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Supporting Positive Relationships in Families where Fathers Suffer with Mental Distress

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Abstract

The quantitative research literature has found negative outcomes for the children of fathers diagnosed with mental distress. However, qualitative research exploring both the children and parents' perspectives demonstrates mixed outcomes and more complex parent-child relationships. This article reviews the qualitative research literature, highlighting the expressed needs of family members. Recommendations for research and mental health policy are made with the aim of supporting positive relationships in families where a father suffers with mental distress.

Introduction

Many men who suffer from mental distress are also fathers. This article provides a review of the research literature that addresses both the positive and negative impacts of paternal mental distress on children. Recommendations for changes in research agendas, as well as changes in practice policies are made based on these findings.

This article is based on a report commissioned by the Public Health Agency of Canada which provided an international integrative review (Harrigan, Ratliffe, Patrinos, & Tse, 2002; Klunklin & Harrigan, 2002; Whitmore & Knafl, 2005) of the literature on fathers and mental distress from four countries: Australia, Canada, the United Kingdom (UK), and the United States of America (USA) (LeFrançois, 2009). Although many of the research articles include both mothers and fathers as participants, this article focuses primarily on the issues relating to fathers.

The Quantitative Research

For the most part, the international research literature covering paternal mental health focuses on the effects on the mental, emotional, behavioural, and physical functioning of children, including the ultimate risks of developing mental distress in the children of fathers diagnosed with mental distress (LeFrançois, 2010, 2009). The quantitative studies focus

specifically on negative effects of paternal mental distress on parent-child interactions (Kane & Garber, 2009; Paulson, Dauber, & Leiferman, 2006; Sethna, Murray, Psychogiou, & Ramchandani, 2009; Spector, 2006), children's physical health (Ortega, Goodwin, McQuaid, & Canino, 2004), children's life satisfaction (Powdthavee & Vignoles, 2008), child development (Field et al, 2006; Manning & Gregoire, 2006; Ramchandani & Psychogiou, 2009; Spector, 2006; Wanless, Rosenkoetter, & McClelland, 2008;), early child emotional and behavioural problems (Beardslee, Versage, & Galdstone, 1998; Fletcher, Matthey, & Marley, 2006; Kahn, Brandt, & Whitaker, 2004; Meadows, McLanahan, & Brooks-Gun, 2007; Spector, 2006;), impaired functioning in adolescent girls (Reeb, Conger, & Wu, 2010), and the development of 'psychopathology' in these children when they become adults (Ramchandani, Stein, O'Connor, Heron, Murray, & Evans, 2008).

As such, these studies demonstrate poor outcomes for children of distressed fathers on a variety of levels, both in terms of present and future functioning. Moreover, the mental health of all family members appears to have an intricate and reciprocal impact on each other (LeFrançois, 2010, 2009). However, there are other factors in these families' lives that are also associated with poor outcomes. For example, there is a strong association between marital discord and poor outcomes for children in terms of the development of mental distress (Beardslee, Versage, & Galdstone, 1998; Manning & Gregoire, 2006; Mordoch & Hall, 2002). In addition, there is an association between unemployment, poverty, social isolation, homelessness, and general economic disadvantage with parental mental distress as well as with poor child outcomes (Manning & Gregoire, 2006; Thomas & Kalucy, 2003). These associations are stronger in racialized families (Greene, Pugh, & Roberts, 2008). The experience of stigma is rife for parents suffering with mental distress (Ackerson, 2003; Green et al., 2008; Reupert & Maybery, 2007) and this stigma is also experienced by their children (Ackerman, 2003; Greene et al., 2008; Mordoch & Hall, 2008). Stigma – or perhaps more appropriately termed as 'sanism' (Perlin, 2004, 2003) - in the form of discrimination, exclusions, prejudice (Green et al., 2008), and harassment (Ackerson, 2003), among other forms, is apparent in the behaviour of mental health professionals, including social workers, as well as the general public (Ackerson, 2003; Reupert & Maybery, 2007). Therefore, focusing merely on genetics and paternal diagnosis, as the mediating factor in poor outcomes for children, ignores the complexity of the role played by environmental factors, as well as the circular role played by deeply entrenched structural inequalities within society. Rather than focusing on fathers and families, as is the case within much of the research literature and practice, more attention needs to be paid to studying and alleviating the effects of discriminatory economic and social barriers within society (Reupert & Maybery, 2007).

Changing the Research Agenda

Elevating marginalized people as knowledgeable beings, and forming an understanding of their everyday lives from their perspective, requires an ontological acceptance of their views as pointing to lived realities that are not less factual than the views contained within quantitative research. The parallel trend in research over the past decade to directly explore children's perspectives and mental health service users perspectives has involved using qualitative methodologies within their research designs, using open-ended questionnaires, and less structured interviews in an attempt to enable participants to contribute more fully to the research,

using their own language and discussing issues that are not strictly predetermined (LeFrançois, 2007).

In the area of fathers struggling with mental distress, a few recent studies have emerged in the research literature that explore fathers and children's perspectives of the impact of paternal mental distress on families and children (Ackerson, 2003; Cooklin, 2006; Evenson, Rhodes, Feigenbaum, & Solly, 2008; Mordoch & Hall, 2008; Stallard, Norman, Huline-Dickens, Salter, & Cribb, 2004). A fuller review of this literature is detailed elsewhere (LeFrançois, 2010; 2009); however, this article addresses some of the more salient findings that represent knowledge that is not addressed adequately within the quantitative mental health research.

In a study exploring the views of fathers diagnosed with psychosis, Evenson et al. (2008) indicate that many of the fathers held fears in relation to their children's functioning, which were provoked by the bio-medical information they received from mental health professionals. That is, they feared their children would also develop a 'psychotic disorder', given the biased education they received regarding the genetic basis of their distress. Many of the fathers in this study also feared their children would experience the same stigma that they were enduring in society in relation to their mental health status and sanist ideas/practice. In terms of their relationships with their children, many of these fathers felt either alienated or disengaged from their children. Specifically, many felt that the side-effects of their medication, such as lethargy, poor memory, irritability, blacking out, blocking of emotions, and poor concentration, had a negative impact on their interactions with their children. Many of the fathers in this study also pointed to a lack of a positive role-model in their lives for engaging in the fathering role, given some extreme experiences of suffering abuse at the hands of their own fathers when they were children themselves.

In terms of studies exploring the views of children who live with a parent who has been suffers with mental distress, children have expressed distress over feeling ignored by their parent (Cooklin, 2006), witnessing bizarre and fluctuating behaviour (Mordoch & Hall, 2008), and fearing the breakdown of the family (Cooklin, 2006). Many of the children in the Mordoch and Hall (2008) study demonstrated abilities in distancing themselves from their parent during difficult times. Those children who were unable to do so experienced painful and intense emotions during these times. Many of the children worked hard to hide the distress they felt in relation to their parent's behaviour and, indeed, were observed by the researcher to appear calm but disclosed that they were actually feeling drained and stressed. The children further disclosed experiencing conflicting feelings toward their parent. They felt a mixture of love, fear, and confusion. They expressed a desire to protect their parent whilst also wanting distance from them. Daily emotions felt in relation to their parent, as experienced and described by the children, may consist of "joy, love, pride, sadness, worry, frustration, anger, guilt, fear, despair, anxiety, grief, hurt, discouragement, embarrassment, relief, hope, and loathing" (Mordoch & Hall, 2008, p.1139).

Despite these mixed emotions about their parents' mental distress, qualitative research also demonstrates that most of the children studied who live with a distressed parent and most of the distressed fathers in general viewed their relationships with each other in positive terms (Ackerson, 2003; Evenson et al., 2008; Mordoch & Hall, 2008; Stallard et al., 2004). In fact,

some children indicated sharing a stronger bond, trust, and respect with their parent than children in other families (Mordoch & Hall, 2008). This perception described by children was echoed by distressed parents (Ackerson, 2003; Stallard et al., 2004) and specifically by distressed fathers (Evenson et al., 2008).

In terms of parenting issues, the positivist literature focuses on the poorer quality of parenting practices amongst fathers suffering with mental distress. These parenting practices are then related to the higher risk of children being diagnosed with mental distress as adults (Spector, 2006). As such, the literature focuses on poor parenting skills and parents' 'symptomatology' rather than on the strengths fathers may exhibit in their parenting role (Reupert & Maybery, 2007). Although this intergenerational link is by no means conclusive, social workers and psychologists carrying caseloads in mental health and child protection tend to make assumptions regarding the strength of this link in their practices (Jacobsen & Miller, 1998). These working assumptions carry the risk of social workers and other professionals disempowering and demeaning those fathers who may be engaging in good quality parenting, consistent with that of the average father, through prejudicial decisions made because of their diagnosis (LeFrançois, 2010, 2009). For example, there is evidence that children of parents with mental health diagnoses are over-represented in the child welfare system in the UK (Greene et al., 2008) and in the USA (Ackerson, 2003; Jacobsen & Miller, 1998), which heightens their risk for developing mental distress themselves (Jacobsen & Miller, 1998). Moreover, parents with mental health diagnoses report not seeking professional help with parenting issues due to fears that their children will be put in care (Aldridge, 2006).

Another issue highlighted in the qualitative research is the relationship difficulties that arise from disruptions in parenting as a result of hospitalizations. All members of the family are likely to experience increased stress when a parent is hospitalized repeatedly, for long periods of time, and when they are forced into involuntary treatment regimes (Greene et al., 2008). Both parents (Greene et al., 2008) and children (Mordoch & Hall, 2008; Reupert & Maybery, 2007) express fears over the possibility of children being placed into care when a parent is hospitalized. However, this is more likely to happen in practice when a mother is hospitalized rather than a father (Smith, 2004). For fathers diagnosed with psychosis, Evenson et al. (2008) noted that fathers tended not to allow their children to visit them in hospital, despite feeling intense pain over being separated from them. This self-imposed separation from their children served the purpose of protecting their children from witnessing the psychiatric hospital environment, as well as protecting themselves from the shame and stigmatization associated with involuntary committal.

While living together at home, many children with a parent suffering with mental distress will take on the role of a 'young carer' (Ackerson, 2003; Aldridge, 2006; Cooklin, 2006; Reupert & Maybery, 2007). That is, these children may take on a parenting-type role, engaging in caring responsibilities such as personal and emotional care of parents, caring for siblings, and household chores (Ackerson, 2003; Aldridge, 2006). Traditionally, the literature in this area has deemed young caring to be an attachment disorder and the 'parentification' of children's roles. However, recent research suggests that complete role transference does not occur but instead the parent maintains the 'status of parent' even during times when children are taking on a heavier caring role, such as during times of heightened distress (Aldridge, 2006). Instead, the parent-

child relationship may be more accurately characterized as one of interdependence (Aldridge, 2006; Reupert & Maybery, 2007) rather than of unidirectional parent dependence on child. Those children who are young carers require recognition for the work they do, support, and information in order to help them cope. Aldridge (2006) notes that support in the form of respite care, leisure and play activities, befriending services, in-home help for parents, and afterschool or homework clubs should be made available in order to meet the needs of these young carers. It appears that children are not given the necessary information from mental health professionals about the nature of their parent's distress and the services they are receiving (Cooklin, 2006; Mordoch & Hall, 2008; Stallard et al., 2004; Thomas & Kalucy, 2003) nor do they appear to be consulted or included in the care planning for their parent (Greene et al., 2008; Reupert & Maybery, 2007), despite having a unique understanding and insights into their parents' practical needs, given their role as young carers. Under the UN Convention on the Rights of the Child (1991), ratified in every country around the world other than in Somalia and the USA, these children have the right to actively participate in the treatment and care decisions regarding their parent, given their role as young carers (UNCRC, 1989). However, the literature suggests that the important contribution young carers may make in the lives of distressed parents remains unrecognized (Aldridge, 2006; Mordoch & Hall, 2008) and these children remain largely uninformed and not consulted by mental health professionals (Aldridge, 2006; Greene et al., 2008; Mordoch & Hall, 2008; Reupert & Maybery, 2007).

In the absence of obtaining information regarding their parents' distress, some children may hold themselves to blame (Cooklin, 2006). Many children themselves report feeling distressed by their parent's unexplained behaviour during difficult times (Cooklin, 2006; Mordoch & Hall, 2008). Having accurate information has been shown to be a protective factor leading to resiliency in children who live with a parent who suffers with mental distress (Beardslee et al., 1998; Cooklin, 2006; Walsh, 2009). Cooklin (2006) indicates that children can cope well in their families if they are given sufficient information to enable them to make sense of what is happening to their parent and in order to enable them to make decisions about what they can do to help their parent through the recovery process. Approaching children in this way acknowledges their agency and gives them credit for knowing how to use the information in a beneficial way for themselves and their parents (LeFrançois, 2010; 2009). Mordoch & Hall (2008) detail several sophisticated and successful coping strategies used by informed children. Efforts by social workers and other mental health professionals to '*protect*' children from information and direct involvement in decision making (Aldridge, 2006; Mordoch & Hall, 2008) may actually serve to reduce resiliency (Cooklin, 2006), deny children's agency and their status as rights holders, as well as increasing their own experiences of distress (Mordoch & Hall, 2008). Although this article focuses on the issues of distressed fathers, many of the issues are also important for mothers who suffer with mental distress. For example, the disruptions in parenting due to involuntary hospitalizations, discriminatory and prejudicial practices of mental health and child protection practitioners, and fears of children being placed in care represent concerns of mothers (Williams, LeFrançois, & Copperman, 2002, 2001). In order to develop a better understanding of families where either or both parents are distressed, the commonalities and differences in issues relevant to fathers and mothers should be explored further. This deeper understanding should then lead to more relevant research, practice, and policy development. This circular approach to gaining understanding leading to improving social workers' efforts in

terms of research and practice, should ultimately increase positive social action to improve the social circumstances of these families from their standpoints.

Changing Policy

Given the discrimination and stigma experienced by parents who have been diagnosed with mental distress and their families, governments need to find ways to encourage understanding, inclusion, and respect for people suffering with mental distress. Enabling the participation of people suffering with mental distress and their families in the development of research, policy, and programs is a way forward in attempting to achieve these ends. The voice of service users is essential to ensure appropriate policies and practice as well as tackling the issue of discrimination (LeFrançois, 2009) and sanism (Perlin, 2004, 2003). This must be accomplished in a meaningful and sensitive manner rather than as the tokenistic gesture which all too often has been the approach within many user involvement strategies (Berry, Gerry, Hayward, & Chandler, 2010; Grant, 2007; Jackson, 2009; McDaid, 2009; Roberts, 2010; Storm & Davidson, 2010). Moreover, public education designed to debunk the negative stereotypes of 'mental illness' may go some way in combating stigma and sanism more generally. The targeting of the media in these education strategies is essential in order to expose the role it has played in promulgating stigma (Reupert & Maybery, 2007) and reinforcing a popular culture where sanist ideas and practice remain unchallenged.

Given the association between poverty, unemployment, and low socio-economic status with parental distress and poor child outcomes (Manning & Gregoire, 2006), governments need to address the issue of poverty. Special efforts to reduce poverty, homelessness, and unemployment amongst racialized groups and First Nations people need to be undertaken, given that racialized parents suffering with mental distress are even more likely to experience economic and social disadvantage (Greene et al., 2008). Efforts to end poverty must take all of these issues into consideration and governments need to be persuaded not only to devise poverty reduction projections but also to follow through with their implementation.

Policies that promote a culture of care that recognizes children's agency and values young carers' participation as partners in their parents care and treatment is essential for the health and well-being of both parents and children (Aldridge, 2006). As such, "young carers must be included along with other stakeholders in decision making regarding the care, treatment, and recovery plans for their parents" which means providing these children with "information, being allowed to voice their opinions regarding their parents' strengths and difficulties, being consulted by mental health professionals, and giving their opinions due weight in decision making" (LeFrançois, 2009, p18). Governments, such as in Canada and Australia, which do not have national policies regarding young carers, should devise policy and practice guidelines as well as services to support young carers, perhaps following the UK model (see Aldridge, 2006; Cookin, 2006), as part of children's rights to the provision of relevant services (UNCRC, 1989). Given the heightened distress experienced by children and other family members, when fathers are involuntarily committed to hospital, policies should be developed to help support parents remaining in their homes with their families as a priority over involuntary committal. Family-focused policies in mental health should focus on keeping families intact whilst supporting positive relationships. In cases of voluntary committal, the limiting of distress experienced by

families when a parent is hospitalized should include enacting child-friendly policies and practices that ensure an empowering and comfortable environment for family visitation (Mordoch & Hall, 2008; Reupert & Maybery, 2007).

Conclusion

The depth of understanding gained from qualitative studies provides meaningful information regarding the lived experiences of distressed fathers and their children. Some specific information regarding parent-child relationships in this context, such as the existence of strong family bonds, the prejudicial approach of many professionals working in mental health and child protection, the intense impact of disruptions in parenting due to involuntary hospitalizations, and the impact of not informing children, as well as actively involving young carers in their parents' treatment, all point to issues that have been missed or ignored in positivist mental health research. Social workers undertaking research in this area would do well to consult the qualitative literature in order to inform their research agendas in a manner that will reflect the direct needs of families, particularly in terms of supporting positive parent-child relationships.

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