Doornbos, 2002).

Even though not all family members identify as caregivers, many do perform some degree of caregiving to their relative, and the social expectation to perform that role
is pervasive. Regardless of whether or not they provide care, research suggests that family members may feel guilt, shame, and blame for their relative’s illness due to the stigma that surrounds these types of disorders and because family members have been traditionally viewed as the “primary toxic agents” of mental illness—the source from which the dysfunction was planted and permitted to grow (Lefley, 1989, p. 556).

Although the definition of mental illness and understandings of its etiology have evolved, the lingering residual effect of this perspective continues to be salient in public perceptions, and in how family members frame their understanding of the illness, their role and responsibility, and their relationship to their relative.

**Defining Mental Illness and Examining Questions of Etiology**

As political debates were waged in Europe and America over what role society should play in caring for the mentally ill, the psychiatric community debated over the etiology of mental illness. One group of theorists argued that physiologic and biologic factors were the cause, while another set of theorists claimed that dysfunctional environments and traumatic experiences led to distortions in cognition and abnormal behavior. Although the exact origin of mental illness remains unknown, the dominantly held belief in the psychiatric community today represents a melding of these perspectives and a movement toward a biopsychosocial model where a combination of genetic predispositions, biochemical, and environmental factors result in mental and behavioral disorders. Sabshin (2008) describes this integrative perspective as “the relevant constellation of all these variables over time” (p. 53). In an effort to standardize and operationalize the diagnosis of mental disorders and provide “a common language for clinicians to communicate about their patients,” the American Psychiatric Association
(APA) developed the first Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1952 (DSM-5: Frequently Asked Questions, 2018). Since the original, the DSM has been revised five times to reflect advancements in research on and understandings of psychopathology.

As is reflected in the multiple iterations of the DSM, the definition of mental disorders has been, and continues to be, the subject of controversial debate. Defining mental (relating to or of the mind) disorders (synonymous with disease) seems relatively simple at first, but gets decidedly more nuanced and complex when one considers that diseases of the mind are only diagnosable through outward behaviors, and are extremely variable in how they manifest. Even individuals diagnosed with the same disorder may exhibit different cognitive and behavioral effects. Unlike illnesses like cancer, there is no consistent, widely accepted empirical support for biological indicators of mental disorders. Even so, the current definition of mental illness reflects a belief in its biological roots. For instance, the DSM-5 and the World Health Organization’s International Classification of Diseases (ICD-11) define a mental disorder as “a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in psychological, biological, or developmental processes underlying mental functioning” (APA, 2013). Moreover, this definition states that the disturbance is “usually associated with distress or impairment…in important areas of functioning.”

Although the etiology of mental illness is not a central subject of the current study, the evolution of the clinical understanding of what causes mental illness provides an important contextual basis for this inquiry. Early scholarship on mental illness and the
family “was dominated by the belief that families had a powerful etiological role” in the mental illness of individual members (Muhlbauer, 2002, p. 1077). In other words, mental illness was traditionally seen as the product of family dysfunction. This perspective stemmed from the systemic theory that “what happens in a group will be intelligible if one can retrace the steps from what is going on (process) to who is doing what (praxis)” (Laing & Esterson, 1965, p. 8). In other words, this theoretical perspective posited that mental disorders are a “family illness” and understanding the communicative practices and patterns of family systems and subsystems can reveal the environments in which schizophrenia and other mental illnesses are permitted to blossom. For instance, Hirsch and Leff (1975) presented research that parents’ “deviant” and “defective” communication patterns contributed to the development of their child’s schizophrenia and was associated with their likelihood of relapse. Barrowclough and Tarrier (1997) note that even though this perspective has now been largely discredited, the negative residual effects of this once widely held belief are still evidenced in the contentious and apprehensive relationship between family members, clinicians, and the general public. They argue that family members still struggle with this inaccurate perception and that it adds to an already stressful situation: “to have a relative suffering from a severe mental illness was bad enough, but to be blamed for causing the illness added to the family’s already considerable burden” (p. 17).

Research has since moved away from this belief, and focused instead on the impact of mental illness on the family and how the family manages the illness experience. Although the literature in this context has largely been dominated by research identifying the effects, outcomes, and risks associated with having a mentally ill family...
member, research has more recently begun to explore family perspectives on and experiences with mental illness. This research has reinforced that the family serves a primary role in the care of a loved one with a mental illness (Bevan & Pecchioni, 2008; Rose, Mallinson, & Gerson, 2006). Additionally, previous studies examining mental illness and the family have focused on the phases or stages of the illness experience for the family (Jeon & Madjar, 1998; Muhlbauer, 2002), the impact of mental illness on family roles, responsibilities, and dynamics (Nicholson, Sweeney, & Geller, 1998), the stigma associated with mental illness (Hinshaw, 2005; Lefley, 1989; Ostman & Kjellin, 2002), and on coping, management of the illness, and affective outcomes like caregiver burden (Francell, Conn, & Gray, 1988; Hoenig & Hamilton, 1966; Perlick, Rosenheck, Clarkin, Maciejewski, Sirey, Struening, & Link, 2004; Thompson & Doll, 1982).

Thus, taken together, it is well documented that the experience of mental illness is not confined to the mind and body of the individual with the disease, and that because mentally ill persons function as a part of an interdependent system, the family of the ill individual is profoundly affected as well. This is reflected in the roles, rules, and dynamics that influence communicative patterns and practices among and between family members. Inquiry in this area has focused largely on the outcomes, effects, and risks of having a mentally ill family member, while fewer studies examine how family members make sense of and strategically navigate this experience. Moreover, much of the research conducted on family members highlight parents of children who are mentally ill or spouses of the mentally ill, while significantly less attention has been paid to the relationship between adult children and their mentally ill parent. The present study expands on existing research on the family experience of mental illness by exploring how
adult children make sense of having a mentally ill parent. More specifically, this inquiry highlights how the interplay of dialectical tensions and negotiation of multiple competing goals define this experience and frame adult children’s understanding. My research questions stem from these frameworks, but are also informed by my own experience with a bipolar mother.

**Positioning Myself in the Research**

My personal experience is reflected in the literature on family and mental illness. Around the time I started graduate school, my mother, who had struggled my entire life with a mild, functional mix of depression and anxiety, fell into a severe clinical depression that lasted almost three years. During this time, my family and I tried desperately to get her help and support her, but became increasingly more despondent over time as she refused to take medication, would not leave her bed or take care of her personal hygiene, avoided all social situations, and attempted to take her own life twice. When, after the second suicide attempt, she finally agreed to seek the help of a psychiatrist, she was treated for major depression, which was consistent with the symptoms she was presenting at the time, but was an inaccurate diagnosis. We learned she has bipolar disorder when the medicine for depression flung her in the opposite direction and she presented with the symptoms of hypomania. Then, following the sudden death of my father, she spiraled into severe mania where she remained for two and a half years. Having just come out of a deep depression, she was unable to see that what she was experiencing was not happiness and would not accept the diagnosis of bipolar disorder, nor would she take medication for it. Even after growing up with a
bipolar father herself, she was blind to the parallels and rejected the notion that she was manic.

Without my father, the responsibility to manage her symptoms fell to my sister and me. It was during this time that she struggled with impulse control, specifically regarding finances, and over the course of a year and a half, she had spent over half of what she and my dad had worked and saved for their entire lives. Ultimately, we had to petition the court to become her conservators, taking control of her finances so that she did not completely deplete her savings. After almost two years of severe mania and a handful of crisis situations that led to three acute involuntary hospitalizations and at least one arrest, we were successfully able to have her admitted to a long-term care and recovery facility where she spent three months. Following her release, she was remitted to our care, moving between my sister’s house and my house every week. Returning to life outside of the facility proved difficult for her and for us. Aside from adjusting to feeling as if she had become a dependent to her dependents, she also had to confront what she had done in the past, and wrestled with guilt, shame, social anxiety, and depression. At the same time, we struggled to reconcile feelings of resentment for what had happened in the past with a sense of helplessness about what we could not fix, and anxiety about what the future might hold.

Thus, it is not an exaggeration to say that most of my young adult years have been spent entangled with my mother’s illness. Throughout most of this time, I have felt extremely lost: when we could not get her to take her medication; when we were unable to get her admitted to a facility because she would not say she had thoughts of harming herself or others; when she would launch verbal assaults against us and threaten us
physically and legally; when she would disappear for days; when thousands of dollars would inexplicably go missing from her bank account; when she spent nights driving up and down the interstate after not sleeping for days; when people would call us concerned that she was sleeping in parking lots; when she would threaten others in a paranoid rage. Where should we go for help? Should we intervene, or wash our hands of it? Should we take legal action and have her declared incompetent by a judge, or just ride it out and watch as her illness dismantled her (and our family’s) life as we had known it?

As a graduate student, my natural response throughout this entire period was to do my research and be as informed as I could be. Do other family members of mentally ill individuals struggle with these same issues? What is the best way to effectively help my mom without it overtaking my life? Will she recover from this? Who should I talk to? Will they judge her, or us? Who can help guide us through this? What rights and responsibility does the family have? In my efforts, I discovered that most of the empirical findings on mental illness and the family were based in studies about parents who are managing a child’s illness, or somewhat less frequently, spouses or siblings of mentally ill individuals, while substantially less research centered around adult children with mentally ill parents. Although there are significant parallels that are consistent across the family experience of mental illness, the relationship between adult children and their parents is fundamentally different from those that most conclusions are based on, and warrants its own inquiry. Moreover, those studies that did examine adult children who have mentally ill parents typically fell into one of two categories: (1) quantitative examinations of the risks and negative outcomes for individuals who grew up with a mentally ill parent, and (2) qualitative analyses of retrospective accounts from childhood
and growing up with a mentally ill parent. A voice that was comparatively neglected in this research was mine: that of the adult child navigating adulthood with a mentally ill parent, and explorations into how they make sense of and strategically respond to issues arising from their parent’s illness.

**Overview of Dissertation**

This dissertation is inspired by my own experience, but is informed by theory and existing research on families and mental illness. The ultimate goal is to illuminate an underrepresented voice in family and mental health research, promoting greater understanding of their lived experience and the strategies they employ to navigate it. This study is presented in nine chapters. Chapter Two will provide a broad overview of the literature on the effects of mental illness, starting by establishing the prevalence of mental illness in parents, and then examining the effects research in this area to highlight the personal, social, and relational risks of being a child of a mentally ill parent. Chapter Two will also discuss research that has shed light on adult children’s reflections of growing up with a mentally ill parent, including how perceptions of stigma and caregiver burden play a prominent role in shaping family members’ subjective reality. Chapter Three will construct the theoretical foundations for this study, outlining the major tenets of relational dialectics theory, and how together with a multiple goals perspective, adult children’s understanding of and communicative practices surrounding their ill parent are illuminated. At the conclusion of Chapter Three, I provide the research questions that frame my analysis. Chapter Four explains why a qualitative approach of adult children’s experience with their mentally ill parent is justified, and also explains the research design, outlines the recruitment procedures, provides sample demographics and
background on the biographical information of the participants, details the interview procedures, and details the processes employed in analyzing the data. Finally, at the conclusion of Chapter Four, I reflect on my own positionality as both a researcher and child of a mentally ill parent.

My analysis is divided into three separate chapters. Each chapter explores a distinct dialectical tension and how those contradictory forces framed how adult children made sense of their parent’s illness and subsequently shaped and reflected their communicative practices. Chapter Five explores how the interplay of the dialectical tension between connection and autonomy influence the relationship and communication with their parent, including how perceptions of agency and the illness itself play a role in how this tension is negotiated. Chapter Six highlights the interplay of the contradictory forces between concealment and revelation, and examines how and why children strategically manage the information surrounding their parent’s illness with others. Chapter Seven focuses on how the tension of predictability and change, highlighting how the instability and uncertainty of the illness itself is juxtaposed by children’s efforts to strategically satisfy the need for certainty in how they reframe the illness and actively seek stabilizing outlets.

Chapter Eight summarizes the analysis chapters by addressing the research questions outlined in Chapter Three, and then discusses the theoretical implications and practical applications of the findings. Finally, Chapter Nine identifies some of the limitations of this study and offers directions for future research based on both the findings and the limitations. I then conclude by providing some personal reflections on the findings and how they illuminate my own experience with a bipolar mother.
Chapter Two: Review of Literature on Mental Illness in Families

Prevalence of Mental Illness in the U.S. and Worldwide

Mental illness is a pervasive health epidemic in the United States and worldwide. According to results from the Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Survey on Drug Use and Health: Mental Health Findings (2017), an estimated 44.7 million adults in the U.S. had any mental illness (AMI) in the past 12 months, which represents 18.3 percent of all adults in the country. This number is estimated to be on the rise, as it reflects at least a million person spike since the 2015 survey. AMI is defined as having at any time in the past 12 months a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (SAMHSA, 2015). The same national survey presents that there were an estimated 10.4 million adults, representing 4.2 percent of the U.S. population, who have had in the past year or currently have a Serious Mental Illness (SMI), which SAMHSA defines as a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) that has resulted in serious functional impairment, which “substantially interfered with or limited one or more major life activities” (SAMHSA, 2015, p. 28). This number has increased .1% in the course of a year, representing almost a million more people.

Although now over a decade old, data from The National Comorbidity Survey Replication (NCS-R) estimates that the percentage of adults suffering from mental illness in a given year is even higher, suggesting that approximately 26.2 percent of adults in the
U.S., roughly 1 in 4 adults, experience a diagnosable mental disorder (Kessler et al., 2005). If this number experienced the same average increase as those numbers in the annual SMHSA survey, this number may have been approximately 31% in 2017. Thus, not only is mental illness a widespread issue in the U.S., this public health issue only seems to grow with each passing year.

**Prevalence of Mental Illness in Parents**

Given that national survey data suggests that anywhere between approximately 18-30% of adults in the U.S. experience a diagnosable mental health issue in their lifetime, it is reasonable to deduce that a large percentage of those individuals have children. In fact, an analysis of the NCS data estimates that “equal or greater percentages of adults meeting criteria for [serious mental illness] in the previous 12 months are parents than are individuals without psychiatric disorders” (Nicholson, Biebel, Katz-Leavy, & Williams, 2002, p. 123). Moreover, of those individuals with a diagnosable serious mental illness in the past year, it is estimated that 67.2 percent are mothers and 75.5 percent are fathers. The prevalence of parents among those with a diagnosable mental disorder is consistent across psychiatric diagnostic categories. Specifically, according to the NCS sample, women and men who are parents are estimated to represent over half of adults meeting the criteria for affective disorders, anxiety disorders, posttraumatic stress disorders, and nonaffective psychosis. This data suggests that, on average, parents (both mothers and fathers) meeting the criteria for affective disorders and nonaffective psychosis have children several years prior to illness onset, whereas parents with anxiety and post-traumatic disorder are more likely to experience illness onset before having children.
A more recent analysis of results from the National Survey of Drug Use and Health, 2008-2014 (Starnbaugh, Forman-Hoffman, Williams, et al., 2017) suggests that approximately 2.7 million parents had a SMI in the past year, which represents 3.8% of the population. A significantly larger number of parents (12.8 million; 18.2%) qualified as having AMI in the past year. Ultimately, taken together, available data suggest that in the U.S., parenthood is more common than not among mentally ill adults (mentally ill adults are statistically more likely to be parents than not be parents), meaning that millions of children a year have a parent with a diagnosable mental disorder.

The prevalence and continued growth of parental mental illness means that millions of children in the United States are growing up or did grow up with a parent with some form of mental health issues. This has significant implications for these children from early developmental ages into adulthood. The bulk of the literature examining these implications in adulthood has been focused on determining risks and long-term psychopathological and psychosocial effects on adult children who grew up in a house with a mentally ill parent. Much of the effects literature reflects a belief that this experience is a traumatic one with long lasting mental, emotional, and relational effects that carry into adulthood. Moreover, taken as a whole, it reflects a heavy emphasis on enduring issues in adulthood attributed to a dysfunctional childhood, and does not account for the effects of parental mental illness on children when the illness does not manifest until later in life, as is true for over half of the participants in this study. Ultimately, however, it is important to provide an overview of the psychosocial and psychopathological risks for adult children with a mentally ill parent in order to
contextualize and further understand the potential factors that frame their relationship with their parent in adulthood.

The Risks of Being a Child of a Mentally Ill Parent

Children of parents with mental illness are disproportionately likely to develop a mental illness themselves. Multiple studies have shown that children of mentally ill parents have higher rates of psychiatric disorders in early and middle childhood than children of parents without a mental disorder (Billings & Moos, 1983; Cowling, Luk, Mileshkin, & Birleson, 2004; Vandeleur, Rothen, Gholam-Rezaee, Castelao, & Vidal, 2012). Further, research from Rasic, Hajek, Alda, and Uher (2014) suggests that due to a combination of genetic and environmental factors, children of parents with a SMI (primarily schizophrenia, bipolar disorder, major depressive disorder, or borderline personality disorder), have a 50% chance of developing AMI and a 32% chance of developing SMI, which is approximately 2.5 times the risk of children of parents without a mental illness.

The age of the child at diagnosis and the duration of the parent’s illness have been correlated with a greater risk of psychopathological issues for the adult child. Specifically, in a study of adult children with parents who have been diagnosed with major depression, Peisah, Brodaty, Luscombe, and Anstey (2005) suggest that the younger the child at the time of the onset of the parent’s illness and the longer the duration of the parent’s illness, the more increased risk of the adult child developing mental health issues themselves. Parental major depression has been demonstrated to exacerbate the degree to which their adult children experience depression (Timko, Cronkite, Swindle, Robinson, & Moos, 2009) and adult children up to 28 years old with a
mentally ill parent have been shown to be at a greater risk of depression, suicide, and suicide attempts (Stenager & Qin, 2008). Given the increased risk of psychopathy among children of mentally ill parents, the bulk of literature examining the parent-child relationship where the parent has a diagnosable mental disorder have focused on the impact that the parent’s illness has on normal child development.

In addition to psychopathological effects, research also overwhelmingly demonstrates that parental mental illness also has profound psychosocial effects on offspring, putting them at a significantly greater risk of experiencing social, emotional, and behavioral problems during childhood and throughout their lifetime (Beardslee, Keller, Lavori, Staley, & Sacks, 1993; Beardslee, Keller, Seifer, Lavori, Staley, Podorefsky, & Shera, 1996; Somers, 2007). For instance, Rutter and Quinton (1984) concluded that children of mentally ill parents are at a greater risk for pervasive emotional and behavioral disturbance, and Brown (1989) suggested that adult children might experience greater difficulties with social risk taking and engagement due to an increased fear of rejection and further hits to their self-confidence. Subsequent literature reinforces Brown’s findings, suggesting that adult children of parents with a mental disorder are more likely to experience lower self-esteem (Williams & Corrigan, 1992), and greater social anxiety and adjustment issues than children and adolescents of parents without mental illness (Jacob & Windle, 2000). Moreover, Weissman, Warner, Wickramaratne, Moreau, and Olfson (1997) discovered that adult children of mentally ill parents experience increased marital and professional discord and lower overall functioning than adult children of parents without a psychiatric diagnosis, while Neff (1994) found increased levels of alcohol consumption among adult children of mentally
ill parents. Mowbray, Bybee, Oyserman, MacFarlane, and Bowersox (2006) interviewed mothers who had a SMI and at least one young adult child and found that their adult children “experienced problematic functioning in several domains” and also had significant “relationship problems” (p. 105). In fact, parental SMI—specifically in this study, bipolar disorder—was a strong predictor of a number of adult child problems including drug use, alcohol abuse, legal trouble, and psychopathological issues. Furthermore, 54% of the offspring of the mothers sampled demonstrated a significant problem in one or more of these domains.

A large body of research suggests that attachment patterns are one of the major pathways through which parental mental illness affects psychopathological and behavioral issues in children. For instance, children of mentally ill parents have demonstrated insecure attachment and developmental issues from infancy (D’Angelo, 1986; Murray, Fiori-Cowley, Hooper, & Cooper, 1996) through early childhood and adolescence (Cunningham, Harris, Vostanis, Oyebode, & Blissett, 2004; Sroufe, Egeland, Carlson, & Collins, 2009). Attachment patterns established in childhood have implications into adulthood. Longitudinal research has consistently revealed that attachment patterns are enduring (although not entirely irreversible or resistant to change) (Bowlby, 1988b). Nathiel (2007) associates insecure attachments established in childhood with long-term pathological consequences, explaining “young children of mothers with psychotic disorders are more likely to have insecure attachments by the time they’re two, and…in adulthood, more than half of the children of mentally ill parents have either a mood disorder or a substance abuse problem” (p. 10).
In addition to psychopathological and behavioral issues, these insecure attachments may manifest relationally in adulthood. For instance, both longitudinal and reflective cross-sectional in depth interviews suggest that adult children of mentally ill parents continue to experience attachment issues in adulthood, with a decreased likelihood of being able to maintain committed romantic attachments and difficulty trusting others (Duncan & Browning, 2009; Mowbray, Bybee, Oyserman, MacFarlane, & Bowersox, 2006). In her qualitative in depth interviews with 18 daughters of mentally ill mothers, Nathiel discovered a pervasive feeling of emptiness and loss among the women that was rooted in their relationship (or non-relationship) with their mother, but malignantly pervaded their approach to relationships in adulthood. Although these interviews represent only a small sample of women’s experiences with their mother’s mental illness, these accounts suggest the residual, and potentially damaging effects of parental mental illness on a child, and have been echoed in other studies (Duncan & Browning; Foster, 2006; Rose, Mallinson, & Walton-Moss, 2002; Sved Williams, 1998).

In addition to experiencing enduring attachment problems in adulthood, the adult offspring of mentally ill parents are vulnerable to the development of other relational difficulties. For instance, Lancaster (1993) demonstrated that adult children of mentally ill parents have low emotional literacy, owing largely to the fact that they were often unsure how their parent felt about them, which lead to additional relational difficulties with others. Other studies have also found that this perceived rejection by their parent led to adult children emotionally and sometimes physically withdrawing from any relationship with their parent as a defense mechanism (Rose, Mallinson, & Walton-Moss, 2002). These relational difficulties with parents have been shown to cultivate an enduring
and significant fear of rejection in social situations and a general mistrust of others (LeClear O’Connell, 2008) and a strong need for control in personal relationships (Brown, 1989), which then may impact their ability to create and sustain successful friendships and romantic attachments (Foster, 2006).

Although risks and effects research is important to understand the potential implications of growing up with a mentally ill parent and provides context to this study, this type of research has largely dominated the already limited literature pertaining to this particular type of family members’ experience of mental illness. In order to gain a more rich and contextualized understanding of how an adult child negotiates and reconciles his or her identity and relational goals while coping with a parent’s mental illness, research in this area has begun to move beyond risk factors and likelihoods to qualitatively exploring the subjective perspectives of adult children’s lived experience. Most of these studies are centered on soliciting the now adult’s reflections and memories surrounding their childhood with their ill parent. These studies begin to shed some light on the knot of contradictions and conflicting goals that characterize adult children’s experience of the illness.

**Adult Children’s Reflections on Parental Mental Illness**

Adult children’s perspectives on their experience of growing up with a mentally ill parent are still focused on obtaining reflective accounts from childhood. For instance, through qualitative in depth interviews with adult offspring of a mentally ill parent, Dunn (1993) revealed that children’s experience of parental mental illness centered on the themes of abuse and neglect, isolation, guilt and loyalty, grievances with mental health services, and supports. Although participants reported feeling a sense of alienation,
loneliness, shame, and confusion as a result of their mother’s illness and subsequent dysfunction, children also felt a strong sense of loyalty toward their mother and guilt over not doing enough to help her or shoulder the burden among their family members.

Although this study was atheoretical, the findings provide some justification for the theoretical frameworks used in the current investigation by suggesting that adult children feel multiple, seemingly conflicting and contradictory emotions surrounding their mentally ill parent at any given time. Specifically, it suggests a dialectical push and pull between loyalty and anger, guilt and absolution, and shame and resilience. Ultimately, Dunn’s work moved away from the dominant effects literature in this area of study, but it did not explore participant’s experiences or perspectives of navigating adulthood with a mentally ill parent, focusing only on childhood reflections.

Consistent with Dunn (1993), retrospective accounts from adult children of a mentally ill parent on their childhood have consistently revealed feelings of neglect, guilt, isolation, and stigma. For instance, Knutsson-Medin, Edlund, and Ramklint (2007) discovered that growing up with a mentally ill parent was characterized by worry, increased responsibility, negative emotions, and a changed parent-child relationship. Specifically, adult children recalled worrying about their parent committing suicide, not getting the treatment they needed, and the uncertainty and unpredictability of home life. Children reported a lack of traditional parental support, discomfort and anxiety about their parent’s unstable and unpredictable behavior, and a sense of walking on eggshells in the relationship to avoid triggering a breakdown. Those sampled also noted feeling a number of negative emotions as a result of their parent’s illness, including shame, fear,
neglect, insecurity, deflated confidence, insufficiency, loneliness, and envy of peers with “normal” home lives.

Since Knutsson-Medin et al. (2007) focused on retrospective accounts from childhood, it is unclear from this study whether these same experiences continue to manifest into adulthood and how, which is an objective of the current study. Further, although Knutsson-Medin et al.’s analysis was atheoretical, the findings suggest that children of mentally ill parents may have multiple, conflicting goals, and that how children make sense of and strategically pursue specific goals over others have personal and relational implications. For instance, in adulthood, children of a mentally ill parent may want to intervene in their parent’s care, but avoid doing so out of fear damaging the relationship or some sense of loyalty to their parent, or concern over inciting symptoms of the illness (like rage or paranoia).

Qualitative data from adult children of a mentally ill parent have consistently revealed that negative emotions they experienced growing up often contributed to decreased functioning in their daily activities, and that their relationship with their parent growing up was significantly altered by their parent’s illness. For instance, Kinsella and Anderson’s (1996) findings suggested that the praxes that children employ to manage feelings surrounding their parent’s mental disorder are potentially dysfunctional and harmful. Among these unhealthy strategies were internalizing or “closing off” intense emotions, altering their own behavior to accommodate the needs of the ill family member and diffuse chaotic and distressing situations, and isolating themselves and withdrawing from peers to avoid social stigma. Like Knutsson-Medin et al. (2007), these findings point to a complex system of contradictory forces at play in managing their relationship.
with their parent while also managing their identity and other instrumental goals. Like much of the inquiry that explores adult children’s perspectives of parental mental illness, Kinsella and Anderson used adult’s retrospective accounts to focus on childhood experiences, whereas the present study focuses on understanding how they make sense of and manage their experience in adulthood.

Importantly, as is suggested by research on risks and effects, qualitative research of adult children’s reflections reinforce evidence that negative feelings, unhealthy coping skills, and a general disruption in daily functioning is not something the offspring of mentally ill parents leave behind in their formative years. Rather, the residual effects of growing up with an ill parent may continue to manifest daily in their adult lives. For instance, Foster (2010) used narrative interviews to gain insight into the experience of growing up with a mentally ill parent and to understand how adult children managed to find a sense of normalcy and acceptance throughout different stages of their lives in the face of the multiple adversities associated with their parent’s mental illness. Consistent with Knutsson-Medin et al. (2007), Foster discovered that in adulthood, children interviewed experienced significant uncertainty and instability, difficulties maintaining relational closeness (with the ill parent and in other relationships), reluctant acceptance of caregiving responsibilities reflective of traditional parent-child role reversal, and finally, the need to negotiate boundaries and develop coping strategies in order to gain mastery and control over their own lives. Although Foster’s inquiry was exploratory and atheoretical, the findings of this study are consistent with framing the discourse surrounding adult children’s perspective using a dialectical approach, as participants indicated that their experience was defined by contradictory forces surrounding certainty.
(instability and control), connection (intimacy and distance), and agency (blame and absolution).

A consistent finding in much of quantitative effects research and the exploratory qualitative research is that offspring of mentally ill parents encounter multiple and varied issues of identity, including but not limited to role ambiguity, envy of “normal” peers family life, and the shame, rejection, and isolation felt in negotiating their openness and relationships with others. The stigma attached to mental illness is a well-established and salient part of the family experience of mental illness and is thus explored further in the following section.

**Courtesy Stigma and Family Toxicity**

Research suggests that mental illness is stigmatized (Hinshaw, 2005; Ostman & Kjellin, 2002) and that family members of individuals diagnosed with a mental illness experience shame, guilt, rejection, and other by-products of stigma as a result of their connection to the mentally ill person (Lefley, 1989). Goffman (1963) explores the notion of stigma, or the contaminated, “spoiled” social identity of persons in possession of a “discrediting attribute” that causes them to “depart negatively” from societal expectations (p. 5) and consequently become defined by their discredit or “differentness” (p. 4). In other words, a stigma is an insignia of deep discredit, shame, handicap, and/or other personal failing. Goffman argues that “normals,” or “those who do not depart negatively from particular expectations,” (p. 5) modify their communication with stigmatized individuals to reflect that negative perception and maintain distance. Since we define ourselves by the way in which we believe others see us, for the stigmatized individual, this can have significant physiological and psychological implications.
Mentally ill parents and those associated with them would possess what Goffman (1963) terms discreditable stigmas in that the discrediting attribute may be concealed, but it is very much discoverable. Thus, the issues arising from the stigmatizing condition are centered on issues of privacy management, or “managing information about his [or her] failing” (p. 42). Therefore, as Goffman suggests, to the discreditable, the questions then become “to display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; and, in each case, to whom, how, when, and where” (p. 42). Thus, for a person living with a mental illness or for their family, issues of privacy management are paramount as they strategically make choices about what to reveal and what to conceal about their relative’s illness (Chang & Horrocks, 2006).

The family and others closely associated with a mentally ill individual are bestowed a “courtesy membership in the clan” (Goffman, 1963). In other words, those who are related to a stigmatized individual through marriage, friendship, genetic or other strong familial tie (e.g., offspring, sibling, parent, cousin, aunt/uncle, niece/nephew) may be viewed and treated as one with their stigmatized relative or friend. Notably, this connection can result in the stigmatization of an otherwise “normal” person. Stigmatization by association, deemed a “courtesy stigma” by Goffman, suggests that those who are related to the stigmatized are “obliged to share some of the discredit” (p. 30). Applied in the context of mental illness, Goffman’s concept suggests that family members, and more specifically children of a mentally ill individual, possess a courtesy stigma, and must manage their identities and information surrounding a discredit that is not their own.
As previously noted, Thompson and Doll (1982) contend that since the 1950s, there has been a “major shift in the nation’s public treatment of its emotionally disturbed members from a hospital-based to a community-centered system” of treatment and care (p. 379). This deinstitutionalization of mental health care has created a system in which “many relatives have become a major link in their kin’s treatment/rehabilitation team…de facto therapists who bear the day-to-day burden of coping with a mentally ill family member” (p. 379). Importantly then, although Goffman (1963) suggests that courtesy stigmas can cause the relational ties that create them to be either avoided or severed, the deinstitutionalization of mental health has often placed the burden of care for those diagnosed with a mental illness squarely on the family members (Grob, 1994; Rose, Mallinson, & Gerson, 2006) making the severance or avoidance of ties especially difficult, and in some cases, impossible. Within this notion of courtesy stigma, along with the objective burdens of caring for family members who are ill, relatives also incur the subjective burden of stigmatization. Lefley (1989) asserts, “social barriers are frequently erected against the relatives and households of negatively valued persons,” adding that “the behaviors of persons with psychotic disorders may further isolate the family, diminish its reputation, and jeopardize relationships with friends and neighbors” (p. 557).

One source of courtesy stigma for families of individuals with a mental illness is reflected in Lefley’s (1989) notion of family toxicity, which asserts that family members may experience courtesy stigma as a result of a prevailing societal view of relatives as the “primary toxic agents” (p. 556), or the source of the spoiled identity. In other words, the family is perceived as the cradle from which the discrediting attribute was permitted to develop and grow, and as a result, relatives receive “a message of their own culpability in
generating or precipitating the devastating illness of a loved one” (p. 557). Thus, family members may have “residual and unjustified guilt” due to the lingering public perception that something about the family (genetics, demands, dynamics, etc.) served as a toxic agent that infiltrated and spoiled its members. Since many mental illnesses are now recognized as having both social and genetic etiological roots, this notion of family toxicity is especially applicable in this context and may contribute to adult children’s conflicting feelings of shame, guilt, and defensiveness. Ultimately, the family’s courtesy stigma is borne out of normative perceptions of blame, responsibility, and failure that permeated the entity and created the perfect storm for the deviance.

Indeed, research examining mental illness within the context of family has demonstrated that the notions of courtesy stigma and family toxicity are salient in family members’ perspectives on and experiences with their parent’s illness. This literature is largely divided into two separate camps: (a) perceptions of the general public toward family members of mentally ill persons (Burk & Sher, 1990; Mehta & Farina, 1988), and (b) family members’ understandings of how the public perceives them. Both types of inquiry have yielded results confirming the existence of courtesy stigma in families of the mentally ill. For instance, through an experimental design, Mehta and Farina revealed that students with a father who had a stigmatizing condition (mental illness, alcoholism, incarceration) were viewed as having a harder time across all areas of daily functioning than students with fathers in possession of characteristics that are less stigmatized, or not stigmatized at all (elderly, amputee, career that requires extensive travel and long periods of absence). Thus, although conceivably the college student with an elderly parent may have to contend with levels of hardship similar to those experienced by a student with a
depressed parent, the larger public view is that the student with the “toxic” parent will have more difficulty. These results have been echoed by studies like Burk and Sher (1990), who found that participants were more likely to rate teens with a stigmatized parent (mentally ill or substance abuse) as more socially negative than teens with “normal” parents.

The second camp of research suggests that family members are aware of the negative public perceptions of them as a result of their association with a stigmatized “other,” and that this serves as a stressor that significantly impacts their communication with others, their own sense of self, and how they manage their identity and relationships. For instance, harkening back to the notion of contamination and toxicity, in her first person account of being both a daughter of a schizophrenic mother, and a mother to a schizophrenic daughter, Lanquetot (1988) states that “growing up with a mentally ill mother was oppressive and worrisome, and it interfered with the development of my sense of self. I was terrified that I was like my mother and therefore had something wrong with me. Acutely self-conscious, I felt inferior to other children” (p. 337). Further, on a wider scale, Phelan, Bromet, and Link (1998) surveyed spouses and parents of patients recently admitted to a hospital or other type of psychiatric facility for mental illness and found that over half of the family members surveyed reported some level of concealment about the hospitalization in an effort to avoid being the recipient of the stigma attached to their relative’s illness. Phelan et al.’s results are not an isolated anomaly, as similar survey studies have consistently found that at least half of family members believe that their relative’s illness is something to be hidden, and/or is a source of shame to the family (Thompson & Doll, 1982; Wahl & Harman, 1989). Studies show
that this feeling of shame is especially unique to families of mentally ill persons, as Ohaeri and Fido (2001) discovered that family shame was 40 times more prevalent in families with a mentally ill relative than families with a relative diagnosed with cancer. Thus, this sense of shame and blame are salient in how adult children see themselves, and in how they attempt to discursively manage their own (and their family member’s) identity.

Research has demonstrated that family members of people with a mental illness may not be unjustified in their perception that their relative’s stigmatizing characteristic extends to and negatively affects their own lives. For instance, studies have found that family members frequently report strained and distant relationships with friends and extended family as a direct result of their relative’s mental illness, noting that their support network had gradually, but significantly dwindled since a family member’s diagnosis or manifestation of symptoms (Corrigan & Lundin, 2001; Lanquetot, 1988; Veltman, Cameron, & Stewart, 2002). These studies do not attempt to address whether the narrowing of the support network is due to others actually stigmatizing them and closing off ties, or more the result of the adult child’s self-protective and isolationist response to shame and guilt. Although avoidance of outsiders as a result of shame plays a role in damaged relationships (Phelan, Bromet, & Link, 1998), public perceptions of toxicity, blaming, and uncertainty appear to also contribute to lost and/or strained social network ties (Veltman, et al.; Weiner, 1995). For instance, Greenberg, Kim, and Greenley (1997) found that siblings of mentally ill adults felt concern for their relative’s adherence to treatment regimens, not only for the sake of their relative’s health and wellness, but
because of a sense of responsibility over their care and a belief that they would be blamed for relapses resulting from noncompliance.

Together, this research suggests that family members experience ownership, whether real or perceived, over their relative’s stigmatizing characteristic and demonstrates the notion of the courtesy stigma in that family members, by association, are tainted by and culpable for their relative’s mental illness. This perceived family stigma referenced in the literature has implications for adult children of mentally ill parents, and in the framework of the current study, may be salient in how they communicatively navigate contradictory forces in their relationship with their parent, and how they manage information surrounding this illness with others. For instance, concerns about others casting blame on them for their parent’s deviant behavior may contribute to feeling social pressure to stay involved and “fix” the problem. Also, for that reason, it may serve as a significant motivator to conceal information about their parent’s illness from others so as to not invite judgment on self or family. Since this research suggests that it is not just the person with the illness who is responsible for managing it, notions of family toxicity and courtesy stigma may feature prominently in how children negotiate and make sense of their role. Although this notion has been extensively explored with regard to parents of a child with a mental illness, spouses, and siblings, a considerably less explored context is in understanding the perceptions and rationalizations of adult children of mentally ill parents.

Stigma is considered a type of subjective burden for family members of the mentally ill and is associated with heightened psychological distress. Thus, another topic that has been extensively explored and well documented in literature on families and
mental health is caregiver burden. In addition to being some of the most widely investigated topics in this context, caregiver burden and stigma feature prominently in how family members frame the experience of mental illness. Even though not all of the participants in the current study identified as caregivers, over half of them indicated that they provided some level of care to their parent. Given that burden in family members of mentally ill persons is well documented in the literature (Saunders, 2003), an overview of this research is provided below.

**Caregiver Burden and Distress in Families of the Mentally Ill**

Family members of individuals with a mental illness experience significantly higher levels of psychological distress than the general population (Olridge & Hughes, 1992; Provencher et al., 2003), and caregiver burden has been consistently associated with distress in family members of mentally ill persons (Lefley, 1996; Noh & Turner, 1987). Caregiver burden has been defined as “the multidimensional negative consequences of care giving” for an ill loved one (Rose, Mallinson, & Gerson, 2006). Hoenig and Hamilton (1966) distinguished between the objective and subjective experience of burden experienced by lay caregivers, and these two types of caregiver burden are still recognized and explored by scholars.

According to Rose, Mallinson, and Gerson (2006), objective burden involves the visible disruption to a family’s daily life that result from the mentally ill member’s dysfunctional behaviors. For instance, this may involve reduced leisure time, negative effects on the family’s interactions and relationships within and outside of the family (i.e., neighbors, family friends, extended family), reduced ability to function as a family, and the negative financial implications of mental illness (i.e., unemployment, cost of
continued medication and therapy). Subjective burden refers to the “invisible” emotional load the family experiences as a result of the mental illness (Marsh & Johnson, 1997). This type of burden is characterized by the family’s feelings of worry, guilt, resentment, loss, and grief. Research on caregiver burden is especially prevalent, as studies have reflected the shift to community-based care and emphasis has been on gaining a better understanding of the implications of deinstitutionalization for both the patients and their lay caregivers. Importantly, beyond direct outcomes for family members, research in this area has found an association between levels of family caregiver burden and health-related outcomes of the mentally ill individual, such as symptoms and adherence to treatment (Perlick et al., 2002).

Although early research on the impact of family care for the mentally ill primarily examined issues related to objective burden (Loukissa, 1995), more recent exploratory, qualitative research has revealed that issues related to subjective burden are often the most salient for caregivers, especially with regard to worry about the future, grief, stigma, and guilt over not being able to do more to remedy their family member’s hardships (Jeon & Madjar, 1998; Marsh & Johnson, 1997; Muhlbauer, 2002; Rose, Mallinson, & Gerson, 2006). Although objective burden might be most prominent in family members who also identify as primary caregivers, subjective burden is not exclusive to family members who are providing care. Research on caregiver burden has largely focused on samples of parents caring for adult children with a mental illness and spousal care giving, but has comparatively neglected the population of adult children with a mentally ill parent, and the implications that this traditional role reversal has on the relationship. One notable exception is a study by Marsh, Appleby, Dickens, Owens, and Young (1993) who
explored the perspectives of members of a Sibling and Adult Child (SAC) support network of NAMI. Their analysis of interviews and support group transcripts indicate that adult children of mentally ill parents experience significant subjective burden (e.g., guilt, resentment, fear, confusion, anxiety, loss, and chronic sorrow) and objective burden (e.g., reduced leisure time, coping with behavioral and emotional symptoms, demands of crisis intervention, and challenges navigating the mental health system).

One source of significant burden for family members of mentally ill individuals who provide some level of care is the chronic and volatile nature of mental disorders. Although mental illnesses can be treated and symptoms controlled with the correct pharmacological concoction and behavioral therapies, families are frequently confronted by the reality that their relative will never be “cured” and that symptomology will persist in some form and require management throughout their lifetime (Potasznik & Nelson, 1984). In his Family Systems Illness Model, Rolland (1994) argues that with chronic illnesses like mental disorders, the perpetual nature of the family’s caregiving responsibilities and the unpredictability of the illness can cause family members to be in a constant state of hyper-vigilance that can seem indefinite, and this can contribute to fatigue and distress. In fact, burden has been identified as an outcome of having to continually respond to and cope with their relative’s abnormal behaviors while simultaneously providing them with emotional and instrumental support (Reinhard & Horwitz, 1995). Especially relevant to the current study, Reinhard and Horowitz discovered that feelings of burden are exacerbated when the caregiving role is nonnormative for that relationship. For instance, their findings revealed that sibling caregivers reported stronger perceptions of burden than were reported by parents.
providing care to children who were mentally ill. This suggests that the inherent role 
reversal and nonnormative care provided by children to mentally ill parents in the current 
study may lead to increased feelings of stress than would be experienced by parents 
caring for children with mental illness.

Of course, not all family members providing care experience the same amounts or 
types of objective and subjective burden, and the degree to which it is associated with 
distress is variable and mediated by a number of different factors. For instance, Noh and 
Turner (1987) found that mastery, operationalized as a feeling of personal control, 
mediates the distressing effects of caregiver burden. Specifically, they found that for 
family members who indicated higher assessments of their own personal agency, the 
relationship between “strain” or burden and psychological distress was nonexistent. 
Given that the ability to cope is associated with personal agency, this also highlights the 
importance of effective coping strategies for the reduction of burden in families of 
mentally ill individuals. For instance, deficient coping skills have been associated with 
higher levels of subjective burden (Solomon & Draine, 1995).

Overall, the literature suggests that improvements in coping skills and access to 
resources for learning about them are associated with lower levels of burden (Doornbos, 
1997; Saunders, 2003). This research offers empirical support for participation in 
psychoeducational and peer groups to reduce burden (Lefley, 1996). For instance, when 
family members participate in self-help programs designed to provide information on the 
disease and offer skills training, family members report lower subjective and objective 
burden, lower levels of maladaptive, dysfunctional coping strategies like coercion and 
resignation, and higher levels of adaptive, functional coping strategies like positive
communication with the ill relative, seeking and maintaining social interests/activities outside of caregiving, and social contact (Magliano, Fiorillo, Fadden, et al., 2005). Similarly, in their evaluation of the 12-week NAMI Family-to-Family program, Dixon, Lucksted, Stewart, et al. (2004) found that participation was associated with significantly lower perceptions of subjective burden and worry, and increased knowledge about severe mental illness and the mental healthcare system, feelings of empowerment, and engagement in self-care activities. Thus, while there is evidence that learning and applying adaptive coping mechanisms can function to reduce certain kinds of burden, research has found that a lack of facilitation and referrals on the part of mental health care providers results in families’ general lack of knowledge about and participation in support groups (Biegel & Song, 1995; Doornbos, 2002).

Incidentally, another factor frequently associated with burden is family caregivers’ experiences with and perspectives on the mental health care system. Literature on family caregivers documents a “widespread dissatisfaction with the services offered by the mental health care system” such that over one-third of the 76 caregivers interviewed by Doornbos (2002) were unable to identify even one single aspect of the system by which they felt supported (p. 45). Due to a perceived lack of communication on the part of professionals (Levine, 1998), family of mentally ill individuals feel alienated from important aspects of their relative’s care by mental health providers, contributing to feelings of powerlessness and lack of control (Ewertzon, Lutzen, Svensson, & Andershed, 2010). Specifically, family members report not being included on discussions of treatment options or plans (Biegel, Song, & Milligan, 1995; Doornboos, 2002), and a feeling that professionals generally do not value or consult their lay
knowledge of and personal experiences with their family member in developing courses of treatment (Goodwin & Happell, 2006; Rose, Mallinson, & Walton-Moss, 2004). Wilkinson and McAndrew (2008) suggest that family members feel that they are treated as outsiders by mental health providers and that they feel ignored and excluded from the process. In addition to feeling alienated and discounted, family members also note a deficiency in the amount of information provided to them about their relative’s illness, treatment options, and resources for outside support (Muhlbauer, 2002; Pejlert, 2001).

Perceived lack of support from health professionals can lead to negative psychosocial outcomes for family members like increased subjective burden (Ewertzon et al., 2010) and depression (Song, Biegel, & Milligan, 1997), whereas an emphasis on educating family members has been found to reduce burden and heighten feelings of empowerment and self-efficacy (Biegel, Robinson, & Kennedy, 2000; Dixon et al., 2004). Thus, taken together, this research suggests that family members and their ill relative are benefited by a more collaborative and affirming partnership approach with their relative’s mental health provider, and that the family’s perceptions of the health care system can significantly impact emotional distress and burden (Doornbos, 2002; Greenberg, Greenly, & Brown, 1997).

Outside of professionals and peer support groups, social support from the family’s network has also been investigated with regard to its effect on perceptions of burden in families of mentally ill individuals, and research has offered some conflicting results. In general, social support is believed to have positive physiological and psychological effects on health (Cohen & Wills, 1985), and those findings have been widely replicated in this context. For instance, research has found that when family members are satisfied
with their support networks and perceived availability of support, feelings of both objective and subject burden are reduced (Potasznik & Nelson, 1984). Alternatively, assessments of insufficient social support can have a detrimental effect on the family, including being a strong predictor of depression (Song, Biegel, & Milligan, 1997), and associated with increased burden and maladaptive coping strategies like resignation (Magliano, Fadden, Madianos, et al., 1998). How social support is measured has implications for its effects. For instance, Potasznik and Nelson found that larger support networks do not always mean more support, and that among family members of mentally ill individuals, a “small dense network” was associated with greater satisfaction with social support and with decreased burden. Provencher et al. (2003) suggests that this may be due to the fact that if a significant subset of one’s “support” network do not have a mentally ill family member and thus cannot relate to their situation, it may make them feel more alone, foster negative social comparison, and overall greater feelings of subjective burden. Taken together, this research suggests that positive evaluations of enacted social support may reduce burden, but a larger support network of “unsympathetic” others may enhance burden.

Although assessments of caregiver burden was not a specific focus of this study, the prevalence of caregiver burden among family members in the research suggested that it may play a significant role in how adult children make sense of and define their experience. Further, notions of burden and psychological distress may surface as salient in how children strategically navigate contradictory forces surrounding this relationship. Moreover, competing goals may be reflective of and contribute to burden in adult children.
Overview and Summary

Thus, much of the research conducted on adult children of mentally ill parents focuses on outcomes, and more specifically on the heightened risks of clinical psychiatric disorders and psychosocial risks in these offspring. However, Duncan and Browning (2009) argue that this focus ignores other lasting effects of parental mental illness on children, and suggests that if “the person is sane and has a spouse, the outcome is ‘successful’ and no further attention is warranted” (p. 77). Of course, childhood development cannot and should not be extracted from what happens in adulthood, but it is important that research begin to explore adult children’s perspectives on parental mental illness and their experiences in this later stage of life. Going beyond this, it is also essential that research attempt to understand how adult children make sense of the illness and their role, and how they negotiate the challenges that accompany this particular relationship. The current study attempts to shed light on both of these questions.

As previously mentioned, children who have mentally ill parents are underrepresented in the research, and qualitative studies exploring adult children’s experiences as adults represent only a small portion of this already limited area of literature. After conducting a meta-synthesis of research on adult children and parents with a mental illness, Murphy, Peters, Jackson, and Wilkes (2011) contend that the literature largely “reflects on [adult children’s] experiences as children growing up with one or both parents who had a mental illness,” meaning that studies in this area are primarily retrospective in nature, focused on investigating childhood experiences with the parent, as opposed examining the participants’ experiences as an adult, navigating the now with their parent (p. 3431). Although research should certainly account for issues of
childhood development that arise from parental mental illness, it should not neglect the adult experience of having a mentally ill parent.

Moreover, noticeably absent are empirical investigations focused on the adult child’s evolving relationship and communication with the mentally ill parent. The research that does examine the adult child’s experience focuses on the attachment issues that adult children of mentally ill parents carry with them into adult relationships, the emotional tolls experienced by these adult children, or on their own mental instability as a result of their ‘abnormal’ childhood. Although frequently framed in the literature through the lens of attachment theory (Duncan & Browning, 2009; Nathiel, 2007; Sroufe, Egeland, Carlson, & Collins, 2009), an analysis of the qualitative literature “demonstrates that adult children are not framing their narratives in the realms of attachment theory…[and]…for their story and narratives to be truly represented in scholarly literature, then it must reflect their chosen conceptualizations and discourse” (Murphy, et al., 2011, p. 3439). It is the objective of the present study to offer an analytic lens that more accurately reflects how adult children make sense of this experience and how the illness and their understanding of it influences how they enact their relationship with their parent and with others. The narratives surrounding having a mentally ill parent do not end with an individual’s childhood, but the bulk of the literature examining adult children of mentally ill parents narrows in on this earlier period of life, neglecting later stages. This dearth is especially troubling considering that it signifies an avoidance of a complicating but inescapable reality; a child’s relationship with his or her mentally ill parent does not end when he or she becomes a legal adult. Nor does the relationship only exist in formative memories and reflective anecdotes once the child becomes a legal adult.
Moreover, the literature demonstrates that substantial empirical effort has been
dedicated to documenting the experience of stigma, burden, and psychological distress in
family members of mentally ill individuals, but only a limited number of these studies
have examined adult children who have a parent with a mental illness. Although it is not
the goal of the current study to probe these specific topics in depth, since these have been
established in the literature as salient aspects of having mentally ill family member, it is
expected that these phenomena will be reflected in and influence how adult children
discursively frame this experience.

Although existing research provides significant justification for further study, it is
vitally important that research in this area move beyond outcomes and explores the lived
experiences of adult children of a parent with a mental disorder from their perspective.
While research has begun to examine adult children’s perspectives, most of these
investigations are retrospective, reflective accounts of childhood experiences, rather than
a focus on the adult relationship between the offspring and ill parent, and how their
discourse reflects and influences the contradictory forces that define this experience. In
the next section, I argue that the experience of having a mentally ill parent is dynamic
and shaped by the interplay of many competing forces. Specifically, I contend that adult
children discursively frame their experiences involving their mentally ill parent as
dialectical tensions, and that these contradictions are often expressed as and reflective of
multiple goals. Thus, relational dialectics theory (Baxter & Montgomery, 1996) and a
multiple goals perspective (Berger, 2004; Brown & Levinson, 1987; Clark & Delia,
1979; O’Keefe, 1988; O’Keefe & Delia, 1982) are presented as lenses for illuminating
adult children’s perspectives surrounding their mentally ill parent.
Chapter Three: Theoretical Perspectives

As the previous chapter established, being the child of a mentally ill parent can be complicated and challenging. Research has consistently demonstrated that children of mentally ill parents are at a greater risk of negative psychopathological and psychosocial outcomes. The large bulk of research in this area quantitatively examines the effects of having a mentally ill parent, but researchers have comparatively neglected inquiry that qualitatively explores the perspectives of adult children and the communicative processes that define their relationship with and to their parent. Moreover, much of the literature in this context is atheoretical. The present study attempts to address these empirical gaps. Although qualitative studies in this context point to a contradiction-ridden discourse in the perspectives of adult children who have a parent who is mentally ill, my reviews of the literature in this area did not uncover any applications of a dialectical or a multiple goals framework.

Throughout the analysis, children’s sense making and talk about their mentally ill parent was framed in contradictions. For instance, on the one hand, adult children struggled with resentment and blamed their parent for their perceived emotional and behavioral dysfunctions (i.e., “I always ask myself, why does she want to live this way?”), but at the same time, they would frame their parent as a powerless victim of their illness (“I remind myself that wasn’t her. That isn’t who she is.”). Or alternatively, children negotiated the desire to establish independence from their parent’s issues (i.e., “What she does is not my responsibility”) with the interplay of interdependence that often characterizes being in a “caregiving” role (“I check in with her everyday because I just want to make sure she’s doing okay.”). Thus, based in the notion of the multivocal flux of
relationships and the discourse that constructs them, relational dialectics theory (Baxter & Montgomery, 1996) emerged as the most appropriate theoretical lens through which to understand the perspectives and communicative practices that define adult children’s relationship with their mentally ill parent. After an overview of relational dialectics theory and a justification of this theoretical framing, I will make an argument that a multiple goals perspective (Berger, 2004; Brown & Levinson, 1987; Clark & Delia, 1979; O’Keefe, 1988; O’Keefe & Delia, 1982) further illuminates how adult children make sense of their experience. After explaining how multiple goals and relational dialectics theory can work in tandem, I provide an overview of multiple goals perspective and how it is best applied to this context. Finally, in light of previous research and these theoretical frameworks, at the conclusion of the chapter, I will outline the research questions that guide my analysis.

**Relational Dialectics Theory**

Relational dialectics theory has its roots in the philosophical works of Mikhail Bakhtin (1981). Bakhtin rejected theories that presented social life as univocal, fixed, determinate, and closed, and instead promoted theories that reflected the multivocality and indeterminacy of social life where “multiple voices” are involved. This perspective has come to be known as dialogism in order to capture the nature of social life being defined by the constantly evolving dialogue from multiple voices. Baxter (2006) suggests that relational dialectics theory takes its cue from the dialogic idea of multivocality, a stark contrast to what Baxter calls “monologic” theoretical approaches. According to Baxter, monologic theories tend to take an “either/or” position, where one thing is understood as a positive and it is defined by and contrasted with its polar opposite, which
is viewed as its complementary negative. For example, monologic approaches might suggest that “closeness” is positive and the desired goal in relationships, and that “distance” is its binary opposite, and is therefore an undesirable state.

However, regarding the interpersonal context of family, Baxter (2006) states that “the dialogic move is one of recognizing that family life is a both/and experience—families gain their meanings from the give-and-take interplay of multiple, competing themes or perspectives […] No theme or perspective is better or worse than its opposites—their interplay is what is important” (p. 131). Thus, according to the dialogic perspective, relational products and processes are always evolving, operating along a malleable continuum between poles, where the meaning is derived from the interplay of the opposites. In this view then, “distance” is not an undesirable state, but rather an inevitable and essential piece of the discourse of connection.

Baxter (2004) contends that Bakhtin’s dialogism grounds relational dialectics theory by conceptualizing dialogue as the center of our selves and our relationships. In other words, relational dialectics, by way of dialogism, adopts a constitutive perspective of communication, rejecting more traditional conceptualizations of communication as a functional activity to transmit the self to others. Communication in this traditional view is understood as a part of, but conceptually separate from, relationships. In contrast, a constitutive approach argues that the self and relationships do not exist outside of communication; it is only through communicative practices in relation with others that selves are continually authored. Thus, in this perspective identities and relationships are emergent and constructed in coordinated interaction. Relational dialectics proposes that relationships are simultaneously creating and becoming—both continually producing and
fluid products of multiple discourses or “webs of meaning spun through communication” (Baxter, 2006, p. 139). From a dialectical perspective, then, the adult children’s perspectives reported here are relationally constituted and reflective of joint communicative efforts.

According to Baxter and Montgomery (1996), there are four central assumptions that underlie the dialectical perspective: (a) contradiction, (b) dialectical change, (c) praxis, and (d) totality. Central to relational dialectics theory is the meaning that is created in this interplay of tensions or contradictions created in communicative practice. The notion of dialectical tensions has its etiological roots in Bakhtin’s (1981) belief that interpersonal relationships are built from “a contradiction-ridden, tension-filled unity of two embattled tendencies” (p. 272) called centripetal and centrifugal forces. Bakhtin argues that centripetal forces are those that bring us together and create unity, centrality, and homogeneity, whereas centrifugal forces are those that create difference, disconnection, and displacement. The interaction between these forces are “constructed in communicative practices” and create what Baxter (2006) calls a dialectical contradiction, which “is an energizing source of vitality” in relationships—aiding in defining and redefining them through dialogue (p. 139). Therefore, the centrality of dialogue and competing voices suggests that in this view, “relating is a complex knot of contradictory interplays” (Baxter, 2004, p. 8).

In relational dialectics theory, contradictions are the manifestation of multivocality. Importantly, from a dialogic perspective, “voice” is not synonymous with talk, but instead represents perspectives, ideologies, or values, and an “utterance” is “not the product of individual cognitive work...[but is] jointly constructed by interacting
parties” (Baxter, 2004, p. 14) in communicative exchange. In other words, any single communicative product can be the result of multiple voices. For instance, adult children’s talk about their parent’s illness in the present study is reflective of competing dialogues. On the one hand, children talk about their parent in a language of culpability, which is an ideology constructed in the belief that an individual is personally accountable for their actions and has a choice when it comes to their emotional or mental state, and how they let those cognitions affect their behavior. This “voice” is reflected in statements from children to their parent like “stop acting that way,” or “why are you acting like that,” where the implication is that their parent has a choice. This is juxtaposed by the language of exoneration, which is an ideology constructed in the fatalistic belief that the mentally ill are not in control of their own thoughts or behaviors, and therefore should not be held personally responsible. In this voice, the parent is the victim and is acquitted of wrongdoing. This voice is reflected in statements like, “this is the illness speaking,” and “she wasn’t herself,” that clearly differentiate between the person and illness, where it is the illness that is to blame.

For Baxter (2006), the “interplay of competing voices comprise a contradiction” (p. 139). Thus, a dialectical tension is not an internal cognitive dilemma, but the product and reflection of multivocality and “located in the relationship between parties, produced and reproduced through the parties’ joint communicative activity” (Baxter, 2004, p. 14). From this perspective, the adult children’s narratives reported here are not the results of solitary construction but of a relational enterprise conducted in coordination with their parent and evolving over time.
Three central contradictions.

Baxter and Montgomery (1996), in their original iteration of the theory of relational dialectics, propose that there are three central contradictions or dialectical tensions whose constant interplay define relationships. Importantly, in this theory these three contradictions are not meant to be applied to any relationship as a “cookie-cutter template” (Baxter, 2006, p. 136), but since variations of these tensions are salient in how adult children define and make sense of their relationship to/with their parent, they are outlined in greater depth here.

The first is the dialectic of integration, which examines the discourse that takes place between the unified opposites of connection, assimilation, affection, and interdependence on one side, and separateness, distance, and independence on the other. Baxter and Montgomery argue that separateness is typically conceptualized as an adversary to closeness in relationships, and that relational connection is perceived and discussed as an inherently good or preferable state (e.g., “getting closer” to someone), whereas relational distance is posited as bad and undesirable (e.g., “growing apart”). However, rather than an “either/or” understanding of connection, relational dialectics theory proposes a “both/and” perspective. Wherein, all relationships are constantly operating along a closeness continuum, and the interplay of centripetal (unifying) forces and centrifugal (divisive) forces are at work simultaneously, continuously re-defining the relationship over time. Although posed as opposing, contradictory forces, Baxter and Montgomery note, “the emphasis is not on contradictions-as-nouns but on contradicting-as-joint-action” (p. 99) that are proactively constructed through communicative practice between the relational parties. This important notation is made in order to highlight that
the tensions created by these dialogic exigencies are fluid, multivocal processes rather than a somewhat rigid state-of-being or binary in nature. As with the other tensions, the dialectic of integration is not resolvable, and will be continuously enacted throughout the duration of the relationship.

The second primary dialectic is expression according to Baxter and Montgomery (1996). This tension addresses the interaction between privacy, concealment, disengagement, discretion, and closedness, and the opposing forces of disclosure, revelation, openness, and sharing. Tied to the integration dialectic, this tension suggests that “openness” or disclosure is typically construed as one of the primary avenues to connection and closeness, and that protection of information about the self inhibits or stunts the potential to connect. Since in a monologic view, relational closeness is positive and distance is negative, openness is often encouraged to foster connection and intimacy, whereas privacy or closedness is seen as a protective act that can create distance. However, Baxter and Montgomery argue that the ongoing interplay between these two simultaneous forces is a dynamic dance between relational partners surrounding revelation and concealment, neither of which is inherently good or bad. From this perspective, relational parties are always communicatively negotiating candor and revelation with concealment and discretion through the construction and deconstruction of boundaries. Additionally, in this theory, the context, relational background, history, and social and cultural norms are believed to influence our inner and outer utterances, and how we interpret what is said and what is unsaid. Particularly important here is the notion that self-disclosure does not operate in a vacuum and is not always a catalyst for relational growth. Privacy and discretion at the appropriate time, place, and amount can
be just as advantageous, and a relational unit is all at once neither totally open or totally closed at any given time. Like with the integration contradiction, the “discursive dance” relational parties engage in to determine what information to share and what to “keep private” continues throughout the course of the relationship.

The third is the dialectic of certainty, which captures the dynamic exchange that takes place in the discourse between predictability, stability, consistency, familiarity, and routine, with the competing discursive notions of change, novelty, variation, originality, and spontaneity (Montgomery & Baxter, 1996). The centripetal unifying force in this dialectic is certainty, since order and predictability are traditionally valued as contributors to connection and familiarity is regarded as a building block (and a reflection) of intimacy. The centrifugal divisive force, then, is uncertainty, which implies change, instability, and disorder. However, importantly, consistent with the theory’s principle of “both/and,” Baxter and Montgomery note the complex, non-dualistic nature of relationships by noting that “relationships are never given but instead are always posited in the living dynamics of interaction…[they] are living systems that are in a perpetual process of becoming through the interplay of the given and the new” (p. 107). Further, it is noted that the very nature of a relationship implies continuity as it takes place over time, but it also involves “two physically separate entities that alternate in and out of each other’s presence” in a discontinuous fashion, so relational parties are always going to have to reconcile “constructing a sense of continuity out of what is fundamentally discontinuous” (p. 119). Ultimately, this dialectic suggests that relational partners are constantly negotiating a need for stability and consistency in their relationship with a simultaneous need for novelty and spontaneity, and that insights into the dynamics of the
relationship are found in the communicative practices that reflect and reveal these ongoing negotiations.

**Praxis patterns.**

As suggested above, the vibrant dialectical interplay that takes place between these “big three” contradictory forces occurs in communicative practice and ultimately defines the nature of the relationship(s) between the individuals or groups of individuals as a collective. Praxis is a major tenet of this theoretical perspective and is also the communicative root of the theory. According to Baxter and Montgomery (1996), praxis involves “the concrete practices by which social actors produce the future out of the past in their everyday lives” (p. 14). In other words, this assumes that people are proactive participants in making communicative choices, but are at the same time reactive objects to the ritualized interactions and experiences that they previously established in their past interactions. In other words, “people are actors in giving communicative life to the contradictions that organize their social life, but these contradictions in turn affect their subsequent communicative actions” (p. 13-14). In this vein, relational parties’ communicative choices in situ are both inhibited and shaped by their past interactional history, and those choices that are made in the present function to constrain future interactions.

Baxter and Montgomery’s (1996) original theory identified eight primary praxis patterns. Denial and disorientation are both labeled as dysfunctional patterns since they seemingly reject contradictory pulls. Denial involves the prioritization or legitimization of one end of the dialectical spectrum to the relative exclusion of the other end. In other words, only one side of the tension is responded to, while the pull for the oppositional
pair is ignored and denied. Disorientation is described as an inherently nihilistic response to contradictions in that relational partners “feel fatally trapped” (p. 62) and powerless to manage the tensions in a constructive manner. It reflects the belief that tensions are fundamentally negative and that nothing can be done to change things. Ultimately, disorientation can lead to relational dissatisfaction and dissolution. Adult children in this study who indicated that these patterns were used in their relationship with their parent were most often those who were estranged, or who had a very strained relationship.

The other six patterns are labeled as functional ways to jointly negotiate dialectical tensions. The first two were most prominent in how adult children managed the contradictions that defined their experience with their ill parent. Spiraling inversion, referred to hereafter in the present study as alternation, involves shifting back-and-forth between prioritizing one pole over the other at different points in time. For instance, in response to feeling like they are too connected with their parent (e.g., spending too much time with them or devoting too much of themselves to their caregiving duties), they may opt to spend a weekend away to privilege the oppositional force of autonomy and distance. This is called spiraling inversion because the weight given to one force will inevitably and eventually shift to the opposing force. Segmentation is a praxis pattern characterized by compartmentalization where one side of the contradiction is fulfilled in one area, and the other side is satisfied in another domain. For instance, adult children may respond to their need for revelation about their parent with others by disclosing only to their spouse or sibling, whereas in other areas of their life—like the professional
domain—they prioritize concealment and regard the topic of their parent as being off limits.

The praxis pattern of balance reflects a compromise where both needs are satisfied simultaneously, but “responses to the oppositional poles are diluted at any given point in time” (Baxter & Montgomery, 1996, p. 64). For instance, adult children may fulfill the contradictory needs for revelation and concealment by sharing only a small amount of information about their parent’s illness with a friend, while also making the strategic choice to keep certain details private. The praxis pattern of integration involves a simultaneous response to the contradictory forces but does not dilute either one. Adult children may exhibit this praxis by finding patterns in their parent’s seemingly volatile behavior, thereby coming to make sense of it as predictably unpredictable. The pattern of recalibration represents a reframing of the tension so that, at least momentarily, the contradiction or oppositional nature of the forces seemingly disappears. Reaffirmation is a praxis pattern that reflects an acceptance of the oppositional forces and endures the existence of the tension. Adult children might exhibit this pattern in the certainty tension by resigning to the belief that the trajectory of their parent’s illness is always going to be a defining factor in determining the course of their relationship and deciding to accept the inevitability of change and instability.

Although tensions are not psychological states according to this theory, individual perspectives and retrospective accounts can be used to provide some insight into these discursive contradictory interplays as they are understood by those that experience them. In fact, most current research utilizing relational dialectics theory, including research by the theory’s authors, relies on cross-sectional, qualitative interview data with individual
participants. Baxter states that observational and longitudinal data is most ideal for discovering and analyzing discursive dialectical tensions in flux, stating that “to understand the indeterminate quality of meaning-making, [researchers] must gather data from a minimum of two points in time,” adding that existing research applying the theory “has a static quality to it” (p. 137). However, first person, cross-sectional interview accounts are ideally situated to meet the goals of the current study, which is aimed at identifying the how children make sense of this relationship that can be wrought with contradictions, and illuminating how children frame and attempt to strategically manage those tensions.

Although the original theory only detailed three primary dialectical tensions, Baxter (2006) calls for researchers “to identify contradictions other than integration, certainty, and expression that may animate specific family situations” (p. 137). This study explores the notion of competing but complementary voices in the context of a mentally ill parent and adult child, specifically examining the contradictory push and pulls that adult children negotiate in their relationship with their mentally ill parent. The present study found that even though adult children do identify experiences with their ill parent consistent with “the big three” original contradictions, the “voices” that underlie those tensions are unique to this context, and have practical implications for lay and professional support networks.

For example, one factor underlying and influencing the push and pull between integration (connection) and separation (autonomy) in this context are the notions of agency and blame. When adult children assigned the blame to the disease and exonerated their parent for perceived wrongdoings, dysfunctions, and transgressions, they felt pulled
to maintain closer contact with them, in many cases even committing themselves to their parent’s treatment. Communicatively, this pull was often related to the frequency with which the child had contact with their parent. However, at the same time that children would feel pulled to exonerate their parent, there was a discursive push to convict them and hold them personally responsible for their skewed perspectives and deviant behaviors. When children framed their parent as a culpable agent and perpetrator, they were pushed toward autonomy and separation; they were more anxious to move away from their parent (both emotionally and physically) with a desire to have a more independent existence not enmeshed with their parent. Communicatively, experiencing this push meant contact was generally less frequent and exhibited a lack of emotional intimacy (primarily task-focused—e.g., “What groceries do you need this week?” “Did you take your medication?”).

**Utility of a relational dialectics framework in this context.**

Dialectical tensions have been frequently used to provide insight into family communication (Baxter, 2006). One of the most frequently studied relationships in dialectics research is between marital partners (Baxter & Braithwaite, 2002; Braithwaite & Baxter, 1995; Erbert, 2000; Hoppe-Nagao & Ting-Toomey, 2002; Pawlowski, 1998). Relational dialectics theory is particularly illuminating when applied to married couples that are confronting specific challenges or trials in their relationship. For instance, in their study on wives of deployed military members, Sahlstein, Maguire, and Timmerman (2009) found that wives experienced multiple levels of dialectical contradictions in their marriages throughout their husband’s deployment, and that those predominant tensions defined the communicative practices surrounding the relationship at these specific points.
in time. Specifically, Sahlstein et al. found that for the wives interviewed, the tension of certainty-uncertainty was the defining tension prior to their husband’s deployment, the tension of autonomy-connection was central during the deployment, and the tension of openness-closedness defined their marital communication once their husband had returned home. In another example, examining a different type of marital challenge, Sabourin and Stamp (1995) used relational dialectics theory to frame their understanding of the contradictions surrounding the communication between married couples with a history of spousal abuse and those that are nonabusive.

Especially relevant to the current study, relational dialectics theory has also successfully been applied to studies examining health issues within the context of family. For instance, Golish and Powell (2003) framed their exploration of parents’ grief over the premature birth of an infant using relational dialectics theory. The authors found that in navigating an “ambiguous loss” or preterm birth, parents experience a number of contradictions stemming from an overarching tension of joy-grief—joy that their child is alive, but simultaneous grief over the loss of a ‘normal’ birth and a healthy baby. Like the present study, Golish and Powell also examined the communication praxes, or strategies used in practice to manage the tensions that parents experienced. In another study examining pregnancy, Baxter, Hirokawa, Lowe, Nathan, and Pearce (2004) used a dialectical framework to understand the competing discourses women experience surrounding pre-partum alcohol consumption. The authors found that during pregnancy, women often negotiate the discourse of individualism with the opposing discourse of responsible motherhood, and offered theory-based, practical implications for the tailored design of a campaign to target this behavior. Although both of these studies apply
relational dialectics to issues surrounding pregnancy, these demonstrate the utility of using this theory as a lens for understanding how people make sense of a complex and challenging health issue.

Other studies have successfully applied a relational dialectics framework to illuminate the experience of family caregivers. For instance, Braithwaite, Golish, and Olson (2002) examined the dialectical tensions experienced by wives of husbands with Alzheimer’s disease and how they communicatively managed the contradictions created by the tension of being a “married widow,” or, in other words, having a husband who was physically present, but cognitively and emotionally absent. Through qualitative interviews with the wives, the authors found that underlying the overarching presence-absence contradiction were tensions between 1) certainty that their husband’s “true self” would emerge in fleeting moments of lucidity and simultaneous uncertainty about when those moments would occur, or if they were even really “there,” 2) openness about personal information that might provoke the presence of their “real” husband and encourage cognitive participation in their shared life, and simultaneous closedness about what and how much information to reveal in order to keep their husband from getting hurt, sad, or angry, and finally 3) a sense of longing for the past when their husbands were still their “true” selves, with a simultaneous need to live and function in the present. Although not all adult children interviewed for the present study viewed themselves as caretakers of their parents, almost all participants indicated similar types of tensions as are found by Baxter et al. For instance, the certainty of instability with regard to the trajectory of the illness, a longing for a return to traditional roles, but a realization and acceptance of its impossibility, and a strategic management of information flow to others
about the parent’s illness. Overall, this study illustrates the utility of applying a dialectical framework to understand the perspectives and coping strategies employed by family members of those living with a psychological impairment.

**Justification for Blending a Dialectical and a Multiple Goals Perspective**

From a relational dialectics perspective, praxis patterns are inherently communicative—not psychological—phenomena and contradictions manifest and are managed in communication. As stated by Baxter (2006), “contradictory voices are not inherent system features or the psychological states of constituent family members, but rather discursive constructions—that is, discourses, ideologies, or codes of meaning” (p. 135). In her 2004 essay, Leslie Baxter positions relational dialectics in direct opposition to what she labels “traditional” theories that conceptualize communication as being “a manifestation, and determined by, a speaker’s individual dispositions, goals, and social locations” (p. 3). Instead, she views communication as constitutive; an approach that purports relationships cannot be understood apart from the communicative practices that create them. In other words, this reflects the assumption that relationships do not exist outside of communication. As a result, she argues that attempting to understand relationships as an individually driven activity fails to capture how relationships are a jointly coordinated and constructed process, whereby each communicative act functions to shape and constrain the communication that follows it. In fact, specifically outlining the foundational propositions of relational dialectics, Baxter (2004) asserts that this perspective rejects the “conception of relating as goal-rationality and means-end instrumentalism” (p. 14).
Given that one of the primary theorists behind relational dialectics contends that this perspective is epistemologically incompatible with more “traditional” goal-driven approaches to communication, why then do I attempt to use them in tandem in this study? Although I view the perspectives and communicative practices reported by adult children in this study as the product of a jointly enacted process in coordination with their parent, I also contend that a more comprehensive understanding of adult children’s sense-making about their parent’s illness is illuminated by integrating a multiple goals perspective to the analysis. Even Baxter and Montgomery (1996) acknowledge the salience of “choice” in the enactment of relationships through praxes, asserting, “communicative choices made in the present are steeped in historicity; they inherit the constraints imposed by prior actions and cultural history…[choices] are steeped in anticipation, as parties negotiate joint actions in light of what they expect as outcomes (p. 67; italics added for emphasis).

Importantly, the analysis of the current study subscribes to the dialectical premise that the communicative choices made by adult children (represented by praxis patterns) are constrained by the relational history of past interactions and serve to shape future interactions with their parent, but also acknowledges that these choices are reflective of goals (e.g., “expected outcomes”), however jointly created and negotiated they may be. Furthermore, understanding the underlying—and at times competing—goals of the participants in this study helps to illuminate the praxis patterns they strategically employ to negotiate the interplay of contradictory forces. Thus, I do not see these theories as diametrically opposed, but rather as mutually informative. With this in mind, below I outline the basic premise of a multiple goals framework, and elucidate its utility in
understanding the nuanced complexities of the contradictions that define adult children’s experiences surrounding their mentally ill parent.

**Multiple Goals Perspective**

The multiple goals perspective represents a conglomeration of planning and message production theories (Berger, 2004; Brown & Levinson, 1987; Clark & Delia, 1979; O’Keefe, 1988; O’Keefe & Delia, 1982) that attempt to explain the mechanism that motivates human communication. This perspective places goals at the forefront of message production and performance. According to Wilson and Feng (2007) goals are defined as “future states of affairs that individuals desire to attain or maintain” (p. 71). In other words, goals are “desired end states for which individuals strive” (Berger, 2004, p. 50). Specifically, communication goals are described as desired outcomes that necessitate communication and coordination with others (Wilson & Putnam, 1990). A major assumption of goals theories is that message production and performance are purposeful and strategic, but not necessarily always intentional. In other words, communication is viewed as messages exchanged in order to accomplish some end(s) or used to achieve some outcome(s) (Caughlin, 2010). According to this perspective, intentionality is no longer considered a necessary component of goal-driven communication because in some situations, message production may be or become automatic, such that the goal-driven actions are pursued at an unconscious level, as a habitual or ritual behavior requiring minimal cognitive energy (Caughlin & Vangelisti, 2009).

Arguing that communication is a goal-driven activity, O’Keefe and Delia (1982) state that “messages begin as purposes” and that they “can be seen as the product of reconciling multiple objectives in performance” (p. 51-52). Importantly, as suggested by
O’Keefe and Delia, a major premise of multiple goals perspectives is that human beings are not singular in their goal pursuits. In fact, Wilson and Putnam (1990) suggest that people “often pursue multiple, conflicting goals” within a single communication exchange and that these goals and their salience may evolve over the course of a conversation. Although multiple goals may be in play at once, not all goals are created equal in an interaction. Importantly, multiple goals theorists have distinguished between primary and secondary goals in a communicative exchange (Dilliard, Segrin, & Harden, 1989; Wilson, 2002). As suggested by the term, primary goals are those goals that are defining in an interaction. In other words, they are the general, over-arching goals that may point to the primary purpose or objective of the communicative exchange. For instance, a primary goal of an adult child of a mentally ill parent may be to seek instrumental social support in the form of treatment information for their relative. Secondary goals are those that stem from, but may not be less important than, the primary goal. Secondary goals may be more readily apparent than primary goals in that they “often shape or constrain how (and even whether) a primary goal is pursued” (Caughlin, 2010). If one believes that they do not have the skill or competence to effectively or successfully implement and achieve a secondary goal, they may not make an attempt to accomplish or pursue their primary goal (Dillard et al., 1989).

Thus, secondary goals may take precedence and ultimately act as a hindrance to the achievement of primary goals, and vice versa (Dillard et al., 1989). For instance, in the example above, a secondary goal of the adult child of a mentally ill parent may be to protect his or her own (or their parent’s) image from negative evaluations. If the individual believes that knowledge of the illness would cause his or her close network to
develop a negative impression, then the achievement of the secondary goal may take precedence, causing the individual to conceal or neglect to seek out the desired instrumental support. In other words, this secondary goal may prevent that person from pursuing their primary goal of gaining support and information about the illness (Caughlin & Vangelisti, 2009). Thus, in the context of a potentially stigmatizing health condition of self or a loved one, protecting one’s face may come at the expense of acquiring needed support or information due to this goal conflict.

Beyond the distinction between primary and secondary goals in an interaction, multiple goals theorists have further distinguished between goal types. For instance, Wilson and Putnam (1990) suggest that goals may be instrumental or interpersonal in nature. In other words, a person’s objectives in an interaction may be either task-oriented or relationship-oriented. Moreover, Clark and Delia (1979) contend that generally, all communication goals fit into one of three categories: (a) instrumental goals, (b) relational goals, and (c) identity goals. Generally, instrumental goals are “the focus of the interaction,” whereas relational goals “offer a commentary on the relationship between the two interactants” and identity goals “contribute to the situational identities of the interactants” (Clark & Delia, p. 196). Specifically, instrumental goals are task-oriented. Examples of instrumental goals may include reducing uncertainty by seeking information, asking for a favor or for assistance, and the provision or procurement of social support (Caughlin, 2010; Clark & Delia, 1979). In the case of an adult child of a mentally ill parent, they may reach out to a close friend for emotional support after an upsetting outburst from their parent or consult a spouse for advice on how or whether to intervene. Relational goals “refer to communicating in ways that reflect and promote the
type of relationship one has, or wishes to have, with a partner” (Caughlin, 2010, p. 827). For instance, the objective of an adult child in an interaction with their mentally ill parent may concern the trajectory of the relationship, including the desire for relational initiation, maintenance, or dissolution. Finally, identity goals are those that “involve both wanting to manage one’s own impression in conversation and protecting the impressions that others make” (p. 827). In other words, identity goals are often employed in an attempt to save one’s own or another’s face (Brown & Levinson, 1987). For instance, in a simple and fairly common example, an adult child may choose to conceal their parent’s mental illness from friends, co-workers, or love interests in order to manage positive impressions and avoid the risk of a courtesy stigma.

Importantly, as suggested previously, another major premise of this perspective is that an individual may pursue multiple incompatible goals simultaneously (Dillard et al., 1989). In other words, an individual’s identity goals, relational goals, and instrumental goals may conflict, such that the attainment of one may jeopardize the attainment of the others. For instance, research suggests that a person may choose not to disclose an HIV diagnosis for fear that the revelation would cause others to view them negatively due to the stigma surrounding it and that it may ultimately contribute to the decline in relational satisfaction with close ties (Caughlin, Bute, Donovan-Kicken, Kosenko, Ramey, & Brashers, 2009; Greene & Faulkner, 2002). Thus, applying the multiple goals perspective to the family health crisis context, for the adult child of a mentally ill parent, the procurement of needed support or information (instrumental goals) may come at the expense of one’s desired presenting self (identity goals) and the maintenance of strong ties (relational goals). For example, an individual with a mentally ill mother or father may
desire social support or other types of instrumental support (such as seeking out legal or medical advice), but due to the potential for courtesy stigma, or potential damage to outside relationships, the individual may choose to conceal their parent’s illness and not seek support. Alternatively, if a person prioritizes their relational goals with their parent and take steps to be involved in their parent’s life, they may be unable to successfully achieve certain instrumental goals related to their professional or personal life, their ability to present a desired public self may suffer, or their outside relationships (with spouses, friends, other relatives, their own children) may weaken as a result.

**Utility of a multiple goals perspective in this context.**

A primary strength of employing a multiple goals theoretical perspective to the exploration of adult children’s experiences surrounding their parent’s mental illness is that it has the potential to explain the motivational mechanism underlying the praxis patterns that influence the interplay of dialectical tensions. Specifically, as Caughlin (2010) notes, relational communication is fraught with complexities, and a multiple goals perspective “has the potential to bring much needed nuance to our understanding of communication in relationships” (p. 825). In the context of illuminating the experience of navigating a relationship with a mentally ill parent, the multiple goals perspective provides an insightful lens through which participant’s perspectives and communicative behaviors might be understood. For instance, although the concepts of courtesy stigma and family toxicity discussed in the review of literature suggest that individuals may experience identity-related concerns as a result of a relative’s mental illness, understanding how those concerns interplay with other relational and task-related issues (both inside and outside of their parent’s illness) and ultimately function as a mechanism
motivating communicative behaviors is not sufficiently explained by stigma alone, or even the application of a dialectical perspective.

A multiple goals framework provides insight into how children of mentally ill parents make strategic, goal-driven decisions in an effort to navigate their own life in the face of their parent’s illness, and informs how contradictions between goals are negotiated. For instance, applied to the context of this study, after experiencing courtesy stigma as a result of their parent’s illness, an adult child may conclude that maintaining a relationship with their mentally ill parent is too costly, and prioritize (consciously or unconsciously) identity goals (self-preservation) over their maintenance of a close connection with their parent (relational goal). In this case, even the absence of a relationship indicates a goal, as the actions that lead to that non-relationship are purposeful, ongoing, and deliberate. A multiple goals perspective will be particularly useful in understanding how stigma plays into the purposeful and strategic management of the expression tension, and how communicative behaviors may shift as the salience of goals change over time and are influenced by contradictory forces.

**Theoretically Informed Research Questions**

In this study, data revealed that conflicting goals of adult children of mentally ill parents are often reflected in and convoluted by dialectical tensions whose push and pull can influence the degree to which a particular goal is pursued or ignored. Therefore, in addition to relational dialectics theory (Baxter & Montgomery, 1996), this study also employs a multiple goals perspective (Berger, 2004; Brown & Levinson, 1987; Clark & Delia, 1979; O’Keefe, 1988; O’Keefe & Delia, 1982) to illuminate the standpoints and experiences of adult children with a mentally ill parent, a group whose lives may be
defined by complex web of contradictory forces. Although relational dialectics theory and a multiple goals perspective are separate and seemingly very different theoretical frameworks, used in tandem, they can shed light on the complicated experience of adult children who have a parent with mental health issues and the communicative practices they employ in making sense of and managing their parent’s illness in their own lives.

Two underlying shared assumptions that are critical to each of the two theoretical approaches are important to note here because they help to explain how these two frameworks can work together to provide insight in this family health context. The first and most important to the current study is the idea of contradiction. Although this is a central tenet of relational dialectics theory, the multiple goals perspective is also predicated on the notion that primary and secondary goals can be in conflict and can manifest as contradictions. Further, and important to the current study, the negotiation of the salience of these competing goals is similar to the notion in relational dialectics theory of dialectical flux. Identifying these competing goals (or tensions) and understanding how they are meaningful to the adult children interviewed for this study could provide a motivational mechanism for understanding their communicative behaviors (or praxes) in this context. For example, if adult children perceive that their relationship with their parent has begun to weigh heavily on the side of connection and interdependence, they will then make strategic communicative steps in order to manage this tension. They may decide to purposefully find time to prioritize autonomy and separation, they may try to ignore this tension and hope it resolves itself, they may decide to segment and fulfill their need for autonomy in other areas of their life, etc. Regardless, the communicative decisions made and praxes employed by adult children are reflective
of a jointly enacted and coordinated relational discursive process, but goals can illuminate the motivation behind these decisions.

It is at the intersection of these two theoretical perspectives where a greater understanding of adult children’s experience surrounding their mentally ill parent can be gained. This experience is fraught with multiple competing goals and dialectical dilemmas, and up until now, research on this particular phenomenon has been largely atheoretical. Thus, not only is there a dearth of research that examines individual perspectives on having a parent with a mental illness in adulthood, in its limited capacity, research in this context has not been heavily guided by theory. Ultimately then, using a multiple goals and relational dialectics theoretical framework to guide analysis, and in order to more fully explore the ways in which adults negotiate multiple contradictory forces surrounding their close relative’s mental illness, the following research questions are posed to guide inquiry:

RQ1: What dialectical tensions most prominently define adult children’s experience of parental mental illness?

RQ 2: What goals underlie and influence the interplay of these dialectical tensions?

RQ 3: What praxis patterns do adult children employ to negotiate these contradictions?

The next chapter will describe the methods that are employed in this study to answer the research questions outlined above and provide justification for these methodological decisions in light of the overall objectives of this inquiry.

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Chapter Four: Research Methods

Introduction and Justification for Qualitative Approach

The overall objective of the current study is to highlight the lived experiences of adult children of mentally ill parents; attempting to elucidate on the ways in which they navigate the emotional, relational, and communicative challenges they experience as a result of their parent’s illness, and to understand how these strategies and their outcomes are meaningful for them. Given my research objective is to gain a greater understanding of how participants make sense of this experience and find common themes across varied backgrounds and perspectives, it was appropriate to design the study within the interpretive tradition since “the goal of interpretive work is the identification of recurring patterns of behaviors and meanings” (Braithwaite, Baxter, & Harper, 1998, p. 104). Thus, qualitative in-depth interviews were used to solicit adult children’s subjective perspectives of their own experiences with their parent’s mental health issues. This approach was appropriate for this study because interviews are “particularly well suited to understand the social actor’s experience and perspective” (Lindlof & Taylor, 2011, p. 173). LeCompte and Schensul (1999) lend further credence to this methodological choice, contending “ethnographic stories are built around and told in the words, views, explanations, and interpretations of the participants” (p. 12). Thus, consistent with the goals of interpretive research, qualitative in-depth interviews enabled me to gain insight into participants understanding of their communicative practices by allowing them to define their own lived experiences.

Specifically, in-depth interviews for this study were designed in the form of respondent interviews. According to Lindlof and Taylor (2011), respondent interviews
are designed “to elicit open-ended responses” in order to discover participants’ “subjective standpoints” about the phenomenon of interest (p. 179). Thus, the goal of this type of interview is to clarify and illuminate participant meanings, motivations, and subjective interpretations of their own communicative behavior. Importantly, in respondent interviews, participants are positioned as experts of their own subjective experience. This type of interview was conducive to the research objectives of this study because it is typically semi-structured and follows an interview guide. Using an interview guide allowed for a more structured and focused interview that prompted relevant narratives from participants and probed for more information on certain subjects, but allowed for divergence and flexibility in the interview so that unforeseen topics could be explored (Berg, 2007; Bernard, 2006; McCracken, 1988). Further, the semi-structured nature of this type of interview promoted consistency so that comparisons could be made across participant responses and patterns could emerge from the analysis.

In-depth, semi-structured respondent interviews locate meaning in situated action, not in the determination of frequency and correlation of types of communication. Identifying patterns of behavior as they are perceived and experienced by participants through interviews allows researchers to understand how communication is navigated and negotiated in symbolic practice (Bochner, 2002). Although Baxter (2006) notes the importance of observational research to advance communication theory and more “accurately” and objectively capture what is taking place in practice without the subjective filter of participants’ biases, I am more interested in exploring the impact and interpretation of the events rather than the events themselves, so respondent interviews were an ideal method to use in this investigation. Since this approach is particularly well
suited to exploring the ways in which people make sense of their lived experience and how they purposefully coordinate communication practices to create meaning, through this method, I was able to gain greater insight into how discourse surrounding their parent’s mental illness is reflective of the contradictory forces that define their experience of this stigmatized and dynamic family health issue. In other words, a strength of this method for exploring the ways in which adult children navigate having a mentally ill parent is that in-depth interviews have the potential to capture communicative behaviors and their outcomes as they are understood by and meaningful to the individuals enacting them, revealing not only strategic action, but the motivations behind the actions.

Further justifying this methodological approach, respondent interviews are particularly conducive to obtaining retrospective accounts, allowing participants to reflect and expand upon past experiences (Lindlof & Taylor, 2011). Although this study does not purposefully solicit or attempt to obtain participant’s retrospective accounts of their experience with their parent from childhood, it was expected that memories from this time would be an essential part of some participants’ narratives, meaning that the ability of the interview to fluidly move from one time period into another was important. Reiterating the fluidity of respondent interviews, Lincoln and Guba (1985) contend that they are adept at “obtaining the then and now constructions of persons, events, activities, organizations, feelings, motivations, claims, concerns, and other entities” (p. 268). Since the objective of this study is to gain insight into the ways in which adult children of mentally ill parents negotiate life events within the frame of their family member’s illness, interviews offered the flexibility to solicit narratives from the present while acknowledging the importance of the past. Allowing for participants to fluidly move from
past to present and even project into the future was necessary in order to understand how and why participants negotiate communicative strategies and the meaning that these practices have for them. Consistent with empirical research on other stigmatizing health conditions like infertility (Bute, 2009; 2013) and HIV (Greene & Faulkner, 2002), it would be difficult to attempt to observe these experiences in situ, therefore, in-depth respondent interviews enable participants to describe and reflect upon their experiences (in both past and present), communicative practices, and emotional and relational outcomes surrounding their parent’s mental illness, while offering their own subjective interpretations of these events.

Although I appreciate the strengths of qualitative interviews and the potential these methods have for illuminating my topic, I also recognize the limitations of this method. A few of the often cited weaknesses of in-depth qualitative interviews are that this method fails to offer clear and simple solutions to the questions it raises, and it lacks (but does not strive for) the ability to generalize, due to the relatively small samples and purposive sampling strategy that many qualitative researchers employ (Lincoln & Guba, 1985). Thus, in-depth interviews are often criticized for their inability to produce generalizable results that allow researchers to draw conclusions about a larger population from the sample. However, Butler-Kisber (2010) contends that the lack of generalizability is not actually a limitation of this method, but merely reflective of the assumption within the interpretive paradigm that objective truths do not exist, therefore the ability to “generalize” is a myth and is not desire or a concern of an interpretive scholar. In designing this study, the limitations of this method were acceptable to me because, although in depth qualitative interviews may lack the ability to predict, control,
and generalize, these were not my objectives. I am interested in understanding participant’s perceptions of their subjective experience as an adult who has a mentally ill parent and attempting to discover patterns and consistencies. Therefore, gaining accurate descriptions of what *actually* happened in an interaction is less important to me than the participants’ *interpretation* of those events.

Importantly then, in-depth qualitative interviews offered the potential to capture the rich, nuanced, and contextual nature of motives, practices, and outcomes as they are perceived and experienced by participants. Qualitative mental health research like that conducted by Nathiel (2007) and Foster (2010) demonstrate the utility of in depth interviews for garnering rich, contextualized data and capturing reflective accounts of participants lived experience in the context of mental illness and families. Ultimately, by acknowledging and embracing multiple perspectives and realities, qualitative interviewing is not epistemologically limiting and it offered in depth insight into situated communicative processes that would have been difficult or impossible to achieve in more quantitative, formulaic, social scientific approaches.

**Research Design**

As mentioned previously, the primary objective of this study was to attempt to illuminate the experiences and perspectives of family members of individuals who live with mental health issues. Gaining a greater understanding of the challenges, hopes, fears, and needs of this often neglected group is a critical public health issue since family members tend to serve as one of the primary sources of support and care for those with mental illness (Thompson & Doll, 1982). In the spirit of full transparency, the roots of my interest in this study and the motivation behind its design were deeply personal.
Advocating for the merits of autoethnographic research, Ellis and Bochner (2000) contend “the reflexive qualities of human communication should not be bracketed ‘in the name of science.’ They should be accommodated and integrated into research and its products” (p. 743). Although the findings presented in this dissertation are not autoethnographic, I do have a personal connection to this project, so it is important to include a reflexive note here concerning the research design and the inspiration behind the conceptualization of this project. From February to early May in 2015, I participated in a 12-week program developed by the National Alliance on Mental Illness (NAMI) in Lexington, Kentucky called Family-to-Family. According to the NAMI website, Family-to-Family is an “educational program for family, significant others and friends of people living with mental illness” and is designed to improve “the coping and problem-solving abilities of the people closest to an individual living with a mental health condition” (NAMI Lexington, 2018). I originally participated in this program not as a researcher with the intent to study it, but as an individual wanting to learn strategies for coping with a mother diagnosed with bipolar disorder. Lindlof and Taylor (2011) note that some researchers “treat their research agenda as a way to explore issues related to their biographical selves,” and this is certainly true for the etiology of this particular study (p. 77).

This particular class was the largest Family-to-Family class in NAMI Lexington’s history, with between 35 and 40 relatives of mentally ill individuals attending every week. Although exact demographics of the group were not taken, the group was comprised of a mix of parents, siblings, and children of loved ones with a mental illness. Like the mix of types of relatives, the illnesses represented were also varied, ranging
from schizophrenia, to bipolar disorder, to severe depression, to anxiety disorders. Many family members present indicated that their loved one had issues with co-morbidity, meaning that their loved one suffered from two conditions simultaneously (schizophrenia and drug abuse was common). After attending the first couple of introductory classes with my husband and hearing the rich discussions taking place between the participants of the program, with the permission of the instructor, I began to jot down general observational notes on the concerns, fears, hopes, challenges, and questions of the people involved. As Berg (2007) notes, “many people arrive at their research ideas simply by taking stock of themselves and looking around” (p. 21). Importantly, for my purposes, this endeavor did not become part of the data collection or included as part of the analysis, but was purely exploratory and, along with the literature, served as an inspirational and informational base from which to narrow my focus, draft my proposal, develop an interview guide, and anticipate conversations with future participants.

It was during this experience and through reflecting on my notes that I began to formulate the direction I wanted to take my study and the conceptual lens I wanted to use to better understand and illuminate a meaningful aspect of family members’ experience of mental illness. Specifically, it was during my participation and observation of the NAMI Family-to-Family course that I began to discover that a family member of a person living with a mental illness manages multiple, oftentimes contradictory goals and feelings related to their loved one, and this concept became a part of the design of my study, primarily by determining that I needed to solicit open-ended, narrative responses from participants in order to more fully highlight the experiences in this context that are meaningful to them, and then also in informing the types of questions that I asked in the
interview script. This is reflective of the iterative, non-linear process of research
development described by Berg (2007). For instance, an observation that I noted
numerous times during class was the struggle that participants of the program had with
the conflicting notions of the selflessness of caring for someone who was ill, and the
feeling of selfishness that accompanied their own self-care. Thus, one of my interview
questions asked participants to address if there had ever been a time that they felt
obligated to be or stay involved in their parent’s lives, and another line of questions asked
about what they might do (or have done) differently with their daily lives if they did not
have a mentally ill parent.

Another contradiction that was continually noted during this process that helped
in the design of the study and the development of the interview guide was the notion of
victimization and conviction. Throughout the duration of the course, when participants
assigned blame for their relative’s deviant behavior to the illness, they tended to identify
their loved one as a helpless victim to a ruthless disease, but when the deviant behavior
was determined to be within their family member’s purview of control, participants in the
program identified their relative as perpetrators who needed to learn a lesson and change
their ways. Participants in the program often struggled with these conflicting
perspectives, alternating between them even during a single narrative. As a result, one of
my interview questions asked participants about their perspective on how much control
they believe their parent has over their thoughts and behavior, and how in control they
feel over their own lives. Ultimately, although the actual content of the conversations that
took place in this course and my own observations were not included in the analysis, this
process and my reflections on the experience did serve an important purpose in
developing the focus of my project, and provided me with direction during the planning phase of this study, so I felt it pertinent to address.

**Recruitment**

After obtaining approval through expedited review from the University of Kentucky’s research ethics board, the Office of Research Integrity, participants were sought through the snowball sampling method, which is a method based on a series of referrals made by individuals who share some common characteristic or interest (Lindlof & Taylor, 2011). Berg (2007) notes that snowball sampling is particularly well suited to “studying various classes of deviance, sensitive topics, or difficult-to-reach populations” (p. 44). Since mental illness is still regarded as a stigmatizing condition and having a parent with a mental illness is typically not something that is visible or outwardly known by outsiders, this seemed to be an ideal way to reach participants. Additionally, it was believed that participants might have sought or found support from others in similar situations and thus would serve as a useful resource for finding additional eligible and willing participants. I began with a personal network of family and friends, which resulted in the first set of four interviews. A second round of recruitment was initiated a couple of months later. In addition to following up on referrals from earlier participants, I posted flyers at local businesses (primarily coffee shops and high traffic buildings around campus), and posted the recruitment message on social media and asked people in my network to “share” the study with their followers. Although I initially attempted to recruit participants through a NAMI newsletter and flyers posted at the NAMI Lexington location, this endeavor yielded no eligible participants; therefore, snowball sampling was determined to be a more lucrative method. In other words, referrals were received from
early participants to obtain later interviewees. Even though my recruitment methods were unsuccessful through NAMI, I did have three interviewees who had participated in the Family-to-Family program in the past, or had been involved in other capacities with the organization.

There were specific requirements for inclusion in the study. In order to participate in the study, participants had to be at least 18 years old and have a parent who had been diagnosed with a mental illness. Although participants had to be a child of a mentally ill parent, they did not have to be actively involved in their parent’s life, nor did their parent have to be living. This was to ensure that more varied perspectives and experiences were obtained, as some participants were actively involved caretakers of their parent, whereas others were not on speaking terms, had a contentious relationship, or their parent had passed away. During recruitment, I had 12 participants who I reached out to from referrals who turned me down, or who initial discussions revealed did not meet the inclusion criteria. Those participants who stated they did not wish to participate usually cited inadequate knowledge of their parent’s diagnosis and did not feel comfortable labeling them or speaking about their experiences. A few others I spoke to had concern about confidentiality, even after repeated attempts to reassure them. Additionally, I had four participants reach out to me who did not meet the eligibility requirements (e.g., the parent of a child with a mental illness, or the sibling of a person with a mental illness). In all, including those who did not wish to participate and those who were ineligible, I was in contact with 31 individuals over the course of data collection.
Sample Demographics and Biographical Information

Thus, intermittently, over the course 2 years (fall of 2016 to summer of 2018), I recruited and interviewed 15 participants—9 women and 6 men, all of who identified as a child of a mentally ill parent. Although I could have chosen to open up recruitment to any family member of a mentally ill individual, I decided to keep my sample limited to children since this particular group had not received as much attention in the literature, and to examine how the traditional role reversal that is implied with an ill parent makes this particular relationship unique. The resulting sample of participants were predominantly white ($n = 14$), and ranged in age from 25 to 63. For a more information on participant demographics, see Table 1.

**Table 1. Participant demographic information**

<table>
<thead>
<tr>
<th>Subject Pseudonym</th>
<th>Age</th>
<th>Race</th>
<th>Sex</th>
<th>Number of Siblings</th>
<th>Marital status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lily</td>
<td>29</td>
<td>W</td>
<td>F</td>
<td>1</td>
<td>Married</td>
</tr>
<tr>
<td>Peggy</td>
<td>63</td>
<td>W</td>
<td>F</td>
<td>2</td>
<td>Divorced</td>
</tr>
<tr>
<td>Hannah</td>
<td>30</td>
<td>W</td>
<td>F</td>
<td>3</td>
<td>Single</td>
</tr>
<tr>
<td>Emily</td>
<td>37</td>
<td>W</td>
<td>F</td>
<td>3</td>
<td>Divorced</td>
</tr>
<tr>
<td>Erica</td>
<td>25</td>
<td>W</td>
<td>F</td>
<td>2</td>
<td>Single</td>
</tr>
<tr>
<td>Penny</td>
<td>57</td>
<td>W</td>
<td>F</td>
<td>1</td>
<td>Divorced</td>
</tr>
<tr>
<td>Kerry</td>
<td>34</td>
<td>W</td>
<td>F</td>
<td>1</td>
<td>Married</td>
</tr>
<tr>
<td>Macy</td>
<td>41</td>
<td>W</td>
<td>F</td>
<td>4</td>
<td>Married</td>
</tr>
<tr>
<td>Sarah</td>
<td>31</td>
<td>AA</td>
<td>F</td>
<td>1</td>
<td>Married</td>
</tr>
<tr>
<td>Adam</td>
<td>55</td>
<td>W</td>
<td>M</td>
<td>1</td>
<td>Divorced</td>
</tr>
<tr>
<td>Stuart</td>
<td>30</td>
<td>W</td>
<td>M</td>
<td>0</td>
<td>Married</td>
</tr>
<tr>
<td>Eric</td>
<td>33</td>
<td>W</td>
<td>M</td>
<td>1</td>
<td>Married</td>
</tr>
<tr>
<td>Ben</td>
<td>50</td>
<td>W</td>
<td>M</td>
<td>4</td>
<td>Divorced</td>
</tr>
<tr>
<td>Will</td>
<td>33</td>
<td>W</td>
<td>M</td>
<td>2</td>
<td>Married</td>
</tr>
<tr>
<td>James</td>
<td>24</td>
<td>W</td>
<td>M</td>
<td>0</td>
<td>Single</td>
</tr>
</tbody>
</table>

Snowball sampling yielded participants from various cities across the Southeast and Midwest regions of the United States. Although I did not specifically ask participants to reveal their parents’ diagnoses, all participants did, through the course of the
discussion, identify or label their parent’s mental health issue(s). Over half \((n = 9)\) indicated that their parent was bipolar, whereas two indicated their parent was schizophrenic, and the remaining four noted that their parent had severe depression or anxiety issues. Interestingly, almost all suggested that their parent suffered from comorbidity; for instance, noting that while they might have been diagnosed bipolar, it was their lay (but informed) opinion that their parent also had an anxiety disorder, or was an alcoholic, or had some other behavioral/emotional issues. Overall, interviews revealed that the majority \((n = 13)\) of the participants in this sample were actively to moderately involved in their parent’s lives, while two were not on speaking terms with their parent. Further, two participants had lost their parent to suicide, which had culminated after a bout with bipolar disorder and severe depression, but both had been involved in their parent’s life prior to their death. Finally, most of the participants \((n = 11)\) interviewed referenced that their mother was the ill parent, while a smaller portion \((n = 4)\) identified their ill parent as their father. For a breakdown of additional subject information relevant to their biographical backgrounds surrounding their parents’ mental health, see Table 2 at the conclusion of this chapter.

**Interview Procedures**

As discussed previously, qualitative interviews were chosen for this study because they were ideal for meeting my research objectives in that they particularly well suited to “understanding the perceptions of participants or learning how participants come to attach certain meanings to phenomena or events” (Berg, 2007, p. 97). Interviews were conducted using a carefully designed interview guide, and took place at a location of the participant’s choosing. Participants were encouraged to select a location that would allow
them to feel comfortable to speak freely and privately. Options presented to the participants included private rooms in the library on the University of Kentucky’s campus, the participant or the researcher’s home, or coffee shops convenient to the participant. As selected by participants, most interviews took place at coffee shops, but a handful took place in the participants’ homes. For those interviews that took place out of the state of Kentucky, I travelled to meet the participant at a place convenient to them, and the interviews took place at coffee shops of the participants’ choosing.

Interviews were audio recorded with a digital voice recorder (Olympus Digital Voice Recorder VN-5200PC) and then I transcribed the interview recordings verbatim using the software ExpressDictate Digital Dictation. I made the decision to personally transcribe the interviews myself, rather than hiring a third party to complete the transcriptions, because I wanted to “begin the process of pulling threads of meaning out of the accumulating stories and accounts” (Lindlof & Taylor, 2011, p. 212). Through this process, I was able to “revisit powerful moments, ponder meanings that may have gone unnoticed in real time” (p. 212) and make analytical notes to myself. Interviews were conducted with a semi-structured interview guide for standardization purposes in order to compare responses across interviews, but also allowed for deviations to ask follow up questions for clarification or probe for more information. Generally, participants were asked questions related to their childhood, their relationship with their parent, their involvement in their parent’s everyday life and treatment (if applicable), their perspectives on mental illness and the role of the family, the impact of their parent’s illness on their personal, social, and professional lives, and perspectives on stigma and disclosure.
Many questions were worded in such a way to solicit specific stories and narrative examples in order to encourage participants to reflect more deeply on their experiences and highlight the meaning of these experiences for them. For instance, “can you tell me about a time that you felt any responsibility or obligation to care or look out for your relative as a result of their mental health issues?” Another example of this type of narrative solicitation was, “can you give me an example of a time or an event that his or her illness caused a shift in your relationship?” And another, “can you tell me about a specific time when you felt others’ perception of you changed as a result of your association with your parent?” The full interview guide (see Appendix A) was composed of questions that were informed by the existing literature, observations and notes from the pre-fieldwork phase, theory, and my own experiences. Questions were largely organized by theme; specifically, themes were generally derived from the major tenets of a multiple goals framework and were reflective of the notion of task goals, relational goals, and identity goals. This allowed me to explore motivations and justifications for behaviors, and to delve into related pertinent concepts like stigma, disclosure, and contradictory forces.

In an effort to “put the participant at ease and to create a climate of trust” (Legard, Keegan, & Ward, 2003, p. 143), each interview began with my own self-disclosure about my personal experience with my mother’s mental health struggles, an explanation for why I was interested in studying this topic, and how I hoped to use the information gathered to help people in the future. According to Lindlof and Taylor (2011), “by saying something about who you are—including, perhaps, your own reasons for doing the study—you can help along the equal-footing nature of the interview” (p. 196). It was also
anticipated that this opening self-disclosure might make the participants more
comfortable opening up about sensitive topics and potentially shameful experiences,

since groundwork of camaraderie and empathy could be laid. After establishing rapport
and asking a few demographic questions, interviews began with questions asking
participants to reflect on their childhood with their parent, and any specific times or
events they could recall from the past that they may have suspected their parent of having
mental health issues. Then, questions were asked relating to task/instrumental goals and
outcomes, relational goals and outcomes (both with the parent and with others), identity
goals and outcomes (including questions related to disclosure), and thoughts about the
future. Finally, every interview concluded with final thoughts about what it is like to have
a mentally ill parent, and any advice they would offer to others going through a similar
situation. Interviews always ended with asking participants if there was anything they
wanted to add that we had not covered, or to clarify from earlier in the interview.

Data Analysis

In depth interviews ranged in time from 1 hour to 2 hours and 15 minutes, with
the average interview time being approximately 1 hour and 30 minutes. Overall, in total,
interviews resulted in 26 hours and 32 minutes of interview data that generated
approximately 204 pages of text. I employed a grounded theory approach in my analysis
of the data, and the constant comparative method to identify recurrent patterns and refine
them into conceptual categories (Glaser & Strauss, 1967). Specifically, this involved
inductively coding the interview data, writing reflective memos to examine preliminary
developing themes during data collection and analysis, devising categories based on the
interrelatedness of the codes, and continually reexamining and refining the categories as
new data was collected (Charmaz, 2000; Ellingson, 2009). Inductively developed categories were the result of the patterns that emerged from comparisons made across the data, but were then compared to existing theory and literature for further refinement. My analytic process reflects Butler-Kisber’s (2010) assertion that data analysis is an iterative, complex process that is ongoing from the very start of a project.

Consistent with a grounded theory approach, data collection and analysis were occurring concurrently. One way in which I did this was by writing reflective memos, which Powers and Knapp (1990) define as a “written record of ideas and hypotheses about the data” (p. 60). Consistent with Saldaña (2013), immediately following each interview, I reflected on the interview by writing a brief analytic memo, which I then attached to the corresponding transcription upon its completion. This in process writing allowed me to reflect on that particular interview experience, including my perceptions on the overall flow of the discussion, the rapport between myself and the participant, how candid or guarded that the participant seemed to be to talk about their experience with parental mental illness, points of connection between myself and the participant, areas in which our experiences deviated, and my own musings or observations of significant aspects of the interview that I knew may not come across over the recording (e.g., nonverbal elements like facial expressions, body positioning, etc.).

Additionally, this type of analytical writing allowed me to begin the process of identifying conceptual categories, reflecting on emergent themes, and exploring the relationships between those themes (Glaser, 1978). For instance, one of my interview memos from August 15, 2017 noted how one of my participants, Emily, and I connected on the difficulties of the dual role of being a mother of young children while also being a
daughter of a parent with a mental illness. A sample of this memo is included in Appendix B. In addition to serving as a reflexive exercise wherein I could confront (and even embrace) my subjectivity and proximity to this subject matter, memos enabled me to make note of and explore resonant themes that emerged in that particular discussion. This written record allowed me to track my interpretive process and became especially meaningful when trying to find coherence and commonalities across a large number of codes. Specifically, the memo written following my interview with Emily reflects the formation of the notions of the “pull” of connection and interdependence felt toward their parent and how it is complicated by the need for autonomy to attend to other priorities.

Consistent with Bernard (2006), I transcribed the interview data myself so that I could re-experience the interview and begin to formulate ideas about potential categories and themes. While transcribing interviews, I continued the analytic process with in process writing through asides and commentaries on the interview data. This allowed me begin to muse about motivations and justifications of participants, make note of compelling stories that could serve as exemplars, and highlight recurring perspectives and experiences that ultimately helped inform the codebook (Linlof & Taylor, 2011).

As previously mentioned, I employed the constant comparative method of analysis in order to allow emergent themes to guide my interpretation of the interview data (Strauss & Corbin, 1990; 1998). This data analysis method involves working back and forth across the data in order to create, expand, and contract categories through inductive coding. Throughout this process, both open coding and in vivo coding were used in order to reflect patterns in participant perceptions and experiences (Strauss, 1987). Open coding allowed me to categorize chunks of data by their overall meaning as
I understood them in an unrestricted manner, whereas in vivo coding was used when participants’ way of describing or understanding a situation appeared multiple times across the data (Given, 2008). For instance in my initial coding of the data, after multiple participants used the phrase “it is what it is,” I used this as an in vivo code to capture the notion of resignation and acceptance of what could not be changed. I began open coding and developing a codebook as I transcribed to reflect on and catalogue those emergent themes and ideas (Auerbach & Silverstein, 2003), and subsequent readings of the transcripts resulted in a merging, reformulation, or rephrasing of codes to more accurately fit the data.

I digitally coded using the review/comment feature of Microsoft Word. Each code was identified by a single phrase as a “comment” in the right-hand corner of the transcribed page. Consistent with Saldaña (2013) and LeCompte and Schenshul (1999), for each new code that was created, on a separate document, I recorded the code name, a more detailed definition of that code’s conceptual characteristics, an example of each code, and a catalogue/listing of where each code was identified (e.g., 1.15.2 indicated this code was applied on the first interview, 15th page of the transcript, for the second time on that page). To more easily navigate locating the codes in the text, coded text in the transcript was also highlighted in a specific color associated with that code. This codebook served as a reference throughout the analysis to ensure that all data to which that code was applied fit within those conceptual constraints. For instance, the in vivo code “who else is going to do it?” was initially used to capture participants’ perception that they had no choice but to step in as caretaker for their parent since no other entity could be relied upon to fulfill those duties. As a result, the definition for this code was
“continued involvement with parent due to a perceived lack of outside support for mental illness.” Upon completion of each transcription, I re-read through the interview to gain greater familiarity with the data and to code excerpts that were overlooked as I was transcribing.

Since data collection was spread out over the course of a two-year span and took place intermittently in three sets, the initial codebook was not created in a single “round” of coding, but rather formed and refined throughout and following each “set” of interviews. For reference, the first set of interviews took place in the winter of 2017 and consisted of four interviews, the second set of interviews took place in the summer of 2017 and consisted of seven interviews, and the third set of interviews took place in the summer of 2018 and consisted of the final four interviews. During and immediately after each “set” of interviews, I transcribed and open coded using the approach outlined above, re-examining and continuing the construction of the codebook with each set. Since data for this investigation was gathered in an sporadic manner and not all at one period of time, this was especially conducive to theoretical sampling, and built in time to reflect on interviews and codes developed in earlier interviews and apply that emerging analysis to interviews collected in later sets.

For instance, prior to beginning the second set of interviews, I reviewed my previous transcriptions, memos, and codebook. In a memo I wrote before the first interview of the second set of interviews (June 10, 2017), I noted that a salient theme of the first four interviews was that children frequently explained that their parent could not control their behavior, yet expressed frustration with their parent for failing to be accountable. Reflective of an attempt to engage in theoretical sampling, this memo noted,
“…need to try to probe participants further on their understanding of control. Especially about who or what that they perceive is in control of their parent’s behavior.” Thus, even though this was not an explicit question that was initially addressed on the interview script, reflective memos like this one offered a space to muse about emergent categories and influenced future data collection by probing participants to expound when traces of these concepts were mentioned during the interview. This also enabled me to focus on and more fully develop these themes as collection and analysis were ongoing concurrently.

At the conclusion of the first “round” of coding (when all data collection was complete), the initial codebook consisted of 53 codes. A significant portion of the codebook (74%; 39 codes) was established in the first set of interviews, the second set of interviews produced 11 additional codes, and the last set of four interviews produced only three unique codes. Importantly, even though codes were renamed or re-conceptualized to capture the evolving nature of the analysis in the second and third set of interviews, a new code was developed when an idea was completely novel.

After all of the interviews were collected and the initial codebook was developed, I re-read through all of the transcribed data in order to revisit the earlier interviews and to ensure that the entirety of the codebook (including codes that were developed in later interviews) was applied to all 15 interviews. I then met with my advisor to examine and discuss the intersections of these 53 codes. Although I predominantly used inductive coding in my analysis, the existing literature, theoretical constructs, and my own assumptions and experiences that were used in the development of the interview guide inevitably acted as filters and sensitizing concepts, naturally influencing my
interpretation and organization of the data (Charmaz, 2000; Strauss & Corbin, 1998). Sensitized by the multiple goals theoretical framework that contributed to the development of the interview guide, we observed that many of the identified codes functioned as “goals,” and that, consistent with relational dialectics theory (Baxter & Montgomery, 1996), these forces were often at odds, influencing the push and pull of contradictions that defined the adult child’s experience with their parent’s illness. Although children did not specifically identify their experience as one defined by conflicting goals or relational tensions, these interpretive frameworks provided an organizational structure and added coherence to the codes, and ultimately aided in the formation of the theoretically based categories that informed the remainder of the analysis. Specifically, as codes were organized into interrelated groups based on theme, discussions and reflections on the categories revealed that they were reflective of three overarching paired themes. The three themes mirrored the three primary dialectical tensions identified and expounded upon in Baxter and Montgomery’s (1996) original iteration of relational dialectics theory: (a) integration (e.g., connection and autonomy), (b) expression (e.g., revelation and concealment), and (c) certainty (e.g., predictability and change). These tensions and the conceptual definitions of each pair were discussed in depth in Chapter Three, and provided an interpretive lens through which to give coherence and meaning to how codes were interrelated.

It was also during this discussion that I refined some of the codes and conceptual definitions that were developed while open coding in order to condense and address the conflation of some of the codes. For instance, the codes “sympathy for parent,” “exoneration of parent,” and “forgiveness of parent” were all related to absolution and
served to reinforce pulls of connection. In other words, all were rooted in the notion of victimization and a belief that the parent was pardoned for wrongdoings because he or she was a victim of a powerful disease. As a result of their common origin and overlapping nature, these three codes were combined into “parent as victim.” Similarly, the codes “hostility toward parent,” “questioning legitimacy of the diagnosis,” and “blaming parent,” were initially used to identify factors that contributed to negative emotions and beliefs related to parents’ actions, and strengthened pulls for autonomy and separation. However, upon further examination, these codes often overlapped in the data, such that, for instance, “hostility toward parent” was often also coded as “blaming parent,” and each code represented a perception of the parent as a perpetrator who should be held accountable. As a result of the shared underlying origin of these codes, they were collapsed into “parent as culpable perpetrator.”

Additionally, as codes were organized into conceptually related categories, in depth discussion and examination of the data revealed the conflation of four of the codes that were grouped under the “connection” category. The in vivo code referenced earlier, “who else is going to do it,” along with “reimbursement,” “acting as dutiful child,” and “moral imperative,” were all related to the larger sense of obligation that was implied by family membership for participants. In other words, each of these codes was representative of participants’ understanding of their role as a child and the belief that providing support was a requirement in the fulfillment of that role. Thus, these four codes were collapsed into a single category of “family obligation” in order to more accurately capture the concept that they represented. Additionally, two codes that were ultimately grouped under the theoretically derived concept of change were “disruption of life” and
“unpredictability,” but after re-reading through the data associated with these codes, it was determined that they were related to the same underlying causal concept. Specifically, the data assigned to these two codes all referenced or related to the volatility of mental illness. Thus, these two categories were collapsed into one single category called “volatile symptomology.”

After re-organizing the codes into theoretically based categories and refining the conceptualization of the codes based on the interrelatedness of the data, I coded all 15 interview transcripts for a second time using the revised coding scheme. Although I used the refined conceptual codebook in the second round of coding, I remained open to any new themes that were not considered in prior readings of the data. No new codes were added in the second round of coding, but codes did continue to expand and contract as their salience and overall frequency (or infrequency) became apparent. For instance, initially, under the category of revelation, the codebook accounted for disclosure as a means to procure informational support, instrumental support, and emotional support. But the infrequency of the instrumental support code, and the predominance of the emotional support code led to collapsing these into general term “seeking support.” See Appendix C to reference an abbreviated version of the codebook used in the second round of analysis.

Validating the analysis

As an interpretive researcher, I subscribe to the notion that meaning is intersubjective and is co-constructed through our interactions with others and the world around us. Expanding on the intersubjectivity of meaning, Ellingson (2009) notes that meaning does not exist outside of us, or even in any one person, but between people who continually renegotiate it. As such, the collection and analysis of this data was a product
of this co-construction of meaning. Darling-Wolf (2004) suggests that “objectivity is a particularly clever myth” (p. 33) and value-free research is impossible. It may be argued that this is especially true in a case where the researcher is exploring a topic that has deep personal relevance and connection to their own life, as is the case with the present study. However, interpretive researchers should still strive to accurately reflect the lived experiences of their participants, so I strived to engage in reflexivity throughout the development of the interview script, data collection, and coding process in order to make sure that my interpretation of the data was reflective of participants’ perceptions and not merely a product of my own biases. Although I took steps to be reflexive and transparent and place participants’ perceptions and experiences at the forefront of the analysis, ultimately I was responsible for framing and interpreting participants’ words, so I wanted to make additional efforts to ensure that my interpretations were valid and accurate.

One qualitative analytical tool that I used in order to confirm that I was not drifting away from participants’ perspectives in my analysis was conducting member validation checks. Member validation checks involve the researcher going back to the participants to confirm that the interpretation of the data provided by the researcher reflects participants’ subjective realities and lived experience (Lewis-Beck, Bryman, & Liao, 2004). I attempted to use member checks in both my data collection procedures and in my analysis. First, my participation in the 12-week NAMI Family-to-Family course helped to serve as a member validation check, informing the development of the interview guide to ensure that it addressed salient issues for participants during data collection. More specifically, participating in the Family-to-Family course allowed me to
make note of common concerns of family members, which helped form the basis of the major theoretically driven themes in my interview guide.

Second, following my second round of coding and after developing my initial themes, I reconnected with a random selection of seven of the participants and asked if they would be interested in providing me with feedback on some of my initial findings in order to verify that they recognized my analysis as true or accurate of their experience. I wanted to be reflexive in my process of data collection and analysis so that, should it be discovered that my questioning in the interview guide or my coding of the data had “drifted away from the realities” of participants (Lindlof & Taylor, 2002, p. 222), I could incorporate informant feedback into the analysis. After all seven agreed to participate in this follow up, I emailed each a summary of my developing themes. This email and summary is provided in Appendix D.

Some responses from the participants provided general commentary on the analysis as a whole, whereas others made a number of specific comments about the themes and sub-themes. For example, in response to the expression tension and the factors motivating concealment, Emily noted:

I think I did try to conceal his illness from others for a long time because of the stigma. I knew of no one who could conceive of what I was going through to talk to about it with, and felt that people who didn’t understand it would jump to uninformed judgments and stereotypes.

Participants’ feedback was largely affirmative and validated my interpretive framework. Some participants suggested ways in which their own experience deviated from my analysis, but they would then acknowledge that it had been true for them at one point in time (even if it was not resonant with their current experience), or ultimately acknowledged that it may be true for them, but that this analysis presented a new way of
framing it. Since my small sample size was conducive to me reaching out to all of the
participants, on the recommendation of my committee members, I sent a member check
request to the remaining eight participants after drafting this dissertation. I received
detailed responses back from five of those additional participants, and one participant
responded with a few sentences validating the analysis as a whole without offering
specifics. Kerry’s email stated,

The way you’ve laid it out is really true for me. I’m always conflicted about my
mom. I want to be there for her and feel guilty when I’m not, but I’ve got my own
life. It’s interesting that I’m not the only one who feels that way and that a lot of
other people deal with the same things I do.

Additional samples of more detailed commentary from participants can be found
in Appendix E.

Evidence of saturation

In another effort to demonstrate the validity of my analysis, I discuss and provide
evidence of reaching saturation in my interview data. The achievement of saturation is
the goal in any qualitative research that uses a Grounded Theory approach, and is one of
the primary ways to demonstrate the trustworthiness and credibility of the findings
(Charmaz, 2006). In qualitative research, it is one way “to inspire confidence in readers
(and themselves) that they have achieved a right interpretation” (Lindlof & Taylor, 2011,
p. 274) and is evidence of methodological rigor. Theoretical saturation “refers to the
point in data collection when no additional issues are identified, data begin to repeat, and
further data collection becomes redundant” (Hennink, Kaiser, & Marconi, 2016, p. 2).
Although saturation is a benchmark of Glaser and Stauss’ (1967) Grounded Theory
approach, in their review of 24 qualitative research textbooks and seven databases, Guest,
Bunce, and Johnson (2006) concluded that qualitative methods literature inadequately
operationalizes this concept, “providing no description of how saturation might be
determined and no practical guidelines for estimating sample sizes for purposively
sampled interviews” (p. 60). Furthermore, there is no consensus in the literature
regarding the number of participants needed to achieve saturation in qualitative studies,
with some researchers suggesting it can be reached with as few as six participants (Kuzel,
1992; Guest et al., 2006), and others suggesting that anywhere from 15 participants
(Bertaux, 1981) to 36 participants (Bernard, 2000) is necessary.

Even though saturation serves as and “is the most frequently touted guarantee of
qualitative rigor…it is the one we know least about” (Morse, 2015, p. 587). The lack of
clarity on this concept is reflected in qualitative studies, where saturation is frequently
claimed without support or justification, which ultimately renders the phrase “reaching
saturation” meaningless (Hannink et al., 2016). In an effort to provide clarity and
transparency on how and why I claim saturation was reached in the present study with a
sample of 15 participants, I discuss literature that demonstrates the adequacy of this
number to achieve saturation, and then apply the guidelines outlined in those
methodological studies to the current investigation in order to document my analytical
process and provide justification for claims of saturation.

Although I had a small number of participants, it is not impossible to achieve
saturation with a small sample size. In fact, in their analysis of 60 in depth interviews,
Guest et al. (2006) found that 80 of the 109 total codes (73%) were developed in the first
six interviews, and by 12 interviews, 100 of the 109 codes (92%) were developed.
Emphasizing the stability of their codebook early in data analysis, they note, “the full
range of thematic discovery occurred almost completely within the first twelve
interviews” (p. 66). Guest et al.’s (2006) findings on codebook development have been replicated elsewhere. For instance, in their analysis of 25 interviews, Hennink, Kaiser, and Marconi (2016) report that 84% of their 45 codes were developed by interview six, and 91% of codes by interview nine. Moreover, they note that code definitions were stabilized by interview nine, with 92% of any changes to code definitions made by that point in the analysis process. Similarly, in the present study, 39 of the original 53 codes in the initial codebook (74%) were established in the first set of four interviews, and only three codes were added from the last set of four interviews. Thus, my codes were well established by the time I began my final set of interviews, with 94% of the initial codebook resulting from the first two sets of interviews ($n = 11$).

Moreover, Guest et al. (2006) argue that the absolute number of times a code is identified across a data set is of less importance in establishing its overall thematic significance than how many individual participants expressed the same idea. Thus, they equate thematic prevalence to code frequency, and operationally define it “as the proportion of individual interviews to which a code is applied” (p. 72). They suggest that in their analysis, codes that were applied with high frequency in early interviews maintained their high frequency throughout, and furthermore, that 97% of the high frequency codes had already been identified after 12 interviews. This suggests that “in terms of the commonly expressed themes…very little appears to have been missed in the early stages of analysis” that would have only been discovered with more interviews (p. 73). This is not to discount or dismiss the analytical benefit of larger qualitative sample sizes, but merely to demonstrate that saturation is possible with a smaller number of participants. Moreover, having a relatively homogeneous sample and theoretically guided
research where a researcher is interested in targeted, overarching themes may reach sufficient saturation with a smaller number of participants, especially when in process memos and variations of theoretical sampling are utilized (Aldiabat & Le Nevenec, 2018). Guest et al. suggested that this could be accomplished in as few as six interviews, and has been documented in a sample of eight interviews (Aldiabat & Le Nevenec, 2018).

In the current study, codes occurred with high frequency early in the interviews and were consistently applied throughout. For instance, some categories, like that of the stigma of mental illness, victimization and exoneration (parent-as-victim), lack of control due to the volatility of the illness, and lack of control due to institutional barriers were developed from codes that were expressed by all 15 of the participants. Other categories were expressed by as many as 13 or 14 of the participants: familial obligation (87%), perpetration and conviction (parent-as-perpetrator) (93%), disclosure for emotional support (93%), and anxieties about the genetic link (87%). Of all of the categories, the only one that was mentioned by fewer than eight people was advocacy and mentorship (as a justification for disclosure), which was only mentioned by four total participants (27%). Moreover, of the 21 categories presented in the analysis, 16 of those categories were coded in at least ten of the 15 participant interviews. This means that 76% of the categories were present in at least 67% or more of the sample. For a more detailed breakdown of the prevalence of the themes presented in the analysis, see Appendix F.

Importantly, however, there is a difference between code saturation and meaning saturation. Unlike Guest et al. (2006), Hennink et al. (2016) argue that although nine interviews was “sufficient to identify the range of new issues raised,” more interviews
were needed to “capture all dimensions of the code to fully understand the issue” (p. 10). In their analysis, the point at which a code reached meaning saturation varied, with some codes being captured from all dimensions by the ninth interview, while others required more interviews to be fully understood (between 16 and 24 interviews). Thus, even though a code may be identified in an earlier interview, it requires multiple interviews to capture all dimensions of the code to fully understand the issue. The argument is that even if a code is established early, replication of the code over the course of multiple interviews does more than hint at its importance, it can also reveal different facets and properties of a single code.

Applying this logic to my study of 15 participants, although the prevalence of a code certainly does not indicate that it is of absolute thematic importance in understanding the research question(s), it does suggest, in this conceptualization of meaning saturation, that multiple dimensions of a single code have greater possibility of being revealed with each participant who independently expresses it, thereby gaining a more comprehensive view of the concept. Given that 76% of my categories were coded (most of them multiple times) in at least ten interviews (67% of the sample), I feel confident that I was able to capture multiple properties of each overarching theme and sub-theme I discuss because they were identified consistently and with high frequency across my sample. Moreover, 12 of the 21 categories were addressed in 80% of the interviews. As previously discussed, by the third set of four interviews, only three new codes were created, and those codes that appeared with a high frequency in previous interviews continued to be significant in the final four interviews.
A Reflexive Note on Positionality

In her reflective essay on how her own personal experiences and her academic pursuits have come to affect and reflect one another, Bute (2011) invites other scholars “to engage in ongoing conversations about what drives our research interests, how those forces shape our approach to scholarship and the implications such issues have for those of us living the life of the mind” (p. 105). Moreover, Darling-Wolf (2004) contends that scholars need “too keep on developing a more theoretically sophisticated understanding of the significance for our research of the fact that we all embody multiple selves and multiple positions” (p. 40). Emphasizing the importance of reflexivity, Butler-Kisber (2010) suggests, “in qualitative inquiry, no apologies are needed for identity, assumptions, and biases, just a rigorous accounting of them” (p. 19). Thus, as a budding qualitative scholar, positioning myself within the research and identifying experiences that have shaped my own perspectives is a necessary reflexive practice, and one that I have attempted to outline in detail below.

As previously explained, one inspiration for this research project was my own mother’s battle with mental health issues throughout my adult life. From 2010 to 2012, my mom experienced a severe episode of major depression. During this period, she had two suicide attempts, would only leave the house when necessary, and refused any medication or treatment. In the spring of 2012, my family was able to convince her to go to an outpatient treatment program, where she attended full day group therapy and was put back on a pharmaceutical regimen by a monitored by a physician. Upon completion of the program, she appeared to have returned to her “old” self, but unbeknownst to us at the time, she was misdiagnosed with and being treated for major depressive disorder
when she was actually bipolar. Because of this misdiagnosis, she was not receiving the correct medications, so she was showing early signs of mania. It was at this time that my father passed away unexpectedly, launching her into a full manic spiral. She became increasingly more manic over the course of a two and a half year period where she was arrested at least once, extravagantly spent money nearing the point of bankruptcy, got caught up in a catfishing scam, hoarded to the point that her house became uninhabitable, and ultimately put herself and others in such danger that my sister and I were forced to obtain a court-ordered conservatorship over her. 

Ultimately, we were able to get her admitted to a 90-day treatment facility where she underwent intensive therapy and medication regulation under the supervision of a team of doctors. In the years that have followed this treatment, she has experienced varying degrees of depression, but has recently agreed again to outpatient therapy and taking medication for bipolar disorder. Over the course of the last year, her mental health has shown some improvement, and my sister and I are less actively involved in the maintenance of her health and daily routine.

Due to my deeply personal connection to this topic, at times throughout this process, I struggled to find a balance between distancing myself from my participants in order to draw more unbiased conclusions while also recognizing—and even embracing—how my positioning was influencing the inquiry. Interestingly, I believe my connection to this topic has been an advantage and has aided me in gaining more honest and open perspectives from my participants. In addition to informing what and how to ask questions of my participants, my unique positioning as a person who has “been there” created a natural sense of trust and rapport between myself and my interviewees. On
multiple occasions, I had participants comment during the interview about how much easier it was to talk to an empathetic person who could relate to their experiences. For instance, many times during the course of an interview, a participant would often comment on specific experiences they have had with their parent that they identified as embarrassing, shameful, upsetting, and/or frustrating, and in almost every instance, I was able to relate. A number of participants noted about how that shared experience caused them to feel more at ease and less alone, with one interviewee suggesting that she felt that I had “been in the trenches” with her.

Although I did make every effort to stick to the interview guide and minimize disclosures about my own experiences throughout the interview in an effort to avoid inadvertently influencing their responses, I did intentionally open each interview with a brief explanation about my objectives and personal connection to this project. Additionally, at the conclusion of many of my interviews, participants ended by inquiring about how my mother was doing now and other things related to my experience. Bernard (2006) notes that even after the official part of the interview ends, researchers should leave their recorder on because “even though you’ve finished…your respondent may have more to say” (p. 228). I discovered during this process that I should keep my recorder going even after I finished asking questions because their questions and my disclosures would often lead to reciprocal disclosures and interesting discussions.

My position as an adult child of a mentally ill mother also provided me with a unique perspective on the lives of my interviewees. For instance, I was able to relate to the stigma participants often felt surrounding their family members’ illness. I was also able to empathize with participants as they identified many of the challenges and
anxieties they had experienced in the face of their parents’ mental and behavioral health struggles. I was also able to understand when participants noted that it was difficult to separate their own lives and priorities from their parents’ needs. Interestingly, throughout our discussions, we also found points of humor and shared laughs over moments that others outside of the experience may have been unable to find funny.

Conclusion

In summary, qualitative respondent interviews work well for this project because my objective is to understand how adult children of mentally ill parents make sense of their lived experience, and to illuminate patterns and shared perspectives that influence communication in this context. Throughout the recruitment process I was able to conduct in depth interviews with 15 adults, all of who had parents with mental and behavioral health issues. My position as someone with a bipolar mother informed the research process throughout, and required me to remain diligent in my reflexive efforts. In the following three chapters, I will offer a summary and analysis of the interview data, identifying and exploring recurring themes formed around major tensions in relational dialectics theory (Baxter & Montgomery, 1996).
Table 2. Participant Biographical Information

<table>
<thead>
<tr>
<th>Subject Pseudonym</th>
<th>Parent (M=mom D=dad)</th>
<th>Parent’s current health status &amp; marital status</th>
<th>Parent’s diagnosis</th>
<th>Age when child became aware</th>
<th>Child’s current relationship/role with parent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lily</td>
<td>M</td>
<td>Living, active treatment,* Widowed</td>
<td>Bipolar disorder; major depression</td>
<td>Early high school</td>
<td>Actively involved in activities of daily living, including, but not limited to maintenance of house, personal hygiene, and vehicle, coordination of social activities, regular check ins on treatment routine, addressing urgent matters.</td>
</tr>
<tr>
<td>Peggy</td>
<td>M</td>
<td>Living, no treatment,** Divorced</td>
<td>Bipolar disorder; Alcoholism</td>
<td>Late primary school</td>
<td>Actively involved in activities of daily living, including, but not limited to paying bills, travel, stocking of groceries, delegating and disseminating tasks among siblings, diffusing and handling conflicts that arise with others.</td>
</tr>
<tr>
<td>Hannah</td>
<td>D</td>
<td>Deceased (suicide) Married</td>
<td>Bipolar disorder; Alcoholism</td>
<td>Early 20s</td>
<td>Was actively involved socially, including, but not limited to frequent check ins via phone and in person, which increased in frequency over progression of the disease until death. Actively involved in devising and executing treatment plan before death.</td>
</tr>
<tr>
<td>Emily</td>
<td>D</td>
<td>Deceased (suicide), Married</td>
<td>Bipolar disorder; Alcoholism</td>
<td>Early 30s</td>
<td>Was involved socially, including, but not limited to daily check ins via phone with open, intimate, and confidential conversations, and an affectionate and supportive relationship. Intervened during crises.</td>
</tr>
<tr>
<td>Name</td>
<td>Gender</td>
<td>Living Status</td>
<td>Diagnosis</td>
<td>Illness Onset</td>
<td>Relationship Details</td>
</tr>
<tr>
<td>-----------</td>
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<td>----------------------------------</td>
<td>---------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Erica</td>
<td>M</td>
<td>Living, no treatment, Divorced</td>
<td>Schizophrenia; Alcoholism; Drug Abuse</td>
<td>Early childhood</td>
<td>Involved socially with regular check ins (2-3 times a week). Relationship conducted long distance with an average of 3 or 4 face-to-face visits a year.</td>
</tr>
<tr>
<td>Kerry</td>
<td>M</td>
<td>Living, active treatment, Widowed</td>
<td>Bipolar disorder; Major depression</td>
<td>Early 20s</td>
<td>Actively involved in activities of daily living, including, but not limited to paying bills, daily check ins via text or in person, maintenance of house, car, and appearance, coordination of social activities.</td>
</tr>
<tr>
<td>Penny</td>
<td>D</td>
<td>Living, no treatment, Divorced &amp; remarried</td>
<td>Bipolar disorder</td>
<td>Middle school to early high school</td>
<td>Involved socially with sporadic check ins. Relationship conducted long distance and primarily over the phone with 1 to 2 face-to-face visits annually, with some periods of estrangement.</td>
</tr>
<tr>
<td>Macy</td>
<td>M</td>
<td>Living, active treatment, Married</td>
<td>Bipolar disorder</td>
<td>Late teens, early 20s</td>
<td>Socially close, “best friend” relationship. Daily check ins on things mostly unrelated to illness. Has in the past been central in plan and execution of treatment in response to crisis events.</td>
</tr>
<tr>
<td>Sarah</td>
<td>M</td>
<td>Living, active treatment, Widowed</td>
<td>Major depression; Anxiety</td>
<td>Early college (late teens)</td>
<td>Actively involved with regular check ins. Helps with some activities of daily living, especially during times of crisis.</td>
</tr>
<tr>
<td>Adam</td>
<td>D</td>
<td>Living, no treatment, Divorced &amp; remarried</td>
<td>Bipolar disorder</td>
<td>Middle school</td>
<td>No longer speaking to parent, and not on good terms.</td>
</tr>
</tbody>
</table>
Table 2 (continued). Participant Biographical Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Gender</th>
<th>Living Status, Relationship Status</th>
<th>Diagnosis</th>
<th>Age at Onset</th>
<th>Treatment Status</th>
<th>Treatment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stuart</td>
<td>M</td>
<td>Living, no treatment, Divorced</td>
<td>Major depression; Anxiety</td>
<td>Early high school</td>
<td>Actively involved in activities of daily living, with contact averaging 2 to 3 times a week. Helps to pay bills, manage house, and provide transportation.</td>
<td></td>
</tr>
<tr>
<td>Eric</td>
<td>M</td>
<td>Living, active treatment, Married</td>
<td>Schizophrenia; bipolar disorder</td>
<td>Late 20s</td>
<td>Regular contact, but not daily. Stays geographically close to help mother when needed, but no longer needed to complete tasks of basic functioning. Monitors and helps to oversee adherence to medications.</td>
<td></td>
</tr>
<tr>
<td>Ben</td>
<td>M</td>
<td>Living, no treatment, Divorced</td>
<td>Bipolar disorder</td>
<td>Early childhood</td>
<td>No longer speaking and not on good relational terms since his mother denies she is ill and refuses treatment.</td>
<td></td>
</tr>
<tr>
<td>Will</td>
<td>M</td>
<td>Living, no treatment, Widowed</td>
<td>Major depression; Anxiety; Alcoholism</td>
<td>Early college (late teens)</td>
<td>Regular contact, but not actively involved on a daily basis. Goes through periods of active involvement during crisis events, and assists with instrumental tasks when called on to do so.</td>
<td></td>
</tr>
<tr>
<td>James</td>
<td>M</td>
<td>Living, active treatment, Divorced</td>
<td>Major depression; anxiety; obsessive-compulsive disorder</td>
<td>Early childhood</td>
<td>Regular contact, with moderate levels of involvement and intervention (as needed but not daily). Does help to monitor and oversee adherence to treatment, and in communication with mother's psychiatrist.</td>
<td></td>
</tr>
</tbody>
</table>

*Active treatment is operationalized as regular maintenance of mental health provider visits; general compliance with recommended medication regimens.

**No treatment is operationalized as not currently seeing a mental health provider and not taking medications. It does not mean that they have never sought treatment, just that they are not presently undergoing any form of therapy.
Chapter Five: Analysis of the Dialectic of Integration

Introduction to the Analysis

When an individual is ill, family members are one of the first and primary lines of support. When the ill person is a parent, the responsibility for support and caretaking may fall to their children, especially if the person is without a spouse. The concept of a child providing care to a parent conflicts with traditional notions of what these roles entail, and instances in which the child-becomes-parent are therefore naturally wrought with complications and contradictions (Aldridge, 2006; Foster, 2010). Thus, although interview questions were focused on and structured around exploring the multiple goals of adult children with a mentally ill parent, emergent themes in children’s perspectives and discursive practices revealed a larger phenomenon grounded in dialectical tensions.

Specifically, data revealed that adult children of mentally ill parents experience seemingly opposing tensions in the enactment of their identity, relational, and instrumental goals. The interplay of these dialectical forces is prominent and powerful in shaping their discursive practices surrounding and with their ill parent, and illuminate the multiple goals they manage in the face of what can be, in the words of Ben, the son of a mother with bipolar disorder, “an emotional rollercoaster.” The tensions experienced by the adult children interviewed for this study mirrored those developed by Baxter and Montgomery (1996), thus, relational dialectics theory was used as a sense-making framework to understand this complex and multifaceted experience, while a multiple goals perspective buttressed this framework by providing insight into the source of these tensions and how they manifest in communicative practice. Put another way, multiple goals contributed to the dialectic discursive interplay between these contradictory, yet
unified forces, and these tensions had implications for adult children of mentally ill parents’ perception of self, how they enacted their relationships, how they made daily decisions, and how they planned for the future. First, in this chapter I will explore the contradiction of integration (connection-autonomy). In Chapter 6, I will discuss the contradiction of expression (revelation-concealment), and in Chapter 7, I will discuss the contradiction of certainty (predictability-change). For an overview of the analysis, see Table 3, provided on the next page, which briefly outlines each contradiction and the forces and goals that influence the interplay of the tension.
Table 3. Summary of Analytical Themes

<table>
<thead>
<tr>
<th>Contradiction</th>
<th>Centripetal Force</th>
<th>Contributing Pulls</th>
<th>Centrifugal Force</th>
<th>Contributing Pulls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integration</td>
<td>Connection</td>
<td>Autonomy</td>
<td>Social Expectations</td>
<td>Pursuit of relational &amp; instrumental goals</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Familial Obligation</td>
<td>Identity Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nostalgia for the Past and Hope for the Future</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Victimization &amp; Exoneration</td>
<td>Perpetration &amp; Conviction</td>
</tr>
<tr>
<td>Expression</td>
<td>Revelation</td>
<td>Concealment</td>
<td>Emotional Support</td>
<td>Stigma</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Advocacy &amp; Mentorship</td>
<td>Anticipated Lack of Empathy &amp; Support</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Saving own Face</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Saving Parent’s Face</td>
</tr>
<tr>
<td>Certainty</td>
<td>Predictability</td>
<td>Change</td>
<td>Acceptance &amp; Resignation</td>
<td>Lack of Control due to Volatility of Illness</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Patterns &amp; Agency</td>
<td>Lack of Control due to Restrictive Institutions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Behavioral Patterns</td>
<td>Anxiety about Parent’s Future</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Internal Strength</td>
<td>• Security</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Suicide</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Anxiety about own Future</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Genetic link</td>
</tr>
</tbody>
</table>
The Dialectic of Integration: Connection

From a relational dialectics perspective, the dialectic of integration centers on the discourse surrounding the need for connection, assimilation, intimacy, and interdependence on one side and the simultaneous, but contradictory need for autonomy, distance, separateness, and independence on the other (Baxter & Montgomery, 1996). The adult children of mentally ill parents that I interviewed felt inextricably tied to their parent and obligated to maintain that connection due to the values implied by family membership, pressure from third parties, hope for the future, and a belief that their parent was a victim of a disease and required their support to fight it. This side of the tension and the forces and goals that underlie its management are referred to as connection in this study. However, at the same time, these children felt a strong pull for autonomy and a desire to live a life free from the constraints, shame, and limitations that could accompany having a mentally ill relative. This side of the tension and the forces and goals that underlie it are referred to as autonomy in this study. The ongoing interplay of the tension between connection and autonomy were apparent not only in their discussions with me, but also in how they described the communication patterns and practices they engaged in with and as a result of their mentally ill parent. The intricacies of this tension, and the identity, relational, and instrumental goals that underpin it are explored in the sections below.

Connection: Social expectations.

One of the underlying factors that influenced adult children of mentally ill parents pulls toward connection was social pressure they perceived from others and the identity goals that were tied to those expectations. Social pressure is related to the belief that
others expected them to “take care” of their family member and “handle” issues arising from their relative’s illness. This is consistent with Greenberg, Kim, and Greenley’s (1997) findings that family members’ concerns over their relative’s adherence to treatment is in part due to the belief that they would be blamed by others for relapses and the belief that other people saw them as a responsible party. Lily, a daughter of a mother who has bipolar disorder, lamented the social pressure she felt to stay involved in her mother’s care, noting that she felt as if she really did not have a choice in her involvement because people in her small town wouldn’t let her not be involved. She said that this was an explicit expectation, saying that “they would reach out to me when they’d see her acting strangely, or when she wouldn’t pay her bills or whatever, and it was expected that I do something about it.” Thus, even if she felt she did not want to be involved, she often felt she had no choice because she was pulled back in by the expectations of others.

Peggy, the daughter of a bipolar mother, also says she receives weekly phone calls about her mother’s aggressive interactions with fellow residents of her apartment building. This external pressure felt by children to “fix” the problems created by their mentally ill parents was especially prominent when the parent was without a spouse, whether because of divorce or death, because they were “next in line for the throne,” joked Will, whose depressed mother had lost her husband over five years ago. Eric, son of a schizophrenic mother, reflected on a time when he was approached at a party by his mother’s neighbors who were upset about the dilapidated and disordered state of her house. He noted he “was cornered” and “was basically told—not asked—that it needed to get cleaned up.” In response to this interaction, he said that he and his sibling went over
the next morning to work on it because they did not want his “mom’s problems to be causing other people problems.”

This sense of social expectation kept those who might have preferred to distance themselves from their parent inextricably tied to them. Kerry, whose mother had major depression and now bipolar disorder, said this pressure was so palpable that she chose to take a proactive, hyper-vigilant approach and try to anticipate what others’ issues might be with her mother before they occurred. She explained, “I’d rather try to remedy that before I hear from third parties who just like to be in your business.” For those participants who remained actively involved in their parent’s life, the external demand from others was a powerful force that was often motivated by identity goals; more specifically, the desire to be seen as a dutiful or devoted child. Or, at the very least, not be perceived as a neglectful one. Lily sums up these identity concerns noting, “honestly, selfishly, it reflects poorly on me if her wellbeing isn’t stable. People wonder, ‘why are her children not doing anything to help her?’ Or, ‘why would they let her do this or act this way?’

Sarah, the daughter of a mother with major depression, echoed this sentiment suggesting that “whatever her state of being is at the time reflects upon me and who I am as a daughter. If she’s not maintaining things in her life, it falls to me and I don’t want to be seen as negligent.” The perceptions others had of them were sometimes forefront in their mind and, although the cause for some anxiety, were also powerful forces contributing to pulls of connection. Even though many participants said they did not know exactly what others thought about them and the role that they took (or did not take) in their parent’s life, they wondered if they were seen as a sympathetic figure. Kerry
feared that others’ perceptions of her were dependent on her active and visible presence, noting:

I always wonder if people think, ‘oh, they’re not around enough’ or ‘they don’t do enough for her to maintain her appearance or her relationships or her house,’ or whether they think, ‘we don’t blame them at all, we wouldn’t want to come home to this all the time either.’

Thus, adult children were often managing others’ impressions in prioritizing forces of connection. This is reflective of and motivated by underlying identity goals, or efforts to present a certain image of themselves to others.

**Connection: Familial obligation.**

The idea that children had an obligation to care for their parents was one of the most prominent themes throughout the interviews. This obligation was reflective of a moral imperative and duty that was implied by family ties. In other words, for many participants, that was perceived as “just a part of what it means to be family” and sometimes framed as indebtedness, specifically for care provided to them as a child. Peggy summed up the feelings of many of the individuals interviewed saying:

She’s my parent. She’s my mom. If I don’t look after her, she’ll be homeless on the street. She took care of me when I was a baby, and it’s part of the circle of life. I just had to start my circle earlier than most people.

As Peggy indicated, at times this feeling of obligation to parents was rooted in a notion of reciprocity and reimbursement for the care they were provided when they were younger. Indebtedness was one of the roots of children’s sense of obligation to stay connected and involved, especially when their parent’s illness manifested later in life.

When her dad’s illness escalated and he began exhibiting suicidal tendencies, Hannah drove two hours back and forth every other day from where she was living and
going to graduate school to her hometown in order to support her mom. When asked why she did this, she stated:

I just didn’t see any other option. This is my dad. And he’s given me everything, and provided for me, and loved me. I never considered anything different. I had an abiding appreciation and love for my parents and I never considered an alternative to doing whatever I had to do to help.

Lily also pointed to familial obligation as the reason she felt pulled toward a close involvement with her mother despite the emotional turmoil she felt she’d caused: “She’s my mother and we would do anything for those we love and care about. Just like I hope I would do if someone I loved got cancer.” Interestingly, participants frequently compared having a mental illness to having cancer, in both an effort to demonstrate the similarities in the need for support, and to contrast how the general public perceives the two types of illnesses.

These relationships do not occur in a vacuum and thus it is impossible to separate them from the context in which they occur. The connection felt by adult children is associated at least in part with the deinstitutionalization of mental healthcare in our country and the public perception that the family are the primary caretakers of mentally ill individuals (Thompson & Doll, 1982; Lefley, 1996). Of the 15 people interviewed for this study, 10 either directly or indirectly alluded to the lack of professional support available to them and how that contributes to their burden and obligatory connection to their parent. This is consistent with research that demonstrates family members are generally dissatisfied with the support they receive from the mental health care system (Doornbos, 2002). Peggy, who has breast cancer and was going through chemotherapy at the time of this interview, used the support she’s gotten for that illness as a point of
comparison, saying that although mental illness is chronic, mental illnesses do not receive
the same levels of support from the community. She expounds:

Everyone is out in left field because there is no outside support. I have cancer and
the American Cancer Society will call me and check in on me. But with mental
health issues, nobody calls and checks in, especially with the family. No one is
there to relieve you of your burdens or take up the cross for you. You have to
carry it. You’re left to figure things out for yourself.

Similarly, Will, whose mother struggles with comorbidity of major depression,
anxiety, and alcoholism echoed the burdensome nature of familial responsibility and the
general feeling of alienation of family members by the mental health care system noting:

There’s really not a lot of places you can go for help, especially when they’re not
suicidal. It’s just you, and a lot of the time with mental illness, you’re dealing
with a person who doesn’t think logically, and may not even believe they’re sick,
so good luck finding any help.

Feeling as if they were one of their parent’s few sources of support added to adult
children’s sense of obligation and personal responsibility, and resulted in a greater sense
of connection and interdependence. Macy, whose mother is being treated for bipolar
disorder, echoed these sentiments and made a point to say that even if she needed
someone or something to take part of the responsibility over for her,

There’s nothing—there’s nothing that’s available to relieve me. It’s not like meals
on wheels or something where someone will be there to take care of things if I
don’t. With mental illness, it’s on the family. And, lucky me, I’m the family.

Feeling as if they could not depend on the healthcare system, many of the adult
children managed the integration dialectic by prioritizing familial interdependence and
connection. The instrumental goals related to their parent’s care and wellbeing (other-
focused) were made primary over self-focused instrumental goals that may favor and
enable greater levels of autonomy.
Over half of the participants interviewed for this study were actively involved in their parent’s treatment or were a participant in their daily activities of living. Some, whose parents were receiving effective, regular treatment, noted that it was an effort to maintain that well state-of-being. Maintaining her mother’s wellness had become a central part of Lily’s day-to-day routine because “we’ve been there where we’ve let things fall into disrepair, and it’s much easier to be in a state of maintenance and be proactive about it than it is to be reactive and try to fix all of the mess.” When parents refused treatment, the demands of the illness necessitated that they be “on call” and consider their parent in their daily schedule (Rolland, 1994). For these individuals, the integration tension was managed through the praxis of alternation, where connection was prioritized over autonomy during times of crisis, and they remained in a kind of limbo between autonomy and connection in between crises. Stuart, whose mother suffers with major depression and anxiety said,

I literally have to include her in my plan every day. She’ll call and say, I need this or I need that, and I may not drop what I’m doing right away, but at some point, I have to make sure that she gets what she needs. She’s like my special needs child like that.

Even those who do not consider themselves active participants in their parent’s treatment or daily life do feel the need to check in regularly and to help them when they ask for it. Erica tries to text or talk to her mom at least every other day in an effort to be proactive and head off any potential problems before they compound. She explains:

I don’t do this because I enjoy talking to her or because I need something from her—in fact, it’s the opposite. I text her because I think maybe that contact will keep her from dipping back into a bad place. She’s come a long way and I don’t want her going backward.
Interestingly, even though Erica said she checks in with her mom nearly every day and helps her out financially when she needs food and other necessities, in the same sentence, she said that she does not feel like it is her responsibility to look out for her mom. Many children of mentally ill parents struggled with the role reversal that came with having an ill parent, but even when they claimed to not take responsibility for their parent—like Erica—their actions (and justifications for those actions) told a different story.

Those who were still involved in their parent’s lives acknowledged the desire for a life that greater separation would allow, but the sense of duty and obligation to their parent was so strong that they would deny or ignore those opportunities. Now in her 30s, Lily acknowledged that there are things, like going back to school or taking a job out-of-state, that she “dismissed as options” and “didn’t even consider” because she needed to stay in close proximity and be available to help the rest of her family with her mom. In explaining the decisions she made to not pursue other more “selfish” options during what is normally a decade of life notorious for being self-centered, she said, “I would really be burdening everyone else if I left.” At a time when many of her peers were building their own lives, she said, “I just needed to be here to keep hers [mom’s] from crumbling.” These decisions are reflective of how other-focused instrumental goals could inhibit the pursuit of self-focused instrumental goals, and influence the interplay of the dialectic between connection and autonomy.

Prioritizing the connection end of the spectrum left many participants feeling trapped or “stuck,” and this was a common theme among participants. While her father was struggling with severe depression and psychotic episodes, Hannah moved home to help support her mom in managing his illness, which she said, “is something I never
wanted to do. I was eager to explore my options.” Adult children would frequently reference missed opportunities but rationalize that those things were not “real” possibilities because they felt responsible for their parent. Even after her father’s suicide, the pull of interdependence and connection was so strong that Hannah stayed for another four years. She felt “obligated to stay and support” her mother, even though her mom might have encouraged her to go. “I put those limits on myself,” she clarified, “no one made me, I just felt like I needed to be there for her.” Eric, whose mother is schizophrenic, said that his friends from college would even tease him about being narrow-minded and joked that he was tethered to his hometown, but explained that this was not necessarily a voluntary decision:

Well, the truth is, that they don’t know that I would have left in a moment if I could have. I just didn’t feel like I had the option to do that. I guess I did, but it didn’t feel like it would be right.

For those who felt a familial obligation to provide care for their parent, it was clear that instrumental goals related to tending to and caring for their parents’ needs were prioritized over other goals, including sometimes other instrumental goals, and this was a strong factor influencing how this tension was strategically managed.

Connection: Nostalgia for the past and hope for the future.

For nine of the participants, the pull toward connection and integration with their parent was more than just feeling an obligation to do so, but also had an emotional, reminiscent, and even hopeful component. Hope was represented by the belief that—even though there is no “cure” for mental illness—their parent would be able to eventually gain control over the emotional and behavioral symptoms and be able to function at a “normal” level without their assistance. This was primarily a pattern found among
respondents whose parent’s illness had not progressed until later in life \( n = 7 \). These individuals held on to memories of who their parent was (referred to here as nostalgia), and believed that they were working toward a goal of seeing that person again, and were reenergized by seeing even small glimpses of them. For instance, Kerry said that those “times when mom is happy, I really enjoy seeing hints of the person that she was all through my childhood, so anything I can do to bring that person back, I try to do.” This sentiment reflects optimism for recovery that was not always apparent at other points throughout the interviews.

Emily, whose father was bipolar and an alcoholic before his suicide said that before “his illness took over” he was vibrant and full of life, and even when he was severely depressed, he would still have “fleeting moments of light and we all lived for those.” Although Erica did not have a happy childhood, and she acknowledges that her schizophrenic mother is still struggling with issues of comorbidity, she tries to stay focused on the positives of the present and the opportunities for continued relational growth in the future. She explains:

Even though she’s probably still doing a few drugs here and there, I just want to overlook it and remember that she’s made big steps in a positive direction. I just want her to get to a point where she’s happy and we can have a relationship, and I think we’re getting there.

For Erica and for others, the hope that their parent’s symptoms would continue to improve (or at least not get worse) and the belief that their relationship with their parent was improving, and had an opportunity to continue to grow, intensified the pulls for connection.

As previously mentioned, a recurring theme among participants was the strain that the role reversal has on the parent-child relationship. James confessed that he gets
“frustrated and resentful” toward his mother because “she can’t function like a normal mother would. She’s never going to call and see if I need her to pick anything up for me at the grocery. But she’s doing better, and that’s all I can ask.” Similarly, Peggy said that one of the hardest things about having a mentally ill mother is that she’s incapable of mothering. Lily recalled having to plan her entire wedding by herself because her mother was too depressed to show any interest. Although the resentment in these sentiments reflects disconnectedness from their parent and a sense of emotional distance, children remained hopeful that this could change. Thus, the desire and hope for a more “normal,” closer parent-child relationship was a strong motivating factor for adult children in purposefully maintaining ties to their parent, despite the hardships they had been through. For instance, although Lily admits that her mother’s mental illness has prohibited her from achieving the kind of mother-daughter relationship that she wants and believes many of her friends have, she still says that she “would rather have some sort of relationship with her and work toward something, even if it’s not always ideal, than not have her in my life at all.”

Echoing these sentiments about how hardships and trials have formed a point for connection and continued involvement, Erica points to their shared history as a bonding agent between her and her mother, saying,

We have been through a lot as a family. I will say that I’m pretty close to her because of that. Not as close as I would like to be, and not in the way that some people are close to their mom. We’ve just been through a lot together.

Even though adult children of mentally ill parents felt emotionally disconnected from their parent due to symptoms of their illness that may prevent them from being the
ideal parent, the emotional ties and shared past experiences were often enough to keep adult children responding to pulls of connection.

**Connection: Victimization and exoneration.**

The adult children of mentally ill parents interviewed for this study had been through some traumatic experiences. Hannah and Emily had both lost their father to suicide by hanging after an affair, battle with alcoholism, and a psychotic episode. Macy found her mother lying on the floor covered in blood with slit wrists after a suicide attempt. Kerry had to bail her mother out of jail for sleeping in her car and harassing a police officer the night of her engagement party. Lily’s mother nearly bankrupt herself after becoming severely manic and romantically involved with an online scammer. Adam’s father disowned him after a tumultuous relationship. Eric’s mother became so manic that she went to the horseracing track and gambled away almost everything in her bank account. Erica’s mother would regularly do cocaine and became romantically involved with a man who sexually abused her and her sister. Peggy had to have her mother involuntarily hospitalized three separate times.

These are only a small selection of the stories participants relayed to me, and yet almost all of them were still enmeshed in their parent’s lives. A handful of them felt so connected to their parent that they had a difficult time distinguishing where their life ended and their parent’s began. “It’s all so intertwined,” Peggy remarked, “her problems are my problems.” One of the primary underlying reasons that children were able to maintain these close ties in spite of the resentment, guilt, shame, and frustration that often accompanied this lopsided relationship was that they were able to, at times, exonerate their parent by distinguishing their parent ‘the person’ from ‘the illness.’ When children
would frame their parent as a victim of their disease, and a person who lacked the agency
to overcome this powerful overwhelming force, children were able to acquit their parents
of wrongdoing and rationalize their maintained connection to them. For instance, Hannah
has been able to forgive her father for his suicide and everything leading up to it because,

He wasn’t really there. He was just so tormented at the end. He was fighting so
many demons. He just could not get out of the thought patterns he was in, so I
don’t even feel like he was my dad at the end.

In believing that her dad had been overtaken by the demons that he valiantly fought
against for so long, Hannah was able to justify and even understand what many deem a
selfish act. Peggy recalled a time when her mother had cancer and believed that the
cancer treatments somehow “overrode” the bipolar and she was able to glimpses of her
mother ‘the person.’ However, she explained that when the chemotherapy treatments
were over and the cancer was gone, “the mental health issues resurfaced with a
vengeance. My mother was gone again. It’s a tenacious illness.” That time period opened
her eyes to how powerfully overcome her mother was with her mental illness. She noted,
“it’s amazing how much the illness takes over her.”

Others like Sarah, whose mother suffers from major depression and severe
anxiety, talked about the illness as if it was a malignant cancer and “zombie-fying force,”
noting, “when she’s depressed, she’s just like, vacant in the eyes. Her body is there, but
there’s nobody home.” Emily noted that her father’s bipolar disorder was like an enemy
that progressively “invaded” his mind, and ultimately “bore down on his soul and crushed
him.” Stuart said he did not know who his mother was anymore because she was “lost
and buried in her depression.” In these moments, what adult children shared was a belief
that the illness bore the guilt for the events that had transpired, not the parent. I say, “in
these moments,” because all of my participants struggled with this; at times exonerating their parents, while other times convicting and casting blame on them. I will explore this in greater depth when I examine adult children’s pull toward autonomy.

In separating their parent from the illness, children were able to, at least partially, absolve their parent of wrongdoing. The reasons for doing this were two-fold. On the one hand, it aided them in more easily meeting a relational goal by allowing them to let go of some of the anger and resentment they harbored toward their parent, thereby making it easier to maintain the relationship and stay in their parent’s life. On the other hand, in their mind, it was also necessary to make sense of it this way in order to meet the instrumental goal of caring for their parent’s mental and emotional health. For instance, even after being repeatedly harassed and threatened by her mother while she was manic, Kerry said,

I always want her to be around because I want to try to give her any reason to feel happy and wanted. A whole other layer of her illness is that she feels so much shame and guilt and doesn’t feel worthy of anyone’s time and attention because of everything she put everyone through when she was really sick [italics added for emphasis].

Importantly, Kerry was able to separate her mother from who she was when she was manic, largely because her mother had demonstrated remorse for her actions. Adult children whose parents had not expressed this remorse had more difficulty exonerating them.

As illustrated by Kerry’s efforts to liberate her mother from the shame that plagued her by spending time with her, participants often wanted to free their parents of blame so that their parent was not more likely to succumb to it and be flung back into the throes of their illness. For instance, Erica, who suggested multiple times throughout the
interview that her schizophrenic mother was passively complicit in her sexual abuse by “being too messed up to pay attention,” was also eager to exonerate her mom and “just stay positive around her and tell her that I love her” so that they “could move on from the past,” and so her mother did not become suicidal. She elaborated:

I just want to try to show her that I do care for her, I do love her, and that everything that happened in the past is going to stay in the past. I know she cries a lot about what she put us through, and I don’t want to have a situation where I express my true feelings to her and then have her do something bad like kill herself.

In this way, participants whose parents were in active recovery not only felt the need to bury the past and separate illness from person in order to move forward in their relationship with them (in an effort to meet a relational goal), but also felt like their parent’s continued recovery depended on this exoneration (reflecting an instrumental goal of supporting their parent). For instance, Eric said he tries to “keep it light” with his mother and that he tries “to be really positive around her and tell her that I love her. I just want show her that, sure, shit’s happened, it sucked, but it wasn’t your fault. You are trying now, and that’s what matters.” James brushed away the idea of blaming his mother for periods of abandonment when he was a child. “She’s not always been the best mom, but she does do the best she can given the cards she’s been dealt. I have to believe that.”

Children whose parents were in active recovery and seeking treatment for their illness often employed phrases like, ‘when he/she was really sick,’ or ‘…but that wasn’t really her/him’ when talking about periods or episodes when the behavioral and emotional manifestations of the illness were most severe and when their parents did and said things that were hurtful and upsetting. Making this separation between the person and the illness would allow them to make sense of their continued connection and
involvement in what could be considered a toxic situation, and helped illuminate the rationale behind discursive strategies that favored connection. Lily explained how she believes she suffers from a mild form of PTSD after experiencing her bipolar mother’s rage-filled psychotic episodes:

I would get a slew of threatening text messages everyday about how she hated us, wished we were never born, how she could go after us legally to destroy our lives and things like that. And a couple of times we found her sitting menacingly outside of our house watching us.

However, since Lily’s mother is now maintaining a regular treatment regimen and “has come out of it,” she rationalizes that during that time her mother was hurting her, “it definitely wasn’t her. I know who she is, and it’s like a demon had taken over her body and mind. It’s hard to explain, but it was like she was possessed.” Compartmentalization like this was a strategy used by participants who maintained an active relationship with their parent in order to resolve the dissonance of caring for a parent that has not always cared for or been caring to them.

Another example of this attempt to compartmentalize was Penny, whose father is bipolar. She struggled for most of her adult life in trying to reconcile maintaining a relationship with her father who had extremely narcissistic tendencies and was highly critical. Although her relationship with her father is strained, Penny has tried to reframe her thinking on who the victim is in their relationship. When her father would say and do hurtful things to her,

I started to say to myself, wow, maybe this is his illness speaking—like a degraded state of mind…Maybe we should even show sympathy and empathy, and maybe stop reacting to him as victims, but rather now that we’re cognizant of his issues, we need to take the higher road and we need to be caring for the ill one.
Reframing her father as a victim of his illness rather than seeing herself as a victim to her father’s actions helped Penny rationalize her desire to maintain a connection to and with him.

Similarly, Hannah suggested that her father’s depression and attempt to self-medicate with alcohol was to blame for the affair he had on her mother and the demise of his prestigious career as a top prosecutor. “His ability to think logically was gone. That part of his brain was just very damaged with the illness, the medication, and the alcohol.”

When adult children were able to frame their parent as the victim to a chronic, severe illness, they were more easily able to justify the pulls they felt toward the connection end of the dialectical spectrum. However, this was not without its challenges, and most participants found themselves struggling at times to justify their continued involvement in their parent’s life. Lily summed up this sentiment, explaining:

> She was just overtaken by her illness. And it was hard for a while to separate the illness from who she was as a person. Like where does one end and the other begin? But it was easy to see she wasn’t herself. She was lost. I still struggle with a lot of resentment from the things she did, but I try to remind myself it wasn’t her.

For others, like Adam (who does not speak to his bipolar father), it has been more difficult to determine where the line was between person and illness, so he has not been able to exonerate his father and maintain a connection with him.

> So how much of his condition do you blame? It’s either he’s an asshole and he’s at fault, or he’s a helpless, passive victim and the illness is to blame. And all of us have to answer that question about where we put it. Either you exonerate him because he’s out of his mind, or he’s guilty and you give no credence to the effects of mental illness.

> Interestingly, however, as most of the adult children’s sense-making about their parent’s illness illustrates, this is not so black-and-white for them, and it is the shades of
grey that intensify and contribute to the interplay of the dialectic they experience between connection and autonomy.

The next section will explore these pulls toward autonomy—separation, distance, and independence—that adult children experience, how this desire for separation manifests in their everyday lives, and attempt to illuminate some of the underlying factors and goals that contribute to this tension.

The Dialectic of Integration: Autonomy

Only two of the participants interviewed for this study managed the integration tension with their ill parent using what Baxter and Montgomery (1996) identify as denial and disorientation. Specifically, this praxis pattern is characterized by feeling helpless and pessimistic or ignoring their need for connection with the other completely. In the context of this study, perceiving the relationship with their parent as too toxic and seeing very little or no personal benefit to maintaining a connection to their parent, these two adult children managed the tension by cutting ties and fully embracing the autonomous pull. Ben, who had cut ties completely from his mother, suggested this management strategy was motivated by an instrumental goal of self-preservation, explaining, “I just think it’s cathartic for myself to not hold on to it. Like, why would I keep doing that to myself?”

However, even those who maintained what would be considered a strongly interdependent relationship with their parent still alluded to (or directly expressed) their need for separation and distance in some areas of their life or during certain spans of time. Peggy summed up this pull toward a degree of autonomy:
You can’t stop caring about your own needs, because it’s very easy to get caught up in everything that your family member is going through that you start to not take care of yourself or the things that are dear to your own life outside of them.

Peggy’s advice was guidance that was offered by a number of participants, although most acknowledged that they could do a better job of managing this dialectic, meaning most of the participants wished they could exert greater autonomy, but felt unable to put this into practice. Regarding the difficulty in managing this tension and responding to his need for space, Stuart joked, “That’s easier said than done. Do as I say and not as I do, by the way.”

**Autonomy: Pursuit of relational and instrumental goals.**

The need for autonomy was sometimes rooted in a belief that maintenance of a close relationship with their parent impeded the accomplishment of instrumental goals or relational goals with others. For instance, Erica at one time maintained almost every-other-day contact with her mom “because I love her, and want her to be okay,” but found that associating too closely with her was detrimental to her professional life. Providing an example, she described how one time, at a reception honoring her and other high performing students from her college graduating class, her mom had a public breakdown that was witnessed by high-level administrators and faculty. At the same time this incident occurred, she was also applying for an administrative job with this same college. She explained:

> After escorting my mom and the rest of my family off the premises, I was directly asked by the President of the College if they could expect more of the same type of chaos if I worked there. I was so embarrassed. And, I’m not positive, but I’m pretty sure it was why I didn’t get the job.

Erica says after that happened, she decided that it was in her own best interest to “step back from her a bit.” Harkening back to that ever-present pull for connection, however,
she felt the need to add, “I do love her though. I just had to distance myself.” Lily also recalled that her performance in her previous job was “definitely hindered” by prioritizing her connection with her mother over her professional pursuits, and that in order to be more successful in her current position, she had to “create some boundaries and some separation” when it came to her mom.

Adult children also favored the need for autonomy or “pulled back” during those times when the connection with their parent hampered relational pursuits with others, which was a constant balance for many participants. In these cases, many used the segmentation praxis strategy where they would try to compartmentalize in an effort to keep their parent separate from other areas of their life. For instance, Sarah’s mother’s illness had taken “a big toll” on her romantic relationships in the past because she felt that it was burdensome to the other person, especially in the beginning of a relationship. She noted:

I’m still very scared to take any boyfriends over to see her. It was something I had to explain and set up, and it was like I was just putting this burden on them, not to mention I thought it would scare them off or be too heavy. So I just decided to stop taking them over there unless I was in a really serious relationship. Keeping her separate from my love life is best.

Thus, relational goals with others often were pitted in direct opposition to relational and instrumental goals with their parent, so in an effort to maintain both, children would segment those areas of their life. In instances like Sarah’s, participants implied that their goals with their parent (both relational and instrumental) were at odds with their relational goals with others, making it difficult to balance both effectively. As with Sarah, participants indicated terminating or attempting to terminate personal relationships because it was believed they could only successfully maintain one of them,
or because they did not want to “burden” any outsider with family issues. Kerry recalls that early in their relationship, she tried to “break up with my now-husband” because she felt “guilty about bringing anyone else into the mess.” She is grateful now that she did not allow her guilt over her mother to sabotage their relationship, but recognizes that her interdependence with her mother continues to be a lingering issue in her marriage. “If I give my time to one of them, that is taking time away from the other,” she noted. Lily also frequently found the need to disconnect with her mom in order to reconnect with her husband. She stated:

There are times when I prioritize her needs when I need to be prioritizing our needs as a couple. When I’m focused on her, I tend to neglect us, so I’ve tried to get better about establishing those boundaries. I have to for the sake of my marriage.

Experiencing conflicting relational goals was common among participants in their management of the integration dialectic, and which goal was chosen as primary at a given time influenced how the tension was managed. For instance, although Peggy did not blame her mother for her two failed marriages, she does say she has not been seriously romantically involved with anyone in years simply because it is too hard to remove her focus from her mother long enough to put in the time or work of a committed relationship. She explained:

If I really fully committed to a having a relationship, which I’d like to do, I wouldn’t be able to devote as much time to my mom’s needs. When I have had a guy I’ve dated, it’s usually a nice distraction, but hard to commit to anything long term.

Thus, even though she has a desire for greater autonomy, in prioritizing her mother’s needs and making those goals primary, her management of this tension continues to favor connection. In cases like Lily’s, Kerry’s, and Peggy’s adult children used the praxis of
alternation—or favoring one end of the spectrum over the other at different times in an
effort to satisfy the most pertinent goal at that moment.

**Autonomy: Managing identity goals.**

Identity goals relating to managing impressions of self also underlie some of the
motivation for movement away from their parent. Identity goals for children were most
salient in terms of managing others’ perception of them personally, their parent, and the
family as a whole. For instance, Eric suggests that a feeling of shame and embarrassment
prompted him to find ways to disassociate with his schizophrenic mother. Now a doctor,
he notes that he felt it was necessary professionally to shift away from her at certain
points in his life in order to better himself. He explained his reasoning, noting that it is
selfish:

I tried hard, even at a young age to not let her affect me and what I wanted to do.
That sounds selfish, but I was forced into taking a selfish perspective. I didn’t like
the way that other people looked at her, especially when I was younger. I was
very embarrassed of the way she would act. So whatever she did, I just tried to do
the exact opposite to distance myself from her as much as possible.

The “distance” many referred to was largely one that was not entirely geographic
or physical, but more of a mental distance. This disassociation was not just in their own
minds, but also maintained in an effort to create a distance between themselves and their
parent in the minds of others. Consistent with the notions of courtesy stigma and family
toxicity, adult children of mentally ill parents contend that the stigma placed on mental
illness spilled over into the family and was hard to wash off.

As an example, Kerry suggested that this “scarlet letter” was with her anytime she
was around anyone who knew anything about her mom’s struggles with mental illness,
especially people from her hometown. This theme was especially prominent among those
participants who were from smaller towns. Kerry explained being successful in her own
right was extremely important to her because “I really wanted to separate myself from her
and discourage people from making that association. Say to them, see? I’m not my
mother.” Sarah recalls that after her mom went through a prolonged, significant major
depressive episode and attempted suicide, it altered others’ perception of her and felt like
“chains tethering” her to an image she had a hard time shedding. Specifically, when
people would make the connection that she was her mother’s daughter,

Knowing that would immediately color their impression of me. I could see it on
their face. Like something must be wrong with me too. Or at the very least I could
see sympathy dripping from their face. And I just don’t want that association if I
can avoid it.

Thus, when prioritizing identity goals and preserving “face,” autonomy was often
sought over connection. In these cases, adult children’s attempts to maintain some sense
of control over others’ impressions of them trumped their pull toward interdependence
and obligation to their parent’s needs. For instance, Macy says:

I try not to talk about it [mom’s illness] around work people as much because I
don’t want people to think it’s taking away from me being able to meet standards
or expectations. I feel like it would always be in the back of their minds.

In this example, Macy, like a number of other participants in this study, saw her work
domain as separate from the relational domain of her life with her parent. For some
participants, work was an area in their lives in which they could assert independence and
they did not have to feel tied to their parent. Thus, adult children emphasized the
importance of maintaining this autonomy, especially in their professional life.

**Autonomy: Perpetration and conviction.**

How children responded to the connection-autonomy dialectic was heavily
influenced by how children managed and responded to multiple goals. However, another
significant factor that ultimately strengthened the pull toward autonomy relates back to the concept of agency, which was previously discussed in the section on connection. When adult children were able to exonerate their parent from blame, seeing them as the victim and the illness as the primary culprit, the pull toward connection was fortified. Importantly though, the opposite is also true; when adult children convicted their parent and framed their parent as the culpable agent and perpetrator of their own emotions and behaviors, this functioned to intensify the pull toward autonomy. In other words, if an action or a mental state was framed as something that was within their parent’s purview of control, children had a difficult time resolving the cognitive dissonance they experienced in caring for someone who refused to care for themselves.

Importantly, and congruent with the theory of relational dialectics, participants were not consistent in how they framed and talked about their parent’s illness. In one moment, an interviewee would explain to me how they felt the need to be there for their parent because their parent had been overtaken by his or her illness, and in the next moment, they would float or even jump to the opposite spectrum and express frustration, resentment, and outright anger with their parent for perceived wrongdoings or failures and explain their need for distance as a result. So much of this reflected an internal (and carried over to a discursive) struggle to determine how much of their parent’s state of being and behavior could be attributed to the illness and how much was just a part of who their parent is. Peggy demonstrated this struggle to assign blame, explaining, “I feel like a lot of those traits in her personality helped to fuel or exacerbate the illness. So I don’t know where exactly the line was between the two.” Adam ultimately assigned blame to his father and made the decision to separate himself completely from him as a result,
explaining that in the end, he was just tired of putting up with “that same bullshit.” His simple reasoning for convicting his father was revealed in his reflection: “Is he an asshole because he is ill? If he was normal, he would probably be the same asshole.” Penny found herself constantly questioning her father’s agency and therefore found herself in and out of his life. “I have to tell you, I vacillate sometimes thinking, bipolar aside, what if he isn’t even bipolar? What if this is just who he is and that was a convenient excuse? That makes it so much harder.”

In a revealing statement on agency, Erica illuminated her own struggle with whether and how much to hold her mother to account for her perceived failings. Her inability to reconcile what her mom allowed to happen to her as a child prevents her from acquitting her mother. She explained:

I think that is why I don’t take responsibility for my mom in a lot of instances because I still have a lot of resentment towards her for keeping us there [in an abusive situation] for so long and letting so many bad things happen to us and not being the mom that she should be and that I deserved—the mom that other people had.

Here, Erica’s words reveal her inability to completely acquit her mother of her wrongdoings, explaining she still has anger toward her mother for “letting” her children be put through so much. The implication is clearly that her mother could have stopped these things from happening by simply being rational and competent. However, in the very next sentence, she seemingly retracts that conviction, suggesting, “There is a lot that I blame on her, but I try to be realistic and know that she was going through a lot that was out of her control.” The logical, more “realistic” side of herself that she refers to is what has allowed Erica to remain in contact with her mother and continue to do favors for her, even providing for her monetarily when necessary, whereas the emotional, resentful side
contributes to her need to turn away and keep her mother separate from certain parts of her life.

Even adult children whose lives were significantly entangled with their parent and strongly prioritized the connection end of the dialectic had difficulty reconciling questions of agency and control. Kerry, who continues to pay her mother’s bills, help care for her house, oversee her hygienic practices, and countless other caretaking responsibilities explained that this was a lingering question in her mind:

I sometimes get angry and think she could do better or be better. And I wonder, why does she want to live this way? Why doesn’t she want a better life for herself? Why doesn’t she want to better herself? All the time I struggle with that.

Kerry even references having to mentally “pull” herself back out of that kind of thinking and “try to remember that it’s not her fault that she doesn’t think rationally about things or see things the way a healthy person would.” She acknowledges that she realizes that to an outsider, it may not make sense why she’s stayed so involved in her mother’s care.

I get it. It makes more sense to remove myself where I can. And I try to in some ways. It’s a struggle to empathize with a mentally ill person. Even for me, who has been standing on the front lines and down in the trenches with her. But even when I get frustrated and pull away, I always seem to get sucked back in because I know deep down that she can’t help it.

Thus, as a direct result of her inability to see her mother as the fully competent perpetrator of her actions (or inactions), even when she feels resentful and tries to separate herself, she remains enmeshed.

Peggy explained that although she realizes the illness deserves much of the blame for her mother’s narcissistic and eccentric behavior, her siblings do not, and therefore she has been left with the bulk of the caretaking duties.

My brother believes that she has the ability to pull herself up by her bootstraps and do differently. Think differently. He will just say, you know, mom, stop all of
this nonsense. Stop saying that. And he thinks that should be the end of it. So they [my siblings] have just basically gotten fed up and removed themselves from all of it.

Since Peggy’s siblings have assigned the blame to their mother, they are liberated from the sense of obligation and responsibility that keeps Peggy so connected to her. In other words, they are more responsive to the autonomous pull, whereas Peggy’s acquittal of her mother causes her to lean toward interdependence and connection.

Will, whose mother tried to take her own life, also illustrated this back-and-forth struggle with blame in how he tried to reconcile his mother’s suicide attempts:

Suicide really forces you between the two camps of, one, they’re sick, they can’t help it, there was no way out. And this is contrasted by the other side, the pervasive idea that if they take their own life, they’re selfish and they were making a conscious, logical decision that they could’ve stopped—which implies that they have control over their actions. Can both be true? I don’t know. Because I’ve seen my mom where she wasn’t my mom, and where her actions were not characteristic of who she is as a person. So I know deep down I can’t blame her. But it’s something I’d struggle with forever if she’d been successful [in taking her own life]. Was she a victim of something horrible, or did she make that decision consciously?

Will’s inability to resolve this question of blame reflects a consistent theme throughout the interview data. How an adult child answered this question greatly influenced his or her management of this dialectical tension. Sarah’s reflection on the impact of her mother’s period of severe depression reveals that although she oscillates between seeing her mother as a culpable culprit and a casualty of a force beyond her control, ultimately her acknowledgment of the power of a chemical imbalance prevails, and she justifies her continued connection to her mother.

It’s frustrating because there are still quite a few things that I’m dealing with even years later that were caused by her illness [italics added for emphasis]. Cleaning up messes that she made, or just dealing with her inability to maintain things even now, or do for herself. So that strains the relationship because most of the time spent with her is trying to clean up messes she made. So after I spend that time
fixing stuff for her, I find that I need to take time away. Just step away from it for a bit and regroup. I have to for my own sanity.

Although Sarah responds to her need for autonomy by “staying away” from her mother for a week or two at a time after a period of prolonged, overwhelming connection where she has difficulty justifying her inability to function “normally,” she, like most of the participants in this study, used the praxis of alternation to manage this tension; taking time “away” when needed, but eventually coming back due around to a strong sense of connection and interdependence.

Whereas the integration dialectic was primarily centered on the relationship that participants had with their parent and the affect that connection had on other goals, the expression dialectic was less about how open or closed adult children were in their communication with their parent, and more about how they managed privacy with others surrounding their parent’s illness. As such, the integration dialectic discussed above would be understood as an internal tension, while the expression dialectic is most appropriately understood as an external tension between the relational partners and others outside of the relationship (a tension between “us” and “them”). This dialectic and the underlying goals motivating these communicative practices are explored in greater depth in the next chapter.

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Chapter Six: Analysis of The Dialectic of Expression

The Dialectic of Expression: Concealment

From a relational dialectics theoretical perspective, the dialectic of expression centers on the discourse surrounding the need for revelation, openness, sharing, and disclosure on one side and the simultaneous, but contradictory need for concealment, privacy, and discretion on the other (Baxter and Montgomery, 1996). Unlike the other two tensions, in which contradictory discourse was internal to the relationship (between the child and the parent), the expression tension manifest most prominently as what Baxter and Montgomery call an external tension, or a contradiction between the relational partners and others outside of the relationship (us vs. them).

The adult children of mentally ill parents that I interviewed believed mental illness was stigmatized and had witnessed or felt this stigma directed toward their parent, their family, and/or themselves personally. The stigma experienced by these family members significantly contributed to their desires to strategically manage privacy around issues regarding their parent’s mental illness. However, at the same time, pulls toward openness were most often apparent in adult children’s need to reveal their parent’s illness. The need to share despite the risks of stigma was motivated by various factors; sometimes they disclosed out of necessity to a boss or romantic interest, other times it was to seek out and procure support, and at times it was to simply bring greater awareness by advocating for their parent or offering guidance to others. The ongoing interplay of these tensions were evident in their discussions with me, but were most apparent in how they described negotiating privacy boundaries with others. The intricacies of managing this tension, and the identity, relational, and instrumental goals
that underpin it are explored in the sections below. First, I will offer an analysis of the pulls for concealment that characterized adult children’s perceptions of and experiences, followed by an exploration of the pulls for revelation, or openness and the forces that contributed to it.

**Concealment: The stigmatization of mental illness.**

Participants in this study were very strategic and intentional in their privacy management decisions regarding their ill parent. Underlying the decisions made to only reveal selective information about their parent with others—or to carefully conceal everything about their parent from others—was the stigmatization of mental illness. The stigma surrounding mental illness reinforced and made identity goals prominent in how this dialectic was managed. All 15 participants directly referenced or alluded to the stigma surrounding mental health at least once during the course of our conversation, but most made it a central point of discussion. Hannah directly alluded to the issue of family toxicity in her decision to conceal her father’s illness and subsequent suicide from others, arguing that, from her perspective, there continues to be a general lack of sympathy (and empathy) for the mentally ill that others with “blameless” illnesses benefit from. She explained that she has a fear of talking about her dad because,

> It’s just this pervasive idea that if a family member has a mental illness, that there must be something wrong with the everyone in the family. Something must’ve gone really wrong. Like, what did they do wrong so that this outcome happened? When really, no one did anything wrong, it’s just a sickness, like anything else.

As previously discussed, the deinstitutionalization of mental healthcare has put family firmly at the center of responsibility in terms of caregiving for a mentally ill person. Additionally, and important to understanding the effect of courtesy stigma, in a systemic view, the family is also the responsible party, and therefore blameworthy when
deviance occurs. As Hannah explained, questions arise about what the family missed, neglected, willfully ignored, or enabled that allowed the deviant behavior to continue. Or in terms of tracing the etiology of the illness, a widespread assumption that it starts at home, and something abnormal in the family dynamic, functioning, or makeup was the source of the depression, mania, anxiety, etc. Fueling this etiologic fire is the genetic component; specifically, the growing evidence that mental illness has a hereditary link (Uher, 2009). Eric notes that although he is not worried about the genetic link himself, he is fearful of that perception that others’ hold, and it makes him more reluctant to share that aspect of his life with others:

I feel like there’s a view of the type of family that produces a schizophrenic person. And it’s not good. So in the times when I do tell others about mom, I have a fear that they are going to automatically assume that I have ‘crazy’ tendencies too, or be more watchful of my behavior as a result, or try to attribute certain aspects of my personality or actions to having that in my DNA.

Emily is hyperaware of the general public’s lack of understanding about mental illness and says all you have to do is turn on the news to know that this discrediting view still exists. She expanded on this idea:

There have been so many celebrity suicides lately, and with that always comes a brief wave of people talking about mental illness. Of course there is some good that comes of that discussion, and it certainly sheds light on the issue. But it also highlights the negative view people still hold about mental illness. It really shows you how so many people still don’t understand that mental illness is like any other physiological illness. There’s still such a stigma. Even today.

Like Eric and many of the participants, Emily explained that her awareness of the stigmatizing nature of the illness makes her hesitant to open up with others about it. “I have such a fear of sharing it. I don’t know what people would think about my family, or me, or my dad,” Emily said. Lily, whose father suffered from an immobilizing chronic neurological disease said that she feels a noticeable difference in how people respond to
the information about her parent’s various health issues, and that speaks to the continued stigmatizing nature of mental illness and how people view those with a mental illness.

When new people come into my life, I have no problem talking to them about my dad and all the things he suffered and overcame, because it feels like he didn’t bring that on himself. He’s the hero that was so brave and strong. But I find it very difficult to talk about my mom’s struggles. She’s not the hero in a lot of people’s eyes even though she overcame a lot too. People just don’t understand it in the same way.

Kerry said that her in-laws’ commentary on a celebrity suicide while watching the news one night made her aware of how pervasive the stigma around mental illness continues to be and that the public perception is still not as enlightened and informed as she may have hoped. She recalled:

In the way they were talking, I started to realize, they don’t view it as an actual illness. They are painting this person as the one at fault, saying they were selfish, asking why they would do that when they have such a good life, saying that the problems they had were fixable, and how could they leave those problems behind for their family to deal with.

Kerry added that this encounter “absolutely” made her more hesitant to share her own experience with others because it’s hard to combat that negative perception when it is so deeply rooted, and she wants to avoid having to be on the defensive about it. Similarly, Sarah also decided to not open up to her boyfriend’s parents for over a year because of the talk she would overhear about their cousin who was an alcoholic. Although alcoholism and mental illness are different conditions, she explained that the blame and judgment were similar. From those interactions, she recalled:

I’d hear so much judgment. Things like, ‘she should be able to stop that,’ and ‘why is she doing this to her poor kids?’ I didn’t want to deal with that, and I didn’t think we deserved it, so I didn’t share with them.
Like the others, the uncertainty about what views others hold about mental illness makes Erica more cautious and protective of information about her mom. She says this question mark is forefront in her mind when an opportunity to share arises.

If I were to be more open about my mom to certain people, which side would they fall on? Would they be understanding and acknowledge that it’s a chronic illness like cancer? Or would they think there was or is something she could do to fix it and blame her—or us—for not doing those things? People can be so judgmental of things they know nothing about.

According to Peggy, for evidence that people just have a general lack of understanding about mental illness, you have to look no further than how government institutions and entities like the health insurance industry treat the mentally ill. She notes that in her experience, the system tends to apply the same standards to mental illness as they do to other illnesses, which reflects a blatant disregard for what separates mental illnesses from other types of disease. She, like seven other of the participants, had been involved in the process of attempting to involuntarily hospitalize her parent, but ran into obstacles when her mother (who was highly manic at the time) would not proclaim in front of a judge or health professional that she intended to hurt herself or someone else. “I mean, if you can’t even get the state to recognize and have appropriate ways of procuring healthcare for the mentally ill, how can you expect John Q. Public to understand it?” She explained that expecting a mentally ill person to acknowledge their own incompetency is not only evidence of an illogical, flawed system, but is also representative of a larger societal view that those who are mentally ill should be able to “recognize it, fix it, and take the steps to handle it themselves.”
Concealment: Lack of empathy and unsolicited support.

Although some participants talked about their parent’s illness with close family and friends, the level of relational closeness was not necessarily a determining factor in participants’ privacy management decisions, but an expectation of judgment and a lack of anticipated understanding did play a role. This is consistent with research on topic avoidance suggesting that multiple goals influence privacy management decisions, and that identity goals related to attempts to manage others’ impressions can be more salient than relational or instrumental goals when the decision is made to conceal by omission (Afifi & Guerrero, 2000). For instance, Lily said that she intentionally avoids the topic with most of her close friends because,

I don’t have a single friend who could empathize with the situation. They can sympathize or they can cast judgment, but I don’t really know what to say to any of them. So most of the time, I don’t say anything at all.

As an act of reciprocity, only recently did Lily open up to one of her close friends about it when her friend shared that her sister was having mental health issues. At that point, she explained, she knew her friend would be able to relate, there would be no judgment, and she could even potentially offer her friend some guidance based on her own experience. In this case, opening up allowed her to meet instrumental goals of providing and potentially procuring support, while also keeping intact her identity goal of preserving a desired image by disclosing to an empathetic other. Similarly, Stuart explained that he talks about his mom’s issues with no one except for his spouse because he expects “nothing but sympathy or judgment from them” and he’s not looking for either.
Moreover, a number of participants mentioned the unsolicited support they have received from others in response to disclosure as a reason for guarding their privacy about their parent’s illness. This motivation for managing privacy is consistent with research that has demonstrated that receiving unsolicited support, especially in the form of offering advice, tends to be evaluated less positively than informational support that is sought out or requested because it is an inherently face-threatening act, and as such is more likely to be seen as inappropriate, intrusive, and unhelpful (Boutin-Foster, 2005; Feng & MacGeorge, 2006). Moreover, support in the form of advice that is interpreted as invasive by the recipient may actually increase levels of stress (Shumaker & Hill, 1991). For instance, Peggy believes that even though “a lot of people don’t truly understand mental illness,” when she does open up about it, they instinctively want to offer informational support in order to help her. Although children of mentally ill parents recognize that some people’s intentions are good, participants often saw this type of support as uninformed at best and intrusive at worst. Will explicated this frustration, recalling:

I’ve had friends that know nothing about it try to make suggestions about treatment or recommend doctors or therapists, or say things like, ‘have you tried X?’ I’m like, yes, I’ve tried everything. She doesn’t believe she’s sick and screams and hits me when I try to get her to take her meds. But thanks anyway.

In the face of unsolicited informational support, participants would sometimes respond defensively, which in turn could hurt the other advice-givers’ feelings and ultimately cause damage to the relationship. Similar to Will’s encounter, Sarah recollected one time when her mother was extremely depressed, she told a friend as a form of cathartic release, but when the friend responded by “telling me how I needed to handle her [Sarah’s mom] and the situation,” Sarah got frustrated and told her friend that
none of those suggestions were viable, or had already been tried. The implication that Sarah was incapable or inadequate was especially upsetting to her and prompted a negative reaction:

We’re still friends, but I don’t know that our friendship has been the same after that. She was just trying to help I know, but she didn’t know what she was talking about, and I hated the idea of people implying there were things I could have been doing that I hadn’t already tried. Especially when they know absolutely nothing about it.

These examples are representative of the situation many of participants experienced in managing the tension between concealment and revelation where multiple goals were at odds. Specifically in this situation, Sarah’s instrumental goal of procuring emotional support was in direct opposition with her identity goals as a family member and caretaker, especially when the response was informational instead of emotional support. As a result of this incident and others like it, Sarah has reinforced privacy boundaries around her mother’s illness and has prioritized concealment when it comes to information about her mother. In response to one friend who suggested he just make his mother go to therapy for her anxiety, Will said sarcastically, “‘that’s a great idea, man; I hadn’t thought of that. You wanna help me force her in the car?’ [laughs.] He shut up about it after that, and I kind of just stopped telling him things about her because that made me realize how little he understood about it.”

Concealment: Saving face.

Thus, participants often took unsolicited advice as personally insulting, and as a subtle way of implicating an incompetency and inadequacy to provide effective care to their parent. This was exacerbated by the idea that they may already feel insecure about these abilities when various attempts to re-direct the course of their parent’s illness had
failed. Viewed this way, the anticipated reaction to revelation and the decision to construct privacy barriers around a parent’s illness may reflect the salience of identity goals in managing the expression dialectic. In other words, maintaining a sense of self as a capable caregiver may dominate over instrumental goals of disclosure, such as catharsis and asking for help, and end up favoring the privacy end of the contradiction.

In addition to preserving face as a capable and informed caretaker, the adult children interviewed for this study were also motivated to build strong privacy boundaries in an effort to protect other aspects of their public image, especially in the context of workplace relationships. Emily noted that even though she is a professional counselor and works in an inherently empathetic environment, she had still chosen to keep her father’s mental illness and suicide a secret from her co-workers for a long time. She explained her decision to protect the information at work, stating:

I feel like that information creates such a vulnerability and a shift in power dynamics with your colleagues, so I’m very protective of that. Being professional and taken seriously is very important to maintain, so revealing that could change things in how the people I work with view me.

Emily went on to explain that even though she knows she would have found an understanding audience in many of her colleagues, it was difficult to overcome “the sense of shame” that accompanied it, and the concern that it could alter the way she was viewed as a professional. Kerry also explained that she doesn’t like the idea of “airing my dirty laundry at work” because she worries that colleagues could see it as a potential hindrance to meeting expectations. But ultimately, she says, the image she has created at work “is not congruent with the craziness of my personal life. It’s just embarrassing, and I don’t want the people I work with everyday to see me as fragile or flawed.” Thus, strategically shaping and preserving others perception of them was a primary goal that often
influenced how adult children negotiated the tension of expression, and many used the praxis of segmentation, or choosing to conceal in the professional context, as a way to manage this tension and meet this identity goal.

**Concealment: Saving parent’s face.**

Privacy around a parent’s mental illness was not just maintained by participants in an effort to protect their own image, but boundaries were also erected in an effort to save face for their parent, demonstrating the primary nature of identity goals in managing this tension. Hannah, whose father committed suicide after a mania-induced psychosis, tended to respond to the expression dialectic through the praxis of balance (only partially revealing certain aspects; both concealing and revealing) in order to preserve her father’s legacy. She explained that although she is not trying to hide it completely, she does tend to only very selectively share in an attempt to preserve his good name:

Most of the time I avoid talking about it because I think about my dad. How would he want to be remembered? I want people to remember him in the good times. He worked so hard to become a figure in our community. I don’t want to reveal too much and disparage his image. So that’s always a factor in what I share with others.

Echoing this belief in remaining loyal and protecting her father’s image, Emily explained that she chooses not to reveal information about her father’s major illness with others because “he’s so much more than his depression. I just don’t want him to be defined by it.”

The stigmatizing nature of mental illness means that this information is likely to carry a negative valence, and therefore there are more risks to self and others associated with revelation (Petronio, 2000; Vangelisti & Caughlin, 1997; Smith & Niedermyer, 2009). Consistent with research on topic avoidance, protecting the other person’s image
from further tarnishing was motivating factor behind my participant’s decisions to maintain privacy around the topic of a parent’s mental illness. For instance, Lily feels that by concealing information about her mother’s illness from others, she is helping her mother maintain some level of respect.

The way she was living and the decisions she was making when she was at the height of her mania really created a situation where she was losing her dignity. At this point, I’m just trying to keep her from losing all of it.

Similarly, Macy noted that she believes that her mother receives the brunt of other people’s judgment when she opens up about things that have happened in the past, and she doesn’t want to open her mother up to that scrutiny.

I don’t want to be responsible for people thinking less of her or acting differently around her. I don’t think people judge me for her illness, necessarily. I think maybe I’m judged on my response to it, but not the illness itself because it’s not mine. But she is judged for it, and I don’t want to bring that on her. If she wants to invite that judgment on herself through her actions, that’s one thing, but I don’t want to be responsible for it, especially when most of the time I’m only telling someone in order to bitch about it.

Thus, the act of concealing in order to protect their parent’s presenting self was an identity goal that was often prominent among participants.

Although the stigma of mental health plays a significant role in children’s privacy management decisions surrounding the issue of their parent’s illness and contribute to a pull to conceal information about it from others, certain conditions and factors contribute to revelation of information about their parent, favoring greater openness along the dialectic of expression.

**The Dialectic of Expression: Revelation**

Although the adult children of mentally ill parents who were interviewed for this study acknowledged that the stigma surrounding mental illness was a primary factor
motivating them to conceal this information (or at least intentionally and very strategically manage privacy boundaries), there were other factors that contributed to a desire to be more open and to share information about their parent’s illness with others, even in spite of the potential risks incurred. This is consistent with research on family secrets and topic avoidance, which suggests that catharsis and the attempt to procure social support (among other reasons) can be significant motivators to reveal information to others in spite of risks.

Revelation: Emotional support.

The most prominent reason participants cited for choosing to reveal information about their parent’s illness was reflective of the instrumental goals to procure or to provide emotional social support. Kerry summed up the sentiments of many of participants, explaining,

You tend to think that the only person who needs treatment is the person with the illness, but you know, I need it too. Even now, after going through this for so long, I sometimes don’t even realize how much I need the support system.

Interestingly, contrary to some of the research on privacy management, which states the quality of the relationship with a potential disclosure recipient may play a large role in the decision to reveal family secrets and other private information (Vangelisti & Caughlin, 1997), as discussed in the previous section, participants were more likely to open up to others that they anticipated to be empathetic to their plight, regardless of closeness. In fact, even though Erica said she has talked about her mom with one of her closest friends in order to “vent and lean on someone,” contrary to what one might expect, she found the act of disclosing in this context to be isolating:

It’s like being stranded on a desert island. You can tell your friend and they know you’re there, and maybe they can even see you struggling on this island by
yourself. But they can’t get there; they can’t be on the island with you to know what it’s like. So even if you can talk to them about it, they can’t relate, so then you’re just stuck there by yourself feeling even more alone.

Not having her friend be able to relate to what she was going through, Erica felt less support and more alone after disclosing than she did before. Thus, the expectation of an empathetic audience was often a stronger pull to reveal information about their parent’s illness to others than closeness for participants, and was rooted in the notions of shared experience and reciprocal disclosure.

For instance, Emily decided to take part in NAMI’s Family-to-Family program and found herself being more comfortable revealing the intimate details of her father’s struggles with the people she met in the program than she did with her oldest and dearest friends. She noted that she tended to be more open with these “strangers” than she was even with her own siblings because her family preferred to ignore the problem and deny that there was an issue with her dad. But she found the group of people she met through the NAMI program to be the ideal sounding board because they “had been there and understood.” She expounded on this community of support:

I remember sitting in this class and hearing people’s nightmares come true about their family member. Some were parents of children who struggled, others were siblings who were caring for their brother or sister—their parents were no longer around and it fell to them. It was crazy though that even in that class, with how different everyone’s situations were, how we could all relate to one another, commiserate, and share ideas.

Being bound by this shared experience created an environment where the threat of judgment was lessened, and the notion of reciprocity made these participants more likely to reveal. Kerry, another participant in the Family-to-Family program noted,

Seeing others open up about their stories and feelings about their relatives, I just felt inspired to share, too. The support I received in response was invaluable. Even though they couldn’t step in and solve my problems, just knowing you’re
not alone and gaining some perspective was priceless and something I couldn’t have gotten anywhere else.

Even those who did not participate in any sort of support group found reciprocal disclosure to be a strong pull to reveal. Hannah explained that she is normally very guarded about her father, but that a colleague in her last job opened up to her about having a mother who is severely depressed and threatens suicide regularly. The openness of her colleague “made me feel more comfortable” and prompted her to reveal that her own father had completed suicide after a manic episode. “We were able to connect and relate, and now I have a new outlet for support when I need it because I know she gets it.” Similarly, Lily had kept her mother’s illness from one of her closest friends because she believed “she didn't have a problem in the world—her family had more money than God and they seemed perfect on the outside.” But one day after her friend’s sister was sent to a rehabilitation facility for mania, her friend opened up to her about all of the “crazy things” that had been going on in her family. This act of disclosure ultimately motivated her to reveal their shared connection in order to act as a support for one another:

After that I realized I had someone who could relate to me, and someone I didn’t have to feel any sense of shame with because I knew that she knew what this was like. So I started to open up to her and didn’t hold any of the gory details back. She’s become such big source of support for me, and I think I am for her, too.

In order to manage the dialectic of expression and fulfill a need for openness with others about the illness, participants’ communicative patterns often reflected the praxis of alternation, where certain things are only revealed to specific people at specific times in order to meet an instrumental goal (usually seeking emotional or informational support or understanding for a missed obligation). For instance, Peggy revealed selective
information about her mom to close friends “usually to vent, but sometimes to bounce ideas off of them.” She explained that her friends have different areas of expertise, so she had told them certain things about her mom in order to procure informational support from them. “I will go to my nurse friend for medical advice and another friend of mine if I am having trouble with mom’s insurance.” She explains that it is such a large part of her “everyday,” that she would have a difficult time keeping it from her close friends completely, but what she discloses, when, and to whom is very selective. Although Peggy notes that part of this is because they cannot relate to what she goes through, she also says she also worries about burdening any of them with too much information:

They are nice about it and will invite me and my mom over for holidays if we don’t already have someplace to go, and I appreciate that a lot, so opening up has allowed me to have that kind of support from them. But I don't want them to get fed up with me and be like, ‘ugh, it’s always something with her’ and end up distancing themselves from me. So it’s a delicate thing.

Finding the right balance was an idea noted by many of the participants. Privacy management decisions regarding when to reveal thus also reflected the praxis pattern of balance, wherein adult children would find a compromise between the opposing forces by revealing degrees of information on a specific topic, but concealing other aspects. James explained that he had told his friend some things about his mom in order to address abnormalities in her behavior, but he did not like the idea of talking about it too much or too often. “I have enough material to talk about it for hours for days on end. But who wants to be that guy? So I tell him enough to explain when things are going on, but I don't dwell on it.”

Also employing the praxis of alternation, many participants explained that they kept information about their parent to themselves until they could not afford to anymore.
For instance, even though participants generally preferred to keep their professional life separate from their life with their parent, necessity dictated that Stuart open up about his mother to his boss because his obligations to and for his mother began infringing on responsibilities at work.

Eventually I needed to give my boss the head’s up because there are times, especially if it’s like she’s suicidal or she hasn’t responded to me in days, then I’ve got to be on call. But really it’s just close friends and people on a need-to-know basis that know anything.

Similarly, Sarah recalled a time when she had to call into work for a couple of days because of a suicide scare with her mother. She acknowledged that revelation was not her first choice, but that a crisis situation made it absolutely necessary to reveal her mother’s issues with her boss. She recalled:

I didn’t really have any PTO left and I felt like I finally had to tell her [boss] about my mom. That was the time we had to get a search and rescue team out looking for her at the Gorge [an area of a National Forest in Kentucky] because she left us a note saying she was going to jump off a cliff there. We found her in her car in the parking lot and she was fine, but I had to take that next day off. I just was so emotionally drained, just frazzled. So I had to tell her. But I hated letting my personal life bleed into my professional life like that.

By choosing to only disclose on a selective, need-to-know basis and only revealing certain details, most participants engaged in some degree of alternation and balance to manage the expression tension and meet the underlying needs motivating revelation.

**Revelation: Advocacy and mentorship.**

Another theme stemming from reciprocal disclosure was a motivation to reveal in order to advocate and to aid others, reflecting another underlying instrumental goal. Those who mentioned being more open about their parent’s illness in an effort to bring awareness was relatively small ($n = 4$), but worth mentioning because it shows the
opposing effect that the stigmatization of mental illness can have on the expression of tension. As previously mentioned, concealment (or partial concealment) was used as a defensive tool by participants in an effort to protect themselves, their parent, and their family as a whole from scrutiny, criticism, isolation, rejection, and other risks incurred by openness about a stigmatizing condition. Whereas stigma had a silencing effect on almost all of participants to some degree, these four participants noted that they felt compelled to be more open about it in an effort to combat the stigma attached to mental illness and be an advocate for their parent. For instance, Emily explained that she saw openness as a kind of calling and higher purpose:

> It was the shame and stigma that prevented my dad from getting the help that he needed. Stigma and shame is the reason that he deteriorated. It prevented him from getting help. So I’m very open about it. It’s a part of my story, and I can use my experience to help others, I want to do it, in spite of the potential negative repercussions.

Since Emily witnessed how the shame of mental health issues slowly ate away at her father, she saw it as her duty to be open and honest in order to educate others. In fact, we conducted Emily’s interview in a public place (which was her choice), and when given the choice to conduct the interview somewhere more private, she declined, saying, “I don’t care if people hear us talking about dad. I hope they do hear it. Maybe that will encourage other people to talk.”

Thus, according to these four participants, the potential to chip away at the stigma was a reason to disclose. Kerry explained that even though she was reluctant at first to share her mother’s issues with her in-laws since they had such a narrow view of mental illness, she then realized it was a chance to educate them and open them up to a new
perspective on what it means to grapple with a mental illness. Similarly, Peggy perceived revelation as an outreach opportunity, explaining,

Mental illness is not a singular disease. It affects everyone in the family. And it is in every single family. It’s prevalent. It’s an epidemic. If I stay quiet about my mom, what good does that do for anyone else? You never know who you might help by sharing your experience. Maybe their dad or sister or somebody is suffering and they don’t know what to do or who to talk to.

Although one of the primary motivators to reveal information about a parent’s mental illness to an outsider was to procure emotional or informational support, these participants also recognized the opportunity that openness provided to offer support or information to others. When Lily discovered her friend’s sister was struggling with her mental health, she felt like she had an obligation to disclose to her mother’s health issues. It was important to her to not just be able to see her friend as an outlet of support, but also to let her know that her friend could also rely on her:

I wanted her to know that I understood and she could talk to me. I told her everything that had happened because I wanted her to feel comfortable coming to me for advice, no matter how embarrassed she might be. I thought maybe if she knew the hell I’d been through, she wouldn’t feel like she had to be ashamed and I could be an outlet for her.

In addition to managing tensions related to integration and expression, participants’ experience with their parent’s mental illness also reflected a grappling with what Baxter and Montgomery (1996) term the dialectic of certainty. The certainty dialectic and the underlying goals motivating these communicative practices are explored in greater depth in the next analysis chapter.

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Chapter Seven: Analysis of the Dialectic of Certainty

According to relational dialectics theory, the certainty dialectic centers on the dynamic and discursive interplay between the opposing, yet unified need for predictability, stability, and familiarity, and the disruptive forces of change, spontaneity, novelty, and variation. In this context, the inherent instability of the illness was the impetus for change and resulting uncertainty, providing fertile ground to sow seeds of anxiety and distress, especially those about the future (both their own and their parent’s). The instability of the situation created a desire for greater predictability and normalcy. However, interestingly, adult children found and satisfied a need for predictability and routine by recognizing and adapting to the emotional and behavioral patterns exhibited by their parents throughout the course of their illness. Also helping to satisfy their need for predictability, participants readily and freely expressed a belief in their own agency, and in their ability to overcome challenges and be an impetus for change. Contrasting the sense of helplessness that accompanied discussions about change and the uncertainties that accompanied it, discussions of predictability and stability espoused a sense of hope.

First, this chapter will explore the external forces that created and contributed to change and instability in adult children’s lives, followed by a discussion of how children strategically coped with this volatility by integrating praxes enabling stability and predictability.

Dialectic of Certainty: Change

In the traditional iteration of this theory, Baxter and Montgomery (1996) explain that all relationships require some level of predictability, certainty, and stability in order to exist. A complete lack of certainty would mean that the relationship is totally
unpredictable and lacks any sense of dependability. However, a relationship where the partners manage the tension with too much certainty can become stale. Relational partners denial of their need for uncertainty is not ideal because, according to Baxter and Montgomery, some level of change and spontaneity is necessary to maintain interest and a sense of novelty. However, applied in the context of mentally ill parents and their children, these opposing forces take on a slightly different meaning. People who have a mental illness may be labeled as “emotionally unstable,” thus, it is a disease characterized by inconsistency and instability, and mentally ill persons can exhibit abnormal and unpredictable behavior, or what many participants would refer to as “swings” or “episodes.” Harkening back to the notion of the interdependence characteristic of the family-as-system perspective, the emotional instability and behavioral unpredictability of mental illness spills over into the family dynamic and how the relationships within the family operate. Data from the current study revealed that the change and uncertainty that is characteristic of mental illness is distressing to children of mentally ill parents, and many participants expressed a desire for the greater stability and predictability that fewer disruptions from their parent would afford.

Embedded in this dialectic was the theme of perceived control, or more accurately, the lack of perceived control that children believed that they had over their parent, the disease, and how their parent’s disease affected their own lives. The relationship between uncertainty, perceived lack of control, and distress has been theoretically and empirically supported (Hoff, Mullins, Chaney, Hartman, & Domek, 2002; Mishel, 1990). Applying a multiple goals perspective to understand the distressing nature of uncertainty in this context, it is important to recognize that the change and
instability aspect of this dialectic is not motivated by or reflective of specific goals as was seen with the other tensions. Rather, the distressing part of this change and instability for participants was in having instrumental, identity, and relational goals threatened and thwarted by outside forces that were often beyond their control. Two primary factors influenced adult children’s uncertainty with regard to control: (a) Lack of control over their parent’s illness, and (b) lack of control over legal and medical institutional barriers. First I will demonstrate how the ever-changing and unpredictable nature of the illness itself contributes to feelings of helplessness, and then how institutional barriers amplify anxieties over this volatility.

**Change: Lack of control due to a volatile illness.**

At the core of the dialectic of certainty for participants was the constantly changing and unstable nature of the illness and its emotional and behavioral effects. Referring to the chemical nature of the illness and the lack of control family members and others have over someone experiencing mental health issues, Adam quipped, “there’s this joke. There are only two things that make you happy in life: Serotonin and dopamine. External things aren’t going to fix it because depression isn’t coming from the outside, it’s coming from the inside.” All participants expressed frustration about the unpredictable nature of the disease, and especially over their inability to change its course. Sarah learned that “there’s so much that’s beyond your control” when a relative is mentally ill, and “you can’t fix them. They have to want to get better first.” She acknowledged that accepting that is difficult. Hannah reflected on how her father’s inability to control his thoughts, emotions, or actions left him and his family feeling powerless:
Mental illness is an illness; not something you can control. I think people tend to think about a mentally ill person, ‘just stop acting that way,’ or ‘just stop feeling that way.’ But I’m here to tell you, I certainly saw a man who was incapable of controlling anything. It was completely out of his control. It was out of our control.

In response, some participants noted ways in which they try to regain a sense of control over the illness by making conscious efforts to stay involved and in close contact. Although this is related to the integration dialectic explored in Chapter Five, with regard to change and uncertainty, this tension reflected an underlying sense of futility and a belief that they were “fighting a losing battle,” in Ben’s words. For instance, Lily reflected:

There’s nothing more that I would like to do than to fix my mom’s depression. She’s definitely in a down state now, and I still do everything I can to reach out to her. Call her, text her, go over to her house, trying to pull her out of it. And I end up taking it personally when those things don’t work. I end up wondering, why isn’t she happy with us? Why is she so sad? And it’s frustrating because I’m realizing that there’s nothing I can do to change it.

Ultimately, the lack of ability to control the changes that are precipitated by mental illness contributed to greater feelings of instability and despondency in many participants. Stuart explained that he struggles with this frustration regularly, even though he knows it is not something his mom can easily change about herself:

Sometimes I wanna just shake her and be like, why are you acting this way?—stop it! I know she can’t help it, but it’s hard. Because you have to remember, okay, I think logically, but she can’t always connect the same dots. She’s got a different filter she sees things through. But honestly, because of these imbalances [in her brain], I never know what I’m going to get thrown my way day-to-day, and that can be pretty unsettling to say the least.

Never knowing what to expect from their parent, or learning to “expect the unexpected” in Macy’s words, was a significant source of uncertainty for participants. While he was in a manic state, Emily said she watched her dad engage in indulgent and
impulsive behavior that was uncharacteristic of him, and although she struggled to understand his choices, she felt like because he was her parent and an adult, she was not in a position to question him or step in. She explained:

He had a closet full of so many expensive designer clothes and shoes. He would purchase things we didn’t need on a whim. Like buying multiple pairs of the exact same $400 shoe, like five luxury cars for he and my mom. It’s crazy. It just did not make sense. But I didn’t know what I could do to stop it. It wasn’t my place.” She went on to say that by the time that it got bad enough where her family felt like they could intervene, it was too late. She recalled, “it is just not predictable at all. Out of nowhere, it spiraled so quickly that we couldn’t have ever anticipated at the beginning how fast things would go downhill. And we were powerless to stop it.

As mentioned in Chapter Five, many participants made frequent allusions during the interview to the disease overtaking their parent and consuming them from the inside out. Framed this way, adult children perceived the mental illness to be a powerful force, and one they did not feel they were equipped to fight, in part, due to the institutional barriers put in place to protect individual rights in healthcare.

**Change: Lack of control due to restrictive institutions.**

Seven family members interviewed for this study told me that their family member was not currently receiving treatment for their illness at the time of the interview because “they do not believe that they are sick.” According to the National Alliance on Mental Illness, this is a condition called Anosognosia, “coming from the Greek meaning to not know a disease” (Anosognosia, 2018). Specifically, this is when a person rejects the notion that they are mentally ill, and is the result of a lack of awareness or absence of clear thinking. Even those whose parent were currently receiving treatment at the time of the interview could recall a time when they were enmeshed in a battle to get their parent to recognize and admit that they required outside help. Due to protective regulations in
place from the Health Insurance Portability and Accountability Act (HIPAA) and other legal and medical protocols regarding informed consent, a right to refuse treatment, and other procedural protections designed to safeguard patients rights, family members may be left out of the process (Doornbos, 2002). Further, without the recognition and admission of the ill parent that they are ill, adult children have very few options that they can pursue to get their parent help. If the parent commits a crime, they could be accepted into mental health court as alternative to serving regular jail time and they would be required to complete treatment as part of this program, but according to SAMHSA’s GAINS Center for Behavioral Health and Justice Transformation, this program is not widely available in every state (Adult Mental Health Treatment Court Locator, 2018). If the parent threatens to hurt themselves or someone else, they could be involuntarily committed to a mental health facility, but even in cases where people do get admitted, average stays may only last a few days to a week, and “involuntary treatment requires a complex combination of legal, law enforcement, medical, and mental health agencies,” so it can be difficult to obtain any meaningful length of stay (McFarland, Faulkner, & Bloom, 1990, p. 146). Seven participants had attempted to pursue this option.

Finally, a family member could file for guardianship, but this process is tedious and complicated in many states since it takes away a person’s civil rights, often requiring, at a minimum, multiple filings of official statements, serving your family member with papers, and a hearing in front of a judge with both parties present. In Kentucky, where this study was conducted, the hearing is to be seen before a judge and jury, and requires the respondent (in this context, the mentally ill parent) to be examined by a three-member team consisting of a psychologist, social worker, and physician. Additionally, according
to the Department for Aging and Independent Living in the Kentucky Cabinet for Health and Family Services, the person filing for guardianship (in this context, the child), is required to file periodic reports after guardianship has been granted, and can be held personally responsible for actions they take as guardian (Wayne, n.d.). I did not have any participant who had chosen to file for guardianship of their parent, but I did have one participant who filed for conservatorship and became responsible for their parent’s financial affairs. As a result, only one of my participants had any form of legal rights over their parent, but none had legal rights to oversee or intervene in their medical treatment.

These limited, and mostly not ideal options, further contribute to a lack of control over change and a sense of uncertainty in adult children of mentally ill parents. Peggy recalled a time that her mother refused to say in front of a judge that she wanted to hurt herself or someone else, so the judge denied Peggy’s order to have her mother involuntarily hospitalized. She elaborated:

Mental health is such a nightmare to get any kind of medical help with. They just don’t—for all the lip service it gets—they don’t recognize that it needs its own processes and procedures and support system, but it’s so flawed because it relies on that person’s logic to get treatment. Then you’re left in this limbo because you, as their family, you’re expected to take care of them, but you can’t get them help without their consent. And in my case, she wouldn’t give it [consent]. I don’t think this is an anomaly.

If my small pool of participants is any indication, Peggy is correct in that Anosognosia and frustration with legal and medical protective regulations is less the exception than it is the norm for adult children of mentally ill parents. The lack of resources available to family members and other caretakers of mentally ill individuals was the source of defeatism and despondence for all participants (even those who were no longer in contact with their parent), because they felt that even though they were often
looked to by outsiders as a responsible caretaker, they were not given the tools that they needed to be effective in this role. Erica elucidated this point, explaining:

I know she needs medicine, but she doesn’t think she does. Even when she has it, she won’t take it. And what can I do about it? I’m not allowed in any of her doctor’s appointments without her permission, so I can’t tell them what’s really going on. I’ve tried to have her hospitalized but she won’t say she’s suicidal or homicidal in front of a judge or medical professional. I’m fighting with my hands tied behind my back. I guess I could give up my whole life and go to her house everyday and force-feed it [medicine] to her, but who’s to say that would even help anything.

Lily expounded on the impossible position adult children are put in when a family member refuses treatment or does not believe in the legitimacy of their diagnosis. Specifically, she addressed the conflicting values of individual health-related privacy and the importance of an informed support network:

It’s like, I recognize why consent for treatment is important, especially with certain illnesses. I value a person’s right to choose what’s right for them, especially when it comes to their own body. But she’s got a diagnosis saying her mind’s not right, and you’re telling me you are still asking her to recognize and tell you she’s not in her right mind? In what world does this make sense?

Although participants acknowledged how and why these regulations are essential for preserving patient’s rights and dignity, many of the adult children interviewed for this study expressed exasperation at what they believed to be a broken system that relies on relatives to care for the mentally ill, but provides them with few resources to do so. These institutional barriers contribute to adult children’s feelings of powerlessness, and ultimately their feelings of instability and lack of control.

**Change: Anxieties about parent’s future.**

Due in part to a perceived lack of control over the trajectory of the illness, adult children of mentally ill parents experienced significant uncertainty regarding their parent’s future, and this uncertainty was distressing to them. This is consistent with
research that has demonstrated the association between uncertainty and distress in illness (Hoff, Mullins, Chaney, Hartman, & Domek, 2002), and that family members can experience “proxy uncertainty” due to a lack of direct illness experience and an inability to make educated decisions for or on behalf of their relative (Kerr & Haas, 2014). For instance, Kerry says that as a result of experiencing the unpredictable highs and lows of her mom’s illness over her entire lifetime,

I live in constant fear, and it’s underlying, that the other shoe is going to drop at anytime. And I worry constantly, even if it’s not on the surface or justified, but it’s always a fear that no matter how calm things may be at the moment, something bad is on the horizon. And I structure my life around that; that it’s a possibility at any given moment.

Relying only on observational evidence and what Kerr and Haas refer to as a “gut feeling,” adult children of mentally ill parents indicated that they have to be “on their toes” at all times in order to be quick to respond to emotional swings and crisis situations.

Anxieties about the parent’s future fell into two primary categories: (a) anxieties about the parent’s safety and security, and (b) anxieties about potential parent suicide.

Anxieties about the parent’s safety and security.

One of the most frequently cited worries adult children had for their parent’s safety and future concerned housing (or the possibility of a lack of housing). Specifically, nine of the 15 respondents expressed that most of the anxiety that they feel regarding their parent involved the very real potential that they would end up homeless. For instance, Peggy’s mother was in a state-run assisted living facility at the time of this interview, but had had multiple complaints against her due to her delusional, temperamental, and volatile behavior. Because of this, Peggy explained,

I live in fear every day that I’m going to get a call that they’re going to put her out. That she’s finally offended and upset enough people that they can’t keep her
anymore and I’m going to have to find someplace else for her to go. And I have no idea where that would be.

Six months after the interview, Peggy reached back out to me to tell me that her fears were justified and that her mother had been evicted from the facility with very little warning due to her highly manic behavior. She then “had to scramble to find her a place to live.” Peggy explained that she only has a one-bedroom apartment for herself and very limited resources, so she was unable to pay out-of-pocket for a private facility. Instead, she was forced to put her mom into another state-run (but less desirable) facility almost an hour away. “I told you it was going to happen,” she said. “It was a matter of time.”

Similarly, underlying and amplifying Eric’s worry about his mother becoming homeless was his own lack of financial means to assist her if that should happen. He explained that he has “always been concerned about her having a place to stay—being homeless and on the street. I’m not in a position to take her in, and a lot of places for people in her condition have waiting lists to get in.” Lily was also very worried about her mother ending up homeless, and said most of this worry was because that meant that she would eventually have to move in with her or her sister, and about the financial and relational strains that would put on the family. Will echoed this fear, explaining that even though it is not overwhelming, it is ever-present:

I try not to worry about what hasn’t happened; there’s too much that is happening to worry about. But where she is going to live when she’s evicted is always in the back of my mind. It’s not really about if, but when it happens at this point. And what then?

Considering the prospect of his mother having to move in with him, he then joked, “our relationship would never survive [living together]. Hell, let’s be honest, only one of us would come out of that one alive.” Similarly, Hannah recalled a time after her father’s
suicide that she confronted with the reality her father’s worsening condition before his death was leading down a path of potential homelessness. She recalled:

I saw a man about dad’s age stumbling on the street in the middle of the day in a not-so-nice part of town. And I remember thinking so vividly, that could’ve been my dad. If he were still here, that could have easily been him. That’s where things were going. And what’s better—knowing your dad is wandering completely incompetent and alone on the streets, or dead? I don’t know. But I know if he had lived, I would be worried about that all the time.

The idea that the death of their parent could be preferable to homelessness or a complete loss of mental faculties was not isolated to a single participant. At least five of my participants openly admitted to, joked about, or alluded to this thought, including Emily who said she is sometimes relieved for her father’s suicide because “he had squandered all of his money and there was nothing left to get him treatment. And then he’d have just been this shell of a person wandering the streets and we’d be left to just watch it happen, helpless.”

**Anxieties about the parent’s potential suicide.**

Similarly, another frequently cited concern that children had for their parent’s safety and future was the threat of suicide. According to the Centers for Disease Control’s Morbidity and Mortality Weekly Report (MMWR), this is not an unwarranted fear, as there were 44,965 deaths by suicide in 2016, and 10.3% (or ~4,649) of these individuals had a diagnosed serious mental illness. Although the data suggested that 54% of those who committed suicide in 2016 had no known mental illness, they note, “it is possible that mental health conditions or other circumstances could have been present and not diagnosed, known, or reported” (Stone et al., 2018). Thus, even though it is certainly not the only factor, mental illness can be a precursor to suicide. In the context of this study, suicide was mentioned frequently, as 11 of my 15 participants had their parent
seriously threaten or attempt to take their own life at least once, and two participants’
parent had completed suicide.

The very real threat of suicide added to participants’ uncertainty and was clearly
distressing for adult children to consider and to speak about. It was a fear that in many
cases significantly influenced adult children’s communication with their parents. For
instance, Erica said that she wishes that she and her mother could have an honest
conversation about the drug use, sexual abuse, and violence that she was subjected to
growing up, but feels that bringing it up would de-stabilize her mother and potentially act
as the impetus to suicidal thoughts:

I tiptoe around the past with her because I don’t think she could handle it. So I
just want to keep things positive and light and focused on the present and not
bring up all the bad stuff from before, because I just have this feeling in my gut,
this nightmare, that one day I’m going to get a call that she’s done it. And then I’ll
never get over that it was my fault for dwelling on the past and not letting us
move on.

Erica was not alone in strategically modifying the content of the conversations
with her mother in an effort to avoid triggering a suicidal episode. Kerry explained that
she waited until she was close to five months pregnant before telling her mother the
news. She explained:

Most of my friends tell their mother first thing, sometimes before their husbands! But not me. I kept it from her because I didn’t know what the news would do to
her emotional state. Instead of being happy about it like a normal soon-to-be
grandmother, she was going to be anxious. She’d shut down. It could spiral into a
depression where her thoughts became destructive. I just kept delaying the
conversation because of that.

Providing additional evidence that the uncertainty about what events could ignite
suicidal tendencies influenced children’s communication practices with their parent,
Stuart put the delicacy of the situation in more general terms, explaining, “if something is
going on that is going to upset her, I’ll be very careful about what I tell her, and when. I don’t always know what’s going to send her down the rabbit hole, but best I can do is try and anticipate it.”

The threat of suicide not only influenced the content of the communication between the child and their parent, but also the frequency. For instance, Sarah noted that she tries to talk to her mom almost every day to try to prevent “something bad from happening.” More specifically, she elaborated, “she’s cut herself and attempted suicide before, so I’m always worried if we don’t talk for a few days. So I make sure to call her and make multiple attempts to reach out on a regular basis.” Even though her mother was doing well and following her doctor’s treatment recommendations at the time of the interview, Sarah said that this has changed on a dime in the past, so remaining vigilant and “on top of things” is the best strategy she has found to create some sense of stability. Thus, even children whose parents were receiving treatment at the time of this interview were susceptible to chronic worry, largely due to the unpredictable nature of the illness and the potential for “relapse” if strict treatment regimens were not followed.

**Change: Anxieties about own future.**

In addition to having specific worries about their parent, adult children also experienced a rippling effect wherein the variability and uncertainty surrounding their parent permeated other aspects of their lives. Unprompted by interview questions, six participants referred to this response as “hyper-vigilance” and others explained a need to always have to be “ready.” Others, like Lily, explained it as an underlying, but perpetual feeling of dread. She elaborated:

I do have a sense, and I always have it, that the bottom is going to drop out. Something is going to go wrong. So I always have to be reinforcing with myself,
that’s not necessarily true. The bottom doesn’t always drop out. But I carry that fear with me all the time now because it seems like with mom, it usually does eventually. I even carry it into friendships, looking for a job, love interests, all of that. So it’s just trying to always actively and consciously turn that mentality on its head.

In Lily’s case, the instability of her mother’s condition infiltrated her perspective so that predictability in her life was seen as only just a brief period of an inevitable and never-ending cycle of instability and change, and a kind of moment’s calm before the storm. Calling it “being in her lizard brain,” Emily said the hyper-vigilance and heightened anxiety she developed in response to her father’s mania is something that she has to work to combat and “coach” herself through every day. Thus, for some participants, the uncertainty of their parent’s illness contributed to an intense, distressing, and constant state of being overly sensitive to potential pitfalls.

Anxiety over the uncertainty of what was coming next would at times lie dormant, and was not necessarily an overwhelming or dominant force. Peggy explained that she had learned to bury her fears and not let them overtake her life, but certain events would act as a trigger.

It just hangs over me. I may not think about it every day, but when the phone rings and I see it’s my mom, it wells up from my gut. I think, Oh God, what fell apart, or what disaster am I going to have to fix now. I can almost feel my heart skip a beat and my skin tingle.

Many others cited phone calls or text messages from their parent or other family members as triggers for anxious feelings. After multiple suicide attempts, Eric noted that calls from his sibling and other family members can prompt a “feeling like a mild form of PTSD. I see that name pop up, and for a second, I have to remember to breathe.” He says that although it may seem like he’s over dramatizing it, there has been so much bad news
that has come through that medium that it seems like a natural response. For these participants, the uncertainty was unsettling and distressing, but seemingly irreconcilable.

*Anxieties about the genetic link.*

One type of anxiety-inducing uncertainty for self that was experienced by many participants was the question of the genetic component of the disease and how it might affect their future. Although this was not an ever-present concern or necessarily manifest in their communicative patterns with their parent—or with others about their parent—it is worth exploring here due to the number of participants who noted it during the interview. Hannah said that when she sees her own behaviors or thought patterns mimicking her father’s, she worries about whether they are “normal” or could be early signs of an inherited chemical imbalance. “Even if I’m at a store and I indulge and buy something I don't need, I think, ‘oh Lord, am I manic?’ And then I have anxiety over it.” Emily said her tendency to have panic attacks has been a source of serious concern because of her family history of mental illness, and how quickly she knows that it could spiral into something worse due to that predisposition. She said that after one of her panic attacks, her sister told her that she was concerned about the parallels between her and their father. She recalled:

> The state of utter fear and despair in my face looked just like dad’s. And that was a wake up call for me. I have my dad’s genes, so whatever made him that way created me. So, I have to be aware of that and always be cognizant of how I’m feeling and acting and question it. Because it’s critical that I nip it in the bud if I see it.

Constantly second-guessing their own thoughts and actions and questioning their origin was common among participants. For Penny, this is a vital and necessary “check in” with herself. “I am constantly tracking, like, am I losing my mind? Am I thinking
rationally? Have I inherited this craziness?” Amplifying this concern, Penny’s father reminds her “every freaking conversation” that is it is hereditary, and that even if she doesn’t have depression, her son could, and “that is terrifying” to her. For at least one participant, this fear of the unknown genetic lottery was a factor in the decision to have children. Lily explained that even though she worried about herself some, she felt that she had confidence over her ability to recognize the signs and take the steps to treat it. But it has come up as a topic of conversation when she and her husband have talked about when and if to have children.

I mean, my grandfather was bipolar, my mother is bipolar, my cousin is bipolar. The likelihood of one of my children having to deal with it is heartbreaking and scary, but very real. It would be negligent of me to not acknowledge that and at least consider it.

In an effort to find some semblance of stability and manage the unrest, volatility and sense of dread that accompanied it, participants would use various strategies. For example, Stuart explained that when he needed to “take a break from the crazy,” he would temporarily block his mother’s number. This is reflective of the alternation strategy, where one side of the dialectic is favored at different times (Baxter & Montgomery, 1996). Similarly, Peggy would put her phone away at special events where she wanted to be totally present, like when she is visiting her grandchildren. A couple of participants mentioned managing this dialectic through their faith or spirituality. This reflects the praxis pattern of segmentation, where participants would compartmentalize in order to satisfy both tensions. Kerry explained that even though sometimes her life with her mother is chaotic and unpredictable, she finds her peace in “doing things in service to the Lord” and maintaining her relationship with God, which satisfies her need for stability.
This can also take the form of the praxis pattern of recalibration, which involves reframing a tension so that the contradiction disappears. For instance, Sarah said that while she never knows what to expect from her mother, she is “certain in God’s plan,” demonstrating how she tries to reframe the uncertainty she experiences to see it as part of a larger, predetermined plan. Although I did not have many participants who were not speaking to their parent, those who did cut ties cited the inability to subject themselves further to the volatility that accompanied the relationship and the need for peace and to regain control of their own lives. From a relational dialectics perspective, this action reflects the praxis of disorientation, whereby the person feels overwhelmed and helpless to reconcile the contradiction, so they escape the tension by ending the relationship. All of these praxis patterns demonstrate ways in which participants attempted to meet their needs for stability in an undeniably uncertain situation. This is explored in greater depth in the following section.

The Dialectic of Certainty: Predictability

According to Baxter and Montgomery (1996), the dialectic of certainty is characterized by the interplay between the discourse of change, spontaneity, and novelty, and that of stability, predictability, and consistency. As explored in the previous section, participants’ experiences with their relative’s mental illness were often fraught with feelings of uncertainty, helplessness, and anxiety due to the ever-changing nature of the illness, so it is difficult at first to imagine that this is experienced or best understood as a part of a dialectic, or, more directly, that there are more than negligible elements of predictability and stability. Interestingly, the pulls toward uncertainty in this context were often the result of outside forces: the unpredictability of the disease and the variable
trajectory of its emotional and behavioral effects, the lack of control perceived by family members as they navigate the healthcare system, the inability to establish reliable expectations for what lies ahead in terms of the immediate or distant future. However, in spite of this, participants found centripetal forces in their lives that gave them a sense of predictability, constancy, and order. This is consistent with the theory, which suggests that relationships, at their core, require some level of continuity in order to exist. In other words, to be completely discontinuous would negate the existence of a relationship. Even those participants who had ceased communication with their ill parent, or whose parent had passed away, had to manage this dialectic due to the notions of familial interdependence and the existence of emotional ties. In the case of many participants, the predictability end of this dialectic manifest as a certainty in self that was born out of an uncertain and complex situation, expectations were established by recognizing and responding to patterns, and stability was discovered in acceptance and hope.

**Predictability: Acceptance and “it is what it is.”**

Adult children of mentally ill parents expressed frustration with the uncertain nature of the illness and how little control that they had over its trajectory, its affect on their life, and their relative’s life. Many of the stories relayed to me over the course of the interviews were easily categorized by the sense of helplessness and defeat that can accompany having a parent with mental health issues. However, there were instances throughout our discussion where instead of allowing the uncertainty to create distress, participants would redefine the experience as one of acceptance and resignation in order to find stability in their lack of control. Emily says that much of her understanding and enlightenment about her father’s illness comes from hindsight, and acknowledged that it
might not be as easy to accept things if they “were still in the thick of it.” She advised that from her experience, she learned that:

You have to accept that it is out of your control. There is nothing you can do except be patient and supportive and compassionate. I had to realize that I could not control the outcome. I could not control his illness. I could be compassionate and patient. And I think I did the best I could to do that. But it’s important to understand that it’s not your fault, whatever happens.

Applied to the theoretical framework of relational dialectics, Emily’s resignation reflects the praxis pattern of reaffirmation, or an acceptance of the tension as a part of the relationship. Acknowledging and accepting their own lack of control over certain aspects fosters some sense of peace, relief, and relinquishment of responsibility.

Similarly, Erica’s resignation regarding her mother’s Schizophrenia took the form of an exonerating self-talk, wherein she seemed to reassure herself of her own lack of control, which allowed her to absolve herself from potential undesirable outcomes.

I’m always saying to myself, I want to make you [her] better, but just wanting that and trying to force it is not going to make her any better. It’s just kind of like, all you can really do is hope that they’re aware of their situation and how to deal with it. Like the old saying, you can’t help someone who doesn’t want to help themselves. I’ve learned that—well, maybe still learning it—the hard way. So I have to remind myself of that all the time, and just try to be there for her in a helpful way when she needs me instead of imposing myself on her in a way that ends up hurting both of us.

Thus, resignation often took the form of “lessons learned” along the way. Feeling as if they were able to learn what to accept as out of their own control, what they could tolerate from their parent, and modify expectations accordingly seemed to be a source of stability for the adult children I interviewed. Managing the tension in this way demonstrates the praxis strategy of reaffirmation and recalibration in which they are able to consciously choose to re-frame the tension so that the contradiction is no longer there.
Adult children frequently drew direct and indirect social comparisons between their own parent and what they perceived as “normal” parents, especially those of their friends. Although this could (and did) contribute to some feelings of resentment, it also over time paved the way to acceptance by way of lowered expectations. For instance, Will explained:

I’ve never had a mom that takes care of me. Or makes me lunch and does my laundry. Or does anything for me really. I’m always in charge of myself. I take pride in that. But now I’m in charge of her too. It sucks, but it is what it is.

Peggy explained her relationship with her mother in terms of what it was not, even going as far as to say her mom is not really “a mom” in any traditional meaning of that word, but that she has come to terms with that over time.

Just because my mom is still alive doesn’t mean that I have a mom. I haven’t had a mom since who knows when. Not someone I can call and talk to about things or bounce ideas off of or depend on. Just those normal parent things. Like, she’d never come over and cook for me or take care of me. Would it be nice? Sure. But I’m never gonna have those things. I accepted that a long time ago, and I’ve gotten along fine.

Thus, acceptance, and in Will’s and a number of the participants’ words, recognizing that “it is what it is,” was a way that many of the participants reconciled this tension and found stability. Ironically, it was often their lack of control over the situation that allowed them to do this.

Additionally, a large part of acceptance for the adult children I interviewed was based in expectations. This is consistent with the robust literature borne out of the social exchange theory (Thibaut & Kelley, 1959), which suggests that relational satisfaction is relative, and based on comparison level. This comparison level is largely constructed from social norms and past experiences, and suggests that satisfaction with a relationship is calculated based on the difference between what a person expects to experience and
what he or she actually experiences. For those participants whose parent had a long
history of mental health issues but had shown improvement, they expressed contentment
with where they were, even if their parent did not meet their ideal of “normal.” For
instance, Stuart spoke of how his friends’ parents would buy them groceries, make food
for them, help them move, or take care of them in various ways. But he added:

That’s just not something that will ever happen with my mom. And it doesn’t
matter really; it doesn’t affect my livelihood or my ability to survive. I can just
never expect them from her. I’m just happy that she’s now able to call and check
in with me, where before she was so manic that she’d go on a bender and I
wouldn’t hear from her for days.

Thus, dialectically speaking, adult children may find stability in lowered
expectations (a form of the praxis pattern of recalibration) and in viewing their situation
in relative terms. Even for those participants whose parent was not receiving treatment or
doing well at the time of the interview, there was some level of acceptance on the part of
the adult child that although there may very little they could do to change the outcome,
they could change their own perspective. This was particularly evident when Kerry
explained that her framing gives her some power over events surrounding her mother’s
illness that seem beyond her control:

A good friend of mine once told me, ‘it is what it is.’ And I know that seems like
an overly simplistic, silly statement, but I took it to heart. I’ve tried to apply it to
how I see my mom. I think it gives me some peace. It kind of says, do what you
can do, but then be okay with how things are.

Although Kerry says this is easier said than done, adopting this perspective has helped
her maintain a relationship with her mother through difficult times. This suggests that
dialectically, recalibrating and finding some level of acceptance and absolution may
satisfy the need for stability in a situation typically characterized by uncertainty. This is
closely related to agency, which was another thread that was strung throughout these
discussions; specifically, how adult children of mentally ill parents have found ways to re-capture a sense of certainty of self in what can be a volatile situation and relationship.

**Predictability: Behavioral patterns and personal agency.**

Although outside sources contributed to the centrifugal, divisive pulls in the certainty dialectic, often fueling personal and relational discord and distress, the origins of the centripetal forces at play tended to come from within, or were based in an understanding of patterns in their parent’s behavior. In other words, participants expressed that they found their equilibrium and stability in their own resiliency and strength, and in learning to expect what might seem to be unexpected. Relational dialectics theory frames the centripetal forces in this tension as the need for predictability, stability, continuity, and familiarity in a relationship. However, as participants clearly illustrated in our discussions, these were not things that were consistent, naturally occurring, or plentiful in their relationship with their mentally ill parent. Thus, much of the certainty and consistency came from the intimate knowledge that entangled and defined their shared experience with their parent, and from their belief in their own personal power to evolve, adapt, learn, and overcome. This belief was a unifying force that allowed, in many cases, the relationship with their parent to remain in tact. Even in cases where the person no longer had ties to their parent, this certainty of self is what acted as a stabilizing force to carry on with their own life.

**Behavioral patterns.**

One of the outside sources of certainty in this relationship was the irrevocability of family ties and the familiarity bred by a unique shared history with their parent. All participants acknowledged that no matter the current state of their relationship, their
parent was always their parent (e.g., “that’s just mom,” in the words of Stuart), and that fact was inescapable. Whether they liked this fact or not, there was a strong sense of familiarity and certainty that accompanied this. For instance, Macy explained that even though her mom’s behavior is unpredictable and erratic to outsiders, she knows her patterns and can see the highs and lows coming when no one else can.

I think I know her better than she knows herself. She can do or say one thing and I can see the writing on the wall. I can see what’s coming. That helps some because then I can anticipate it and take the steps to try to head it off before it goes to the extreme.

In Macy’s case, and in others, the predictability came from the unique knowledge that is fostered by patterns in past experiences. Lily began picking up on her mother’s patterns early in her childhood:

My mom used to get super depressed at certain times of the year or after certain events. Especially when something was ending that she had looked forward to, like a vacation or a party. We knew it was coming. Like, well, mom’s not going to get out of bed for the week, better plan around that. [laughter] Eventually she’d come out of it—it wasn’t as bad back then—so that was just expected.

In this case, what may seem like erratic behavior became predictable and routine for Lily and her family. In other words, the unexpected became expected. Expecting the unexpected by learning to respond to patterns of behavior reflects the praxis pattern of integration, where both sides of the tension (both certainty and uncertainty) are satisfied simultaneously.

This knowledge of the signs and behavioral patterns could become a source of stability for the relationship, and would influence an adult child’s communication with their parent. Kerry said she knew her mom was entering into a manic phase when she would suddenly start talking incessantly and without a filter. “So I’d see that and I’d just flat out say, ‘Mom, you taking your meds?’” Similarly, Will would notice an absence of
communication, and that would be his alert that his mom had slipped into a depression or
had started drinking again. Although these ‘routines’ may be atypical, seemingly
dysfunctional, and not the kind of stability that Baxter and Montgomery (1996) had in
mind when developing relational dialectics theory, these patterns did act as a unifying
and familiarizing force for participants in many cases. For Sarah, their history and
intimate understanding of one another created a unique bond that, despite the hardships,
made her relationship with her mother an undeniable certainty, for better or for worse:

At the end of the day, my mom is and always will be my mom. She disrupts my
life a lot of days, and sometimes she embarrasses me and isn’t always the most
reliable person. But really we’ve been through so much together. No one can
really understand what we’ve been through except us. So on the bad days, I
always come back to that.

However, understandably, these dysfunctional routines could become
overwhelming and divisive over time, causing rifts in the parent-child relationship, and in
some cases, a total dissolution. During these times, the children I interviewed found
certainty and a sense of stability within themselves. Explained another way, a personal
belief in their own ability to overcome, to adapt, and to survive (or even thrive) in the
face of the challenges posed by their parent’s illness reflected a sense of certainty in self
and, in some cases, helped to buttress and stabilize the relationship.

*Internal strength and resilience.*

The adult children of mentally ill parents interviewed for this study demonstrated
incredible resiliency and developed an appreciation for their own strength. This acted as a
stabilizing agent and source of predictability and certainty, even in the face of the
distressing changes and uncertainties about the situation and the relationship. Even those
who admitted to struggling with their own personal emotional demons like anxiety,
depression, or self-doubt expressed pride and confidence in their ability to prevail through discouraging times and continually adjust to challenging situations. For instance, in reflecting on her father’s psychosis and ultimate suicide, Hannah explained that the one constant has been her ability to adapt and overcome:

I think, you know, I have kind of faced the worst thing that can happen, and so I try to draw on that as a strength. No matter what happens, even if the bottom does fall out, or the other shoe drops, I know that I’m equipped to handle it.

Although this positive outlook and tension management strategy cannot have a tangible impact on Hannah’s relationship with her father since he is now deceased, navigating his illness and grieving over his death with her siblings and mother has provided her with a reassuring and dependable source of support, reconstructing and stabilizing a unit that had been shaken and fractured. Similarly, in looking at the past and toward the future, Lily believes that her ability to handle complicated situations and problematic emotions had evolved as a direct result of her relationship with her mother.

I’ve learned how to manage my feelings and how to cope with challenging situations because of everything that’s happened. It can feel lonely sometimes having a bipolar mother, but you figure out what to do and not do to make the situation better. I think I’m better at it than I was five years ago for sure, and that’s probably one of the reasons we’re still in each other’s lives.

Thus, one important factor for some of participants’ maintenance of their relationship with their parent was in their own ability to more effectively manage their own emotions and communicate more strategically, thereby acting as the stabilizing force and agent of predictability themselves. Illustrating that stability is not easily achieved and is often the result of an ongoing cognitive process, Macy explained, “the earlier I can identify what’s going on with her, address its impact on my own life, categorize it, and
then compartmentalize it, the better I’ve gotten in handling whatever comes my way in my relationship with her.”

A few participants noted specific resources that they had found to be particularly helpful as outlets for support in recharging and rediscovering equilibrium for themselves and for their relationship with their parent. Seeking out and satisfying this need for predictability and certainty through other activities reflects the praxis pattern of segmentation, or satisfying the need through compartmentalization. As previously mentioned, faith and spirituality in some form was mentioned by at least five participants as being a strong stabilizing force. Sarah said that her relationship with God and her belief that he is control is what has allowed her to let go of what is not in her control and to accept her mother as she is:

I know that ultimately, it is in His hands. When I feel alone, when things are totally out of whack, when I feel despair, I turn to my faith and I know that it is all part of His plan. Psalm 46:10: ‘Be still and know that I am God.’ This helps me find some peace. Hopefully, then, I transfer some of that peace into our relationship. Given things that have happened, sometimes it’s hard to stay ardent in that faith, but I always come back to it.

In addition to spirituality, a couple of participants, like Emily, mentioned that practicing meditation and Yoga have helped them “stay centered,” which has allowed them to proactively seek out and find security and a sense of harmony throughout discordant times.

Finally, others found that helping others through trying periods, whether it is in counseling others professionally or in a more informal capacity, has also indirectly been a stabilizing force in their relationship with their parent by continually reinforcing their capacity for empathy and compassion. Kerry explained that her work as a teacher and her relationship with her mother are very symbiotic in that in both contexts, she has had to
learn to view events from other perspectives and be sensitive. She feels that she has grown significantly in her ability to relate to others through and because of her status as a daughter and as a teacher:

I carry what I learn in one area into the other. I think being a teacher has really helped me communicate with her [mother] better because I’ve become more empathetic. Also just the act of doing for others and getting out of my own stuff for while at work gives me the space I need to gain perspective sometimes.

A handful of the children that I interviewed for this study had lost any sense of consistency in their relationship with their parent and the tension was completely pulled toward change, discontinuity, and uncertainty. Even these participants found a way to negotiate this tension by finding certainty in their own agency. For instance, Adam believed that the volatility of his father’s illness contributed to toxicity in their relationship that was ultimately impossible to overcome. Although their relationship succumbed to the praxis of disorientation with this tension, Adam explained that he achieves a sense of certainty through his confidence in his ability to forge his own path, even in spite of an unstable relationship with his father:

I had to tell myself, you’re not destined to repeat the mistakes of your dad. So in many ways, I have defined myself in direct opposition to him. So in my relationship with my son and daughter, I try hard every day to be everything my dad wasn’t. You get to rewrite your story. You’re a lot freer than you think.

This realization was empowering for Adam, who found stability in not only freeing himself from his relationship with his father, but also in his ability to be what his father was not. Although this has not been a unifying force for he and his father’s relationship, it has allowed him to find some peace and acceptance in its dissolution.

Unlike Adam, Penny had not cut ties with her bipolar father, but also found that recognizing her father’s undesirable characteristics and defining herself in opposition to
him was a source of agency for her and contributed to a sense of empowerment for her. Although she acknowledges that some aspects of her life, like her genes, are not within her control, the decisions that she makes for her own life are within her purview, and she feels more certain of herself because of what she has seen that she can overcome.

Specifically, Penny recalled:

One time, a therapist told me, you know, you can just get off the phone with him. You don’t have to stay and listen to any more of it. Just say, ‘dad, I gotta go,’ and be done with it. And that was a revelation for me. So now I try to put that toward my whole relationship with him. I always have the power to walk away. That gives me a sense of control.

Realizing her agency in the relationship was not only gratifying for Penny, but ultimately unifying. In finding her own strength to remove herself when the situation became unhealthy for her emotionally, she was able to maintain a relationship with her father. In the framework of relational dialectics theory, this reflects the praxis of integration, wherein although there is an inherent uncertainty that accompanies her relationship with him (e.g., how he will react, what he will say, if he will cut her out of his life, etc.), she has found that realizing her power to walk away has been a source of certainty and control, allowing her to experience seemingly contradictory forces simultaneously.

Based on the analysis and the themes explored in the previous three chapters, the next chapter will offer answers to the research questions posed in Chapter Three, and then discuss the theoretical and practical implications of those findings.

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Chapter Eight: Discussion

The previous analysis chapters revealed that adults with a mentally ill parent experience competing, contradictory forces in making sense of their parent’s illness and their relationship with their parent. Specifically, these contradictions manifest as dialectical tensions, defined as unified opposites. Discursive practices both with and surrounding their ill parent reveal and are influenced by the dialectical interplay of these tensions. Although the contradictions uncovered here aligned with the three categories identified by Baxter and Montgomery’s (1996) original theory, the tensions of integration, expression, and certainty took on a unique form in this context. Further, a multiple goals perspective helped to illuminate the rationale behind the praxis patterns adult children used to manage these tensions. This chapter will summarize the primary findings of this study by providing answers to the research questions posed in Chapter Three, and then discuss the practical and theoretical implications of this exploratory inquiry.

Answers to Research Questions

Taken together, adult children of mentally ill parents experience seemingly opposing tensions in the enactment of their identity, relational, and instrumental goals. The interplay of these dialectical forces is prominent and powerful in shaping their discursive practices surrounding and with their ill parent. In terms of the dialectic of integration, children expressed feeling inextricably connected to their parent while also needing the space to live autonomous lives. Regarding the dialectic of expression, adult children noted the stigma surrounding mental illness and how that significantly influenced their decision to conceal their parent’s illness from others. Concurrently
however, many suggested that the need for support from others was at odds with those goals to protect their own and their parent’s identity from the stigma and was a force motivating revelation and openness. Finally, related to the tension of certainty, adult children spoke about the volatility and lack of control that comes along with having a mentally ill parent, suggesting that the instability of their own goals and relationships mimics and reflects the unpredictable nature of mental illness. At the same time, and even sometimes in the same breath, interviewees would express a confidence and assurance in their own agency, due in part to their ability to recognize and respond to patterns in their parent’s behavior, and in their ability to overcome any impending (or inevitable) challenges that lay ahead. That certainty had its limits when confronted with the hereditary nature of their parents’ condition.

With those conclusions in mind, the research questions posed in the theory chapter can be answered accordingly:

RQ1: What dialectical tensions most prominently define adult children’s experience of parental mental illness? Data revealed that for an adult child of a mentally ill parent, the parent-child relationship itself is inherently contradictory. Even in cases where adult children had not accepted a caregiving role, they reported experiencing a role reversal with their parent, whereby they accepted responsibilities and displayed the characteristics most typically required of and exhibited by a parent (e.g., anxiety about the future, a desire to protect, feelings of obligation, etc.). Thus, this contradictory relational context brought three dialectical tensions to the surface and intensified them. The tensions that framed adult children’s lived experience aligned with Baxter and Montgomery’s (1996) original three primary tensions: integration (connection to and
autonomy from their parent), expression (concealment from and revelation to others about their parent’s illness), and certainty (change that characterized the illness and predictability gained through agency). Importantly, in this study, the certainty and integration tensions were explored as internal contradictions (within the boundaries of the relationship), and the expression tension was explored as an external contradiction (between the relational pair and the larger social system of which they are a part).

When applied to this context, these tensions took on slightly different forms from their original conceptualization. This was especially apparent with regard to the integration and certainty tensions. One “localized particularity” (Baxter, 2006) in this context was in how notions of agency were salient in the interplay between the connection-autonomy dialectic. When children framed their parent as a victim of their illness who was not responsible for their actions, they were more likely to respond to pulls of connection, but when they framed their parent as the perpetrator who should be held accountable in spite of their illness, they were more likely to respond to forces of autonomy and distance.

Another contextual variation from the original conceptualization of these contradictions involved the tension of certainty. From a relational dialectics perspective, elements of uncertainty are framed in relation to positively valenced notions of novelty, originality, and spontaneity, and as necessary ingredients of relational existence. However, for adult children of mentally ill parents, uncertainty was often experienced in the form of anxiety inducing instability and change, a cause of relational discord, and not something that needed to be manufactured—it manifested naturally out of the situation,
largely produced by the volatility of the illness itself and children’s lack of control over events that affected their lives.

RQ 2: What goals underlie and influence the interplay of these dialectical tensions? The data revealed that multiple goals are reflected in and influence the dynamic interaction that continually takes place between these simultaneously occurring, opposing forces. Which goals were prioritized as primary and which were secondary was fluid, and influenced the interplay of the contradictory forces in the relationship. With regard to connection, instrumental goals, like overseeing their parent’s treatment and responding to their various needs for support dominated this pull and served to further enmesh their life with that of their parent’s. Relational goals, specifically, a desire to have a more traditional relationship with their parent, also played a role in the manifestation of this force. For some, identity goals, namely wanting to be perceived as a dutiful and responsible family member, also strengthened the forces of connection. On the other side of this tension, children’s identity goals, usually feelings of shame and embarrassment stemming from stigma, contributed to the autonomous pulls. Relational goals that they had with others, usually their commitment to a spouse, but also a desire to foster and tend to other relationships, were easily inhibited by obligations to their parent. Finally, instrumental goals, usually related to their professional aspirations, contributed to the need to assert independence and maintain a level of autonomy from their parent.

With regard to the tension of expression and the pull toward concealment, this desire was largely dominated by identity goals and motivated by the stigmatization of mental illness. Although they themselves were not the person with the illness, notions of courtesy stigma and family toxicity influenced their desire to conceal the illness from
others. Many noted that they believed others’ perception of them would be negatively influenced by knowledge of their parent’s illness, so that strengthened the pull toward the privacy end of the dialectic. This pull for concealment was most salient as an external and not internal contradiction, meaning that discursively, this pull manifested in how they managed their privacy with others outside of the parent-child relationship. On the opposing end of this dialectical spectrum, children’s instrumental goals, typically their need to procure emotional and informational support from others, contributed to their need to reveal their parent’s mental illness and issues related to it. Another instrumental goal driving this pull to reveal to others (that was also concurrently a relational goal) was to foster greater awareness and understanding in others about mental illness and provide support for others in their position. When it was determined that they were speaking with a person who could empathize and even relate to their situation, privacy management practices were more likely to reflect openness and contribute to reciprocal disclosure.

Finally, regarding the tension of certainty, the centrifugal divisive force was the changing and volatile nature of the disease and the lack of control perceived by the adult child. This volatility contributed to disorder and distress. Although forces of change were largely the result of outside factors, the sense of anxiety and powerlessness children reported was born out of having instrumental, relational, and identity goals thwarted by the unpredictability of the disease and its variable emotional and behavioral effects. This instability manifest in their communication practices with their parent, and also had a negative impact on the parent-child relationship. In terms of the opposing centripetal forces in this tension, children found stability and predictability by pursuing instrumental goals. On the one hand, those instrumental goals related to their parent, namely in
identifying behavioral patterns of the illness and in being able to anticipate what might come next based on these patterns, and on the other, instrumental goals acted as a stabilizing force by compelling them to engage in activities outside of the volatility of the illness. Another stabilizing force that was achieved through the pursuit of identity goals was their enhanced sense of self-certainty in their ability to overcome challenges, adapt, and to initiate change.

RQ 3: What praxis patterns do adult children employ to negotiate these contradictions? Adult children of mentally ill parents exhibited a number of praxis patterns to navigate dialectical tensions that arose out of their parent’s mental illness. Regarding integration, adult children most often employed the strategy of alternation. Specifically, children would prioritize one side of the tension over the other at different times, largely depending on and influenced by their most primary goal at a given time. For instance, when relational goals with others (like reaffirming a commitment to their spouse) superseded instrumental goals related to their parent’s needs or care, children would disconnect and disengage from their parent for a period of time by prioritizing autonomy, but in most cases among participants, this autonomous response was temporary. Regarding expression, in response to stigma, children of mentally ill parents would generally prioritize and respond to the need for concealment, but use the strategies of alternation and balance to incorporate their need for revelation to others. These strategies enabled them to satisfy this need by only sharing only certain aspects of their parent’s illness and other issues to specific individuals under certain conditions. Revelations were motivated by and reflected in instrumental and relational goals. Segmentation was also used in order to establish restricted areas where concealment was
prioritized in order to manage identity; this was usually in the workplace. Finally, regarding the dialectic of certainty, one of the praxis patterns children would use was that of reaffirmation, accepting their lack of control, and integration in learning to expect the unexpected by discovering patterns in their parent’s typically unpredictable behavior. Children would also use segmentation, finding stability, control, and peace in other areas of their life to counterbalance the volatility and uncertainty caused by the illness, namely in practicing their faith, participating in centering activities, and engaging in helping others.

**Implications**

**Theoretical implications.**

Adult children of mentally ill parents were confronted with managing multiple, sometimes competing goals in the face of coping with an illness that was not their own. These goals manifested as unified opposites, or contradictions. Although all participants expressed a desire to live independent, autonomous lives untethered to the complications and volatility of a mentally ill family member, they concurrently felt inextricably connected to their parent due to social pressures, a sense of familial obligation, hope for what could change, a belief that their parent was a victim, or some combination of the above. The adult children here also all expressed a desire to conceal information related to their parent’s illness from others in an effort to protect themselves and their relative from the scrutiny and the social tarnishing that often accompanies possession of or association with a stigmatizing condition. This desire was juxtaposed by a simultaneous need to strategically reveal certain information at specific times as a means to procure or provide support, explain errant behaviors, and bring awareness to mental health issues.
Thus, privacy management for all participants was very intentional, and cautiously and carefully negotiated. Finally, the adult children’s lived experiences relayed here also revealed the complications and complexities of attempting to find and maintain predictable stable lives stability and establish routines in the midst of a notoriously volatile, de-stabilizing condition. Although from a theoretical standpoint, traditionally, relational partners may need to manufacture some degree of uncertainty to balance the predictability of a relationship, in this context, uncertainty and change was plentifully produced and supplied by outside forces beyond their control, and the need for predictability was often satisfied by recognizing their parent’s behavioral patterns, reframing their understanding, altering their expectations, and by engaging in personally gratifying extracurricular activities.

The experiences of the adult children of mentally ill parents explored here are also illustrative of the concept of totality posited by Baxter and Montgomery (1996), and more specifically, the idea that tensions operate as part of an interdependent system and “change in relation to one another over time” (p. 16). Rather than the tensions existing and operating as binary pairs in isolation from one another, tensions revealed in this study functioned as a network of entangled, mutually influential contradictions. For instance, for adult children of mentally ill parents, the integration dialectic was intricately entwined with the certainty dialectic, such that the management of one was dependent on how the other was experienced and managed. The obligation that children felt to their ill parent often left them feeling trapped and “stuck” on this “emotional rollercoaster” of highs and lows on which they had little or no control.
The sense of being tied to their parent’s disease is not purely reflective of the force of familial interdependence and the dialectic of connection, but is also reflective of the salience of change and uncertainty in framing their interpretation of that connection as stifling and restrictive. In other words, in this context, the negotiation of the integration and certainty tensions were best understood in relation to one another. Children were easily disoriented and overwhelmed by the pulls of connection toward and with their parent when they perceived the situation as unstable, unpredictable, and uncertain. Similarly, when forces of change and uncertainty were strong, it was associated with the degree of connection and interdependence felt in the relationship, and in order to manage it and satisfy the need for stability and predictability, children would distance themselves from their parent and engage in other activities.

Thus, illustrating the theoretical construct of totality in relational dialectics, autonomy was strongly associated with predictability (and concurrently, connection was associated with change and uncertainty), and praxis strategies used to manage one tension often fulfilled and influenced the management of the other. When children were highly involved in their parent’s life, the volatility of the illness framed how this connection was interpreted and managed. More specifically, when the parent’s state of being was perceived as being unpredictable and uncontrollable, the connection could feel repressive. For some \( n = 2 \), it resulted in a suppression of the need for autonomy, reflecting an underlying belief that it was impossible to maintain separation from their parent. While for most participants \( n = 11 \), the most prominent management strategies were alternation (taking short periods of time apart from their parent) or fulfilling needs for independence through segmentation (i.e., professional pursuits or other relationships). In
some extreme cases \( n = 2 \), even outright disorientation (disillusionment with the tension and the severing of relational ties).

This interrelatedness was also evident in the association between the integration and expression tensions. For instance, the more that a child responded to the autonomous pulls of the integration dialectic, the more that they were able to conceal information from others about their parent’s illness because it did not necessarily interfere in their daily life. For instance, Eric was able to keep his mother’s illness relatively private, especially professionally, because his level of involvement with her did not interfere with work and therefore did not necessitate disclosure to colleagues. When children were more connected to and involved in their parent’s treatment and care, that also meant greater necessity and opportunity for revelation to others. For example, obligations or responsibilities to their parent may interfere with time spent with their spouse, dating partner, friends, or colleagues, and this would prompt them to reveal information (even if only in small amounts) that they may not have felt compelled to share otherwise. Thus, connection seemed to be associated with openness in this context.

Moreover, with regard to the notion of totality, this study highlights the importance of examining contradictions as they are embedded in historical, relational, and social context. Baxter and Montgomery (1996) note that it is inadvisable to “reduce contradictions to abstractions stripped of their localized particularities” (p. 17) and that they are best understood when examined in social context, as products of the relational, historical, and social environment. In the current study, adult children’s perspectives were positioned within the context of mental illness, the deinstitutionalization of mental health care, and their family, and it is impossible to separate their communicative practices from
these larger systems. For instance, most participants’ parents were single, divorced, or widowed \((n = 9)\), placing the familial burden of responsibility squarely on them as their parent’s closest tie. For some participants, the responsibility was “shared” among their siblings, but this was not always perceived as being an equitable distribution of responsibility. This situation undoubtedly amplifies their experience of these tensions and influences how they are negotiated in communicative practice. This, especially when understood in the context of deinstitutionalization, provides additional insight into how participants managed the integration tension, why many participants felt that they were obligated to maintain involvement, and why they felt their lives were so significantly entangled with their parents’ lives.

Relational history is another contextual lens through which to understand and interpret the findings. Those adult children whose parent’s disease manifested later in life (young adulthood or after) tended to have more positive memories of a happy childhood \((n = 7)\), and this also influenced the management of the tensions, especially those of integration and expression. It could be that these children’s management of the integration contradiction was influenced by their desire to recapture the intimacy they once shared with their parent and repay the care that was given to them in their childhood. Those whose parent had experienced mental health issues for most of their life \((n = 8)\) did not necessarily have those same types of positive memories tethering them notions of regaining a traditional parent-child relationship, and it became easier to respond to autonomous pulls by maintaining emotional and physical distance. Interestingly, relational history also influenced children’s privacy management and the negotiation of the expression tension. Children who had a positive relational history with
their parent also demonstrated a strong loyalty and dedication to maintaining a socially acceptable image of their parent, and this often meant a greater pull toward concealment of their parent’s stigmatizing illness. Taken together, all of these findings underscore the importance of contextualizing dialectical inquiry.

These contradictions not only lend credence to the existence of dialectical tensions in family relationships and how these tensions are mutually influential and contextually bound, it also provides further support that these contradictions constantly shape and are shaped by the communicative practices of the relational partners. For instance, in managing the integration tension, adult children’s discourse revealed a strong feeling of obligation to provide support and care to their parent, whether due to some greater sense of morality, or due to social pressure to intervene, and this sense of obligation served to further enmesh their personal lives with that of their parent. This perceived entanglement not only increased the frequency of their contact, it also restricted the content and quality of their conversations with their parent—often limiting it to topics related to the parent’s treatment, current state of being, or other task-related issues. As a result of this task-centered communication, the emotional intimacy for those children interviewed was lacking and largely tied to nostalgia for the past, or noticeably absent altogether. In simultaneously negotiating their need for autonomy in this tension, adult children would initiate periods of separation or distance from their parent wherein they would limit contact with them temporarily, or re-direct their attention to other interests and relationships.

While the integration tension provided insight into how the contradictions can shape the communication between the child and their parent, the children’s
communication practices outside of the relationship revealed the complexities of the expression dialectic and its influence on privacy management decisions surrounding the parent. For instance, stigma was clearly the most salient factor in how children managed the tension between revelation and concealment. Perceptions of stigma amongst participants were widespread, with all 15 participants directly or indirectly reporting feeling stigmatized themselves or on behalf of their parent as a result of their parent’s mental illness. This is reinforces previous research on families of the mentally ill’s experience of stigma (Burk & Shur, 1990; Phelan, Bromet, & Link, 1998; Ohaeri & Fido, 2001). Children acknowledged that choices made to conceal varying degrees of their parent’s illness from others was a protective act to save their own or their parent’s face. This is consistent with extant research findings that one of the primary motivations or functions for maintaining privacy boundaries in families was in an effort to avoid a negative evaluation like shame or blame (Vangelisti, 1994; Vangelisti & Caughlin, 1997). For instance, in an effort to protect themselves from negative impressions, especially when forging new relationships, children indicated that they would choose to avoid the topic of their parent completely. This reasoning was especially prevalent in the context of workplace relationships, where concealment was an effort to preserve an image of professionalism.

Revelation of their parent’s illness to others proved to be the result of a “complex mental calculus,” (Caughlin & Petronio, 2004, p. 388) and based on a combination of different factors. Consistent with research by Vangelisti, Caughlin, and Timmerman (2001), relational security was in most cases a minimum prerequisite in the decision to reveal a parent’s illness to a person outside the family—reflective of a feeling of
closeness and trust with the recipient(s). Interestingly, however, relational security was not the primary impetus influencing disclosure, as 10 of the 15 participants indicated that the topic of their parent’s illness was intentionally not discussed with even their closest friends because they did not believe that they would understand or be able to provide them with helpful support. Instead, revelation was usually contingent on anticipation or expectation of an empathetic response from the recipient, and relational security was secondary to that criteria. This indicates that one of the primary goals underlying disclosure is instrumental—to obtain helpful support—and sheds light on why some participants indicated that they felt more comfortable talking about their parent’s illness with acquaintances “who shared their plight” than they did with their closest friends who could not relate (Potasznik & Nelson, 1989, p. 603). Taken together, this suggests the importance of adult children establishing connections with other relatives of mentally ill individuals as outlets for satisfying the need for expression and resources for obtaining meaningful social support.

Revelation also occurred when it was deemed an unavoidable necessity. This is consistent with research that suggests disclosure of private family information is likely to occur when an outsider has an important reason to know the information (Vangelisti, 2001). Children of mentally ill parents indicated that many decisions to reveal to others occurred for precisely this reason. This reasoning reflects the salience of goal interference for privacy management decisions. For instance, if meeting instrumental goals related to the parent’s needs interfered with other personal instrumental, identity, or relational goals, children might choose to reveal their parent’s illness in an effort to explain decisions that would otherwise garner a negative impression or have harmful effects. For
instance, nine of the 15 participants recalled times when they felt forced to reveal their parent’s illness to a supervisor or colleague in order to explain falling short of professional expectations. This was especially true in the context of the workplace with colleagues and supervisors where identity goals were paramount. Even when revelation occurred in these circumstances, it was often only incremental, centered on a single event (e.g. attending a parent’s doctor appointments as a reason for taking off work) and non-specific in nature in order to protect themselves or their parent from further stigmatization. Thus, in the present study, the interplay between revelation and concealment was complex, heavily influenced by perceptions of stigma, and reflected in (and shaped by) their communication practices with others outside of the parent-child relationship.

Beyond simply illuminating the intricacies of the contradictions that define the lived experience of adult children with a mentally ill parent, this study also revealed that children used a number of different praxis patterns in order to manage the tensions. According to Baxter and Montgomery (1996), “praxis focuses attention on the concrete practices by which social actors produce the future out of the past in their everyday lives” (p. 14). The adult children in this study made intentional choices in how they communicated with and about their ill parent, and these actions reflected their strategic management of the dialectical interplays that defined their experience. For instance, in managing the integration tension, adult children would frequently use the praxis strategy of alternation in order to satisfy the need for both connection and autonomy. Employing this strategy, 10 of the 13 children who were otherwise moderately to highly involved in their parent’s daily life indicated that they would take periods of separation away from
them in order to focus on other goals, like reconnecting and spending time fostering the relationship with their spouse or romantic partner, or pursuing professional ambitions, for example. By alternating between periods of connection and autonomy, children were able to meet goals related to both forces. Interestingly, however, although children employed this alternating strategy in response to the integration tension, none indicated that they felt satisfied with how they manage these competing forces, with many feeling oppressed by the interdependency, but simultaneously expressing guilt for needing space and responding to their need for autonomy.

The children managed privacy surrounding their parent’s illness very purposefully and intentionally. As previously discussed, privacy management decisions were heavily influenced by perceptions of stigma and performed a protective function for self and other. This defensive boundary not only protected the child and the parent; it was meant to shield the family as a whole from the stigma attached to having a mentally ill relative. This illustrates and lends further credence to the notions of courtesy stigma (Goffman, 1963) and family toxicity (Lefley, 1989), and suggests that these conceptual lenses may have utility in framing future research on privacy management practices in families of mentally ill persons. In order to “manage” information about their parent’s illness, children tended to use the praxis patterns of alternation, segmentation, and balance.

Generally speaking, adult children tended to privilege concealment over revelation, but did alternate into periods of openness with others about their parent’s illness under specific conditions and/or with certain people who were believed to be empathetic. For instance, those participants who had participated in the NAMI Family-to-Family program or attended another support group \((n = 4)\) found those meetings to be a
time to satisfy their need for revelation and cathartic release. Even those who did not attend a support group had established a network of close family and friends as an outlet to openly share information when needed to meet specific goals, such as using them as a resource for emotional or informational support. For most of the participants in this study who were married ($n = 7$), their spouse/romantic partner usually anchored this network, which is consistent with research illustrating the importance of a supportive spouse as a resource for coping (Potasznik & Nelson, 1984). For those participants who did not have a romantic partner or siblings (or did not have a strong relationship with their siblings), a close friend or group of friends became the outlet to share information about their parent. Interestingly, however, as previously discussed, being a close friend was not an automatic qualifier for revelation, as most participants indicated that they did not share the topic of their parent with their friends because they did not feel as if they would be empathetic, and they felt as if sharing opened them up to receiving unsolicited—and often unhelpful—advice.

Using the praxis of balance meant that even in relationships where the parent’s illness had been revealed, content was usually restricted so that specific details that might invite judgment were omitted, and discussion only occurred during or immediately following a specific event, like a crisis or emergency situation (e.g., a manic or suicidal episode) to avoid “overburdening” their network. Using a combination of balance and alternation allowed children to carefully negotiate concealment while also pursuing goals that required revelation. For instance, in the past when a parent had been suicidal, children indicated that they tended to over-share, but during periods that were relatively calm, they tried to be mindful and limit their openness.
Segmentation was employed as a strategy in determining areas of their life in which little to no information about their parent was revealed. For my participants, the most restricted area was their place of employment, where they felt their professional image could be tarnished and abilities questioned by revealing and openly discussing their parent’s illness. The one exception to this rule was that information about the parent could be revealed to a supervisor or colleague in order to meet an instrumental goal, such as when the information was necessary in order to seek pardon when parental obligations took precedence over professional responsibilities. By segmenting their lives and concealing their parent’s illness at work and revealing only in the confines of specific personal relationships, adult children found ways to negotiate these opposing needs.

The present study also found that children of mentally ill parents employed specific strategies in managing the certainty dialectic. Since change and instability were naturally produced by fluctuations in the parent’s mental and emotional state, praxis patterns were primarily used in an effort to satisfy the need for predictability and stability. One management strategy children employed was reaffirmation, where the tension, and specifically the parent’s condition, was accepted as being beyond their control. Resignation and acceptance allowed children to exonerate themselves and provided a sense of relief when their parent’s illness, the situation, and their relationship with their parent was especially volatile. Children also learned from past experience and used patterns in their parent’s behavior in order to find a degree of predictability in a situation that was notoriously unpredictable. Understanding and responding to patterns of their parent’s behavior illustrates the utility of the praxis of integration—finding ways to satisfy both forces simultaneously—for children of mentally ill parents in negotiating the
certainty tension. For instance, children explained how they had learned over time that specific events would trigger depressive or manic episodes, so when these events would occur, they would be able to anticipate and respond appropriately. Children noted that being cognizant of these specific situational and behavioral cues satisfied their need for predictability with their parent in a notoriously unpredictable situation.

Additionally, children found stability and satisfied the need for predictability through segmentation. Participating in activities outside of their obligations to their parent helped satisfy their need for an established, predictable routine. For instance, many children noted that regularly participating in activities that were personally gratifying gave them a sense of stability and control that they often struggled to obtain inside the parent-child relationship. Activities like doing Yoga or exercising, maintaining involvement in church and other spiritual engagements, focusing on other relationships, and mentoring others were some of the strategies cited by my participants as useful for attaining a degree of consistency and stability.

A multiple goals perspective (Berger, 2004; Brown & Levinson, 1987; Clark & Delia, 1979; O'Keefe, 1988; O’Keefe & Delia, 1982) helped to illuminate the communicative dilemmas adult children of mentally ill parents confront as they attempt to integrate goals born out of their parent’s health issues into the management their own independent lives. The salience of goals was especially evident in examining praxis patterns. Analysis revealed that adult children of mentally ill parents navigate communicative dilemmas regularly in their enactment of their relationship with their parent, wherein multiple goals are experienced simultaneously, but are at odds, meaning that pursuing one goal impedes the accomplishment of others. For instance, for
participants in the current study, the goal of maintaining a relationship with their parent and the demands that entailed could interfere with the instrumental goal of pursuing a new opportunity in their personal life (e.g., making a geographical move, changing careers, or pursuing academic ambitions). This was reflected discursively in the frequency of communication or the regularity of contact. If children prioritized instrumental goals related to their parent’s care and maintaining the parent-child relationship (“other-focused”), communication was frequent and task-centered, whereas the prioritization of other “self-focused” instrumental goals considerably lessened the frequency of contact with their parent.

Another example of this that frequently occurred among participants was reflected in children’s privacy management practices regarding their ill parent, where instrumental goals (e.g., procuring social support) often operated in direct opposition to identity goals (protecting the self and the parent from judgment and criticism). Although these multiple goals could work in tandem to achieve multiple purposes, at times the goals were inherently at odds and obstructive. For instance, in the professional context, if the identity goal of image protection was deemed primary, face saving attempts may have restricted the amount of revelation necessary to obtain the boss’ or colleagues’ understanding and reprieve for falling short of expectations. Thus, the identity goal would have been achieved, but at the expense of the instrumental goal of being pardoned from certain professional responsibilities.

Although a multiple goals framework provided insight into the complex motivations and dilemmas that underlie the communicative practices, it did not by itself capture how adult children made sense of their role in their parent’s life or how that role
was discursively negotiated. The intersection of these two theoretical perspectives lies in
the notion of the “dilemma.” In the present study, conflicting goals were representative
manifestations and the product of dialectical tensions, or unified contradictions, and were
reflected in praxis patterns. For instance, adult children expressed the belief that they
were inextricably connected to their parent, and that the interdependence was an
inescapable necessity brought on by the illness, while simultaneously expressing a need
to pull away and assert their autonomy from their parent because of the demands the
illness placed on them. In this case, strategically and intentionally pursuing an
instrumental goal relating to the care of their parent, like assisting a parent daily with
their medication compliance, for example, is reflective of and reinforces the connection
end of the dialectical spectrum, but can inhibit the successful accomplishment of other
instrumental goals, like taking a promotion at work that would require a geographical
move, or relational goals, like taking a weekend getaway with their spouse to strengthen
their marriage. In other words, how and why children pursued certain goals over others
was reflective of how they experienced and managed these contradictions.

It is important to recognize that although dialectical perspectives posit that all
relationships experience contradictions and that tensions are defined by and reflected in
discourse, this study offers support to the body of research that suggests that tensions are
amplified and especially salient in the midst of chronic health issues, especially as they
occur within the context of family relationships. Although this study relies on individuals
as the source of analysis, the perspectives highlighted here are representative of “persons-
in-relation as they interact with others” (Montgomery & Baxter, 1998, p. 5) and examines
how contradictions are managed on an individual-level through the goals and reasoning
that underlie discursive action and on a relational-level as goals are negotiated and reflected in interactive conjunction with the other person. This is explored further in the future directions for research section in the conclusion chapter.

Beyond theoretical implications, a number of practical applications can be taken away from the findings of this study. Those are explored in greater depth below.

**Practical implications.**

In addition to the theoretical implications of this exploratory investigation, these findings offer beneficial insights and concrete applications for healthcare providers, legislators, and for family members of mentally ill persons. Petronio (2007) contends that it is only in becoming research translators that “we are able to preserve the integrity of the research and theory because it bridges knowledge production with knowledge utilization” (p. 88). Given my personal history and connection with this topic, it is especially important to me that the discoveries here can be translated into practice and have utility for improving how adult children of mentally ill parents navigate this complicated and challenging experience. Thus, below, I elucidate some of the practical implications of this research, including how my findings have applied value.

At the most basic level, this analysis demonstrates that despite their legal emancipation from their mentally ill parent, adult children are still active participants in their parent’s lives, and in many cases serve as one of their parent’s primary sources of support, even if they did not identify as a “caregiver.” Especially in instances where the parent was without a life partner (e.g., single, divorced, or widowed), 12 of the 15 children interviewed for this study (in conjunction with their siblings) did perform some level of caregiving for their parent. For some, this was a daily responsibility of attending
to their parent’s basic needs and acting as a healthcare advocate, whereas for others, the role was less demanding and consisted of regular “wellness checks” and offerings of various types of emotional and instrumental support. Regardless of the degree of their involvement, it is clear that many adult children play at least some role in the maintenance of their parent’s health. This is consistent with research that suggests that the “burden” of caring for persons with a mental illness falls heavily on the family due to the deinstitutionalization of mental health (Marsh, Appleby, Dickens, Owens, & Young, 1993; Thompson & Doll, 1982), and highlights why more resources are needed to assist family members in these efforts.

Aside from believing that they were not given the tools to be effective in a caregiving role, eight of the 15 children in this study explicitly stated that they felt like their ability to be efficacious in supporting their parent’s mental health was actively impeded by the systems and institutions that are supposed to help them, and at least three other participants indirectly alluded to feeling this way through a story or their tone. Despite varied levels of involvement and caregiving among the participants of this study, a consistent theme throughout the interviews with adult children was frustration with the barriers that prevent family members from being a more active participant in the maintenance of their parent’s health. Although family is expected to oversee or provide care for mentally ill relatives, family voices are often excluded from the process or severely restricted or undervalued. Consistent with the present findings, research has demonstrated that not being consulted or informed about a family member’s mental illness or changes in treatment is a source of added stress and frustration for family members (Doornbos, 2002). Five participants in the present study acknowledged that
they understood why protective barriers are put into place, but found them to be fundamentally flawed, and in many cases, to be more harmful than beneficial to their parent’s overall wellbeing.

However, the conclusion to be drawn from this study is certainly not that the mentally ill should be stripped of their individual rights, but rather that a family-centered approach should be the goal in mental healthcare. Family-centered care has been advocated as an effective method in treating children with emotional and behavioral disorders (Bailey, Buysse, Smith, & Elam, 1992; Shelton, Jeppson, & Johnson, 1987), and has even been endorsed by the Institute for Patient- and Family-Centered Care as a strategy in confronting the opioid epidemic (Dardess, Dokken, Abraham, Johnson, Hoy, & Hoy, 2018). From this perspective, family members are valued for their lay knowledge and expertise, and are thus incorporated as stakeholders into the planning and implementation of treatment, involved in the evaluation process, and practitioners support family member’s ongoing care effort throughout (Hunter & Friesen, 1996). In other words, according to Roberts and Magrab (1991), this paradigm promotes a model of care in which “the family and professional together determine what avenues to take and what priorities to address” and the role of the health practitioner is to “help the family meet the developmental, mental health, and social goals they have set for themselves” (p. 144).

Although this type of a partnership approach is admittedly more challenging with emancipated mentally ill adults than with dependent minors, modeling this approach—or at least embracing this philosophy of care—has the potential to empower support networks by giving them a voice, offering resources for support from providers, and lessening their objective burden, thereby potentially improving health outcomes for
individuals with mental illness (Kuhlthau et al., 2010). These recommendations parallel those of Doornbos (2002), who reported that family caregivers have a desire for an inclusive partnership and quality communication with their relative’s mental health provider, but that this desire often goes unmet. As they attempt to navigate the integration and certainty tensions in their relationship with their parent, adult children’s narratives revealed that one of the most distressing aspects of their sometimes-ambiguous role was that they felt entangled in a situation that was beyond their control. By making an effort to maintain open dialogue with adult children, practitioners could enable them to feel a greater sense of control and mastery by keeping them informed of the status of their parent’s course of treatment and updating them of any important alterations to treatment, consulting them as lay experts of their parent’s behavior, and offering referrals to outside resources of support.

A family-centered approach to mental health could be beneficial to all stakeholders, if successfully executed. By more intentionally and strategically incorporating adult children into the figurative conversation, practitioners would be able to offer more effective, tailored courses of treatment for patients by considering family perspectives, functioning, and dynamics into plans. Family members would be empowered as partners and provided with informational and instrumental resources to more effectively navigate their role, which, in turn, could enable them to more satisfactorily and strategically respond to the contradictions they experience, potentially decreasing feelings of distress and subjective burden. In fact, research has demonstrated that when family members perceive a more collaborative relationship with their relative’s provider(s), they experience lower levels of distress (Greenberg, Greenley, & Brown,
Finally, mentally ill parents would be offered the opportunity to collaborate with their provider and support networks to develop plans that increase adherence to treatment, and ultimately improve mental health outcomes (Perlick et al., 2004). Importantly, though, more research is needed in order to actually demonstrate the positive effects listed here, but it is evident from the findings of this study that many adult children, especially those who are actively involved in their parents’ lives and care, would advocate this approach.

The challenges to this approach under these circumstances are complex, however, and I would be remiss to not acknowledge them. As previously mentioned, mentally ill persons, including many of the parents of the children interviewed for this study ($n = 10$), experience a condition called Anosognosia, where they reject the idea that they are mentally ill. This could obstruct a family-centered approach because it would mean that the individual denies the need for treatment and may not seek the help or follow the plan of a mental health provider, even at the behest and encouragement of close friends and family. Moreover, even if a parent is seeking treatment for their illness, as a legal adult, they are protected by HIPPA, and family members do not have access to their health information without their consent (or without obtaining legal guardianship). Thus, a family-centered approach would require acknowledgement on the part of the parent that they are ill, and permission from the parent to allow their provider to share their health information with their child(ren). These conditions are not always in place, and may be difficult to attain. Nonetheless, analysis of the adult children’s perspectives in this study suggests that in situations were the parent is seeking treatment and consent is given, practitioners should more actively and intentionally take this collaborative approach in
order to provide family members with resources for negotiating the dialectical tensions they experience and developing strategies to cope.

Additionally, and related to the discussion above, this research highlights the importance of self-care for immediate family members of mentally ill individuals, especially in cases where the family member acts as one of the primary caregivers or sources of support. Family members of individuals with a mental illness consistently report high levels of emotional and psychological distress (fear, anxiety, depression, insomnia, emotional drain) (Saunders, 2003), and family caregivers of the mentally ill are two to three times more likely to report distress than the general population (Oldridge & Hughes, 1992; Winefield & Harvey, 1993). Viewed through the lens of a relational dialectics and multiple goals perspective, the negative psychosocial effects on family caregivers of the mentally ill are not surprising. Even if the family member is not providing primary caregiving duties, the findings of the present study suggest that how tensions in the relationship with their parent are managed can have implications for adult children’s mental and emotional wellbeing. For instance, when children employed praxis strategies that reflected an over-emphasis on the dialectic pulls of connection and change, they expressed intensified feelings of distress (anxiety, helplessness, concern, exhaustion, frustration, etc.), whereas integrating discursive practices and prioritizing goals that fulfilled needs for autonomy and predictability provided some respite from these negative psychosocial outcomes.

Thus, these findings suggest that the praxis patterns of segmentation and alternation in the management of the integration tension are critical to children’s self-care and should be utilized liberally, especially when the connection can seem especially
burdensome, such as during times of crisis, or immediately following them. The findings of this study suggest that actively seeking out and engaging in activities that reinforce an individual sense of self is therapeutic for adult children of mentally ill parents. For some, the autonomous pull was satisfied in pursuing relational goals outside of their parent (e.g., getting away for the weekend with a spouse or group of friends), reflecting the praxis of alternation. Others maintained an identity separate from their parent by pursuing professional goals, reflecting the praxis of segmentation. Adult children acknowledged that these activities, although they could be stress inducing in their own right, were an important coping strategy for them.

The positive impacts of strategically using segmentation to manage this tension is consistent with research that has found that family caretakers of mentally ill adults who maintain full-time employment are less likely to experience psychological distress than those who do not have full time jobs (Provencher et al., 2003). Although it might be expected that providing support to a mentally ill family member while maintaining full time employment would increase distress by adding to their responsibilities, examining this finding through a dialectic lens suggests that engaging in work-related activities serves as an outlet for and a method to negotiate the integration tension and satisfy a need for autonomy. As a result of these findings, health providers and peer support groups should encourage adult children of mentally ill parents to find and maintain self-gratifying and fulfilling activities in order to more effectively manage the integration tension and cope with the sometimes distressing effects of having a parent with a mental illness.
With regard to self-care, the current study also illustrates the complexities of social support and the complicated dynamics of support networks for relatives of individuals with a mental illness, especially as they are considered in light of the experience and management of the expression tension. Participants were more likely to reveal information pertaining to their parent’s illness when it was expected that the recipient of the information would have a shared experience or be able to empathize with their situation, regardless of how close they felt to that person. This finding cautions against researchers equating the size of a family member’s network, or even their number of close ties, with their availability of social support, since the adult children in this study suggested that they tend to conceal or avoid the topic of their parent with close friends who do not share this experience.

Provencher et al. (2003) proposes that restrictive privacy management practices with close ties who do not have experience with mental illness are deliberate because “sharing experiences with those friends may make [family] caregivers feel that they are dealing with particular responsibilities that few others can really comprehend, accentuating feelings of loneliness and fostering negative social comparison” (p. 602). Consistent with this conjecture, participants of this study suggested that the “support” they received from revelatory acts to inexperienced friends often came in the form of unsolicited informational support that they perceived as intrusive, uninformed, and critical, and ultimately only made them more protective of information about their parent’s illness. More research is needed to explore the specific components of messages that are perceived negatively in order to determine what is evaluated as helpful and unhelpful support in this context, but this finding reveals that for children with a mentally
ill parent, a larger network does not necessarily equate to enhanced social support, the composition of the network does matter, and that not all supportive messages are created equal.

Moreover, the finding that children are more likely to reveal issues regarding their parent’s illness to those who can relate to their plight lends further credence to the utility of peer groups as an outlet to share and to pursue instrumental goals like procuring emotional and informational support. Children expressed that they felt more inclined to open up to another person about issues surrounding their parent’s illness if they felt they were in the company of like-minded others who would not judge or criticize them. Given that children reported that stigma played a significant role in negotiating the expression tension, mental health practitioners should connect relatives to peer groups and encourage their participation by understanding and explaining the advantages of these communities. Although the number of children interviewed here who participated in peer support groups was small (n = 4), their accounts of this experience revealed that their involvement was pivotal to their satisfactory management of the expression tension. Indeed, research has consistently provided evidence of the benefits of peer groups for empowering family members of the mentally ill through information sharing and enhancing problem-focused coping strategies (Dixon et al., 2011).

This study also addresses an empirical gap in the literature by exploring the experiences of adult children of mentally ill parents. The current body of research on families of the mentally ill is heavily comprised of studies that examine individuals characterized as “caregivers,” but has comparatively neglected the perspectives of family members who are not providing care. Additionally, conclusions about family members of
mentally ill individuals are largely based on parents’ experiences with their mentally ill children, and therefore may not capture all of the nuances entailed in other types of family relationships. Given that available data suggests that parenthood is more common than not among mentally ill adults and that not all children of mentally ill parents consider themselves caregivers, the present investigation fills an empirical gap in the literature by shedding light on an under-represented voice: adult children who may or may not be providing some form of care to their mentally ill parent.

The findings of this study suggest that researchers should not rely on data obtained from parents about their mentally ill children to generalize to the experience of other types of family relationships. Adult children face unique challenges and role ambiguity in coping with their parent’s “invisible” illness. From a dialectical perspective, for instance, the concept of the integration-separation tension is unique in this context because its interplay is complicated, and in part defined, by the multivocality of the ideologies of exoneration and/or conviction. In other words, how involved an adult child is in their parent’s life at a given point in time is influenced by and reflective of the amount of blame they place on their parent for their perceived transgressions and deviances. This contradiction is situated in this particular localized context (Baxter, 2006). Further complicating this tension is the role reversal that occurs when it is a parent who has a chronic illness. Even if the adult child is not a primary caregiver of the parent, the interdependent nature of family as a system may mean that the autonomy that is traditionally characteristic of a child from their parent in their adulthood may be restricted in unique ways when the needs of their parent supersede their own individual
needs, or when a parent’s deviant behaviors impede a child’s pursuit of identity, relational, or instrumental goals in their personal life.

Importantly, despite their varied levels of involvement in their parent’s life, the adult children in this study reported experiencing the same contradictory pulls in coping with having a mentally ill parent. In other words, those who were deeply involved with and close to their parent experienced the same basic tensions as those who had no contact with their parent. However, the interplay of those tensions and how they were strategically and discursively negotiated were markedly different. For instance, whereas those children who were providing care to their parent may alternate between the contradictory poles of autonomy and connection, those who had a strained or severed relationship with their parent used and exhibited the pattern of denial (ignoring their need for connection with their parent) and disorientation (feeling that they were powerless to resolve the tension by any other means than ending the relationship). Thus, the findings of this study suggest that although caregivers may use different strategies in order to cope and maintain their relationship with their ill parent than non-caregivers, all children—regardless of caregiving or relationship status—frame their experience as being defined by the same basic dialectical pulls.

Moreover, although they only represented a small percentage of my sample (n=2), this study also illuminates the parallels in the experience of adult children who have lost a parent to suicide and those whose parent is still living with a mental illness. Even though their parent was no longer physically present, children whose parent had committed suicide still grappled with the same tensions and used similar praxis strategies to manage them. Although some of the tensions were located in their recollections of past
interactions with their parent prior to their completion of suicide, both participants continued to confront these contradictions in the present. For instance, the tension between concealment and revelation was especially salient for these children as they attempted to manage information surrounding their parent’s illness and cause of death with outsiders, and stigma (both surrounding the suicide and illness that precipitated it) was a central factor in prioritizing discretion. However, interestingly, children whose parent committed suicide also experienced the tension between connection and autonomy, most notably regarding their emotional attachment, fluctuating between acquittal of their parent for their wrongdoings (fostering and reflective of connection) and conviction of their parent (fostering and reflective of autonomy). This tension was experienced relationally in their reflections on the events that led up to their parent’s death, and continued on the cognitive level posthumously. These findings lend themselves to more empirical exploration, but do suggest children whose parents have committed suicide struggle to manage similar contradictory forces as those whose parent is still living, and that they may benefit from similar coping strategies, even if they are no longer able to negotiate tensions dyadically and discursively with them.

This chapter explored the findings of this study in greater depth by answering the research questions posed in Chapter Three, and by discussing both the theoretical and practical implications. The next and final chapter will take a closer look at the limitations of this study, and from those, provide suggestions for future research in this area. Finally, at the end, I offer some concluding reflections.

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Chapter Nine: Conclusion

The present investigation explored how adult children of mentally ill parents made sense of and attempted to cope with this complicated experience. As the preceding chapters revealed, adult children’s experience and relationship with their parent in the midst of their mental illness was wrought with contradictions. Children felt inescapably connected to and responsible for the actions of their parent, while simultaneously expressing and demonstrating that they were autonomous entities and therefore should not be held accountable for their parent. Children felt compelled to protect themselves, their parent, and their family as a whole from the stigma of mental illness by maintaining privacy boundaries and concealing information about the illness, but simultaneously needed to reveal aspects of the illness to others in spite of the risks in order procure certain instrumental goals as support, catharsis, mentorship, and advocacy. The volatility of mental illness and its symptoms contributed to an unpredictable, unstable situation that left children feeling powerless to control or even anticipate the events that dictated the direction of their own lives. However, in the midst of disruptive change, children expressed a belief in their own agency to cope and find strategies to regain a sense of stability, predictability, and order.

In negotiating these dialectical tensions, children were confronted with and managed multiple—and sometimes conflicting—goals. The multifaceted nature of their goals was illuminated in the praxis patterns that were used to manage the tensions. Although this study shed light on an underrepresented voice in the family and mental health context and the findings suggest areas ripe for further investigation, it did have limitations that should be acknowledged. In the concluding chapter, I will address these
limitations, outline directions for future research in this context, and offer some concluding reflections.

**Limitations**

Despite the prevalence of mental illness in parents, and despite the fact that multiple recruitment methods were pursued over a two-year period, there were challenges in recruiting an adequate and a diverse sample. This could be attributed to the stigma that continues to envelop mental illness that has been well documented in the literature and was reported by all of the participants in the current investigation. Even though I was an empathetic other whose initial interest in this topic was personal, participants often did not know this until the interview. The notion of speaking to a stranger about an issue that is deeply private and stigmatized may have contributed to some reluctance to volunteer to participate. Thus, I found some success in using network sampling methods where I would ask participants for names of anyone else they knew who was eligible and might be willing to participate. However, this naturally limited the diversity of the sample that I was able to recruit. First, 10 of my 15 participants were women. Although the female perspective is noticeably dominant in this investigation, this may simply be reflective of larger trends. Sharma, Chakrabarti, and Grover (2016) note that despite incremental changes in social norms, “family caregiving still remains a predominantly feminine activity” (p. 8). Empirical evidence suggests that women also comprise the majority of caregivers among those with schizophrenia and other mood disorders (Awad & Voruganti, 2008; Caqueo-Urizar, Miranda-Castillo, Lemos, Lee, Ramirez, & Mascayano, 2014).
Even though it may be that women are just more willing and comfortable opening up about private family information like a parent’s mental illness, it seems that my numbers may simply be reflective of women being more involved to some degree in their parent’s care. Interestingly, and as an aside, in my limited sample, the only two participants who had cut ties with their parent were male. Although this is certainly not sufficient to draw any conclusions, coupled with the imbalance of the sample, it does suggest some gender differences may be at play. Future studies could take a quantitative approach to examining this conjecture further.

In addition to gender, other demographics of note were relatively homogeneous. For instance, the majority of participants were white \( (n = 14) \), college-educated \( (n = 15) \), with middle to upper-middle class incomes in professional careers. Moreover, the majority participants \( (n = 11) \) either held or were working toward advanced degrees. This is an important consideration since it implies that, comparatively speaking, my participants are coming from a relatively privileged perspective whereby they have more resources at their disposal to seek out and obtain informational and instrumental support. Five participants worked, are currently working, or are pursuing careers in the medical profession, so at the very least, their informational resources are assumed to be greater than the average family member of a person with mental health issues. Throughout the interviews, participants who were in the medical field also alluded to how their education had increased their sense of efficacy and empathy in coping with their parent and the illness. Although this was not a subject of the current study, it is an area that could be explored further, both qualitatively and quantitatively.
Even though my participant pool was relatively homogeneous demographically, a couple of areas that were diverse were the ages of the participants and their current relationship and level of involvement with their parent. Participants ranged in age from 25 to 63, with two in their 20s, seven in their 30s, one in her 40s, three in their 50s and one in her 60s. Interestingly, among my participants, there did not seem to be a pattern or relationship between a participant’s age and his or her current relational status with their parent. There also did not seem to be a relationship between a participant’s age (or age range) at the time of diagnosis or awareness of their parent’s illness and how involved they were in their parent’s life. Among my participants, although there was some diversity in the diagnoses of the parents (with the majority representing mood disorders), there were not any patterns that emerged regarding the parent’s specific illness(es) and the child’s level of involvement. The exception to this would be that the two participants who were no longer speaking to their parent were both male and had a parent who was bipolar (one mother and one father). The majority of participants interviewed had a mother with a mental illness \((n = 11)\), so that also has implications for the insights that can be drawn from the analysis. For instance, it could be the case that a child’s perspective varies depending on whether it is the father or the mother who is mentally ill. However, from my analysis of this small sample, there were many significant consistencies and patterns between the two groups and there did not appear to be notable variations based on the parent’s gender.

As previously discussed in the methods chapter and noted here, I had difficulties recruiting. Originally, my goal was to obtain at least 25 to 30 interviews with adult children of mentally ill parents. I believed that the NAMI Family-to-Family program
would yield a large percentage of those participants, but unfortunately, it did not prove to be a fruitful resource for eligible individuals. Only a handful of people responded to my recruitment methods, and those who did reach out to me about participating were not eligible because they did not have a parent with a mental illness, but rather fell into some other category of relative. For instance, one person who reached out to me was a parent of a child with schizophrenia and had misread the flyer. Thus, the narrow eligibility requirements (i.e. choosing to focus only on adult children with a mentally ill parent) limited my participant pool. Even though it most certainly would have increased my sample size in number, I made the decision to not broaden my eligibility requirements because I believed this familial relationship to have some important distinctions from other types of relatives, and I was interested in exploring how the anticipated shift in traditional roles affected the negotiation of multiple goals. Although my sample size is small, I did reach saturation in my analysis (for evidence, see discussion of saturation in the data analysis section of Chapter Four), the data obtained offered new and interesting insights, and patterns were consistently occurring across the data.

However, future research in this area may better anticipate these recruitment challenges, and find ways to overcome them. For instance, although I created a written recruitment message, I never went to speak to the groups in person in order to pitch my study. This may have allowed me to better establish rapport and trust by telling briefly of my own experience, the inspiration behind the project, and disclosing that I was a former participant in the program, which may have made participants more comfortable volunteering for an interview. Along these same lines, I was geographically limited by the in-person nature of the interview. I could have broadened this by posting on NAMI
message boards and NAMI Facebook groups, and by receiving IRB approval to conduct interviews over Skype or FaceTime. This would have eliminated the geographical restrictions and expanded my pool of potential participants.

**Future Directions**

This study was exploratory in nature and a dialectical perspective was emergent in my analysis. First, since adult children’s experience surrounding their parent’s illness was framed dialectically, future research should be conducted in order to understand more fully how these tensions manifest in communicative practice, and attempt to illuminate how the interplay of these tensions is not a solitary activity, but a relational one that is enacted discursively in coordination with their parent. The current study only examined the perspectives of the adult children and did not solicit or attempt to explore the parents’ experience or how their goals and praxis patterns influence this interplay of unified but opposing forces on the relational level. Importantly, Baxter (2006) notes that “from a dialogic perspective, internal psychological thoughts and feelings are conceptualized as inner dialogues in which multiple discourses are at play” and that “family members exist in webs of meaning spun through communication with others” (p. 133). In the context of this study, it is suggested that the “inner dialogues” of the adult children are not just reflective of and provide insight into their individual cognitive processes, but that they are reflective of “dialectical flux [as] a discursive phenomenon,” continually and mutually shaped by and shaping communication at the relational level. Although the dialectic perspective is not conceptualized at the individual level, Baxter and Montgomery (1996) suggest that analyzing individual partner accounts is an appropriate data-gathering method, as long as the analysis “contributes to an understanding of how
the various ironical and dialectical interpersonal orientations interact to yield relational change” (p. 226). Accordingly, this is methodological choice is not viewed as a limitation of this study, but rather suggests avenues for further empirical exploration in this context.

Thus, the present study does attempt to highlight the “both/and quality” of adult children’s relational experience with their mentally ill parent through “rich, thick descriptions of experienced dialectical dilemmas” (Baxter & Montgomery, 1996, p. 227) and “the multiplicity of dialogic voices it contains” (Baxter, 2004, p. 15). Importantly, the concept of voice goes beyond enacted talk and includes ideologies, perspectives, and values. In other words, multivocality can be located in the sense making process and the competing ideologies that are intertwined at the individual level. For instance, a salient aspect of the integration tension is constituted in adult children’s contradictory beliefs that their parent is both the blameless victim of a powerful illness and an active perpetrator of their own wrongdoings. However, future studies should solicit the voices of both partners in order to more comprehensively capture the ongoing flux and multivocality of the contradictions as they are jointly constituted.

One methodological way to accomplish this would be to compare the two individual perspectives by interviewing adult children and their parent separately in order to locate the source of the contradictions in their diverse relational experiences through examining points of intersection and division. Or, alternatively, future inquiry could explore this phenomenon through the analysis of conversational texts between the parent and the child. For instance, considering that most adult children interviewed for this study lived apart from their parent and relied heavily on mediated channels like text messaging and phone calls to communicate with their parent, it would be interesting to conduct a
textual analysis of these conversations to understand the dialectical interplay “in practice” at the discursive level. Examining the text message threads between the adult child and their parent over a period of time, or the transcription of their phone calls, would provide insight into how dialectical tensions are discursively constructed. This type of research would answer Baxter’s (2004) call for more micro-level analysis of “enacted talk to illuminate further how contradictions are constituted” (p. 15). It would also allow researchers to observe the interactions from a distance without being a physical presence that could disrupt the natural enactment of talk. Or, lastly, another way to do this would be to conduct a joint interview with both the parent and the child to attempt to understand how these tensions manifest in verbal and nonverbal dialogue. However, it is important to acknowledge that there are significant limitations to this method as well—the most notable being that participants may be reluctant to be as open or honest as they would in a solitary, private interview.

The findings of this study demonstrate that adult children’s relationship with their mentally ill parent is at once manufacturing the unified contradictions while also being an ever-evolving product of them. Although the concept of flux—“the ongoing interplay of competing voices” (Baxter, 2006, p. 137; emphasis added)—is implied by this study in re-constructing children’s lived experience with parental illness through retrospective accounts and relational histories, this represents an “artificial” conceptualization of the flow of time. Bakhtin’s dialogism, which acts as the theoretical grounding for relational dialectics, presumes that relationship development cannot be understood in a traditional linear progressive fashion working toward some end or idealized state, but rather that because relationships are constituted in communication, they are fluid and indeterminate.
This notion of “unfinalizability” means that the way in which a contradiction manifests at one point in time in a relationship will be different at another point in time. For this reason, Baxter (2006) suggests that data be gathered from at least two different points in time. For instance, interviewing adult children once—at a specific moment in their relationship with their parent—limits our understanding of the intricacies of the interplay of the tensions as they occur over time. Future research could attempt to more fully capture flux in this context by having adult children keep a daily journal or diary of their experiences over a specific span of time. This diary method would provide some insight into the ongoing flux of the contradictory forces that define this relational experience, and illuminate how the joint negotiation of conflicting goals influences this process.

Additionally, although it was not a focus of the current investigation, future research should examine the role of caregiver burden in the experience and management of dialectical tensions in relatives of mentally ill individuals. Feelings of objective and subjective burden have been found to mediate the relationship between primary stressors (disruptive behaviors) and psychological distress in family members (Provencher et al., 2003). According to Rose, Mallinson and Gerson (2006), objective burden involves the visible disruption to a family’s daily life that result from the mentally ill member’s disruptive behaviors, and may involve reduced leisure time, negative effects on the family’s interactions and relationships within and outside of the family (e.g., neighbors, family friends, extended family), reduced ability to function as a family, and the negative financial implications of mental illness (e.g., unemployment, cost of continued medication and therapy). Subjective burden refers to the “invisible” emotional load the family experiences as a result of the mental illness and includes feelings of worry, guilt,
resentment, etc. Future research could use a mixed methods approach in order to more fully explore sources of burden for adult children of a mentally ill parent using the theoretical frameworks of multiple goals and relational dialectics. For instance, Reinhard, Gubman, Horwitz, and Minsky’s (1994) Burden Assessment Scale (BAS) could be used to assess levels and kinds of burden most prominent in this type of relationship, and then those could be probed further through an in depth interview.

The current study suggests that the objective and subjective burden felt by adult children of mentally ill parents may play a role in the experience of dialectical tensions, how they manifest, and how they are strategically managed. For instance, analysis reveals that an adult child may feel obligated to complete tasks to meet their mentally ill parent’s needs, and respond to these pulls of connection by dedicating a significant amount of time and energy to providing this support. However, the amount of time that providing this support takes away from meeting other relational or instrumental goals (objective burden) may build resentment (subjective burden) over time, so the child responds by attempting to pull away and discursively distance themselves from their parent. This period of separation may in turn lead to feelings of guilt for not doing enough to help their parent (subjective burden), so they respond again to pulls for connection. Thus, in this example, the experience of the integration tension (from the perspective of the child) and how it is strategically and discursively managed may be further illuminated by the constructs of objective and subjective burden. Although the association between burden and dialectical tensions is indicated by the findings of the current investigation, future research should explore this connection further in order to locate sources of burden, and
ultimately uncover ways that the sources of burden might be addressed and more effectively regulated.

**Overall Conclusion**

This study straddles the line between my personal and academic selves. As I have previously discussed, the inspiration for this study was derived out of my personal experience with my bipolar mother. My goal was to better understand my own experience and how it aligns with or diverges from other adult children with a mentally ill parent, and ultimately, I hoped to be able to discover strategies for more effectively navigating what is unquestionably a complicated and challenging relationship.

One of the primary personally comforting insights that I uncovered in conducting this study was that, although being an adult child of a mentally ill parent can often feel lonely and isolating, we are far from alone. Throughout the interviews, participants and I found many moments of shared understanding, even though the relationships we had with our parent and what we had been through were considerably varied. Consistent with my findings, during the interview, it was clear that the topic of their parent’s illness or how they respond to it was not something that many felt comfortable discussing openly and that they had become accustomed to burying, repressing, spinning, and concealing. Although the number of public figures who have openly admitted that they or a family member struggle with mental illness seems to be becoming more prevalent, it is apparent from the accounts of the adult children interviewed here that we are far from the goal of achieving widespread acceptance and de-stigmatizing mental illness. I found that even though children were resistant to talk early in the interview, once they found an empathetic listener, the floodgates opened, so to speak, and our exchange became an
emotional and cathartic experience for them, and for me. A number of participants shed a tear during their interview, and as objective and removed as I tried to be, I could not help but become invested and involved as I discovered that many of the tough situations they had been a part of, the complicated decisions they have had to make, and the knot of contradictory feelings in which they have found themselves frequently entangled, mirrored my own experience.

While I was in the process of writing this dissertation, my mom went from a functional low to a state of hypomania (a kind of precursor or mild form of mania), where she remains as I write this final chapter. I had hoped it might be cathartic to write about this as I was experiencing it, but in full transparency, it was also challenging, as it meant that I was unable to escape from it. Unlike some of participants, I did not find reprieve from my situation in my work; my work (my writing) was imitating my personal life. Like many of the participants who are actively involved in their parent’s life, I struggle everyday to prioritize my own goals with goals related to my mother, and often the two are so co-mingled that it can be difficult to distinguish between them. Aligning with the stories highlighted in this study, the goals I have for myself can be at odds with the goals I have for and surrounding my mother, such that they can seem mutually exclusive. For instance, my primary goal most days has been to set aside a certain number of hours to write, but over time, this has proven to be at odds with certain instrumental goals involving my mother, especially if she is experiencing an episode, or there is a crisis. If I choose to write during those times, I feel distracted and guilty for burdening my sister and other family members with the responsibility, but if I choose to get involved with my
mother’s situation, it can be draining (both of my time and energy), and impede on my ability to accomplish my writing goals.

The multiple, and sometimes conflicting goals I have encountered are both a reflection and a product of the dialectical tensions in my relationship with my mother. Although the themes and theoretical framing of my findings were certainly filtered through my own experience, contradictions were salient in how adult children (including myself) talk about and make sense of their parent’s mental illness, the role they play in their parent’s life, the individual and relational implications of their decisions, and how they cope with these implications. Another of the lessons that I am personally taking away from this inquiry is the importance for adult children of finding an outlet. For some, that outlet may be through participation in a peer support group, while for others who may be less comfortable with outward expression, it may be in writing or journaling. For others, it may be through engagement in a personally gratifying or fulfilling activity or relationship that serves as an escape. Baxter and Montgomery (1996) contend that dialectical tensions are an ever-present inevitability of relationships and that their affect is less about the existence of the contradictions than it is about how they are discursively negotiated. It is my hope for all of my participants that, despite what challenges may lay ahead, they find a way to mindfully manage the tensions that define their relationship with their parent. I hope this for myself, also.
Appendix A: Interview Guide

Background
I’m interested in hearing about your experiences as a person who has a mentally ill parent. My mom was diagnosed with a mental illness and has struggled with it most of my life. Because of my experiences with my mom, I’m really interested in learning more about your experiences with your parent.

1. Can you begin by telling me a bit about your parent, including when and how you became aware that they might have a mental illness?
   a. *Follow up if necessary:* What mental illness do you believe your relative has (or had)?
   b. *Follow up if necessary:* Can you tell me about a time growing up that you realized your relative was “different” or might have mental health issues?

2. Does (did) your relative receive medical treatment for their mental illness?
   a. *If yes:* Do (did) you play any sort of role in their treatment?

Instrumental Goals:
When a person is diagnosed with a mental illness, they are not the only person affected. Family members lives are often impacted in various ways. I’m interested in hearing more about what affect your parent’s illness may have on your day-to-day life and priorities.

1. Can you tell me about a time that you felt any responsibility for your parent as a result of their mental illness?
   a. What actions did you take as a result of this feeling?
   b. Why do you think you felt this responsibility? What prompted it?
   c. *If they are not or were not ever involved in parent’s life:* Are there specific reasons why you don’t take responsibility for your parent?

2. Can you tell me about a specific instance when you believe your parent’s illness had an impact on your personal life?

3. Can you tell me about a specific instance when your parent’s illness had an impact on your professional pursuits?

4. Can you tell me about a specific time when something about your parent’s illness prevented you from doing, achieving, accomplishing, or getting something that you wanted?
   a. *Follow up if necessary/applicable:* Are there any things that you would or could do differently with your life if your parent were not mentally ill? Can you think of a specific example?

5. When you need help dealing with any issues that are directly or indirectly the result of your parent or their illness (e.g., advice, guidance, support, etc.), where do you typically go, or who do you turn to? Why?
   a. *Follow up:* Is there anywhere or anyone you have learned not to turn to or rely on for help? Why?
Relational Goals with Parent:
Now I’m interested in learning more about your relationship with your parent and the factors that impact your relationship with them.
1. Growing up, how close were you and your parent?
   a. *If applicable:* Can you tell me about a time *when you were younger* that a symptom of their illness had an impact on your relationship with them (good or bad)?
2. Can you tell me about a time that something your parent did as a result of their illness made you upset (sad, angry, stressed)?
   a. Did you talk to anyone about how you were feeling or seek support from anyone or anything following this event?
3. Currently, how close do you feel to your relative? *Or:* How close were you to your relative when they passed?
   a. Can you give me an example that illustrates how close (or not close) you are/were with your parent now?
4. Do you believe that any aspect of your parent’s illness impacts your relationship with them now?
   a. Can you give me an example of a time or an event that his or her illness caused a shift in your relationship with them?
5. Do you wish that any aspect of your relationship with your relative were different?
   a. *Follow up if necessary:* Can you give me any examples of a time when you desired a different type of relationship with them?

Relational Goals with Others:
I’m interested in learning more about other relationships in your life and whether they are at all impacted by your parent’s illness.
1. *If applicable:* Can you tell me about a specific time when your parent’s mental illness affected your relationship with your spouse/partner?
2. *If applicable:* Can you tell me about a specific time when your parent’s mental illness affected your relationship with siblings or other immediate family members?
3. *If applicable:* Can you tell me about a specific time when your parent’s mental illness affected your relationship with extended family members?
4. Can you think of a time when your relationship with another person (friend, family member, etc.) changed as a result of your parent’s illness?
5. *If not already addressed:* Have any of your relationships benefited or been positively impacted by your parent’s mental illness?

Identity Goals & Experience of Stigma:
A relative’s mental illness can affect how a person views him- or herself. I’d like to ask some questions about how your sense of self is affected by your parent’s mental illness.
1. Do you believe that your parent’s mental illness has affected the way others think about *you* (e.g., personal life, professional life, social life, family life)?
a. *Follow up if necessary:* Can you tell me about a specific time when you felt others’ perception of you changed as a result of your association with your parent?

2. Do you think how you view yourself has changed at all over the course of your parent’s illness? How so?

3. Have you ever experienced a time where you felt like you needed to conceal your parent’s mental illness (or aspects of it) from others?
   a. *Follow up if necessary:* Why do you think you choose to do (or not do) this?

**Thoughts about the Future:**

1. Sometimes when a family member is ill, we experience uncertainty or fear about the future. Can you tell me about a time you experienced any uncertainty or fears for your parent’s future due to their mental illness?

2. Can you tell me about a time that your parent’s mental illness gave you any fears or uncertainties about your own future?

3. Do you have anything about how you handle aspects of your parent’s illness that you wish you could change in the future?

**Final thoughts**

1. Has anything about your parent’s illness’ impact on your life been positive or improved? Any specific examples you can provide?

2. What do you wish other people would understand about what it’s like to have a mentally ill parent?

3. Looking back (and forward), what advice would you offer to others who have a mentally ill parent?

4. Is there anything that you would like to add that we have not covered today?
Appendix B: Sample Memo

Most of Emily’s narrative surrounding her father’s illness and tragic death were wrapped up in playing the dual role of being both child and parent simultaneously. Emily, like myself, at the height of her father’s bipolar symptoms, was trying to balance supporting her father in the way he needed while also balancing the responsibilities that come along with being a mother to two children under two years old. Even though I only have one child, we really connected on the challenges of managing our priorities and guilt. The guilt of not being able to “be there” for our parent the way we “should be” because our priorities have shifted away from our family of origin and redirected into our nuclear family, with our kids occupying the top spot. She told me that when her father was really struggling, she said that she never felt like she was able to adequately fulfill her role as the daughter he needed her to be because she was also trying to be the perfect mother who didn’t miss anything in their children’s lives. Even though I do struggle with this too, I think that she has more guilt than me about it because her father committed suicide and that compounds it for her. But at the same time because she was pulled away from her kids a lot during the period of time when he was sick and while trying to manage a number of crises with her dad, she also never felt adequate as a mother. In trying to be everything for everyone, she says she started feeling like she was “nothing to nobody.” I also have felt pulled thin and inadequate in fulfilling my roles as mother and daughter lately so this resonates with me. But I need to be careful to not assume that all children who are also parents themselves will feel this same obligation to their parent. If they feel less obligation to be involved in their parent’s affairs, their priorities to their children (and their role as a parent) may be clear and unambiguous. I can’t expect this to feature prominently in all or even most of my participants’ experiences, even if they are also a parent like me. (August 15, 2017).
Appendix C: Abbreviated Codebook (List of Codes)

INTERDEPENDENCE—LINKED LIVES
  Family as obligation (burden)
  Desire for traditional relationship
  Social comparison
  Loyalty
  Social pressure/expectation
  Shared history
  Parent as victim

INDEPENDENCE—SEPARATION
  Stigma and disassociation
  Self-preservation (self-care)
  Other relationships
  Other obligations
  Parent as culpable, perpetrator

MANAGING PRIVACY—CONCEALMENT
  Protection from Stigma
  Saving face (self)
  Saving face (parent)
  Unsolicited/unhelpful advice
  Low expectation of empathy

MANAGING PRIVACY—DISCLOSURE
  Seeking support (informational or emotional)
  Seeking validation
  Seeking compassion/forgiveness (excuses)
  Helping others
  Defending parent (advocate)

INSTABILITY & UNCERTAINTY
  Volatile symptomology
  Lack of institutional support from providers
  Alienation from information & Privacy protection laws
  Fears of homelessness
  Suicide risk
  Concerns for self

STABILITY & PREDICTABILITY
  Expectation of instability
  Behavioral patterns of the illness
  Spirituality
  Confidence and belief in own agency
  Fulfillment in other activities
  Fulfillment in other relationships
Appendix D: Member Validation Summary Sent to Participants

Hi, [X]. Thank you again for participating in my study and for being so open with me about your experiences with your parent. I also really appreciate your willingness to provide me with feedback as I refine my analysis. Below is a summary of my major themes. I would appreciate it if you could read through my interpretation to see if it resonates with your experience and what we discussed during our meeting. Feel free to make comments on each aspect I list below, or just offer some general commentary based on these two questions:

1. Based on the summaries provided, do you think you experience any or all of these contradictory forces in your relationship with your parent? Feel free to expand on why.
2. What parts (if any) of the ideas presented below do not line up with your experience?

If you think anything is off base or if I am missing an important aspect of your experience that we discussed during our meeting, please let me know. Positive feedback and constructive criticism are equally beneficial! The goal is for my research to reflect your experience, so if anything below doesn’t fit, I’m eager to learn this and have the opportunity to re-frame my thinking about it. Thank you!

Summary of Analysis

Adult children of parents with a mental illness experience seemingly opposing forces simultaneously. These contradictions are reflected both how they define and make sense of their relationship to and experiences surrounding their parent, and in their communication patterns and practices. These contradictions or “tensions” are revealed in three broad categories.

1. Integration: Children express a strong notion of connection (interdependence) to their parent. This manifests as feeling entangled with and even responsible for their parent in various ways to varying degrees, while also simultaneously expressing a belief in (and desire for) their own independence and a need for separation from their parent.
   a. Factors underlying connection to parent: the belief that others expect them to be involved (or impose that responsibility on them), a sense of obligation, a belief that their parent can recover (or that their relationship can find a sense of normalcy), and a belief that their parent is not at fault but is the victim of an illness.
   b. Factors underlying separation from parent: the need to prioritize other relationships or task-related goals, the need to disassociate or distance themselves from their parent to avoid negative impressions from others, and a notion that their parent is at fault and accountable for their behaviors.
2. **Expression:** Children express a need to keep information about their parent and their parent’s illness carefully and strategically concealed from others, while also simultaneously expressing a need to reveal this information to others.
   a. **Factors underlying privacy:** The belief that mental illness is stigmatized and misunderstood by the general public, the belief that they will not receive empathetic or helpful support in response to disclosures, and a desire to save face and manage others impression’s of their parent, their family, and his or her self.
   b. **Factors underlying disclosure:** the need to procure support from empathetic others, a need to educate others and act as an advocate for mental health.

3. **Certainty:** Children express a belief that factors beyond their control create instability and unpredictability in their everyday lives, while also expressing that they have actively sought and maintained stability by recognizing patterns in their parent’s behavior and accepting “what is.”
   a. **Factors underlying feelings of instability:** An understanding of the illness is volatile and beyond their control, a belief that restrictive institutional barriers (like a lack of provider communication and patient privacy rights) alienate and “shut them out” while also expecting them to “step up” to care for their parent, and anxieties associated with an unknown, unpredictable future (both for self and parent).
   b. **Factors underlying feelings of stability:** A belief that control comes from acceptance of what is, and a conviction in the ability to confront problems “come what may.” Recognition of parent’s behavioral patterns increased a sense of predictability. Children also find and regain a sense of stability and routine by fulfilling this need in other domains of their life.
Appendix E: Sample Member Validation Checks

• I had never thought about it in this way really, but this makes a lot of sense. I do feel really conflicted about mom in so many ways. Especially when you talk about “expression” in what I say to other people about her, and “integration” in how much of it is on me to fix her problems. (Lily)

• One thing that stuck out to me was under the integration theme and how you said we fault our parent for their actions, but also at the same time recognize that it’s probably their illness that’s the cause. I think I do this all the time. I get so mad at her for doing hurtful things or odd things, but I also know that she can’t really help it a lot of the time. (Erica)

• When you talk about factors for separation (1b), I don’t know that I necessarily agree that I “disassociate” with her to keep other people from seeing me negatively. There have been times when I don’t advertise certain things that have happened or when I don’t invite her to come around my friends because I don’t know how she’ll act and I don't want to have to explain it. So maybe there is some truth to that, but I don’t like to think of it that way. (Stuart)

• In factors underlying instability (3a), I really relate to the part about restrictive institutional barriers. A lot of the time I do feel like I don’t have a voice or any control over decisions that directly affect my life and that is a real source of frustration for me. On one hand I get it, it’s not my body or my illness, but that’s also kind of bullshit because outside of her, I’m one of the main people that those decisions affect. So that’s a big struggle for me. (Stuart)

• I think this part is pretty accurate [referring to “acceptance of what is”]. Accepting does help provide some level of reassurance and peace about it all. But sometimes I wonder if I’ve really accepted anything about her illness, or if I just tell myself that I need to. That might be an important thing to point out—the difference between actual acceptance and pseudo acceptance. (Peggy)

• This is pretty much my life to a T, especially where you talk about the contradiction between the connection to my mom and my need for separation. I always feel pulled in a million different directions. I feel like I can’t win with that most of the time because whenever I devote time and energy to my mom, that usually means I’m doing a poor job at home or work or in other areas of my life. And vice versa. So in the end, I lose no matter what. (Sarah)

• Since my dad completed suicide, some of these resonate with me more than others. When I think back on it, the integration and certainty themes may have reflected how I felt in the past when he was sick before his suicide, especially the part about feeling a lack of control. But I really feel like the expression theme you listed captures how I feel most of the time now. He’s not here to defend himself, so I feel like I want to watch what I say. I don’t want people to think he was a bad
person. Even though there are times when I’ll talk about him more than others, most of the time I’m just really aware of what I say about him, if I say anything at all. (Hannah)

- In terms of resonating with my experience, most of your themes do. The integration theme really makes a lot of sense to me in how I feel about trying to juggle my mom and the other parts of my life. For expression, most of the time when I tell someone else something about her, it’s because I have to. Like for missing work or something. I don’t know if that falls under a “need to procure support,” but that is one of the main reasons why I usually talk about it. I don’t know if I said that too much in my interview, but looking over this now, I thought I should add it. Also, for the certainty theme and talking about control, I think I have a decently open line of communication with my mom’s doc now so I don’t know that I really feel that I’m left out of her care like some people might. But I do feel like most of my anxiety comes from not being able to control her illness. Things can be great one day and then we’re in crisis-mode the next, and sometimes it’s hard to see it coming. That can be really stressful living like that. (Macy)
Appendix F: Saturation Tables

Table 4. Integration Tension Prevalence (79% average)

<table>
<thead>
<tr>
<th>Sub-theme</th>
<th>Prevalence</th>
<th>Percentage of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Connection</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social expectations</td>
<td>11/15</td>
<td>73%</td>
</tr>
<tr>
<td>Familial obligation</td>
<td>13/15</td>
<td>87%</td>
</tr>
<tr>
<td>Nostalgia/hope</td>
<td>9/15</td>
<td>60%</td>
</tr>
<tr>
<td>Victimization/exoneration</td>
<td>15/15</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Autonomy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pursuit of relational &amp; instrumental goals</td>
<td>13/15</td>
<td>86%</td>
</tr>
<tr>
<td>Identity goals</td>
<td>8/15</td>
<td>53%</td>
</tr>
<tr>
<td>Perpetration &amp; conviction</td>
<td>14/15</td>
<td>93%</td>
</tr>
</tbody>
</table>
Table 5. Expression Tension Prevalence (72% average)

<table>
<thead>
<tr>
<th>Sub-theme</th>
<th>Prevalence</th>
<th>Percentage of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Concealment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stigma of mental illness</td>
<td>15/15</td>
<td>100%</td>
</tr>
<tr>
<td>Lack of empathy &amp; unsolicited support</td>
<td>11/15</td>
<td>73%</td>
</tr>
<tr>
<td>Saving face</td>
<td>8/15</td>
<td>53%</td>
</tr>
<tr>
<td>Saving parent’s face</td>
<td>9/15</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Revelation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional support</td>
<td>14/15</td>
<td>93%</td>
</tr>
<tr>
<td>Advocacy &amp; mentorship</td>
<td>4/15</td>
<td>27%</td>
</tr>
</tbody>
</table>
Table 6. Certainty Tension Prevalence (83% average)

<table>
<thead>
<tr>
<th>Sub-theme</th>
<th>Prevalence</th>
<th>Percentage of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Change</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of control (illness)</td>
<td>15/15</td>
<td>100%</td>
</tr>
<tr>
<td>Lack of control (institutions)</td>
<td>15/15</td>
<td>100%</td>
</tr>
<tr>
<td>Anxieties about safety &amp; security</td>
<td>12/15</td>
<td>80%</td>
</tr>
<tr>
<td>Anxieties about parent suicide</td>
<td>10/15</td>
<td>67%</td>
</tr>
<tr>
<td>Anxieties about own future &amp; genetic link</td>
<td>13/15</td>
<td>87%</td>
</tr>
<tr>
<td><strong>Stability</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acceptance</td>
<td>12/15</td>
<td>80%</td>
</tr>
<tr>
<td>Predictable patterns &amp; personal agency</td>
<td>11/15</td>
<td>73%</td>
</tr>
<tr>
<td>Internal strength &amp; resilience</td>
<td>12/15</td>
<td>80%</td>
</tr>
</tbody>
</table>
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