

Strategies for parenting by mothers and fathers with a mental illness¹

Prepublication for the article:

Van der Ende, P.C., Van Busschbach, J.T., Nicholson, J., Korevaar, E.L. & Van Weeghel, J. (2015). Strategies for parenting by mothers and fathers with a mental illness. *Journal of Psychiatric and Mental Health Nursing* 2016 23, 86–97 doi: 10.1111/jpm.12283.

¹ In this chapter British- English language will be used, because it is based on the publication in a UK journal.

Abstract

Introduction: Understanding of the problems of parents with mental illness is growing. Gaining insight into strategies for parenting, while taking the opportunities formulated by these parents themselves as a starting point is fairly new.

Question: What are the strategies of parents with a mental illness to be successful?

Method: Experiences of 19 mothers and eight fathers with a mental illness were explored with in-depth interviews. Data were content analysed, using qualitative methods.

Results: Next to feelings of inadequacy, interviewees also describe how children enrich and structure their lives and are not only a burden but serve as distraction from problems. Developing activities that interest both child and parent provides avenues for emerging strength. Mental illness constrains fathers, but also gives opportunities to develop a meaningful relation with their children.

Discussion: Strategies like being fully dedicated to the parental role, finding a balance between attention for one's own life and parenting and finding adequate sources of support are found to be fundamental for recovery in the parent role.

Implications for practice: Peer groups can be of valuable help and mental health workers can support parents to set self-chosen parenting related goals.

Accessible summary

What is known on the subject?

- The combination of coping with their mental health problems and caring for children makes parents vulnerable.
- Family-centred practice can help to maintain and strengthen important family relationships, and to identify and enhance the strengths of a parent with a mental illness, all contributing to the recovery of the person with the mental illness.

What this paper adds to the existing knowledge?

- Taking the strength and the opportunities formulated by parents themselves as a starting point is fairly new.
- Parents with severe mental illness find strength for parenting in several ways. They feel responsible, and this helps them to stay alert while parenting, whereas parenthood also offers a basis for social participation through school contacts and the child's friendships.
- Dedication to the parent role provides a focus; parents develop strengths and skills as they find a balance between attending to their own lives and caring for their children; and parenting prompts them to find adequate sources of social support.
- In this study these strategies were found to be the fundamentals of recovery related to parenting.

What are the implications for practice?

- Nurses can support and coach patients who are identified as parents and self-chosen parenting related goals are set and addressed.
- A family-focused approach by nurses can be used to prevent problems for children and their families, identify their strengths as well as vulnerabilities, and address the challenges to build resilience.

Introduction

During an episode of mental health problems, people may leave or lose social roles, such as that of employee or student, for a short or longer period (Hunt & Stein 2012).

Functioning in the parenting role can also be disrupted or restricted when mental health

problems intensify or when a parent is admitted to a psychiatric hospital. There are many who face the challenge of combining (severe) mental illness (SMI) with parenting tasks. In the United States, about two-thirds of people meeting the criteria for SMI and living in the community had children (Nicholson et al. 2004). In The Netherlands, it is estimated that 48% of the people with SMI were parents of children younger than 18 years of age (Van der Ende et al. 2011).

In general, parenting varies from so-called 'good enough parenting' to 'problematic parenting' (Eckshtain et al. 2009).

The combination of coping with mental health conditions and caring for children makes parents more vulnerable to stress and challenges. Seeman (2012) found that in the United Kingdom, almost 70% of mothers with the diagnosis of schizophrenia lost custody of their children. Dipple et al. (2002) found 68% of parents with mental illness were separated from their children for at least 1 year. In another study in the United States, mothers with serious mental illness were almost three times as likely to have involvement with the child welfare system or to have had children in out-of-home placement (Park et al. 2006). If children stay in the family, parents may be confronted with prejudices and discrimination, given the stigma individuals with mental illness who are parents often face. Jeffery et al. (2013) reported 23% of individuals receiving community- based psychiatric services felt discriminated against for starting a family and 28% in their role as a parent.

Essential social support, like providing information about making the best of the parental role in this situation and offering opportunities for conversation about feelings and possibilities, is not always available; fear of stigmatisation often renders the topic off-limits and leads to secrecy and concealment (Hinshaw 2005).

To date, several studies have addressed the need for support for parents with SMI (Nicholson & Deveney 2009; Howard & Underdown 2011; Reupert & Maybery 2011).

Family-centred practice can help maintain and strengthen important family relationships, and identify and enhance the strengths of a parent with a mental illness, all contributing to the recovery of the person with the mental illness (Goodyear et al. 2015). The way these parents develop in and value their role can also be seen in the context of a recovery process (Bonfils et al. 2014). From this perspective it is important to understand more about the meaning of parenting and the strategies parents can develop to deal with the challenges and vulnerabilities that a mental illness may convey. By giving parents the opportunity to tell their own stories, with an emphasis on how they manage to parent, insight can be gained that can be helpful in creating supportive arrangements for others. It is important to understand differences in how both mothers and fathers value and shape their role of parents. Mothers may have no choice but to care for their children even when they are ill (Nicholson et al. 1999), whereas only one of four men with severe mental illness is actually parenting (Luciano et al. 2014).

A number of qualitative and quantitative studies on parents living with a mental illness have been conducted. Topics in selected studies include the prevalence of parents with mental illness (Nicholson et al. 2004), assessment of their needs (Howard & Underdown, 2011), and the development and evaluation of programmes (White et al. 2013). However, not much is known about the way these mothers and fathers come to grips with challenges in their parental role or about the meaning of parenting in their recovery processes. The strategies they use can give an input to the recovery of others. To learn more about these strategies and processes, a qualitative, exploratory approach is appropriate.

Because fathers with a mental illness are frequently a minority or totally absent in studies on parenting, there is an additional need to understand how they see their role and, for those who actively parent, what ways of coping they have found. Reupert & Maybery (2009) investigated fathers' needs and also the relationship between paternal mental illness and children's development but did not focus on their strategies for dealing with fatherhood.

Aim and research question

The aim of this exploratory study was to gain in-depth knowledge into the challenges, strengths and strategies of people with mental illnesses who have parenting goals and tasks, and the meaning of parenting in their recovery processes. The main research question was: What are the strategies of mothers and fathers living with a mental illness to parent successfully and with satisfaction?

Method

Personal characteristics and relationships with participants

The two interviewers (female) and the researcher (male) were trained in research and were interested in the subject of recovery and supported parenting. Only the interviewer and the participant were present during the interview. Because of purposive sampling, the contact persons invited several people.

Theoretical framework

For this exploratory study, qualitative methods were used. This approach was appropriate given that our aim was to obtain rich narrative descriptions of the parenting experiences of women and men living with mental illness in the context of their everyday lives (Holloway 1997; Patton 2005). The open-ended nature of the interviews gave participants the opportunity to talk in a non-restricted way about their own experiences, challenges, strengths and opportunities. An iterative method was used, in which gathering data and drawing inductive conclusions were implemented in a circular design (Miles & Huberman 1994; Maxwell 2004). Reflecting on the data from the interviews, new questions were asked and, in a process of purposive sampling, new types of participants were invited for

interviews, to explore the issues more fully. Also a narrative approach (Miles & Huberman 1994) was used with extra attention to patterns of inter-connection in the data that differed from what might have been expected, the so-called 'following up surprises' that have the potential to reveal patterns, which might be very informative.

Participant selection

The sampling for this study was purposive. Participants were recruited who met the study criteria of having a psychiatric diagnosis while actively parenting at least one child younger than 21 years of age in the past year. In addition, participants were invited to participate who were perceived as able to express their feelings about parenting verbally. Participants were recruited through three sources. In the first place, teachers of the Expert by Experience education programme at a university for applied sciences asked adult students with children to participate in the study. The Expert by Experience programme is a 2- year associate bachelors' degree programme for people who are, or were, consumers of mental health services. Second, providers from mental health organizations in our professional network invited patients who had children. A third source was parents outside of our network, several of whom volunteered themselves after participating in a workshop about supported parenting.

After the first 10 interviews, the collected data were reviewed and analysed by the first author: (1) to ensure the interviews were meeting the aims of the study; and (2) to establish the types of additional participants who were needed to provide a broad perspective on the parenting experience, to inform further purposive sampling (Patton 1990). This led to the conclusion that it was necessary to recruit more male participants and more people with substance abuse issues. Among the first 10 participants, only one person with substance abuse issues emerged. Given that parents with co-occurring mental illness and substance abuse

issues might have specific challenges, strength and opportunities, the decision was made to engage more participants to meet these criteria. All participants gave written informed consent. Full review of study procedures was waived by the Dutch Medical Review and Ethics Committee as the risk to the participants posed by the study were thought to be minimal. No intrusive questions were asked.

For this portion of the thesis, we did not differentiate between a mental illness and a severe mental illness when recruiting participants, but focused on parents interested in speaking about how they had coped with the challenges of parenthood in the presence of mental health problems. Consequently, verbally competent people, who had mostly overcome their problems, were overrepresented in our sample. Table 1 clarifies that based upon the diagnosis and the duration of the mental health problems, most participants nonetheless belonged to the group of people with severe mental illness, and all participants had previously received long-term care.

A gift amount of 25 euros was given to each participant. This is an amount common in research in The Netherlands as return for participation in interviews of 1–2 h. Since participants were directly invited for these interviews, no response bias was expected from this gift. Since all participants had an income from salary or health benefit and the gift was not extreme (did not exceed a 2 h salary) we do not think it can be seen as coercive.

Setting

The interviews were conducted at locations that the parents preferred, at a time convenient for them. Two interviews took place at a parent's work site, three in a psychiatric hospital, and the rest of the parents were interviewed at home.

The 27 participants in this study were between 19 and 59 years old. Their youngest children were between 6 months and 18 years of age (see Table 1). The sample included 19 mothers and 8 fathers, with more than half of them living with a partner. Half of both the mothers and the fathers were working in a voluntary or paid job. Mood disorders, psychotic disorders and borderline personality disorders were the primary psychiatric diagnoses in this group of participants. Mental health problems tended to be of long duration, with a range from 8 months to 50 years. Seventy-eight percent of the parents had mental health problems before their youngest child was born. Twenty-five parents lived with their children at the time of the interview. The children of two respondents lived with foster families.

Table 1. Demographic data of the study participants (N=27)

Description	Mothers (n=19)	Fathers (n=8)
Age		
Min. - max.	19 – 54y	30 – 52y
19 - 30y	2	1
31 - 40y	2	4
41 - 50y	12	2
51+	3	1
Marital Status		
Married/in a relationship	8	6
Divorced/widow	4	1
Unmarried	7	1
Living arrangement		
Independent	16	5
Sheltered/supported	3	3
Highest education		
University/college	2	-
Middle school/junior high	7	3
Elementary school/basic education	10	5
Employment or other regular daytime activities		
	9	5
Number of children		
1-2	13	5
3-6	6	3
Age youngest child		
Min - max	1-18y	0.6-11y
0 - 5 y.	6	4
6 -11 y.	6	3
12-18	7	1
Psychiatric diagnosis		
Mood disorder	5	4
Anxiety disorder/PTSS	1	-
Psychotic disorder	5	1
Addiction	2	-
Personality disorder	5	2
ADHD	1	1
Duration problems		
Min-max	1- 50y	0.7 - 15y
Shorter than 10 years	3	5
11-20	9	3
21 years and longer	7	-
Total	19	8

Data collection

An in-depth interview guide was used to elicit data about parents' experiences. The guide comprised open-ended questions such as: 'What does parenting mean to you?' 'What are the effects of your mental illness on parenting?' and 'What strategies do you use to overcome your disabilities?' The interviews were audio recorded and typed out verbatim. Two participants checked their own typed out interviews (member check); both evaluated the

reports as complete. The interviews lasted about 1½ h. Because of purposive sampling, the contact persons invited several people. Refusal to participate was not recorded or evaluated. Only the interviewer and the participant were present during the interviews.

Data analysis

The first author conducted a careful review process with interview transcripts, searching for new concepts and associations in this area. Themes emerged and codes were assigned.

Recurrent issues were identified by a thematic analysis of the data (Miles & Huberman 1994).

Using Atlas-TI (a qualitative data analysing software program, Muhr 2004), the first author began axial coding. After this process selective coding is used to derive themes from the data (Miles & Huberman 1994). A total of 21 salient themes emerged. Three interviews were selected at random and checked by an independent researcher who gave additional viewpoints with regard to the coding process. Data from mothers and fathers were reviewed and analysed separately, and compared across sources. The themes that emerged regarding the impact of mental illness on parenting distinguished mothers from fathers. Consequently distinct codes were developed. Themes regarding successful parenting strategies converged across data sources, with mothers and fathers both providing evidence of common themes.

Reporting

In the Results section the major strategies of parents with psychiatric disabilities are presented. Some findings around the main strategies are consistent across participants and in previous research, but also new and unique information is found. The diversity of cases is described as are the individual themes. Quotations are reported as provided by participants, and identified by participant number.

Results

First, the results of interviews with mothers are described, starting with their perceptions of the negative effects of mental illness on parenting and then followed by their reports of the positive aspects of having children. Next, the findings pertaining to the parenting experiences of the fathers are presented. We conclude with the overall parenting strategies that emerged in these interviews.

Effects of mental illness on parenting – mothers

All the mothers said that their mental illness caused parenting problems, on top of the challenges every parent experiences with raising children. Lack of structure and fewer social contacts, and limited energy or ‘lust for life’ negatively influenced their resources and time for sharing leisure activities with children and setting limits or boundaries. Besides the benefits and the problems that all people have when raising children, parents with a mental illness have an extra challenge. On the one hand, having children puts pressure on the parents, while on the other hand, the children contribute to a sense of regular life.

Negative effects of mental illness

Feelings of inadequacy. Mothers expressed feelings of inadequacy regarding their ability to demonstrate empathy, set limits and keep boundaries, structure daily life around a child’s needs, and in organising and coaching children’s activities as they felt a parent should.

A few mothers expressed the concern that they had failed to show their children enough empathy and understanding, which they felt was essential in the contacts with their child. A single mother with a 15-year-old daughter explained:

She [her daughter] felt like she was living on an island. She missed the support she needed from me, during my depression [F1].

Mothers reported it is often difficult to handle the combination of one's own vulnerability with paying attention to the children and other obligations like housekeeping. A married mother with two children age 6 and 10 years old described:

After the last admissions to the hospital, I noticed that I am no longer the person who I was and that I will not be it again. I experience that it is difficult for me to do the housekeeping, to care good enough for my children; I know I have my limitations [F2].

Some mothers felt themselves inadequate parents directly after giving birth to a baby, when they were confronted with their confusion about the big change in their families or, in some cases, by a traumatic birth. A married mother with two children ages 5 and 7 said:

When my first son was 1 year old, I was suicidal. I felt bad as a parent. I could not fulfil the mother role [F3].

This inadequacy was sometimes also confirmed or independently expressed by the organisations or services that are supposed to offer support. For example a mother living with her 12-year-old child felt suppressed:

Before my daughter was born I went to therapy and this information was passed on to Child and Youth Care. It [the information] followed its own course. Instead of being supportive, they kept me under strict control, based on the psychiatric diagnosis in my file [F4].

Two interviewed parents found themselves in complicated situations due to their mental illness and lost their parental status. This not only meant losing legal parental power, but also the loss of contact with the child.

Experience of transference of problems to their children

Several others expressed that they were afraid that their children would inherit their problems.

A single mother with a son of 16 years of age said:

I'm really afraid that my child will go that way. He had two parents who were addicted. That will be in the genes, I'm afraid [F5].

Some of these parents clearly expressed the need for information and support in this matter. A divorced mother with a 3-year-old son explained:

It would be nice if nurses talked about the transference of psychiatric problems to the children. They should make it clear that we have to deal with it . . . although it is hard to do it [F6].

Experience of positive aspects of having children

Positive stimulus to parents' life. The birth of a child gave a positive stimulus to these mothers' lives, providing new substance to their life and a source of joy. A single mother with a 2-year-old child:

Motherhood gives me a lot of satisfaction and yes, since I am a mother, I have stood firmly on my feet. It has changed me a lot. I have to take responsibility that already starts after waking up. You have to be there all day; you cannot leave your child [F7].

The burden of the parenting tasks is concrete during the first years of the child's life.

For a married woman caring for a 2-year-old child the parental role meant:

(.) you as a mother have the lead direction, you wash them, you put on their clothes, and you feed the child [F8].

While for an older child more emotional problems may arise. A single mother with two children ages 5 and 7 said:

My son gets older and now the issue is the bullying at school. I am worried about that.

It is a new responsibility to me [F3].

Issues like these, for older children, pose more emotional or social challenges, compared to when children are younger.

Structure to life. Having children can give structure to life. Another married mother with two children of 6 and 10 years old explained:

Our children helped us, because they forced us to structure our lives: rising in the morning, making breakfast, taking children to school, getting them from school, lunch . . . [F2].

Due to mental health problems, the rhythm of life of these parents was disrupted but, due to the responsibility of caring for their children, a new rhythm and structure was developed.

Effects of mental illness on parenting – fathers

In our sample eight fathers were interviewed. The amount of time they spend with their children varied from living with them full-time to visiting on weekends and holidays.

Fathers at a distance

Three fathers had contact with their children about once every fortnight. They fulfilled their fathering role albeit only for short periods. This limited their ability to engage in a more personal way with their children and, potentially, to overcome the stigma of being a father with mental health problems. For example a father who was divorced with an 8-year-old child had delusions and lived in sheltered housing:

It is like they [ex-wife and her family] see me as having a contagious disease. When I drop a cup it is not just that I do this, no it is because I have a mental illness [M9].

It seemed that he could not do anything right in the eyes of his ex-wife. Still he fought against this, and wanted to be accepted. Another father with children of 7 and 9, married for the second time, mentioned needing support in parenting once in a while. In his case this support was provided by his second wife. Even with this support, he felt he was not taken seriously by professionals because of his mental illness:

Well my oldest daughter was here once when we discovered bruises, when she came from my ex-wife. We mentioned this to the AMK [child maltreatment reporting service], but they did not do anything with it. They listened to us, but did not take us seriously [M10]. These professional helpers considered him as a questionable person, not able to have sound judgment in delicate matters such as child maltreatment.

Empowerment, also for fathers in the background

Four of the interviewed fathers were in the role of being 'the second parent', with the mother occupying 'first place'. The mothers, or in one case the foster family, did most of the childrearing, while the fathers had additional contact with their children. A 32-year-old man who became a father 7 weeks before the interview provided an example of how hard it was to establish a close relationship with his child. He was in a relationship, although not living together with the mother, and saw his child only a few times:

Glad to be a father. Because her mother breastfeeds the baby there is not much to do for a father [M11].

He tried to be as close to his child as he could to create a bond with her. When a person feels he is improving in his role of the father, this can increase feelings of empowerment.

Developing more of a father role can be a part of one's recovery process. This was expressed by a father living with a partner and children of ages 10 and 11:

I learn how to regain the trust of my children. Doing nice things with them, asking them about school, being interested, and knowing when my child has to give a talk at school. Regaining my parental role is one of my key points in this clinic [M12].

'Role' change with the mother

In our sample there was one father (of two children of 3 and 6 years) who had full child care responsibility, staying at home while his wife had a full-time job. He expressed the challenge conveyed by his mental illness:

(Earlier on) the children walked over me; I could not keep standing because of the burden of my depression [M13].

After treatment by a psychologist he came to the insight:

It is like what stewardesses explain about how to handle in the case of an airplane crash: first put your oxygen mask on your own face, so next you can help your child [M13].

This father first wanted to have control over his own life, by taking advantage of professional treatment and 'finding' himself, before he was able to be available to his children. After this insight he managed to do the housekeeping and care for the children and reflected on the positive effect this had on him.

Strategies for successful parenting

The mothers and fathers we interviewed developed specific strategies for parenting. In these paragraphs the results are summarized under several headings. Since broad concepts of strategies are described, no distinction is made between mothers and fathers. According to the

results of the interviews, their strategies are based on dedication to the parental role, finding a good balance between having children and their own activities, recovery in the context of parenting, and requesting support.

Full dedication to the parental role

One of the effective strategies mentioned by participants was making a plan for doing parenting activities during a week, coached by a nurse.

Another strategy suggested by parents is facilitating contact with children through shared activities and searching for joint interests. From this, it follows that an activity needs to be chosen that fits the child's age and that also gives pleasure to the parent.

Being together as a family and being a good role model is seen as important goals of the parental role. A married father with children of 1, 5 and 8 years old described how he intentionally used this strategy:

Getting up in the morning, together as a family, eating together again, doing family things together, yes, that is coming back [M14].

Loss of dedication leads to a less effective parenting strategy, for example, fleeing from parenting responsibilities. A single mother with daughters of 5 and 22 years old reported:

When I feel bad I leave. It does not happen very often. Last year I did this about five times. Then I took my bike and went away [F15].

Balancing raising children and time for oneself

For several participants it was difficult to stay balanced in their lives. Paying attention to one's own mental health, to the housekeeping, and to relationships with friends, relatives and

children must be balanced together. A mother of a 2-year-old child, who is living with a man:

Since I was pregnant I didn't have hobbies anymore. Once in a while I go to visit friends and family, for instance, to celebrate birthdays [F8].

Although this is true for most people, if one is burdened by a serious mental health condition, it may be extremely challenging to keep a balance between obligations and time for oneself (i.e. time needed to cope with one's own vulnerability or take a rest). Besides the obligations of caring for their children and receiving professional support, a majority of parents stated they were hardly able to find enough time and energy for leisure activities. Like a married mother with two children of 6 and 10 years old explained:

I am easily tired. Sometimes I put my daughter in front of the television. And I go to sleep. Before my breakdown I did not have this [F16].

Using the parental role as a road to recovery

The recovery of valued roles is an important theme. Children can change parents and, in the case of mental health problems, they can stimulate parents to develop competencies to solve problems. A 45-year-old married mother with children of 6, 10 and 12 years old explained:

You can be empowered by your own problems. That period offered me a lot. With my child I learned to see my own limits [F17].

Parenting is also a good inducement for participating in social activities. A single mother with children of 5 and 7 reported:

My life is very busy, it revolves around the children and their friends; sports, soccer, swimming lessons . . . [F3].

Being a parent in all the stages of their children's lives gave these participants strength and an identity.

Requesting support

Requesting support was another strategy the participants mentioned during the interviews. Support was solicited from informal resources, like relatives and friends. Also, support came through valued contacts with peers in support groups or through the internet. Often support focused on practical concerns, but also emotional support was also provided. A divorced mother with a child of 17 described:

It was good to talk with other parents about the limits they use for their children [F18]. Several grandmothers played an important role in the family support and being there for their grandchildren. A 23-year-old mother living together with a man and her 1-year-old child said:

My mother saw that I was isolating myself, that my world became small and that I got stressed by raising my child. She said to leave him [her child] with her so I could breathe [F19].

Requesting support from family and friends is another successful parenting strategy. It is important for parents to recognize they cannot do it all on their own, and to ask others for help. A single mother with one child of 18 reported:

I think I am a good survivor. Also I am very creative in imagining positive sides and advantages of new developments. Having a good network of friends that have experience with children is very important to me. I could see how to do it [parenting the child [F20].

Although some participants rely on informal resources in the first place, others do not want to talk about their problems with their family or friends. Rather their preference is to share their concerns with professionals.

The potential positive effects of professional support are described by a married father with children of 1, 5 and 8:

Yes, during that parenting course in the clinic my strong capacities as a father were emphasized. This gave me self-confidence as a father [M14].

A good combination of informal supports and professional treatment supported this individual in the parental role.

Discussion

This qualitative exploratory study offers insight into the challenges of parents with mental illness, into the ways they bring their strengths to the tasks, and into the strategies they use to cope with these challenges. In particular, findings provide insight into the challenges faced by men living with serious mental illnesses who are fathers.

Primary outcomes

In general, participants reported that mental illness had a negative effect on the parental role, with increased feelings of inadequacy and the extra fear of transference of their problems to their children. Given the research on inheritance and the multi-generational transference of the risk of mental health issues for children in cases of depression, anxiety and addiction (Landman-Peeters et al. 2008; Hosman et al. 2009), it is not surprising that parents were worried about these issues.

Although all interviewed parents mentioned diverse negative effects of their mental health problems on parenting, they also found strength by meeting this role's challenges. Parents with a mental illness often feel a heightened sense of responsibility, and this helps them to stay alert when having a child. Raising one's own child offers a basis for social participation through school contacts and through the child's friendships. Developing activities that interest and engage both child and parent provides avenues for emerging strength. Despite experiencing themselves as vulnerable, these parents found a way to raise

their children and enjoy this. They were all highly motivated and committed to parenting and they, overall, experienced having children and parenting to the extent possible as a positive contribution to their recovery.

As Wilson & Crowe (2009) concluded in a study with parents with bipolar disorders: Self-monitoring and self-management are important topics for anyone. Nurses can work with parents to find alternate strategies for self-management that do not feed a cycle of deficit, guilt and inadequacy. These principles of the strength programmes were the starting point of our study. Korhonen et al. (2010) reported that issues related to parenting and family life are not part of basic nursing education and basic professional qualifications but rather are developed through professional and personal growth. Working with clients who are parents and with their families should be an integrated part of the basic education of nurses.

Focusing on the role of the father, we found a few fathers who really took responsibility for their children, and were dealing with their own mental health problems in a very constructive way. For this, they sometimes needed to develop new competencies or discover lost possibilities. Where ex-partners or officials were suspicious of the effect on the children of the father's mental illness, the development of a relationship between father and child was constrained and was sometimes even used as a weapon in battles over the children. Mayberry et al. (2015a) concluded that in the gender issues fatherhood remains in the background in most discussions about families where a parent has a mental illness. The findings of our study can be used to inform a personal recovery programme for fathers with a mental illness.

Lacey et al. (2015) concluded that fathers are more likely to perceive stigma related to the impact of their gender, while mothers with severe mental illness are more likely to perceive an internalised stigma associated with their mental illness. In our study, one father

reported that his family saw him as having a contagious disease and who was not freely allowed to spend time with his daughter.

The stigma of having a mental illness and the fear of losing their parental role had a constraining effect on some of the participants. In a few cases, discrimination by family, friends, neighbours and colleagues was an impediment on the road to achieving their goals. Obtaining support and communicating openly about problems could have a preventive effect on future problems for the children.

Strategies

The main strategies that we found for the parental role of people with mental illness are: being fully dedicated to the parental role, finding a good balance between attention for one's own life and for parenting, and finding adequate sources of support.

Carpenter-Song & Nicholson (2012) found five themes in the ways in which parenting affects one's whole personality and life when living with mental illness. Parenting: (1) gives a person living with mental illness a positively valued identity; (2) affects interpersonal dynamics; (3) provides meaning and structure; (4) affords opportunities for growth; and (5) facilitates the exchange of positive emotions, such as love and joy. Participants in our interviews corroborated many of these themes. The women and men in our study reported that fulfilling the parental role provided a valued identity. Creating a daily routine, pursuing shared interests and activities, solving problems and finding strength in meeting parenting challenges contributed to personal growth and recovery. Relationships with children, family, school contacts and community members allowed parents to express their feelings and seek support through informal and professional networks. Successful parenting strategies were

further developed through participation in self-help peer groups, and with the support of friends, family members and professionals.

Also peer-facilitators (Thomson et al. 2015), that are experts by psychiatric and paternal experience, can be trained to support parents. Parents can be stimulated to find out their own effective strategies. They like to be supported by people they recognise. Schrank et al. (2015) confirm this: Peer support may be important in parenting interventions and evidence on the feasibility and effectiveness of peer-provided parenting interventions is beginning to emerge. Reupert & Maybery (2011) emphasized the peer support programmes. Also for parents with lived experience, while Salzer et al. (2010) advocated for peer specialists who are parents themselves.

The parents in our study felt capable of raising their children, despite their mental health challenges, limitations in time and energy, and other negative forces like the stigma of mental illness and parenting and associated discrimination. They needed to wash, dress and feed their children, and keep their houses in order. When their children were older, they provided companionship. Being a parent did not solve their problems; however children brought structure to their lives and opportunities for community integration and support. One way or another, they managed their mental health problems, mustered enough time and energy, took advantage of opportunities, and developed strategies to raise children. Most participants stated that they mastered the competencies of requesting and accepting support from informal network or professionals. Still, giving birth to and raising a child was, for some parents, confusing and burdensome. For other parents, it was a part of their recovery process. Informal support seemed to be essential to these parents. In many ways, their challenges and needs are not dissimilar from those of all parents striving to be successful in this role. Family-centred practice can help to maintain and strengthen important family relationships, and to

identify and enhance the strengths of a parent with a mental illness, all contributing to the recovery of the person with the mental illness (Goodyear et al. 2015).

Limitations

This exploratory study has several limitations. First, the strong emphasis on the positive aspects of parenting could be a consequence of the fact that we recruited people for interviews who were actively, successfully parenting, and who were willing to talk about and could express themselves well with regard to parenting. This was an important research decision, however, as our goal was to shed light on strategies leading to successful outcomes for parents and children. Second, the interviews were only conducted with the parents. No children, professionals or partners were interviewed. Third, the number of participants was set at 25–30 prior to starting the study, given time and budget constraints. Consequently, we do not claim to have achieved saturation regarding topics or themes identified, we suspect, in this first exploratory study, that we have not reached saturation, and recommend further research on these topics. Fourth, steps to analyse trustworthiness with the scheme of Shenton (2004) were not executed. Results from participants' interviews are only summarized. Future research should use the scheme by recommended by Shenton.

Implications for practice

Nurses and other professionals in health care settings must be aware of the special meaning to people with a mental illness of being a parent, the challenges they face, their vulnerabilities and increased awareness of and concern about their perceived or real inadequacies. Attention must be paid, not only to children's needs, but also to parents' attitudes, commitment and functioning. As Foster (2012) has commented on this issue: Nurses

are in prime positions to support children and families. A family focused approach by nurses can be used to prevent problems for children and their families, and identify their strengths as well as vulnerabilities, address the challenges and to build resilience. Mental health nurses can learn from this exploratory study that if patients have children, they will probably be the most important part of their social network (Ackerson, 2003a). For many people parenting can be an important context for recovery and conveys a positively valued identity. Promoting parental self-confidence and providing appropriate emotional and concrete support for everyday functioning may reinforce parental empowerment, thereby enhancing families' well-being and coping, as well as improving their access to required services (Vuorenmaa et al. 2015). In our study we found evidence of a need for this. Recovery can be initiated and coached by nurses in their various settings. Nurses can also start peer-groups with parents. Using specific parenting strategies and discovering one's own strategy can be part of it. This fits in prevention projects that have their focus on vulnerable groups and on handling stigmatization and discrimination (Hosman et al. 2005). And as Enns et al. (2016) stated it: health policies and promoting prevention of mental illness in the general public are under-recognized facets of primary prevention. Increasing awareness and adoption of such strategies could reduce the burden of mental illness in individuals, families, communities, and society. This is confirmed by Fernandez et al. (2016) by the statement: there is a lack of implementation and/or evaluation of mental health promotion activities conducted by primary care professionals. More research is needed to clearly understand the benefits of promoting mental health in this setting.

The fathering role requires special attention. As direct contact seems to be highly beneficial for developing adequate role functioning and positive relationships with children, spouses or partners should be encouraged to allow fathers opportunities for contact and

caring. Fathers who may be out of work will have more time available to be with their children and contribute to raising them.

Mothers and fathers can be supported by interventions provided by nurses in which patients are identified as parents, and self-chosen parenting related goals are set and worked upon.

Programmes for all parents can be found, for example the Positive Parenting Programme (Triple P., Sanders et al. 2014), that gives parents practical strategies to help them confidently manage their children's behaviour, and build strong, healthy relationships. If there is a need for these specific strategies it is also relevant for parents with a mental illness. For fathers special Triple P. programmes are developed (Fletcher et al. 2011). The so called 'Stepping Stone Triple P' is used for parents of children with borderline to mild intellectual disability (Kleefman et al. 2014). If a part of this program can be used for the group of our study is unclear, but a lesson to be learned is that there is a high dropout in attending the programme. Parents with drugs or alcohol-related problems can be supported by the programme 'The Incredible Years' (Leijten et al. (2015) and for young addicted parents 'The parents under pressure programme' (Barlow et al. 2013). As an early intervention there is the programme 'Mellow Parenting'. This is a more specific family of parenting and relationship programme developed to support parents and their young children in making good relationships (Puckering et al. 1994; www.mellowparenting.org). Since addiction is closely related to mental illness programmes may go together or at least professionals who work with these programmes can learn from each other.

For parents with mental illness also several specific programmes are developed. Cook & Mueser (2014) observed a new generation of recovery-oriented Psycho-Social Rehabilitation services for mothers and fathers. Opportunities for enhanced services are provided in particular by self-help, peer support programmes for parents with lived experience

(Hinden et al. 2006, Reupert & Maybery 2011, Van der Ende et al. 2014, Schrank et al. 2015). These programmes are recovery-oriented and more aimed at the attitude of the parents than on the behaviour of the children. As a difference with the former programmes for parents these programmes do not have a deficit approach with an emphasis on problems and pathology. The programmes are not fitting parents and children into preexisting service plans.

Providers of all types, mental health, medical, and social service, and school personnel can be encouraged to focus on family strength (Reupert & Maybery 2014). Parents living with mental illness can be encouraged to share ideas with other parents, and to engage in talking about parenting concerns, to benefit from peer support (Hinden et al. 2006, Reupert & Maybery 2011, Van der Ende et al. 2014). Nurses may serve as good role models for parenting as well.

People without mental health problems may face comparable issues in their parental role. A future study comparing these diverse groups of parents could explore their experiences, with an eye to optimizing the parenting experience for all adults and their children. Also attention should be paid to the topic of how fathers and mothers can divide tasks and learn from each other's strengths in situations of parental mental illness.

What the exploratory study adds to existing evidence

Our study can be seen in the light of a growing attention for a more rehabilitative approach towards those who are patients and parents. From this point of view several studies addressing parental needs have been conducted (Nicholson & Deveney 2009, Howard & Underdown 2011, Reupert & Maybery 2011). Parallel to this line of research, supported parenting programmes were developed and evaluated (Nicholson et al. 2001, Hinden et al. 2006; White et al. 2013; Cook & Mueser 2014). Most recently Aldersey & Whitley (2015) conducted a study on the role of family members on recovery and found that, apart from

practical support, the family also may give moral support and functions as a motivation for recovery. Other researchers also studied recovery in the context of parenting (Topor et al. 2006; Carpenter-Song & Nicholson 2012; Bonfils et al. 2014; Maybery et al. 2015b). However, taking the strength and the opportunities formulated by parents themselves as a starting point is fairly new, and no studies were found that focus mainly on strategies that are formulated by these parents themselves. In this study these strategies were found to be the fundamentals of recovery related to parenting. Several types of strategies are distinguished in this study: being fully dedicated to the parental role, finding a good balance between attention for one's own life and for parenting, and finding adequate sources of support. This leads to a new advice for nurses and other professionals in health care settings: Focus on existing and self-developed strategies in parenting to reach an optimum situation in case of parental mental illness. If needed professionals can serve as one of these sources of support and so help to find the balance needed. However more important is their help in facilitating parents to find their own way of managing the challenges of parenthood.

Conclusion

Mental health problems can be a factor when faced with the challenges of parenthood. From the accounts of parents in this situation, the following strategies can be successful: the choice to fully dedicate oneself to the parental role, finding a good balance between attention for one's own life and for parenting, and finding adequate sources of support. Although most fathers felt limited in their role, examples showed that fathers with mental health problems can find ways to play a bigger role. As direct contact is a prerequisite for developing adequate role functioning and positive relationships with children, spouses or partners should be encouraged to allow fathers' opportunities for caring.

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