

## **Chapter One: An overview of the thesis**

### **Introduction**

There is a long history in western society of portraying an idealised account of motherhood. Within contemporary society, the media and popular journalism continue this tradition with the romantic image of motherhood conveyed by pictures of smiling contented babies and slim, attractive mothers engaging with their babies in a fun, educational way (Douglas and Michaels, 2004). The attempt to emulate this idealised portrayal is deeply challenging for many mothers and, in particular, for women who experience what is termed 'enduring' or 'serious' mental health problems, such as severe depression, schizophrenia and bi-polar illness. The conflict between what society portrays as effective mothering and this group of women's experiences of coping with stigma, illness and the challenges in caring for their children, leave women feeling under surveillance, inadequate and alone (Nicholas et al. 1998), coping with consequent feelings of fear, shame, embarrassment and guilt (Miller 1997; Davies and Allen 2007). Women also frequently found themselves parenting alone, had smaller social networks and lived in suboptimal accommodation (Chernomas et al. 2000; Oyserman et al. 2000). Marital discord, social isolation and conflicts with extended family were also common within this group of women (Oyserman et al. 2000). These women were also at greater risk of poverty with high rates of unemployment (Mowbray et al. 2001; Nicholson et al. 1998). In addition to the challenges of motherhood, they have to deal with the stigma of a mental health problem, symptoms, medication side effects and the constant fear of their children being taken into care (Downey and Coyne 1990; Beardsley et al 1998; Mowbray et al. 2001; Reupert and Maybury 2007).

The degeneracy theory of mental illness resulted in mothers with enduring mental health problems being accused of infecting the genetic pool and, historically, in some countries, this theory gave rise to such radical measures as laws that authorised sterilisation without informed consent (Apfel and Handel 1993). A review of the literature suggests that research on mothers with mental health problems has tended to emphasise the cost of the mother's pathology on the development of the child (Hammen 1991; Weissman et al. 1993; 2006; Beardsley et al. 1996; Mordock and Hall 2002). Montgomery (2006) suggests that women with 'enduring' mental health problems are viewed as the wrong women giving birth in the wrong circumstances, rather than being acknowledged for their mothering abilities.

Mothers with a diagnosis of depression are considered to interact less and be less affectively and interactionally synchronized with their children (Cox et al. 1987; Hammen et al. 1990; Mullick et al. 2001). While not discounting that a small number of women with psychotic symptoms may experience thoughts leading them to harm their children (Mullick et al. 2001), the tendency within the research to emphasise the negative has resulted in motherhood and mental 'illness' becoming synonymous with negative parenting, regardless of diagnosis, severity of experiences, support systems and family circumstances. Oyserman et al. (2000) point out that the risks a child may experience depends on the child's developmental phase and the sociocultural context in which parenting takes place, and not only on the existence of enduring mental health problems. However, the 'medical gaze' (Foucault, 1977), which views and judges women by the label of mental illness, identifies this group of mothers as unfit and reminds them that their position and expertise as mothers cannot be taken for granted. (Mowbray et al. 1998; Nicholson et al. 1998; Davies and Allen 2007; Oyserman et al. 2000). This negativity towards people with mental health problems was also evident in a recent Irish national survey. Of the 1039 people surveyed 38% of respondents felt that people with mental health problems should not have children (National Disability Authority 2011). This framing of mothers as 'unfit' places enormous pressure on women to prove their mothering competence (Montgomery 2005; Nicholson et al. 1998; Davies and Allen 2007; Perkins 2003). Consequently, women are often reluctant to reveal a mental health problem or seek help with parenting for fear of allegations of poor mothering practice and loss of custody of children (Montgomery et al. 2006; Davies and Allen 2007). The UK Confidential Enquiry into Maternal and Child Health (CEMACH) report *Saving Mothers Lives* (Lewis, 2007: 153-154) states that women experiencing 'serious' mental health problems are not protected by pregnancy from relapse at that time, and are at higher risk, with at least one in two, developing mental health problems in the postpartum period. In CEMACH's last report, 'over half of the women who died from suicide had a previous history of serious mental illness' (Lewis 2007: 154). Yet the absolute rates of suicide have come down in the period covered by this latest report (2003-2005), for this deeply vulnerable group of women. CEMACH attributes this welcome decline to its recommendations being followed for better attention, support and counselling being given to women during the pre-pregnancy, antenatal and intra and postpartum care. So

mothering can be successfully supported for women dealing with 'serious' mental health issues.

In a small number of qualitative studies, mainly from Norway, United Kingdom, USA and Canada, women with 'enduring' mental health problems, with children between the ages of 2 and 16 years, report that looking after children was rewarding and central to their lives, even though the demands of parenting were considerable and constructive support from services minimal. Motherhood provided these women with an opportunity to express feelings of care and concern, and provided an identity and role associated with normalcy, security and responsibility (Mowbray et al. 1995; Oyserman et al. 2000; Perkins 2003; Montgomery et al. 2006; Chernomas et al. 2000; Blegen et al. 2012). However, the women in these studies also highlighted their struggles to maintain or obtain custody, and to achieve normal lives for themselves and their children (Sands 1995; Nicholson et al. 1998; Oyserman et al. 2000). In addition, they spoke of the difficulties they experienced in remaining engaged with mental health services, due to transport, child care and economic issues.

There are no national figures on the exact number of women who are mothers with mental health problems in Ireland. However, there are some useful proxy statistics. Out of 2711 respondents of the National Psychological Well-being and Distress Survey (NPWDS), carried out by the Mental Health Research Unit (MHRU) of the Health Research Board (HRB) in 2006 18.5% (n=490) of women respondents had dependent children younger than 18 years old living in their household (Tedstone Doherty et al. 2007). Out of those, 15.9% (n=78) reported that they had experienced mental, nervous or emotional problems in the last 12 months, whereas about 11% (n=54) spoke to their GP at least once in the past 12 months about being anxious or depressed. Slightly over six per cent of women living with children under 18 (n=30, 6.3%) reported use of mental health services or professionals (such as in-patient units, psychiatrists, nurses or day centres) at least once within the past 12 months. It is evident, however, from the international literature, that many women routinely seen by the mental health services are not identified as parents and the parent role function is ignored in care and treatment planning. Nicholson et al. (1993) found that few American Mental Health Services routinely collected data on whether women attending services had children and neglected to ask about family roles and responsibilities. Dipple et al.'s (2002)

study in the UK also highlighted the inadequacy of women's case notes, regarding their role as mother. This included records with no mention of children, the incorrect number of children, inadequate information to enable mother or staff to easily contact children and incidents where a major event such as the death of a child was not recorded. This is indicative of the tendency of services to neglect the specific psychosocial needs of mothers, in a context of community and family living. It is also indicative of the biomedical paradigm and its focus on the woman as 'patient' as distinct from her role of mother. Consequently, the identity of the women as 'mentally ill' becomes primary, supplanting all other identities (Montgomery et al. 2006; Oyserman et al. 2000).

The report of the expert group on mental health policy, which was accepted by the government as the basis for future development of mental health services in Ireland, recommends a 'family-centered' approach to mental health provision that is child-friendly and addresses the needs of children of 'service users' (Department of Health and Children 2006). Emphasis within this document is also placed on the need to strengthen peri-natal mental health care (Department of Health and Children 2006). In addition, The National Women's Strategy 2007-2016 identifies the need to consider the introduction of awareness campaigns relating to mental health among women in the peri-natal period (Government of Ireland 2007). A number of documents highlight the importance of gender as a health determinant (The Women's Health Council 2005, Department of Health and Children 2006), with a call being made to improve the health status of women through gender-focused mental health policy and service provision (The Women's Health Council 2005, Government of Ireland, 2007). While mental health services are addressing needs for housing, work and education among people with enduring mental health problems (Government of Ireland 2006), they are far behind in responding to the needs of women as mothers. There is limited knowledge available on the unique needs of this group of women as mothers or what contributes to their success as mothers. There is also little information on what environmental and social barriers this group of women may experience in accessing mental health services within the Irish context, or what services or supports they receive. Such information is essential in providing a service that is based on and is responsive to women's needs, a service as advocated by government policy that is sensitive, flexible and respectful (Department of Health and Children 2006).

## **Generating the idea**

The idea for this research began formally when I applied to and was accepted as a student by the School of Nursing and Midwifery in Trinity College Dublin in 2008. However, the route by which I came to this point is more difficult to trace. I have worked in mental health services for a number of years in the UK and in Ireland. During that time I was involved in various organisations and groups. I worked with groups of Irish men and women in London and over time became aware that some aspects of life were not discussed especially in relation to parenting experiences when children were no longer in daily contact. Mental health services rarely asked about parental status when a person was referred to services. It was as if there were unwritten rules around the content of interactions. The existence of absent children was alluded to but not openly discussed. My interest grew especially in relation to mothers. I was particularly interested in supporting women in the aftermath of separation from children. Women found it difficult to discuss their feelings and worried that they would be judged if it became known that their children were no longer living with them. If mental health practice is informed by person-centered care then how could such an important area of a person's life not be discussed and supported? As a result I set out to gain an understanding of women's lives as mothers experiencing mental distress.

## **Aim of the research**

The aim of this study is to build on the small body of work that currently exists on mothers experiencing mental health problems, by exploring the subjective mothering experiences of this group of women and their experiences of accessing mental health services.

The objectives of the study are:

- to explore the experiences of mothering with women in the context of mental health problems;
- to explore the experiences of this group of mothers when they engage with mental health services;
- to explore these women's preferences for psychological, emotional, social and practical support.

### **Selecting feminist standpoint theory**

Feminist standpoint theory was chosen for this research because it offered an approach that gave me the tools to add to the existing body of knowledge with and for this group of women informed by their own terms of reference. By using feminist standpoint theory to guide my research I would be in a position to focus attention on the experiences of this group of mothers and on their social location. In addition, I would be challenged to focus on their knowledges which were subjugated by ideologies on motherhood and mental 'illness' and the oppressive policies and practices that arise from these ideologies. I would also be required to question the historical processes that created the prevailing view that this group of mothers are not 'ableminded' and examine the social and political structures that maintain this view. By using the concepts of reflexivity, 'strong objectivity', relations of ruling, 'situated knowledge' and 'subjugated knowledge' to challenge and expand thinking and knowledge with this group, feminist standpoint theory provided a theoretical basis from which to expand understandings of the dominant ideology that places and maintains mothers experiencing MHPs in their current position.

### **A personal statement**

Letherby (2000) suggests that in feminist research the researcher's personal biography needs to be acknowledged as it has an impact on the research in terms of choice of topic, method of data collection, relationships with participants and in the analysis and presentations of the findings. Therefore the purpose of a personal statement, in this instance, is to help the reader judge to what extent this thesis is influenced by my personal biography. To situate myself in the research I will provide some personal information. I am a woman, nurse, mother and accidental researcher. I have many years' experience working as mental health nurse and I judge myself as competent and empathic in that role. I endeavour to have compassion and hope at the core of my interactions with people. This was the jumping off point for me as, more often than not, I saw women as mothers within our services being disempowered. My experiences as a mental health nurse working with women and my values of empowerment and justice developed an active consciousness about women's agency which did not fit with how mainstream services responded. My observations about these disjunctures led me into the world of research, more by chance than design, through a series of chance meetings and discussions. The world of research has

taken me out of my comfort zone and into a bewildering world of texts and academic language.

However I am passionate about gaining a deeper and more holistic understanding of mothering in the context of mental distress. I have long questioned the value of the biomedical view of mental distress and have found it restrictive in its view of mothers as negatively impacting on children's health and development. Therefore I embraced the challenge of undertaking this research.

### **Format of this thesis**

The thesis is structured around eight chapters. Chapter One focuses on the introduction, rationale, thesis aims and objectives; the chosen methodology, personal statement and thesis structure are presented and discussed. Chapters Two and Three focus on literature in the areas of motherhood, mothering and mental health. Chapter Two traces the ideologies of motherhood which have developed over time and how these ideologies set up expectations and influence the way women mother. Chapter Three explores existing research around the area of motherhood and mental distress and highlights the dearth of accounts of lived experiences of mothering in the context of mental distress.

In Chapter Four the epistemological and philosophical underpinnings of feminist standpoint research are examined. The process of the research from initial conception, to ethical approval, recruitment of participants, methods of interviewing, transcribing and analysis is discussed and explored.

The findings are set out in Chapters Five, Six and Seven. The findings are presented in three chapters to clarify the process involved in gaining a feminist standpoint of the experiences of this group of women. Chapter Five examines and explores the ideologies of mothering and motherhood and how these ideologies place pressure on women to mother in a particular way. The focus of Chapter Six is on how women mother in the context of mental distress and on how they mother in the context of 'relations of ruling'. In Chapter Seven the focus moves to how services respond to mothers distress and traces how women first accept and then challenge existing ideologies.

The final Chapter of the thesis provides an in-depth discussion of the findings in the context of oppression and resistance. It attempts to address implications of the findings for mental health policy, mental health services, education and research.



## **Chapter Two: Motherhood in the context of Ireland**

### **Introduction**

Rich (1976: p.11) asserts that there is one unifying experience for every person, that is that everyone has a mother and has been 'born of woman'. However, here the commonality ends and she suggests that we have major gaps in our knowledge in relation to motherhood. Experiences of mothering and being mothered are influenced by many different factors and there are many different beliefs about what it means to be a mother. Being a mother is not only the biological event of giving birth but is also influenced by the social, psychological, emotional, cultural, economic and political circumstances that provide the context in which mothering takes place. There is a vast body of literature on motherhood and, in an attempt to make sense of what it means to be a mother in the 21<sup>st</sup> century, in this chapter, I will explore, discuss and analyse some of the contemporary representations of motherhood that have emerged from writings on motherhood in the late 20<sup>th</sup> century and into the 21<sup>st</sup> century with particular reference to Ireland. I will first briefly define and differentiate between the terms mother, motherhood and mothering.

### **Defining terms: mother, mothering and motherhood**

Being a mother means different things to different people therefore a single understanding is difficult to reach. The complexity of being a mother in modern society is clear from the extensive literature and academic papers written on the subject in the last fifty years. Various themes have been explored, for example older mothers, younger mothers, single mothers, lesbian mothers, mothers and daughters, mothers and sons, policy, work and race. Andrea O'Reilly, an academic and feminist at Toronto University, argued for and created motherhood studies. Motherhood studies, according to O'Reilly (2010), seeks to acknowledge 'this new scholarship on motherhood as a legitimate and distinctive discipline, one grounded in the theoretical tradition of maternal theory developed by scholars such as Patricia Hill Collins, Adrienne Rich, and Sara Ruddick' (p.1). O'Reilly (2010), drawing on the work of the aforementioned theorists (Collins 1994; Rich, 1976; Ruddick 1989), argues that the term motherhood refers to the patriarchal institution of motherhood (Rich 1976), while mothering refers to the experiences of mothers as they negotiate this patriarchal institution of motherhood and its oppressive ideology (Ruddick 1989). Drawing on the work of Patricia

Hill Collins (1994), maternal identity is the final area identified by O'Reilly (2010) and focuses on how a woman's sense of self is shaped by the patriarchal institution of motherhood and her experiences of mothering.

The term mother encompasses more than the biological act of reproduction. Each mother is unique in her experiences and expectations although there may be some commonalities in societal expectations of mothers. Being a mother involves a changed sense of selfhood and consequently affects self-esteem, body image and self concept.

Mothering and motherhood are often used interchangeably with the term mother. However, the recent literature offers some clarification of these terms. The term mother is defined as someone who is responsible for 'the relational and logistical work' (Arendell 2000, p.1192) of child care, whereas mothering refers to the behaviours, actions, feelings and emotions associated with caring for a child/children. It is what mothers do on a daily and nightly basis for and with their children. Jagger (1983) defined mothering as a historically and culturally variable relationship 'in which one individual nurtures and cares for another' (p.256). Forcey (1994) expanded on this definition and suggested that mothering is 'a socially constructed set of activities and relationships involved in nurturing and caring for people' (p.357).

The act of mothering has been studied from the perspective of the needs of the baby and young child in the work of John Bowlby (1958) and Donald Winnicott (1953), the former writing of attachment theory and the latter about 'good enough mothering'. The mother, Winnicott (1953) suggests, needs to provide an environment with minimal frustration in order for an integrated, good sense of self to develop. Winnicott (1971) went on to reassure mothers that to be 'good enough' was preferable to striving to be ideal. Mothers who are good enough provide children with the opportunity to learn to cope effectively with disappointment and failure in the context of love. The concept of the 'good enough' mother gives each individual woman the room to see her baby, her baby's needs and her own needs within a highly personal and social context.

The third term used in the literature is 'motherhood' and the explanation emerging from the literature suggests that this is the societal structure in which mothers do mothering work.

Motherhood has often been defined in the past from the perspective of a male standpoint providing a rigid structure where women are expected to mother in particular ways (Badinter 1981). Rich (1976) defines mothering as 'the *potential relationship* of any woman to her powers of reproduction and to children' (p13, emphasis in original). Rich (1976) separates mothering from motherhood and defines motherhood as 'the *institution* which aims at ensuring that that potential, and all women, shall remain under male control', (p13, emphasis in original). Therefore according to Rich (1976) motherhood is a patriarchal institution which is male-defined and controlled and is oppressive to women. However, she goes on to argue that the term mothering refers to women's experiences of mothering which are female-defined and centred and potentially empowering for women. Umansky (1996) expanded on Rich's distinction between motherhood and mothering, arguing that patriarchal motherhood was a negative discourse that was oppressive and damaging to women's independence and that non-patriarchal motherhood/mothering: 'holds the truly spectacular potential to bond women to each other and to nature, to foster a liberating knowledge of self, to release the very creativity and generativity that the institution of motherhood denies to women' (p.2/3). However, Umansky (1996) does not give any suggestions on how to achieve non-patriarchal motherhood.

Similar to Rich's (1976) distinction between motherhood and mothering, De Marneffe (2004) highlights the importance of maternal desire and argues against the suggestion that mothers' lives are subjugated by childbearing and mothering. De Marneffe (2004) theorised maternal desire from within a feminist framework. Thus, while acknowledging the oppressive nature of patriarchal motherhood she goes on to theorise the desire to have children and the enjoyment that can be had through this relationship. De Marneffe (2004) expands on Rich's work in acknowledging Rich's distinction between the pleasures offered by mothering and the oppressive parts of mothering. De Marneffe, however, adds to Rich's work by theorising a mother's desire for and delight at being present with her child. The concept of maternal desire is different from maternal instinct. Thurer (1994) provides a definition of instinct: 'an instinct is an innate and invariant behavior pattern, common in 'lower' animals but rare in humans whose sophisticated nervous systems enable them to adapt to the environment, so whatever pure urges they may have started with are rapidly overlaid, perhaps overturned, by the effects of learning' (p.6). The notion that women know

instinctively how to mother is questionable. Hrdy (1999) goes on to argue that women are not 'naturally' or 'essentially' mothers. She emphasises the importance of the environment and the circumstances in which each woman finds herself. Instead of a universal 'maternal instinct', time, culture and place impact on how women approach birth and motherhood. Mothering therefore is not just a 'natural' response, but is sensitive to both nature and the environment. Hrdy explains that 'attention needs to be focused on the complicated interactions among genes, tissue, glands, past experiences, and environmental cues, including sensory cues provided by infants themselves and by the individuals in the vicinity' (p. 174).

Motherhood continues to be presented, in childcare manuals and parenting magazines (Douglas and Michael 2004), as natural, instinctive, intuitive and the ultimate fulfilment for women. However motherhood and mothering are social and historical constructions that are influenced by cultural, economic and historical factors, as described by Hrdy (1999), and are not biologically determined (Bassin, Honey, Kaplan 1994; Glenn 1994). Every society or culture in every era creates its own norms about mothering (Hager 2011). Thus women, men and society are socialised to view mothers and mothering in particular ways.

For the purpose of this study, I will focus on western representations of mothering. Although there are a variety of representations across the world I argue that there is one dominant ideology that has taken hold in modern western society that shapes how men, women and society set up expectations of how women should mother.

I support Rich's (1976) view that the institution of motherhood is a cultural construct. The culture in Ireland is patriarchal resulting in a patriarchal view of motherhood. This patriarchal institution of motherhood sets up societal expectations, assumptions, laws and rules which govern how a woman is expected to mother her children. For example Ireland's traditional patriarchal society confined women to the home and characterized them as unidimensional (Beale 1987). The basis for this limited role is enshrined in the 1937 Irish Constitution Article 41.2.1: 'In particular, the State recognises that by her life within the home, woman gives to the State a support without which the common good cannot be achieved', and in Article 41.2.2: 'The State shall, therefore, endeavour to ensure that mothers shall not be obliged by economic necessity to engage in labour to the neglect of

their duties in the home' (Article 41, 1937, Constitution of Ireland). As a result of this positioning of women in the home the notion of the strong male breadwinner model developed in Ireland (Lewis 1993). Since the 1970s women in Ireland have become increasingly involved in the labour market, especially during the Celtic Tiger years 1995-2007, with employment rates for women reaching 61 per cent in 2007 (European Commission 2009). Drew and Humbert (2012) argue that this rise in employment rates for women 'is not always accompanied by any reallocation of domestic and family work or in reassigning of gender roles' (p.50), therefore women seem to be expected to become 'dual' breadwinner, in addition to 'housewife' and provider of most of the care for children. In the following section on contemporary mothers, mothering and motherhood I will explore how Irish mothers are positioned within each of these representations. I will also attempt to unravel how women in Ireland negotiate being modern mothers.

### **Contemporary representations of mothers, mothering and motherhood**

In the literature there are many different descriptions and explanations of mothering and motherhood, for example: traditional mothering (Thurer 1994), feminist mothering (Glickman 1993), neotraditionalist mothering, intensive mothering (Hays 1996), extensive mothering and sacrificial mothering (O' Reilly, 2006). In the following section I will discuss each of these ideas. As this research is based in Ireland, I will concentrate my discussion on representations of mothers, mothering and motherhood pertinent to Ireland. I will attempt to link the contemporary literature on mothering with the structures in Ireland that place women as the main carers of children and offer suggestions on how empowered mothers may be one way to change patriarchal motherhood.

### **The traditional mother**

The traditional mother role was a product of the emergence, in the twentieth century, of the nuclear family and a labour market based primarily on male participation. Thus, in Ireland and elsewhere, up to the 1960s, women were expected to be stay-at-home mothers with responsibility for childcare and household management (Thurer 1994; Connor 1998; Schlessinger 2000). This traditional view of mothering was supported by the reality that men were the 'breadwinners'. There was also a theme that men would provide a strict moral code of behaviour for children (Lakoff 1996). In Ireland this traditional mother role fitted

very well with male-dominated policy and structures. At a cultural and constitutional level, Irish women were expected to be the primary carers of children. At this time married women were not allowed to work outside the home; however, over two thirds of younger women and more than half of older single women worked outside the family home (Horgan 2001). The exclusion of married women from employment ensured that they had limited choices and as a result were placed in a subordinate position in Irish society. O'Connor (2000 p. 83) suggests that this social subordination of women was, until very recently, seen as 'natural', 'inevitable' and 'what women want'. Horgan (2001) concluded that many Irish women decided to remain single when faced with the choice of a life of dependency in marriage or an independent wage-earning single life.

### **Feminist mothering**

Feminist mothering which began to take shape in the 1970s offered an alternative to traditional mothering. Chodorow (1978) posed the question 'Why do women mother?' and went on to demonstrate that mothering was not biologically determined but socially and psychologically created and 'reproduced'. She argued that mothering, rather than being natural, was grounded in a gendered division of labour that promoted empathy and nurturance in girls and women, and this in turn contributed to inequality in society with women being responsible for and more suited to caring roles. Chodorow (1978) went on to propose equalisation of male and female social and parenting roles. Mothers and fathers would then share parenthood and as a result they could assume similar roles in social and economic life. Feminist mothering advocated community involvement in childcare with a move from private to public involvement (Valeska 1983), leading to a child-centered culture in which both children and women as mothers are valued (Kittay 1983). The focus was on empowered family relationships (Ehrensaft 1983; Held 1983). Community support services were central to the arguments favouring feminist mothering (Ferguson, 1983). Women were seen as people in their own right and not as an extension of the child and, as a result, had the right to pursue their own interests (Barnett & Rivers 1998; Hanson & Sloane 1992; Peters 1997).

As a result of the changes in the Irish economy in the 1970s, women expected and demanded a life outside the home. For example, in 1973, the Irish Government removed the 'marriage bar' (Government of Ireland 1973) as its removal was a pre-condition to Ireland's

membership of the European Economic Community (EEC). In the thirty years between 1971 and 2001 the number of women in paid employment rose by 140 percent and, in 2008, 61 percent of women aged between 15 and 65 were employed, which was above the European Union (EU) average of 59 percent (Central Statistics Office (CSO) 2010). However women were still held responsible for domestic duties and childcare therefore much of their paid work was part-time (Beechley and Perkins 1997; Coveney, Murphy-Lawless and Sheridan 1998; Murphy-Lawless 2000). Equal relationships in domestic responsibilities, childcare and paid employment work were not a feature of Irish family life.

### **Neotraditionalist mothering**

Neotraditionalist mothering was a product of the 1980s and describes women who decide to stay at home once they become mothers (Dagnan 1999). Keller (1994) suggests that the main difference between traditional and neotraditional mothering is that women following neotraditional mothering argue that they are staying at home as a result of adopting a feminist position and are consciously making a decision to stay at home. Writers on neotraditionalist mothering argue that mothers are making an empowered choice and that they gain personal fulfilment through caring for their children (Keller 1994, Hakim 2000). Hunter (2000) argues that women who use these child-centered reasons in deciding to stay at home fulltime are conforming to De Marneffe's (2004) notion of maternal desire outlined earlier in this chapter. Neotraditionalist mothering embraces some of the notion of intensive mothering, which is discussed in the next section, as such children received intensive attention from their mothers and mothers increasingly relied on experts to guide them through their child's developmental stages. For example, women sought guidance from books, magazines and, in more recent times, web sites. However, in the Ireland of the 1980s some women were beginning to choose to postpone having children until their career was established (White 2010). In addition, Drew et al. (1998) make the point that there was limited choice as women in Ireland needed to work but could only work part-time because of the total absence of state supported childcare here.

## **Intensive Mothering**

Sharon Hays introduced the term intensive mothering in 1996 to describe yet another aspect of what contemporary society appears to expect from women as mothers. Hays (1996) suggests that the underlying premise of intensive mothering is that mothers need to be everything to their vulnerable and sacred children. Hays argued that under intensive motherhood, 'Good childrearing requires the day-to-day labor of nurturing the child, listening to the child, attempting to decipher the child's needs and desires, struggling to meet the child's wishes, and placing the child's well-being ahead of their [mothers'] own convenience' (1996, 115). Therefore, to be good mothers, women must spend countless hours stimulating their children, taking care of their physical needs, making decisions in the present that determine the future success or failure of the children as adults. Love is the only acceptable emotion for women to have towards their children. Intensive mothering requires an enormous investment of time and energy by women and insists that women need the guidance of experts such as doctors, psychologists and childcare books. In addition women are expected to enjoy the experience of mothering and nurturing their children. In a critique of these arguments Badinter (2011) suggests that intensive mothering sets unrealistic standards and expectations for modern mothers and that these expectations have increased over time. Badinter (2011) also asserts that this is a retrograde step and has set mothers further back to an extent not seen since the 1950s. She writes that 'for a majority of women it remains difficult to reconcile increasingly burdensome maternal responsibilities with personal fulfilment' (p.2). Consequently, the woman's identity as mother becomes her only identity and becomes the primary defining essence of her being (Arendell 2000; Choi et al. 2005; Miller 2005, 2007).

## **Sacrificial mothering**

The notion of sacrificial mothering is derived from the good mother ideology (O'Reilly 2004a). O'Reilly (2004a) coined the phrase sacrificial mothering and describes its six interconnected components: children can only be cared for by the biological mother; this mothering must be provided around the clock; the mother must always put children's needs before her own; mothers must turn to experts for instruction; the mother is fully satisfied, fulfilled, completed and composed in motherhood; and finally, mothers must



lavish excessive amounts of time, energy and money in rearing their children (O'Reilly 2004b). O'Reilly (2004) argues that this ideology is deeply oppressive to women. The expectations and beliefs underpinning sacrificial mothering coupled with the accompanying notion of the 'good/perfect' mother ideologies prompt mothers to 'don the mask of motherhood (Maushart 1999). The mask of motherhood must be worn as a direct result of the pressure on mothers to be good, perfect, and sacrificial. Maushart (1999) argues that, as a consequence, mothers must hide from others those parts that do not fit the perfect mother image. Maushart (1999) concludes that the mask is donned in an effort by women to avoid being judged as bad or incompetent mothers. Furthermore the mask may keep mothers from talking about and getting support for any mothering challenges they experience. In Ireland a number of studies have shown that caring for children can be socially isolating for women and that Irish women who were fulltime in the home were twice as likely as those in paid employment to be psychologically distressed, their response to that situation being exacerbated by poverty (Fitzgerald and Jeffers 1994; Whelan, Hannan and Creighton 1991). O'Connor (1998) suggests that in Ireland a particular image of mothers is portrayed: this is one of a passive, self-sacrificing mother. She further argues that this image has strong roots in Irish Catholicism and is linked to Mary as a woman who obeyed without question and who devoted her life to the service of her son and God. Consequently, in Ireland, the image of motherhood was idealized with the expectation that women take the leading role in family life through being responsible for childcare.

### **Extensive mothering**

Extensive mothering is an extension of the perspectives previously introduced. Extensive mothering refers to women who work outside the home and who are also mothers. The employed mother is only considered 'good' by society when she ensures that childcare is delegated to an acceptable other in her absence, however, the mother remains responsible for the quality of this care. Acceptable others are usually other women, childcare workers, relatives, neighbours or nannies. Work is justified on the basis that the motivation for working outside the home is for the child's benefit and not the mother's benefit (Christopher 2012). Extensive mothering, as with the intensive mothering perspective, accepts women as primary carers of children and reinforces traditional beliefs that women

and not men are the best carers of children. In Ireland, by 1996 241,400 married women were working outside the home, an increase of more than 600 percent since 1971. Fifty one per cent of mothers with one or two dependent children are also in employment (CSO 2010). However since Ireland continues to have one of the lowest levels of state funded childcare in the European Union it would seem that childcare in Ireland is still construed as the mother's responsibility. As argued by White (2010) the traditional culture in Ireland, the kind of work available and access to part-time work impacts on the employment opportunities for women who have children.

### **Mother war**

The competing perspectives and arguments underpinning the stay-at-home mothers (intensive, sacrificial mothering) and the mother who goes outside the home to work (extensive mothering) gave rise to what Buxton (1998) called the 'mother war' and in Ireland the 'mammy wars' (White 2010, p. 72). Buxton (1998) highlighted the stereotypes of the 'superwoman' who manages work with caring for her children and the 'earth mother' whose primary purpose is to care for her children, who is ever present, always fully attentive to the needs of her children and has no personal interests outside of her children. De Marneffe (2004) describes the 'super-mom' and goes on to describe the pressure of this ideal on women, 'this cultural ideal pressures mothers to perform excellently on **all** fronts, in a job, with their children, with their partner, at the gym, and in the kitchen, making those fifteen-minute meals' (p.10). With the limited and expensive childcare provision in Ireland Irish parents have little choice in providing childcare for their children.

Whilst acknowledging that various contemporary perspectives on mothering exist (Collins 1994, 2000; Duncan and Edwards 1999; Johnston and Swanson 2006, 2007; Lamphere, Zavella, and Gonzales 1993; Segura 1994; Stack and Burton 1993), there is general agreement in the literature that the intensive model of mothering is the one favoured in western society (Arendell 2000; Douglas and Michaels 2004; Garey 1999; Hattery 2001; Hays 1996; O'Reilly 2006). This model of mothering has given renewed backing to the notion of a 'good mother' and its opposite, a 'bad mother'. Given the constraining social circumstances in Ireland for women who are mothers and the continuing lack of extensive

support at institutional and political levels for mothering and parenting which shapes their realities, this model of 'good' and 'bad' mothering can be argued as reflecting the ways in which a patriarchal ideology about mothering is reinforced in daily life.

### **Good mother/bad mother binary**

In exploring the above representations of mothering, it is clear that there is an underlying notion of a 'good' mother. What constitutes a 'good' mother is judged by particular knowledge and beliefs at any given time. The long history of the notion of 'good mother' impacts on how women mother their children (Hays 1996; Miller 2005). Indeed, Hays (1996) and Miller (2007) assert that most western women, regardless of age, social class, ethnicity or sexual orientation, recognise the notion of 'good mothering', accept the premise that there is a correct way to bring up children and attempt to live up to this ideal. The suggestion that there is a 'right' way to mother is also a strong image, with both contemporary literature and pervasive media coverage setting up almost impossible expectations about mothering.

Attachment theory has been a strong influence on the notion of 'good' mother, where mothers need to anticipate and respond to children's needs. In the first part of the 20<sup>th</sup> century children's physical health was seen as the mother's responsibility. Women were expected to follow advice from medical experts (Arnup 1994; Ehrenreich and English 1978; Weiss 1978; Hardyment 2007). In the second half of the 20<sup>th</sup> century, in addition to physical concerns, mothers were now also expected to be responsible for children's emotional and psychological wellbeing (Hardyment 2007). The attachment theory movement was led by the work of John Bowlby (1952, 1958, 1969) who focused attention on maternal attachment and maternal deprivation. As suggested by Hays (1996) this has led to the ideology of intensive mothering, where 'good' middle-class mothers spend time, energy and financial resources on an ever increasing list of children's needs and desires. These ideas added to the mothers' role and resulted in an increased intensification of mothering. The norm of 'stay-at-home mother' reinforced through Bowlby's (1952) attachment theory, where he argued that children required full-time mothering as without it they would suffer what he termed 'maternal deprivation'. Bowlby's work added a 'scientific' basis for the view that mothers' attention and devotion to children in the early years was crucial to the

development of emotionally and psychologically healthy children thereby ensuring a healthy adult, (Eyer 1992; Ehrenreich and English 1978). As suggested by Hardyment (2007), Bowlby's ideals meant that 'mothers had to devote themselves wholeheartedly to their babies to ensure their inoculation against the danger of emotional hang-ups and unfulfilled intellectual potential in later life' (p.228). Hrdy (1999) noted that in many cultures there was a period of indifference among mothers while they recovered from the exertion of delivery. However, the assumptions inferred from attachment theory have become part of the beliefs and practices in childrearing into the 21<sup>st</sup> century (Eyer 1992; Belsky and Cassidy 1994). With the focus on children taking centre stage in family life (Hays 1996; O'Reilly 2004; Thurer 1994) women's/mothers' needs become secondary in a child-centred world (Weiss 1978; Thurer 1994; Hardyment 2007). De Marneffe (2004) developed the notion of 'maternal desire' which focuses on the emotional and relational aspects of mothering from the perspective of the mother. De Marneffe points out that having and wanting to care for children is a major part of some women's lives. Therefore it is important to acknowledge this and to explore what women get from mothering, not only in terms of being responsive to children's needs, but also in how mothering can be responsive to the mother's needs in a growth promoting way.

Schafer (2009) and Green (2011) describe the good/perfect mother. Green (2011) argues that the 'good/perfect' mother is so ingrained in society that the mere mention of the words conjures up a picture of her in our minds. Caplan (2000) suggests that there is a 'good mother' myth that sets impossibly high standards for women. Within this myth the standards for perfection are that the good mother never gets angry, is always giving and nurturing and has the knowledge to produce happy well-adjusted children. The 'bad' mother on the other hand is characterised as a mother who is the opposite of the good mother. The 'bad' mother is not available to meet the emotional and physical needs of her child, and is seen as not nurturing her child (Gustafson 2005). The 'bad' mother puts other interests ahead of her child. This can be for a number of reasons, such as working outside the home (choosing a career or from economic necessity) or being separated from her child through being admitted to a mental health facility. The good/bad mother binary sets rigid gender and cultural norms that judge women who may choose to, or need to, mother their children outside of this construction, thereby controlling and policing the actions and

activities of mothers who are expected to meet or conform to dominant standards of motherhood. Miller (2007) suggests that the notion of the good/bad mother places enormous pressure on women to mother in certain ways. If women move outside patriarchal motherhood they are considered 'bad mothers', for example if women live outside the expected traditional nuclear family, if mothers do not protect their children or if their children do not grow up to become productive members of society, mothers are blamed. Mother-blame is part of patriarchal motherhood, and as a result mothers become anxious and ashamed about their inadequate mothering and strive to conform to the idealised notion of patriarchal motherhood. This idealised notion of motherhood is impossible to achieve leading to more anxiety and guilt for mothers. If some women choose to mother (or are seen as different, for example, mothers experiencing mental health problems) outside of the institution of patriarchal motherhood they are classed as 'unfit' and their mothering becomes open to scrutiny and surveillance by social and health institutions (Miller 2005; Collins 1994; Chesler 1987). Thus women who mother differently are placed outside the notion of 'good mother', for example teenage mothers, single mothers and mothers with mental health problems. Women are given a strong message that there are accepted norms that need to be adhered to, which in turn sets up a 'self-policing' of mothering practices (Douglas and Michaels 2004, p.141). Douglas and Michaels (2004) capture this idea in the following quote: 'everyone watches us, we watch ourselves and other mothers, and we watch ourselves watching ourselves... [m]otherhood has become a psychological police state'(p.6).

## **Conclusion**

In conclusion, in exploring the contemporary perspectives on mothering it is clear that there is a dominant intensive mothering ideology in western society that sets up impossible standards for mothers in the 21<sup>st</sup> century. Patriarchal motherhood, as discussed earlier, places enormous pressure on women to mother in a particular way. The image of motherhood in Ireland has been idealised with the expectation that women will assume the leading role in family life through being responsible for childcare. The patriarchal structures in Ireland in relation to childcare and employment also mean that women have limited choices once they become mothers. As a result of the absence of extensive and creative measures for state supported childcare if women want to or need to work, part-time work is

often their only option. Idealised mothering in the context of patriarchal motherhood is impossible to achieve. Nevertheless women strive to achieve this ideal leading to anxiety and guilt when they fall short of the expectations of patriarchal motherhood. As highlighted, if women are seen as different, for example if they experience mental health problems or choose to mother outside of the institution of patriarchal motherhood, they are classed as 'unfit' and their mothering becomes open to scrutiny and surveillance by social and health institutions.

I argue that being a mother is socially constructed and that 'maternal desire' exists; however, I do not accept the notion of mothering as 'natural' or 'instinctive'. Understandings of mothers, mothering and motherhood change in response to specific personal, social, cultural, economic and political factors. How women mother is dependent on their position in society. Individual mothering practices, experiences and thinking both shape and are shaped by various ideologies on mothering (Kawash 2011, p. 97). There is no one definition of mothering but there are a series of ideologies that have shaped our understanding of motherhood and set up the good/bad mother binary, which in turn sets up a surveillance and policing of mothering practices under the gaze of patriarchal motherhood.

## **Chapter Three: Mothering while experiencing mental health problems**

### **Introduction**

The focus of this chapter is on providing the reader with an overview of the literature in relation to mothers and mental health. The past lays the foundations for how the present is perceived; therefore, literature from the recent past will be used to highlight how mothers with mental health problems were viewed then and how they continue to be viewed into the present. The literature will be explored and discussed from the perspective of how the privileging of the biomedical and individualist view of mothers with mental health problems, has resulted in this group of women being portrayed as flawed and their children in need of protection. The term biomedical is familiar to most readers. In the context of mental health it is defined most simply as any dysfunction that affects mental functioning being regarded as 'disease' and assumed to be a consequence of physical and chemical changes which take place primarily in the brain. Symptoms of distress are then grouped together and classified into a 'mental illness', with a belief that the true cause of the distress can eventually be discovered and appropriate physical treatment administered. In this biomedical understanding 'mental illness' is thus defined as residing in the individual (Stoppard, 2000). Consequently the focus is on an individual's subjective and bodily experiences and not on the context of their lives.

### **Feminisation of 'mental illness'**

The World Health Organisation (2012) state that mental health problems (MHPs) are among the most important contributors to the global burden of disease and disability, and estimate that about 450 million people worldwide experience some form of 'mental disorder' or brain condition, and that one in four people meet criteria for diagnosis of mental health problems at some point in their life. The overall rates of MHPs are similar for men and women; however, there are significant gender differences in patterns and symptoms of MHPs (WHO 2002). The prevalence of depression (including postnatal depression) and anxiety is much higher in women, while substance abuse and antisocial behaviours are higher in men. There are no consistent gender differences for the diagnosis of schizophrenia and bipolar depression; however, men are said to have an earlier onset of schizophrenia,

while women are more likely to exhibit more serious forms of bipolar depression (WHO 2002). Gender differences have also been reported in age of onset of psychotic symptoms, frequency of psychotic symptoms, course of MHPs, social adjustment and long term outcomes. Higher levels of disability are associated with co-morbidity (the occurrence of more than one disorder concurrently) women predominate in this category.

Depression, anxiety and high rates of co-morbidity are significantly related to interconnected and co-occurrent risk factors such as gender based roles, stressors and adverse life experiences and events (WHO 2012). Gender specific factors that affect women include gender based violence, socioeconomic disadvantage, low income and inequality in income, and relentless responsibility for the care of others. In addition, socially determined roles and responsibilities place women, far more frequently than men, in situations where they have very little control over important decisions concerning their lives. For example, globally, sexual violence is experienced more by girls and women, and there is a strong association between being sexually abused in childhood and the presence of multiple mental health problems in adulthood. Mental health problems such as depression, anxiety and post traumatic stress disorder (PTSD), dependence on psychotropic medications and substance abuse and suicide, are associated with violence in women's lives (Bifulco et al. 2002; WHO 2002). Psychotic disorders have also been linked to childhood abuse (Read et al. 2003; Janssen et al. 2004); the consequences of this abuse often only emerge in adulthood.

Figures from Ireland reflect global trends in mental health problems, with women in Ireland reporting lower levels of positive mental health than men (Department of Health & Children 2009). Irish women also experience lower income and lower social status, with both factors contributing to lower psychological well being. The gender pay gap persists in Ireland, as women earn fourteen per cent less than men (The Institute of Public Health (IPHI) 2005). The Department of Health and Children (2009) report higher levels of depression among people with medical-cards and lower income groups. Poverty has been identified as a contributing factor to mental health problems for lone parents (the majority of whom are women) with seventy-six percent of lone parents believing that stress, anxiety and depression affects the quality of their parenting (OPEN 2007). In addition, Irish women experienced stress in relation to maintaining multiple roles and responsibilities, for example, unpaid care of children, the sick and the elderly (Women's Health Council 2005). The Sexual Abuse and



Violence in Ireland (SAVI) report (2002) reported that one in five Irish women experienced sexual abuse in childhood and more than four in ten of women reported some form of sexual abuse or assault in their lifetime (Mc Gee et al. 2002).

There are several theories available that explore gender differences in mental health problems, for example biological, psychological, and behavioural differences between men and women have been explored in an effort to explain these gender differences. A biomedical understanding of illness focuses on the body as the site of 'disease'. Historically women's bodies have been scrutinised and pathologised (Foucault 1980; Ussher 1991, 2006) and have been seen as the source of women's weakness and 'madness', and therefore in need of medical intervention and surveillance. Ussher (2003a, 2003b, 2006) suggests that biomedical labels such as premenstrual tension (PMT), premenstrual dysphoric disorder (PMDD), and postnatal depression (PND) are used to regulate and control the female body and women. Women are presented as irrational, neurotic and out of control particularly around times of change in women's bodies for example during menstruation, pregnancy and menopause (Christer and Caplan 2002; Ussher 2006).

Psychological explanations of gender differences focus on how women and men respond differently to stress. Nolen-Hoeksema (2000) suggests that women engage in an emotion-focused style of coping, whereas men tend to engage in a problem-focused style in dealing with stress. Therefore, in explaining higher rates of depression in women, researchers suggest that women respond differently to stress and tend to ruminate on their problems, internalising distress rather than taking action (Mazure et al. 2002; Nolen-Hoeksema 2000). Others such as Tamres et al. (2002) also argue that women, unlike men are more likely to use coping strategies that involve verbal expression to self or others. In exploring gender differences, Emslie et al. (2007) found both similarities and differences between women and men in how they address their distress. In their study while both men and women valued talking to health professionals, both found it difficult to recognise and talk about mental health problems. Men, in contrast to women, valued health professionals' skills that helped them to talk and emphasised the importance of getting practical help, while women valued their listening skills.

While biomedical and psychological explanations of gender difference in rates and types of mental distress offer a useful perspective, the fact that the focus is on the individual as the site of the 'illness', results in an unquestioning of women's unequal position in society as a

possible source of women's distress, or as Ussher (2006) describes it 'women's misery'. Many feminist researchers have critiqued biological and psychological explanations of women's distress suggesting that the wider social and political context of women's lives needs to be considered (Stoppard 2000; Ussher 1991, 2006). Women are socially, politically and economically marginalised in society. The higher rates of poverty, sexual violence, and other forms of abuse experienced by women compared to men, in addition to the gendered division of care-giving and household labour, have long been identified as central contributors to higher rates of depression among women (McGrath et al. 1990). In relation to care giving, Miller (1991) suggests that women are encouraged and expected to prioritise other people's needs and that caring for others is often invisible and undervalued by others. This socialization and cultural devaluation of caring work is likely to feed into low self-esteem, powerlessness, overdependence, feelings of worthlessness, and depression (Caplan 1992; Chesler 1972; Miller 1991). In addition, Broverman et al. (1970) argued that there is a bias in how male and female behaviour is viewed, and suggests that expectations of male behaviour is viewed as closer to understandings of mental health than expectations governing female behaviour. Chesler (1972) expands on Broverman's work and argues that concepts of mental health are not gender-neutral and feminine behaviour is more likely to be pathologised. This pathologising of female behaviour has led to over-diagnosis and the over inclusion of women in many diagnoses (Busfield 1996; Cowan 1996; Steen 1991).

As stated earlier, women's bodies have been seen as the source of women's weakness and 'madness' especially around times of change in women's bodies. Pregnancy, childbirth and motherhood result in profound changes in a woman's life. However the distress and feelings of being overwhelmed at this time is often constructed as mental 'illness' and labelled postnatal depression and puerperal psychosis. These biomedical labels and explanations provide one view; however, many researchers have offered explanations that arise from women's socialisation as another way of exploring women's experiences. Feelings of ambivalence, loss, frustration, sadness, and exhaustion have repeatedly been identified in investigations of women's depression following childbirth (Lewis and Nicholson 1998; Nicholson 1998; Weaver and Ussher 1997). Mauthner (1998, 2002), in her research with mothers experiencing depression, concluded that women experience conflict between the perfect mothers they want to be and the mothers they felt themselves to be. Women

wanted to live up to cultural representations of 'good' mother (as discussed in chapter 2), which meant denying their own needs and desires and focusing their attention on their child.

### **Historical perspectives on women with mental health problems**

Women who experience MHPs voice expectations and hopes of leading lives like those of their peers (Apfel and Handel 1993; Miller 1991; Ritsher, Coursey and Farrell 1997), including achieving the typical milestones of having a partner, reproducing and mothering. However, historically this group of women have been seen through a biomedical lens that focused on disability rather than ability and consequently they have been viewed by society as unsuitable mothers. Mental health problems were thought to have a strong genetic component and as a result, reproduction for this group of women was feared and prohibited where possible (Whitaker 2002; Shorter 1997). In the 1900s marriage, in some countries, for people with mental health problems was prohibited (Krumm and Becker 2006). Barr (1912), writing at the beginning of the 20th century, reports that eugenic arguments were made for the removal of women's ovaries and, in some countries, degeneracy theory underpinned laws that authorised sterilisation without informed consent (Kevles 1995). In addition, women with a biomedical diagnosis of a 'mental illness' were confined to mental institutions. The institution provided the social control to minimise possible reproduction through gender segregation that guarded against any liaisons between men and women (Showalter 1985; Busfield 1996; Apfel and Handel 1993).

Remnants of social control remain today in the use of psychotropic medication with its effects of suppressing sexual desire and impacting on women's prolactin levels, thus negatively impacting on fertility (Higgins 2007a). Vendereycken (1993) suggests that the image of people with no control over their sexual drives, especially women who experience psychosis, supports the use of medication to suppress sexual desire.

However, despite these measures, some women with mental health problems became pregnant and had children. In an analysis of psychiatric textbooks in the first half of the 20<sup>th</sup> century many writers noted that the complete and prompt separation of these mothers from their children was the order of the day (Grunebaum et al. 1975; Apfel and Handel 1993; Howard 2000). Grunebaum et al. (1975) suggests that this practice was underpinned

by a number of beliefs dominant in psychiatric discourse at the time: the belief arising from psychoanalytic theory that the mother's MHP was partly due to her hostility towards her child, a belief that the mother was potentially dangerous with homicidal or suicidal tendencies, and a concern that the presence of a child on a psychiatric ward would upset the management of the ward. The notion of the 'schizophrenogenic mother', put forward by Fromm-Reichmann as a cause of schizophrenia, gave further support to the belief that mothers who experience MHPs were dangerous and should be separated from their children (Howard 2000). Schen (2005) noted that women who experienced MHPs often gave birth under general anaesthetic and their babies were taken away immediately after birth and were put up for adoption. These adoptions were often carried out in secret and were not well documented and therefore it was impossible for children to be reconnected with their mothers. The profound effects of bereavement and loss for these women were not acknowledged by staff in the institution and as a consequence, expressions of unresolved grief were seen as signs and symptoms of mental 'illness' and treated accordingly (Apfel and Handel 1993).

Many writers suggest that women in institutions were seen as genderless, asexual beings, with a presumed incapacity or desire, due to their MHPs, to pursue adult roles, such as that of becoming a mother (Test and Berlin 1981; Showalter 1985; Apfel and Handel 1993; Busfield 1996). Miller (1997) disputes this notion and suggests that MHP in and of itself does not influence sexual desire. Nevertheless the portrayal of women with mental health problems as asexual, lacking sexual desire and the desire to parent is evident, even today. Research suggests that mental health services routinely fail to discuss contraception or the impact of prescribed medication on fertility and sexual function with women (Higgins 2007b; Cole 2000; Dorsay and Forchuk 1994). They also fail to collect data on whether women attending their service have children (Hansson et al. 2013; Houlihan et al. 2013; Dipple et al. 2002; Nicholson et al. 1994). Houlihan et al. (2013) in their study of a cohort of Irish psychiatric nurses reported a failure on the part of many nurses to enquire if service users were parents and, if they were aware of parental status, there was an uncoordinated approach to providing parents with follow up support and help. Indeed the Irish Mental Health Commission asserted that there was little evidence of systematic practices or policies regarding children during the annual inspections of adult mental health services (Mental

Health Commission 2007, 2008). In Ireland, on admission to mental health services, statistics on gender, age, employment, marital status are available; however, the status of women as mothers is not recorded. Statistics are therefore not available on the number of women who experience mental health problems and are also mothers.

Prejudice towards people with mental illness having children also continues today within the general population. In a national survey of Irish people's attitudes (n=1,000) toward disability, 83% (n= 830) were of the opinion that people with a learning disability and people with physical or sensory disability had the same rights as everybody else to fulfilling relationships. However, fewer respondents (59%) were of the opinion that people with mental health problems had those same rights. This negative attitude was also reflected in their views on reproduction. Forty percent were of the opinion that people with a mental health problem should not have children. However, opinion on whether people with physical disability (9%) or learning disability (13%) should not have children was far less negative (National Disability Authority 2006). Negative attitudes towards people experiencing MHPs continue as the NDA 2011 survey has shown. The survey was based on a representative sample of 1,039 adults aged 18+, plus a booster sample of 256 people with disabilities. The results were as follows: the majority of respondents were supportive of adults with vision, hearing or speech disabilities having children if they wish (69%), with the majority also supportive of adults with physical disabilities having children if they wish (68%). However, only a small minority of respondents agreed that adults with mental health problems (38%) or adults with intellectual disabilities or autism (37%) should have children if they wish (National Disability Authority 2011).

### **Mothers who experience MHPs: social and personal circumstances**

The closing of mental institutions and the development of community mental health services means that mothers experiencing MHPs have relationships, become pregnant and give birth (Cogan 1998; Mowbray et al. 2000; Oyserman et al. 2002; 2004, Bybee et al. 2003; Diaz-Caneja and Johnson 2004; McPherson et al. 2007). Studies show that this group of women are sexually active, have children, live with their children in their own homes and are often the primary parents of their children (Apfel and Handel 1993; Joseph, Joshi, Lewin and Adams 1999; Brunette and Dean 2002).

Research studies carried out in the USA reported that women who experience 'serious' mental illness (SMI) are just as likely to be mothers as women who do not experience MHPs. These studies also found that the fertility rates of women with MHPs are no different from those of the general population of women (Nicholson et al. 2001, McGrath et al. 1999). Howard (2001) in UK research disputes this finding and suggests that women with SMI have lower rates of fertility than women without SMI; however, she goes on to report that most women with MHPs have at least one pregnancy (Howard et al. 2001). Reder et al. (2000) estimate that globally approximately sixty per cent of women with MHPs have children under the age of sixteen years. In the UK Gillam et al. (2003) identified between 25% and 49% of people using the community mental health services were parents of dependent children. In 2010 there were 19,619 admissions to Irish psychiatric units and hospitals, a rate of 462.7 per 100,000 total population. There was an equal proportion of male and female admissions and the admissions rates were similar for both: 464.6 per 100,000 for males and 460.9 for females. Single persons accounted for over half (54.5%) of all admissions in 2010, married persons accounted for 27%, widowed accounted for 4% and divorced accounted for 3% (Daly and Walsh 2011). However, statistical data are not available regarding parenting status of these service users.

Research suggests that women with MHPs, especially those who have received a diagnosis such as schizophrenia, bi-polar disorder or depression, are at heightened risk both of poverty and of being single parents (Montgomery 2005; Mowbray et al. 2000, Mowbray et al. 2001; Nicholson et al. 1998b) and have smaller social networks (Caton et al. 1999; Cheromas et al. 2000; Oyserman et al. 2000). Beardsley, Versaye and Gladstone (1998) suggest that families affected by parental MHPs are among the most vulnerable in our community and agree that such families are more likely to experience social isolation. Marital and family strife and experiences of domestic and partner violence are also likely, increasing the difficulties that these mothers and their children experience (Belle 1990, Downey and Coyne 1990, Olson and Banyard 1993). In explaining these phenomena, Reupert and Maybury (2007) suggest that having MHPs often leads to a 'snowball' effect as other problems follow, such as increased risk of unemployment, poverty, violence, and isolation. In addition to these social factors, research also highlights that a large percentage of mothers with MHPs experienced neglect and/or sexual/physical abuse in childhood,

which resulted in their increased risk of developing MHPs as adults (Cogan 1998; Dubowitz et al. 2001; Oyserman et al. 2002; Mowbray and Mowbray 2006; O'Connell 2008). Furthermore women who had experienced abuse as children were more likely to be in abusive relationships as adults (Cogan 1998).

In addition to social factors, mothers who experience MHPs have to deal with the effects of psychotropic medication, relapses and hospital admissions (Cogan 1998; Joseph et al. 1999; Mowbray et al. 2000; Dipple et al., 2002; Diaz-Caneja and Johnson, 2004; Montgomery et al., 2006; Munk-Olsen et al. 2006; Davies and Allen 2007; Barr 2008). Women reported that psychotropic medication slowed them down and affected their concentration making it difficult for them to focus and have energy to respond to their children. Symptoms such as tiredness, depression and psychosis had an effect on their mothering abilities. Women experienced a feeling of insecurity and lack of confidence in their mothering (Nicholson et al. 1998; Diaz-Caneja and Johnson 2004; Montgomery et al. 2006; Davies and Allen 2007; Barr 2008). Mothers also reported experiencing increased tension in balancing their mental health problems and their mothering, with all mothers reported difficulty in relinquishing child care responsibilities when their distress increased (Cogan 1998; Joseph et al. 1999; Mowbray et al. 2000; Dipple et al. 2002; Diaz-Caneja and Johnson 2004; Montgomery et al. 2006; Davies and Allen 2007; Barr 2008).

Pregnancy and childbirth for women experiencing MHPs is often seen as problematic by mental health and maternity services (Fox 2012). Services believe they need to plan how they will manage the woman with her MHPs and how to protect the baby from possible risky behaviour of the mother. These beliefs come from an understanding that 'mentally ill' mothers may have a negative impact on the development of their child (Somers 2007; Downey and Coyne 1990). These beliefs underpin a deficit-based approach to the support and care for this group of women. This will be discussed in detail in the next section.

### **Impact of mother experiencing mental health problems on the child**

Much of the research into parenting and MHPs has taken a deficit-based approach, this approach focuses on the possible risks to children when a parent has a MHP (Rutter and Quinton 1984; Stott et al. 1984; Silverman 1989, Apfel and Handel 1993; Kinsella and Anderson 1996; Oyserman et al. 2000; Mowbray et al. 2002). Firstly, children are portrayed

as either being 'at risk' of developing MHPs themselves (Beardslee and McMillan 1993; Lieb et al. 2002; Normura et al. 2002; Smith 2004; Gladstone et al. 2006) and secondly as being 'at risk' from their mothers. In addition to the social-environmental risk factors and genetic vulnerability (Shorter 1997; Kendler et al., 1999) discussed in the previous section, heightened risk has also been attributed to family dynamics, for example parenting and child-mother relationships (Berg-Nielsen et al. 2002; Bifulco et al. 2002; Smith 2004). The deficit-based approach with its biomedical focus presents a view of parenting in the context of MHPs as one of inadequacy, fear and grim predictions for the futures of both mothers and children. For example, some research suggests that children raised by parents experiencing MHPs may be at risk of increased emotional and psychological difficulties themselves (Nicholson et al. 2001). Mothers who experience depression have been found to lack confidence in their mothering role and report a lower sense of self-efficacy than other mothers (Downey and Coyne 1990; Field 1992; Gelfand and Teti 1990; Goodman and Emory 1992; Kochanska, Radke-Yarrow, Kuczynski, and Friedman 1987). Therefore it is argued that women experiencing MHPs have difficulty relating sensitively to their children and have difficulties with reciprocal parent-child interactions (Brunette and Dean 2002, Miller 1997). Oyserman et al. (2000) highlighted the point that depressed parents might be physically but not emotionally available to their children leading to psychological difficulties for the child. Other research suggests that mothers with a diagnosis of schizophrenia may be less responsive, sensitive or energetic, and more remote, silent or intrusive with their child emotionally (Wan et al. 2007; Salmon et al. 2003). Blegen et al. (2010) suggests that this prevailing negative view of mothers experiencing MHPs reinforced in this group of women feelings of 'not being good enough' as mothers.

The severity and duration of MHPs are also thought to have an adverse impact on the mother child relationship. Researchers have shown, for example, that it is the persistence and severity of the disorder rather than the diagnostic specificity that predicts significant impairment and higher rates of MHPs in children (Beardslee, Schultz, and Selman 1987; Hammen 1991; Keller et al. 1986; Murray, Sinclair, Cooper, Ducournau and Turner 1999; Rutter and Quinton 1984). Mothers with co-morbid diagnoses, such as co-morbidity of major depression and panic disorder or agoraphobia and co-morbidity of parental depression and a personality disorder, are reported to display poorer quality interactions



with their infants and to have infants with higher levels of insecurity than either mothers with depression or mothers without MHPs (Downey & Coyne 1990; Carter, Garrity-Rokous, Chazan-Cohen, Little, & Briggs-Gowan 2001). The findings of the above studies provide one view of mothers experiencing MHPs, one that is focused on perceived deficits in their mothering and how these 'deficits' may impact on children. What is missed is the strengths this group of women bring to their mothering role, the challenges they face in dealing with mental health problems and the lack of material and emotional support for this group of mothers.

As stated earlier, mothers with a diagnosis of schizophrenia are more likely to experience greater emotional, financial and social deprivation than mothers without this diagnosis (Chernomas, Clarke and Chisholm 2000; Brunette and Dean 2002; Wan, Salmon, Riordan, Appleby, Webb, Abel 2007a). Social deprivation has been found to be a stronger predictor of developmental and psychiatric diagnosis in children than maternal diagnosis alone (Johnson, Cohen, Dohrenwend, Link and Brook 1999; Kessler, Foster, Saunders and Stang 1995; Robins and Regier 1991). Weak and unstable social support for this group of mothers may have a negative impact on their children's cognitive, emotional, behavioural and social development (Miller 1997; Bosanac, Buist and Burrows 2003; Walker and Emory 1983). In addition, coping with the effects of medication, the experiences of depression, delusions and hallucinations resulted in this group of women questioning their mothering abilities (Nicholson et al. 1998, Diaz-Caneja and Johnson 2004; Montgomery et al. 2006; Davies and Allen 2007; Barr, 2008). Mothers reported struggling to attend to their children's needs whilst also having these distressing experiences (Brunette and Dean 2002; Bosanac, Buist and Burrows 2003; Snellen, Mack and Trauer 1999).

In keeping with the negative view of mothers with MHPs, Gladstone et al. (2006) highlight how children who did not develop 'mental illnesses' were considered extraordinarily resilient. Interestingly, when the outcome was perceived as positive mothers were not credited with having any influence on the children, their impact only commented on when the outcome was perceived as negative. In the 1990s terms such as mad (Apfel and Handel 1993) bad (Swigart 1991) or toxic (Oates 1997) were associated with women with MHPs. Montgomery (2005) further suggests that such labels contribute to the woman being

viewed as an unsuitable mother. Labels such as mad, bad or toxic highlight the differences between mothers with MHPs and other mothers and do not fully describe the experiences of mothering for this group of women and their children. These terms also distract mental health professionals from gaining knowledge and an understanding of the experiences of mothering for women experiencing MHPs and highlight the undesirability of their mothering. This suggests that some women are considered to be 'good' mothers and other women are seen as 'bad' mothers, with mothers experiencing MHPs often viewed in the latter category.

### **Positive aspects to parenting for the woman**

A small number of studies have focused on the meaning of mothering for women experiencing MHPs and have found that the experience of motherhood can have positive and motivating effects for this group of women. Studies have highlighted that motherhood holds enormous emotional importance for this group of mothers (Ackerson 2003, (n=12); Chernomas 2000, (n=28); Davies and Allen 2007, (n=11); Khalifeh et al. 2009, (n=18); Montgomery 2006, (n=20); Mowbray et al. 1995, (n=24); Savvidou et al.,2003, (n=20); Blegen et al. 2012, (n=5)). Motherhood, for many women in these studies, was a motivating factor in their recovery and in remaining well (Diaz-Caneja and Johnson 2004, (n=22); Nicholson et al. 1998, (n=42)). Motherhood led to an increased motivation in having psychiatric treatment, and an enhanced ability to deal with their psychiatric concerns (Diaz-Caneja and Johnson 2004, (n=22); Davies and Allen 2007, (n=11); Edward and Timmons 2005, (n=6); Heron et al. 2012, (n=5); Sands 1995, (n=10)). Motherhood also gave women a valued role in society and having children gave them the opportunity to express feelings of care and concern (Mowbray et al. 1995 (n=24); Sands 1995, (n=10); Diaz-Caneja and Johnson 2004, (n=22); Nicholson et al. 1998, (n=42); Blegen et al. 2012, (n=5)). Montgomery (2006) reported that mothers (n= 20) spoke of their struggle to maintain meaningful relationships with their children whilst also experiencing MHPs. In this study the importance of keeping their children close gave mothers a sense of security, responsibility and normality. Mothers were also conscious of the need to protect their children from their MHPs and used strategies such as masking, censoring speech, and being mechanical. The place and identity of 'mother' offers meaningfulness to this group of marginalised women and also signifies possibilities of normalcy, security and responsibility that were not otherwise their

experiences as mothers experiencing MHPs (Bassett, Lampe and Lloyd 1999; Mowbray, Oyserman and Bybee 2000a; Blegen et al. 2012).

Mowbray et al. (1995) in a study of 24 mothers experiencing MHPs found that most of the women voiced positive feelings about their children and felt that being a mother was a way of promoting personal growth and development and improving self-esteem (Mowbray et al. 1995). Joseph et al. (1999) also highlighted the importance the women in their study (n=32) placed on being involved in raising their children. Similarly, Chernomas (2000) reported a range of positive effects of having children: women in this study (n=28) reported experiencing a sense of love, purpose and identity and support from children once they had grown up. Diaz-Caneja and Johnson (2004) also identified positive aspects of motherhood among a group of women with a medical diagnosis of 'schizophrenia'. In their study the majority of women (n=22) said that having children had given them a purpose in life, made them feel fulfilled as women and increased their self esteem. In structured interviews of 379 mothers with SMI recruited from a public mental health system in USA Mowbray et al. (2001) suggest that there was evidence of positive effects of mothering on the course of the women's MHPs, more than 20% of the women described positive behavioural consequences, such as giving up drugs or ending bad relationships (Mowbray et al. 2001). Despite the positive comments by women, they also described their struggles to maintain or obtain custody and to achieve normal lives for themselves and their children (Nicholson et al. 1998; Sands 1995; Mowbray et al. 1995; Montgomery 2006).

### **Custody issues for mothers who experience mental health problems**

Mothers who experience MHPs often have the additional fear of losing custody of their children. Kumar et al. (1995) found that approximately half of mothers with a diagnosis of schizophrenia admitted to in-patient psychiatric care lost custody of their children. Other, more recent studies confirm this finding and further suggest that custody loss rates may be as high as 38-89% (Sands et al. 2004; Nicholson et al. 2001; Cogan 1998, Joseph et al. 1999, Mowbray et al. 1999). The rate of custody loss for women with MHPs varies from 26% in community samples (Hollingsworth 2004, (n=322)) to 60% in in-patient samples (Sands et al. 1995 (n=20); Miller and Finnerty 1996, (n=46)). The rate is higher if the percentage of women with MHPs who have lost custody of their children at earlier points of time or who

have relegated parenting duties to others is considered (Dipple et al. 2002, (n=58); Joseph et al. 1999, (n=32); Miller and Finnerty 1996; Nicholson et al. 1998a; Sands et al. 2004). A recent study from the US found that women with MHPs were three times more likely than those without MHPs to have experienced recent custody loss (Park et al. 2006, (n=4,827)). It is not possible to determine rates within an Irish context as there is no national data on the prevalence of custody loss for these women within Ireland. In addition to loss of custody, women experiencing MHPs report having a constant fear of losing access to their children (Diaz-Caneja and Johnson 2004; Joseph et al. 1999; Sands 1995). Some studies explored the social and clinical characteristics of mothers whose children are supervised or in care. They found that single women with a medical diagnosis of schizophrenia or other illness involving psychosis, living on low income or below the poverty line, and with low social supports, had a particularly high risk of having their babies supervised by social services and/or raised by someone else (Hollingsworth 2004; Howard et al. 2003; Miller and Finnerty 1996). Schen (2005) argues that there is no evidence that a diagnosis of MHPs brings with it damaged parenting and concludes that the stigma of mental illness is powerful 'and undermines a mentally ill mother's ability to care for her children through negative family and social attitudes, impoverished social services, and the mother's internalization of assumptions about her own incapability' (p. 236).

Mothers who lose custody of their children experience emotional distress (Sands et al. 2004, Hollingsworth 2004). Dipple et al. (2002), in a study about the experience of women with MHPs (n=58), have shown that after many years of separation some mothers interviewed still expressed great sadness, anger or frustration about their loss. A small number of studies reported that women who experience separation and loss often end up in crisis and need support and help (Hollingsworth 2004; Sands et al. 1995; Miller and Finnerty 1996; Llewellyn et al. 2003; Park et al. 2006). However, Schen (2005) suggested that there is little research on a mother's reaction to loss and separation from her child/children. Schen (2005) concluded that this absence of research is because mothers who are separated from their children in traumatic ways are 'mostly mothers who are cut off from sources of power because of poverty, race, immigrant status, or mental illness' (p.235). Hollingsworth (2004: 199) asserts that a diagnosis of persistent mental illness (schizophrenia, schizoaffective disorder, bipolar disorder with or without psychosis, and major depression with or without

psychosis) is increasingly being used to 'fast track' the termination of parents' right to the custody of their children.

### **Mothers' experience of stigma**

Mothers experiencing MHPs often report on negative reactions from health care professionals and family members towards their desire for pregnancy, children and motherhood. Some studies, focussing on the subjective experiences of mothers with MHPs, showed that mothers experience negative reactions to their pregnancy and motherhood (Diaz-Caneja and Johnson 2004; McNeil et al. 1983; Savvidou et al. 2003). Some mothers reported feelings of being constantly monitored by health professionals and suspected of abusing their children (Nicholson et al. (1998a). Mothers, in a study in Greece (Savvidou et al. 2003), reported that they experienced strong negative reactions from family members and neighbours. The women felt that these reactions reinforced the view that people experiencing MHPs should not be parents. Negative reactions are not restricted to family and friends. Other studies have found that health care professionals such as psychiatrists, GPs, nurses and midwives hold similar views (Apfel and Handel 1993; Owen et al. 1998; Edwards and Timmons 2005; Read and Baker 1996; Dipple et al. 2002; Nicholson et al. 1998a; Begley et al. 2010). Many studies focus on the effects of MHPs, medication and hospital admission on women's mothering abilities (Cogan 1998; Joseph et al. 1999; Mowbray et al. 2001; Dipple et al. 2002; Diaz-Caneja and Johnson 2004; Montgomery et al. 2006; Munk-Olsen et al. 2006; Davies and Allen 2007; Barr 2008). In these studies the effects on women of their distress and being viewed as 'flawed' as mothers is not explored. Women often internalise stigma and, as described by Edwards and Timmons (2005), experience 'self stigma' because they see themselves as 'bad' mothers (p. 477). When women were unable to cope with the practical and emotional challenges of being mothers, often as a result of medications, they experienced feelings of guilt and anxiety and were fearful of being perceived as not 'good enough' as mothers (Nicholson et al. 1998; Diaz-Caneja and Johnson 2004; Montgomery et al. 2006; Davies and Allen 2007; Barr 2008). Furthermore, studies by Cogan (1998) and Nicholson et al. (1998) reported that mothers felt that they were being monitored by mental health professionals therefore women often concealed their pregnancies, did not attend antenatal care and stopped taking psychiatric

medication in order to avoid the negative attitudes of health care professionals. Nicholson, Sweeney and Geller (1998) conducted focus groups to explore the parenting experiences of mothers with MHPs, the women identified day-to-day issues common to most mothers. In Ireland a study commissioned by The National Disability Authority (NDA 2010, n =78) to explore the pregnancy, childbirth and mothering experiences for women with disability when accessing services in Ireland. Some women experienced stigmatising and discriminatory encounters with health care professions. Women in this study, experiencing MHPs (n=20) reported a lack of understanding around their distress. Consequently, these women described encounters with healthcare professionals that were insensitive, unsupportive and lacked empathy (Begley et al. 2010). Some studies asked women what their preferred service would be and, when asked, women had clear ideas about what they felt would be helpful. Women highlighted the need for more practical help with child care during a mental health crisis (Diaz-Caneja and Johnson 2004; Nicholson et al. 1998; Venkantaraman and Ackerson 2008). Women also wanted more information on parenting issues (Heron et al. 2012 and peer support groups Diaz-Caneja and Johnson 2004; Alakus et al. 2007; Mowbray et al. 1995; Venkantaraman and Ackerson 2008). Women suggested that peer support groups would give them the opportunity to share their experiences and explore parenting issues. Through this type of social support, mothers experiencing MHPs may be able to move away from the 'good mother/bad mother' binary and embrace Winnicott's notion of the 'good enough' mother.

### **Services for mothers who experience mental health problems**

Several studies report that women diagnosed with MHPs including schizophrenia, schizoaffective disorder, bipolar disorder, and major affective disorders often parent without adequate support from psychiatric and mental health services (Blanch et al. 1994; Mowbray et al. 2000a; Nicholson and Henry 2003; Nicholson et al. 1998). Community services providing education and support around mental health issues are not available to mothers and families (Reupert and Maybury 2007). Some studies show that mothers want mental health services to provide help and support and to acknowledge their parenting concerns (Bassett et al. 1999; Joseph et al. 1999; Mowbray et al. 2000b). However, services appear to be only offered when parents or children have a diagnosable problem or after

abuse or neglect has been identified (Nicholson et al. 2001). These services then offer interventions and programmes which are aimed at meeting needs of the child (averting risk, developing resilience) or the parent (mental health education, parenting classes), rather than the needs of the families affected by parental MHPs (Blanch et al. 1998; Reupert & Maybery 2007). Wang and Goldschmidt (1996) found that parents wanted family focused interventions rather than interventions that focused solely on them as the identified patient. In a review in the United States Nicholson et al. (2007) found only twenty-three services focused specifically on helping parents with severe mental health problem to parent effectively. In Australia, Children of Parents with a Mental Illness (COPMI) programmes are offered. The goals of these programmes include the development of good practice principles and action guidelines for services, professionals and other workers, the development of resource materials for professionals, parents and young people, and the provision of advice to governments. However, Maybury et al. (2009) found over a five year period that only 26 such programmes with 18 facilitators for approximately 2000 children existed and concluded that whilst not completely 'invisible' programmes for COPMI do not feature as a significant intervention in Australia today. Given the estimate that 21 to 23% of Australian children live with a parent who has, or has had a MHP (Maybury et al. 2009), this would appear to be an insufficient service response to an 'at-risk' group of children in the community. In an Irish study exploring the impact of mental illness on children (n=37), Somers (2007) found that there was a lack of professional input and support for children and their families. Somers (2007) goes on to suggest that with the continued development of community mental health services support may become available; however, she questions whether support for 'those with severe and enduring mental health difficulties are a priority' (p.1330).

## **Conclusion**

In conclusion, research on motherhood and mental illness follows a particular 'illness' model and fails to take into consideration: the construction of mental illness; the construction of motherhood; and the construction of gender; all of which intersect to form representation of women's identities as mothers and as women who are experiencing mental health problems. The focus within the research on women's pathology and on children as being at

risk can result in stigmatization, surveillance and control over the lives of women, ultimately limiting not only their authority and autonomy, but also their willingness to access and avail of supportive resources, even if they are available. There is a need for research to move away from the biomedical view and move towards a holistic view that will provide a clearer picture of these women's experiences and thus increase knowledge in this area.

The following research attempts to provide an alternative representation of the discourse on mothers experiencing mental health problems by examining, through the voices of this group of women themselves, their positioning within the larger social and health care structures that govern their lives; the affect these institutions have on their experiences; and analyse how women mother in and through these structures.



## **Chapter Four: Methodology and methodological issues that relate to the study and field work**

### **Introduction**

In this chapter I will discuss the methodological approach used to guide this research drawing on feminist theory and specifically feminist standpoint theory. The epistemological basis of feminist standpoint theory and how this theory has guided the research, from design through to dissemination, will be explored. I will discuss how feminist standpoint theory informed the process of recruitment, the use of the in-depth interview to facilitate data collection, and the data analysis process. The process of reflexivity, which was central to my work, will also be addressed, as will the ethical challenges in undertaking research with the women in this study.

### **Aims and objectives of the study**

The aim of this study is to build on the small body of work that currently exists on mothers with 'enduring/serious' mental health problems by exploring the subjective mothering experiences of this group of women and their experiences of accessing mental health services. The terms 'enduring' and 'serious' are used in the literature; however, in this study, these words are not used as they have negative connotations for many people. For the purpose of the work presented here, I will use the terms mental health problems (MHPs) and mental distress.

### **Objectives**

The objectives of the study are:

- to explore the experiences of mothering with women in the context of mental health problems;
- to explore the experiences of this group of mothers when they engage with mental health services;
- to explore these women's preferences for psychological, emotional, social and practical support.

## **Inclusion and exclusion criteria**

For the purpose of this study, mothers with mental health problems were defined as follows:

- mothers experiencing mental health problems of one year or more duration
- mothers who have had contact with the mental health services at least twice in the last year
- mothers with child/children up to the age 18.

Contact was defined as: an admission to an in-patient unit; use of out-patient mental health services such as day hospitals/day centres; or contact with a psychiatrist or psychiatric nurse (out-patient or domiciliary visits); general hospital liaison service; psychiatric social workers; community mental health nurse; and psychologist employed by the mental health services. The women in the study were volunteers and self-selecting, therefore it was their understanding of the concept of mental health problems that was important rather than any particular diagnostic category.

## **Feminist theory**

Feminist standpoint theory (FSH) was the perspective that informed this study, and is one approach to feminist knowledge building. Prior to discussing feminist standpoint I will provide a brief examination of feminist theory to set the subsequent discussion of feminist standpoint in context.

Developing from the women's movement of the mid-twentieth century ('second wave' feminism) feminist theorists have questioned the political, economic and social inequalities between men and women. Feminist theorists have highlighted the androcentric nature of traditional approaches to research, such as the practice of placing the male point of view at the centre of knowledge production and the androcentric bias in research where women's experiences are ignored, distorted or excluded (Oakley 1981; Mies 1983; Stanley and Wise 1993; Ramazanoglu and Holland 2002).

McCarl Nielsen (1990) argues that 'women's culture, history, and lives have remained underground and invisible, relegated to the underside of men's culture, history and lives' (p.10). Feminist theorists have sought to gain an understanding of why men hold more powerful positions than women in society (Mies 1983; Stanley and Wise 1993; Fonow and Cook 2005). They concern themselves with questions such as the following:

- What are the reasons for and conditions in which men maintain this position of power?
- What knowledge is perceived as most valuable?
- Why are men's work, ideas, and activities seen as having greater value and higher status than women's?

In asking and seeking answers to these questions, a greater understanding of the process of knowledge production and of women's experiences has gradually been achieved (Fonow and Cook 1991; Letherby 2003; Hesse-Biber 2007). One of the main aims in achieving these understandings is to change positively the conditions of women's lives and to produce more inclusive knowledge. Consequently, issues of inequality and power are at the heart of feminist theory.

Feminist theorists (Maguire 1987, 2001; Haraway 1989; Harding, 1991; Stanley and Wise 1993; Hartsock 1998; hooks 2000; Code 2001; Lorber 2005) argue that gender asymmetry is the central issue in maintaining inequality. Gender asymmetry explains that women and matters associated with women are not only different from, but inferior to and of lesser value than men and matters associated with men. In psychiatry and medicine and in various psychological and social theories of family, work, sexuality and deviance that draw upon those disciplines, women are seen as 'other' and often inferior to the male ideal (Hearn 2004). For example, until quite recently, women were seen as primarily responsible for caring work including childcare, and men were seen primarily as the breadwinners. The continuing gender pay gap reflects this ideology, despite the vastly increased presence of women in the workplace over the last four decades. Many theorists, whilst agreeing with gender asymmetry as one explanation of inequality, have also suggested that this intersects with race, class, age, sexuality, culture, able-bodiedness, able-mindedness and other

differences, reinforcing and maintaining inequality between men and women in all sections of society (Mohanty 1988; Crenshaw 1989; hooks 2000; Hill Collins 2000).

Intersectionality has developed as an explanation of the different axes along which women's experiences can be further explored (Crenshaw 1991). Davis (2008) defines intersectionality as 'the interaction between gender, race and other categories of difference in individual lives, social practices, institutional arrangements, and cultural ideologies and the outcomes of these interactions in terms of power' (p.68). Other differences include sexuality, age, disability, social class, religion, and nationality. Intersectionality is not about difference or addition, it is about exploring the 'matrix of domination' (Hill Collins 1990, p.79) and examining how this impacts on people's lives.

Haraway (1989) suggests that androcentric research performs the 'God trick' of speaking authoritatively about everything in the world without including the personal and social location of the knower. Drawing on feminist theory, feminist research questions this androcentric approach to research and knowledge production (Maynard and Purvis 1994) and offers feminist principles to guide research such as: questioning how knowledge is produced; valuing women's experiences as a legitimate source of knowledge; respecting the role of reflexivity in the research process; rejecting traditional subject-object dualisms; attending to gender and power within the research process, and finally focusing on transformative social action within the process (Campbell and Bunting 1991; Campbell and Wasco 2000; Cook and Fonow 1991; Harding 1987; Lather 1991; Webb 1993; Ramazanoglu and Holland 2002). Thus, feminist theorists have highlighted the mismatch between women's experiences and the structures and theoretical frameworks offered to explain these experiences. The fact that these structures and frameworks do not give meaning or accurately reflect women's lives has led women theorists to developing and constructing these new ways of knowledge building. This means that women and their concerns are the focus of research. Research is beneficial for women and not just about women. The aim of feminist research therefore is to 'capture women's lived experience in a respectful manner that legitimises women's voices as sources of knowledge' (Campbell and Wasco 2000, p. 783).

Epistemology is the theory of knowledge and poses questions such as: who can be the knower; what can be known; what constitutes valid knowledge (Harding 1987). For feminist researchers a recognition of the importance of women's experiences as a valid source of knowledge is the starting point for gaining understandings and knowledge of the world. Flowing from this first principle it is important to analyse the structural, political and ideological conditions of women's experiences to gain a greater understanding of how these factors influence women's position in society and through this bring about social change where necessary (Fonow and Cook 1991; Akman et al. 2001; Harding 2004). The epistemological basis for feminist theory therefore, as suggested by Rose (2004), involves the creation of a practice of feeling, thinking and writing that opposes the abstraction of male and bourgeois scientific thought' (p.76). These ways of looking at the world developed by women for women have provided knowledge that is representative of women's lives. Therefore, feminist epistemology stresses that knowledge is situated in everyday experiences and that people's experiences are shaped by their social roles and status. These experiences are seen as a core resource and therefore the focus of feminist research is on investigating and theorising on these diverse socially shaped experiences. In this way women are knowers and their experiences constitute valid knowledge.

### **Feminist standpoint theory: epistemological basis**

As stated, feminist standpoint theory is one approach to feminist knowledge building. In the following section I will provide the epistemological basis of FST as well as providing a discussion on why I used this theory to inform my research.

The epistemological basis for FST draws on two main claims. Firstly, FST argues that knowledge can be gained from beginning an inquiry from the positionality of the lives of marginalised people. Secondly, FST argues that this situated knowledge (Haraway 1991) is inherently more robust because, as suggested by Harding (1991), the knowledge produced from the lives of marginalised people, as they understand their lives, is more complete and different from the knowledge produced through the lives of marginalised people as understood from the positions of powerful dominant institutions. Therefore, for feminist standpoint theorists, in addition to recording marginalised lives, of equal importance is the exploration of the relations of ruling (Smith 1987) and how key institutions within

modernity, such as formal health, social and education structures, can create and maintain oppressive practices through their policies and practices. Harding and Norberg (2005) refer to this as 'studying up' and this includes focussing on powerful institutions as well as those whom these institutions govern. In critically examining the organisation, administration and management of these social institutions, an understanding is gained of how lives are governed by institutions and the diversity of marginalised experiences can be recorded and challenged and 'subjugated knowledges' (Collins 1990 p. 301) can be uncovered, discovered and recovered. Therefore, rather than producing knowledge for dominant groups, who then use this knowledge to administer and manage the lives of marginalised people, a feminist standpoint aims to produce knowledge for marginalised people through which social change can be achieved. In other words, marginalised people see the world from their own position and also from being at the receiving end of, for example, policies and structures from those in positions of power. Haraway (1988) and Harding (1991) suggest that this is the 'standpoint' from which marginalised groups can articulate a point of view that is more complete than that of people who do not need to see an issue from various sides in order to survive from day to day. Harding (2004) gives several examples of how dominant institutions present one view of the world that maintains the status quo. For example, Harding (2004) questions how violence against women is seen by legal systems as women 'asking for it' and 'deviant men' doing it? How did it occur that a double day of work, one unpaid, was regarded as normal and desirable for women but not for men? How come women who were going through such expected biological life-events as menstruation, birthing or menopause are treated by the medical profession as if they were ill? Therefore, rather than proclaiming the one true story about the world, feminist standpoint epistemologies seek partial and less distorted views. Haraway (1988) argues that these partial views, or situated knowledges, can be far less limited than the dominant view (Haraway 1988).

Feminist standpoint theorists (Smith 1987; Collins 1990; Harding 1991, 2004; Hartsock 1998; Haraway, 1988) agree that important knowledges are produced from the experiences of marginalised people. Ackerly and True (2012) define FST as follows: 'standpoint epistemology is a theory of knowledge that argues that one can 'know' the world more fully and more critically (with less of a material or ideological stake in maintaining the status quo)

from the subject position of the marginalised or oppressed, be it the worker marginalised by class structure or the female immigrant oppressed by gender/patriarchal structures and the political economy of global labor for instance' (p.27).

However, feminist standpoint theory is a complex theory that involves several layers of investigation in the research process referred to by Smith (1987) as the relations of ruling. The first layer is the recording of the experiences of marginalised people, the second layer involves questioning the historical processes that create hierarchical inequality in the lives of marginalised people, and the final layer examines the social and political structures that maintain these inequalities in the present. Therefore, feminist standpoint theory offers a position rooted in an account of marginalisation from which to theorise about knowledge and knowledge production. In order to reach this position, feminist standpoint theorists (Harding 2004; Smith 1989; Haraway 1988; Collins, 1990; Hartsock 1984) offer a number of concepts that are crucial to this process of knowledge production. These are: situatedness (Haraway 1991), strong objectivity (Harding 1991 ), subjugated knowledges (Hill Collins 1990), and 'relations of ruling' (Smith 1987). I will now discuss these individually even though in practice these concepts interact with each other and work together to provide an integrated and complete understanding of the process of feminist standpoint research and knowledge production.

In relation to situatedness, Harding (1997) recognises the hierarchical nature of status categories, such as gender, race, class, ablebodied, ableminded. Individuals and groups can be located at the various intersections of two or more of these hierarchies and these are what Harding (1997 p.383-4) refers to as 'social locations'. She further suggests that the knowledge produced by individuals is influenced by these social locations and that the social location gives the individual a distinctive insight into how hierarchical social structure works. It is this social location that provides the starting point to knowledge production which can be used by marginalised individuals and groups to argue for inclusivity through political activism. Dominant mainstream institutions rarely, if ever, wish to dismantle their existing hierarchies and therefore become more inclusive, so knowledge is useful only in the formation of concerted challenges to those same institutions. However, not all marginal lives are the same and different standpoints will produce different knowledges. Stanley and Wise (1993) suggest that, as a consequence, knowledge claims will always be partial.

In relation to 'objectivity', the situatedness of the researcher and the respondents is important. This means using the place from which people speak as a resource and this becomes part of the method of inquiry. Haraway (1988) and Smith (1987) suggest that analysing 'situated knowledge', which people have of their experiences, helps uncover and deconstruct the power relations in institutions and systems. They further suggest that insiders and marginalised people are uniquely positioned to suggest effective changes for individuals, groups and systems. In addition, Harding (2004) urges researchers to be critically reflexive of how their social location shapes the research. This reflexivity together with engaging in research from the lives of marginalised groups will result in 'strong objectivity', as distinct from 'weak objectivity' which ignores the assumptions and social location of the researcher and how this may influence knowledge production. In standpoint theory the knowledge beliefs of the researcher are acknowledged and put under scrutiny, whereas objectivity, in the traditional positivists' view, suggests distance and does not acknowledge the role or social location of the researcher. In other words, feminist standpoint theory claims that social location or situatedness and political struggles advance the growth of knowledge, contrary to the dominant view that politics and situatedness block rigorous scientific inquiry.

In relation to subjugated knowledge it is important to note that a standpoint does not automatically arise from a particular social location, although the experiences of an oppressed social location can make the achievement of a standpoint more likely. The term subjugated knowledges describes the understandings of marginalised people that does not reflect the predominant modes of thought. Subjugated knowledges are not always readily accessible. It is through the process of questioning and being aware of how dominant modes of thinking become embedded and taken as the only view of life that subjugated knowledges become accessible. A feminist standpoint is achieved through struggle with oppressive systems/structures. Hartsock (2004) argues that these standpoints are gained by actively resisting oppressive structures and overcoming political and social obstacles to equality. In order to achieve a feminist standpoint both Hartsock (2004) and Harding (2004) stress that, whilst recording the experiences of marginalised groups is important, it is also necessary to explore the beliefs people hold about their experiences because these groups often believe the explanations put forward by dominant ideologies. These explanations are



often turned inward in self-criticism. Therefore, Harding (2004) argues that 'the perspectives of the marginalised cannot be automatically privileged as articulations of reliable claims' (p.31). This does not mean that the accounts of experiences are not believed but that the experiences are taken as one aspect of the feminist standpoint view. Therefore, a feminist standpoint, as an 'achieved' standpoint that is, is not a perspective shared by all women simply by virtue of being women. It also requires a commitment by the researcher to examine the ideologies that support society as we know it. Thus, a feminist standpoint is achieved through discussion and exploration of subjugated knowledges through attention to the social location of the researcher and the participants in research and starting knowledge development from there (Harding 2004). It is important to distinguish between a standpoint and a perspective (where one is positioned) as often the term 'standpoint' is synonymous with 'perspective'. In feminist standpoint theory, standpoint is a technical term used to describe how knowledge is achieved through this complex interaction in the world (Harding 2004) whereas perspective refers to where one is positioned in society.

Smith (1987) suggests that a feminist standpoint is a political process that involves consciousness raising and exploration of 'relations of ruling'. Relations of ruling refers to 'that extraordinary complex of relations and organization mediated by texts that govern, manage, administer, direct, organize, regulate, and control contemporary capitalist societies at least those of the fully "developed" first world' (Smith 1987, p.41). It is through exploring 'relations of ruling' that the ways in which dominant structures administer and manage social relations are uncovered. For example, everyday experiences of marginalised groups may be categorised as pathological (welfare cheats, juvenile delinquents, absent fathers) and therefore need to be managed by health care or social systems. Smith (1987) argues that this situation enables a few to govern the many. Therefore in achieving a feminist standpoint it is necessary to ask individuals about their experiences, to reflect on how the 'relations of ruling' work and to explore how individuals may be empowered to overcome systematic inequalities.

A feminist standpoint is also concerned with the creation of group consciousness through the process of consciousness-raising. Consciousness-raising occurs through political struggles firstly in accessing particular groups' experiences and then in developing research and knowledge with groups. Through exploring individual and group experiences,

commonalities of experiences can be shared and a group consciousness developed. Individuals may not be aware that their experiences are shared by others. Thus, as suggested by Harding (2004), a woman may be oppressed as a result of being a member of a particular group ('mentally ill', black, poor, disabled) not because she, as an individual, deserves to be oppressed but because she is so labelled. In gaining a feminist standpoint it is necessary to 'place less emphasis on individual experiences within socially constructed groups than on the social conditions that construct such groups' (Hill Collins 2004 p.247).

Thus, a feminist standpoint is taken when a marginalised group critically questions the conditions of their lives and then engages in political struggle to change these conditions. Therefore, a feminist standpoint is always a politically engaged activity.

To summarise, feminist standpoint theorists offer concepts such as 'strong objectivity' (Harding 1991, 2004), 'situated knowledges' (Haraway 1991) 'subjugated knowledges' (Hill Collins 1990), and 'relations of ruling' (Smith 1987) to theorise about the diversity of women's experiences. Feminist standpoint epistemology argues that the social position of the knower will not only create knowledge but will also set limits on knowledge, and it further argues that the social position of the knower is epistemically significant. A feminist standpoint is an 'achieved' position gained through understanding experience and critically examining the social nature of knowledge production. As suggested by Smith (1998) it is the 'rupture' or 'gap' between personal experience and dominant structures and the description and analysis of that experience that gives the space to explore how women's lives are influenced by dominant institutions and how women live within this space. It is at this interface that new insights and knowledge are gained.

### **Rationale for selecting feminist standpoint theory for this study**

I will now discuss why feminist standpoint theory was used to inform my research. As discussed in the previous chapter, much of the research available on mothers experiencing MHPs tends to emphasize the costs of the mother's MHPs on child development and focuses on mothers as 'patients' as distinct from their roles as mothers (Rutter and Quinton 1984; Stott et al. 1984; Silverman 1989, Apfel and Handel 1993; Kinsella and Anderson 1996; Oyserman et al. 2000; Mowbray et al. 2002; Gladstone 2006). A small number of studies, which explored the experiences of mothers with 'serious' mental health problems, suggest

that mothering is a rewarding and positive experience even though the demands of parenting are considerable and supports from mental health services are inadequate (Ackerson 2003; Chernomas 2000; Davies and Allen 2007; Khalifeh et al. 2009; Montgomery 2006; Mowbray et al. 1995; Savvidou et al. 2003; Diaz-Caneja and Johnson 2004; Nicholson et al. 1998; Davies and Allen 2007; Edward and Timmons 2005; Heron et al. 2012; Sands 1995; Blegen et al. 2012). Therefore the aim of this study was to build on the small body of work that exists by exploring the subjective mothering experiences of this group of women and their experiences of accessing mental health services.

FST was chosen for this research because it offered an approach that gave me the tools to add to the existing body of knowledge with and for this group of women, informed by their terms of reference. FST also facilitated an approach that would offer a different understanding of their lives and the knowledge embedded in their experiences as mothers in the context of mental health problems. By using FST I hoped to be in a position to focus attention on the experiences of this group of mothers and on their social location under relations of ruling. In addition, I would be challenged to focus on their knowledges that were subjugated by ideologies on motherhood and mental 'illness' (as discussed in the previous chapters) and subjugated by the oppressive policies and practices that arise from these ideologies. FST would also require that I question the historical processes that created the prevailing view that this group of mothers are not 'ableminded', while challenging me to examine the social and political structures that maintain this view. By using the concepts of reflexivity, 'strong objectivity', 'situated knowledge' and 'subjugated knowledge' to challenge and expand thinking and knowledge with this group, FST would provide a theoretical basis from which to expand our understandings of the dominant ideology that place and maintain mothers experiencing MHPs in their current position. While recognising that women are not passive victims of their circumstances and they have agency, it was hoped that FST would also provide the lens through which I would be enabled to explore women's experiences differently and to see if there was a different story to be told. A story of possible resistance (resistance occurs when oppressed groups challenge and act against aspects of dominant discourses (Scott 1990)) and thus form a distinctive challenge to the powerful 'relations of ruling' that place these women at the margins of knowledge and practice.

As a researcher, exploring the experiences of mothers experiencing MHPs, my view is partial and the view of the mothers is also partial. In achieving a standpoint as described earlier, the women and I will be able to produce knowledge from their everyday lives. My view is not only partial but also located in privilege and power, by virtue of being a researcher and health care professional. I needed to be aware of this and I endeavoured not to position myself as the 'norm' (in my position as a mother) and mothers experiencing MHPs as different to that norm. I endeavoured, as Harding (1991) suggests, to '[make] strange what had appeared familiar' (p.150) and see the world as this group of mothers understand it. As I understood this process, it is about 'seeing from below' through immersing myself in the experiences of this group of mothers. I was then able to gain multiple and socially situated understandings that could be used to challenge and replace the present existing dominant understandings of the experiences of mothers with mental health problems. Campbell (2004) suggests that people in marginalised or subjugated positions have double vision and can see from their position of marginality, whilst also seeing from the dominant position. For example mothers in this research know their world and also know the world of mental health and ill-health and the dominant discourses within that world which position them as not being 'able-minded'. They also have access to another world that is unknown to the world of the presumed 'able-minded'.

One of the difficulties I anticipated was how not to take over and see 'for' rather than see 'with' the mothers. This is where reflexivity is a vital tool which I will discuss later. Harding (1991) suggests that reflexivity is recognising the historical and social location of our values and beliefs and also the social historical location and values and beliefs of research participants. From this reflexive position and through developing an 'oppositional consciousness' (Harding 1991) I sought to offer an exploration of the dominant ideologies and structure that impact on the lives of this group of mothers.

### **Recruitment and sampling method**

As stated, feminist standpoint theory informs research that is embedded in the lives of marginalized people (Smith 1987, Collins 1990, Harding 1991, 2004, 2008, Haraway 2004, Haraway, 1988). Therefore, they are a group of people that may be hidden or hard to find by an outside researcher. However, as Ackerly and True (2012) suggest they may be known

to each other but not publicly known. Atkinson and Flint (2001) suggest snowballing as a good method of identifying participants within marginalized or hard to reach groups, as each participant may recommend other participants. Atkinson and Flint (2001) identify a number of advantages to using this method of selection. The snowballing method enables access to previously hidden populations and provides a means of accessing participants who may not usually be included in large scale studies, thus it provides knowledge from the margins that help to give a more complete picture of a particular area of study. It is also a way of including the voices that may not be heard in traditional approaches to sampling. Snowball sampling has been found to be 'economical, efficient and effective in various studies' (Atkinson and Flint 2001, p.2). There are, however, possible limitations to this method, in that, for example, there is a selection bias as participants volunteer and may recruit their friends. The sample therefore may not be representative of the marginalized group. Also, as participants recommend others, participants who are not connected to any network will be excluded. Despite these limitations it was considered an effective method and was used in this study because it allowed me to uncover experiences and knowledge that has been previously 'hidden' from view.

To commence the recruitment process I used various organizations and social networks of identified respondents to provide me with an ever-expanding group of potential contacts (Thomson 1997). I approached voluntary organizations in the first instance because I viewed these organizations as more empowering and less hierarchal in nature than the statutory organizations. There was a stronger likelihood that women who attended such organizations would not feel pressurized into taking part in the research and would more likely be truly self-selecting. The women were recruited, by poster campaign, through a number of voluntary organizations involved in mental health care, for example, Shine, Irish Advocacy Network, Aware, and Grow. Information was sent to organizations such as the Irish Country Women's Association and Macra na Feirme (an Irish organization for adults living in the countryside and working in the farming sector). My decision to recruit through voluntary organizations was based on my concern that if I recruited women through the statutory mental health services, the women might feel that I was part of the services and therefore might feel inhibited or obliged to present their experiences in a way that mirrored public accounts given by mental health professionals.

All the organizations offered to disseminate information for me, including posters and information on the proposed research. The poster (see appendix 1) advertised the inclusion criteria and provided details on how to access further information about the study. I also posted an advertisement on Active Link website (activelink.ie is an online network for non-profit organisations, that provides information on jobs, tenders, volunteering, events, fundraising, training, publications and funding in the non-profit sector) and spoke to a journalist who wrote an article on 'Mothers with mental illness 'afraid to talk'', and published it in one of the national newspapers with reference to the study (Hough, 2011). Glucksmann (1994) and Standing (1998) both argue that working-class women are less likely to respond to requests in written form, especially on official stationery. Standing (1998) further suggests that there is often a 'mistrust' of authority among certain groups of women. Therefore, I spoke at meetings, conferences, and met with women where possible. Some voluntary bodies such as Grow, Shine and Mind Freedom facilitated me in meeting with mothers who experience MHPs and, where this occurred, I attended meetings to explain the proposed research and to answer any questions that arose. It was through these strategies that initial contact was made with women who then assisted in disseminating information to other women and helped in developing a snowball sample. I also wrote to health care professionals inviting them to get involved (see appendix 2) only two health care professionals responded.

When women made contact with me I explained the study and sent each one an information pack (Appendix 3) containing a cover letter inviting participation, an information leaflet, and the consent form. Once women indicated their willingness to participate, by returning the completed consent form directly to me, I contacted them again and made arrangements to conduct the interview. Prior to each interview I spoke to each woman on one or two occasions by telephone. This provided women with the opportunity to ask questions about the research and about the focus of the interview. When replying to initial telephone calls, texts, letters and emails, I endeavored to make it as clear as possible what the research was about so that the women knew what the study involved, what my expectations were and what my focus and interest were. I only arranged to meet women when and where they felt comfortable about being interviewed. I began recruitment in September 2010 and completed the final interview in September 2011. In total 50 women

volunteered to be interviewed and 42 women who fulfilled the criteria for the study were interviewed.

Women were interviewed at a time and place convenient for them. Some women (n=37) were interviewed in their own homes, which was the women's choice. The remainder (n= 5) were interviewed in hotels. I met with three women on more than one occasion. I was very aware of their primary position as women and mothers and their involvement in the research was always secondary to that. Meetings had to be carefully planned to fit in with the women's and my own childcare responsibilities, school runs and other commitments. Once the date was arranged, I was conscious of the need to give sufficient time so I set aside at least half a day for each interview. This allowed time to offer support should it be needed. For example, if the woman became distressed I could spend time with her to help alleviate distress. When meeting women in a public place I offered to buy them a tea/coffee and/or a snack. This was always met with a counter offer from them to do the same for me, which required a sensitive response as I was conscious that many were on disability allowance.

### **Profile of the women**

The forty-two women in this study included women living in rural and urban areas of the Republic of Ireland. They ranged in age from twenty-three to fifty-five years and had between one and five children. Twenty-eight women were married or in a committed co-habiting relationship and fourteen women were not in relationships. At the time of the interview, thirty-three women had their children living with them and nine had their children in care. For the latter group of women their children had been taken into care by social services and some of the children were placed with foster parents and some children were with their fathers, two were with other family members, for example, placed in the care of an aunt (mother's sister). All the women had contact with the mental health services and had been given diagnoses such as depression, anxiety, schizophrenia, and bipolar disorder. My intention was to interview women who reflect the diversity of women who mother whilst also experiencing MHPs.

## **Data collection: interview method and interview process**

**Interview method:** In using feminist standpoint theory (FST) for this study I was aware of the need to choose a method of data collection or, as Mason (1996) suggests 'data generation', that enabled women's voices to be distinct and discernible. Therefore, in line with FST and in an attempt to gain a full understanding of and to elicit the meaning of the experiences of this group of mothers, an in-depth, semi-structured interview was used as the data collection method. Mason (1996) makes the point that information is not just there to be collected but is generated through the interview process. It needs to be worked at and is mediated through experiences and ideologies that give, as suggested by FST, a standpoint that is achieved (Harding 2004). Therefore a standpoint was achieved through retelling of experiences during the interview, through the interaction between the women and myself in the interview and then through exploring dominant structures and ideologies to gain a deeper understanding of women's experiences. The meanings of experiences are socially constructed and are bound by history, ideology and how life is lived in these intersections. Meanings of experiences are also mediated through the process of the interview and are influenced by the interaction between the participant and the researcher within the interview. In other words, both people in the interview will create a synergy for the exploration of experiences. Smith (1987) suggests that the in-depth, unstructured interview provides the opportunity to discover, recover and uncover the subjugated knowledge of the diversity of mothers' realities, in other words knowledge that is hidden and unarticulated. In using FST as the theoretical framework for the interviews I explored and asked questions about the realities of mothering whilst experiencing MHPs. I also listened for the dominant discourses that were informing, influencing and maintaining mother's experiences. The final part of FST is an exploration of issues of social change and social justice for this group of women. Therefore, I spoke to the women about their needs, and the changes they would wish for as well as discussing ways of creating changes.

To assist within the interview encounter I used an 'aide-memoire' (Letherby, 2003 p.89) of themes or topics to address. In keeping with FST this 'aide-memoire' was developed to include questions that would elicit women's understanding of their experiences and the underlying ideologies on mothering and mental health difficulties that informed their



understanding (see appendix 4) I also collected demographic details at the end of the interviews (appendix 5).

**Interview process:** I was excited, full of enthusiasm and eager to meet with the women. However, I also experienced feelings of anxiety and distress regarding the possibility that I might make things worse, that women might become re-traumatised in the telling of their experiences. Motherhood, mothering and mothers are topics that many people have strong opinions on and find easy to discuss. However, mental health problems are more difficult for people to discuss especially for women who are also mothers because of experiences of stigma and prejudice. Therefore in using the interview to gain meaning and understanding it was necessary for me to develop rapport with the women. I was conscious from the outset of the ethical dilemma of 'doing rapport' (Duncombe and Jessop 2008, p.107), the dilemma being that I might use my interviewing and communication skills to elicit information from women that they might later regret sharing. As an experienced mental health nurse and counsellor, I needed to be clear regarding the purpose of the interview and I needed to balance my desire to gain an understanding of women's worlds with providing support and yet not get into the role of counsellor or therapist. I was also aware that central to the interview process is how I construct and interpret reality and also how my values, beliefs and emotions impacted on my position within the relationship. Therefore, I was also conscious of the situated knowledge (Haraway, 1991) I brought to the interview, and how my position as a nurse, counsellor and 'perceived expert' might influence the process.

At the beginning of the interviews I spent time discussing general topics ranging from the journey time, traffic and childcare to their experience of being involved in research. This gave the women the opportunity to get to know me. I answered questions about myself, about my experiences as a mother, about the research study, about recording the interview and about consent. I asked the women when they wanted to start the interview and then turned on the tape recorder.

One of the aims of feminist standpoint theory is to uncover the subjugated knowledge (Hill Collins 1990) embedded in women's everyday experiences. Women wanted to talk about their experiences as mothers and also to explain the difficulties they experienced when interacting with social and mental health services. They were familiar with being questioned

by psychiatrists and other professionals about their parenting and coping skills. As a result they spoke about their support systems and I felt initially they wanted to convince me of their competence as mothers. This area is discussed in more detail in Chapter 5 where women highlight the ideology of ideal mother as the template from which they gauged their mothering. As the interview progressed the women relaxed in my company and gave more descriptive accounts of their daily lives as women and mothers. The interview moved from what I surmised they felt I wanted to hear to what it was really like for them on a daily basis. Thus, the knowledge subjugated by stigma and power was being given voice by them and heard by me. The stigma of having a biomedical diagnosis of 'mental illness' influenced women in a very real way, in the sense that they were careful to keep their mental distress hidden from neighbours and friends. Therefore, they had a public face and a private face in relation to their MHPs.

The interview was a two way interaction, I was aware of the need to provide a supportive presence so that women would feel able to speak about their experiences. Maintaining the flow of conversation required a delicate balance. Through adopting a collaborative approach to the interview, as advocated by FST, I was able to gain an understanding of the complexity of the women's lives as mothers. Ribbens (1989) suggests that research relationships are complicated encounters and I certainly found this to be the case. Many of the women said that they had never had the opportunity to discuss their feelings and experiences as mothers and I felt privileged to hear about their lives. I realised that there was a feeling of being safe (Cotterill 1992) in the research relationship, with its promise of confidentiality and anonymity for the women which 'allowed' them to voice what had been previously unsaid.

Women with children in care were particularly brave in speaking out as they were in a powerless position regarding their children. But their need to tell their story was very strong and I felt deeply privileged to be seen as a 'safe' person to be entrusted with their experiences. I paid attention to what was not said and to women's nonverbal cues and silences (Parr 1998). For all the women, and especially for women whose children are in care, there was hesitancy about what to say to me. The women were so desperate to be heard that I felt they took a 'chance', and my obligation not to abuse the relationship and the information I was given was heavily felt. They trusted that I would do 'good' with the

accounts of their experiences and put their side of the 'story' across. For example, one woman asked me to return to her as she wanted to make sure that her account was clear, that she did not want to be judged. On this occasion I returned with the transcript and with her consent we went through it together. She made some changes and added further information.

I often experienced strong emotions whilst doing the fieldwork and meeting the women. I felt distressed at the level of their emotional responses and at the level of their powerlessness in a system that did not seem to listen to them, or if it did listen then it seemed to judge them in a negative way. It was all the more difficult for me as I had been previously working in the same system that had caused them so much pain and anguish. It was heartening to hear accounts of instances where the women had experienced positive support from health care professionals and services. I used anger and frustration positively by using every opportunity to challenge negative stereotypes of women and mothers with mental health problems, both with friends, students and practitioner colleagues.

### **Power in the research relationship**

Letherby (2003) argues that the research relationship is 'fluid and changing and is always jointly constructed' (p.115 Letherby). Therefore, the balance of power is a negotiated one (Cotterill 1992; Collins 1998 and Luff 1999. Power can be constructed in many ways and as a researcher I may be viewed as being in a powerful position, in a position of privilege in setting the research agenda. I may also be seen as an 'academic' and therefore in a privileged position. Letherby (2003) makes the point that it is patronising of researchers to always place the participants in the role of 'potential victim' (p116). Therefore, as a researcher I was conscious of my position and I believe that researchers do not always hold the balance of power as I had no control over women's involvement in the research (see discussion on recruitment). At all stages of the research the women had control over their involvement and could have refused to be involved and had the power to withdraw from the research at all stages. However I was keenly aware that, for women with mental health diagnosis, lack of power is an even more dire situation (Caplan 1995; Chesler 2005; Morrow 2006).

Letherby (2003) suggests that self selection as a recruitment method has an 'influence on the data in that it affects what respondents say and how they say it' (p. 106). Indeed, some women in the study spoke to me because they felt passionately about their experiences and wanted changes in services and they wanted to use the interview as a political step to getting changes introduced in legislation, for example, the issue of children in care. Because of the recruitment strategy used, and the principles of FST, women approached me and all were very interested in having their experiences recorded with the view to effecting changes in policy and in the decisions arising from existing policies.

Women whose children were in care highlighted the lack of support for them as mothers and through the interview process this lack became clearer to the women. As a result of their discussions with each other following the interviews with me I received a phone call asking me if I would facilitate a group with them. I agreed and set up a group with them to provide support for mothers whose children were in care. One of the aims of the support group was the creation of awareness, 'consciousness raising' and activism around this issue. How the group was set up and functioned will be discussed in Chapter 8. In the setting up of this group the phrase 'the personal is political' had real meaning as the women clearly recognised that their personal situations were shaped by systemic power relations in Irish society, which placed them in a powerless position in relation to their children.

### **Data analysis**

Feminist standpoint theorists introduced concepts such as 'situated knowledges' (Haraway 1991), 'subjugated knowledges' (Hill Collins 1990), 'relations of ruling' (Smith 1987), 'strong objectivity' and 'reflexivity' (Harding 1991) to theorize the multiplicity and diversity of women's experiences. As discussed earlier in the chapter, these concepts provide the layers or lenses through which women's experiences can be explored from their marginalized position, thus providing a standpoint that is different from the dominant view of mothers experiencing MHPs. Data analysis in this study was by no means straightforward or linear. Indeed I found the whole process of analysis difficult and challenging. Throughout the analysis process I was constantly going back and forth between the interviews and the available literature attempting to grasp the knowledge embedded in women's lives, knowing it was different from the knowledge in mental health literature. At every juncture I

struggled to find the words to bring this knowledge to life. On more than one occasion I found myself full of anger at the way this group of women were viewed and treated by mental health professionals. I was coming from a recovery oriented background (Copeland 1997) which stresses the centrality of the woman's voice and their understanding in their recovery journey. I found the rigidity and emotional distance of the mental health professionals, as described by the women, difficult to understand.

In an attempt to provide structure to my analysis I used the following analytical techniques: description, memoing, and contextualization.

### **Description**

With the women's permission all the interviews were audio-recorded and later transcribed in full. Alldred and Gillies (2008) make the point that 'the process of transcription, making a written account of the verbal interaction, is one of the least problematized parts of the research process, not generally recognised as an act of representation or embodying interpretation' (p.159). With this in mind the epistemological position of feminist standpoint theory provided me with a position from which to explore the use of transcripts in this research. In feminist standpoint epistemology the researcher takes an active role in ascribing meaning to the words of the respondents. The transcription is the representation of a complex interaction between the women and me. It represents the spoken word; however the 'life' of the interview can be lost. In reproducing the speech there are compromises made, the interview in the transcribing conforms to rules of punctuation and grammar that may result in loss of meaning. The direct transcription from spoken to written word means that the qualities (tone, pace, volume, emphasis) of the words are not captured (Burman 1992). Alldred and Gillies (2008) highlight the possibility of the researcher interpreting and inserting meaning on behalf of the respondent, for example the use of humour or sarcasm may be lost in the translation of spoken word to written word. Therefore, the potential was there to unintentionally misrepresent what was said by the respondent. With an awareness of the limitations of transcripts as a completely accurate representation of the interview I nonetheless made the decision to use transcripts. I employed a transcriber to do the technical work. My rationale for this was my slowness as a typist and also the possibility that I might 'sanitize' the interview. The transcriber

transcribed everything, for example pauses, laughs, tears, over talking, my hesitant and sometimes multiple questions, my interruptions, and my use of certain phrases were included. In addition other interruptions to the interview, for example other family member coming into the room, children asking for attention, or noise and activity in public areas, were included. The advantage of the transcriber was that she did not judge the content of the interview and typed exactly what she heard. However she did conform to use of punctuation and grammar as previously mentioned.

Once I received the transcripts I listened to the audio recordings while reading the transcripts and in doing this I was re-creating the interviews to ensure an accurate reflection of the women's experiences.

## **NVIVO**

In deciding to use feminist standpoint theory to guide my research I was aware that I would have a large amount of data to analyse. I had heard about NVIVO and was aware that it was a computer software package that managed research data. Other than that I had no knowledge or skills in how to use NVIVO therefore I attended a training programme. On completion of the training I decided to use NVIVO for data storage, coding and memoing. I found other aspects of NVIVO more difficult to grasp and therefore I did not use the section on 'querying your data'. NVIVO is a computer-assisted qualitative data analysis software (CAQDAS) developed by QSR International. This software facilitates data analysis in a number of ways: managing and organising data, managing ideas, retrieving data, graphically modelling ideas and concepts emerging from the data and reporting from the data (Bazeley 2007). I was able to import audio material as well as text to the software package. I was then able to listen to the interviews and simultaneously read the transcripts to check for accuracy and to begin the coding of the data. Coding the data begins with the development of nodes. Bazeley (2007) defines a node as a collection of references about a specific theme, place, person or other area of interest. In NVIVO there are three main types of nodes: tree nodes, these are codes organised in a hierarchal structure; free nodes, these are free standing codes and not related with a structured framework of themes or concepts; and case nodes are nodes with attributes such as participants age, occupation, number of children, duration of MHPs. I began the process of coding by developing free nodes from the transcripts of the interviews, I created 134 free nodes in total. The number of references

coded to each free node ranged from 170 coded to 'motherhood beliefs' to 1 in 'outpatient services'. I then coded the 134 free nodes on to tree nodes creating a hierarchical structure from parent nodes (general category) to child nodes (specific category) organised into three themes:

### Theme 1: Mothering with expectations: the challenges of being a mother

- The meaning of mothering: mothering under the patriarchal construction of ideal mothering
- The meaning of motherhood: mothering as 'doing'
- Ambivalence towards mothering

### Theme 2: Mothering in distress: being good enough

- Mothering in the context of mental pain
- Mothering in context of childhood and adult experiences of trauma
- Mothering under 'relations of ruling':
  - 1) Mothering as influenced by expert opinion
  - 2) Mothering as a source of comparison
  - 3) Mothering in the context of stigma
  - 4) Mothering in the context of fearing that children would be taken into care
  - 5) Mothering in the context of children being taken into care

### Theme 3: Interface between women and 'professional' services: 'relations of ruling' and resistance

- Hospitalisation and being the person with a 'mental illness'
- Biomedical explanation of distress and use of medication
- Experiences of professional support that acknowledged mother and 'patient' identities
- Beginning resistance: Mothering in the context of hiding distress; managing time and planning ahead
- Beginning of resistance: questioning the value of medication and biomedical explanation

- Beginning of resistance: seeking support outside the mental health services
- Beginning of resistance: seeking alternative approaches and routes to wellbeing

I found using the software for the coding allowed me to see how certain nodes had more quotes than others, and enabled me to count the number of women who had made each point. At this stage I wrote a definition for each child node and completed memos for the tree nodes. I included in the memos my reflexive thinking, ideas, theories and supporting literature. The process of coding and memo writing required a great deal of time and energy and took approximately eighteen months.

The advantages for me in using NVIVO were that a large amount of data could be stored and easily retrieved, I was able to listen to the audio recordings and read the transcripts separately and together, I was able to check the attributes of the women very easily and quickly. However I also found some disadvantages in using NVIVO. I am not fluent in the use of computers and I found the 'tactile-digital divide' (Gilbert 2002, p.216) uncomfortable at times. I wanted to be able to handle the data without having to turn on my computer. I spent a considerable amount of time learning to use the software and analyse on screen. I was fortunate that I had an expert who was able to remotely take over my computer when I ran into difficulties.

## **Memoing**

Memos have been described as a tool to assist the researcher in making conceptual connections between the data and the researcher's reflexive thoughts on what is being learnt from the data (Birks 2008). Guba and Lincoln (1994) refer to memos as reflexive journals. I used memoing (Ackerly and True 2010) throughout the whole research process. Some memos were recorded in NVIVO and others were handwritten. Firstly I wrote memos following each interview to include how I was feeling and any other observations that might add to the account. As I was simultaneously engaged in the processes of data collection and data analysis I used memos to keep track of the interview process and wrote memos on ideas that I thought connected interviews or ideas and hunches which I wanted to explore in a subsequent interview. In this way I was able to use information from the first interviews to follow up and explore ideas in further interviews and identify themes in the data that were



confirmed with subsequent interviews. This was also a vital part of reflexivity in the research as I was able to capture, document and question similarities and differences in the experiences of the women, and document my own emotions and thoughts throughout. As I became more immersed in the analysis of the transcripts I began to see ideas and concepts emerging. I wrote data memos that linked the emerging concept within data or transcript to the published literature. I also used memoing to explore concepts that challenged the dominant thinking or discourses within the literature and through this process I was able to uncover the subjugated knowledge embedded in the women's experiences.

### **Contextualization**

Feminist standpoint research highlights the importance of context in which research takes place. I needed to consider the historical, political, institutional, and socio-cultural contexts in which women's experiences were embedded. I was interested in exploring the ideologies on motherhood, mothering and mental health and how these ideologies were 'voiced' by the participants. For example, did the women accept or reject these ideologies? Did they attempt to live their lives in accordance with these ideologies? Did they resist these ideologies? Did living in Ireland raise particular issues for women? Therefore I used these questions to frame my thinking as I read and reread the transcripts throughout the analytical process.

### **Ethical considerations**

My approach in the research process was informed by an ethics of care (Gilligan 1993). Gilligan asserts that there are two different moral 'languages': a language of impartiality or 'justice' and a relational language of 'care'. The latter she refers to as the 'different voice' and in her view it is mostly associated with women in contemporary society reflecting how gendered divisions of work subscribe caring to women. Therefore my emphasis throughout the research process was on responsibilities and relationships rather than on rights and rules (Tong 1995). This means that the relationships that develop between the researcher and participants are central to the practice of feminist research. In order to foster a climate for positive relationships to grow my approach with all the women was one of unconditional positive regard. I also drew on feminist standpoint theory to underpin my approach to ethics. FST research highlights the importance of valuing women and validating their

experiences, the importance of recognising the conditions that oppress, exclude, marginalise or silence women, being aware of power in the research relationship and process and finally the importance of bringing about social change through critical analysis and political action (Ackerly and True 2010; Hall and Stevens 1991). I endeavoured to keep these principles in mind throughout the research process.

Edwards and Mauthner (2008) suggest that in many institutions the aim of ethics committees 'appears to be to avoid ethical dilemmas through asserting formalistic principles' (p.18). For this study ethical approval was sought from the University Faculty of Health Sciences ethics committee. In addition, one voluntary organisation requested that I submit an ethics application form to their ethics committee. For both committees the application process was similar. I completed and submitted detailed ethics forms to both committees. Completion of the University's detailed forms was a time-consuming process. At the commencement stage of my research I used the form filling as an opportunity to explore many ethical issues pertinent to the research. However, I was attentive to the possibility of the ethics of the research becoming merely a form filling exercise. The research proposed to interview mothers who experienced mental health difficulties; therefore it was a sensitive area that needed careful ethical consideration. Ackerly and True (2010) argue that a feminist research ethic is 'a commitment to inquiry about how we inquire' (p.22). As discussed, they highlight the importance of being aware of the power of knowledge, marginalisation, silences and intersections, the research relationship and possible power differential within this relationship and finally the 'situatedness' of the researcher. Ethical issues in relation to these areas as well as consent and confidentiality became more evident during the course of the study.

### **Informed consent**

Informed consent requires that the women were fully informed about the research and research process. It also implies that the researcher has made every effort to ensure that participants have been given information about the risks and benefits of participating in the study, they are informed of their rights, and that they have independently consented to being involved in the research without any pressure or coercion (Green and Thorogood 2009; Moule and Goodman 2009; Parahoo 1997). Informed consent begins at the first

interaction with the person when information about the study is given. However, Green and Thorogood (2009) suggest that it is impossible to predict what will happen during the research process. I considered this to be the case particularly in feminist standpoint research methodology and in using a semi-structured in-depth interview method of data generation. Therefore, the process of informed consent was ongoing throughout the study, and the women were involved and informed at all stages of the research. There was open discussion between me and the women that endeavoured to foster a collaborative and empowered approach to the research. By using skills, such as listening, attending, clarifying and making explicit the implicit I attempted to address the women's concerns and questions. Usher and Arthur (1998) refer to this type of consent as process consent.

I endeavoured to ensure that there was informed consent, firstly because of the qualitative nature of the study and secondly because of the involvement of a group of women who were perceived to be vulnerable. All women who volunteered to take part in the study were sent a letter and an information sheet (appendix 3) with the details of the study. The information sheet included the purpose, process, voluntary participation, the right to withdraw without prejudice, assurance of confidentiality, my contact details and an offer to answer any questions. Those who indicated a willingness to be involved were contacted by me. This initial contact gave me the opportunity to answer any questions, begin the relationship and arrange a date for the interview. The women had at least a week to read the information before giving consent. I also sent all written information to National Adult Literacy Agency (NALA) to ensure the language I used was clear and to the point.

I am an experienced psychiatric/mental health nurse with a Masters in Counselling Psychology and I have experience of interviewing women in a sensitive, nonintrusive manner. While I felt a level of confidence in my skills, I was also anxious not to harm the women. At the beginning of the interview, the consent form (appendix 3) was discussed in detail. Each woman either read the form on her own or we did this together, the choice was hers. Each woman was then asked to sign the consent form prior to the interview thereby consenting to be interviewed and audio recorded. Women were given the opportunity to ask questions and seek clarifications prior to giving written consent. I restated that their participation was voluntary and with their consent the interview was audio recorded. I informed them that they could withdraw from the study at any time and if they requested

the recorder would be turned off. The sensitive nature of the study meant that on many occasions women became distressed and emotional during the interview. When this happened I offered to turn off the recorder and provided support. The interview continued only when the woman again gave her consent to do so. A list of local support groups and services was given to each woman. I also provided information regarding accessing services, for example GP, and community mental health teams. At the end of each interview I allowed time for the woman to ask questions and often at her request I stayed and shared a tea/coffee and engaged in more social conversation. I checked with each woman at the end of the interview on how she was feeling and provided support if needed. I followed up each interview with a phone call, texts and/or emails. I also contacted each woman one week after the interview to discuss the interview and offer additional support as necessary.

Transcripts of the interviews were sent to the women, if they wished, so that they had the opportunity to make changes and check the accuracy of the information. Four women asked for copies of the transcripts and two of these women sent further information to me on their experiences. All new information was added to the transcripts.

### **Confidentiality and anonymity**

In the study I carefully considered issues of confidentiality and anonymity. As stated in the recruitment and sampling section, the women in this study are marginalised in society. The stigma of mental 'illness' was keenly felt by some women; therefore, confidentiality and anonymity was important for them. Women who had lost their children through the courts expressed concerns about being identified because of the strict rules around family courts, in particular the 'in camera' rule maintaining anonymity of children. If women break this rule they feel that they may lose all access to their children.

The women were assured of the procedural issues around confidentiality and anonymity. Women's identities and information were protected through the following measures:

- Following interviews each audio recording was given a code number. Code numbers were also used in all written hard copy records to protect the identity of the women.

- To protect privacy the signed consent forms were stored in a locked, secure place separate from the audio recordings and transcripts, to which only the researcher has access.
- Careful attention was given to ensure that all other information, for example biographical details, was removed and did not identify participants in the final write-up of the study.
- All data was stored on a password protected computer.

The transcriber also had access to the audio recordings. I delivered the recordings to the transcriber and uploaded them to her computer. I stressed the importance of not speaking to anyone about the content of the interviews and she agreed to this. However, even with all these procedures in place there were other issues that needed further exploration to ensure confidentiality and anonymity. For example, in arranging the interviews some women wanted to meet in a public place (hotel or café). I was conscious of the need for confidentiality when this occurred; therefore, we chose a table away from other people and did not commence the interview until coffees/teas had been ordered and received. I used a small digital recorder that was unobtrusive and looked almost like a mobile phone, this I placed to the side of the table. I was conscious of how I dressed for all the interviews, taking care not to appear too official when meeting in public or when going to women's homes.

As stated earlier I used a snowball method to access women to participate in the study, therefore women were sometimes known to each other or had spoken to each other about their involvement in the study. For example, women whose children are in care are a marginalised group within a larger marginalised group and as a consequence often are known to each other. Consequently, during the course of the interviews some women mentioned other women to me. If I had received a personal introduction from one woman to another then I felt I could acknowledge that I knew them. However, there were situations where women had discussed their involvement in the study with each other and I was unaware of this. In these instances I reinforced the concept of confidentiality and did not enter into any discussion about other women. However I did tell the women that if they wished to discuss their involvement in the study with others that was their right. Finally, at each interview when I was discussing confidentiality I stated clearly the bounds of confidentiality as a researcher. I followed guidelines from Children First (2011) on

confidentiality and I made the women aware that if there was any danger of harm to self or others then I would break confidentiality. With this stipulation all the women signed the consent form. Therefore, confidentiality on this basis can be described as limited.

As a researcher with counselling and mental health nursing experience I was aware of the need for respondents to be protected from people like me (Ribbens, 1989). What I mean by this is that women in this study may divulge more than they intend because of the seeming safeness in the interview. As discussed earlier, I spent time establishing rapport with the women prior to the interview so that when we met at the interview there was a feeling of familiarity with each other. I took various steps to minimise this possibility, I made decisions about whether or not to ask probing questions during the interview. When women made comments like 'I have never told this to anyone before' I gave them time to consider the possible impact and repercussions of divulging sensitive information, before continuing the interview. I was also conscious of not causing them added distress through retelling painful experiences both past and present. I was very clear about the personal support I could offer. At all times the women's well-being took priority over the research study. If any women experienced distress the following steps were taken, the interview was stopped and either temporarily or permanently discontinued, immediate emotional support was given. At all times it was the woman's decision to discontinue or continue with the interview. In two instances the interview was stopped when the women became distressed and tearful. I spent time talking to and supporting them and after a few minutes, when they said they wanted to continue recording the interview, I then turned on the recorder. When further support was needed the woman was guided towards support services and a list of national and local support agencies was available when needed. In the interviews there was potential that sensitive data in relation to motherhood and child care might be discussed. I am experienced in dealing with this type of information.

### **Reflexivity in the research process**

Reflexivity is central to all feminist research and in particular in FST (Fonow and Cook 1991; Clough 1992; Maynard 1992; Harding, 1996). Reflexivity is concerned with investigating the power embedded in one's research and also about doing research differently. The need to do research differently arises from the ethical and political problems and questions raised

by feminists about traditional research methods (Oakley 1981). As mentioned earlier Harding (1991) suggested the notion of 'strong objectivity' and developed reflexivity out of a critique of androcentric research that insisted on 'objectivity', 'value neutrality' and the separation of the researcher from the researched (Harding 1991). Harding and Norberg (2005) suggest that reflexivity as a research practice could transform detached research practice into a collaborative process of hearing listening and doing research 'with' instead of 'on' research respondents, thus equalizing the research relationship.

In feminist standpoint research (FSR) reflexivity is essential in situating the researcher in the process and in exploring the structures and institutions that inform and influence individuals understanding of their experiences (Smith 1989; Hill Collins 1990; Harding 1991, 2004, 2005; Hartsock 2004; Haraway 1988). Reflexivity in FSR is used to do research differently and to explore power within the research process, for example: the power in the relationship, the power both the researcher and the participants bring to the interviewing relationship and, at another level, the structural power (the power of the academic institution) within the research process as a knowledge producing activity (Mauthner 2000; Campbell 2004). Therefore, in this research, reflexivity was threaded through the whole research process from the pre-research stage through to data collection, data analysis and the write-up phase.

For example, in the pre-research stage and in developing the recruitment materials for the research I spent a lot of time deciding on the logo for the poster. I did not want to use images that set up expectations, for example the idealised representations of motherhood, and the nuclear family image. There are many different families and I wanted to represent this in the image chosen. Therefore the image I chose is comprised of small and large gender neutral figures linked together, always connected though sometimes distant and sometimes closer (appendix 1). The colour was also important for me I choose purple as a strong yet calm colour that might draw women's attention to reading the poster. I spent a long time deciding on the language to use in the poster, as I wanted to use language that was clear but not discriminatory or offensive, for example the terms 'enduring' and 'serious' mental health problems were removed as they have negative connotations for many people, yet I

wanted to recruit mothers who have had mental health problems that have significantly restricted their lives in some way.

In the data collection stage I needed to be vigilant in recognising the multiple potential power issues. For example, I was aware of how women may see me in my position as researcher and also as a mental health nurse/counsellor. I was aware of the possibility of replicating a relationship based on the notion of 'patient' and 'professional' and also that the women may see me as an 'expert'. Whereas I considered the woman to be the expert and therefore having the power in the relationship, I was also aware that I brought certain attributes to record these experiences. Throughout the research process I was also aware of how powerful discourses in psychiatry, motherhood and mothering might impact on women in their daily lives and how these discourses affect policy and practices of agencies, services and organizations. Therefore throughout the process I was concerned with how my views on mental health and women's position as mothers might adversely influence the type of data I heard and collected. I have knowledge of the various explanations of mental distress for example, biomedical, hormonal, chemical, behavioural, cognitive and I understand how gender bias can influence psychiatric interpretation and diagnosis. However, I came to this research from a recovery oriented (Copeland 1997) understanding of mental distress and I had worked in a recovery oriented way for a number of years. Therefore I was able to hear women's explanations of their distress that were influenced by traditional views of 'mental illness' and diagnosis. At the same time I was also listening for stories of hope, empowerment, personal responsibility, education and support-elements of recovery in their interviews. I used reflexivity to ensure that I was not 'putting words in their mouths' and that I gave an accurate account of their experiences.

### **Summary and conclusion**

This chapter focussed on the theoretical underpinnings of Feminist Standpoint Theory (FST) and on how I operationalised this approach in my research. I discussed the practical issues in relation to access, sampling, interviews and analysis. I endeavoured to highlight some of the challenges I encountered from a personal, ethical and methodological point of view. The process of the research was not straightforward. I was constantly going back and forth between the experiences described in the interviews and the literature in an attempt to



grasp the context of both worlds. The following three chapters will present the findings and present the standpoint of this group of mothers.

## **Chapter Five: Mothering with expectations: the challenges of being a mother**

### **Introduction**

The previous three chapters provide the conceptual, theoretical and methodological background from which I will present and discuss the experiences of women with mental health problems as mothers. In the following three chapters I will focus on women's everyday experiences as they balance how they mother in the context of representations of motherhood and mental 'illness'. In the first findings chapter I will present how the women negotiate western understandings of what it means to be a mother and I will explore how the women in this study attempted to live up to western cultural ideals about mothering in the context of patriarchal motherhood. The second findings chapter focuses on how mental 'illness' is seen as risky in the context of motherhood and how women negotiate their mothering whilst also experiencing mental health issues. This chapter also highlights the relations of ruling women negotiate on a daily basis in their role as mothers. The third and final chapter of findings highlights the dominance of the biomedical explanation of mental 'illness' and explores how this explanation is different from the women's experiences and understandings of their own mental distress. It also includes discussion on how the women negotiate their mothering under this medical gaze and discusses the interface between the relations of ruling and resistance.

In this first chapter of findings I will present the women's everyday expectations of themselves as mothers. It is important for the reader to note that these understandings take shape within the overall context of a society, Ireland, marked by patriarchal relations so that the issue of gender lived under patriarchy is both an individual experience and one which is embedded in the way Irish institutions mediate and respond to women's personal experiences. In this way, women as mothers are under the shadow of the ruling relations of patriarchy (O'Connor 2000) and this is especially acute for women who are doubly marginalised in Irish society by virtue of having mental health problems. The majority of women in this study experienced mental health problems prior to becoming mothers and, for four of the women, their mental health problems appeared to commence following childbirth. In keeping with feminist standpoint theory, I will explore the meaning the women attached to the term mothering, their expectations of motherhood and the discourses that

influenced their expectations. In addition, this chapter will explore how the women attempted to live up to their expectations of mothering within the constraints of patriarchal thinking, and the challenges they encountered as a result. I present the women's descriptions of what being a mother meant for them under the following themes: mothering under the patriarchal construction of ideal mothering; mothering as doing and ambivalence towards mothering. Although the chapter is divided into various themes in reality it was clear that, as the women described their expectations of motherhood, there was a constant interplay between all the themes and all had a strong influence on how the women mothered.

**The meaning of mothering: Mothering under the patriarchal construction of ideal mothering.**

As discussed in Chapter Two in Ireland there is a patriarchal view of motherhood. This understanding of motherhood idealises motherhood and sets up societal expectations and assumptions about how women should mother their children. The notion of idealised (Hays 1996) mothering can be seen as a product of a patriarchal society. In Ireland low levels of childcare provision, high childcare costs and limited attempts by government to facilitate work and family life places the responsibility for childcare firmly on women (O'Connor 2000). In addition to being responsible for childcare women are expected to be all things to their children. The expectations of mothering under patriarchy are impossible for all mothers. However women struggle to meet these expectations and mothers who experience MHPs have the added fear of being deemed 'unfit' in their role as mothers and struggle to achieve the impossible. All the women in this study expressed firmly held beliefs of what mothering is for them. The women described mothering almost as a state of being that was not reducible to component parts. They spoke of mothering as being about '*nurturing*', '*supporting*' and '*moulding*' the next generation in a selfless, all consuming and intense manner. In attempting to capture the intensity and completeness of the mothering experience women used expressions such as: '*it means everything to me*'; '*It's the most important thing I've done with my life to date ...*'; '*Motherhood is very important ... having my own children meant everything to me, everything to me*'; '*I love my kids so much and I'd do anything for them*'. In many situations the women's descriptions corresponded with Hays' (1996) description of intensive mothering and with Rich's (1976) concept of patriarchal motherhood. Hays (1996) suggested that the underlying premise of intensive

mothering is that mothers need to be everything to their vulnerable and sacred children. Hays argued that within idealised motherhood “Good childrearing requires the day-to-day labor of nurturing the child, listening to the child, attempting to decipher the child’s needs and desires, struggling to meet the child’s wishes, and placing the child’s well-being ahead of their [mothers’] own convenience” (1996, 115). Therefore to be good mothers, women must spend countless hours stimulating their children, taking care of their physical needs, making decisions in the present that determine the future success or failure of the children as adults. Love is the only acceptable emotion for women to have towards their children. Intensive mothering requires an enormous investment of time and energy by women but also insists that women need the guidance of experts such as doctors, psychologists and childcare books. In addition women are expected to enjoy the experience of mothering and nurturing their children.

Aisling summed up her expectations of motherhood as follows:

*Aisling: ‘I knew I would always be the stay at home type Mum. I wanted to do everything myself ... I was always so into the childcare like, so I suppose I wanted to carry a lot of that on at home ... I just wanted everything to like ... my kitchen was always like a wee playschool. I always had the wee sand tray and the water tray ... I just wanted it to be perfect for them’*

Linda described what being a mother means to her:

*Linda : ‘Well it means the world to me that I was actually to have a baby you know in the first place, because a lot of people can’t , and he’s such a character you know ... I think it’s great. I really enjoy it now ... Well it makes me proud, I suppose you know to have a son like that and that I produced him (laughs)’*

For the women being a mother was more than a role, it encompassed their whole being. Aisling speaks about wanting it to be ‘perfect’ and Linda says ‘it means the world to me’. For women whose identity had previously been bound up with having a mental health problem becoming a mother represented a new beginning and a new life for them. Eleanor, Sinead, and Niamh, having experienced mental health problems for a number of years, described how being a mother took over their lives, with the intensity of being a mother captured in their thoughts and feelings:

*Eleanor: ‘... I was never so happy in all my life. I remember the feeling. I remember having my son strapped to my chest all the time. I just loved him so much and I just*

*never let him go. I remember so much enjoying the time I had with him. It was lovely'.*

Sinead: *'But this [being a mother] is my focus. That's all I can think of'.*

Niamh: *'I've always put them first. It's the most important thing to me this is ... making sure that they get a good start in life and then I'm always saying to them look I'm trying my best, I'm always going to do my best ... I wanted to make sure that like I did it right with my kids'.*

As already discussed in patriarchal societies women are expected to be responsible for childcare. In this study the women were of the view that as they were the primary caregivers, they were responsible for every aspect of their children's well being, growth and development.

Eileen, mother of three daughters, one of whom has a physical disability, attempted to put her understanding of motherhood into words and she concentrated on how the work of being a mother is nourishing not only physically, but also emotionally and spiritually.

*Eileen: 'To me mothering is more about a process of emotions, of actions, of creating atmospheres, like that nourishment I talked about, but yet with enough flexibility to allow freedom to grow ... So I think mothering, real mothering, is about nourishing the uniqueness of each child. It's about support. It's about physical affection, guidance and good craic as well and a bit of sport. But I do think mothering can be misinterpreted sometimes to mean being controlling, having high expectations, wanting your child to perform extremely well all the time, not accepting them to be as they are, which is problems and all, warts and all, up one day down the next maybe, especially through those teen years'.*

From this perspective the women also spoke of not controlling their children and allowing children the freedom to grow. Women highlighted the tensions in achieving a balance in their mothering. Carol felt that her role is to nurture her children, and Grainne described herself as a 'guardian':

*Carol: 'Well I suppose mother for me would be to nurture my children to the best of their ability, try my best not to control them, always hear what they have to say and to love them'.*

*Grainne: ' my experience of being mothered and my mother's experience of being mothered has affected my mothering and how I feel about being a mother. How I feel about being a mother is I feel like guardian to my children, like a really good guardian'.*

Eileen struggled to express some elusive part of mothering, elusive in the sense that it is hard to name. However to capture it, Eileen used a vivid image or picture of holding a person:

*Eileen: 'Well I would. I think real mothering is ... it's a complex role. I think the act of mothering is about nourishing, enabling, freeing, supporting, guiding and holding, you know, if you know what I mean by that, but just generally holding a person'*

The metaphor of 'holding' captures a feeling of safeness, protection and security from which children can grow and flourish. Through focussing on not controlling their children, mothers acknowledged that children have some autonomy in their own development which also hints at deconstructing the notion that mothers are entirely responsible for how their children develop physically, emotionally, spiritually and morally.

For many of the women there was also the expectation that to be a mother was a natural extension of being a woman, as described by Sinead: '*... it's a natural thing to be a Mum, you know it's a kind of an everyday natural thing*'. Ita went on to expand on this and suggested:

*Ita: 'I would ... when I became a mother first, I would have looked at this little bundle in my arms and I would be thinking God how can you trust me, knowing me, with this little bundle ... I would be thinking, he [God] must think I can handle it because he is supposed to give you nothing unless you can handle it ... when each one of those kids were born [it] was the most joyous, joyous thing in my life ... Oh it is part of me, definitely yeah, part of me'*

Therefore, to be a mother was an expectation that the women felt they could fulfil, as they saw it as natural extension of being a woman.

The notion that becoming a mother as a 'natural' part of being a woman not only led to the expectation that women would know what to do when the child was born, but that all else would come naturally. However, the challenges of mothering and the contradictions in the experiences that motherhood is natural and easy became apparent very quickly. For many women the impact of becoming and being a mother was life changing. Joan summed it up in the following:

*Joan: 'your whole life changes the minute you become a mother. You cannot envisage what it's like till you're pregnant you know'*

The notion that becoming a mother is a 'natural' part of being a woman also set up an expectation that childbirth would happen naturally. When there were complications such as Caesarean section the women felt cheated, let down, and some felt traumatised. Helena described the emotional turmoil that this caused for her and set up an unravelling of the notion of a '*natural experience*'.

*Helena: 'I suppose I wanted everything to be natural, breast-feeding and giving birth natural, and I suppose I didn't have any say in the natural ... you know ... because I knew at that stage that I couldn't have her naturally .... I suppose what really got to me at that stage is I had [baby's name] by IVF, then I had to have her by C section, which meant I didn't have any natural experience of anything, conceiving her, giving birth to her, so it was traumatic at that stage'*

As stated, most women in the study accepted the notion of motherhood as a natural extension of being a woman. Jennifer, however, questioned this notion. As a young single mother she accepted her role as mother and changed her life to take care of her son and made the distinction between being a mother and being motherly.

*Jennifer: 'I suppose someone whose main purpose is to be a mother, whereas I wouldn't really, even though I make it a priority, it wouldn't be my natural priority I suppose, if that's the word, yeah ... I'm maybe not the best person because even though it [being a mother] means everything to me, my son means absolutely everything to me, but I'm really ... I'm a very good mother but I'm not motherly, mother material. I was never ... It's never what I intended to do with my life and yet now that he's here you know ... my number one project is to ... he's a fantastic child'.*

The expectations of motherhood, as a totally responsible and all consuming role, may arise from one strand of present day discourse that places mothers at the centre of children's lives and responsible for the physical, psychological, and emotional well-being of their children. This strand of thought on motherhood promotes the expectation that mothers should be the main carers for their children, be present and available to their children at all times and provide the best source of love, guidance and nurturing for their children (Thurer 1994; Hays, 1996; O'Reilly 2004; Horwitz 2011). The expectations of motherhood, as described by all the women, suggests that a child's needs always come first (Douglas and Michaels, 2004; O'Reilly, 2004). In Western culture the ideal mother is positioned as a woman who is always present to care for her child and who does mothering selflessly and seamlessly (Choi et al 2005). Malacrida (2009) suggested that mothers are ideally expected to be all things, at all times, to their dependent children. Badinter (1981) argued that

historically, at least since the Enlightenment, women have been made responsible for the preservation and education of their children (Badinter, 1981) as well as for the moral upbringing of their children (Arnup 1994; Badinter 1981; Donzelot 1997; Ehrenreich and English 2005). This idealisation of mothering means that women no longer see their needs as important and 'sacrifice' their needs for their children's needs. To deviate from this expectation for the women in this current study invokes the fear that there will be harsh judgements from a society which judges them harshly because of their mental health status.

While the expectations set up by ideal mothering discourses place pressure on all women who are mothers, there are added pressures on women experiencing mental health problems as these women are already under pressure to prove themselves in a society generally unsupportive of women experiencing mental ill health. While all women try to prove their competence as mothers, the women in this study felt they needed to constantly prove themselves, as they were aware that their competence was under quite close surveillance and open to question by professionals in the social and mental health services. Louise was acutely aware of this and portrayed the deep sense that she was under surveillance and that she was somehow seen as likely to fail in her mothering role.

*Louise: 'Well I just find that I'm kind of hyper ... maybe a bit hyper-sensitive to kind of scrutiny of my parenting skills ... and I know a part of it is myself ... I put myself under huge pressure to be the ultimate mother ... I have to prove myself and I have to work harder at being ... keeping the house ... I remember the community nurse used to come down once a week ... I'm a mother with twin premature babies and I was fretting, making sure the house was clean, you know that everything was ... you wouldn't get that from a mother that had just had twins ... even with one child you know, you expect to walk into a mess but I was ... I know I put huge pressure on myself to you know ... not just reach the expectations but to exceed them so there could never be any question over my ability to cope or to parent ... Yeah and maybe a lot of it is pressure you put on yourself but certainly you are more scrutinised'.*

Some of the women identified another source of surveillance in the form of other parents. Jane, for example, believed that she would be judged if people knew her mental health history and therefore made a conscious decision to keep her mental health status private and thus showed a limited self to her neighbour. In doing this she hoped that the self she was showing would fit within the norm, at the same time as protecting her son from any



possible shame or stigma. Thus she was viewed as a mother and not as a woman with mental health problems:

*Jane: 'but I'm not telling the mother [of son's friend] about my experiences [mental health] because I don't want her to judge me ... It's probably me being extra vigilant about but I just felt that I just don't want him [son] to be taunted about me'.*

Being mothers gave this group of mothers a purpose in life and a way of being seen as other than being 'mentally ill'. However, the need to seek affirmation of this was evident in both Ita's and Aoife's explanations:

*Ita: 'He [God] must think I can handle it'*

*Aoife: 'Well I love being a mother. I could never hold down a job very well but I can handle the kids and I look after the kids grand, well I think I do a good job and ... [husband's name] seems happy enough anyway'*

For women who experience mental health issues, there is also a real fear that their children may be taken from them and for some women this became a reality (this area will be discussed in more detail in chapter 6). Therefore, the women in this study constantly strive to meet what they believe are the expectations of being a 'good' mother through 'doing' mothering. The women had a strong desire to be mothers and had firmly held beliefs about how they wanted to mother their children. The women had agency in how they mothered and they actively created their role as mothers adhering to dominant ideologies of acceptable mothering, while creating a role for themselves as mothers that offset the negativity of their mental health status.

### **The meaning of motherhood: mothering as 'doing'**

The ideology of ideal mothering is maintained through the actions of mothers who strive to achieve its goals. Malacrida (2009) suggested that women, through these actions, experience a sense of achievement and success as mothers when they 'pull off a flawless-appearing enactment of ideal mothering' (p.103). For women in this study, ideal mothering was also strived for through 'doing' or 'performing' many practical tasks that comprised the visible part of mothering.

Firstly the 'doing' of motherhood involved a never ending set of concrete tasks, such as

keeping the house clean, cooking meals, doing the shopping, and washing clothes:

Aisling: *'My job was to do the basics ... It was to do all the washing, the clothes, the feeding, the changing, play-school, all that stuff ...'*

Maria: *'Get up, get them up, get their breakfast. We'd go to the shops if we needed to go to the shops or they would go to school. I'd come home, clean, normal housework, dinner.'*

Sinead: *'That's [taking care of children] all I can think of. Like I, do you know ... do everything else for them, do you know, I cook and I clean and'*

Nora, a mother of five children aged five to eighteen, described:

Nora: *'It's meet the kids, drop the kids, keep the house, then the same thing when they come back from school. On Friday I will go out if we have to do shopping at the weekend then come back'*

These tasks were all observable to the women and to others and were used by the women to confirm to themselves and others that they were doing the job of mothering 'right'. Because of their marginalised position as mothers with mental health problems and subject to ongoing professional scrutiny, the women struggled more with the notion of what comprises 'right' or 'best' mothering. This idea was summed up by Aisling:

Aisling: *'If my house looks clean and tidy, if my child looks clean and tidy, then it looks like I'm doing a good job, it looks like I'm doing it [mothering] right'*

Secondly the 'doing' of motherhood also involved engaging with developmental tasks to assist their children. The mothers took responsibility for their children's well being and development. Being present to interact with their children was seen as an important part of mothering, for example, being involved in socialising and creative play.

Linda: *'He likes ... well he loves being outside so obviously, weather permitting, I take him for a little walk all round because there is quite a lot of land around you know the fields and stuff. He likes drawing and we try and do a little craft, do things with him'*

Una: *'Like I do art with him and I might go out there and kick the ball with him'*

The women also felt a responsibility for their children's social well being and recounted the range of activities that their children were involved in, from toddler groups to after school activities:

Myra: *and I used to bring him to ... with the local mother and babies group up in [names location] like and we used go on trips and all you know and things like that.*

Jennifer: *'I'd be out and about ... going for walks with my family or going to all my son's matches and everything and cheering him on the sidelines ... just normal stuff really ... walks around here, yeah'.*

Eileen: *'dressing up, because we love to dress up, doing fun things with her, going swimming, going for a walk with the dog, playing with her'.*

Aisling: *I really ... right now I feel like I'm where I want to be as a Mum, I'm able to do what I want to do and really, really enjoy it, like ... taking them through the woods, and taking them swimming and things like that'*

Maria: *'When they were really younger, you know, play games, take them out to the park'.*

In addition to having a clean and tidy home and helping children develop relationships outside the home, the women also discussed how they felt they were responsible for providing an educational environment where certain activities, such as colouring pictures were seen as 'good' and other activities such as watching television were seen as 'bad'. Consequently they spoke of encouraging the former and minimising the latter.

In addition, it was not enough to take children to groups, the women felt they had a responsibility to ensure that their children had friends. This is clear from Fiona's explanation:

Fiona: *'I had to make openings for her. I had to attend mother and toddler [groups] ... and later I had to try and find friends for her'.*

Some of the mothers had internalised a sense that mothering with mental health problems meant 'failing' no matter what they did. Therefore the women carefully watched how they mothered and were acutely aware of how other women and healthcare practitioners might perceive them. Although they wanted to see themselves as good mothers, they realised that others might not view them as such. Women described the importance of being engaged in stimulating activities with their children. For example, sitting down doing nothing with their children was not an option for this group of mothers. Although at times when their distress was overwhelming they had no choice but to sit and just be (this area will be discussed in detail in Chapter 7). The women tried, wherever possible, to focus on engaging in developmentally stimulating activities with their children.

Lisa: *'sitting down on the ground with my children colouring and'*

Allison: *'he wasn't going to watch cartoons'*

Eleanor: *'I started doing a lot of work with her, play-time and stuff'*

Kay: *'Oh that I would be able to do work on crafts with them, that I would be very ... like much you know ... sitting down playing with them constantly, interacting, like going through books and teaching them, and that my children would be so much more advanced when they went to school because they'd have great start'*

The women spoke of both the positive aspects and the demands of trying to ensure children were involved in activities from toddler groups to after school activities. On the positive side Jean highlighted the learning and support she received at the toddlers group.

Jean: *'I went to mother and toddler which was very good, new mothers and whatever else you know. You'd be all in the one boat with small babies crawling all over the place and somebody would say "oh I didn't sleep much last night, somebody was sick" and you know you'd be transferring information to one another about what will work and what won't and that was a very good thing'*

Deirdre, on the other hand, highlighted the challenges of trying to meet the needs of all her children:

Deirdre: *'Aye, I would drop [child's name] off to football, [child's name] might go Irish dancing, [child's name] then would be doing something else, she might want to go swimming'*

The expectations set by subscribing to idealised mothering places enormous pressure on the women. For example, Bridget describes the struggles and contradictions in her mothering, if she completes the practical tasks of mothering, she does not have time for the creative tasks and if she plays with her children she does not have time to do the practical tasks:

Bridget: *'I'm always beating myself up about it, I don't have the time, I'm so busy like, looking after them, doing the day to day things... I feel when I really don't get outside to play with them. I do try and the days when I do get out to play with them or even bring them to the park – I feel really good those days. I feel I made an effort and you know, who cares about the housework then. At the end of the day the kids are the most important'*

For women who were working outside the home, these various activities had to be done as described by Sue:

Sue: *'I come in from work, he'd come from school. Normally we'd go down to my Dad's for an hour. He'd go out a while playing with his friends. We'd cook the dinner and stuff or... Today now is Monday, so it's football, so we go to football from quarter past five to quarter past six and then I drop him back here and then from seven to eight he goes to the other football down in the Resource Centre here'*

Sue's son is now twelve so she was conscious of the need to keep her son 'busy' to ensure not only his physical development, but also the development of socially appropriate behaviour.

*Sue: 'oh we're kept going, we're very busy people in this house. [laughs] I like to keep him off the road you know because I'd be saying they get into trouble and you know'.*

Despite the challenges the women described these various activities as fulfilling for them as well as for their children.

*Ruth: 'I mean I find it very fulfilling in certain ways. I enjoy, do you know, all the different activities that they used be involved in when they were younger. You know, taking them here, there and everywhere'.*

*Fiona: 'I find it very fulfilling [pause] to be a mother I think you have to go down to the level of the child and interact at that level and to do whatever it takes to keep activities going, to get involved and be aware that there's a need to keep the circles going, to keep the activities, to keep things turning and ticking over for the child'.*

Many of the women took pride in the fact that they did not leave their children to be cared for by other people unless it was absolutely necessary, for example if they were working. Orla's son, who is now nine years old, has on two occasions been with a baby sitter and Sue similarly describes her situation. Because of the scrutiny they were under from the mental health services, the women felt they needed to show that they were beyond reproach.

*Orla: Yeah, I'd always make sure that he [son] was included and he's coming with us or, you know. He's been with a babysitter I think, twice.*

*Sue: 'Even today, [son's name] is twelve, even to today I never had a weekend away, just to go away myself and leave him there. No I take him with me. Come on we're going away for the weekend, you know. Silly really, like, but I suppose you have to protect them in some way you know'.*

Mothering as 'doing' demonstrates how the women negotiated their role as good mother by being accessible and ever present for their children. The women managed their time at home centred round their children and ensured that they spent time doing educational and other social activities with them. Working mothers also ensured that time outside of work was spent with their children. The patriarchal construction of motherhood and the ideology of intensive mothering reflecting as it does these values from the ideology of patriarchy of family and childcare traditionally seen as women's responsibility and paid work men's responsibility (O' Connor 2000) seems to be at the heart of how they see themselves as

mothers, and this appeared to be heightened because of their marginalised position as women with mental health problems. In addition, their mothering practices were intertwined with their awareness of the ideology of ideal motherhood. Women in this study had an awareness of how others might view and judge how they performed mothering. However for many women engaging in child care activities and mothering was a rewarding experience and provided an important source of meaning and purpose in their lives.

### **Ambivalence towards mothering**

Women also spoke about the challenges of looking after children. Being a mother encompassed a range of emotions from joy to resentment, anger and frustration (Maushart 2000). Horwitz (2011) suggested that some aspects of motherhood are silenced by an ideology that promotes the notion that being a mother is always a fulfilling and happy experience. Being a mother has many facets, however, many women are reluctant to talk about the challenges of being a mother (Boulton 1983; Maushart 2000). The challenges, for the women in this study, became all the more difficult because of the importance they gave to the notion that motherhood was natural and that a mother should intuitively know how to care for her child. Women were balancing on one hand the voice of the expert about mothering and on the other their lived understanding and experience of what it means to be a mother. This balancing act is all the more fraught because of their marginalised position as women with mental health problems. Mothering as 'doing' highlights the 'rules of mothering' that women use to judge themselves. The emotion that women expected to experience, arising from their understanding of motherhood, was love as described by Ita: *'the unconditional love for your children'*. When women became caught up in a cycle of domestic and childcare activities they often felt frustrated, exhausted and unfulfilled. As a result some women felt they did not measure up, they judged themselves as 'bad' or 'not good' mothers, commenting *'I'm not good at it.'* Other women said that they did not want to 'fail' for example Kay who says:

Kay: *'I want to be the best at being a Mum. I want to be a good Mum. I don't want to fail them basically.'*

Kay goes on to describe feelings of inadequacy leading to a cycle of disappointment and guilt, often with the devastating conclusion that her children would be better off without her.

Kay: *'why did I expect that it would be all rosy in the garden? It was just pure stupid of me really I suppose ... and I'm disappointed ... really I am disappointed that I don't ... that I'm not good at it [being a mother]. I don't feel I ... some days I think that they would be better off with other people because I'm not a good Mum'.*

The all consuming nature of ideal motherhood leads to a loss of self. Women do not have the time or energy to attend to their own well being. Bridget: *'the work is done but there's so much more that you can give your kids, you know'* This left little time for themselves, consequently their identity became subsumed into 'mother' identity with a subsequent loss of 'self' identity:

Bridget: *'I've kind of forgotten about myself as such, you know'*

Badinter (2011) suggested that every woman feels torn between love of her child and personal fulfilment, between wanting the best for her baby and wanting the best for herself. 'A child conceived as a source of fulfilment can, it turns out, stand in the way of that fulfilment. And if we pile up a mother's responsibilities to the point of overload, she will feel this contradiction all the more keenly' (p117). With these understandings and expectations of motherhood it is not surprising that some women expressed the almost unspeakable, in our child centred world, and voiced the other side of motherhood, one that is frustrating, boring and not fulfilling.

Jill: *'Yeah ... yeah ... but ... I think there's a lot of people that won't admit it's not all it's [being a mother] cracked up to be, to be honest, do you know. Obviously if I had known that I was going to go through [child with disability], people say oh you wouldn't change him for the world but I would ... when he is good he is great, you know I hate him sometimes ... I don't hate him, I hate his behaviour.'*

Jane: *'I suppose that there is a degree of [I know it sounds awful] but boredom, with younger children.'*

Kay: *'And how boring it is. It is so boring and like ... I don't know ... it's like if I went back to work I couldn't afford to have four kids being minded and I suppose the ideal would be for me to go back to work and maybe I would regain some of my identity but then.'*

Bridget: *'It's a very long day, you're up at seven and sitting down at ten and then you're exhausted and fall asleep on the couch. You want to watch a programme on TV but you're so tired you fall asleep and then back up again and every day seems to be the same (laughs) day over and over again ... you're on the go the whole time, you don't get to sit and you get no thanks for it'.*

Women expressed ambivalent feelings about motherhood and questioned whether they had done the right thing by having a child.

Noelle: *'that night that he was born like, I looked at him and that was the first time I thought, God, did I do the right thing?'*

Some women, echoing adverse responses when they announced they were pregnant, questioned whether they were worthy to have children (this area is discussed in detail in the next section) possibly internalising the view that some women are more suitable to being mothers than others.

Grace: *'From a very early age, yeah, and I was a hundred per cent convinced that I wasn't worth being a mother, I didn't deserve to be a mother and they'd [her children] be all better off if I was off the scene.'*

Mothers are not only constructed but they also construct an ideology of motherhood. Negative feelings towards mothering are not tolerated in our child centred world. Therefore it was difficult for women to voice this part of their mothering experience and this is especially true for mothers who experience mental health problems as they are already in the position of being viewed as unsuitable as mothers. However, it is through voicing the frustrating part of mothering and the bravery of these women to speak that it may be possible to construct other ideologies of motherhood.

## **Summary**

This chapter has presented how women in this study understand mothering under the patriarchal construction of ideal motherhood. Ireland is a patriarchal society the women in this study experienced patriarchy at both an individual and institutional level. At an individual level in being seen as responsible for childcare and at an institutional level through having an awareness of the relations of ruling - mental health and social services - as a result of experiencing mental health problems. Women in this study internalised Irish society's understanding of motherhood. Becoming and being a mother changes women's lives. When women described their expectations of motherhood, they spoke about mothering as 'all consuming and natural'. The 'doing' of mothering involved a set of rigid rules on what is acceptable mothering. The women in this study struggled to live up to these expectations. They were acutely aware of the notion of 'good' and 'bad' mothers and strove to be the 'good' mothers they wanted to be. Their understanding of mothering as natural, labour intensive, child centred and all consuming left them with little time to devote to their own wellbeing. For women who had experienced mental health problems



prior to having children, there was a heightened awareness that they might be viewed as 'not perfect' mothers. Therefore they did everything possible to prove their abilities as mothers to themselves and others. The findings in this chapter highlight the deep contradictions inherent in women's experiences. Ideal motherhood is unattainable and blaming to all women, however, for women who experience mental health problems, it is a particularly difficult ideology to negotiate because of social and institutional prejudices and practices towards women experiencing mental health problems.

In the next chapter I will present how this group of mothers go on to attempt to achieve this 'ideal' motherhood whilst also experiencing mental health problems.

## **Chapter Six: Mothering in distress: being good enough**

### **Introduction**

There are many different explanations of 'mental illness' or 'mental distress'. Dominant theories of 'mental illness' have focused on individual 'factors' such as neurotransmitters, hormones, or cognitive coping styles to explain women's 'misery' (Stoppard 2000, Ussher 2006). However the theory that dominates in the mental health services in Ireland is the biomedical explanation. The biomedical explanation of mental distress presents mental distress as a discrete illness entity and something that can be measured with objective diagnostic tools. From this understanding the accounts of the women's distress in this study would be considered to reflect the signs and symptoms of 'mental illness' leading to a diagnosis of 'mental illness'. The 'illness' is seen as part of a woman's pathology and obscures the embodied, subjective experiences of what it feels like to be distressed. As previously discussed (chapter 3), the lens then becomes focused on the woman and moves away from the cultural, social, political and interpersonal realities of the woman's life (Marecek 2006; Stoppard 2000).

Instead of beginning from the standpoint of the medical explanation of mental distress, this study begins from the standpoint of the women experiencing mental distress, and thus a different view begins to emerge. As suggested by Smith (1987, page 19) it is the 'gap' between personal experience and dominant structures or 'relations of ruling', and the description and analysis of that experience that gives the space to explore how women's lives are influenced by dominant institutions and how women live within this space. In Smith's view it is at this interface between lived experiences and the structures imposed by powerful institutions which are patriarchal in nature that new insights and knowledge are gained.

In this chapter I will present the women's experience of mental distress which, as described by the women, was one of the key events forming the context from which they mothered. The periods of distress in their lives were not always constant. However, there were times that women experienced such extreme distress that they contemplated dying by suicide as the only way to escape from their distress. At other times the women were able to cope with their distress, and for long periods of time they felt 'ok', apart from the usual

challenges faced by all mothers as outlined in the previous chapter. The first part of this chapter presents the women's experiences of mothering in the context of distress as one principal reference point within their work as mothers. The context of their lives also included 'relations of ruling' as reflected through expert opinion, and such mechanisms and reactions stemming from those relations of ruling like comparison with the 'norms' of mothering, experiences of stigma, the fear of losing children and, for some women, experiences of having their children taken into care. Mothering for these women was a balancing act as they struggled to live up to the ideal of the 'perfect' mother. The women felt that they had very little leeway in how they mothered and could easily be judged an 'unfit mother' and consequently they devised strategies (these strategies will be discussed in chapter seven) that helped them to continue mothering in the face of distress, fear, stigma and surveillance.

### **Mothering in the context of mental pain and loss**

In order to give an accurate account of women's mothering experiences, I believe it is important to gain a clear understanding of their expressed mental distress. In this section therefore I will present a picture of the distress the women experienced and the emotional context within which they mothered their children. When the women spoke of their distress it was clear that their experiences and distress were not always present and there were variations in intensity and duration. It was also clear that their distress was at times all encompassing and could not be neatly packaged and understood in isolation to the whole of their being and lives. Being distressed affected how the women felt about themselves and had a huge impact on how they lived their lives, how they mothered, the support they accessed and the support they may or may not have received on a personal and professional level. Some women described feelings of despair, sadness, fear, and distress. They described feeling '*black pain*' and being in a '*black hole that's full of fear and anxiety*'. Many women felt bewildered and lost in these emotions. They spoke about isolation, altered reality, frightening experiences, like '*faces in the water*', and thoughts of suicide.

In the following section, the women interviewed give a vivid description of their distress. Anna, who had been struggling with mental distress for a number of years, gives some understanding of the pain:

Anna: *'It was horrendous and the pain was shocking like it wasn't a physical pain... it was just a pain... that's all I can describe it... a black pain'*

Jane using the same description of *'black'* goes on to describe her state of extreme distress as the *'black hole'*, as it goes beyond her physical being and becomes something much more encompassing and all consuming.

Jane: *'Because the depression is just ... complete ... I mean people say a black hole but it's just ... it's like a black hole that's full of fear and anxiety. A black hole indicates to me that you're kind of ... there's safeness in it, but there's no peace in your head and everything is ... nothing you enjoyed is enjoyable anymore.'*

Anna, Jennifer and Aisling describe how they are overwhelmed by the intensity of their feelings as they struggled with day to day events. Anna describes the profound effort she has to make on a daily basis to mother her children and how she *'fights'* to do the smallest thing, as she struggles with her lack of energy and depression. She further describes the constant presence of her mental distress as a *'shadow'* and as something that *'hits'* her and *'brings her down'*. The language Anna uses brings into focus the ferocity of her mental distress. Her description gives an insight into the profound effort that is needed for her to get through each day.

Anna: *'It's ferocious ... and the smallest thing is so big ... so big ... it's just like ... it's a shadow and you never know when it's going to hit you, but when it hits, it hits, and it likes to bring you down. And you're fighting it every day. You're definitely fighting it every day. I mean I could sit here all day now, not move, do you know.'*

Jennifer adds to the picture and describes the lack of motivation and energy and how she struggles to overcome this. Jennifer talks of *'clearing'* her head and having a *'plan'*. In the midst of the distress women continue to struggle with pushing themselves as Jennifer describes *'because you know what needs to be done'*.

Jennifer: *'Yeah, you're aware of what needs to be done but there's no motivation ... no ... it's not even not wanting to ... because you know what needs to be done ... it's just physically can't muster the energy to get out of bed, clear your head enough to think of a plan for what needs to be done. It could be something as simple as cooking a meal that you need to do this, this and this and everything seems huge, putting on a load of washing seems like a huge task.'*

Despite how the women felt in their own bodies, they pushed themselves to the point of exhaustion because they wanted to be mothers and to mother. The embodied nature of being a mother and caring for children and the embodied nature of mental health problems leave women in a constant state of struggle where their needs and

the needs of their children are balanced from hour to hour throughout the day.

Aisling sums this up:

*Aisling: 'I really don't know. I really, really don't know how. It was exhausting. Because to get out of the bed, in the morning, was exhausting. The thought of just getting up and facing another day was – I don't know how I managed to get through it ...I just felt I had, I just have to do everything like. I always wanted to be a Mum. It was determination in me. It was like I just, I'm going to do this'.*

The pain, anguish and emotional exhaustion associated with the distress is only one aspect of the distress experienced by the women above while other women described experiences that were unfamiliar and frightening. These experiences were outside their usual perceived realities and, using psychiatric language, are labelled 'hallucinations' and 'delusions'. For example, Rebecca, experienced voices which she describes as:

*Rebecca: 'Actually I was so scared I didn't understand what happened with me, the voices, so strange ... in television. I was so scared'.*

Orla explained her strange experiences as follows:

*Orla 'I thought that the house was bugged and that the guards were after me. I've never been in trouble with the law or anything. The guards were after me. I thought that my neighbours were against me. I was doing a course for my job and I felt the girls on the course were all against me. I just thought everyone was against me'.*

Some of the women actually lived in terror of their experiences. Deirdre describes:

*Deirdre: 'I would get feelings like the devil was after me or that I had to fight the devil on my own ... it felt like God was weak and ... me and maybe a few other people have to ... had to fight the devil sort of thing, on our own, you know'*

The sheer terror of these experiences had a huge effect on Deirdre's life. When she experienced thoughts about the devil she had to find a place of safety, and for Deirdre this meant going to bed.

*Deirdre: 'It was that I had a particular stage in the mental health that it took me to my bed and I didn't want to hardly look out above the duvet, you know, that sort of thing'.*

Constant checking and rechecking that their children were safe was the nightly reality for some women. Sinead, whose children are now fourteen and sixteen, describes this as follows:

*Sinead: ' Like a lot of nights there I would wake my husband up and I'd be crying, do you know, that there is someone trying to kill me or kill the kids or someone inside in*

*the house. I could get up and check on the kids four or five times every night. I'd go into their bedrooms to check that they are breathing ...Oh it's like an awful ... it's a horrible sensation ... like even you are walking but you can't really hear or feel your legs on the ground. It's awful, awful sensation and like I'd have awful nightmares. Most nights I would have awful nightmares. I would never be in the house on my own, never by night. I just think there is someone coming in and they're going to kill us'.*

The intensity and duration of these experiences varied from woman to woman. For some women their experiences were so relentless that they contemplated suicide. In their desperation some women such as Kay and Karen felt that suicide was a positive strategy and a better alternative for their families and the best option for their children.

*Kay: 'Yeah, oh it would be all over, wouldn't it be lovely. I do feel sometimes that they [her children] would be better off without me'.*

*Karen: 'I've felt like days I couldn't go through the day or would I be better standing on a bridge somewhere, do you know that way'.*

Eileen gives a vivid account of how she felt and thought when she contemplated suicide.

*Eileen: 'Terrible. It's what it [depression] is ... terrible. You're in a no-man's land. Okay it's not as bad as the psychotic thing but it's awful. It is quite awful and you want it to end. You'd do anything for it to end, which is why suicide becomes so compelling, because it's [depression] non-stop agony, mental agony. It's quite difficult to describe it you know, to pare it down to something explainable. It is an all-consuming, agonising place to be ... it was utterly logical in my head and I was absolutely convinced it was the biggest present I could give my family and my husband, was to not have me around anymore. So there was no consciousness in me that I would hurt them to bits. It was the opposite, I would be releasing them'.*

Eileen's words exemplify the thoughts and feelings of most of the women in this study. The women who contemplated suicide felt so desperate and distressed that suicide was seen as a way to ease the pain and agony for their families and themselves. They constantly struggled to do the right thing for their children and family and the mental anguish of needing release from the '*pain and agony*' placed enormous pressure on the women. The women described the internal dialogue they had while struggling in this way. On one hand, suicide would release their families, and yet something was stopping them from completing suicide. Eileen goes on to describe how she found the strength to choose life.

*Eileen: 'but there was some little voice, thank God, there was the tiniest, weakest, but nonetheless a little voice that was saying no, no, no, no, no, this is wrong, this is*

*wrong, you need help. And that day, going to the church, I said '[husband's name] please bring me home and get me help because I don't know how, I can't live for the next minute'.*

Nora and Lisa capture the complexity of their emotions, the responsibility they feel towards their children and how their children give them a reason to live.

*Nora: 'sometimes I feel like ... it's not worth living but when you ... when I see them [children] and ... things they do and all that stuff... I feel proud of myself and proud of them and ... but when I'm down, down, down ... it's like how I wish I didn't have any [children]. It's full of mixed feelings but in most times I usually say that I'm living because of them ... Yeah, the reason that I am living'.*

*Lisa: 'Well I suppose it's a reason for living. It gives me ... it's an unbelievable love ... I love her and she loves me and it's unconditional you know. I live for her you know ...well she's my saving grace, I live for that child and I think at times if I didn't have her would I have come out of the blackness in my life, the darkness. She was always my light at the end of the tunnel'.*

The women in this study described aspects of their distress that depleted their energy and left them struggling to survive on a daily basis. They describe a constant and unrelenting balancing act between competing forces: balancing the care for their children with their desire to leave their children, and balancing the desire to die with the will to live. For these women their children provided them with a powerful motivation to continue with their struggle, and the presence of their children meant that the women performed mothering. While suicide was considered as a means of escape from emotional and psychological pain through prioritising their children's needs over their own needs the women overcame their feelings of despair and took the chance that their mothering was 'good enough'. In pulling themselves back from the brink of death and choosing life over death the women demonstrated their strength, resilience and selflessness in making the decision to live for their children.

### **Mothering in context of childhood and adult experiences of trauma**

The experience of trauma is another context from which some women mothered their children. Many of the mothers had experienced childhood sexual, emotional and physical abuse, some women had experienced childhood bullying, and some women experienced domestic violence in adulthood. The effects of childhood abuse and trauma were still present in adulthood and the women were balancing the effects of trauma whilst they cared

for their children. These traumatic experiences shaped how women thought and felt about themselves, as women and mothers. Some women spoke about sexual abuse as children and how they had '*blocked out*' the abuse as a coping mechanism for many years.

Deirdre: *'And then our family suffered sexual abuse from the father ... I was even getting dreams of the father trying to get into the bed with me and that, you know'*

Allison: *'My younger sister and I had been sexually abused by a neighbour ...and my father was sexually abusive to me and I had blocked that out'*

Niamh described how she had never been '*brave*' enough to deal with her sexual abuse; however with the support of [names a peer support group] she was able to address it.

Niamh: *'During the course of that [counselling] then issues of sexual abuse came up, because it was something I always knew was there but had never been kind of ... I don't know ... brave enough to actually address it or whatever ... so it ended up with my having a breakdown and at that point then I ... I found [names a peer support group] and started going to the meetings and stuff and I really felt like it was ... though I suppose crucial in a sense where I had the support of other people who knew what I was going'*

Some women had experienced aggression and violence in the home when they were children.

Carol: *'Shouting and roaring and bawling and oh for God's sake you know so'*

Joan: *'You can't ... your parents ... some parents you know ... you can't trust your parents if they're abusers'*

Grace: *'well first of all there was my father's drinking and the violence'*

Other women spoke about more subtle types of abuse. For example, Ita describes feelings of being '*not loved*' as a child and the effects this had on her growing up:

Ita: *'I would never have experienced a feeling of someone actually loving me for who I was and that's not saying that my parents didn't but that generation were never very affectionate because they were never allowed to show affection and I would have found it awful hard to have ever felt any emotion'*

Sinead describes the psychological and emotional fear (her father might complete suicide) that she and her siblings experienced on a regular basis as a child.

Sinead: *'He'd [her father] like leave a pathway down for us and there might be a little bit of clothing here or like he'd say oh I'll drink [names the poison] and the half bottle would be left there. You'd kind of go Jesus ... he's gone this far, no he didn't take it this far, or I remember my sisters one time he tied the cord of one of those lamps outside in an old house, he tied it around his neck and we'd stand ... will he take it,*



*will he pull it or will he not pull it, do you know'.*

Some women were bullied at school. As described by Anna, this bullying ranged from name calling to having her hair set on fire.

*Anna: 'I was bullied at school ... remember that very very clearly, teased and bullied and names were called, and I was coming out of my grandmother's house one day and she [a classmate] was hiding in the bush and I had long hair when I was little... very long hair... and she set fire to my hair'*

Having experienced abuse in childhood, some women found themselves once again in abusive relationships as adults.

*Una: 'I think it was just I had an unhappy childhood and I'd been through a difficult relationship and I ... I mean a victim of domestic violence'*

The experiences of abuse impacted profoundly on the women. Ita's husband who was aggressive towards her and also violent towards their children, describes her experiences and how this impacted on their family life.

*Ita: 'but he [husband] would get very aggressive s and he would get uncontrollable and he would literally wallop the lads. It could be the big fist down on the back, you know. It would be the roaring and shouting in the house , it would be unreal and it scarred all my family like. They [children] are all scarred. The children are all scarred by that, yeah. I don't know ... the two oldest lads couldn't get away to England fast enough. The oldest lad I can see ... I can see a good few changes in my oldest son since he got married and has his own daughter but ... he would hate [husband's name] deeply.*

Women acknowledged how their own experiences of abuse and trauma influenced how they then went on to mother. This group of women felt that they now had the opportunity to learn from their childhood and made conscious decisions to mother their children in a different way. Maria who experienced sexual abuse as a child, has two children, describes how she is 'over protective' especially towards her daughter. She is vigilant inside and outside the home.

*Maria: 'I'm very over-protective with my children. I suppose too over-protective, even when they were younger .... I used to follow them round the house, what are you doing, what are you doing... where are you going... who with ... and do I know them ... and, you know. I'd even take them to school, even though they didn't want me to take them to school but I'll take you to school ... And like, my daughter when she had a bath, I'd stand outside the bathroom so nobody would go in'.*

Sue expressed similar fears and her need to protect her son. One strategy she used was to

become the sole carer for her son, to the degree that she refused to let her husband take care of him. Eventually this led to Sue becoming exhausted and being admitted to hospital.

*Sue: 'and I think that was mainly the part of things that happened with me because I didn't want no-one near [names son], do you know. I was just really worried that somebody was going to hurt him'*

Lisa's childhood experiences influenced her decision to become a single mother and raise her children on her own, as she felt that it was important her children did not experience what she had experienced.

*Lisa: 'It's all I ever knew as a child, shouting and screaming all the time and I lived in a loveless house, and that's why I reared my children on my own. I said I would rather they'd be with me and have the love of ... rather than living with two parents that fucking hate one another like, and they're just killing one another all the time. I mean I can remember my mother having black eyes and everything and me being so angry ... why are you fucking putting up with like'.*

Niamh felt alone and unsupported growing up. Now with two children of her own, she makes a conscious decision to spend time with her children and to listen to their concerns.

*Niamh: 'I've always put them first. It's the most important thing to me this is ... making sure that they get a good start in life and then I'm always saying to them look I'm trying my best, I'm always going to do my best ... I know myself like that whatever mistakes I have made, I'm quite willing to sit down with them and work through that with them ... because I got such a bad start myself ... I wanted to make sure that like I did it right with my kids'.*

Carol also voiced a similar wish to make things better for her children and to create a 'safe' place for them:

*Carol: 'I think [husband's name] and myself we have provided a warm safe home, safe environment, because my father was an alcoholic and all I remember [as a child] is shouting and roaring and bawling and oh for God's sake you know so... feeling safe is very important for me and for my children'.*

The women in this study attempted to correct their childhood experiences and felt strongly that they as mothers needed to protect their children. All these stories highlight these women's concerns for their children and challenge the dominant discourse of 'bad mothering' ascribed to mothers experiencing MHPs. This dominant discourse focuses on possible risks to children (Rutter and Quinton 1984; Stott et al. 1984; Silverman 1989, Apfel and Handel 1993; Kinsella and Anderson 1996; Garley et al. 1997; Oyserman et al. 2000; Mowbray et al. 2002), thus ignoring the positive aspects that this group of women can bring to their mothering role. Despite their pain and distress their main worries were not for

themselves but how they could protect their children. As a result of their own experiences, the women were aware of possible risks to the children and because of their heightened awareness took steps to minimise risks to their children.

When women later went on to experience mental distress as adults, as described above, they were not asked about their childhood experiences by mental health professionals (discussed in more detail in Chapter 7). In many cases the primary and only response was prescribed medication, which added to their difficulties.

### **Mothering under 'relations of ruling'**

This section explores the particular 'relations of ruling' under which this group of women were mothering, and which strongly influenced the way they mothered. Relations of ruling refers to the organisational processes that control, regulate and inform various institutions such as health and social organisations and includes discourses, scientific, technical, and cultural, that intersect and coordinate how society functions in particular ways (Smith, 1987). The relations of ruling for these women included; expert opinion, comparison, stigma and fear

***Mothering as influenced by expert opinion:*** The women, in their description of mothering, put forward their understanding of mothering as natural and all consuming. However, they also described their need to consult experts who, as the literature suggests (see chapter Three), are so often the source of promulgating mothering as 'natural'. Experts in the area of medicine and psychology suggest to mothers that there is a 'right' way to mother (Thurer 1994; Douglas and Michaels 2004) and that mothers should consult experts for advice so that they learn how to mother (Hays 1994; O'Reilly 2004). Many women consult text books and media and this group of women were no different. However, the fear that they will be deemed 'unfit' was palpable for this group of women and many felt they were commencing motherhood 'under question', therefore it is not surprising that they felt the need to consult and take the advice of these experts even before they became pregnant.

Most of the women, but especially those women who experienced mental health problems and had been given a diagnosis of mental illness prior to pregnancy, knew they were already

marginalised and seen as 'other'. Consequently, they thought carefully about whether or not to have children and consulted 'experts' such as psychiatrists and doctors prior to becoming pregnant. These women recounted numerous episodes of being questioned about their decision to have children, the implication being that somehow they were not suitable as mothers or would not be competent as mothers. Thus their experiences with health care practitioners served to reinforce the dominant script that women who experience mental health issues are 'less than perfect mothers'. Louise consulted her psychiatrist for advice about having a child. The response from her psychiatrist not only demonstrates the authoritarian and paternalistic attitude but the powerful position of some doctors in controlling women's reproduction.

*Louise: 'and I said to her [psychiatrist] you know we're ready to start a family ... 'no way', 'no way', she said, 'you need to be well for at least five years before I'd even consider allowing you to'.*

Louise was fortunate that soon after this her psychiatrist retired. When she consulted her new psychiatrist the response was completely different, highlighting the lottery nature of care and advice women receive within mental health services. As Louise described:

*Louise: 'Then in the meantime the psychiatrist was due to retire, so she retired and we got a new psychiatrist on board, who was actually a male psychiatrist and he just seemed to be really, really up to date and very kind of you know ... he thought this was a great idea, that there was no reason at all why I couldn't get pregnant'*

Allison, a thirty-eight-year-old mother of three children, wanted to have another child. Her doctor's response demonstrates the negative attitude towards women who want to become pregnant and reduce their medication. It also once again highlights the powerful position of medicine in controlling women's reproduction.

*Allison: 'I spoke with my GP again last September about it. He entertained me for a little while and we started reducing and cutting out various medications. When I went back a month later to pursue this reduction, he told me I need another one [child] like a hole in the head [laughs]'.*

Carmel, who had been in contact with the mental health services for four years (from the age of fourteen) became pregnant when she was eighteen years old. She did not consult the experts about her intention to become pregnant and when she informed her doctor the response was as follows:

*Carmel: 'nobody should say that you can't reproduce because you're mentally incapacitated which you know has been suggested to me ... and when I got pregnant'*

*some of the medical doctors suggested I terminate it because I was bipolar ... you know'.*

As a result of this reaction Carmel stopped attending the psychiatrist and moved to a different part of the country. She subsequently received support from a social worker and sought alternative ways to maintain her mental health during and following pregnancy.

For many of the women this negative reaction of the medical profession led them to a hyper vigilance during pregnancy and throughout motherhood. Many of the women internalised this negative and questioning view of themselves. Consequently they described attending parenting courses in the hope of rectifying 'some deficit' that they believed they had. Louise described:

*Louise: '[I] would have done a parenting course, this is how paranoid I was about my own parenting, and when I found out I was pregnant (I hadn't even had them [children] yet) I did a parenting course so that I would be the perfect'*

Eleanor who experienced mental health problems following the birth of her first daughter explained:

*Eleanor: 'After what happened [Eleanor developed MHPs] with my daughter, I actually went off and did a parenting course'.*

The balance between maintaining present wellness with the possibility of future ill-health and their desire to have another child needed careful consideration for many of the women who had experienced mental health problems prior to pregnancy. Emer experienced mental health problems following the birth of her son over nine years previously and had ongoing mental health problems. She would like to have another child but worried constantly about the possible risks to her baby (because of medication) and the risks to her mental health should she stop the medication. It also highlights the vulnerable position of these women as they have to 'trust' the expert. This is another example of how women experiencing mental health problems need to carefully consider their position as mothers. Emer described her situation as:

*Emer: 'We [psychiatrist] had this long in-depth conversation about it [pregnancy and medication] and of course the one [medication] that would be safe would stop fertility, so there wouldn't be any end goal . But what he suggested would be that the minute you become pregnant you switch to the safer anti-psychotics so hopefully ... all I can do is take his advice ... You would be worried about it you know because I was very ... I was very worried about the thought of becoming pregnant, what if I*

*was taking medication ... I was so lucky [not to have caused harm to the foetus] the first time around that I wasn't on medication'.*

Linda, in describing her reasons for making the decision not to have another child, exemplifies many of the struggles and worries of the women in the study, including concerns for the foetus, partners, and their own mental health. Linda also spoke of how the fear of surveillance by health care practitioners influenced her decision.

*Linda: 'I wouldn't enjoy my pregnancy because I'd be feeling that I'd be watched all the time. I get that feeling. Also I'll be thirty six tomorrow ... I think my age as well. I'd be worried that there would be something wrong, and if there was something wrong I'd be worried that I wouldn't be able to cope. My boy is happy and healthy and I'd rather just stick with the one. I think my husband ... he feels the same too you know. I mean there's times, he jokes oh a little brother or sister but ... no. I don't think he could go through it [mental health problems] again either to be honest. It was very tough on him you know'.*

In addition to the usual considerations of age and ability to cope with another child (issues common to most women contemplating pregnancy) women who experience MHPs have other issues to consider. Linda's comments highlight again the balancing act that women who experience mental health problems have to negotiate. For example, Linda feels under surveillance because of her MHPs. She also needs to consider the effect another pregnancy may have on her mental health, the effect on her husband and possible effects of medication on the baby.

As said, there is an extensive amount of advice available to mothers with the central message from the experts being that there is a correct way to mother. Therefore, in an attempt to prove their abilities as mothers to themselves and others, the women also consulted books about childrearing to reassure themselves that they were doing it right. The hope was that 'experts' might help them ensure that mothering was done 'properly'.

*Niamh: 'I take my role very seriously as a parent ... like I've read books on parenting'.*

*Allison: 'I bought the Great Ormond Street Book of Baby and Childcare before [child's name] was born and read it cover to cover'*

Expert opinion also extended to television programmes as a way of women reassuring themselves that they were prepared for mothering.

*Lisa: 'things like Nanny 911 or that Jo Frost ... you know'*

The women in this study thought carefully about becoming mothers, they prepared for motherhood and wanted to be in a position where their mothering abilities would not be questioned.

***Mothering as a source of comparison:*** The women in this study also covertly consulted other mothers, by comparing themselves to what other women were perceived to be doing. They expected, idealistically, to have the time and the energy to provide the kind of mothering they had envisaged. They expected to be involved in all aspects of their children's lives and when this was not possible they berated themselves for not being able to achieve it and compared themselves to other mothers who appeared to achieve this mothering effortlessly. When the women did not live up to their own expectations and to the expectations of 'ideal' motherhood they experienced guilt, anxiety and frustration.

The women spoke of comparing themselves to other mothers and again came up, in their own eyes, as less than ideal. As stated earlier, some women have internalised the idea that mothering with mental health problems means 'failing' in ideal motherhood. For example, Kay explains how this pressure worked in the context of other mothers:

*Kay: 'it's just down at the school you hear these Mums saying oh we baked yesterday ... and if [child's name] goes on a play date she comes home and we made this, and you know I'm like Jesus I don't know how. When I have somebody [child's friend] over here it's like I'm in a sweat trying to think what can I do to entertain them, and I still have to get the dinner on ... So I think some of it comes from other mothers and trying to keep up with them [other mothers]'.*

Jill gave some insight into her struggle as she talked of the 'earth mothers':

*Jill: 'you know these mother earth types ... you meet the ones that ... you know the children are angels and ... they have this fantastic relationship with their children'.*

Women also had the expectation that they should look and dress in a certain way and consequently compared themselves to other women in this regard. Once again, this placed added pressure on women and was viewed as another aspect of life in which they did not measure up to the ideal.

*Bridget: 'You see some of the Mums who are dropping the kids off at the school, they'd [other mothers] be all dressed ... how do they have the time, makeup, how do they have the time to do that because I haven't got the time to do that'.*

In these examples women are beginning to question the notion of ideal mothering, however, they are in a position where it may not be safe for them to do so. Even though

they recognise the impossibility of ideal motherhood they are conscious that they may not have the power to step outside this position.

**Mothering in the context of stigma:** The women were conscious of the negative attitudes in Irish society around mental health and were aware that the price of being open and honest in relation to mental health problems is high. All the women interviewed spoke of concerns about being stigmatised because of their mental health problems. The women's concern about stigma was not an isolated event. Their concerns began with their first interaction with the mental health services in relation to their diagnosis, their pregnancy, and when their children were born. Wilson and Crowe (2009) found that the stigma associated with a psychiatric diagnosis was enhanced by also being a parent. As suggested by Davies and Allen (2007), 'women who are mothers and users of the mental health services face particular challenges of identity management because of the inherent tension between the societal ideals around the 'good mother' and social norms associated with mental illness' (p.369). This point is reflected in Julie's observation on her experiences.

*Julie: 'I just I think society in general and not only with ... medication but also with counselling I think it's kind of the same thing where you know, oh my goodness, if you need to go on medication or if you need to see a counsellor then there is something definitely wrong and I just ... I hate that people think that way. I really, really do because I think it discourages people from ... getting the help that they need, I think it creates kind of stigma as well you know where if you need to resort to medication or counselling then you obviously can't handle it yourself. I think there's a huge ... I think it's societal definitely.'*

Julie's experience of stigma is reported in the literature. Diaz-Caneja (2004) reported that women's distress was exacerbated by having to hide their difficulties and not being able to discuss them openly. Aisling highlighted how stigma prevented her from going out and developing social contacts, and described her fear of being viewed differently.

*Aisling: 'Yes, definitely, I mean you do because it's [depression] not what you want for yourself ... and sometimes you are afraid in case people think differently of you because you are suffering with depression.'*

Ackerson (2003) suggested that the fear of stigma made women more reluctant to seek help. In the following account Orla described her reluctance to seek help and also her fear of being treated differently by her neighbours because of her mental health problems.



Orla: *'It was terrible going in [to psychiatric hospital], so it was. Like, I was afraid to go in. Well that was ignorance as well now, so it was. I was actually afraid to go in because I thought I'd never get back out of it again. You see there is a stigma to it. There is an awful stigma to it. People are ignorant. Even my neighbours, I didn't want my neighbours to know because ... they all do be together talking as well like, oh my God, she was in [name of psychiatric hospital], you know, I've heard them, I've heard them about other people and there is an awful stigma to it and that's why I didn't want them to know'.*

Some women spoke to close friends about their mental health problems but were still wary of being totally open. It was also suggested by the women that some mental health problems, such as postnatal depression are acceptable in Irish society; however, others, such as psychosis are not, as Emer sets out in the following:

Emer: *'I suppose I have been fairly open in the last number of years because you got to the stage where you're hiding, hiding, hiding and you think, you know that way, people will accept you or they should accept you for you who you are, rather than what you endure, and then you sort of think well ... if ... that people's misconceptions about mental health difficulties will never actually go away unless people stand up and be proactive and say well actually, yeah, I was one of those. Now at first there would only have been ... immediate family ... and then one or two close friends. There would have been my friends, the two GPs and then two friends of mine who I had grown up with and who I had known right through childhood, teenage years, stuff like that, and that would have been it. And then, I suppose as you become more used to living with it [mental health problems] or whatever you just sort of say, oh sod it. So now if the question comes up I would say 'yes I was ill' or whatever you know. Now I would probably never really go into the whole psychotic part of it. I would probably let people think it was post-natal depression or something because I think if you mention the other thing[psychosis] they would go running, you'd see dust where they were standing'.*

For some women speaking of their mental health problems was not a positive experience and led to further isolation. Rebecca described her experiences as follows:

Rebecca: *'Yes ... yes ... but just now I am ready to talk about it. Before that I was ... scar y... because of my illness. One friend knows about me and she stopped communicating with me after she knows about my illness, she stopped talking with me, and I was afraid my other friends would do the same'.*

For Jennifer, her fear of stigma means she cannot be open with one of her close friends.

Jennifer: *'Yeah, yeah, there's a huge stigma ... We [friend] have a very open relationship about everything else but I can't share that piece of information [mental health problem] with her. She would take a very dim view of it'.*

While the women wanted to be open about their mental health problems they expressed concern that they and their children might be treated differently and were concerned how possible stigma might impact on their children. The women were clear

that one of their responsibilities as mothers was to protect their children from stigma and consequently they went to great lengths to conceal their mental health problems and worried that their mental health problems would be uncovered and that their children would be treated differently. Therefore, while the women may have wanted to be open and honest, they had to balance openness with the risk of negative impact on their children. Eileen, Carmel, and Jane give examples of their thought process in relation to this:

Eileen: *'It is and so people could say like ... [husband's name] could say she's in [name] hospital and nobody would necessarily think ... because he was worried about [daughter's name], about somebody in school saying to her, your Mammy's mad or you know whatever'*.

Carmel: *'like I mean I'm very open, I'll say to people that I am bipolar, but I am also very conscious that I don't want people to start treating my daughter differently. So that's why in the community I keep it very quiet because you know, kids are cruel'*.

Jane: *'I said to him [son] ... please don't say anything ... It's probably me being extra vigilant ... but I just felt that I just don't want him[son] to be taunted about me, and I probably don't want the embarrassment of thinking that that's happening as well. I want my son to have the best'*.

Living in a small rural community, where very little can be kept secret, posed added challenges for some women. Grainne and Carol highlight some of the issues.

Grainne: *'Well it's obviously a bit of a stigma for him [her son] but ... you know everybody knows in my village that I'm a psycho ... I'm not the only one, plenty of them, but like you know ... he [her son] sees ... humour'*

Carol: *'I think people still view me differently actually. When I say something now I think people might say sometimes 'is she alright like' you know, and I think it is because I am so different. The people that know me all my life [and] can see that difference and they think that's my mental health when in actual fact it's the true me they see now'*.

Women also experienced stigma in their interactions with healthcare professionals. Noelle found that the midwife did not show any understanding of her distress when she was in the maternity hospital.

Noelle: *'Yeah. I know that I had a really ... bad time a couple of days after (which every woman does apparently, they say) and I was in bits. I was crying, couldn't stop, couldn't get out of the bed, couldn't do nothing and two nurses come in and closed the curtain and all, come around and walked away'*.

Emer, having experienced a 'psychotic' episode following the birth of her son, attended a parenting course run by a nurse, where she experienced the negative reaction and language of the nurse facilitator.

*Emer: 'I remember [son's name] was five or six months old I started my first course and it was a registered nurse who was doing the course and I remember being so annoyed after the first three sessions because she kept on using the word psychotic. Everything to her was psychotic and people were psychotic and this was psychotic and that was psychotic. She was using it in a lay term but ... talking about this person psychotic or different instances were psychotic. But I remember she was saying so you all know what psychotic means ... it means mad and it means this and it means mad ... and I was thinking I'm really going to dislike you [laughs]. So that was really my first incident with it [stigma]. So after the class I went up to her and said can I have a word with you for a minute, and she said yes you can. I said I really have a huge issue with you using the word psychotic all the time. I said I have just ... my baby is five months old and I unfortunately did experience a psychotic episode ... and she was standing taking ten steps back. It was funny actually to see her reaction. She looked surprised because she would have thought of me as being a successful young mother and you know ... she was very negative towards anybody with mental health difficulties. In her mind it just didn't happen or it was the person's fault that it happened or ... she just seemed to have that mindset which I was surprised ... I was surprised that someone with a nursing background not having any understanding [of mental health problems]'*

Other women, who were in paid employment, were worried about how their employers might react to their MHPs and on how having MHPs might affect their chances of promotion.

*Eileen: 'Very definitely there is still a huge stigma about mental illness. I would be certain that you wouldn't have a hope of promotion if it were know that you had mental illness. People are afraid of it Teresa'*

*Orla: 'I thought, I'm going to lose my job with the [names the organisation], if they ever found out, I'll lose my job. I'll never be taken back on again and I would have had all that worry like you know'*

*Jane: 'when I was depressed I felt so bad that I actually handed in my notice in my job. Now, in hindsight, I should have told my employer that I was sick but I was again so ashamed of it that I handed in a perfectly fine job.'*

The negative attitudes are not just held by employers, neighbours and health professionals but are also part of the family script. For example, Fiona who lived with MHPs all her life got married late in life and had one daughter, recounts her husband's prejudice towards people with MHPS.

Fiona: *'like I'd see people on the street and [husband's name] would say they're not right you know or they're not well or not that they're not well, I would see people would not be well alright but he'd say they're three sheets in the wind you know and I wouldn't notice any different with them, I'd accept them'.*

As children got older and their awareness of mental health issues increased, the women worried about the reaction of their children if they found out that their mother experienced mental health problems. Jean expresses her dilemma as follows:

Jean: *'Well I am also listening now because they [her children] have all these traditional bits and pieces about depression and about people being mad and 'oh they are not right in the head', they [her children] have all bought into this since they went into secondary school and every so often I think to myself what are they [her children] going to do when they find out Mum is in this category.'*

Hinshaw (2005) argues that mental illness continues to be engulfed by stereotype, prejudice, and stigma, promoting shame and silence and 'perpetuating a vicious cycle of ignorance, distancing, and punitive societal responses' (p.714), thus stigma became another context from which the women negotiated their mothering role. Being diagnosed with 'mental illness' left the women in this study feeling excluded from the in-group of ideal mothers. The women were reluctant to be too open about their mental health status because of the need for privacy and the fear of others' reactions to their mental 'illness' and their children. The women, therefore in their performance of mothering and in an attempt to protect their children revealed a limited self to the world in the hope that the self revealed will fit within the normative notion of the 'ideal mother'. The women also pushed themselves to the limit (as they felt they could not let their guard down and that they had to be 'perfect') in an effort to diffuse the stigma attached to their mental 'illness'.

### **Mothering in the context of fearing that children would be taken into care:**

As discussed, the women strove to conform to social expectations of what comprised a 'good' mother; however, underlying the need to conform to the outward appearance of the good mother was a deep fear and anxiety that their children would be taken into care. The women in this study were acutely aware that they might not be doing it 'right' and, as a consequence, would be judged 'unfit' and 'incompetent' as mothers, which held the potential that their children would be removed from their care. This fear formed a backdrop to their lives and constantly influenced their decisions around seeking help for

their mental health problems. Many women considered going to their GP as the first place to get help; however, their fear resulted in them deferring help seeking. Sue explains:

*Sue: 'Oh I was petrified ... and you see the thing was I knew that there was something wrong. I was saying I'm going mad here, and then I was afraid thinking sure if they [health services] think I'm going mad they're going to take the baby you know. I was convinced then that they were going to take [child's name] off me you know ,so I think I could have maybe went to the GP sooner but that was the fear I had, that someone would take the baby you know like and ... there was no reassurance that nobody was going to take him'.*

Sinead had a similar fear of losing her children and also worried what might happen to her if she sought help and support.

*Sinead: 'I would just be afraid that if you went into the doctor's and you were like telling them that you had this ... I'd say the Social Services would be in here, and like you'd be an unfit mother, and then I think there is not a hope I could live like that. I definitely know then that would be the last anyone would see of me if I thought my kids would be taken off me'.*

As a nineteen year old single mother, with her first child, Eleanor had a difficult experience with health services and felt that she was being watched by them.

*Eleanor: 'Yeah. I couldn't look to anybody for nothing and the district nurses are watching you. It's not like I had a child before and I did something. I never had a child. I never did anything to my children but they still made me feel like I wasn't to be trusted'.*

Eleanor went on to have four children and felt that services had not improved in the twenty years since having her first child, as she explains:

*Eleanor: Oh it's horrible and I can see a lot of women don't tell anyone they've got post-natal depression because there's no sympathy for it ... a district nurse ... they get social workers down and when you think of social workers you think are they going to take my children. They are going to be watching me constantly. Nobody trusts me. They think I beat my kids up. The only person we beat up is ourselves. We don't touch our kids'.*

This fear led to women keeping their distress hidden from public view and to 'mask symptoms' when interacting with health care professionals (Montgomery et al. 2006). The constant worry of loss of custody added to the deep distress they were already experiencing.

*Kay: 'It was very very stressful, yeah. I remember like feeling very exposed, very vulnerable and I was always fearful that the children would be taken away from me'*

Karen also worried that if she ever separated from her husband she would

automatically lose her children. The fear permeated all of her life.

*Karen: 'Sometimes ... I used to always have this fear and like [husband's name] would ... if me and him separated ... I used to fear I would lose the wains because I ... do you know ... I attend a doctor [psychiatrist] and he's [husband] sane, do you know that way'*

In desperation some women sought help even though they worried about how this might affect their role as mother.

*Sue: 'Because I had a hard time after [son's name] was born and I was in hospital for a long time and I felt that I didn't benefit very much from what they were giving to me and I was worried in case somebody would take the child off me. That they'd think I wouldn't be able to look after him so'*

*Louise: 'I felt the pressure was even more so, do you know what I mean, really, really more so you know that I put myself under. It's a wonder that I did it without being hospitalized from the amount of pressure. I was afraid that if they came in and kind of thought that I wasn't coping they might take the children.'*

When Kay was expecting her third child the fear was still there and prevented her from accepting help.

*Kay: 'and I ended up talking to one of the nurses and she was saying we have a social worker here, would you like to talk to her and I remember ... no actually it was at my twelve week scan they offered me to talk to a social worker and to me social worker was they're going to take my kids away because they'll realise how stupid I am you know how mad and crazy I am but I said no, no. I refused. I didn't want to talk to a social worker because if they got involved they probably would take them'*

Seeking support from family was one way to minimise contact with services and help ensure the role of mother.

*Karen: 'Like if I hadn't had [husband's name] and Mammy and [friend's name] as well – I don't know where I would be. I don't know ... there's not enough ... you don't know where to turn like, do you know what I mean, you don't know who to contact because ... you're afraid if someone takes your children off you'*

Most studies exploring mothering in the context of mental distress report that the fear of custody loss 'permeated all they had to say' (Bassett et al. 1999; Ackerson 2003). The women in this study were no different as they described their fear that their children would be taken into care, highlighting their awareness that they are viewed, by the health services, as less than perfect. The effects of stigma were internalised by this group of women and as a result they felt they could not ask for help, without risking being seen as unfit mothers. Consequently to protect both themselves and their children they masked their distress, and kept quiet. This was an added stressor that they had to find the resources to cope with.

## **Mothering in the context of children being taken into care**

For seven women loss of custody became a reality. The women were utterly devastated by the loss of their children and felt their role of mother was completely invisible even though they were still mothers and had a significant part to play in their children's lives. Allison clearly described her loss and grief in this situation:

*Allison: 'I remember coming back into the house and the silence was ... the silence would hit me. I remember there was one time I was crying but the noise I was making ... I can't actually describe the noise, it was actually frightening to me you know I was that upset. I used to sleep with their pyjama tops and stuff like that'.*

In addition to the devastating emotional feelings of loss and grief, there is also a loss of structure and function of day to day life, and going from being a full-time mother to an 'absent mother' was very difficult for the women. Vera describes how her life changed when her daughter was taken into care:

*Vera: 'When you lose your child ...like I lost my role, I lost the school, I lost the activities, I lost the mothers, I lost everything. It was terrible like you kind of just end up sitting around ... isolated ... more isolated you know'.*

Coping with the 'absence presence' of children was a severe emotional struggle for the women as their role as mother had to be re-negotiated; children were no longer physically present; however, they were emotionally present. Photographs of children become important reminders of the women's position as a mother. The absence of the children also became another major distress, as the women worried constantly about the impact of separation on their children. Una described her experiences as follows:

*Una: 'but I love him to bits like you know. I've photographs everywhere and I can't let nobody touch them. They can't be moved either. In the sitting-room and, up there [pointing to the shelves in the room] ... He's nine now he'll be ten next month but he's ... a good kid you know but it had an awful impact on [child's name] life too. It did affect him, being taken away from his Mam'.*

Vera had two children taken into foster care and has weekly contact with her younger daughter who is now sixteen years old. Her older first daughter is now in her thirties and Vera has no contact with her. Vera had no control over this as it was her daughter's decision not to see her again.

*Vera: 'I don't know where she [adult daughter] is living. I don't know where she is working. I don't know what she looks like. I might as well never have*

*had her... well that's not true but you know what I mean ... but I have had ... I've seen her occasionally in the past but not now with a long time. I've seen her in a supermarket and a few things like that you know but ... so I don't know what her situation is but ... like they're always your children like ... you know what I mean'.*

Vera's second daughter is now sixteen years old and Vera does her best to stay in contact on a weekly basis and saves her money to buy things for her. However, Vera is fearful that as her daughter develops interests and friends and becomes more connected with her foster family her connection will gradually get weaker. Vera is also worried about the effect of the separation on her younger daughter.

*Vera: 'It's only now she's beginning to open up. She kept it all sealed up for a long, long time'.*

In situations where women have lost custody, regaining custody and access became the focus of the women's lives. They spent their time seeing social workers, attending family court and striving to regain access to their children. If successful in getting access they once again entered a world where their mothering came under very close scrutiny and surveillance. For example, when Una has access to her son she has to account for what she did with him during that time. As she described:

*Una: 'Then I have to fill out activity sheets, what I'd do if I had him ... say I do art with him there for ten minutes, I had to write all that in and ... I have to do it like because the social worker refers to that you see, so I have to do it you know'.*

The narrative of women with mental health problems being a risk to their children is so pervasive that some of the women had internalised that belief. For example, Annette who sought help with her distress has internalised this notion of 'risky mother' and now agrees that she could never be on her own with her child.

*Annette: 'No, not on my own. I could never be on my own like you know ... not with the baby. They thought I was a risk ... like I was high risk like all the time, because I had been suicidal like going in there, because I did have these thoughts and you know. I thought that just by telling them that you know they could do something for me'*

Women whose children are in care spend time everyday thinking about their children and want their children back. Some women want counselling to help them deal with the loss of their children and their accompanying grief. Other women internalised the risk discourse and viewed themselves as unacceptable mothers.



## Summary

The reality of everyday motherhood as experienced by this group of women is made up of related parts that all intermingle to create a description of their mothering experience. These include personal factors, contextual factors, strongly held beliefs about motherhood and mental distress, and the impact that these beliefs have on how they 'do' mothering on a day to day basis. The women in this study accepted that there are societal expectations of how women should mother. These expectations are strongly influenced by the patriarchal construction of motherhood and this group of women constantly struggle to meet with the demands of idealised mothering. A central tenet of this ideology is being available to your children. The identity of mother is central to the women's self-identity therefore the needs of the women and the needs of their children were deeply entwined. The relations of ruling (in this instance health and social services) and the powerful processes stemming from the ideologies of patriarchal motherhood and mental 'illness' meant that this group of women had a deep understanding of how this ruling apparatus placed them in a particular position in society. They internalised these views this is evidenced through; their preparations for motherhood, turning to 'experts', professionals, books and media for guidance. They spoke of making comparisons as a means of assessing whether they were doing the mothering 'right'.

Whilst all the women did not have the same circumstances, two overall factors from all their accounts were the existence of a mental health problem and the resulting experience of stigma. This label of 'mental illness' framed their lives and powerfully framed how they viewed themselves and how they felt they were viewed by others. This is clearly seen in the experiences of women whose children are in care and also by the fear expressed by all women in the study of the possibility that their children could be taken into care. Their understanding of mothering as natural, labour intensive and all consuming left them with little reserves when they experienced mental distress. Many women in this study experienced trauma in their own lives and these experiences meant that women were aware of the possible trauma for their children and they drew on their experiences to protect their children. In the contexts of mental distress, trauma, and stigma they struggled

to live up to their ideals of acceptable mothering and found ways of coping with their distress that had minimal effect on their children (this will be discussed in chapter seven).

As their distress increased their mothering decreased to the point where some of the women questioned their value as a mother and in their distress questioned whether their children might be better off without them. For some suicide was contemplated as being better for their children. While suicide was considered as a means of escape from emotional and psychological pain through prioritising their children needs over their own needs the women overcame their feelings of despair and took the chance that their mothering was 'good enough'. The women's concern, interactions and desire to protect their children not only demonstrates their constant struggle to be 'good enough' mothers, but clearly demonstrates these women's deep connection with their children and highlights how their lives revolve around ensuring their children's wellbeing.

The next chapter will explore the challenges women face in mothering in the context of mental distress and accessing help for their distress so that they could continue to mother their children, and their experience of the services received.

## **Chapter Seven: Interface between women and ‘professional’ services: ‘relations of ruling’ and resistance;**

### **Introduction**

The previous chapter highlighted the women’s reluctance to seek professional help for fear of being judged. This, the final chapter of findings, will explore the experiences of women as they engage with the ‘formal’ professional mental health services. The women’s experiences will be discussed in the context of relations of ruling and their experiences of being oppressed by the services as well as their growing dissatisfaction and resistance to the patriarchal motherhood and biomedical discourses. As discussed in Chapter Four resistance occurs when oppressed groups challenge and act against aspects of dominant discourses (Scott 1990). The findings in this chapter discuss how women began to demonstrate resistance in various ways. Oppression can be defined as the asymmetric power relations that exist in society, where individuals or groups of people are treated differently because of their marginalised position (Allen 2008). These asymmetric power relations between individuals, genders, classes and racial groups lead to misery, inequality, exploitation, marginalisation and social injustices. Drawing on the women’s accounts of their experiences I suggest that current mental health services are oppressive to this group of women because it eroded their sense of themselves as mothers and also there is no alternative to in-patient hospitalisation, at times of extreme mental distress, in Ireland. In addition, in the majority of situations it served to remove their mother identity or reinforce women’s sense of being a ‘poor mother’. A feminist standpoint approach examines the social location and relation of ruling of marginalised women thus uncovering knowledge of the world that is different from and challenges the existing androcentric knowledge. To explore relations of ruling it is necessary to begin inquiry of women’s experiences from their standpoint and to uncover how this standpoint is shaped by larger social and political relations.

As women engaged with the in-patient mental health services they were seen primarily as a ‘person with a mental illness’, a view that is at odds with the far more complex understandings of how the women as mothers viewed themselves. This change in emphasis from role of mother to role of ‘patient’ was forced on them by health care professionals and services, and was a transition women found difficult. While some women had the support of community mental health nurses (CMHNs) who enabled women to see that both identities

of mother and 'patient' could co-exist and were of equal importance, for the most part women's status as mothers only became of interest to services and health care professionals in relation to the possibility of perceived risk to children. Women initially accepted the biomedical explanations and polarisation of identity, they gradually began to question and resist through engaging in strategies to maintain and regain their cherished role as mother, or at least to balance the two roles. Firstly through mothering in the context of mental distress: hiding distress, managing time and planning ahead. Secondly through seeking other supports such as partners, family members, and community; questioning the medical model in relation to mental health/ill-health; and finding and meeting their own needs through counselling and personal development.

### **Encountering hospitalisation and being the person with a 'mental illness'**

When women could no longer deal with their mental pain and distress they sought help from the mental health services. The help offered often was hospitalisation, which meant that the women were removed from their children and their role as mother. Some women were hopeful that hospital might bring some relief from their distress and acknowledged that they needed to take care of themselves so that they could then care for their children. Anna describes the mixed expectations she had: the need she had to take care of herself and on the other hand the fear of what seeking help might mean.

*Anna: 'I went to the GP for the first time. The GP signed me in... I didn't want to go in... was frightened... I was totally out of my depth altogether. I had nothing familiar around me. I didn't know what had happened to me or why did I do this... apart from trying to get the pain away and... but yet I felt relieved because I didn't have to think about anybody else except myself. So that was... that was good in a way because you know it was the pressure [looking after her children and dealing with her distress]. I didn't have to think about anything else but me and there's times when I know that sometimes that might sound selfish but sometimes that's all you can think about is... you and what you're going to do in the next few minutes'.*

Admission to hospital for some women was not voluntary as some women were what they called 'forced' either by next of kin or their doctor.

*Deirdre: 'I don't know if some of the pressure was coming from my husband or what you know but I ended up in hospital and the doctor said I had a nervous breakdown then and... so I was in hospital for a while'*

*Maria: 'My partner then just found a doctor and he admitted me to psychiatric unit, the doctor...here in [name of area]. I was admitted to psychiatric unit. I was actually in hospital for a long time, nearly a year'*

Grainne: *'but yeah I was very, very low and what had happened was... I had had a high and two weeks later I was out [from hospital], most horrendous experience, those first two times I was hospitalized. I went in for an outpatient appointment with a junior psychiatrist and she said 'had I been having any suicidal thoughts' and I said, 'ah yeah I thought about throwing myself in front of a train like but I'm not going to do it'. She said something about 'staying in'. I said 'what?' and she said 'I don't think you should be allowed to go home'. I was just, oh God, and I didn't have the wherewithal to say to her, will you ever just get a grip you know, everybody has suicidal thoughts. But I suppose if I had gone and thrown myself in front of the train, then they would have been liable ... I don't know. Anyway I had to stay in and I just collapsed into an enormous depression and I was in there for three months'.*

When the women's distress was overwhelming often relatives made decisions which resulted in admission to hospital. Jane describes her first admission:

Jane: *'So ... just ... eventually I just went really bad, that I was very ... paranoid and ... writing things down so that I didn't forget things and I just had ... I had a few panic attacks and I had a really bad panic attack and I called my sister and she brought me in to her (she's an attic room upstairs) and I just went through the worst experience of my life because it was just ... I was so ... my mind was on complete overdrive and I really was (in hindsight) seeing things I shouldn't ... imagining things I shouldn't have been imagining. So ... then the next day ... my Mum rang the GP and my brother-in-law and they brought me to [name of hospital]'.*

In many situations agreement to go to hospital was a way of ensuring that they could continue being part of their children's lives. Fiona felt she had to comply with the request to go to hospital or she might not be part of her daughter's life. Fiona was also trying to decide whether or not to leave her husband as she was not totally happy in the relationship. If she chose to leave her husband she felt that because of her mental health problems she might not be part of her daughter's life. Fiona had been diagnosed with 'schizophrenia' in 1980 and was conscious that her choices were limited because of the label of 'mental illness'. These issues coupled with her awareness of the power of the psychiatrist meant she accepted that she had to get psychiatric treatment so that she could continue looking after her child. In other words she compromised and agreed to hospitalisation and in her words 'shut up'.

Fiona: *'my husband fought with me until I gave in and I went to hospital and then I fought with him to take me back and told him it didn't matter, I'd cope, I'd shut up. I'd go back home and I'd look after the child because I wanted to be with the child. I wanted to be there somewhat for the child ... I wanted to be part of [daughter's name] life so rather than ... well I wasn't going to have any other life other than in the psychiatric unit. If I had of had another life other than the psychiatric unit I possibly could have been a part of [daughter's name] life but [husband's name]*

*wasn't happy to have me anywhere else, he wanted me in the psychiatric service. I put it down to him not knowing what to do or being told by the doctor that I was unwell, that's all I could do. So I couldn't blame him for taking the advice of the doctor. I saw that when I was over there. So that's what made me decide to come back to him and I did shut up and I was very drained after it and he did look after me and brought me back to my feet'.*

Some women felt that going to hospital was the best thing for their family. For example, Julie felt that going into hospital was the best thing for her child; however, she was aware that this might not be seen that way by other people. The ideal mother would not take care of herself at the expense of her child. However, the reason Julie went to hospital was so that she could continue to live up to the ideal of good mother.

*Julie: 'I think there's kind of that link between hospitalization and then like if you're, if you leave your baby or child with family and you're hospitalized, you kind of picture this red flag going up like oh she's leaving her children to take care of herself. Like to me, that's a good thing, that's an excellent thing because you're taking care of yourself so you can, you know, become a healthier, better mother or, you know, you're taking care of yourself so that you can take care of your children but I think people envision that red flag going up. Like you're never supposed to leave your children behind so you can take care of yourself, never. But to me, like that's the best thing that you can do'.*

Julie goes on to explain:

*Julie: 'For putting yourself first and being selfish when really I think taking care of yourself is one of the most selfless things that you can do because you're acknowledging that you need help in whatever way whether it's depression or anything. You're acknowledging I need help so that I can take care of myself and my children and but I think that there is a huge stigma against that like a woman should never leave her children. She should always be the primary caregiver and even if she goes into a facility for three days, four days or a week ... that that's lost time, when really it's not. It's definitely not'.*

Hospitalisation, for a small group of the women, offered the hope of help and support, which in many cases did not materialise. For others it allowed them space and time to cope with some of their distress and a space which they felt protected their children as they did not have to witness their distress. However, in the absence of any professional engagement or support with the children to help them make sense of their mother's absence how beneficial the mother's absence is, is questionable. For many women however hospitalisation was a frightening experience and increased their sense of shame, guilt and the risk of losing their children. For women such as Jane and Allison the experience was

described as 'traumatic' and 'awful'.

Jane: *'I really didn't. I was so traumatised, I didn't know I was in there voluntary ... and I was so scared that I was in the hospital and I was in the bed beside where the nurses' stations were and I genuinely thought, that they [nurses] were staring at me all the time.'*

Allison: *'I was admitted to hospital anyway. I was admitted by a senior social worker on the basis that my behaviour was a risk to the children. It was an awful experience.'*

When the women were admitted to hospital their role as mother became less visible, they were no longer seen as mothers, they were 'patients' and the role of 'patient' came to the fore. Many of the women lost daily contact with their children; however the pain and heartbreak that came with being separated from children was ever present and was another major source of distress for them. The women spoke of constantly worrying about the effect on their children of being separated due to their hospital admission. Rebecca, who was separated from her children and baby describes the separation as 'a terrible time' for her.

Rebecca: *'they put me in [name of hospital] hospital and I spent a... one and a half months in [name of hospital] ... I worried about it, I wanted to be at home and I ... thought about what happened. I called my husband and asked what happened with my daughter because I ... she was so small and I would like ... I wanted to be with her and feed her and care for her and play with her and it was ... terrible time for me.'*

Teresa: *'So you hadn't as much contact as you would have liked for that month and a half while you were in hospital. How often did your husband bring in your baby to you?'*

Rebecca: *'Not often, maybe once a week.'*

Linda talks about her worry about the effects of hospitalisation on her role as mother. She was particularly concerned about the bonding process with her son and her emotional connection with her son.

Linda: *'Yeah. They [psychiatrists] thought it [mental health problem] was obviously severe so Mum stayed then for three months after that then to help but she would bring him [son] in [to the hospital] every day so I saw him every day. But I think one of the things that probably is lacking is you know Mother and Baby Unit because when I did come home after that I know my Mum was very concerned about the bonding process between me and my little boy ... it's hard to think back but ... I was almost a bit scared of him. I came home then, I had been two weeks in the place and I came home. I was almost scared to bath him or you know ... not that I'd drop him but I didn't feel the connection somehow and my Mum was really, really concerned about that ... but now thankfully he's a real Mummy's boy and we've got a great bond and everything.'*

There was no acknowledgement by the health care team in the hospital of the women's status as mother, with a complete lack of facilities, such as a family visiting room. Despite the women's overwhelming distress, even in hospital the women still wanted to have the mother role and to shield children from their distress. For example, Orla tries to balance her desire to see her son with a concern that the visit might impact on him, a perspective that is also reinforced by family who felt that a psychiatric hospital was not the place to bring children, and consequently Orla tries to shield her son by holding the visit in the garden.

*Orla: 'The only thing that was, was when I was in the hospital, I used ask for him to come into the hospital and he said to me, why are you in hospital and I said, because I'm very tired and I need a rest and that's why I'm in hospital and of course it was probably the wrong thing to be asking him to come in, but at the time I was dying to see him and I couldn't get out ... Yeah, he used to say, what's wrong with the other ladies. So that's when I asked then could we go to the gardens . . . so that he wouldn't have to be in there [in the ward] then and then I said to stop allowing him to come in because ... My family didn't really want to bring him in, they said it wasn't the place for him either but I cried so much, I missed him.'*

Orla's comment also highlights the lack of understanding by practitioners of the mothering role for this group of women and how the lack of facilities and support results in women deciding to suspend visits from their child. In hospital, in an attempt to ensure that they could return to their all important role as mother the women did whatever they were asked to do, and that included once again navigating a system that had the potential to deem them an 'unfit mother', and where the identity of patient and mother appeared incompatible. Orla goes on to describe the balancing act that she had to navigate if she says too much about her MHPs.

*Orla: 'I was afraid. I thought if you go up there [the hospital] and you open up too much to them are they going to say to you, are you in such a state that you can't look after your child. I was afraid of that as well, would they take him away from me'*

Often the women remained in hospital for a number of weeks for assessment and treatment and found it difficult to be without their children. There was a possibility of day or weekend leave once their 'symptoms' had stabilised, which Maria identified as an important time that allowed her to resume her mothering role.

*Maria: 'Well, I was allowed out [from hospital] the odd day and ... then had to go back at night. I suppose it was hard on them [children] because ... I wasn't there [at home]'*



Women went to hospital in the hope that they might get some relief from their mental distress, however hospitalisation was difficult for them as it took them away from their cherished role as mother. The mental health services, the psychiatric hospital and the biomedical ideology underpinning these services were part of the relations of ruling under which women had to negotiate their role as mothers.

### **Biomedical explanation of distress and use of medication**

Many women in this study had numerous contacts with the mental health services and not surprisingly used diagnostic terms such as depression, bipolar, schizophrenia, anxiety to describe their distress and began to see their distress as something unpredictable and that they had no control over.

*Julie: 'depression is something that I will probably always kind of have to not struggle with but I'll always have to keep an eye on and be aware of and ... put an effort into learning what depression was and what anxiety was and ... accept it, accept it'.*

*Aisling: 'I think it's something that you have no control over getting you know if it's going to happen to you, it'll happen unfortunately, but you can work with it. It's not the end, you can work with it, you can still live your life, you can still get the help... I think there are times when you are going to get bouts of depression and it's going to affect you'.*

In their explanation and discussion of their experiences the women drew on 'bodily explanations' for their feelings of distress, clearly identifying biochemical changes as the source of their distress. The biomedical explanation made sense to the women and they spoke about having chemical imbalances and hormonal problems and worried that there may be a genetic component to their mental health problems leading to concerns for their children's future mental health.

*Carmel: 'because I'm bipolar. I've got a mental illness ... I'm lacking a chemical in my brain ... it's like a hose where if I step on it you know ... I go all depressed and then it's let go then in a big gush and I go manic, do you know'.*

*Aoife: 'Oh I'd say it's definitely chemical, yeah. It's 90% chemical and then 10% attitude ... yeah I would definitely believe that yeah'.*

*Sue: 'They [psychiatrists] labelled me then as schizophrenic. Oh you have schizophrenia ... I was devastated when they told me. I really was like and I was saying Jesus ... I was worried first off in case [son's name] ... because I looked it up*

*on the internet and it can be hereditary and I was worried sick over [son's name] you know, but he is okay'.*

Gammell and Stoppard (1999) in a Canadian study found similar results with women attributing feelings of distress to their bodily process and suggested that by adopting this understanding women can label their distress as a 'mental illness' thus abstracting the distress from their every day experiences as mothers and thereby maintaining the identity of 'good' mother. Having accepted the biomedical explanation, in the absence of any other explanation, the logical treatment option was medication.

All the women in the study were prescribed medication and most women, in the absence of any other options, took medication as prescribed. Sue describes her experience:

*Sue: 'So I was admitted then. I remember [son's name] was sixteen months old and I had to go to [name of psychiatric hospital] to be assessed again. They got me a bed that day and I was in there then for seven weeks in [name of psychiatric hospital] ...When I was in [name of psychiatric hospital] there was a girl in there and she had post-natal depression, she was after having a baby, and she said to me you know they'll be giving you tablets all day and I was very innocent and I was saying but sure what are they giving me tablets for. They'll give you one now to stop you crying. They'll give you another one then because you have a pain in your head she said and another one then to stop you talking ... and true as God you are lined up in the morning at half past eight, you're lined up at two o'clock ... they're giving you ... for what like? All I wanted to do was go home to my poor child, stop the voices in my head I'll go away home. That's all I used be saying to them, but they give you one to stop this, one to stop that, you know. It's madness, madness, really'*

Women took medication for different reasons, some because it reduced their physical symptoms of sleeplessness, others because they said it helped to control their moods and others because their families wanted them to take medication. The following women describe how medication helped them with the physical aspects of their distress.

*Allison: 'and I did stay on the anti-depressants and I did start to sleep and eat better'*

*Alice: 'I find them [medication] terrible good, they keep my crying at bay.'*

*Emer: 'so I ended up going to see [psychiatrist] he decided to change my medication to [names medication] and immediately the difference ... it was fantastic, I was able to live my life again. I stopped crying. I started sleeping better so it was great'.*

Grainne struggles with taking medication; however, she takes it because her family feels

that she is 'better' and 'safer' on it:

Grainne: *'But I would say I'm much better. People would say to me that I'm ... seem to be much better on it than off it and people feel safer when I'm on it. My family always say, why don't you take the bloody medication, for fuck's sake [laughs] you know'.*

Women also took medication so that they could continue or regain their role as mother.

Aoife describes her reasons for taking medication.

Aoife: *'I am very well when I'm on my tablets but if the tablets aren't there I'm very sick and so ... just because of that, mental illness is just not good you know, but then, saying it, it's not the worst thing in the world either do you know. If I take my tablets, I live well on my tablets and I'm happy on my tablets and I don't mind taking them'*

However the decision to take medication was not taken lightly. Women were aware of the possible adverse effects of medication. This is summed up by Eileen in the following:

Eileen: *'Is the medicine good for me or is it going to destroy me?'*

The driving force for women to take medication was to be in the best possible position to care for their children. So women 'tried' medication, as they were anxious to take the help offered, and to feel better so that they could return to caring for their children.

Agreeing to take medication involved making choices and getting the balance between what was good for them as mothers and what was good for their children. Kay and Aisling describe why they decided to continue taking the medication.

Kay: *'When I had [child's name] I was seeing the GP and she put me on [names medication] and literally all they did was make me feel absolutely dead. You could have told me I had a terminal tumour and I would have just laughed, nothing bothered me you know what I mean. The kids could hurt themselves and I was like oh yeah you know. I just felt absolutely nothing. I felt like I was just like a dead person. There was no emotion in me, no nothing and I hated being like that but then I just couldn't cope [being off medication] ... you know if I came off it I just couldn't stop crying'*

Aisling: *'Absolutely. I just think ... I didn't like the idea of being on medication for so long. I really didn't want that to happen and I did try to come off it myself so many times because I had this feeling of not wanting to be on medication and when I tried to come off it I got those feelings again. I just thought, it's not worth it. Just this [medication] gives me a better quality of life and I'm in a good place for my children and for my husband as well like, you know, because I wasn't in a great place so I thought if this is helping me then it's getting me through life and I'll keep going with it just'.*

Medication was taken on the promise by professionals that it would work, and the women wanted to feel better so that they could continue caring for their children so they took the medication; however, for some mothers the reality was different and the result was to take them further away from their children. Women experienced many side-effects that added to their distress and impacted on the ability to mother their children. Emer explained her experiences of being on prescribed antidepressant medication and how upset she was as she did not wake up to attend to her baby's needs. This negatively impacted on her view of herself as a mother.

*Emer: 'I was tired. I didn't seem to have any sense of enjoyment. It was if my emotions were dampened down and one of the first side effects I would have noticed was that I never woke up at night. The minute I went on it I wouldn't have woken up if [child's name] was crying for a bottle or whatever – I wouldn't have woken up. So it was always my husband who would always have got up and I used to think ... I used to hate that ... deep inside I felt that I should have been the one who was up, not my husband you know that way'.*

For a significant number of women medication exacerbated their struggle with day to day life. Other physical side effects of medication such as weight gain, interrupted sleep and hair loss added to their feeling of inadequacy and low self-esteem.

*Sue: 'You put on a load of weight and it's very hard to lose it you know. You wouldn't sleep properly ... when you say that they want to give you sleeping tablets you know.'*

*Anna: 'When I started the [names medication] my hair started to fall out. I was in the shower and I was like, oh my God'.*

*Allison: 'I was on [name of medication] and it is the most horrible drug. I woke up every morning feeling like I had a hangover ... and I used to get up literally ... having to go back to bed in the afternoon when he [child] was in bed'.*

Some women felt they could not discuss taking medication with their friends because of the stigma attached to taking 'psychiatric' medication, therefore they kept it a secret.

*Jennifer: 'Now I had a very good friend as well who would know that I see a counsellor but again they wouldn't know that I'm taking any medication and even one of my friends is a counsellor and she is adamant against medication'.*

Annette, a twenty-one year old mother of two young boys (one lives with her and one is in foster care), described other side effects that left her existing but not living the life she would like to live.

*Annette: 'No I can't think straight at all. My head is like kind of ... like the fog is even ... that's not even being depressed like or anything it's just that ... you know just my memory, my short-term memory loss is really bad like. I would forget a lot of things. I could forget my shopping like in the supermarket. I could forget a lot of things that I*

*should be doing like, even you know I suppose like things like paying for bills, I could leave them there for a month and they'd be you know just forgetting about things'.*

Annette goes on to describe the impact of medication on her life and her fear that this is how things are going to be for the rest of her life.

*Annette: 'Like before (I was on medication) I could do a lot of things like you know. I had a lot more ideas. I had a lot more enthusiasm. I had a lot more ... I saw the world differently like. Now I see it very differently as well I suppose that is ... part of it is medication you know that a lot of the time I do get tired and want to sleep. There are days ... I don't want to do anything today I just want to go to sleep like you know that kind of feeling that I do get, but then I suppose I'm not feeling so you know like high... or I'm not feeling kind of so low either you know ... it's just you know ... I could just ... I'm here like and that's it but ...I hope to be not on it for the rest of my life. She [psychiatrist] said I probably will'.*

Medication may help some women at times of severe emotional distress; however, the framing of their distress as 'illness', requiring medical treatment, did not help the women in regaining their lives as mothers. Medication, as described by the women in this study is almost worse than their distress. Louise explained her situation as follows:

*Louise: 'And I would have come out [from hospital] very heavily medicated you know. What happened ... the first time I think that the whole mistake hung on my first admission because I was in far too long so when I came out I couldn't ... I couldn't cope, do you know what I mean. I was heavily medicated. I had become kind of semi-institutionalised. I actually couldn't cope so it was inevitable I was going to end up back in ... this revolving door ... huge amounts of medication ... I really think now, when I look back, that the big mistake was on my first admission. It was far too long. Came out too heavily medicated'.*

Women had both positive and negative experiences with medication. For many women medication did not help with their underlying distress, it only covered up the 'symptoms' of distress. Thereby, once again rendering their distress invisible The medication simply treated symptoms of 'mental illness'; however the side-effects of medication such as inability to concentrate, excessive sleeping, weight gain severely impacted on women's lives, while the negative effects of medication outweighed the positive ones, for some women. Ita and Carol highlight this point:

*Ita: 'and I went through all my married life for the rest of that time I was just like a zombie. I was doped, highly doped, with medication and I done things like in a zombie state, you just do them automatically. What brought me through my depressive years was my love for my children. They came beyond anything else, you know, they were there and I had to live for them, I had to cook for them, I had to look*

*after them, they were only small kids and that got me through'*

*Carol: 'I said some very strange things on medication. Very strange things and not really realising [I was saying them]. It's like being in a place and not fully being there'.*

Some of the women like Sue and Kay questioned the use of medication and in some instances made a decision to come off medication all together.

*Sue: 'I'm on 200mg of that [name of medication] and on 100mg of [name of medication] and they [psychiatrists] wanted to up the [name of medication] to 200 in the morning, 400 at night, and I said that I wouldn't dream of it. Like I work, I have my job. I'm living on my own with my child, sure I can't go around the place spaced out. I have to be able to get out of bed in the morning and drive the car, take my son to school you know, like any other mother has to do'.*

*Kay: 'I think at that stage then I had tried anti-depressants but they just didn't suit me. I didn't want to keep taking them, I just felt numb to the whole thing and came off them'.*

Carmel explains her reasons for not taking medication, she was concerned that she would miss out on her daughter's childhood and that she would not be the mother she wanted to be if she 'succumbed' to medication.

*Carmel: 'I wouldn't be the person I am without her and she is my reason for continually battling things. She's my reason for not succumbing to medication. Who wants a shell for a mother. I wouldn't be able to function ... I'd miss her childhood ... do you know what I mean. I'd rather be sometimes up and down and still experience all the wonderful things it is to be a mother than to be flat-lined and just existing... you know what I mean ... Being a mother is like so ... rewarding.'*

While it appeared that the medical professionals believed that mental distress can be categorised into 'mental illness', and secondly that this 'mental illness' can then be treated with medication, or that it is the treatment of choice, the women had mixed views on the usefulness of medication.

Whilst there were some positive effects for some women, for most taking medication was a negative experience. Being on medication interfered with their ability to be the mother they wanted to be and reinforced their feelings of inadequacy in relation to their mothering. Being on medication also reinforced a biomedical view of their distress and offered limited treatment options for them. Some women continued to keep appointments with their psychiatrists and questioned the use of medication, in the absence of any other options a number persevered with prescribed medication, while others attempted to come off it.

## **Experiences of professional support that acknowledged mother and 'patient' identities**

As previously highlighted there is a tension between the role of 'mother' and that of 'patient'. Davies and Allen (2007) suggest that mental health workers have a key role to play in assisting women in managing these two identities giving both equal importance. The women in this study, as can be seen in chapters 5 and 6, worked very hard to keep their identity as mothers visible. Interactions between women and care workers can be helpful and unhelpful in this regard. Helpful interactions support the identity of mother and person experiencing a mental health problem and unhelpful interactions favour one over the other. The women in this study wanted acknowledgement of their mental health needs and how this might impact on their mothering. However they did not want to be seen as 'bad' or 'unfit' mothers. There was a tension between the two identities as the women described how they balanced meeting their needs for mental health care and the needs of their children. Health and social care professionals often can be more concerned about the child to the neglect of mother's MHPs and, as can be seen from the women's stories, they may minimise their mental distress in an atmosphere where expressing it may call into question their mothering abilities (Whitton et al., 1996). Fortunately, some women had the support of community mental health nurses (CMHNs); however, as services varied depending on geographical location, for others this support was not available. In the absence of CMHNs there was no other professional support offered, except social workers, which the women mentioned only in relation to child protection.

Ita describes how her community mental health nurse managed the tension between the two identities; Ita's role as mother and Ita's role as 'person experiencing a mental health problem'. The CMHN, in her care and interactions with Ita, did not call into question Ita's ability to parent. Ita has five children and a twenty-five year history with the mental health services.

*Ita: 'She would just come because she was a really lovely lady, [name of CMHN] was her name, and she was coming to me for years. She would come to see that I was coping well and that everything in the house was fine and the children were fine and you know'*

Bridget explains how the support of CMHN helped her to manage the two identities.

Bridget: *'Well the community mental health nurse, she called out and I find that a good help because it just ... it's someone ... she's like a friend now I know her and I feel very comfortable with her and I would be quite open with her and tell her exactly how things are you know. I actually look forward to her visits you know and she's very good because you know if I am not feeling well, all I have to do is ring her or text her and she'll come out and that's just the way it works you know. So she's basically on call for when I need her you know so'.*

Bridget was able to develop a relationship with the CMHN in which she was able to talk about her mental health *'if I'm not feeling well'* and her role as mother *'I could tell her exactly how things were'*. In this way Bridget could acknowledge and be acknowledged in both roles and accept that the experience of MHPs was compatible with being a good mother to her children.

In the following extract Aisling describes how the CMHN maintained contact with her on the birth of her second child. Aisling had experienced MHPs five years ago on the birth of her first child and was concerned that her MHPs might be exacerbated by the birth of her second child.

Aisling: *'Yeah, because I spoke up the last time and they were all very, very aware ... my daughter was born at half three in the morning and at seven o'clock the next morning they had a psychiatric doctor round to see me to make sure everything was okay and then a psychiatric nurse came to see me every day after that. So the support was good once I'd spoke out about it [MHPs]. They came to make sure everything was okay and if I wanted to talk and the consultant psychiatrist was always keeping an eye on my medication throughout the pregnancy as well, with hormones changing and she put my medication up quite high ... just near the end of the pregnancy just so that if my mood did slip the medication would ... balance it out, kind of thing. So I felt like it was all very much under control'.*

The CMHN accepted the possibility that Aisling might experience MHPs postnatally and provided support for Aisling. In these actions the CMHN demonstrated that being a mother and experiencing MHPs were not incompatible with each other. The acceptance of the possibility of MHPs in this instance may help to debunk notions of idealised birth and motherhood and more importantly creates the space for the woman to seek help if she requires it. For Kay, mother of four children, following the birth of her last child, the CMHN played a crucial role in helping Kay recognise the identity of mother as separate from the



identity of 'person experiencing mental health problems'. Kay was categorising herself as a 'bad' mother because of her experiences of MHPs.

*Kay: 'She did that back in ... after having [name of child]. She was a ... she's a psychiatric nurse but like that now she was trying instead of me seeing me as a bad Mum she was trying to help me see me as a good Mum'*

To care for women who are mothers and who have mental health problems, health professionals must balance the woman as 'mother' and woman as 'patient', within the same therapeutic interaction (Davies and Allen, 2007). The extent to which they can do this successfully will be determined partly by their professional skills and expertise. By acknowledging the two identities CMHNs played an important role in helping women to understand that both identities were acceptable, mothering was possible in the context of their distress and that the idealisation of the 'good mother' could indeed be challenged.

### **Beginning of resistance: mothering in the context of hiding distress; managing time and planning ahead**

As discussed, most of the women in this study experienced mental health problems prior to becoming mothers, therefore they had many years of experience learning to cope with their distress. However being mothers added another dimension to their coping strategies. Their experiences of negotiating the relations of ruling and developing 'double consciousness' from their marginalised position opened up a space from where resistance could begin (hooks bell 2004). The following section explores this site of resistance in the context of hiding distress, managing time and planning ahead. As described in the previous chapter women were able to 'do' mothering; however when their distress increased they developed additional strategies to enable them to continue mothering their children despite the pressures on them. One strategy was to hide their distress.

*Emer: 'I tried ... I never wanted him [her son] to know how I was feeling or whatever so I would have spent my whole time trying to hide my feelings from him you know pretend that everything was rosy in the garden so ... and sometimes that worked and sometimes it didn't you know'.*

Grace also describes how she hides her distress to get her children to school, and when her children are 'not there' she cries for eight hours a day, her distress is profound.

*Grace: 'Well ... well they went to school and everything was fine but basically ... I was putting a smile on to the world and inside I ... I'd probably cry about eight hours out of the day when they're not there, you know, and I'd have to say to myself, you know you have to get your act together, they're depending on you, you're all they have'.*

As described earlier in their experience of stigma women needed to keep their distress hidden from others, so putting on a face also extended to people outside the family as well.

*Emer: 'You're putting on a face the whole time and then I suppose from ... putting on a face as well for the world at large you know so that everybody thinks that everything is rosy ... oh look at her, she has a young baby and it's wonderful and you know'*

*Eleanor: 'So I suppose I faked it till I made it, as they say. That's how I did it and it was tough, it was really tough.'*

'Putting on a face' was done to keep their distress hidden from their children and also from public view. In using this strategy the women were able to portray an acceptable picture of motherhood and were able to concentrate on the particular tasks that were part of being a mother.

Other women such as Louise spoke of having to hand over some of the responsibility to their partners, yet continuing to force themselves to put on a face for the children.

*Louise: 'But like that it kind of caused tension with us because I just couldn't do it [look after the children], I just couldn't do it anymore you know and [husband's name] was having to you know take on the responsibility of basically running the house. Don't get me wrong I didn't stay solid in the bed for that but I had to force myself to get up and you know put on the face if you like for the kids and you know'*

In addition to putting on a face or mask the women were able to maintain their mothering functions through careful negotiation and management of time, as described by Carmel and Orla:

*Carmel: 'My child is brilliant. She's fantastic, she's my balance. She has given me the reason to be balanced. If I'm emotionally all over the place ... I manage being a mother by constraints. I've worked out my days. Like I'm a stickler about times you see like. If I'm having a bad time all I have to do ... is get up in the morning ... function on the routine of getting her lunch and things ready, drop her to school. Then I have until three o'clock to be off my head, crazy ... come home, help her with her homework and she's in bed by seven. So I only have to actually function four hours a day do you know'.*

Orla: *'that's when I'd cry and I'd say to [sister], there's something going wrong with me. I don't know what's wrong with me. I think I'm having a breakdown. But during the day, no, I was able to keep it together'.*

For some there were times when their distress became so overwhelming that they had no choice but to withdraw from their children. Jane made efforts to shield her son from her 'depression' as described in the following:

Jane: *'I looked after him but. I would go to bed for a few hours ... All I wanted to do was go to bed and sleep and block it [depression] out. So I had it that basically when he was in the house with me, he would be unaware of it because I would say to him, look I'm going for a sleep, do you want anything, do you need anything and because he's an only child, he's very self-sufficient anyway'.*

Another strategy that women used was to focus on the practical aspects of mothering. The daily routine of childcare and household tasks provided a structure to support their mothering identity. However as their distress increased women drew on additional strategies to maintain their mothering role. The importance of being good mothers often meant that the women prepared for the times when they might feel unable to do ideal mothering through planning ahead. Women rearranged their routines, and rested when their children were out of the home so that they could be available to mother on their return. Other planned ahead in other ways. Carmel describes how she planned ahead:

Carmel: *'I always keep ready-made foods (I do most of the cooking from scratch) but I always keep ready-made foods in the freezer for those moments so when ... I do go low ... that I still function ... without too much brain ... But I suppose that's where the routine comes in handy to help me parent, do you know what I mean, just to be able to ... set yourself low goals ... okay get to six o'clock and then you can be whoever you want to be and be in whatever mood you are and not affect [child's name], do you know what I mean'.*

Some mothers worked fulltime and this meant a further drain on their resources. Orla is a single mother with one child and works fulltime, so she has to manage her day very carefully so that she has the energy to do everything expected of her.

Orla: *'I had to [plan carefully], yeah I had to. At the end of day like, I have a little boy, so I had to, you know, he's what keeps me going. You know I had to get up and do his regular little things with him, bring him to school and, do you know what I mean, and I had a job to keep down too and I had to be at my job and ... I had to keep going but then it was at night-time then everything would get on top of me and I would say I can't handle it then'.*

While the strategies of hiding distress, 'managing time' and 'planning ahead' helped them

with the 'doing' of mothering and kept women's distress and feelings hidden from view, keeping up the appearance of ideal mother requires considerable strength and determination. Consequently as their distress increased their ability to keep up the pretence of *'everything is ok'* became increasingly more difficult. Women in this situation became exhausted and the effort to keep their distress invisible became more and more difficult. Often their children were the first to notice. Sinead, mother of two teenagers who was finding it difficult to deal with her distress, explained:

*Sinead: 'I would be very good when I am with them [children] and then when they're gone [to school] I could shut myself inside and cry for hours and then build myself back up again until they come home, you know, but like my son has noticed it a bit. He's always asking are you okay, are you okay – for God's sake, if I'm not, I'll tell you, you know.'* [laughs]

The imperative of the 'ideal/good mother' which women had internalised to help give them direction meant that they are acutely aware of the imputed potential damage they might cause to their children through their lack of involvement and their withdrawal. Consequently they drew on all their resources and pushed themselves to the limit to care for their children as described by Anna: *'I would not have got out of bed without them kids'*. In addition, the women spoke of the constant guilt they felt at not getting 'it' right, 'it' meaning 'ideal/good' mothering. Emer and Aisling describe how they questioned themselves and how they 'should' have been better mothers.

*Emer: 'Definitely. I suppose it is hard work. You have the emotional side of it you know because you are emotionally attached to this child. Then if something does go wrong [mental health problems], like it did in my case, you feel guilty because you are the one who has brought this on seemingly you know'*

*Aisling: 'I probably did do more because I felt guilty. I felt like I should be wanting to do all of these things anyway so I just kept on doing it, just to get through each day, make sure he was okay, I suppose.'*

Others, such as Eileen, were concerned that their mental health problems may mean that they would never be able to mother again and that their ability to care for the children will be lost forever.

*Eileen: 'So I was there thinking, oh Jesus, I am never going to be able to connect with my children again. That's the end of the world for me. So it's not just important. It's ... I mean a huge part of my identity is my mothering and the feeling that you might never be able to mother again is paralysing. In fact it could make you even more*

*depressed than you already are because it is such an incredibly helpless feeling. Something that's so precious to you looks like it might be petering away forever'.*

This group of women wanted to care for their children so they dealt with their increasing distress as best they could and kept their 'true' feelings and emotions hidden.

*Eleanor: 'I don't scream, I walk out of rooms, I ignore, I have to. I give her what she needs and then I walk away because I know if I scream and shout I might not stop, I might not stop. If I hit her, I might not stop but I know I have the power to stop'*

The awareness that Eleanor speaks of means that she knows she will not hurt her children despite the fact that she feels distressed. However women were also aware that they might be judged if they spoke about this. Therefore there was a constant holding in of information, thoughts and feelings that was exhausting and added to their feelings of distress.

On occasions women questioned if they should leave their children. However, they did not want to let go of their cherished position as mother. Kay, mother to four children, described when her distress was at its highest level and the pressure to be the ideal mother became almost unbearable:

*Kay: 'I suppose number one I have this absolute rage in me that I just can't control at times, over silly stupid little things and then it starts a cycle like even getting them ready for school in the morning, [child's name] is six so she should be able to dress herself but most days I end up dressing her it's so slow but like you could ask twenty times to put on her shoes and then eventually you just blow and then when you blow you feel so guilty for blowing over something so stupid and then you get really ... the guilt starts and it's just a constant vicious circle I'm on at the moment and ... I just find that there are times then in the evening time if they're at home I just go off into the front room because I just need to get away you know just to ... I just can't cope with them whereas before when [two eldest children] were here on their own when there was nobody else I'd have sat with them and played with them. So the opportunity might be there to play with them for ten minutes I'll choose now to go and sit on my own because I want to get away. There would be days when I'd contemplate getting into my car and just driving off and leaving ... especially if they're fighting, if they're bickering and I just ... I just can't take it sometimes and like I shouldn't ... I should be able to come in and deal with them whereas I just try to run basically and one way of doing it is going into the room or closing the stair gate and going upstairs because they can't open the stair gate yet because even if you go to the toilet they'll follow you, you don't even get to go to the toilet on your own here'.*

For Kay this represented internal signs of distress where she began to question whether she should leave and represented an area of conflict for Kay. The conflict was the mismatch between her expectations of ideal mothering and the reality of her wanting to leave, adding to her feelings of guilt and shame. The distress that Kay is experiencing highlights how hard

society has made it for most women to mother in contemporary society. For this group of women was the added dimension of how to mother with the effects of medication.

During the interviews the women began to question the high doses of medication and the value of medication in their lives. While some women found medication helpful at times of acute distress, they were less sure of the value of continued medication over time. Aoife spoke about how she managed medication to ensure that she is able to care for her children.

*Aoife: 'I'm on [Names an antipsychotic] now ... that gets me very dopey ... when I was taking the [Names an antipsychotic] I was told to take the dose at six o'clock in the evening, so I would take it at six but I'd be in bed by half six and then [husband's name] would be giving me tablets at nine o'clock, like my [Names an antipsychotic] and my [Names an antipsychotic] at nine o'clock, so he'd have to wake me at nine o'clock and then I'd get up about half six (because I was waking very early) and I'd take my [Names an antipsychotic] again and then by eight o'clock I had to go back to bed because I was so ... knackered ... on it. Literally within an hour of taking it I'd have to be in the bed because my head would just go so ... but that's calmed down since I started on it now but ... [husband's name] gets up early now so when he wakes up in the morning about four or five he gives me my morning [Names an antipsychotic] then and then by the time I'm up, getting up with the kids, I'm awake like'.*

Aoife's struggle to find the right time to take her medication so that she is able to care for her children provides an insight into the added pressures that mothers who experience mental health problems experience. Aoife's explanation highlights the importance of her mothering role, and it is only through balancing the time she takes her medication that she is able to keep visible her mothering role, while hiding her mental distress. In this way she attains and maintains social acceptance through her position as mother and manages to resist the relations of ruling that suggest that women who experience mental health problems should not be mothers.

### **Beginning of resistance: questioning the value of medication and biomedical explanation**

The simplistic view from professionals that medication is the 'cure' for mental distress meant that the women were expected to take medication with little or no explanation as to the purpose, duration and possible side-effects of medication.

*Orla: 'No, they never sat me down and talked to me or said they thought it was this or that or ... No, no one ever sat me down ... even when I go back for my visits to the doctors now, they don't say that they think it might have been this or it might have been that, they ask me how am I getting on and is things okay and they just write out my medication and that's it basically.'*

Jennifer: *'GPs write these prescriptions but they tell you nothing you know. You get the leaflet that's in the box but the drug company isn't going to tell you any of that. They'll give you a list of possible side effects, it's this long and probably includes death in it and it's a lot of information but it's no information on a practical level. So the internet is a very good resource for that sort of thing because you find out other people's experiences and what the general experience of the product is'.*

Emer: *'I got somebody [psychiatrist] different one day when I was in there and I mentioned it [side effects] and I was just met with the same wall of silence I was met when with any time I tried to question you know how long would I be on the medication'.*

While the women initially appeared to accept the biomedical explanation and took the medication as prescribed by psychiatrists and doctors, with an increasing sense that their concerns about side-effects were not being listened to, the women began to question the value of medical intervention. For example Sinead did all she could to get the doctors to listen to her about a drug reaction but she was dismissed. This may be due to the inherent discrimination and stigma around mental 'illness' in which there is an understanding that people 'with mental illness' are not to be trusted or believed, or may be due to lack of knowledge by the practitioner involved. Fortunately, Sinead had a supportive husband that was able to advocate on her behalf and as a result she got the treatment she needed to resolve the crisis.

Sinead: *'I had a severe allergic reaction to it [names psychiatric medication], ended up in Intensive Care, but at the time two doctors (I don't remember their names now) came over from the Psychiatric Unit and wanted to admit me to the Psychiatric because in their view I had tried to kill myself. So they didn't take my word for it, it was like they were talking over me and I had to contact my husband. They were taking me on that morning over there [to the psychiatric unit] only that my husband got in on time and said she is not going, she is not being admitted to the Psychiatric, there is nothing wrong with her. He in turn then had to talk to my own GP to reassure the doctors what he had given me and I only took the one. Now there was no apologies given to me for that'.*

The 'trial and error' nature of prescribing medication left women feeling frustrated and angry at their treatment. For example, Noelle described the 'trial and error' element to this supposed scientific endeavour.

Noelle: *'So they were just like, trial and error for months and months with the tablets which was ... and the psychiatrist was very good and she drew diagrams which I was able to understand. She drew a diagram about what this drug does and it was either a bomb or a gunshot, you know, and I knew that when she wanted to put me on this*

*other tablet then you see, and she explained it was a bomb, it had a certain fire power to the brain which would help then better than it would if it was just the wee bullet tablet'.*

During the course of the interviews it was clear that some women found the biomedical explanation did not fit with their lived experiences and offered many other views that helped them to make sense of their lives. The women spoke of other possible explanations including stress, taking on too much, being in unsupportive relationships, childhood and adult experiences of trauma, physical, emotional and sexual abuse. While stress was not the same for all the women, they were clear that the stresses influenced how they felt and added to the pressures of intensive mothering. Some women felt stressed from being at home caring for children, for others stress came from being stretched between work and home and for others it was stressful living circumstances. Bridget describes the stress she feels as a mother with three young children:

*Bridget: 'One day I could be grand and then the next day you know. I suppose with three kids it's quite stressful and every parent I suppose just goes through that, running them to school and they come home and fighting with one another, trying to get the dinner cooked, just normal things that maybe other people could cope with quite well. Sometimes it kind of gets a little bit on top of me you know ... just feel really stressed out ... sometimes I ... the way to describe I suppose sometimes I feel on the edge I just feel really ... I'm just going to pop like you know I just ... real tension as such do you know. I get through it, I get over it and I'm grand you know'.*

Jennifer suggests that the duration and intensity of life stressors may have been one of the reasons for her MHPs. She describes being a single parent adds to the matrix of stressors that affect her life.

*Jennifer: 'I bought a house and there was lot of stress involved in the you know the mortgage application and all that sort of thing and moving into the house and I found over the last two winters I needed to see my GP and get anti-depressants again so ... I suppose, from a single parent's perspective, I actually think it's the ... it's possibly just pressure over a long period of time ... you can cope with so much pressure for a short period of time but it's when you're trying to juggle everything consistently then I think it becomes a problem'.*

In the following extract Ita highlights the extreme stress that living with 'an alcoholic' husband has caused her, and how she blamed herself for her circumstances. When Ita looked for help she was diagnosed as having depression.

*Ita: 'you know home circumstances, you know, living with an alcoholic and you can't ... you see I felt so bad because here I was married to this man and I discovered*



*suddenly from nowhere that he was an alcoholic. When we were going out there was never any sign of it and I blame myself. I stayed at home and reared my kids and devoted my whole life to my kids and reared them through the depression and never kind of came to terms with his drinking and as the years went by my bitterness towards him and his drinking got to a stage that it kind of took over my whole life and I was very unhappy living there, very, very unhappy living there'.*

Being unhappy in their relationships with their partners, was a theme identified by some women. In these situations women's unhappiness was labelled as depression. In the following Jean identifies several stressors in her life: being mother to two small children, experiencing miscarriages, having her third child, her husband having an affair, and being hospitalised left Jean with the explanation that she was depressed.

*Jean: 'He was a year and ten months when [child's name] was born so they were quite near in age. Then everything was fine. I had a couple of miscarriages and they went fine and then I became pregnant with [baby's name] who is my third boy and fine ... was two years ... he was born and in two years I became depressed again. It was as a result of my husband having an affair and over several months of pressure and the children being small and everything and I ended up in hospital. So I was in about a fortnight/three weeks and I was in and out of the hospital because the depression was continued. He was continuing with his affair and I continued to be depressed'.*

Orla and Niamh pointed to study and work as additional pressures in their already stressful lives. They both describe their experiences as having a 'breakdown'.

*Orla: 'I had the breakdown a year ago and it was the September before that that my tumour was removed. I took on a course probably that I shouldn't have taken on as well and there was a lot of pressure on the course. Like, I'm not great with crowds and you'd have to stand up and do a talk on a subject and I wasn't great with that and I used to work myself up and things and with homework you'd get then it would be quite ... a lot of study at the end of it'.*

*Niamh: 'I studied part-time. I was taking care of the kids. I was working part-time and everything was going kind of okay and then my ex came back into my life and decided it would be a good idea to have another go at it and stuff and ... then we decided we were going to get married, we started a business together. It was all overly ambitious but ... obviously the same problems were still there ... his alcoholism and his issues and stuff and I had a breakdown then while I was in that relationship with him'.*

In addition to the above the lack of discussion and therapeutic interventions, especially with women who had experienced sexual abuse left them clearly frustrated and let down by a system that was supposed to offer help. While the women wanted to talk about the abuse, in contrast services wanted to medicate the sequelae of abuse. Sue and Niamh comment:

Sue: *'like I was abused when I was a child. Like I suppose I could have spoken about it more with the psychiatrist but you see all they want to do then is give you tablets for to fix that but you don't need tablets for to fix that like you know ... no ... because I knew that they would be giving me more to take so I didn't go into it with them'.*

Niamh: *'I had a real issue with them when I went to them because the only help they were offering was medication and at that point in time because all the sexual abuse issues had come up, finally, I wanted to deal with it and I wanted to get it out and I wanted to address it and I felt that they were just going to give me something that was going to put it all back down and as scary and all as it was and as difficult as it was – I didn't want it pushed back down.'*

Several studies have linked life events, especially loss, to the onset of depression (Paykel and Cooper 1992; Brown and Harris 1989; Brown 1993). Brown and Harris (1989) suggest that for depression to occur two sets of predisposing factors need to be present. The first set concerns the women's environment: for example, the lack of a confiding relationship or a difficult marital situation. The second is found within the women themselves and includes low self esteem and the tendency to ascribe what happens in their lives as being out of their control. Brown (1993) argues that the presence of both sets of factors means that a life event is particularly likely to be followed by depression. Finlay-Jones (1989) similarly identified 'danger' events are likely to precede the onset of an anxiety disorder. Feminist researchers suggest that it is women's marginalised position in society that impacts negatively on their mental health (Stoppard 2000; Ussher 1991, 2006).

While the women began to question the explanation of their distress as 'illness' and began to seek other explanations for their distress other than biomedical explanations, they were again conscious of their vulnerable situation and the need to balance the risks involved, especially the possibility that their children may be taken into care. Therefore they were constantly balancing being seen to take responsibility for their 'illness' through taking medication and complying with medical opinion with the potential of sanctions such as removal of children. Indeed taking a questioning approach to perceived psychiatric wisdom was a courageous stance for these women to take.

### **Beginning of resistance: seeking support outside the mental health services**

The women in this study saw their difficulties differently to the psychiatrists that they were referred to, and most spoke about the limited value in hospitalisation and medication in helping them to maintain their mothering role. In the absence of limited supports from

within the mental health services asking for and receiving support from family members, for example partners, grandparents, or siblings was critical for the women and helped many of them to continue caring for their children. Women needed family members when their distress increased; however, the decision to allow help was difficult for them. Some partners took time off work to provide added support. In other situations family members came to stay and in a few instances children stayed with family members for short periods of time. At the time when Helena's distress was at its worst she had family support to draw on:

*Helena: '... like I had total support from family, in-laws and my husband up to that time on a one to one like if my husband went to work, my sister was coming in to relieve my husband, if my sister was going my mother-in-law was coming in. So there was someone with me all the time.*

Even though women accepted help and support from family members they did not want to be replaced. They remained with the supporters, so even if they were unable to provide day to care themselves they were still present and available for their children. Bridget describes how her husband helps with caring for their children.

*Bridget: Well in the morning (during the day he's not there) time (and I should actually praise him, I don't praise him enough) he is great in the morning. You know, normally I'm up first and I'll go down and make the breakfast for the kids and then get their clothes ready for school and get the lunch boxes ready and then he'll have a shower, he'll be getting ready upstairs and then he'll come down and he'll... you know wash their faces and their teeth and get them dressed so at that stage I'm up getting ready so when I come down they're all ready for school. I have to say that's a great help because I wouldn't be able to do the morning shift on my own it's just so mad busy ... especially the baby and changing nappies and giving bottles and all that so, yeah ...he is a good help and at night-time, no, he is a help too at night-time. I have to say when he comes home and we both put them to bed and you know, I'll put two to bed and he'll put one or whatever and you know.*

What is interesting from Bridget's quote is how she considers the support from her husband as something unusual; there is a total acceptance that she should somehow be able to do all the childcare on her own. This underpins the notion of patriarchal mothering where the mother is responsible for all children's care and somehow to accept help for her husband means she is failing as a mother.

Aisling also highlights the role of her husband in the care of their child. Implicit in her description is the notion of intensive motherhood with the woman as the primary carer of

children.

*Aisling: 'I mean I did have support, there was friends and my Mum. You know everybody did pull together and even [husband's name]. Mum was always a good support. She would have helped out a lot with [son's name] and things and then [husband] himself obviously was really good. He would have took over in the evenings when he came in from work and things like that. So I did have support'.*

Orla, a single mother, relied on her sister for support with caring for her son. Orla lives with her sister.

*Orla: 'Because he's [son] so close to [sister's name] and [sister's name] like would be like a second mother to him, do you know what I mean, so I was blessed that way, that she was here, like that way'.*

All the women in the study spoke of the importance of support in their coping with their mental health issues and with mothering. Practical support, such as help with childcare, was viewed as being important. Some women had support from partners, extended family and friends and well as in some instances help from after school services.

*Anna: 'That the homework and the dinner would be out of the way [after school service] and if they [children] wanted something later on, fair enough, but that I'd just be able to have the time with them, you know'.*

Whilst some women sought and accepted support there was a feeling by some of the women that this was an admission of failure, that somehow through accepting help they were not doing mothering properly.

*Aisling: 'I did but I found it difficult to take that support ... I didn't want to hand him over'.*

When their distress increased the women in this study sought support from family and friends and in many cases they received it. However, they were aware that whilst family and partners could provide some support before becoming overburdened, there was also a need for other types of support and help. Women highlighted the need for family support workers to give them practical support with their children, and suggested the development of peer support groups where they could discuss openly their experiences, in a safe space. They also spoke about the need for the urgent development of family friendly facilities in psychiatric hospitals.

### **Beginning of resistance: seeking alternative approaches and routes to wellbeing**

Many of the women in this study felt labelled, stigmatised and disempowered by their diagnosis and by their interaction with the mental health services. While a minority of women had the support of CMHNs and found the therapeutic relationship with the CMHN helpful and supportive in their mothering role, the vast majority had begun the process of questioning the value of the services offered and had started to explore other alternatives.

Women spoke of the need for counselling to deal with present and past traumas, they spoke of the need for emotional support and for help in exploring a changed sense of self as a result of motherhood.

*Julie: 'I think you need someone to talk to you need that human interaction. I mean a pill is not going to solve all your problems. It's not going to lift that feeling of isolation. I think you definitely need human contact and the compassion and sympathy of other people which is not being emphasised at all, unfortunately.'*

*Ita: 'The last time I was over at Adult Mental Health I had known for a long time for me personally that medication was not the answer, that I was never going to get to the root of what happened to me without being free of medication'*

*Grace: 'I would have liked someone that would understand what happened me and be comfortable talking to that person without being terrified of working with me and helping me'*

*Niamh: 'Okay, at the time I suppose when I was going through all of that, the ideal for me would have been some sort of respite, where I could have just gone away and just had that time, with support there, to deal with whatever was coming up at that time'*

*Carmel: 'yeah the mental health person dismisses a lot of what you do as crazy which I don't like... I don't think that's right. When you're a mother you have to make decisions every day about how to raise your children, about how to discipline your children, what to feed your children and to go into an environment where someone's dismissing you is incredibly insulting.'*

For many women counselling was not available to them through the mental health services; therefore, the only way they could access counselling was through approaching voluntary bodies or through paying privately for counselling. The following accounts demonstrate that many women availed of private counselling as a means of dealing with their mental distress. The cost and the time involved often was a factor that women had to carefully consider as it may take time away for their

children and when paying privately can use up valuable resources that may be needed for the family. Some women managed to source subsidised counselling others did not.

Jill: *'But I did go to a counsellor privately. It was good, it was good at the time. I mean it did help me kind of look at things differently, it did feel quite self-indulgent to be honest ... but at the time it did help, definitely'.*

Niamh: *'Private counselling, yeah. It's actually with a woman here in [name of town]. The nuns actually subsidised it so it's very attainable, very doable so I stuck with it and ... I think at that stage then I had tried anti-depressants but I just didn't ... they just didn't suit me. I didn't want to keep taking them, I just felt numb to the whole thing and came off them'*

Orla: *'there's no counselling services. They did offer me one but it was very expensive and I couldn't afford it because I only do [work] a couple of hours a week like and I genuinely couldn't afford it. I couldn't ask my family for help again like. They were very good to me when I was in the hospital so I couldn't turn around and ask the family again for ... financially they keep bailing me out, they can't do it either like. So I got in touch with Family Resource which is brilliant and they have a counselling system up there and they're taking me on so they are. So it's on a one to one which I would prefer'.*

Annette sums up the need for and usefulness of counselling and how the mental health services do not address this need. Annette was adopted, is a single twenty one year old mother of two children and one of her children is in care. She has support from her adoptive family. She feels that she has many issues for which she would like to attend counselling. Her mental health care to date has been a diagnosis of bipolar disorder, admission to psychiatric hospital and medication.

Annette: *'But I felt if I had counselling or I had a counselling service like you know when I was pregnant that I could have done a lot better. I think I could have done a lot better with things or I could at least have been able to identify all my issues rather than keeping them [laughs] trying to deal with them and pretending they're not there and you know...Yeah, yeah and it is even harder if you have children I think. People don't ... they don't understand it. They think children will kind of make it all go away, the magic ... like that's the magic cure ... you know when you have children sure that will all be gone like ... you know you won't... that's kind of where it all stems they say like you know. That's what my GP said like that you know like it [pregnancy and childbirth] brought out the worst of my illness, the worst parts of my illness. Yeah and decisions and all this and it you know ... that's what happened to me. There again no supports like, no counselling services like really for that particular kind of issue. You can have counselling services for bereavement, you can have counselling services for a lot of things but for what I was going through there was no counselling services, not even in the hospital had I a counselling service. A lot of the psychiatric nurses weren't even willing to talk about it [foster care] like you know'.*

Annette echoes the findings of other studies; for example Diaz-Caneja and Johnson (2004) suggest that the even though motherhood is highly valued by women experiencing MHPs, motherhood for this group of women is viewed by the public and by professionals as inherently problematic. Mothers in this study experienced stigma because of their MHPs. Annette was doubly stigmatised in that her first child was in shared foster care. Annette felt that counselling might provide her with the support to discuss the many complex issues in her life and help her to maintain her mothering role.

For the women who accessed counselling there were many benefits: being able to look at things differently, dealing with unfinished business, having time to grow and develop and being able to deal with difficult emotions.

Some women spoke of the value of various other therapies such as, kinesiology, meditation, aromatherapy, mindfulness, exercise and reflexology helped them with their mental health problems in a way that they felt in control and empowered as active participants in their care and not as passive recipients waiting for medication to 'work'. Niamh, Jennifer, Eileen and Ita describe how various therapies have worked for them.

*Niamh: 'So I ended up going back to the kinesiologist and working with him and ... it's been invaluable really and ...I still work with the kinesiologist. I work with another lady over in England as well doing theta healing and that's been fantastic as well, it's all really, really helped ... I tried everything like homeopathy, reflexology, massage, reiki, everything in an attempt to just kind of ... sort myself out and just kind of deal with things'.*

*Eileen: 'It was the support I had. I was also ... I had been working, I suppose for ten years now, in mindfulness, just a little bit at home myself, Echart Tole, Jon Kabat-Zinn and those writers and living in the moment.'*

*Jennifer: 'I'm starting to learn a lot about meditation and exercise and just trying to de-stress and I'm learning very much to keep the stress off that comes on me at work or wherever, becoming much calmer in myself and much more solid so long-term I don't think it's [mental health issues] going to be a problem ... I go for a swim sometimes with a friend of mine who's in the gym and even that just to get the tension out of your shoulders and things, it helps a lot. I suppose a holistic approach maybe is better than a GP or psychiatrist'.*

*Ita: 'they had aroma therapy and I used to find that ... I used to find that absolutely wonderful. When there would be so much here of tension you know and you were thinking to yourself oh here I go again now. What is it this time that I can't deal with*

*it, I'm going to make a big song and dance about it because you would be talking to yourself like this and when she would start doing it the aroma therapy ... no need for medication'.*

In the above accounts the women had agency in their treatment for example 'sort myself out and just kind of deal with it' and 'learning to keep stress off'. The active nature of these comments gives a view of women as wanting to find answers, of wanting to feel better and to find a route to well being that could be sustained into the future. As Ita suggests 'you were thinking to yourself here we go again' over the last twenty five years Ita had numerous admissions to hospital, she was now getting help that meant she could change the pattern as in her final comment 'no need for medication'. At the time I met with Ita she had, with the support of her psychiatrist, come off all medication and was taking an active role in understanding her distress. She had made many life changes and felt that she was finally in control of her destiny.

In the context of support a number of women spoke about the importance of religion, their belief in prayer and how their religious communities supported them.

*Rebecca: 'I try to pray ... try to read the bible and think about it and I try to impart these thoughts in my life'*

*Carol: 'I went and prayed every day and sometimes, in real bad times, I'd go to mass in [name of town] here in the mornings and go to mass in [name of town] in the evenings, just to get through, just to give me energy I suppose really or jus t... that was the only place at the time I had peace of mind and ... so that got me through that'.*

*Jean: 'Yes that there is somebody greater than yourself out there that can help you and you know. I think that is important as well'.*

Research has highlighted the positive effects of spirituality and religion on mental (Corrigan et al. 2003; Falloot 1998) and physical health (George et al. 2000). Spirituality offers a way to cope with mental distress (Corrigan et al. 2003; Bussema & Bussema, 2000; Lindgren & Coursey 1995) and can also serve a self-protective function (Blaine & Crocker 1995) in maintaining mental and physical health. From an Irish perspective Watts (2013), in his study of Recovery from mental health issues, also stressed the spiritual dimension.

Other women who felt their mental health was in part due to seasonal affective disorder (SAD), spoke of other routes to taking control, such as physical exercise.



Lisa: *'I think I suffer i f... me saying I'm not bipolar ... I do think I suffer a bit with that SAD. When the weather is dull and gloomy I feel like that but when it's sunshine I want to be out cleaning my windows, cutting my grass, hanging out my washing you know I feel like that. I would love to go away to a hot country'.*

Carmel: *'In the wintertime with the dark and the rain and everything and living in Ireland it's always raining and it's always dark so I've gotten her [social worker] to try and get one of them. She ... she's very good in the way that she's pushed that. She worked out the cost of the anti-depressants and I think it came to 480 quid whereas a SAD lamp is 280 quid ... so she pushed it and I think that's really clever the way she's thinking'.*

Ita and Jean and others highlighted physical exercise as important for them in maintaining their well being.

Ita: *'Ah ... I walked a lot, really walked. I did an awful lot of physical exercise. I think physical exercise and mental health are very closely linked'.*

Jean: *'I also had a therapist who was very good towards the end ... I was on the mend and getting you know ... probably more positive and stuff like that ... an occupational therapist came from the services out to me. Now he was from England and he had a sort of very progressive attitude. He was more into the holistic approach of have you gone for a walk today Jean, did you go swimming, what's your diet like'.*

Many women sought out and found positive and strengths and focused support in counselling and in various other therapies such as kinesiology, meditation, aromatherapy, mindfulness, exercise and reflexology. In addition women highlighted the importance of religion and physical exercise in helping them find support and regain control in their lives. Women felt that through addressing trauma and strengthening social and family supports they were in a better position to cope with their distress and to continue being the mothers they want to be to their children. Women felt that hospitalisation and medication placed them in a powerless and vulnerable position especially in relation to their children and reinforced their fear that their children would be taken into care.

### **Summary**

Based on the findings this group of mothers have the same aspirations, hopes, dreams and expectations of motherhood as other mothers. However because of the relations of ruling, social and medical institutions interfaced with dominant ideologies around motherhood, mental health and illness this group of mothers are perceived as being not the 'same', as 'different', 'unpredictable' and in some cases as 'unfit' as mothers. This creates a series of oppressive circumstances for them.

What can be seen, from the findings presented here, is that this group of mothers strive to live up to ideals and expectations of motherhood, whilst also dealing with mental distress, a result in some cases of childhood and or adult trauma. When women later went on to experience mental distress as adults, their childhood experiences were not asked about by mental health professionals. The range of responses offered by the formal medical services ranged from hospitalisation to ongoing medication and only sometimes included a therapeutic relationship.

In many cases the primary and only response was hospitalisation and prescribed medication, which added to their difficulties and distress. It was clear from the interviews that their confidence was undermined by engagement with some mental health professionals and with a realisation that the competence as mothers of women with mental health issues was questioned, if not undermined, by these professionals. While a small number of women spoke about the positive role CMHNs played in dealing with their distress and in their mothering role; however, the reality for many women was a total lack of supportive, and therapeutic mental health services.

The responses of the mental health services only serve to reinforce a biomedical view of their mental distress and resulted in the women being focused on as the site of 'illness' as opposed to any exploration of the context of their lives. The women were placed in the role of 'patient' with their mothering role being largely ignored. In addition, hospitalisation took them away from their children and added to their sense of stigma and isolation. All were very aware of the impact their mental distress had on their ability to mother. It is important to point out that the level of distress experienced by the women in this study was not constant and did not always remain the same. However when interacting with mental health services the women were conscious that once the label of 'mental illness' was used it remained a constant in future contacts with services, almost 'once a patient always a patient'.

While the women initially accepted the medical view and 'complied' with professional directions around hospitalisation and medication they slowly began to resist the pathologisation of their distress and began to question limited professional advice. However the women were aware of the expectation that they engage with statutory services even though these services did not always provide the support and help they needed. They were

fearful of voicing negative feelings as they felt that these feelings might be interpreted as indicative of mental 'illness' rather than as part the normal range of emotions experienced in motherhood. They were also conscious that they had to carefully balance their involvement with mental health services and their use of alternative services, another balancing act that was necessary in an attempt to keep their children with them and safe. Women struggled with the side-effects of psychiatric medication, however they continued to take prescribed medication in the hope that they could continue to care for and protect their children. The women began to resist the biomedical view of them as flawed mothers and used strategies such as hiding their distress through; 'managing time' and 'planning ahead' to enable them to be the mothers they wanted to be. The women in this study were aware that they were not viewed as ideal mothers and the strategy of hiding their distress arose from the women's belief that they needed to portray an acceptable view of mothering whilst also resisting being stereotyped as less than ideal mothers. These strategies came at a high cost to the women's own well-being, the constant struggle to continue caring for their children meant that their distress was hidden, and at times led to further social isolation as women conserved their limited energy to take care of their children. Women also kept their distress hidden to prevent the experience of stigma both their children and themselves. Women began to search for, and found, ways of dealing with mental distress, trauma and abuse through the use of counselling, kinesiology, meditation and physical exercise. These treatment modalities helped women to commence the process of dealing with trauma and gain a better understanding of themselves and their needs. The women were clear that what they needed was counselling and family support workers to give them practical support with their children. Women also suggested peer support groups where they could discuss openly their experiences. They also highlighted the need for family friendly facilities in psychiatric hospitals. Women also had clear ideas about how they could prepare for times when their distress and despair became overwhelming, and considered advance directives and respite facilities would be important additions to services.

## **Chapter Eight: Discussion, implications and conclusion**

### **Introduction**

The previous chapters have presented the findings from the interviews with mothers who experience mental health problems (MHPs). The findings were presented using, in the main, the women's own words and highlighting their understanding of their experiences as women and mothers. Feminist standpoint theory provided a methodology for linking the everyday worlds of mothers with social and institutional practices and ideologies which impact on the lives of women as mothers. The aim of this chapter, the final chapter in the thesis, is to provide a discussion of the findings under the following headings:

- Feminist standpoint: a more holistic understanding of the women's world
- Motherhood and mothering: experiences of resistance
- Biomedical understanding of mental health issues and women's resistance to biomedical ideology

Following this discussion there will be an exploration of the implications of these findings for mental health service policy, service provision, education of mental health practitioners and research. Finally the thesis will conclude with some personal reflections on my journey as a woman, mother, nurse and researcher.

### **Feminist standpoint a more holistic understanding of the women's world**

Feminist standpoint theory begins from the premise that less powerful members of society experience a different reality as a consequence of their oppression, with feminist standpoint research seeking to uncover women's voices which are often ignored. There are many examples within feminist standpoint research that recognises how women have different experiences from men and therefore the knowledge gained from and embedded in their experiences provides a different view and interpretation of the world (see for example: Bem 1993; Flax 1987; Harding 1986; Kramarae and Sender 1992; Lorber 1994; Stanley and Wise 1983; Zalk and Gordon-Kelter 1992). These writers question how knowledge is produced and who produces it, and in so doing they expose how knowledge from marginalised positions can be suppressed by patriarchal traditions. Smith (1987) argues the standpoint of women is not to be equated with perspective or worldview. It does not

universalise a particular experience. It is a mode of inquiry that creates the space for an 'absent subject', and an 'absent experience' (p.107) that is to be filled with the presence and spoken experience of women speaking of and in the reality of their everyday worlds. In using feminist standpoint theory to guide my research, I have presented a view of the world from the standpoint of the mothers involved. This standpoint moves away from the biomedical ideology of mental 'illness', one that categorises experiences into signs and symptoms and results in an 'objective' diagnosis. Instead, in collaboration with the women I have moved towards a construction of knowledge of maternal mental distress that comes from the specific experiences, location, history and everyday lives of the women involved. In mental health research the everyday experiences of women at the receiving end of treatment and care is not taken into account. Therefore the knowledge in these experiences is often, because of the relations of ruling, subjugated, ignored, not taken seriously, and considered as unimportant by those who are positioned to influence the lives of the women. Instead they work with what is considered authoritative knowledge, for example, biological, social, psychological theories of mental distress. This authoritative knowledge, usually derived from positions of power, is then imposed as a universal explanation and becomes influential in reinforcing existing positions and in subjugating the knowledge of the women (Hill Collins 1990). In contrast to this, a feminist standpoint asks the researcher to explore how social and structural factors impact on women's mental health, and in so doing gain a clearer understanding of the 'rupture' between authoritative knowledge about women's mental health and the complex experiential knowledge embedded in their everyday lives as women and mothers. In this study through exploration of the relations of ruling the subjugated knowledge drawn from the lives of this group of marginalised women has provided different view and can be used to gain a more inclusive understanding of the meaning of maternal distress.

The women in this study were conscious that having a diagnosis of mental 'illness' put them at a disadvantage and they felt that society and its legitimated health and social services viewed them as less than ideal mothers. Women were strongly influenced by the ideal mothering ideology-embedded in patriarchal motherhood-and the notion of 'good' and 'bad' mothers. Although all the mothers set out to be good mothers, the good mother ideology set up expectations of motherhood that women struggled to live up to fully. This was clear from their descriptions of their preparations for motherhood: women consulted

'experts', professionals, books and media for help and support. For many women this process began before becoming pregnant and continued for many years.

Their understanding of mothering as all consuming and child-centered left them with little time to dedicate to their own wellbeing. When the mothers interacted with the mental health services, their interactions with some health professionals undermined their confidence and often left them feeling that they might be viewed as 'not perfect' mothers. For example some women were advised not to have children because of their MHPs. Therefore, when they did become mothers, they did everything possible to prove their abilities to themselves and others. In many situations the women compared themselves to other women as a means of judging whether they were doing the mothering 'right'. In addition the women spoke about the 'rules' of motherhood that influenced how they mothered on a daily basis, and which they measured themselves by.

Patriarchal motherhood, and, stemming from this, the ideal mothering ideology is unattainable, oppressive and blaming for all women. However, for women who experience MHPs it is a particularly difficult ideology to negotiate because of social and institutional practices towards mothers experiencing MHPs. The women struggled to mother their children on a near daily basis and in the contexts of mental distress, trauma, and side effects of medication, they developed many strategies to continue their mothering role and found ways of coping so that their distress had minimal effect on their children. The strategies included such things as 'hiding distress', 'managing time' and 'planning ahead'. Through the use of these strategies and by prioritising their children's wellbeing the women's stories challenge the prevailing view of women with MHP's as 'damaging of children' and 'unfit' mothers. However, in seeking to protect their children the women became further isolated as they conserved their limited energy to care for their children. Most women spoke of the stigma attached to mental health issues and all expressed the fear that their children would be taken in to care.

The women's lives were constantly evolving and changing as they became more experienced in handling both their MHPs and the work of motherhood. However, when they came in contact with the services, most often their experiences were reduced to a narrow interpretation of signs and symptoms. Within this biomedical view the women were diagnosed as having a mental 'illness' and were placed in the role of patient. Hospitalisation

and medication were offered to treat their diagnosed 'illness'. This view provided a static snapshot of their lives at a particular time rather than taking the whole kaleidoscopic film of the complexity of their lives into consideration. The spectrum of feelings both positive and negative attached to motherhood became obliterated and ignored for this group of mothers and their knowledge from their lived experience became subjugated. Hospitalisation removed the women from their children, added further to their feelings of stigma and isolation and their role as mother was pushed into the background. The biomedical model offered limited choices to women and services were seen as powerful in their role in judging their mothering competence. Not only did the women recognise the power of the mental health and social services, but they were acutely aware of their marginalised and subservient position within these relationships. Therefore, the women quickly learned to give professionals the information they were seeking, for example, information on signs and symptoms and effects of medication, rather than revealing the lived reality of their lives. Thus the women had metaphorically 'double vision' (Hill Collins 1991) as they had to move between biomedical knowledge and understandings and, at the same time, had to live in a world in which this model did not make sense to them. Viewing the relations of ruling from the standpoint of women highlights areas of tension and disconnection. For this group of mothers their child is their focus and how to protect their child from the effects of mental distress is their goal. For mental health and social services the mother and child are individuated within an system, governed by professional and bureaucratic organisation and informed by ideologies of motherhood and mental 'illness' that regulates work practices that focus on individuals. Thus mothers are viewed as 'mentally ill' and children are viewed as 'being at risk' from their mothers. The ideologies and practices informed by the relations or ruling do not take into account a holistic view of the family unit.

In addition the women described their struggles with professionals to have their voices heard as the women's voices were often replaced by the voice of experts, for example Sinead's harrowing account of ending up in a hospital intensive care unit following a reaction to medication and how her account was not believed. Because of her previous mental health problems it was assumed that she had taken an overdose of prescribed medication. It was through the intervention of her husband that her account was eventually believed, accepted and appropriate treatment given.

In the interviews, as the women articulated their experiences they returned to their own voice - a voice that had been lost through their interactions with the mental health services. While the women initially accepted their 'diagnosis' and medical label and used biomedical language themselves to describe their experiences, as the interviews progressed they began to speak of how, having initially accepted the biomedical paradigm, they slowly began to resist the pathologisation of their distress. Once the women began to question professional wisdom they started to explore other ways of dealing with their distress and turned to counselling, kinesiology, meditations, religion and physical exercise. In so doing the women began a process of dealing with trauma and gaining a greater awareness of themselves and their needs.

There are hopeful signs that professional practices and understandings may be changing, and the mental health practice is moving towards listening to subjugated knowledge. For example Mary Ellen Copeland's WRAP (1997) and Hearing Voices Network (Dillon 2010) are becoming part of main stream mental health services and people with self experience of mental distress are seen as 'experts' by some professionals. However, the overall findings as presented in Chapters Five, Six, and Seven, highlight the structures and systems in which women's lives are embedded and expose how the powerful positions of the psychiatric system and the ideal motherhood ideology has resulted in oppression and marginalisation of this group of women. When the women became mothers, social inequalities, social expectations and roles, especially in relation to gender, became accentuated. As recipients of the mental health services the women had limited autonomy when they became mothers; they became more reliant on others such as family, the legal system, social welfare, social and health services-whose main reaction was oppressive in nature. They became enmeshed in systems of inequality because of their position as mothers. However, these experiences also create the possibilities of resistance as the women come to demonstrate agency in their lives through their rejection of the prevailing views of motherhood and biomedical ideologies.

### **Mothering and motherhood: experiences of resistance**

The understanding, that mothers are the best people to care for children and that they must do this work selflessly, remains unquestioned in social terms although its burdens are



enormous and well-documented in the literature. In the 21<sup>st</sup> century patriarchal motherhood has been highlighted by many (see for instance, O'Reilly 2004; Thompson et al. 2011) and I discussed this literature in Chapter Two. The literature makes clear the expectations for women, stemming from the ideal mothering ideology at a time when there is less support than ever for mothering in our society (Benn 1998). Women struggle with that fundamental contradiction but are still offered scant support. For women in more vulnerable positions, such as the women in this study, the burdens are greater still (Murphy-Lawless and Edwards 2014).

At the same time, women do not have to be 'victims' of ideologies though it can be a challenge to resist them. Rich (1997) emphasised the importance of resistance and more recently Horwitz (2011) explored the experiences of mothers as they actively resist the ideal mother ideology even in a patriarchal society where women often have little power in changing societal structures. This is certainly true in Ireland where what O'Connor (2000) calls the 'patriarchal dividend' continues to provide men and male-dominant institutions with significant benefits in ways that disadvantage women. Within the home women are held responsible for nurturing children and for the moral development of the next generation, yet they are given this responsibility without the power to influence any broader social changes. Thus, despite the inroads made by second and third-wave feminism, mothers are implicitly and often explicitly not seen as important persons in their own right but have value as mothers. They also have value as workers and as consumers, yet the totality of their work, let alone their personhood, remains unacknowledged. This is a contradictory position that is difficult to reconcile. For mothers who experience MHPs the position is more difficult still. Mothers who experience MHPs struggle to keep their mothering identity intact. Constructing that identity as difficult as it is, becomes a vital counterpoint in their lives. In the interviews the women's mothering identities were very important to them. For this group of women being a mother expanded their sense of self but at the same time reduced the sense of self in the all-consuming childcare practices and in managing their own mental distress. Motherhood for this group of women offered the possibility of being included into the community of mothers. However the women had to balance how they presented themselves to others and had to keep their mental health status hidden from other mothers for fear of consequences and exclusion. They also had to downplay or reinterpret their circumstances in interactions with professionals in ways that

were least prejudicial and damaging to the women themselves. The women's power to resist lay in their presentation of self and interpretation of self to others. Thus the women take hold of their subjectivity in their own terms of reference, or as Dorothy Smith states, they become 'expert practitioners' (1987, p.161). In using feminist standpoint theory to ground the research in the experiences of this group of marginalised women, what has been made evident is exactly how a marginalised group see their marginality most completely and can articulate their lived experience most completely. They make it visible to us who stand outside. Of course, women who experience MHPs are viewed, in much of the literature, as being at risk to their children as discussed in Chapter Three. However the findings in Chapters Five and Six make visible women's strengths and commitment to being 'good enough' mothers, a view that is impossible to discern from the biomedical perspective of mothers with MHPs. The 'relations of ruling' (Smith 1987) that construct women's lives maintain a view of this group of women as flawed and 'unfit'. In using FST the strengths and coping skills employed by this group of women are brought to the surface to contest these other limited and damaging definitions. Previous research that focused on deficits of women as mothers, such as children being at risk of developing MHPs and being at risk from their mothers (Beardslee and McMillan 1993; Lieb et al. 2002; Normura et al. 2002; Smith 2004; Gladstone et al. 2006) failed to notice their abilities, their strong commitment to their children and their desire to be mothers.

Scott (1990) defines resistance as the effort of oppressed groups to challenge and act against aspects of dominant discourses. In this study resistance is taken to mean the effort mothers make to challenge and act against aspects of the dominant ideologies of mothering, motherhood and mental health. For mothers experiencing MHPs thinking about, becoming pregnant and having children becomes a challenge to the dominant ideology of motherhood, in which they are positioned as entirely unsuitable mothers. Some of the women faced hostility from medical professionals in seeking to become mothers (Chapter Five). This group of women first demonstrate their resistance to dominant views of ideal motherhood through the very act of becoming mothers. They are well aware of how they are viewed as women with MHPs and yet they have resisted this and become mothers. In so doing they face the challenges of stigma and negativity to claim their right to be mothers. Whether resistance can be maintained once women become mothers is more difficult to ascertain. Horwitz (2011) describes resistance, in relation to mothering, as a conscious

process that involves questioning societal expectations of mothers. As discussed in Chapter Two the dominant ideology of motherhood is impossible to achieve, therefore for many women resistance began in the questioning of this ideology. The women interviewed in this study did not describe themselves as explicitly resisting dominant ideologies; however, as they shared their stories of how they mothered in the context of mental distress, their resistance in concrete terms was seen through such practices as: hiding distress, managing time and medication; planning ahead; and involving others in the care of their children. Women experiencing MHPs were aware that they were considered far from ideal mothers and some consulted experts in their decision to become mothers. Therefore, I suggest, that making a conscious decision to resist the view that they should not become mothers was a powerful demonstration of agency. However, once the decision to have children was made and children were born, they had to live with the ongoing stigma as evidenced by the women having to hide their difficulties and not being able to discuss them openly with others. As a result, everyday mothering became in itself an act of resistance to challenge and prove that they were good enough mothers. Women also demonstrated their resistance to the all loving mothering ideology through talking about the difficult side of mothering and, at times, their ambivalence in their mothering role. The women also highlighted the frustrations and challenges in day to day care of children and spoke about the challenges of coping with extreme distress and the possibility of suicide. Being so open was a courageous stance for a group of women to take as, given their MHPs, their very role as mothers is considered suspect. The women were constantly balancing the needs of their children and their own needs. At times they felt 'silenced' in their experiences, and they needed to carefully choose when and where they voiced their views because of the danger of being judged and deemed an 'unfit' mother. While the ideology of being the ideal mother lined up against them, in opening up and discussing their everyday challenges and lives they showed determination to build for themselves a more complete and realistic understanding of mothering. However, resistance to the powerful ideal mother ideology in the context of patriarchal motherhood was a constant struggle and was more successful for those mothers whose expectations of themselves as mothers were not unrealistic and who were able to let go of some of societal standards for example, going to bed when their distress threatened to overwhelm them and seeking support in their mothering role.

## **Biomedical understanding of mental health issues and women's resistance to biomedical ideology**

As discussed the biomedical explanation of mental distress presents mental distress as a discrete illness entity, with a focus on signs and symptoms as indicative of 'illness' being present and something that can be measured with objective diagnostic tools. From this understanding the accounts of the women's distress in this study would be considered to reflect the signs and symptoms of 'mental illness' leading to a diagnosis of 'mental illness'. The 'illness' is seen as part of a woman's pathology and obscures the embodied, subjective experiences of what it feels like to be distressed. The feminisation of mental distress was highlighted and discussed in Chapter Four. Feminist writers such as Chesler (1972) and Smith and David (1975) argue that medical science and, in particular, psychiatry pathologises femininity. Barnes and Bowl (2001) highlight the gendered nature of mental health and Marrow (2008) suggests that women are positioned, within psychiatric discourses and practices, as more vulnerable to mental health problems. Women's mental health is also linked to their physical bodies with emphasis placed on, in particular, female hormones as being strongly associated with women's emotions and mental health (Ussher 2006). The continuing predominance of the biomedical explanation fails to take into account the interplay of biology, psychology and social worlds of women and how, as women act and interact in that social world, they gain and regain competence defined in their own terms of reference and the dynamics of their lived experience. By contrast, the biomedical focus is on the individual who is seen as 'sick' (Morrow 2008; Morrow et al. 2009). The biomedical ideology is strong and as discussed in Chapter Six is often internalised and used by the women to explain their distress. In addition, the language of 'psychiatry' is often used to undermine women's experiences of distress through focusing attention on the individual as the site of problems and often blaming the individual and describing them as 'noncompliant' and 'unmotivated' when treatments do not have the desired effect. The biomedical discourse is privileged in interactions with health care professionals as the focus of such interactions is on signs, symptoms and medication. Thus problems are located within the person thereby minimising or negating their experiences of oppression: powerlessness, marginalisation, exploitation, trauma and abuse (as described in Chapter Six). The women in this study were aware that the primary focus of interactions with mental

health professionals was to assess signs and symptoms of mental 'illness' and to check on medication and consequently did not speak of their experiences of oppression and trauma during interactions with mental health services. They were also conscious that information about their lives might be used against them and that they may be blamed for their circumstances and judged as 'unfit' mothers, thus they stayed silent. Yet, overtime, the women began to question and resist the biomedical explanation and develop as I said a 'double consciousness' (Smith 1990, p.19). In other words, they know life from their experiences and also know life from the 'relations of ruling', in this instance the mental health system. From this knowledge base the women began to question the notion of being a risk to their children and began to develop a more positive identity as mothers experiencing MHPs. The women also resisted through developing awareness of and through their struggle to let go of, the social pressures and myths that were unhelpful and at times harmful to them. The women acknowledged the context of their distress and highlighted other possible understandings of their distress. They spoke about how childhood and adult trauma and the existence of multiple stressors impacted on their mental health. Over time they were able to recognise that these experiences explained their distress more fully than the narrow view of their distress presented by professionals, a view that presented their distress as located within a chemical imbalances or inherent disorder in their physical bodies. Thus the women began to resist the notion that they have a 'mental illness'.

The women also began to resist hospitalisation and medication through exploring other therapies and strategies. While the women initially accepted medication and some found it useful in managing their distress, they gradually came to question medication as a solution to their distress and started to explore and use alternative therapies as a means of understanding and coping with their distress. The women felt that they needed help with understanding their experiences of trauma, and were of the view that their life experiences were not addressed by statutory services, and therefore they went outside these services and found the help they required. The women sought out formal support systems in peer support, counselling, kinesiology and through informal support systems such as exercise and religion. Thus, the women resisted the medical model through: questioning the value of this interpretation of their distress; questioning medication; and seeking other ways of being though acknowledging their life experiences and experiences of trauma. In so doing the women found alternative ways to empower themselves which helped them to take control

of their lives and to engage in self care. In this way they were resisting both the notion of ideal motherhood (where self care is not a priority because care of the children always comes first) and the biomedical explanation of their distress. Women also resisted the ideologies of motherhood and mental 'illness' through involving others in supporting them in their mothering role, thus resisting the notion of mother as primary carer. When their MHPs overwhelmed them they involved others, such as partner, family members and friends, thus allowing themselves the time to take care of their mental health.

The women in this study were conscious of the social and medical expectations on them and how these expectations were oppressive to them. Thus, in resisting the medical explanations and treatments, they had a difficult balancing act. As the women began to trust their own judgements rather than turning to experts at all times being very aware that in seeking alternatives to mainstream psychiatry they ran the risk of being judged as 'noncompliant', 'unstable' and 'unfit' as mothers. Thus resistance to relations of ruling and dominant ideologies by this group of women who are already 'suspect' is a brave move.

This study suggests that agency and resistance are clearly positive possibilities for mothers with MHP's as this group of women demonstrate that they are not passive victims of ideologies. However even though agency allows women the capacity to initiate change and transform their lives, it is always limited by the socio-political context within which it occurs (O'Connor 1997, 2000).

### **Some challenges in writing the implications and recommendations**

Before moving on to explore the implications of these findings for service provision, education, policy and research, I think it is important to mention how knowledge is used and how this fits in with FST. In using women's experiences from this research to inform practice there is a possible epistemological mismatch. FST uncovers subjugated knowledge in marginalised experiences and these experiences are bound by the context of women's lives. Through attempting to provide recommendations from these findings I run the risk of providing a reductionist and mechanistic view that is removed from the context of women's lives. FST suggests that knowledge is bound up in culture and power and argues against the notion of value free 'truth'; therefore the struggle is not to value one way of understanding over another (Harding 1991). It is also important to consider how to prevent the findings

from this research being used in oppressive and disempowering ways, for example women's social circumstances may be used to suggest that they have made poor choices and are unable to cope and therefore reinforcing the notion that they are a risk to their children. Despite my best intentions it is possible that the findings may be used to support dominant ideologies. However I think that the findings provide a different view of maternal distress and can help services to consider a different approach to supporting this group of women.

### **The implications of these findings for mental health service provision.**

In exploring the implications of this research on mental health services I suggest that the women's standpoint offers the opportunity for services to engage in more empowering ways to support women as they mother while experiencing mental distress.

The biomedical view of mental distress that currently informs mental health services is not responsive to the needs of women as mothers. As discussed in Chapter Three, most of the literature points to the lack of support for this group of women and their families. The focus of mental health care professionals, in the main, is on the 'illness' and the primary concern for women is their mothering role. The services offered to this group of women were based on the biomedical view of their distress; therefore medication and hospitalization were the only treatments offered. A small number of women had the support of a CMHN and found this to be a positive therapeutic support in dealing with their distress and mothering role.

Policy documents highlight the importance of holistic person-centered care, to achieve this there is a need for major changes in mental health services. Mental health practitioners currently use a range of assessment and intervention practices that do not always take into account the day to day subjective experiences of women as mothers. This often results in mothers not receiving the help and support they need in caring for their children. As is demonstrated in the literature reviews (Chapters Two and Three) and in my findings, mothers in contact with mental health services often perceive the help they receive as undermining, judgemental and controlling and in some cases blaming. Currently mental health services either ignore the mothering role or focus on assessing mothering practices with the lens of child protection and therefore women feel scrutinised and under surveillance. This focus highlights a deficit approach rather than a strengths-based approach, one that would highlight their capabilities as mothers. Thus, services tend to

focus primarily on the child's need and the needs of mothers are secondary to this. Mental health practitioners construct their practice as helping and protecting children, and this means that the child is the focus of their attention rather than the mother or family. It is a balancing act for mothers to juggle their mental distress and their mothering, similarly it is recommended that mental health practitioners need to balance how they can be supportive to both mother and child and not favour one over the other. This study has highlighted the lack of information available on the numbers of mothers experiencing mental health problems. There is no comprehensive data base available in Ireland. Therefore women who experience MHPs who are mothers are neither adequately recognised nor fully addressed in policy and service provision. Mental health practitioners need to take on board the concerns and experiences of women as mothers and to acknowledge their marginalised position in Irish society. Drawing on the experiences of women whose children were in care there are particular implications for mental health services and practice. It was evident from the experiences of the nine women in this study whose children were in care (Alice, Myra, Deirdre, Grace, Una, Joan, Vera, Allison, Annette) that the welfare of this group of mothers was given minimal consideration. Both mother and child should have the right for equal care and services. However services focused on possible risk to the child and advocated for the removal of the child in the context of the mother's increasing mental distress. The women in this study had a different view and felt that with support and help they would be able to continue caring for their children. Being separated from their children caused increased distress and anguish. When women were allowed supervised access they were aware that they had to adhere to strict rules and regulations. The imbalance in care and focus is exemplified by Una's experiences. In Una's situation surveillance was continued during times when she was allowed access with her son. This surveillance caused severe distress to Una and often after these supervised visits she described being distraught, tearful and felt powerless to change her situation. Una wanted her son to live with her but was caught in a situation where she was unable to challenge this. The absence of her son had a detrimental effect on her mental health and this was viewed as evidence that she was unable to care for him so she was caught in a vicious circle of powerlessness and increasing despair. Similarly, Vera's mental distress worsened during the separation from her child with authorities placing her child with a family several miles away from where Vera lived. Women also spoke of the loss of child benefit when children were placed in care this further added to their difficulties as



they had limited financial resources to pay for public transport to visit their children. Women in this study clearly articulated their preferences for practical, emotional and financial support, and these suggestions are included in the recommendations.

In this study women were very clear for the need to change current mental health care practices to support their mental health. They spoke about the importance of self knowledge, and the importance of learning how to maintain their well being and being able to source and avail of alternative services that were more responsive to their needs. The interactions that some of the women experienced with mental health professionals suggests the need for changes in attitudes and practices by mental health practitioners.. There is a need for health professionals to shift their gaze towards the woman's life and away from diagnostic labels. This change in gaze would point to changes at an interpersonal level emphasising the importance of mutual respect, reciprocal listening and acknowledgement of difference (McDevitt 2004; Morrow 2006) as well as an acknowledgment of the women's experiences and the knowledge embedded in these experiences. At a structural level this shift in focus would also highlight empowered practices and system changes so that women's experiences of marginalisation are eliminated.

**It is recommended that those charged with development of mental health services:**

- Move away from the biomedical explanation of women's distress and instead focus on the context of women's lives and their experiences as mothers by providing family oriented community services to include: family support workers to offer practical and emotional support in parenting; support groups of mothers in times of distress; child care and family friendly facilities when admission to in-patient services is unavoidable; dedicated space in hospital for women to receive visits from children; respite services, advance planning and crisis plans.
- Provide specialist mother and child facilities for mothers experiencing MHPs. This might reinforce the notion that the role of mother and women experiencing MHPs is seen as compatible.

Acknowledge that women are competent to make decisions and support these decisions by including them in service planning and decision making.

**It is recommended that practitioners who work closely with women:**

- Advocate for a strength led approach to care planning, which is underpinned by a belief in women's capabilities and strengths, not their perceived deficits and one which engages women in discussion about their experiences and needs so that care can be mutually agreed and shared decision-making and shared responsibility is at the heart of care provided.
- Support mothers whose children are in care and work with mothers, where possible, to enable them gain access and maintain a relationship with their children.

**Implications and recommendations for education**

The literatures reviews on mothering and mental health problems carried out in this study suggest that there is a dearth of research in the area of mothering and mental health that focuses on the everyday lives of this group of mothers. What was available was particularly focused on deficits and in the main perpetuated a view of mothers as being 'unfit' and a risk to their children. Currently mental health professionals working with women receive little training or guidance regarding support of mothers experiencing MHPs, and if education is offered it is constructed within a risk discourse that focuses on child risk and surveillance rather than on support and strengths. Therefore it is not surprising that the emphasis within their clinical interactions is on the impact of mental distress on women's ability to mother and the capabilities of women as mothers.

If services are to respond to and support mothers before a crisis there needs to be an open dialogue with women encouraging discussion of their mental distress and mothering and how these impact on each other. Fear of loss of custody is a major factor for this group of women and this fear has an impact on disclosure and on developing trust with health care professionals. However, a trusting therapeutic alliance may be possible if professionals are interested, knowledgeable and able to offer support and help other than the removal of

children. This study provided a different view of women's experiences from their standpoint, one that can be used in education of future mental health practitioners.

**It is recommended that educators review curricula to ensure that education offered:**

- Includes discussion on the challenging and complex nature of mothering, ideologies underpinning patriarchal motherhood and the oppressive nature of some of these ideologies.
- Raises awareness of the context of women's lives and highlight how the intersection of multiple sites of oppression impact on women's lives
- Provides mental health practitioners with a sound theoretical basis on motherhood and provides them with skills required to engage with mothers in a non judgemental and reflexive way.

**Implications and recommendations for policy-makers**

The findings from this study show that this group of mothers are deeply committed to mothering and their children. They adhere to the ideals of good mothering, taken for granted in Irish society, of selflessness and sacrifice on behalf of one's children. It was demonstrated clearly in this study that women wanted to maintain relationships with their children and to do what is best for them. Yet the health and social institutions and structures that the women had contact with prioritised the needs of the child over their needs as mothers. The women in this study also described how their confidence was undermined by their interaction with mental health professionals. Policy makers need to consider how policies can be changed to include equal consideration for mothers. Future policies need to be underpinned by the following values: optimism about mothering; inclusivity; the acceptance of reasonable risk; respect; assumptions of permanence of the mother-child relationship; support and involvement of mothers.

**It is recommended that policy-makers:**

- Develop gender sensitive policies that acknowledge the needs of mothers with MHP's
- Consult with and include mothers who experience MHP's in policy making.

- Critique the present focus on risk-assessment and management within policy that negatively impacts on mothers and include a more positive focus on creative risk taking.

### **Implications and recommendations for research:**

The literature review carried out for this study suggested that there was a lack of research in the experiences of mothering in the context of mental distress. This study has commenced the process of research in this important area, the findings offering a number of suggestions for future research both from the women's and from mental health services perspectives. The following recommendations are made for research.

### **It is recommended that:**

- A study is undertaken to explore mental health professions experiences in engaging with this group of women.
- A study is undertaken to explore in-depth the experiences of women whose children are in care.

### **Reflection throughout the research process as a mother, nurse and researcher**

As discussed in the methodology chapter reflexivity begins at the start of the research and continues throughout the whole research process. It is at the heart of feminist research, as discussed in Chapter Four, and I was conscious through the research that any inclusion of 'myself' was intentional and situated in the research thereby making my potential blind spots clear. I was drawn to Behar's observation and returned to this throughout the research process:

*'The exposure of self, who is also a spectator, has to take us somewhere we couldn't otherwise get to. It has to be essential to the argument, not a decorative flourish, not exposure for its own sake'. (Behar 1996, P.14)*

Bearing this in mind what can I write here that will add to this study?

I started the research process to gain knowledge and understanding of women's experiences as mothers and to explore the possibilities for a more inclusive and responsible service. Throughout the research I thought long and hard about how to accurately reflect

the experiences of this group of women. I read and listened to the interviews several times. I wanted to be as sure as I could be that I was hearing the knowledge embedded in their experiences. I was attempting to catch a glimpse of or capture what it was like to mother in, around and under the powerful gaze of psychiatry and idealised motherhood. As a mother I had some understanding of the pressure placed on women by the dominant ideology of intensive motherhood. At the start of the PhD I was a single parent with a twelve year old son, as a result I was living the myriad of emotions and constantly juggling home and study. Like many of the women I interviewed I struggled with the feeling of not doing mothering right. As hard as I tried to resist the oppressive nature of ideal mothering, it is like air all around us and all-consuming. To resist takes energy and at the time my energy was limited. Moving back home to the place of my birth and other major life changes impacted on how I mothered and on how I conducted this research. I was mindful of this and struggled at times to separate myself from the women's stories. I did not want to 'pollute' their experiences. Interviewing women who had been diagnosed with MHPs was a very different reality to mine. However, as a mother, I could bring some understanding to the process. Also through my experience as a mental health nurse and counsellor I had some knowledge of the effects of treatment and medication on women's capacity to mother and to live from day to day. The pressures of idealised motherhood are impossible for all women and, hearing about the context of the women's lives, I was left in awe of their courage, strength and resilience. However I was conscious of not romanticising their lives and endeavoured to accurately reflect their experiences. My struggle was to keep balance and to keep my anger and outrage in check. At times I wanted to ring up services and demand a more supportive service. I learned from the women to temper my responses and to persevere with the research as the way to get them the services they need. The women balanced their lives, they negotiated the very strong ideologies and continued to mother their children. Unfortunately for nine women mothering ended and also began in a different way when their children were placed in care.

My previous experience as a mental health nurse has had an impact on the research process in a number of different ways. Having trained as a mental health nurse I had knowledge of various theories that attempt to explain people's distress and I was conscious of the fact that these theories inform practices that subjugate personal knowledge. Quite often these

theories do not fit with the reality of practice and I found in my practice that the theories did not fit the practice and the experiences that I have come up against. My own gut feelings at times did not match what was supposed to be done. I have completed many courses throughout my years as a mental health nurse and counsellor and I have felt at odds with the perceived wisdom. I have sought ways of working outside whilst remaining inside. Nurses are often taught not to get over-involved, not to share experiences and not to forge relationship with 'patients'. This does not sit well with me. I have forged a way of working with people that is in the middle which is similar to the mothers I have met in this research. They have had to balance interactions with mental health and social services that were at times deeply at odds to their understandings and experiences, I too have done this. Whilst I accept in part authoritative knowledge I do not accept that it is the only valid knowledge to explain people's distress. The knowledge embedded in people's daily and nightly experiences has given me a way of working with people that is more intuitive and person centered I think. It is a parallel journey. I have 'qualified' in nursing and counselling psychology; however I found these practices of limited use in some situations. My parallel journey has led me to 'Capacitar' (Cane 2000) and WRAP (Wellness Recovery Action Plan, Copeland 1997). In both these practices the emphasis is on shared learning, peer support and each person as the expert in themselves. In both these approaches the group meet as people not as professionals and services users. Thus, barriers are reduced and power differentials are broken down or not set up in the first place. My experiences as a mental health nurse meant that I approached this research with a clear understanding of how women were viewed; however I also had challenged the dominant understandings from bio-medicine and had a different view of how services might be developed. I think that this bifurcated view helped me notice more clearly the ways in which women balanced their lives.

Power in the research process is well documented. As a researcher I was conscious of the impact of power in the relationships with the women in this study. An example of this power was brought home to me, loud and clear, when I was approached by some of the women who had volunteered to be interviewed for the study. They asked if I would consider being involved in a support group for mothers whose children no longer lived with them full time. I agreed and, following a series of meetings and discussions, the group

started in March 2012. Before starting the group I explained that I would be returning to paid employment later that year (funding for the study was coming to an end). The group was well-attended and the women who attended set the group guidelines and agenda for the 'meetings'. When I informed the group that I might be returning to work in the Health Service Executive (HSE) the discussion of my continued involvement with the group was powerful. The women felt that I would not be able to continue as a group member. I would no longer be Teresa as I would be in a position of 'power' through working in the HSE. The women felt that even though I was still the same person their relationship with me would be profoundly different; they felt they would have to be careful in their disclosures with me and the fear of being judged by me was now a possibility from their standpoint. They had many years' experiences working with the health and social services and had the bifurcated view that made my presence in the group no longer possible. The full power that services had on these women's lives was plain to see and their power to say this to me was an indication of their struggle to have their experiences acknowledged and mirrored the resistance to the authoritative knowledge explained in this study. I was sad to leave the group and we had a heartfelt and heartening final meeting.

Finally, this research has challenged me to think creatively and to develop my writing skills and has helped me find a voice through which, I hope, change can come about for this inspirational and courageous group of women.

### **Summary and conclusion**

In using FST, the women and I have questioned and challenged the understandings of mental distress and mothering. In so doing we have begun a process of questioning existing categories and thus demonstrating that things can be different. We have also begun to question the dominant ways of categorising mental distress and highlighted how they are oppressive and limiting, rather than accurate reflections of women's everyday experiences. The knowledge gained from the standpoint of this group of marginalized women provides a position from which to challenge the status quo. Through exploring the relations of ruling and by questioning these dominant understandings of mental distress the women and I created a space for making available alternatives to what has become the status quo in mental health service provision. The current 'scientific' knowledge used to provide services for these women does not address their needs, rather current 'expert' knowledge in the

field of mental health/ill-health is used against them and does nothing to strengthen their roles as 'good enough' mothers. In addition this 'expert' knowledge contributes to the stigma experienced by the women and reinforces the view that their status as mothers is questionable. Therefore it is imperative to use the knowledge gained from this group of women to inform mental health education and service provision. I began this exploration by arguing that mothers who experience mental distress as an area of study has received little attention. Research has mainly focused on a biomedical view of mothers as 'risky' and 'unsuitable' with the focus of much of the research on the potential damage to children. This biomedical understanding sets up an understanding of mental distress as lifelong management and treatment of 'illness'. Through directing the research through their lived experiences as mothers and away from the biomedical understanding of mental distress a different story can be heard. FST allowed me to explore ways in which mothering and mental distress are constructed, understood and experienced by the women I spoke with. In so doing a story that gives voice to experiences that are frequently subjugated and not heard emerges and new views about women's distress, mothering and efforts to live well are given voice.



## REFERENCES

- Ackerly B. & True J. (2010) *Doing Feminist Research in Political and Social Science*. Palgrave Macmillan, Basingstoke.
- Ackerson B. (2003) Coping with the dual demands of severe mental illness and parenting: The parent's perspective. *Families in Society* **84**, 109-119.
- Akman D.E., Toner B.B., Stuckless N., Ali A., Emmott S.D. & Downie F.P. (2001) Feminist issues in research methodology: The development of a cognitive scale. *Feminism and Psychology* **11** (2), 209-227.
- Alakus C., Conwell R., Gilbert M., Buist A. & Castle D. (2007) The needs of parents with a mental illness who have young children: an Australian perspective on service delivery options. *International Journal of Social Psychiatry* **53**(4), 333-339.
- Alldred P. & Gillies V. (2008) Eliciting research accounts: Re/producing modern subjects. In *Ethics in Qualitative Research* (Mauthner M., Birch M., Jessop M.J. & Miller T., eds), Sage, pp. 147-165.
- Allen A. (1989) Rethinking power. *Hypatia* **13**(1), 21-40.
- Allen A. (2008) Power and the politics of difference: Oppression, empowerment, and transnational justice. *Hypatia* **23**(3), 156-172.
- Apfel R.J. & Handel M. (1993) *Madness and the Loss of Motherhood: Sexuality, Reproduction, and Long-Term Mental Illness*. American Psychiatric Press, Washington, DC.
- Arendell T. (2000) Conceiving and investigating motherhood: The decade's scholarship. *Journal of Marriage and Family* **62**(4), 1192-1207.
- Arnup K. (1994) *Education for Motherhood: Advice for Mothers in Twentieth-Century Canada*. University of Toronto Press, Toronto.
- Atkinson R. & Flint J. (2001) Accessing hidden and hard-to-reach populations: Snowball research strategies. *Social research Update* **33**, 1-4.
- Badinter E. (1981) *The Myth of Motherhood*. Souvenir Press, London.
- Badinter E. (2011) *The Conflict. How Modern Motherhood Undermines the Status of Women*. Metropolitan Books, Henry Holt and Company, New York.
- Barnes M. & Bowl R. (2001) *Taking Over the Asylum: Empowerment and Mental Health*. Palgrave, Basingstoke.
- Barnett R.C. & Rivers C. (1998) *She Works, He Works: How Two Income Families are Happy, Healthy, and Thriving*. Harvard University Press, Cambridge, MA.
- Barr J.A. (2008) Postpartum depression, delayed maternal adaptation, and mechanical infant caring: a phenomenological hermeneutic study. *International Journal of Nursing Studies* **45**, 362-369.
- Barr M. (1912) The asexualization of the unfit. *Alienist and Neurologist* **33**(1), 1-9.
- Barry M.M., Van Lente E., M M., Morgan K., McGee H., Conroy R.M., Watson D., Shelley E. & Perry I. (2009) *SLÁN 2007: Survey of Lifestyle, Attitudes and Nutrition in Ireland. Mental Health and Social Well-Being Report*. Department of Health and Children, Dublin.

- Bassett H., Lampe J. & Lloyd C. (1999) Parenting: experiences and feelings of parents with a mental illness. *Journal of Mental Health* **8**, 597–604.
- Bassin D., Honey M. & Kaplan M.M. (1994) *Representations of Motherhood*. Yale University Press, New Haven, CT.
- Bazeley P. (2003) Computerized data analysis for mixed methods research. In *Handbook of Mixed Methods in Social and Behavioral Research*, pp. 385-422. A. Tashakkori and C. Teddlie (eds). Sage Publications, Thousand Oaks.
- Beale J. (1987) *Women in Ireland-Voices of Change*. Indiana University Press, Indianapolis.
- Beardslee W.R. & MacMillan H. (1993) Preventive intervention with the children of depressed parents. A case study. *The Psychoanalytical Study of the Child* **48**, 249-276.
- Beardslee W.R., Schultz L.H. & Selman R.L. (1987) Level of social-cognitive development, adaptive functioning, and DSM-III diagnoses in adolescent offspring of parents with affective disorders: Implications of the development of the capacity for mutuality *Developmental Psychology* **23**, 807–815.
- Beardsley W.R., Versage E.M. & Gladstone T.R. (1998) Children of affectively ill parents: A review of the past 10 years. *Journal of the American Academy of Child & Adolescent Psychiatry* **37**, 1134-1141.
- Beechley V. & Perkins T. (1997) *A Matter of Hours: Women, Part Time Work and the Labour Market*. Polity Press, London.
- Begley C., Higgins A., Lalor J., Sheerin F., Alexander J., Nicholl H., Lawler D., Keenan P., Tuohy T. & Kavanagh R. (2010) *The Strengths and Weaknesses of Publicly-funded Irish Health Services Provided to Women with Disabilities in Relation to Pregnancy, Childbirth and Early Motherhood*. National Disability Authority, Dublin.
- Behar R. (1996) *The Vulnerable Observer: Anthropology that Breaks Your Heart*. Beacon Press, Boston.
- Belle D. (1990) Poverty and women's mental health. *American Psychologist* **45**, 385-389.
- Belsky J. & Cassidy J. (1994) Attachment: Theory and evidence. . In *Development through life: A handbook for clinicians* (M. Rutter & Hay D., eds), Oxford: Blackwell Scientific Publications., pp. 373–402.
- Bem S.L. (1993) *The Lenses of Inequality: Transforming the Debate on Sexual Inequality*. Yale University Press, New Haven, CT.
- Benn M. (1998) *Madonna and Child: Towards a New Politics of Motherhood*. Jonathan Cape, London.
- Berg-Nielsen T.S., Vikan A. & Dahl A.A. (2002) Parenting related to child and parent psychopathology: A descriptive review of the literature. *Clinical Child Psychology and Psychiatry* **7**, 529–552.
- Bifulco A., Moran P.M., Ball C., Jacobs C., Baines R., Bunn A. & Cavagin J. (2002) Childhood adversity, parental vulnerability and disorder: examining inter-generational transmission of risk. *Journal of Child Psychology & Psychiatry & Allied Disciplines* **43**(8), 1075-1086.
- Blaine B. & Crocker C. (1995) Religiousness, race, and psychological well-being: Exploring social psychological mediators. *Personality & Social Psychology Bulletin* **21**(10), 1031-1041.

- Blanch A., Nicholson J. & Purcell J. (1994) Parents with severe mental illness and their children: The need for human services integration. *Journal of Mental Health Administration* **21**(4), 388-396.
- Blegen N.E., Hummelvoll J.K. & Severinsson E. (2010) Mothers with mental health problems: a systematic review. *Nursing & Health Sciences* **12**(4), 519-528.
- Blegen N.E., Hummelvoll J.K. & Severinsson E. (2012) Experiences of motherhood when suffering from mental illness: A hermeneutic study. *International Journal of Mental health Nursing* **21** (5), 419–427.
- Bosanac P., A. B. & Burrows G. (2003) Motherhood and schizophrenic illnesses: a review of the literature. *Australian and New Zealand Journal of Psychiatry* **37**(1), 24-30.
- Boulton M.G. (1983) *On Being a Mother: A Study of Women with Pre-School Children*. Tavistock, London.
- Bowlby J. (1952) *Maternal Care and Mental Health* World health Organization (WHO), Geneva.
- Bowlby J. (1958) The nature of the child's tie to his mother. *International Journal of Psycho-Analysis* **39**, 350–373.
- Bowlby J. (1969) *Attachment*. Basic Books, New York.
- Broverman I., Broverman D., Clarkson F., Rosenkrantz P. & Vogel S. (1970) Sex role stereotypes and clinical judgment of mental health. *Journal of Consulting and Clinical Psychology* **34**, 1-7.
- Brown G.W. (1993) The role of life events in the aetiology of depressive and anxiety disorders. In *Stress: from Synapse to Syndrome* (Stanford S.C. & Salmon P., eds), Academic Press, London, pp. 23-50.
- Brown G.W. & Harris T.O., eds. (1989) *Life Events and Illness*. Unwin Hyman, London.
- Brunette M.F. & Dean W. (2002) Community mental health care for women with severe mental illness who are parents. *Community Mental Health Journal* **38**(2), 153-165.
- Burman E. (1992) Feminism and discourse in developmental psychology: power, subjectivity and interpretation. *Feminism & Psychology* **2**(1), 45-60.
- Busfield J. (1996) *Men, Women and Madness: Understanding Gender and Mental Disorder*. Macmillan, Basingstoke.
- Bussema K.E. & Bussema E.F. (2000) Is there a balm in Gilead? The implications of faith in coping with a psychiatric disability. *Psychiatric Rehabilitation Journal* **24**(2), 117-124.
- Buxton J. (1998) *Ending the Mother War: Starting the Workplace Revolution*. Macmillan, London.
- Bybee D., Mowbray C.T., Oyserman D. & Lewandowski L. (2003) Variability in community functioning of mothers with serious mental illness. *Journal of Behavioral Health Services & Research* **30**(3), 269.
- Campbell J. & Bunting S. (1991) Voices and paradigms: Perspectives on critical and feminist theory in nursing. *Advances in Nursing Science* **13**(3), 1-15.

- Campbell K. (2004) The promise of feminist reflexivities: Developing Donna Haraway's project for feminist science studies. *Hypatia* **19**, 162-182.
- Campbell R. & Wasco S.M. (2000) Feminist approaches to social sciences: Epistemological and methodological tenets. *American Journal of Community Psychology* **28**(6), 773-791.
- Cane P.M. (2000) *Trauma, Healing and Transformation*. The Union Institute & University, Cincinnati.
- Caplan P. (2000) *The New Don't Blame Mother: Mending the Mother Daughter Relationship*. Routledge, New York.
- Caplan P. & Cosgrove L., eds. (1992) *Bias in Psychiatric Diagnosis*. Jason Aronson, Lanham, MD.
- Caplan P.J. (1995) *They Say You're Crazy: How The World's Most Powerful Psychiatrists Decide Who's Normal*. Perseus Books, Cambridge, MA.
- Carter A.S., Garrity-Rokous F.E., Chazan-Cohen R., Little C. & Briggs-Gowan M.J. (2001) Maternal depression and comorbidity: Predicting early parenting, attachment security, and toddler socialemotional problems and competencies. *Journal of the American Academy of Child and Adolescent Psychiatry* **40**, 18–26.
- Caton C., Cournos F. & Dominguez B. (1999) Parenting and adjustment in schizophrenia. *Psychiatric Services* **50**(2), 239-243.
- Central Statistics Office (2010) *Women and Men in Ireland 2009*. Central Statistics Office, Cork.
- Chernomas W., Clarke D. & Chisolm F. (2000) Perspectives of women living with schizophrenia. *Psychiatric Services* **51**, 1517-1520.
- Chesler P. (1972) *Women and Madness*. Allen Lane, London.
- Chesler P. (1987) *Mothers on Trial: The Battle for Children and Custody*. Seal Press, Seattle.
- Chesler P. (2005) *Women and Madness*. Palgrave Macmillan, New York.
- Chodorow N. (1978) *The Reproduction of Mothering: Psychoanalysis and the Sociology of Gender*. University of California Press, Berkeley.
- Choi P., Henshaw C., Baker S. & Tree J. (2005) Supermum, superwife, supereverything: performing femininity in the transition to motherhood. *Journal of Reproductive & Infant Psychology* **23**(2), 167-180.
- Chrisler J.C. & Caplan P. (2002) The strange case of Dr. Jekyll and Ms Hyde: How PMS became a cultural phenomenon and a psychiatric disorder. *Annual Review of Sex Research* **13**, 274-306.
- Christopher K. (2012) Extensive mothering : Employed mothers' constructions of the good mother. *Gender & Society* **26**(73), 73-96.
- Code L. (1991) *What Can She Know? Feminist Theory and the Construction of Knowledge*. Cornell University Press, Ithaca, NY.
- Cogan J. (1998) The consumer as expert: Women with serious mental illness and their relationship-based needs. *Psychiatric Rehabilitation Journal* **22**, 142-154.

- Cole M. (2000) Out of sight, out of mind: female sexuality and the care plan approach in psychiatric inpatients. *International Journal of Psychiatry in Clinical Practice* **4**(4), 307-310.
- Collins P. (1998) Negotiating selves: reflections on 'unstructured' interviewing. *Sociological Research Online*, Vol. 3(3). <http://www.socresonline.org.uk/3/3/2.html>
- Collins P.H. (1994) Shifting the centre: race, class and feminist theorising about motherhood. In *Mothering, Ideology, Experience and Agency* (Glenn E.N., Chang G. & Forcey L.R., eds), Routledge, London.
- Collins P.H. (2000) It's all in the family: Intersections of gender, race, and nation. In *Decentering the Center: Philosophy for a Multicultural, Postcolonial, and Feminist World* (Narayan U. & Harding S., eds), Indiana University Press, Bloomington, pp. 156–176. .
- Copeland M.E. (1997) *Wellness Recovery Action Plan*. Peach Press, Dummerston.
- Corrigan P., McCorkle B., Schell B. & Kidder K. (2003) Religion and spirituality in the lives of people with serious mental illness. *Community Mental Health Journal* **39**(6), 487-499.
- Cotterill P. (1992) Interviewing women: issues of friendship, vulnerability and power. *Women's Studies International Forum* **15**(5/6), 593-606.
- Coveney E., Murphy-Lawless J. & Sheridan S. (1998) *Women, Work and Family Responsibilities*. Larkin Unemployed Centre, Dublin.
- Cowan P.J. (1996) Women's mental health issues: Reflections on past attitudes and present practice. *Journal of Psychosocial Nursing* **34**(4), 20-24.
- Crenshaw K. (1989) *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics*. University of Chicago Legal Forum, Chicago.
- Crenshaw K. (1991) Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review* **43**(6), 1241–1279.
- Cromby J. & Standen P. (1996) Psychology in the service of the state. *Psychology Politics Resistance Newsletter* **3**, 6-7.
- Dagnan C. (1999) *Pay Day: Treasurer for Stay-at-Home Moms*. College Press, Joplin, MO.
- Daly A. & Walsh D. (2011) *Activities of Irish Psychiatric Units and Hospitals 2010: Main Findings*. Health Research Board, Dublin.
- Davies B. & Allen D. (2007) Integrating 'mental illness' and 'motherhood': the positive use of surveillance by health professionals: a qualitative study. *International Journal of Nursing Studies* **44**(3), 365-376.
- Davis K. (2008) Intersectionality as buzzword: A social science perspective on what makes a feminist theory successful. *Feminist Theory* **9**(1), 67-86.
- De Marneffe D. (2004) *Maternal Desire: On Children, Love, and the Inner Life*. Little Brown, New York.
- Delfabbro P., Barber J. & Cooper L. (2000) Placement disruption and dislocation in South Australian substitute care. *Children Australia* **25**, 16–20.
- Department of Children and Youth Affairs (2011) *Children First National Guidance for the Protection and Welfare of Children*, Department of Children and Youth Affairs, Dublin.

Department of Health & Children (2009) Slán: Survey of Lifestyle, Attitudes & Nutrition in Ireland. Mental Health & Social Well-being Report. Department of Health & Children, Dublin.

Department of Health and Children (2006) *A Vision for Change*. Department of Health and Children, Dublin.

Department of the Taoiseach (1937) Constitution of Ireland - Bunreacht Na hÉireann. The Stationery Office, Dublin.

Diaz-Caneja A. & Johnson S. (2004) The views and experiences of severely mentally ill mothers. *Social Psychiatry and Psychiatric Epidemiology* **39**(6), 472-482.

Dillon J. (2010) The tale of an ordinary little girl. *Psychois* **2**(1), 79-83.

Dipple H., Smith S., Andrews H. & Evans B. (2002) The experience of motherhood in women with severe and enduring mental illness. *Social Psychiatry and Psychiatric Epidemiology* **37**(7), 336-340.

Donzelot J. (1997) *The Policing of Families*. The Johns Hopkins University Press, Baltimore, Maryland.

Dorsay J.P. & Forchuk C. (1994) Assessment of sexuality needs of individuals with psychiatric disability. *Journal of Psychiatric and Mental Health Nursing* **1**(2), 93-97.

Douglas S.J. & Michaels M.W. (2004) *The Mommy Myth: The Idealization of Motherhood and How It Has Undermined Women*. Free Press, New York.

Downey G. & Coyne J.C. (1990) Children of depressed parents: An integrative review. *Psychological Bulletin* **108**, 50-76.

Drew E., Emerek R. & Mahon E. (1998) *Women, Work and the Family in Europe*. Routledge, London.

Drew E. & Humbert A.L. (2012) 'Men have careers, women have babies': unequal parental care among Irish entrepreneurs. *Community, Work & Family* **15**(1), 49-67.

Dubowitz H., Black M.M., Kerr M.A., Morrel T.M., Hussey J.M., Everson M.D. & Starr J.R.H. (2001) Type and timing of mothers' victimization: Effects on mothers and children. *Pediatrics* **107**(4), 728.

Duncombe J. & Jessop J. (2008) 'Doing Rapport' and the ethics of 'Faking Friendship'. In *Ethics in Qualitative Research* (M. Mauthner, M. Birch, J. Jessop & Miller T., eds), Sage, pp. 107-122.

Edwards A.E. & Timmons S. (2005) A qualitative study of stigma among women suffering postnatal depression. *Journal of Mental Health* **14**, 471-481.

Edwards R. & Mauthner M. (2008) Ethics and feminist research: Theory and practice. In *Ethics in Qualitative Research* (Mauthner M., Birch M., Jessop J. & Miller T., eds), Sage, pp. 14-31.

Ehrenreich B. & English D. (2005) *For Her Own Good: 150 Years of the Expert's Advice to Women*. Anchor Press/Doubleday, Garden City, NY.

Ehrensaft D. (1983) When women and men mother. In *Mothering: Essays in Feminist Theory* (Trebilcot J., ed), Rowman & Littlefield, pp. 41-60.

- Emslie C., Ridge D., Ziebland S. & Hunt K. (2007) Exploring men's and women's experiences of depression and engagement with health professionals: more similarities than differences? A qualitative interview study. *BMC Family Practice* **8**(1), 43.
- European Commission (2009) Report on Equality between Women and Men 2009. European Commission, Brussels.
- Eyer D. (1992) *Mother–Infant Bonding: A Scientific Fiction*. Yale University Press, New Haven.
- Fallot R.D. (1998) *New Directions for Mental Health Services, Spirituality and Religion in Recovery from Mental Illness*. No. 80. Jossey-Bass, San Francisco.
- Ferguson A. (1983) On conceiving motherhood and sexuality: A feminist materialist approach. In *Mothering: Essays in Feminist Theory* (Trebilcot J., ed), Rowman & Littlefield, pp. 153–182.
- Field T. (1992) Infants of depressed mothers. *Development and Psychopathology* **4**, 49–66.
- FinlayJones R. (1989) Anxiety. In *Life Events and Illness* (Brown G.W. & Harris T.O., eds), Unwin Hyman, London.
- Fitzgerald M. & Jeffers A. (1994) Psychosocial Factors Associated with Psychological Problems in Irish Children and their Mothers. *The Economic and Social Review* **25**(4), 285-301.
- Flax J. (1987) Postmodernism and gender relations in feminist theory. *Signs* **12**, 621-633.
- Fonow M.M. & Cook J.A. (1991) *Beyond Methodology: Feminism as Lived Research*. Indiana University Press, Bloomington.
- Fonow M.M. & Cook J.A. (2005) Feminist methodology: New applications in the academy and public policy. *Signs* **30**(4), 2211-2236.
- Forcey L.R. (1994) Feminist perspectives on mothering and peace. In *Mothering: Ideology, Experience, and Agency* (E.N. Glenn, G. Chang & L. Forcey, eds), Routledge, New York, pp. 355-375.
- Foucault M. (1980) *The History of Sexuality, Vol 1: An Introduction*. Vintage, New York.
- Fox J.R. (2012) Best practice in maternity and mental health services? A service user's perspective. *Schizophrenia Bulletin* **38**(4), 651–656.
- Gammell D.J. & Stoppard J.M. (1999) Women's experiences of treatment of depression: Medicalization or empowerment? *Canadian Psychology/Psychologie canadienne* **40**(2), 112-128.
- Garey A.I. (1999) *Weaving Work and Motherhood*. Temple University Press, Philadelphia, PA.
- Garley D., Gallop R., Johnston N. & Pipitone J. (1997) Children of the mentally ill: A qualitative focus group approach. *Journal of Psychiatry and Mental Health Nursing* **4**, 97–103.
- Gelfand D.M. & Teti D.M. (1990) The effects of maternal depression on children. *Clinical Psychology Review* **10**, 329–353.

- George L.K., Larson D.B., Koenig H.G. & McCullough M.E. (2000) Spirituality and health: What we know, what we need to know. *Journal of Social & Clinical Psychology* **19**(1), 102-116.
- Gilbert L.S. (2002) Going the distance: 'Closeness' in qualitative data analysis software. *International Journal of Social Research Methodology* **5**(3), 215–228.
- Gillam T., Crofts M., Fadden G. & Corbett K. (2003) *The Interfaces Project Report: Exploring the Links between Mental Health Services for Children, Adults and Families*. National Institute for Mental Health in England. NIMHE West Midlands Mental Health Development Centre.
- Gilligan C. (1993) *In a Different Voice*. Harvard University Press, Cambridge, MA.
- Gladstone B., McConnell B., Boydell K.M. & McKeever P. (2006) Recasting research into children's experiences of parental mental illness: Beyond risk and resilience. *Social Science & Medicine* **62**(10), 2540-2550.
- Glenn E.N. (1994) Social constructions of mothering: A thematic overview. In *Mothering: Ideology, Experience, and Agency* (E.N. Glenn, G. Chang & L. Forcey, eds), Routledge, New York, pp. 1-29.
- Glickman R.L. (1993) *Daughters of Feminists: Young Women with Feminist Mothers Talk About Their Lives*. St Martin's Press, New York.
- Glucksmann M. (1994) The work of knowledge and the knowledge of women's work. In *Researching Women's Lives from a Feminist Perspective* (M. Maynard & J. Purvis, eds), Taylor & Francis, London.
- Goodman S.H. & Emory E.K. (1992) Perinatal complications in births to low socioeconomic status schizophrenic and depressed women. *Journal of Abnormal Psychology* **101**, 225–229.
- Government of Ireland Civil Service (1973) *Employment and Married Women Act*. Government Publications, Dublin.
- Green F.J. (2011) *Practicing Feminist Mothering*. Arbeiter Ring Publishing, Winnipeg, Manitoba.
- Green J. & Thorogodd N. (2009) *Qualitative Methods for Health Research*. 2nd edn. Sage Publications, London.
- Grunebaum H., Weiss J. & Cohler B.J. (1975) *Mentally Ill Mothers and Their Children*. University of Chicago Press, Chicago.
- Guba E. & Lincoln Y. (1994) Competing paradigms in qualitative research. In *Handbook of Qualitative Research* (Denzin N.K. & Lincoln Y.S., eds), Sage, Thousands Oaks, CA, pp. 105–117.
- Gustafson D. (2005) *Unbecoming Mothers: The Social Production of Maternal Absence*. The Haworth Clinical Practice Press, New York.
- Hakim C. (2000) *Work-Lifestyle Choices in the Twenty-First Century: Preference Theory*. Routledge, London.
- Hall J.M. & Stevens P.E. (1991) Rigor in feminist research. *Advances in Nursing Science* **13**, 16–29.



- Hammen C.L. (1991) *Depression Runs in Families: The Social Context of Risk and Resilience in Children of Depressed Mothers*. Springer-Verlag, New York, London.
- Hanson S.L. & Sloane D.M. (1992) Young children and job satisfaction. *Journal of Marriage and the Family* **54**, 799–811.
- Hansson U., O’Shaughnessy R. & Monteith M. (2013) *Maternal Mental Health and Poverty: The Impact on Children’s Educational Outcomes*. The Children and Youth programme (CYP), Belfast.
- Haraway D. (1988) Situated knowledges: The science question in feminism and the privilege of partial perspective. *Feminist Studies* **14**, 575-599.
- Haraway D. (1989) *Primate Visions: Gender, Race, and Nature in the World of Modern Science*. Routledge, New York.
- Haraway D. (1991) *Simians, Cyborgs, and Women: The Reinvention of Nature*. Routledge, New York.
- Harding S. (1986) *The Science Question in Feminism*. Cornell University Press, Ithaca, NY.
- Harding S. (1987) *Feminism and Methodology: Social Science Issues*. Indiana University Press, Bloomington.
- Harding S. (1991) *Whose Science? Whose Knowledge? Thinking from Women's Lives*. Cornell Univ. Press
- Harding S. (1997) Comment on Hekman's "Truth and Method: Feminist Standpoint Theory Revisited": Whose standpoint needs the regimes of truth and reality? *Signs* **22**(2), 382-391.
- Harding S. (2004) A Socially Relevant Philosophy of Science? Resources from Standpoint Theory's Controversiality. *Hypatia* **19**(1), 25-47.
- Harding S. & Norberg K. (2005) New feminist approaches to social science methodologies: An introduction. *Signs* **30**(4), 2009-2015.
- Hardyment C. (2007) *Dream Babies, Childcare Advice from John Locke to Gina Ford*. Francis Lincoln Ltd., London.
- Hartsock N.C.M. (1998) *The Feminist Standpoint Revisited, and Other Essays*. Westview Press, Boulder, CO.
- Hartsock N.C.M. (2004) The feminist standpoint: Developing the ground for a specifically feminist historical materialism. In *The Feminist Standpoint Theory Reader Intellectual and Political Controversies* (Harding S., ed), Routledge, New York and London.
- Hattery A. (2001) *Women, Work and Family: Balancing and Weaving*. Sage, Thousand Oaks, CA.
- Hays S. (1996) *The Cultural Contradictions of Motherhood*. Yale University Press, New Haven, CT.
- Held V. (1983) The obligations of mothers and fathers. In *Mothering Essays in Feminist Theory* (Trebilcot J., ed), Rowman & Littlefield, pp. 9–20.
- Hearn J. (2004) From hegemonic masculinity to the hegemony of men. *Feminist Theory* **5**(1), 575-599.

- Heron J., Gilbert N., Dolman C., Shah S., Beare I., Dearden S., Muckelroy N., Jones I. & Ives J. (2012) Information and support needs during recovery from postpartum psychosis. *Archives of Women's Mental Health* **15** (3), pp 155-165.
- Hesse-Biber S. & Leavy P.L. (2007) *Feminist Research Practice: A Primer*. Sage Publications, Thousand Oaks.
- Higgins A. (2007a) The impact of psychotropic medication on sexuality. *British Journal of Nursing* **16**(9), 545-550.
- Hill Collins P. (1990) *Black Feminist Thought*. Routledge, New York.
- Hill Collins P. (1991) The meaning of motherhood in black culture and black mother-daughter relationships. In *Double Stitch: Black Women Write about Mothers and Daughters* (P. Bell-Scott, B. Guy-Sheftall, J. Jones Royster, J. Sims-Wood, M. DeCosta-Willis & L. Fultz., eds), Beacon Press, Boston, pp. 42-60.
- Hill Collins P. (2004) Comment on Hekman's 'Truth and Method: Feminist standpoint theory revisited': Where's the power? In *The Feminist Theory Reader Intellectual and Political Controversies* (Harding S., ed), Routledge, New York and London, pp. 247-253.
- Hill Collins P. (2004) Learning from the outsider within: The sociological significance of black feminist thought. In *The Feminist Standpoint Theory Reader Intellectual and Political Controversies* (Harding S., ed), Routledge, New York.
- Hinshaw S.P. (2005) The stigmatization of mental illness in children and parents: developmental issues, family concerns, and research needs. *Journal of Child Psychology & Psychiatry* **46**(7), 714-734.
- Hollingsworth L.D. (2004) Child custody loss among women with persistent severe mental illness. *Social Work Research* **28**(4), 199-209.
- hooks b. (2000) *Feminist Theory: From Margin to Center*. Pluto Press
- Hooks b. (2004) Choosing the margin as a space of radical openness. In *The Feminist Standpoint Reader: Political and intellectual controversies* (Harding S., ed), Routledge, New York, pp. 153-159.
- Horgan G. (2001) Changing women's lives in Ireland. *International Socialism Journal Summer*(91).
- Horwitz E. (2011) *Through the Maze of Motherhood: Empowered Mothers Speak*. Demeter Press, Toronto.
- Hough J. (2011) Mothers with mental illness 'afraid to talk'. Irish Examiner, Cork.
- Houlihan D., Sharek D. & Higgins A. (2013) Supporting children whose parent has a mental health problem: an assessment of the education, knowledge, confidence and practices of registered psychiatric nurses in Ireland. *Journal of Psychiatric & Mental Health Nursing* **20**(4), 287-295.
- Howard L., Shah N., Salmon M. & Appleby L. (2003) Predictors of social services supervision of babies of mothers with mental illness after admission to a psychiatric mother and baby unit. *Social Psychiatry and Psychiatric Epidemiology* **38**, 450-455.
- Howard L.M. (2000) The separation of mothers and babies in the treatment of postpartum psychotic disorders in Britain 1900-1960. *Archives of Women's Mental Health* **3**(1), 1.

- Howard L.M., Kumar R. & Thornicroft G. (2001) Psychosocial characteristics and needs of mothers with psychotic disorders. *British Journal of Psychiatry* **178**, 427–324.
- Hrdy S.B. (1999) *Mother Nature: Maternal instincts and how they shape the Human Species*. Ballantine Books, New York.
- Hunter B. (2000) *Home by choice: Raising Emotionally Secure Children in an Insecure World*. Sisters, Multnomah.
- Institute of Public Health (2005) *Health Impacts of Employment: A Review*. Institute of Public Health, Dublin.
- Jaggar A.M. (1983) *Feminist Politics and Human Nature*. Rowman and Alenheld, Totowa, NJ.
- Janssen I., Krabbendam L., Bak M. & al. (2004) Childhood abuse as a risk factor for psycholtic experiences. *Acta Psychiatrica Scandinavica* **109**, 8-45.
- Johnson J., Cohen P., Dohrenwend B.P., Link B.G. & Brook J.S. (1999) A longitudinal investigation of social causation and social selection processes involved in the association between socioeconomic status and psychiatric disorders. *Journal of Abnormal Psychology* **108**(3), 490-499.
- Joseph J.G., Joshi S.V., Lewin A.B. & Abrams M. (1999) Characteristics and perceived needs of mothers with serious mental illness. *Psychiatric Services* **50**(10), 1357-1359.
- Kawash S. (2011) New directions in motherhood studies. *Signs* **36**(4), 969-1003.
- Keller K. (1994) *Mothers and Work in Popular American Magazines*. Greenwood Press, Westport, CT.
- Keller M.B., Beardslee W.R., Dorer D.J., Lavori P.W., Samuelson H. & Klerman G.R. (1986) Impact of severity and chronicity of parental affective illness on adaptive functioning and psychopathology in children. *Archives of General Psychiatry* **43**, 930–937.
- Kendler K.S., Gardner C.O. & Prescott C.A. (1999) Clinical characteristics of major depression that predict risk of depression in relatives. *Archives of General Psychiatry* **56**(4), 322-327.
- Kessler R.C., Foster C.L., Saunders W.B. & Stang P.E. (1995) Social consequences of psychiatric disorders, I: educational attainment. *American Journal of Psychiatry* **152**, 1026-1032.
- Kevles D. (1995) *In the Name of Eugenics: Genetics and the Uses of Human Heredity*. Cambridge University Press, Cambridge.
- Khalifeh H., Murgatroyd B., Freeman M., Johnson S. & Killapsy H. (2009) Home treatment as an alternative to hospital admission for mothers in a mental health crisis: a qualitative study. *Psychiatric Services* **60**(5), 634-639.
- Kinsella K.B. & Anderson R.A. (1996) Coping skills, strengths, and needs as perceived by adult. *Psychiatric Rehabilitation Journal* **20**(2), 24.
- Kittay E.F. (1983) Womb envy: An explanatory concept. In *Mothering: Essays in feminist theory* (Trebilcot J., ed), Rowman & Littlefield, pp. 94–128.
- Kochanska G., Radke-Yarrow M., Kuczynski L. & Friedman S.L. (1987) Normal and affectively ill mothers' beliefs about their children. *American Journal of Orthopsychiatry* **57**, 345–350.

- Kramarae C. & Sender D., eds. (1992) *The Knowledge Explosion: Generations of Feminist Scholarship*. Teachers College Press, New York.
- Krumm S. & Becker T. (2006) Subjective views of motherhood in women with mental illness – a sociological perspective. *Journal of Mental Health* **15**(4), 449-460.
- Kumar R., Marks M., Platz C. & Yoshida K. (1995) Clinical survey of a psychiatric mother and baby unit: Characteristics of 100 consecutive admissions. *Journal of Affective Disorders* **33**, 11-22.
- Lakoff G. (1996) *Moral Politics: What Conservatives Know that Liberals Don't*. University of Chicago Press, Chicago.
- Lather P. (1991) *Getting Smart: Feminist Research and Pedagogy with/in the Postmodern*. Routledge, New York.
- Letherby G. (2000) Dangerous liaisons: an auto/biography in research and research writing. In *Danger in the Field: Risk and Ethics in Social Research* (G. Lee-Treweek & S. Linkogle, eds), Routledge, London.
- Letherby G. (2003) *Feminist Research in Theory and Practice*. Open University Press, Buckingham.
- Lewis J., ed (1993) *Women and Social Policies in Europe: Women, Family and the State*. Edward Elgar, Aldershot.
- Lewis S.E. & Nicholson P. (1998) Talking about Early Motherhood: Recognising Loss and Reconstructing depression. *Journal of Reproductive and Infant Psychology* **16**, 177-197.
- Lieb R., Isensee B., Hofler M., Pfister H. & Wittchen H.U. (2002) Parental major depression and the risk of depression and other mental disorders in offspring: A prospective-longitudinal community study. *Archives of General Psychiatry* **59**, 365-374.
- Lindgren K.C. & Coursey R.D. (1995) Spirituality and serious mental illness: A two-part study. *Psychosocial Rehabilitation Journal* **18**(3), 93-111.
- Lorber J. (1994) *Paradoxes of Gender*. Yale University Press, New Haven, CT.
- Lorber J. (2005) *Gender Inequality: Feminist Theories and Practice*. Roxbury Publishing, Los Angeles.
- Luff D. (1999) Dialogue across the divides: 'moments of rapport' and power in feminist research with anti-feminist women. *Sociology* **33**(4), 687-704.
- Maguire P. (1987) *Doing Participatory Research: A Feminist Approach*. The Centre for International Education, University of Massachusetts, Amherst, MA.
- Maguire P. (2001) Uneven ground: Feminisms and action research. In *Handbook of Action Research: Participative Inquiry and Practice* (P. Reason & H. Bradbury, eds), Sage Publications, London, pp. 59-69.
- Malacrida C. (2009) Performing motherhood in a disablist world: dilemmas of motherhood, femininity and disability. *International Journal of Qualitative Studies in Education (QSE)* **22**(1), 99-117.

- Marecek J. (2006) Social suffering, gender, and women's depression. In *Women and Depression: A Handbook for the Social Sciences* (C.L. Keyes & S. H. Goodman, eds), Cambridge University Press, New York, pp. 283–308.
- Marrow M. (2008) Women, violence and mental illness: An evolving feminist critique. In *Global Science/Women's Health* (C.Patton & H. Loshny, eds), Teneo Press, New York.
- Mason J. (1996) *Qualitative Researching*. Sage, Thousand Oaks, CA.
- Maushart S. (1999) *The Mask of Motherhood: How Becoming a Mother Changes Everything and Why We Pretend It Doesn't*. New Press, New York.
- Maushart S. (2000) *The Mask of Motherhood: How Becoming a Mother Changes our Lives and Why We Never Talk About It*. Penguin Books, New York.
- Mauthner N.S. (1998) It's a woman's cry for help: A relational perspective on postnatal depression. *Feminism & Psychology* **8**(3), 325-355.
- Mauthner N.S. (2002) *The Darkest Days of My Life: Stories of Postpartum Depression*. Harvard University Press, Cambridge MA.
- Maybery D. & Reupert A. (2009) Parental mental illness: a review of barriers and issues for working with families and children. *Journal of Psychiatric and Mental Health Nursing* **16**(9), 784-791.
- Maynard M. & Purvis J., eds. (1994) *Researching Women's Lives from a Feminist Perspective*. Taylor and Francis, London.
- Mazure C.M., Keita G.P. & Blehar M.C. (2002) *Summit on Women and Depression: Proceedings and Recommendations*. American Psychological Association, Washington, DC.
- McCarl Nielsen J., ed (1990) *Feminist Research Methods: Exemplary Readings in the Social Sciences*. Westview, Boulder, CO.
- McDevitt J. (2004) Primary care for mental health nurses: Evidence-based guidelines for nursing assessment, interventions and follow-up. *Journal of Psychosocial Nursing* **42**(10), 22-34.
- McGee H., Garavan R., De Barra M., Byrne J. & Conroy R. (2002) *Sexual Abuse and Violence in Ireland (SAVI): A National Study of Irish Experiences, Beliefs and Attitudes Concerning Sexual Violence*. Dublin Rape Crisis Centre, Dublin.
- McGrath E.K., Strickland B.R. & Rosso N.F. (1990) *Women and Depression: Risk factors and Treatment Issues*. American Psychological Association, Washington DC.
- McNeil T., Kaij L., Malmquist-Larsson A., Naeslund B., Persson-Blennow I., McNeil N. & Blennow G. (1983) Offspring of women with nonorganic psychoses. *Acta Psychiatrica Scandinavica* **68**, 234-250.
- McPherson M.D., Delva J. & Cranford J.A. (2007) A longitudinal investigation of intimate partner violence among mothers with mental illness. *Psychiatric Services* **58**, 675–680.
- Mental Health Commission (2007) *Annual Report 2007*. Mental Health Commission, Dublin.
- Mental Health Commission (2008) *Annual Report 2008: Including the Report of the Inspector of Mental Health Services*. Mental Health Commission, Dublin.

- Mies M. (1983) Towards a methodology for feminist research. In *Theories for Women's Studies* (Bowles G. & Klein R., eds), Routledge and Kegan Paul, London, pp. 117-139.
- Miller J.B. (1991) *Toward a New Psychology of Women*. Penguin, Harmondsworth.
- Miller L.J. & Finnerty M. (1996) Sexuality, pregnancy and childrearing among women with schizophrenia-spectrum disorders. *Psychiatric Services* **47**, 502–505.
- Miller L.J. & Finnerty M. (1997) Sexuality, reproduction, and family planning in women with schizophrenia. *Schizophrenia Bulletin* **23**, 623-635.
- Miller T. (2005) *Making Sense of Motherhood. A Narrative Approach*. Cambridge University Press, Cambridge.
- Miller T. (2007) “Is this what motherhood is all about?”. *Gender & Society* **21**(3), 337-358.
- Mohanty C.T. (1988) Under Western eyes: Feminist scholarship and colonial discourses. *Feminist Review* **30**(Autumn), 61–88.
- Montgomery P. (2005) Mothers with a serious mental illness: A critical review of the literature. *Archives of Psychiatric Nursing* **19**(5), 226-235.
- Montgomery P., Tompkins C., Forchuk C. & French S. (2006) Keeping close: mothering with serious mental illness. *Journal of Advanced Nursing* **54**(1), 20-28.
- Morrow M. (2006) Women's voices matter: Creating women-centered mental health policy. In *Women's Health in Canada. Critical Perspectives in Theory and Policy* (M. Morrow, O. Hankivsky & C. Varcoe, eds), University of Toronto Press, pp. 355-379.
- Morrow M., Wasik M., Cohen M. & Elah Perry K.M. (2009) Removing barriers to work: Building economic security for people with mental illness. *Critical Social Policy* **29**(4), 655-677.
- Moule P. & Goodman M. (2009) *Nursing Research*. Sage Publication, Los Angeles.
- Mowbray C., Oyserman D., Bybee D. & MacFarlane P. (2002) Parenting of mothers with a serious mental illness: Differential effects of diagnosis, clinical histories and other mental health variables. *Social Work Research* **26**(4), 225–240.
- Mowbray C., Oyserman D., Bybee D. & MacFarlane P. (2002) Parenting of mothers with a serious mental illness: Differential effects of diagnosis, clinical history, and other mental health variables. *Social Work Research* **26**(4), 225.
- Mowbray C., Oyserman D. & Ross S. (1995) Parenting and the significance of children for women with a serious mental illness. *The Journal of Mental Health Administration* **22**(2), 189-200.
- Mowbray C., Schwartz S., Bybee D., Spang J., Rueda-Riedl A. & Oyserman D. (2000) Mothers with mental illness: stressors and resources for parenting and living. *Families in Society* **81**, 118-129.
- Mowbray C.T., Jordan L.C., Ribisl K.M., Kewalramani A., Luke D., Herman S. & Bybee D. (1999) Analysis of postdischarge change in a dual diagnosis population. *Health & Social Work* **24**(2), 91.

- Mowbray C.T. & Mowbray O.P. (2006) Psychosocial outcomes of adult children of mothers with depression and bipolar disorder. *Journal of Emotional & Behavioral Disorders* **14**(3), 130-142.
- Mowbray C.T., Oyserman D. & Bybee D. (2000a) Mothers with serious mental illness. *New Directions for Mental Health Services* **88**, 73-91.
- Mowbray C.T., Oyserman D., Bybee D., MacFarlane P. & Rueda-Riedle A. (2001) Life circumstances of mothers with serious mental illnesses. *Psychiatric Rehabilitation Journal* **25**(2), 114-123.
- Munk-Olsen T., Laursen T.M., Pedersen C.B., Mors O. & Mortensen P.B. (2006) New Parents and mental disorders. *Journal of the American Medical Association* **296**(21), 2582-2589.
- Murphy-Lawless J. (2000) "Changing women's lives: Childcare policy in Ireland". *Feminist Economics* **6**(1), 89-94.
- Murphy-Lawless J. & Edwards N. (2014) Marginality and social exclusion: jeopardising health and life chances. In *Sociology for Midwives (In press)*, Vol. (R.Deery & al., eds), Polity Press, London.
- Murray L., Sinclair D., Cooper P., Ducournau P. & Turner P. (1999) The socioemotional development of 5-year-old children of postnatally depressed mothers. *Journal of Child Psychology and Psychiatry and Allied Disciplines* **40**, 1259-1271.
- National Disability Authority (2006) *Attitudes to Disability in the Republic of Ireland*. National disability Authority (NDA), Dublin.
- National Disability Authority (2011) *A National Survey of Public Attitudes to Disability in Ireland*. National Disability Authority, Dublin.
- Nicholson J., Biebel K., Hinden B., Henry A. & Stier L. (2001) Critical issues for parents with mental illness and their families *Substance Abuse and Mental Health Services Administration* (Rockville, MD: Center for Mental Health Services).
- Nicholson J. & Blanch A. (1994) Rehabilitation for parenting roles for people with serious mental illness. *Psychiatric Rehabilitation Journal* **18**(1), 109-119.
- Nicholson J. & Henry A.D. (2003) Achieving the goal of evidence-based psychiatric rehabilitation practices for mothers with mental illnesses. *Psychiatric Rehabilitation Journal* **27**(2), 122-130.
- Nicholson J., Hinden B.R., Biebel K., Henry A.D. & Katz-Leavy J. (2007) A qualitative study of programs for parents with serious mental illness and their children: Building practice-based evidence. *Journal of Behavioral Health Services and Research* **34**(4), 395-413.
- Nicholson J., Sweeney E.M. & Geller J.L. (1998) Focus on Women: Mothers With Mental Illness: I. The Competing Demands of Parenting and Living With Mental Illness. *Psychiatric Services* **49**(5), 635-642.
- Nicholson J., Sweeney E.M. & Geller J.L. (1998b) Focus on women: mothers with mental illness: II. Family relationships and the context of parenting. *Psychiatric Services* **49**, 643-649.
- Nolen-Hoeksema S. (2000) The role of rumination in depressive disorders and mixed anxiety/depressive symptoms. *Journal of Abnormal Psychology* **109**(3), 504-511.

- Normura Y., Wickramaratne P.J., Warner V., Mufson L. & Weissman M. (2002) Family discord, parental depression, and psychopathology in offspring: ten year follow-up. *Journal of the American Academy of Child & Adolescent Psychiatry* **41**(4), 402-409.
- O'Connell K.L.C. (2008) What can we learn? Adult outcomes in children of seriously mentally ill mothers. *Journal of Child and Adolescent Psychiatric Nursing* (21), 84-104.
- O'Connor P. (1997) *The Glass Ceiling*. EU Office: ADAPT Programme, Dublin.
- O'Connor P. (1998) *Emerging Voices: Women in Contemporary Irish Society*. Institute of Public Administration, Dublin.
- O'Connor P. (2000) Ireland: A Man's World? *The Economic and Social Review* **31**(1), 81-102.
- O'Reilly A. (2006) *Rocking the Cradle: Thoughts on Feminism, Motherhood and the Possibility of Empowered Mothering*. Demeter Press, Toronto.
- O'Connor P. (1998) *Emerging voices: Women in Contemporary Irish Society*. Institute of Public Administration, Dublin.
- O'Connor P. (2000) Ireland: A Man's World? *The Economic and Social Review* **31**(1), 81-102.
- Oakley A. (1981) Interviewing women: A contradiction in terms. In *Doing Feminist Research* (Roberts H., ed), Routledge and Kegan Paul, London, pp. 30-61.
- Oates M. (1997) Patients as parents: the risk to children. *British Journal of Psychiatry* **170**, 22-27.
- Olson S. & Banyard V. (1993) "Stop the world so I can get off for a while.": Sources of daily stress in the lives of low income single mothers of young children. *Family Relations* **42**, 50-56.
- OPEN (2007) *Lone Parent's Experiences of Isolation and Stigmatisation*. OPEN, Dublin.
- O'Reilly A. (2004) *Toni Morrison and Motherhood: A Politics of the heart*. State University of New York Press, Albany.
- O'Reilly A. (2004a) *Mother Outlaw: Theories and Practices of Empowered Mothering*. Demeter Press
- O'Reilly A. (2004b) *Mother Matters: Motherhood as Discourse and Practice*. ARM Press, Toronto.
- O'Reilly A. (2006) *Rocking the Cradle: Thoughts on Motherhood, Feminism, and the Possibility of Empowered Mothering*. Demeter Press, Toronto.
- O'Reilly A. (2010) Outlaw(ing) motherhood: A theory and politic of maternal empowerment for the twenty-first century. *Hecate* **36**(1/2), 17-29.
- Owen S., Repper J., Perkins R. & Robinson J. (1998) An evaluation of services for women with long-term mental health problems. *Journal of Psychiatric & Mental Health Nursing* **5**, 281-290.
- Oyserman D., Bybee D. & Mowbray C. (2002) Influences of maternal mental illness on psychological outcomes for adolescent children. *Journal of Adolescence* **25**(6), 587-602.



- Oyserman D., Bybee D., Mowbray C. & Kahng S.K. (2004) Parenting self-construals of mothers with a serious mental illness: Efficacy, burden, and personal growth. *Journal of Applied Social Psychology* **34**(12), 2503-2523.
- Oyserman D., Mowbray C.T., Meares P.A. & Firminger K.B. (2000) Parenting among mothers with a serious mental illness. *American Journal of Orthopsychiatry* **70**(3), 296-315.
- Parahoo K. (1997) *Nursing Research. Principles, Process and Issues*. 1st ed. edn. Palgrave Macmillan, Hampshire, New York.
- Park J.M., Solomon P. & Mandell D.S. (2006) Involvement in the child welfare system among mothers with serious mental illness. *Psychiatric Services* **57**, 493-497.
- Parr J. (1998) Theoretical voices and women's own voices: The stories of mature women students. In *Feminist Dilemmas in Qualitative Research: Public Knowledge and Private Lives* (J.Ribbens & R. Edwards, eds), Sage, London.
- Paykel E.S. & Cooper Z. (1992) Life events and social stress. In *Handbook of Affective Disorders* (Paykel E.S., ed), Churchill Livingstone, London, pp. 149-170.
- Peters J. (1997) *When Mothers Work: Loving our Children without Sacrificing Ourselves*. Perseus Books, Reading, MA.
- Ramazanoglu C. & Holland J. (2002) *Feminist Methodology: Challenges and Choices*. Sage, London.
- Read J., Agar K., Argyle N. & Aderhold V. (2003) Sexual and physical abuse during childhood and adulthood as predictors of hallucinations, delusions and thought disorder. *Psychology and Psychotherapy: Theory, Research and Practice* **76** (1), 1-22.
- Reder P., McClure M. & Jolley A., eds. (2000) *Family Matters: Interfaces between Child and Adult Mental Health*. Routledge, London.
- Reupert A. & Maybery D. (2007) Families affected by parental mental illness: A multiperspective account of issues and interventions. *American Journal of Orthopsychiatry* **77**(3), 362-369.
- Ribbens J. (1989) Interviewing women: an unnatural situation. *Women's Studies International Forum* **12**(6), 579-592.
- Rich A. (1976) *Of Woman Born: Motherhood as Experience and Institution*. Norton, New York.
- Rich A. (1997) *Of Woman Born: Motherhood as Experience and Institution*. Virago, London.
- Ritsher J.E.B., Coursey R.D. & Farrell E.W. (1997) A survey on issues in the lives of women with severe mental illness. *Psychiatric Services* **48**(10), 1273-1282.
- Robins L.N. & Regier D.A. (1991) *Psychiatric Disorders in America: The Epidemiologic Catchment Area Study*. Free Press, New York.
- Rose D. (2001) *Revisiting Feminist Research Methodologies*. Status of Women Canada, Research Division
- Rose H. (1983) Hand, brain and heart: A feminist epistemology for the natural sciences. *Signs* **9**, 73-90.

- Rose H. (2004) Hand, brain, and heart: A Feminist epistemology for the natural sciences. In *The Feminist Standpoint Theory Reader Intellectual and Political Controversies* (Harding S., ed), Routledge, New York and London, pp. 67-80.
- Ruddick S. (1989) *Maternal Thinking*. Ballantine, New York.
- Ruddick S. (2007) Maternal thinking. In *Maternal Theory: Essential Readings* (O' Reilly A., ed), Demeter Press, Toronto.
- Rutter M. & Quinton D. (1984) Parental psychiatric disorder: effects on children. *Psychological Medicine* **14**(4), 853-880.
- Rutter M. & Quinton D. (1984) Parental psychiatric disorder: Effects on children. *Psychological Medicine* **14**, 853–880.
- Salmon M., Abel K., Cordingley L., Friedman T. & Appleby L. (2003) Clinical and parenting skills outcomes following joint mother–baby psychiatric admission. *Australian and New Zealand Journal of Psychiatry* **37**(5), 556-562.
- Sands R. (1995) The parenting experience of low-income single women with serious mental disorders. *Families in Society—The Journal of Contemporary Human Services* **76**, 86–96.
- Sands R.G., Koppelman N. & Solomon P. (2004) Maternal custody status and living arrangements of children of women with severe mental illness. *Health & Social Work* **29**(4), 317-325.
- Savvidou I., Bozikas V.P., Hatzigeleki S. & Karavatos A. (2003) Narratives about their children by mothers hospitalized on a psychiatric unit. *Family Process* **42**(3), 391-402.
- Schafer A. (2009) *Breaking the Good Mom Myth: Every Modern Mothers Guide to getting Past Perfection, Regaining Sanity, and Raising Great Kids*. John Wiley and Sons, Ontario, Canada.
- Schen C. (2005) When mothers leave their children behind. *Harvard Review of Psychiatry* **13**(4), 233-243.
- Schlessinger L. (2000) *Parenthood by Proxy: Don't Have Them if You Won't Raise Them*. HarperCollins, New York.
- Scott J. (1990) Deconstructing equality-versus-difference : or the uses of poststructuralist theory for feminism. In *Conflicts in Feminism* (Hirsh A., ed), Routledge, New York, pp. 134-148.
- Shorter E. (1997) *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*. John Wiley and Sons, New York.
- Showalter E. (1985) *The Female Malady: Women, Madness and English culture 1830-1980*. Virago, London.
- Silverman M.M. (1989) Children of psychiatrically ill parents: a prevention perspective. *Hospital and Community Psychiatry* **40**(12), 1257-1263.
- Smith D. & David S., eds. (1975) *Women Look at Psychiatry*. Press Gang, Vancouver.
- Smith D.E. (1987) *The Everyday World as Problematic: A Feminist Sociology*. Open University Press, Milton Keynes.

- Smith D.E. (1989 ) Feminist reflections on political economy. *Studies in Political Economy* **30**, (Autumn ), 37-59.
- Smith D.E. (1990) *The Conceptual Practices of Power: A Feminist Sociology of Knowledge*. Northeastern University Press, Boston.
- Smith M. (2004) Parental mental health: disruptions to parenting and outcomes for children. *Child and Family Social Work* **9**(1), 3-11.
- Snellen M., Mack K. & Trauer T. (1999) Schizophrenia, mental state, and mother-infant interaction: examining the relationship. *Australian and New Zealand Journal of Psychiatry* **33**(6), 902-911.
- Somers V. (2007) Schizophrenia: The Impact of Parental Illness on Children. *British Journal of Social Work* **37**, 1319–1334.
- Standing K. (1998) Writing the voices of the less powerful: research on lone mothers. In *Feminist Dilemmas in Qualitative Research: Public Knowledge and Private Lives* (J. Ribbens & R. Edwards, eds), Sage, London.
- Stanley L. & Wise S. (1983) *Breaking Out: Feminist Consciousness and Feminist Research*. Routledge Kegan Paul, London.
- Stanley L. & Wise S. (1993) *Breaking Out Again: Feminist Ontology and Epistemology*. Routledge, London.
- Steen M. (1991) Historical perspectives on women and mental illness and prevention of depression in women, using a feminist framework. *Issues in Mental Health Nursing* **12**, 359–374.
- Stock C. & Fisher P. (2006) Language delays among foster children: Implications for policy and practice. *Child Welfare* **85**, 445–461.
- Stoppard J.M. (2000) *Understanding Depression: Feminist Social Constructionist Approaches*. Routledge, London.
- Stott F.M., Musick J.S., Cohler B.J., Spencer K.K., Goldman J., Clark R. & Dincin J. (1984) Intervention for the severely disturbed mother. In *Intervention Among Psychiatrically Impaired Parents and Their Young Children* (Musick J.S. & Cohler B.J., eds), Jossey-Bass, San Francisco, pp. 7-32.
- Swigart J. (1991) *The Myth of the Bad Mother*. Doubleday, New York.
- Tarren-Sweeney M. & Hazell P. (2006) Mental health of children in foster and kinship care in New South Wales, Australia. *Journal of Paediatrics and Child Health* **42**, 89–97.
- Test M.A. & Berlin S.B. (1981) Issues of special concern to chronically mentally ill women. *Professional Psychology* **12**(1), 136-145.
- Thomson R., Kehily J., Hadfield L. & Sharpe S. (2011) *Making Modern Mothers*. The Policy Press, Bristol.
- Thomson S. (1997) Adaptive sampling in behavioural studies. *NIDA Research Monograph*, 296-319.
- Thurer S. (1994) *The Myths of Motherhood: How Culture Reinvents the Good Mother*. Penguin, New York.

- Tong R. (1995) Feminist philosophy. In *The Cambridge Dictionary of Philosophy* (Audi R., ed), Cambridge University Press, New York, pp. 262–264.
- Umansky L. (1996) *Motherhood Reconceived: Feminism and the Legacy of the Sixties*. University Press, New York.
- Usher K.J. & Arthur A. (1998) Process consent: a model for enhancing informed consent in mental health nursing. *Journal of Advanced Nursing* **27**, 692–697.
- Ussher J. (1991) *Women's Madness: Misogyny or Mental Illness*. Harvester Wheatsheaf, London.
- Ussher J. (2003a) The ongoing silencing of women in families: An analysis and rethinking of premenstrual syndrome and therapy. *Journal of Family Therapy* **25**, 388–405.
- Ussher J. (2003b) The role of premenstrual dysphoric disorder in the subjectification of women. *Journal of Medical Humanities* **24**(1/2), 131–146.
- Ussher J. (2006) *Managing the Monstrous Feminine: Regulating the Reproductive Body*. Routledge, New York.
- Valeska L. (1983) If all else fails, I'm still a mother. In *Mothering: Essays in Feminist Theory* (Trebilcot J., ed), Rowman & Littlefield, pp. 70–80.
- Vandereycken W. (1993) Shrinking sexuality: the half known sex life of psychiatric patients. *Therapeutic Communities* **14**(3), 143 - 149.
- Venkataraman M. & Ackerson B.J. (2008) Parenting among mothers with bipolar disorder: strengths, challenges, and service needs. *Journal of Family Social Work* **11**(4), 389–408.
- Wan M.W., Moulton S. & Abel K.M. (2007) The service needs of mothers with schizophrenia: a qualitative study of perinatal psychiatric and antenatal workers. *General Hospital Psychiatry* **30**(2), 177–184.
- Wan M.W., Salmon M.P., Riordan D.M., Appleby L., Webb E.R. & Abel K.M. (2007a) What predicts poor mother-infant interaction in schizophrenia? *Psychological Medicine* **37**, 537–546.
- Wang A.R. & Goldschmidt W. (1994) Interviews of psychiatric inpatients about their family situation and young children. *Acta Psychiatrica Scandinavica* **90**(6), 459–465.
- Watts M. (2013) Recovery from mental illness as a re-enchantment with life: A narrative study. 4th International Nursing and Midwifery Conference 15th - 16th April 2013, Galway.
- Weaver J.J. & Ussher J.M. (1997) How motherhood changes life: A discourse analytic study of young children. *Journal of Reproductive and Infant Psychology* **15**(1), 51–68.
- Webb C. (1993) Feminist research: definitions, methodology, methods and evaluation. *Journal of Advanced Nursing* **18**(3), 416–423.
- Weiss N.P. (1978) The mother–child dyad revisited: Perceptions of mothers and children in twentieth century child-rearing manuals. *Journal of Social Issues* **34**(2), 29–45.
- Whelan C.T., Hannan D.F. & Creighton S. (1991) *Unemployment, Poverty and Psychological Distress*. The Economic and Social Research Institute, Dublin.
- Whitaker R. (2002) *Mad in America: Bad Science, Bad Medicine and the Enduring Mistreatment of the Mentally Ill*. Perseus Publishing, Cambridge M.A.

- White V. (2010) *Mother Ireland: Why Ireland Hates Motherhood*. Londubh Books, Dublin.
- Whitton A., Warner R. & Appleby L. (1996) The pathway to care in postnatal depression and its treatment. *British Journal of General Practice* **46**, 427-428.
- Widdicombe S. (1995) Identity, politics and talk: A case for the mundane and the everyday. In *Feminism and Discourse: Psychological perspectives* (S. Wilkinson & C. Kitzinger, eds), Sage, London, pp. 106-127.
- Wilson L. & Crowe M. (2009) Parenting with a diagnosis bipolar disorder. *Journal of Advanced Nursing* **65**(4), 877-884.
- Winnicott D.W. (1953) Transitional objects and transitional phenomena—A study of the first not-me possession. *International Journal of Psycho-Analysis* **34**, 89-97.
- Winnicott D.W. (1971) *The Child, the Family and the Outside World*. Harmondsworth: Pelican, London.
- World Health Organization (2002) *Gender and Mental Health*. World Health Organization (WHO), Geneva.
- World Health Organization (2010) *Mental Health: Strengthening our Response*. World Health Organization (WHO), Geneva.
- World Health Organization (2012) *Global Burden of Disease*. World Health Organization (WHO), Geneva.
- World Health Organization (2013) *Mental Health Action Plan 2013-2020*. World Health Organization (WHO), Geneva.
- Zalk S.R. & Gordon-Kelter J. (1992) Feminism, revolution and knowledge. In *Revolutions of Knowledge: Feminism in the Social Sciences* (S. R. Zalk & J. Gordon-Kelter, eds), Westview, Boulder, CO, pp. 1-14.

## APPENDICES

### Appendix One: Poster



# Mothers' Voices

**A study of mothering with women experiencing mental health problems**

- **Are you a mother with a child/children under the age of 18 years?**
- **Have you experienced mental health problems for more than one year and been in contact with a mental health services?**
- **Would you like a voice in shaping future services?**

If you can answer yes to these questions, I would like to hear your story.

My name is Teresa Tuohy I am a registered nurse, counsellor and a PhD student, at the school of Nursing and Midwifery, Trinity College Dublin. Through talking with you I will gain a clearer understanding of your experiences and your needs, then I can help develop better support and mental health services for mothers experiencing mental health problems.

**For more information, or if you would like to be involved, please phone Teresa on 085 7643439 or email at [ttuohy@tcd.ie](mailto:ttuohy@tcd.ie).**

This research is funded by the Health Research Board and has been granted ethical approval from the Faculty of Health Sciences in Trinity College Dublin. This research is supervised by Professor Agnes Higgins and Dr. Jo Murphy-Lawless. Who may be contacted at email [ahiggins@tcd.ie](mailto:ahiggins@tcd.ie) phone no: 01 8963703 and [jlawless@tcd.ie](mailto:jlawless@tcd.ie) phone no: 01 8968580.

## Appendix Two: Letter and information leaflet for professionals

**Teresa Tuohy**

**Mobile: 085 7643439**

**Email: [ttuohy@tcd.ie](mailto:ttuohy@tcd.ie)**

Dear colleague,

My name is Teresa Tuohy. I am a registered nurse, counsellor and a PhD student at the School of Nursing and Midwifery, Trinity College Dublin. I have worked with women in the mental health services for many years and I am currently undertaking a research study.

The study aims to build on the small amount of knowledge that currently exists about mothers with 'enduring' mental health problems. I will explore women's mothering experiences and their experiences of using mental health services.

I am interested in interviewing mothers who:

- have experienced enduring mental health problems, and
- have at least one child under the age of 18 years.

### **Inclusion criteria**

'Enduring' mental health problems refer to a wide range of symptoms that persist over time and are functionally disabling in:

- living skills,
- social interactions,
- family relationships, and
- employment or education or both.

This encompasses conditions such as:

- schizophrenia,
- depression
- anxiety, and
- bipolar disorder.

In the absence of a standard definition of 'enduring' mental health problems, for this study, I will consider the interaction between:

- diagnosis,
- disability, and
- duration.

The women in the study will be volunteers and self-selecting, therefore their understanding of the concept of enduring mental health problems will be more important than any particular diagnostic criteria.

### Exclusion criteria

This study will exclude:

- women who are not mothers, and
- women who are unable to give informed consent.

### How do I get more information?

I would appreciate it if you would consider helping me to recruit women for this study. If you need any more information about this research or if anything in this letter is unclear, please contact me:

- by phone on 085 764 3439, or
- by email at [ttuohy@tcd.ie](mailto:ttuohy@tcd.ie).

### What happens next?

1. You read the attached information sheet aimed at mothers taking part in the study.
2. You decide if you would like to help me recruit women to take part in the study.
3. If you decide you will help, you complete the **'Statement of interest for organisations'** that follows this letter and return it to me in the envelope provided. You can also
  - phone me on 085 764 3439; or
  - email me at [ttuohy@tcd.ie](mailto:ttuohy@tcd.ie).

I will then contact you to discuss the study further and answer any questions you might have.



Who approved this study?

The Faculty of Health Sciences, Trinity College Dublin has granted this study ethical approval.

Thank you for taking the time to read this information sheet and considering my request for help with this important study. I fully understand if you do not wish to be involved, but I hope you will consider helping in the recruitment phase of this research study.

Yours faithfully

---

Teresa Tuohy

### **Appendix Three: Letter, information leaflet and consent form for women**

**Teresa Tuohy**

**Mobile: 085 764 3439**

**Email: [ttuohy@tcd.ie](mailto:ttuohy@tcd.ie)**

Dear

My name is Teresa Tuohy. I am a registered nurse, counsellor and a PhD student at the School of Nursing and Midwifery, Trinity College Dublin. I am writing to you to see if you would be willing to take part in a research study that I am carrying out, 'Mothers' voices – a study of mothering with women experiencing mental health problems'.

I have worked with women in the mental health services for many years. We know only a small amount about mothers with enduring mental health problems and my study aims to build on this knowledge. To do this I would like to interview mothers who:

- have experienced mental health problems; and
- who have at least one child under the age of 18 years.

In my study, I would like to:

- explore your experience of mothering and using mental health services,
- identify the strengths and weaknesses of the support offered by mental health services, and
- explore what psychological, emotional, social and practical support mothers with enduring mental health problems want and need.

I would be very grateful if you would consider taking part in this study. Your involvement is entirely your choice. I attach an information sheet about the study to give you more details.

### **What happens next?**

1. You read the information sheet.
2. You decide if you would like to take part in the study.
3. If you decide you will take part, you complete the attached '**Statement of interest**'.
4. You return the statement to me in the envelope provided.
5. I will then contact you to discuss the study.
6. If you are then happy to take part, I will arrange to interview you at a time and place that suits you.
7. You fill in the consent form when we meet.
8. I interview you.

If you need any more information about this research or if anything in this letter is unclear, please contact me on 085 764 3439 or email [ttuohy@tcd.ie](mailto:ttuohy@tcd.ie).

If you decide to take part in this research study, I look forward to hearing from you.

Thank you for taking the time to read this and I do hope you will consider becoming involved in this important research study.

Yours sincerely

---

*Teresa Tuohy*

***'Mothers' voices – a study of mothering with women experiencing mental health problems'***  
***Information for mothers taking part in the study***

**Who is carrying out the study?**

My name is Teresa Tuohy and I am carrying out this study. I am a registered nurse, counsellor and PhD student at the School of Nursing and Midwifery, Trinity College Dublin.

**What is the study about?**

In Ireland, very little is known about mothers who experience 'enduring mental health problems' and about how mental health services respond to their needs. This research is attempting to fill this gap by gathering evidence to show how best to provide effective care for women that is tailored to their individual needs.

**What are 'enduring mental health problems'?**

For this study, mothers with 'enduring mental health problems' have:

- had mental health problems for one or more years, and
- had contact with the mental health services at least twice in the last year.

This contact can include:

- admission as an in-patient (staying in a service for at least one night),
- use of out-patient mental health services, and
- use of day hospitals or day centres.

The contact can also be with:

- a psychiatrist or psychiatric nurse – out-patient or home visits,
- a general hospital liaison service,
- psychiatric social workers,
- a community mental health nurse, and
- a psychologist employed by the mental health services.

### **What does the study aim to do?**

The study aims to:

- explore the experience of mothering with mothers who experience enduring mental health problems,
- explore the experiences of mothers with enduring mental health problems when they use mental health services,
- identify the strengths and weaknesses of the support offered by mental health services, and
- explore what psychological, emotional, social and practical support mothers with enduring mental health problems want and need.

### **Who is taking part?**

The research is among mothers who:

- have experienced mental health problems, and
- who have at least one child under the age of 18 years.

This research excludes:

- women who are not mothers, and
- women who cannot give informed consent.

### **What happens when a mother agrees to take part in the study?**

If you agree to take part in the study:

- I will ask you to sign a consent form, giving me permission to interview you for the study, and
- I will interview you at a place and time that suits you.

The interview will last one hour or less.

My objective is to hear and record your experiences. I will ask you a range of open-ended questions, which you are free to answer, or not answer, in whatever way you choose.

### **What happens if a mother refuses to take part?**

If you do not want to take part, or do not want to answer particular questions, I will respect your decision. I will not ask you to explain your decision. Taking part is entirely your choice.

### **What will you ask people about?**

I will ask you about your experiences of motherhood and of mental health services and about your preferences for psychological, emotional, social and practical support.

### **Will you record the interview?**

Yes, if you agree to take part in the study I will record our interview. This will allow me to listen to it afterwards and make sure that I write up your views and opinions as completely as possible. If you decide to take part you may request a copy of the taped interview.

### **Do those taking part need to sign a consent form?**

Yes, if after reading this information sheet you are happy to take part in the study, I will ask you to sign a consent form before I interview you.

### **What does a mother's consent allow you to do?**

If you consent to take part in the study, it means you give me permission to:

- interview you so I can get information about your experiences,
- record the interview, and
- use the information you give me, without using your name, in reports and publications to explain your needs and opinions.

### **Is there any risk to taking part?**

I don't foresee any risks to you being involved in this study. However, I am aware that you may become upset when talking about your experiences. If this happens, I will stop the interview and I will provide some time for you to talk about your feelings. I am an experienced mental health nurse and counsellor. The interview will only continue if you consider that it is not going to cause you any further upset.

### **Can those taking part stop the interview after it has started?**

Yes, you may stop the interview at any time without giving any reason.

### **Do you offer any advice?**

Yes, I will provide you with a list of counselling or support services locally.

### **Is the interview confidential?**

I will make sure that all of the information you give is private and I will not inform anyone that you took part in the research. Your name, details or any other information that might reveal your

identity will not appear anywhere in any publication or presentation resulting from this study. I will label the interview tapes with a code number and no names will appear anywhere on them.

If you wish to talk to other people about the study you are free to do so.

### **What are the benefits of the study?**

If you take part in this research study, there may be no specific benefits to you directly. It is hoped, however, that the knowledge generated from this study will help others understand your and other mothers' experiences of mothering with enduring mental health problems. This understanding will have a direct impact on improving the quality of service for mothers experiencing enduring mental health problems.

### **How long will the interview take?**

Each interview will take up to one hour.

### **Is there a fee for taking part?**

No. I will not pay any one for taking part in this study.

### **Will there be just one interview?**

I may ask you to take part in more than one interview, but you can choose whether or not to be interviewed more than once.

### **Who approved this research?**

The Faculty of Health Sciences, Trinity College Dublin, granted this research ethical approval. Professor Agnes Higgins and Dr. Jo Murphy-Lawless are supervising this research. You may contact them if you need more information:

- Professor Agnes Higgins – email [ahiggins@tcd.ie](mailto:ahiggins@tcd.ie), phone (01) 896 3703;
- Dr Jo Murphy-Lawless – email [jlawless@tcd.ie](mailto:jlawless@tcd.ie), phone (01) 896 8580.

### **What is the next step?**

If you wish to take part please:

- fill in the attached '**Statement of interest**' form and return it in the envelope provided – if you have a preferred time for me to contact you please state that; or
- phone me at 085 764 3439; or
- email me at [tuohy@tcd.ie](mailto:tuohy@tcd.ie).

**How can people get more information?**

If you need any more information or if you do not understand anything in this information sheet, please contact me. I will be happy to discuss or explain any of the details with you.

Thank you for taking the time to read this information sheet and considering my request for help with this important study. I fully understand if you do not wish to be involved, but I hope you will consider taking part in the study.

Thank you in anticipation.

---

Teresa Tuohy



***'Mothers' voices – a study of mothering with women experiencing mental health problems'***

If you would like to reply by post, please fill in this form and tick the appropriate boxes.

***Statement of interest***

Please let me know if you will or will not take part in the research by:

- filling in this 'Statement of interest form' and sending it to me in the enclosed stamped, self-addressed envelope; or
- phoning me at 085 764 3439; or
- emailing me at [ttuohy@tcd.ie](mailto:ttuohy@tcd.ie).

Name

Please tick one box

I would like to hear more about this research.

Yes

No

If you ticked 'no' but you know a woman who may be interested please feel free to give her this information sheet.

If you ticked 'Yes' please fill in your details below.

Address

Phone:

Email

What is the best day to contact you?

What is the best time to contact you?

Thank you for reading this and for showing interest in this study. I will be in contact with you shortly.

***'Mothers' voices – a study of mothering with women experiencing mental health problems'***

**Consent form for mothers taking part in the study**

By ticking the appropriate boxes and signing this form, you agree to take part in this study.

I have read the study information sheet and this consent form.

I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.

I understand that all information collected in this study will be treated as confidential and that my identity will remain confidential.

I freely and voluntarily agree to be part of this research study without harming my legal and ethical rights.

I have received a copy of this agreement and I understand that the results of this research may be published.

I understand I may withdraw from the study at any time.

Your name

Your contact number

Your signature

Today's date

If you would like to receive a copy of the transcribed interview please tick box.

Investigator's contact details: Teresa Tuohy – 085 764 3439 or [ttuohy@tcd.ie](mailto:ttuohy@tcd.ie)

**Statement of investigator's responsibility**

I have explained the nature and purpose of this study, the procedures to be undertaken and any risks that may be involved to the person named in this consent form. I have offered to answer any questions and have fully answered such questions. I believe that the person named above understood my explanation and has freely given informed consent.

**Investigator's signature**

**Today's date**

**For investigator's use only**

**Participant code:**

***'Mothers' voices – a study of mothering with women experiencing mental health problems'***

**Statement of interest**

**Will your organisation help recruit participants?**

I would be very grateful if you would:

- fill in this form and return it to me, Teresa Tuohy, in the envelope provided; or
- phone me on 085 764 3439; or
- contact me by email at [ttuohy@tcd.ie](mailto:ttuohy@tcd.ie).

Will you help recruit mothers to  
take part in this study? Yes

No

For investigator's use only

Code

Code

Signed

Today's date

Thank you for reading this and for showing interest in this study. I will be in contact with you shortly

## **Appendix Four: Aide memoire**

### **Mothers' voices Interview schedule**

#### **Study objectives in relation to interviewing:**

- To examine the mothering experiences of women experiencing enduring mental health problems including demographics, living circumstances, employment status, relationship status, number of children, loss of custody issues, mental health issues and using mental health services.
- Gain information on women's experiences of being mothers while also experiencing mental health problems, to examine the influence of mental health problems on their experiences of mothering; issues such as stigma, prejudice, exclusion, family and support systems.
- To examine how this group of women view the mental health services and to ascertain how the mental health services can provide a service that is responsive to their needs.

#### **Introduction**

Welcome, thanks and check with woman re **consent**.

The purpose of this interview is to explore with you your experiences of being a mother whilst also experiencing mental health difficulties. I also want to ask you about how experiencing mental health difficulties have impacted on your life and on your experience of being a mother.

The purpose of the study to hear about your experiences and then to identify and recommend supports and services that you need.

I am interested in your experiences of being a mother and how you mother whilst experiencing mental health difficulties. I also want to find out about the services and supports that you use and that are available to you. I also want to ask you about you experiences, in general, in relation to you mental health difficulties, for example family and friend support, community support and your perception of societies attitudes towards mental health issues and how these attitudes have impacted on you and your family.

#### **Areas for discussion.**

##### **1. Mental health problems in general.**

Please tell me about when you first experienced mental health difficulties?

#### **Follow up questions;**

**Family support:** Was there anyone you felt you could get support from?

Who gave you support?

**Partner support?**

**Community support?** Was there support for mental health difficulties in the community? Were local support accessible?

## **Voluntary services?**

**Mental health services support?** Were you involved with the mental health services?

What support did the mental health services offer?

When was support offered and given?

Where was the support available from (local or did you have to travel)?

How responsive was the mental health services to your needs?

Was the support from the mental health services what you needed?

## **2. Disclosing mental health problems**

Have you told people about your mental health difficulties?

Who do you disclose this to?

From your experience what was the attitudes in Irish society towards mental health issues?

What were peoples' reactions to you when you told them you were experiencing mental health problems?

How did these reactions impact on you?

How did your disclosure of mental health issues impact on your family?

Were there any repercussions in your neighbourhood/community/work?

Are there people or situations in which you would not disclose your mental health issues to?

If the women has not disclosed mental health issues, I will follow up with, why have you decided not to disclose you mental health issues? what is the impact on you of not speaking about your mental health issues and how does it affect you daily life?

## **3. Motherhood and mothering**

Are you in a relationship at present?

Have you told your partner about your mental health issues?

How many children do you have? Is the father of the child/ren involved in parenting?

How does your partner support you?

(depending on the age of the child/ren) Are your children aware of your mental health issues?

Are you involved in mental health services that provide support for you as a mother experiencing mental health issues?

As a mother do you have concerns disclosing your mental health difficulties?

If yes; what are these concerns?

Possibly issues to do with custody may come up here if so I will follow up with; what are your concerns regarding custody? Has anyone mentioned possible loss of custody? If yes; who was this? (family member, partner, services)

How do you think your mental health difficulties have impacted on you as a mother?

How have you coped with your mental health difficulties as you mother your children?

Do you think your mental health difficulties have had an impact on your child/children?

(Here I want to get some idea how mothers cope and deal with-depression, anxiety, voices etc- as they mother their children, e.g do they seek help, do they mask how they are feeling, what coping strategies do they use).I also want to get an understanding of what mothering (in general) means for the women and also I want to gain an understanding of what mental health issues/mental illness (depending on what language they use) means for them.

#### **4. Support and services for mothers**

What services do you know about for mothers experiencing mental health problems?

What services have you accessed as a mother experiencing mental health problems?

Please describe your experiences of using these services? (I want to find out if these services are supportive of mothers/mental health problems, ?non-judgemental, ?stigmatising ?symptom spotting/holistic/recovery oriented).

Are you involved in any support groups/networks for mothers experiencing mental health problems e.g local support groups, websites, blogs, facebook etc.

Describe your ideal service?

#### **5. Stigma/prejudice/discrimination**

Have you experienced discrimination because of your mental health issues?

If yes; What form did this discrimination take?

How do you feel about this?

How do you cope with stigma and discrimination?

Have you sought support?

Who have you sought support from?

How do you think Irish society can deal with discrimination in relation to mental health issues?

#### **6. Concluding questions**

Are there any issues that we have not discussed that you would like to raise?

Interview is concluded. I will spend some time, after the interview, with the woman to make sure she has not been distressed by any of the issues raised. If she is distressed I will provide support and also give her a list of local support services available to her. I will also contact the woman within 48 hours to check that she was satisfied with the interview and discuss any other issues of concern with her.

**Appendix Five: Form used to collect demographic details**



# Mothers' voices

A study of mothering with women experiencing mental health problems

Code No \_\_\_\_\_

## Women's Demographic Information

Age in Years: \_\_\_\_\_

What county do you currently live in? Please circle the county.

Carlow	Kerry	Louth	Tipperary
Cavan	Kildare	Mayo	Waterford
Clare	Kilkenny	Meath	Westmeath
Cork	Laois	Monaghan	Wexford
Donegal	Leitrim	Offaly	Wicklow
Dublin	Limerick	Roscommon	
Galway	Longford	Sligo	

Which of the following best describes where you currently live?

Rural                       Urban

Were you born in Ireland?

YES	NO
-----	----

If no, how long have you lived in Ireland? \_\_\_\_\_ Years

How would you describe your current work status?



Retired from employment	Unemployed
Working for payment/profit (full-time or part-time)	Unable to work due to permanent sickness or disability
Looking after home or family	Student
Other: <b>please tell us</b>	

**Are you in receipt of benefits?**

YES  If yes please say which one(s)	NO
---	----

**Which of the following best describes your current relationship situation?**

Single	Co-habiting
Dating	Married
Steady or committed relationship	Other

**What proportion of people know about your mental health problems? Please place an 'X' in the appropriate box.**

	All or almost all	More than half	About half	Less than half	None	Not applicable
Close Family						
Friends						
Neighbours						
Work Colleagues						

**When did you first experience mental health problems?**

**How do you describe your mental health problems?**

**What psychiatric diagnosis have you been given?**

**When did you first have contact with the mental health services?**

**Who was that contact with?**

**How long have you been in contact with the mental health services?**

**What contact do you now have with the mental health services?**

--

**Are you in contact with voluntary support services? (e.g GROW, AWARE, SHINE)**

YES	NO
-----	----

**If yes please say which service(s)**

--

**Have you ever been admitted to a mental health/psychiatric facility?**

YES	NO
-----	----

**If yes was your admission(s) voluntary?**

YES	NO
-----	----

**How many admissions have you had?**

--

**How many pregnancies have you had?**

--

**How many children do you have? (Please state whether male or female and age)**

--

**Do your children live with you?**

YES	NO
-----	----

**Have you had custody issues regarding your children?**

YES

NO

**If yes please say what these issues are.**

--