Young Adults and Their Parents: The (Mis)understandings That Define Mental Illness

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Abstract

Using a symbolic interactionist perspective, I explore and identify meanings of young adult mental illness that are constructed through the relationship between young adults and their parents. Thus far, research on mental illness within the family context has focused on adolescents, while the study of young adult family relationships has ignored mental health. I situate my research at the intersection of these two fields, aiming to fill the gap by representing an overlooked population. While ambivalence is present in most young adult-parent relationships, it is exemplified here as both parties navigate concerns about the young adult's safety and wellbeing. Young adults consciously managed what information they gave their parents about their mental health in order to best meet their needs and their perception of their parent's needs. Though experiences varied, parents expressed concern about providing the best support they could, sometimes feeling a need to intervene in their child's problems in order to mitigate harm. Mental illness is constructed as a challenge to independence atop the usual ambivalence of young adulthood, epitomizing a typical young adult experience concentrated on one subject.

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Introduction: What's in a Diagnosis?

Situated at the intersection of family studies and critical work on mental illness, my research examines how symbolic meaning is attributed to mental illness within the specific age group of and relationship between young adults and their parents. Within family studies, young-adult parent relationships have been studied in-depth, primarily through the lens of tensions between dependence and independence. This field of study often lacks consideration of other factors in the relationship dynamic such as mental illness, however. In the study of mental illness and families, most work studies adolescents, cutting off the participant demographic at the age of eighteen. When considering parental perspectives, the narrative of "storm and stress" is often repeated, which I feel lacks depth by only focusing on a simplified narrative from stress to calm (Arnett, 1999). My thesis asks: how do parent-young adult interactions shape each party's understandings of the young adult's mental illness? I conducted nine semi-structured interviews with both young adults who have a mental illness and parents of young adults with a mental illness. I analyzed my findings from these interviews through a symbolic interactionist lens, looking for themes from the literature as well as recurrent novel themes.

Studying the meaning of mental illness as constructed through the relationships of young adults and their parents may sound pedantic, but I argue that it is important both practically and as a model of mental illness within the massive institution of family, allowing us both to apply the themes of this research directly through, for example, clinical work, and indirectly by informing our conceptual paradigm of mental illness which influences social, political, and institutional frameworks of acknowledging and treating the mentally ill. As Walker (2006) notes, "language *creates* realities", and the reality we linguistically create can incline us towards

different models of treatment- self-determination based, psychological, and medical models, for example, are each influenced by different constructions of what mental illness *is.* By emphasizing the role of the family in this study, I hope to contribute to a robust understanding of how the constructed reality of mental illness plays out, as well as one of the sites where it is constructed.

Literature Review: Symbols, Independence & Support

Symbolic interactionism

A symbolic interactionist framework best fit my interest in studying meanings and relationships. Mental illness is not only a biomedical or psychiatric construction, but a social one, defined by experiences and behaviours that deviate from social norms. The category of mental illness and subcategories of specific diagnoses are reified through consensus and convention (Walker, 2006). Symbolic interactionism proposes that our understandings of concepts are constantly evolving as we interact with others and incorporate information from this interaction. LaRossa and Reitzes describe that social interactionism "focuses on the connection between symbols (i.e., shared meanings) and interactions (i.e., verbal and nonverbal actions and communications)" (pp.135, 2009). This framework considers social interactions to be both expressing and continually shaping meanings.

One example of how social interactions shape our understanding of mental illness is stigma. Stigma is a set of negative views toward a particular group that functions to keep people "in", "down", or "away", that is, behaving properly, unempowered, and not tainting others (Link & Phelan, 2014). Link and Phelan (2014) contextualize this concept in the case of mental illness, saying:

> A person interacting with someone who carries a stigmatized status may behave differently, with hesitance, uncertainty, superiority or even excessive kindness. The person with the stigmatized status reacts, responding perhaps with less self-assurance or warmth, causing the interaction partner to dislike him/her (pp. 25).

As such, stigmatizing beliefs are confirmed and internalized, and the stigmatizing definition of mental illness is reified. Though I applied a symbolic interactionist perspective to all interactions, Link, Wells, Phelan, et al., (2015) define a specific type of stigma as "symbolic interactionist stigma": the perceptions held by others that a mentally ill person anticipates. Symbolic interactionist stigma again describes a process of mutuality wherein the stigmatized person and their interaction partner both actively engage in constructing mental illness' role in their interaction. Moses (2010) pays specific attention to the relationship between parental stigmatization and youth self-stigmatization, finding high levels of both when parents attempt to conceal youth mental health symptoms from others. In this example, parental hiding of the youth's mental illness conveys shame, which the youth internalizes. Stigma is one clear and relevant example of a way that mental illness is constructed in social interactions, but not the only one. It is entirely reasonable to believe that positive social interactions can influence a more positive view of mental illness, for example, conveying acceptance and normalcy through support and nonchalant discussion of the subject.

Family Studies

The central task of parenting is to prepare children for independence, though the age of independence is now later than it once was (Gitelson & McDermott, 2006). In "emerging adulthood", roughly ages 18-25, parents continue to provide emotional and financial support and

pass on family values (Gitelson & McDermott, 2006; Vassallo, Smart, & Price-Robertson, 2009). Emerging adulthood is a transitional period of being 'less dependent' rather than independent (Gower & Dowling, 2008). This period has been qualitatively studied, but usually in a one-sided manner, investigating how parents view their role as their child ages or how young adults relate to their parents- rarely addressing both perspectives. By interviewing both young adults and parents, I attempted to address this gap in the specific context of young adult mental illness.

One common theme of parent-young adult relationships is ambivalence. Ambivalence "emphasizes the tensions between social structure and individual lives", related to symbolic interactionism and role theory as it deals with the meaning of a relationship as produced through role uncertainty (van Gaalen & Dykstra, 2006; Bengtson, Giarrusso, Mabry, & Silverstein, 2004). It represents the tensions between parenting and growing up, dependence and independence, closeness and distance (Pillemer, Munsch, Fuller-Rowell et al., 2012). Yet another way to think about it is solidarity versus conflict, which describes the tensions between familial love or alignment and interpersonal struggle (van Gaalen & Dykstra, 2006). Solidarity has many specific dimensions, such as: intimacy, agreement, dependence, integration, opportunities, and familism (Bengtson, Giarrusso, Mabry, & Silverstein, 2004). Few relationships are entirely harmonious or entirely conflictual, so a degree of ambivalence is almost universal, but the parent-child relationship in young adulthood is particularly ambivalent as both sides must re-evaluate their role in the relationship (Pillemer, Munsch, Fuller-Rowell et al., 2012; Bengtson, Giarrusso, Mabry, & Silverstein, 2004).

Ambivalence is mutually constructed, not caused entirely by one side or the other. While it is a common trope that adolescents engage in lots of parental conflict, a recent meta-analysis also shows that conflict generally peaks early in adolescence and decreases throughout (Laursen, Coy, & Collins, 1998; Arnett, 1999). The initial rise in conflict may not be entirely the adolescent's fault either. Adolescents and their parents both express more contempt toward the other through avoidance behaviors in the teen years. Listening back to recordings of their conversations, both teen girls and their mothers rated each other as less friendly in adolescence than they did in childhood (Kahlbaugh & Haviland, 1994; Beaumont, 1996). Interestingly, Kahlbaugh & Haviland (1994) found from their in-home observations that while avoidance increases, teens do not decrease in approaching behaviours toward their parents, indicating that the development of ambivalence in parent-child relationships is a complex process and not one solely defined by growing conflict or avoidance. Parents and adolescent or young adult children can experience complex tensions between closeness and distance, especially when affected by mental illness.

Mental illness in the family

The family can be a place of both support and stress for people with mental illness (Griffiths, Crisp, Barney, et al., 2011). Heerde, Toumbourou, Hemphill, et al., (2015) show that seeking help from family members can be advantageous but can also draw tensions between the dependence involved in this support and forming independent identities and coping strategies. Furthermore, their survey results demonstrate that seeking help from family and receiving support from family are two distinct factors- families can be unequipped to provide adequate help or can sometimes cause increased harm and stress. High parental criticism is strongly

correlated to adolescent self-injury, and parents of children with mental illness feel high levels of worry, instability, and self-blame (Armitage, Parkinson, Halligan, et al., 2020; Muhlbauer, 2002; Pejilert, 2001; Song, Mailick, & Greenberg, 2014; Wedig & Nock, 2007). These studies generate deep qualitative data; however, most are only interested in the impacts of mental illness on teens or parents: what parental behaviours impact the teen, and what are the parental narratives of the teen's struggle. My approach of interviewing both young adults and parents aimed to begin bridging this gap in perspectives, putting the two narratives in conversation with one another.

There are common processes in the parent-child relationship with regards to mental illness. Just as parents and their children engage in mutual avoidance in the teens, they engage in mutual processes when it comes to opening up about mental illness. Draucker (2005) used interviews with 18–21-year-old youths who experienced depression as teens, as well as interviews with their parents to investigate parent-child interaction patterns in adolescence. She found that both parents and adolescents engaged in active behaviors to hide, hint at, and eventually expose the adolescent's depression, termed "maintaining the façade", "poking holes in the façade", and "breaking down the façade" (Draucker, 2005). Each of these stages requires active participation from both sides, and I was curious about how interactions at each stage construct "the problem".

One study addresses interaction again, this time interviewing mentally ill youth on their perceptions of how parents influence their behaviour (Honey, Fraser, Llewellyn, et al., 2013). The youth in this study identified their parents as either facilitating behaviours (making desired behaviours easier), persuading to behave certain ways (encouragement), or controlling (forcing),

and found that they responded differently depending on how they viewed their parent's motives, their own autonomy, and their acceptance of parental authority (Honey, Fraser, Llewellyn, et al., 2013). This is of interest to me because of how the teen's response depends on their perception of adult motives, demonstrating that youth might construct their mental illness differently depending on whether they feel that they are being excessively controlled or being cared for. The relationship between young people and their parents with regards to mental illness is under-studied, but deeply valuable in assessing congruences and incongruencies in experience and perception, and contextualizing understandings of mental illness within an important relationship.

The majority of literature on parent-young adult relationships is one-sided, researching either parents or young adults impressions of the relationship. Similarly, research on youth mental illness in the context of family either focuses on youth experience or parental experience. I argue that this is inadequate and represents a major gap in the literature. Parent-young adult relationships involve participation from both parties. By considering this from a symbolic interactionist perspective, we can better understand how each side arrives at the meanings they draw from interaction with the other. As neither mental illness nor the parental relationship immediately dissolve when a person turns 18, and parents see their role as continuous, we ought to critically consider how both parties impact each other's experience and understanding of mental health.

In investigating the construction of mental illness within the parent-young adult relationship, I aimed to critically investigate the concept of ambivalence. Though it describes

most parent-young adult relationships, I was interested in whether it would apply the same way or at all when the young adult had a mental illness- would it still be a useful concept for describing relationships in this specific scenario? I believed that it would, and made sure to ask my participants questions about feeling close to their parents or child, and any changes in that relationship between the teen years and present. I also tried to investigate ambivalence between dependence and independence by asking questions about how parents supported or did not support young adults, and how participants felt about that support or lack thereof. I also paid attention to the idea of façade when asking participants to tell me stories about the history of their mental illness, wondering if the concept only applied in adolescent narratives, or if it would still be useful in young adult narratives. Ambivalence gave me a frame of reference to compare this specific experience to "normal" young adult-parent relationships. Theories of interactions around mental illness like façade, or facilitating, persuading, and controlling behaviours acted as a glossary of interactions, which I then investigated the meanings of based on participant accounts of the thoughts and feelings surrounding each interaction. Building on the literature, my research question became: how do mentally ill young adults and their parents define mental illness through symbolic interaction? What meanings are created, and how?

Methods: Facades Under Construction

I conducted in-depth semi-structured interviews with two groups of people: young adults who have a mental illness, and the parents of young adults who have a mental illness. For the purposes of this study, young adulthood was defined as ages 18-30. As for mental illness, I did not require any proof or confirmation of diagnosis, only self-disclosure from the young adult. Similarly, I asked parents to disclose what mental illness their child has. I was concerned that

some parents might only have suspicions that their child had a mental illness, rather than a disclosure from their child or having participated in the process of diagnosis, but this did not occur. Hour-long interviews allowed me to build rapport and trust, and to deviate from my interview guide to follow up on interesting statements from my participants. Other methods like observation and participant evaluation of tapes that have been used in my cited literature would have been interesting, but for my purposes individual interviews allowed me to ask participants to reflect on multiple memories, speculate about future interactions, and describe things that they would not have said in front of their parent or child. While observing in-the-moment interactions would be another interesting approach, I was able to discover overarching narratives of mental illness and relationships that people constructed over time with interviews. Qualitative methods are common in the study of mental health, especially when the goal is to develop and test theories, tools, and measures, and I would consider my research aim to fall into developing and testing theories (Peters, 2010).

I recruited via snowball sampling, beginning with posting my recruitment ad (Appendix A) on my personal Facebook profile and in Dalhousie University-related groups, primarily because this was the main group of people available to me, but also because most university students fall into my desired age range of 18-30 and could recruit their parents. I asked participants to pass along my ad to anyone who might be interested. Though the only demographic I intentionally sought out was people who are 18-30 and have a mental illness or parents of this group, I recognize that by beginning my study in university-related groups and snowball sampling, my demographics were limited. A future study controlling for other demographic markers like class, race, and gender may reveal interesting data, but it is beyond the

scope and purpose of this study. Such a study could build from the results found here and add depth and breadth to the types of interactions and understandings of mental health that I identified.

I used two interview guides, one for young adults and one for parents, which mirrored each other as closely as possible. They centered around the subject of mental illness, asking young adults about their history with mental illness, its effects on their life and their relationship to their parents, and asking parents what they know about their child's mental illness history, how it impacts them, and how it impacts their relationship. I also asked about the general status of their relationship, such as how frequently they interact, what their relationship is "like" generally, and what they want it to be like. While the goal was to center the interview around mental illness, questions about more general aspects of the parent-child relationship rounded out my data, often leading back to the subject of mental illness and uncovering relevant information.

Interviews were audio recorded and transcribed afterwards. I analyzed each transcript by coding for themes, first for top-down themes from my literature, then bottom-up looking for recurring ideas and interesting cases. For the first top-down analysis, I kept in mind the concepts of ambivalence and stigma, and Draucker's (2005) interactive stages of breaking down the façade. In my specific context and demographic, I hoped to analyze these concepts in a new light, expanding upon or re-working them. Using a symbolic interactionist lens, I looked for how participants described their relationships and interactions with either their parents or their child, and how these descriptions conveyed information about mental illness. I was interested in how

the participants chose to narrate their interactions, revealing meanings created in the interpretive process through narrative, tone, and language (Handberg et al., 2014).

The nature of my research was to investigate mental health and family relationships in depth, which may be sensitive for some individuals. I found it reasonable to assume, however, that individuals who knew they would be uncomfortable delving into these subjects would either not respond to my ad or opt out after I described my research to them. All respondents were briefed on what they would be asked to do- one interview lasting about one hour- and the topics of the interview. They were also given a consent form to sign and informed that they could opt out at any point up until my thesis was submitted. When participants became upset during the interview, I offered to stop recording, give them a break, stop completely, and withdraw any responses they had already given if they wish. Several participants became tearful, but after short breaks and my offer to stop and delete their responses, each of them chose to continue- some even thanking me for creating space for them to share these experiences. I aimed to listen empathetically and actively not only for data collection purposes, but out of respect for my participants who shared personal information with me and to provide participants support in this task.

Of course, all responses and participant identities were kept confidential, but extra consideration was taken in the event that any parent-child dyads participated. In that case, I foresaw participants being curious about their parent/child's responses, but I resolved to make clear to them that I could not and would not share any of that information at the beginning of each interview. In this document and all other works making use of this data, all information is

anonymized, any direct quotes are attributed to pseudonyms, and relationships between participants are not indicated.

Analysis: A Calculation of Concerns

The people I spoke to had a range of relationship types with their parents or young adult children. I was able to interview seven young adults and two parents. Of the young adults, none identified as men, some identified as cis women and others as non-binary. Both parents were mothers. Some parent-child relationships were extremely close and described as best friends, while one young adult described theirs as more "like acquaintances". Most fell somewhere in-between, describing loving relationships but not speaking daily or too in-depth on personal topics. There were a whole host of factors that contributed to the closeness of the relationship, and most young adults indicated that their relationship closeness had stayed more or less the same since they were in their early teens.

Mental Illness Across Generational Divides

One commonality across interviews is that all participants had working theories at the ready to describe why they thought their parent or child behaved in certain ways. In conversation, most were able to quickly provide a rationale behind why their parent or child had acted a certain way as well as attributing value and belief meanings to those actions. Generation was one concept that was raised by both young adults and parents to explain reactions or beliefs- every reference to generation invoked that the parental generation was less aware of mental illness than the young adult generation. Another rationale as to why parents held the beliefs they did was their own mental health. One young adult, Charlie, said that their father didn't take their depression seriously and maintained expectations of them that felt incompatible with their mental

illness. Charlie attributed this to the fact that their father has also been depressed and managed it without therapy or medication by "just pushing through it". Though their father had revealed that he had been depressed to Charlie, Charlie made the connection between his personal experience and his expectations of them. In turn, this changed what Charlie would disclose to their father in order to meet his expectations and avoid conversations they find unhelpful.

These two ideas- generation and parental mental illness- fit together well. Given current understandings of mental illness as often having some genetic basis, the prevalence of either known or suspected mental illness in parents makes sense. Parents who were unaware of their own mental illness and/or never received accommodation or treatment for it may be more likely to see their child's mental illness as a normal part of life, and "pushing through it" as the only option. Some young adults used this theory to explain why their parents behaved the way they did, and as a justification for not discussing mental health with them. Some young adults used the word "uneducated" to describe their parents and mental health, sometimes directly linked to generation. If these young adults see their parents as set in their ways, having the knowledge only of their own experience and not consciously being educated, then it makes sense for them not to see their parents as helpful resources for mental health.

The Young Adult Problem: Stigma and Boundaries

Almost every young adult participant felt that living separately from their parents had improved their relationship, but overall, no dramatic shifts in the relationship came up. One young adult, Eliott, who sees their parents as "acquaintances", says that they might be more open about their mental health "if it was something that [they] did all the time or something that became more normal". Their statement about normality elucidates a common sentiment that most

participants were only as open about mental health as was normal for their families. With this in mind, a common theme was that it is easier to talk about mental health intentionally through deliberate conversation while living apart, as it was no longer brought up through arguments about behavioural symptoms. Another young adult, Emily, used the phrase “not making messes in their face” to describe how her relationship to her parents improved with distance- though she still discussed her mental health with them, she no longer had to worry about her obsessive-compulsive behaviours irritating her mother. Distance gave more control to both parents and young adults to decide when and how to broach the subject of mental illness, rather than having it arise from the display of symptoms.

The sentiment that there are different levels of appropriate involvement in mental health in the teens as opposed to adulthood was mentioned multiple times, which could convey a number of things about the meaning of mental illness in young adult-parent relationships. For one, it was affirmed as a normal part of life when mental illness becomes primarily the young adult’s responsibility, and the parent’s levels of knowledge and involvement decrease. Their mental illness, like any other part of their life at this age, is something that is primarily their responsibility which they can disclose as they choose.

Charlie, for example, was open with their mother about being non-binary, but chose not to talk extensively about that identity with their mother. In adulthood, it became easier for them to manage what their mother did and did not not know about aspects of their life. When it came to mental health, Charlie said they would talk about symptoms with their mother, but not specific traumatic events. Rather than being hyper-monitored or hyper-visible, Charlie’s depression was a

private topic just like their queerness. From a parent's perspective, Jennifer struggled with accepting that her two adult daughters didn't want to talk about some topics with her, but didn't push the subject, saying "they just shut us up, not in a rude way but it's their life, that's their decision." She reveals that even if it's difficult, mental health is a topic that her daughters have authority over how and when they chose to discuss it. Lisa, the other mother whom I spoke to, similarly said that:

> My daughter may hide some things from me to protect me. I think if she had a cigarette she wouldn't share that with me because she knows it might upset me, but I feel like she has a cigarette on occasion. It's not because we're not close enough to share that, it's just a boundary thing, an unnecessary fact.

Lisa's perspective is one that permits and encourages independence; rather than creating ambivalence via a conflict between closeness and distance, Lisa appears to have accepted that she and her daughter are close *and* keep some things private from the other. It may be more helpful to think of experiences of mental illness as a boundary between parents and their young adult children, rather than a stigmatized secret. It appeared that my young adult participants mostly felt that mental illness was like other aspects of their lives, and as adults they each deserved autonomy in what they shared.

Conversely, the relief young adults and parents felt in having distance from each other conveyed that mental illness is better heard about than seen. Some participants considered behavioural expressions of mental health issues to be the cause of relationship difficulties. As adolescents, several young adults reported that their mental illness disrupted their sleep patterns,

which often resulted in fights or unhappiness when parents tried to wake them up for school. Other symptoms like repetitive behaviours, mood swings, or impulsive money spending that the young adults struggled with in adolescence would upset parents and result in arguments. Improvements to the relationship with physical distance may illustrate stigma as being more complex than fear, hatred, or disdain; instead, mental illness may be stigmatized by only wanting to deal with it at a distance, through edited verbal reports rather than by witnessing and living with the behaviours.

This discussion within the context of young adults choosing not to disclose also calls back to Link & Phelan's (2014) symbolic interactionist stigma. The young adult's feelings that mental illness is something that would be out of the ordinary, anxiety inducing, or otherwise negative to discuss with parents set the tone of the conversation; rather than parents solely enacting stigma, both sides approach the interaction with stigma on their minds. No parent or young adult I spoke to intended any harm to their child or parent, nor believed that their parent or child intended harm to them. Stigma can be unintentional, however, and still inflict harm. Beyond surface level ideas of stigma- the undesirability or abnormality of certain traits- stigma is present when we engage in behaviours intended to keep mentally ill people behaving properly, from corrupting others, and unempowered to change their circumstances (Link & Phelan, 2014).

Eliott was unsure whether their parents have disclosed their diagnosis to their sister or not; they didn't know if their parents wanted to give them autonomy over disclosure, or if they didn't want to talk about it. They could be trying to conceal the diagnosis, or they could be granting Eliott the freedom to craft their identity through conscious disclosure. The uncertainty,

however, has planted the idea for Eliott that it is possible their parents want this diagnosis concealed. Eliott now approaches the idea of disclosure with this uncertainty in mind, much like the preconceived 'symbolic interactionist' stigma Link & Phelan (2014) defined. Another interaction with parents that both Charlie and Hunter reported was trying to explain that depression sometimes prevented them from accomplishing tasks. They had each been met by the response from parents that depression is not an excuse not to do what is required of them, ensuring proper behaviour.

Boundaries and stigma interact in young adulthood in ways that may be impossible to completely disentangle. Stigma may be part of the reason for setting a boundary around to what extent or in what ways parents and young adults discuss mental illness. In this study, those young adults with closer relationships to their parents told me that they were intentional about how they communicated. Rebecca, a young adult with bipolar disorder, described her mother as her best friend and main support for her mental health. She said that while her mother understood depression from experience, she did not understand manic symptoms as well. The pair overcame this gap in understanding through what Rebecca called "logical conversation"; over time, Rebecca taught her mother how to be helpful during manic episodes. Rebecca said that her mother became more helpful after she was able to communicate about her experience and give feedback on what was and was not helpful, and her mother adapted to that feedback. Nicole, another young adult, similarly taught her mother about her eating disorder by explaining what her experiences were like, and they began to communicate more openly about it after this explanation. Nicole said that her mother does not understand her anxiety, but if she were to explain it like she did with her eating disorder she might understand better- Nicole told me she

was not sure if it would be worth the trouble because she has other supports. These kinds of explicit discussions around what the experience of mental illness felt like, the young adult's needs, and their expectations of parents reduced stigmatizing interactions. The boundary of not talking about mental illness with parents may contribute to the stigma, just as stigma may contribute to the need for that boundary.

Love is Worry

The responsibilities and expectations associated with the parent-child relationship specifically facilitate definitions of mental illness that are unique to this relationship. Many young adult respondents identified that they would turn to either friends or parents depending on what kind of issue they were facing; only two felt that they would turn to their parents no matter what kind of mental health issue. In considering what determines the difference between an issue they would bring to friends or parents, participants indicated a working schema of what kinds of reactions they could predict from each audience based on past experience and knowledge of the other's personality. Young adult participants made calculations about their desired outcomes- both for their mental health and the relationship itself- and whether it would be worthwhile to seek those outcomes from parents. The young adults shared similar ideas around ideal outcomes of talking about mental illness with a parent. Ideally, they would listen closely and validate the legitimacy of your feelings and be able to calm you down- as one participant put it, to "say the right things and say them in a soothing voice"; parents should not show feelings of fear outwardly to their children and not tell their children what they ought to do. In reality, however, different participants felt their parents met these ideals to different extents. Young adults described their parents as worrying about them, leading them to "nag", become anxious,

minimizing, or taking control, and though they each expressed sympathy for their parents' situations, expecting these outcomes led young adults to consciously manage how, when, and if at all to discuss mental illness with their parents.

The unique aspects of the parent-child relationship may make meeting these ideal outcomes more difficult for parents than other types of relationships. Parents are assumed responsible for their children in ways that lovers or friends are not commonly thought to be. A parent's first responsibilities are to meet the child's basic needs, keep them in good health, and keep them alive. The two mothers I interviewed described their role as parents to involve facilitating their children becoming themselves, imparting important values, being a safety net that's always there, and to help them be happy- all of which continue throughout the parent's life. The parent-child relationship is also unique in that (until the parents are elderly) there is minimal reciprocity expected, and the relationship is presumed to exist from the child's birth to the parent's death. These responsibilities are so fundamental, and the relationship considered so primary, it makes sense that to fail would be a great source of anxiety.

In this context, we can understand why parents may be quicker to 'nag' and take control of a situation in which their child is expressing unhappiness or acting unlike themself as the parent knows them, or in which their life may even be in danger. One young adult, Hunter, likes that their friends can be "a little more chill or more casual" about hearing that they're struggling, and they might offer to do small things without "dropping everything"- though they do care, their friends do not have an explicit responsibility for Hunter's wellbeing. Their parents, on the other hand, tend to launch into a flurry of questions like "Do you need to go see a doctor? Do you need

to do that? Do you need serious help?" when Hunter expresses to them that they're struggling. They describe their relationship to their parents surrounding mental health as: "You feel like you really have someone that cares so much about you and is so anxious about you that it gives you anxiety". Hunter's acknowledgement of parental love and preference for the less intrusive support from friends is indicative of ambivalence, as they are caught between familial bonds and independence (van Gaalen & Dykstra, 2006). While they recognize their parents to be expressing love and concern for their wellbeing, their parents level of concern is not calming, and perhaps puts responsibility on them not to struggle in order to avoid causing anxiety.

The relationship between responsibility for another person, the amount one worries about them, and being compelled to action is worth further investigation. In this limited example, it seems reasonable to say that as parents are primarily responsible for their children (at least in their youth), high levels of worry might be associated, and they may be more compelled to act in order to "fix" the situation and decrease worry, rather than listen. Parents might feel responsible for taking action to help their children- by making appointments or imposing ultimatums, for example- especially in young adulthood, while their children are only recently and slowly transitioning toward independence. This complicates the findings of Vassallo, Smart, & Price-Robertson (2009) that parents of young adults primarily see their role as listening and giving advice, rather than providing material and financial goods. This study, however, did find that most parents still felt it was their role to provide physical care for their young adult children when sick, which may similarly apply to mental illness. In the case of young adult mental illness, their independence may be reduced, either genuinely by the mental illness or only in the parental imagination. We can understand it as a normal piece of the transition to adulthood in the same

way as managing money, schoolwork, and career that is over time transferred from parental responsibility to the child. Alternately, we can see it as a unique responsibility in the case where the parent believes, whether correctly or not, that mental illness impedes the child's capacity for independence, having such a fundamental impact on quality of life (or even survival) that it is exempt from the usual transference out of parental responsibility. What participants described appears to show a mixture of both, wherein adult autonomy over conversations about mental health increased, yet parents still felt an urge to take control of the situation when something worrying was disclosed. From the parental perspective, ambivalence manifested in uncertainty about where on the spectrum between dependence and independence their child stood, potentially defaulting towards dependence when they felt worry.

Jessica, mother to two adult daughters with mental illnesses, described the difficulties of allowing them to be independent within the context of their previous struggles. As teenagers, one daughter had anorexia nervosa, the other what Jennifer called "the effects of trauma". At one point or another, she had feared for each of their lives due to their illnesses, whether from malnutrition or suicidality. Jessica and her husband took on the challenge of learning as much as they could about trauma and mental health, finding counsellors for their daughters and themselves to help the family cope. The daughter with anorexia did not want to undergo formal treatment, and Jessica and her husband 'treated' her at home by preparing meal plans, supervising her eating, and imposing a weight goal for her. Jessica told me that her daughter had gained and maintained the weight goal and was physically well, but according to her, would struggle mentally for the rest of her life. As young adults, her daughters don't turn to Jessica for support anymore; they frequently deem topics of conversation "too triggering". Jessica told me

she respected their decisions not to open up to her, but did not like it. For one, she said it was challenging to have normal family interactions while always avoiding serious topics of conversation. She also didn't approve of avoidance as a coping strategy, saying "If you never want to reflect on what the problem is, and your feelings, it's never going to be solved". Jennifer was genuinely responsible for solving problems for her daughters at one point in time, with very high stakes; it makes sense that now, accepting their independence in terms of disclosure might feel uncomfortable.

Some of the ideal reactions were easier for parents to achieve than others or were only achievable by parents. One idea that came up in terms of how young adults wanted to be supported by parents was that of a "mother's gift", an intimate knowledge enabled by the relationship's existence since birth and a unique type of comfort akin to being rocked as a baby. Another element of mental health support unique to parents was an idea of a safety net. While we can understand it negatively in terms of parents as a last resort for help, some young adults expressed this idea positively in terms of knowing that when their mental health is at its poorest or there's a situation they can't handle, they feel secure knowing their parents can help. Several young adult participants described situations of "panicking" or "having a breakdown" and turning to their parents, and the idea that "they're always there for me" as something they appreciate- even if they have criticisms of how their parents have responded in the past. The positive elements of parental involvement in their young adult's mental health also have to do with responsibility in terms of their guaranteed long-term presence and ability to take action.

These young adults consciously decided what to tell their parents about their mental illness not only based on how helpful they thought it would be, but also considering how to protect their parents' feelings and values. Even though some of the young adults I spoke to mentioned actions their parents had taken that they felt specifically traumatized by, they also said they wouldn't tell their parents they felt that way. There were also many scenarios in which young adults described consciously figuring out how to say things the right way, at least partially to protect their parents' feelings.

Robin, a young adult who recently was assessed for a mental health issue and started taking medication, had to talk about it with their mother so she could help with the assessment, but knew they'd have to approach her in a specific way. They described their mother as preferring natural alternatives to Western medicine and trying to avoid it wherever possible. From Robin's perspective, "It just took it being explained to her from someone that she knew she could trust, which was me, and someone that she respected and someone who wouldn't condescend her or like act as if it was because she had failed somehow as a parent" to understand and support the assessment and medication. Robin used examples of friends' experiences with medication to help assuage her concerns and updated her on how it improved their life. Their mother's support was important to Robin, and it was also important to them that their mother's feelings were considered throughout this assessment that conflicted with their idea of their mother's values.

While Robin's experience demonstrated an instance where sharing information in a particular way protected a parent's feelings, others mostly discussed instances where they chose

not to share information to protect their parent's feelings. Nicole, on giving up on asking her mother for support with stressful events in her life said "I just don't really share things with her 'cause I don't feel like she can take it". On top of being unhelpful to Nicole, she emphasized that her mother was unable to handle her own emotions. Charlie, who did talk to their mother about some more general symptoms of their depression, did not talk to her about the traumas they feel to be underlying causes of the depression. They said "I can't be open with my mom about, like, you and [the rest of] my family unit was like a huge traumatic experience for me". Nicole and Charlie both described positive memories of their mothers, and a desire to maintain the relationship. They both indicated that there were certain things they could not or would not share because it would harm the relationship by bringing up negative emotions. Robin felt that their approach to talking about medication with their mother worked because their mother was "hearing it from someone who was not doing this to judge her, or doing this to critique her parenting". While it may be technically possible for Nicole to discuss her mother's unhelpful reactions or for Charlie to discuss their mother's harmful behaviours in a way that does not judge or critique their parenting, it does seem incredibly challenging. Many young adults I spoke to used their own explanations for why their parents behaved the ways they did in order to help make peace with the things they could not discuss.

Façades: From "False Front" to Tidying Up

While Draucker's (2005) concept of façade was a helpful starting point, it did not perfectly fit with my findings. In Draucker's model, the façade is maintained, then holes are poked, then it is broken down: breaking down the façade and knowing are the end point. All of my participants' parents were aware of their young adult's mental illness, in most cases for many

years. When reflecting on the teenage years, the narratives my young adult participants shared generally fit with this concept of façade, but after they broke down the façade and their parents knew, life continued. Framing the narrative this way works well when the story ends before adulthood. Adolescents generally live with their parents, making the management of their mental illness more central to their relationship as evidence can be seen at any time. They also generally require parental assistance in order to access professional mental health care, emphasizing the importance of knowing. However, this model conceptualizes knowing as an event, and the procession from façade to knowing as linear. My participants described these initial events of breaking down the façade and knowing, but as the relationship continued post-knowing, the knowledge shared did not always remain current. New developments or the ongoing, everyday experiences of life with a mental illness were not always shared.

In the ambivalent age of young adulthood, the young adults and parents I spoke to were in an ongoing state of "kind of knowing" and "kind of sharing". The young adults I spoke to maintained semi-facades; not fully concealing, but not being fully open. They spoke of glossing over and beautifying certain parts of their experiences that would be too scary or hurtful for parents to see. Rather than maintaining a façade as in a false front on a building, the process that the young adults I spoke to engaged in was more akin to tidying up an apartment that's usually ridden with beer cans and takeout containers when they know parents are coming over. Their parents knew about their diagnoses, past histories, some details of how they were doing- they had seen the true front at some point in time. These young adults were only making it sound more palatable by saying and not saying certain things or figuring out how to say them right.

Conclusion: Mental Illness and the Ambivalent Age

Mental illness in the relationship between young adults and their parents represents an additional challenge to independence on top of the usual ambivalence of the young adult age group. While there are typically conflicting drives for parents to preserve closeness and young adults to assert independence, this was very present in the specific scenario of managing and communicating about mental illness. Beyond preserving the relationship as it had previously been, in the case of mental illness management, parents may be driven by concern for their children's safety and wellbeing beyond the typical concern for a non-mentally ill child. For young adults, the intensity of their need to assert independence may be heightened by a number of factors directly related to mental illness within this relationship: protecting a parent's emotions, avoiding overreaches of parental control, and forging new supportive relationships. The experience of ambivalence is deeply present in this situation for both parents and young adults, the sense of uncertainty and the stakes seem higher around issues of mental illness than other aspects of the young adult's life.

Mental illness is constructed in the parent young adult relationship through communication about the mental illness, non-communication about the mental illness, and background knowledge of each other. One of the most common themes in each interview was the continuity of the relationship's dynamics, meaning that the extent of communication about mental illness was likely to continue as it had been in previous years. The precedent of communicating or not informed how both parties continued the relationship in most cases. My interviewees also used information about what parents or children had responded positively or negatively to in the past in order to aid decisions about what and how to share in the future. On

top of this, they factored in calculations about helpfulness, and how sharing or not sharing would impact the relationship.

The meaning my interviewees and their parents or children created for mental illness in their relationship was deeply ambivalent. On a deeper level than representing conflict between independence and closeness, it represented seeing themselves in the other. While not all young adult participants explicitly identified this, many of them recognized common traits of mental illness between themselves and their parents. The conflict they then described between harm, negative reactions, or deciding not to share, and love, explanation for their actions, or asking for support was not only a reckoning for their relationship, but ultimately, themselves.

Of course, a sample of nine cannot speak for mentally ill young adults and their parents as a whole. Within that sample, all of my participants were white, none were men, and all of the young adults were college or university students. A more diverse and larger sample would be more conducive to a generalizable study, however, I am satisfied with the results of this study as they identify new themes in this niche area of research.

With regards to gender, several young adult participants identified as non-binary and their gender transition was a relevant aspect of their mental health and relationships with parents. This would be an interesting area to research specifically in the future using literature on transgender and non-binary mental health and family narratives. Furthermore, no young adult participants said they felt closer to their father than their mother. The gendered dynamics of mental health support and family dynamics should be further investigated, drawing on feminist literature and observing whether this phenomenon carries over in a larger sample. With more time, I also

would have liked to specifically investigate relationships with fathers as compared to relationships with mothers. Given the differences in mental health presentation between men and women, I would also be interested to see if participants who identified as men fit within the themes I identified in this study. Ultimately, a robust longitudinal study using a larger sample size would help to study the themes I've identified as they arise and potentially reduce with age, as the literature would suggest that ambivalence reduces in adulthood (Pillemer et al., 2012).

Being critically aware of the dynamics of care, worry, and ambivalence as they influence this central relationship between parents and young adults allows us to add depth to the discussion of mental illness management. This has both clinical and sociological implications. Clinically, informing understandings of relationship functions to best support young adults and parents, who may feel distressed by their uncertainty of how to navigate this relationship and benefit from learning that it is common to feel ambivalence. Sociologically, nuancing our discussion of stigma and ambivalence gives us new avenues through which to discuss mental illness. Studying the family as an institution where meaning is produced allows us to speak to the more common and everyday experiences of mentally ill people, rather than focusing too narrowly on formal institutions or too broadly on the concept of stigma in general.

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Appendices

Appendix A - Recruitment Poster

Appendix B - Consent Form

Project tile: Young Adult Mental Illness and Parent Relationships

Lead researcher: Sydney Patterson, Dalhousie University, sy229646@dal.ca

Supervisor: Dr. Martha Radice,

Introduction

I invite you to take part in a study being conducted by Sydney Patterson, a fourth year honours student at Dalhousie University. Choosing whether or not to take part in this research is entirely

your choice. The information below will tell you what is involved in the research, what you will be asked to do, and any benefits, risks, inconvenience, or discomfort you might experience.

If you have any questions about this study, you're welcome to discuss them with Sydney using the email address provided above. Please ask as many questions as you like.

Purpose of the study

In this study, I want to examine the relationship between young adults with mental illness and their parents. Specifically, I want to look at how they influence each other's understanding of mental illness. I will be interviewing both young adults who have a mental illness, and the parents of young adults who have a mental illness. In these interviews, I want to talk about how mental illness has affected the parent-child relationship, and what the parent-child relationship is like generally.

Who can take part:

You may participate in this study if you are:

- Between ages 18-25 and identify as having a mental illness
- A parent of someone who is between ages 18-25 and has a mental illness

What you will be asked to do:

If you decide to participate in this research, you will be asked to complete one interview that will take about an hour. If you are comfortable and located in Halifax, interviews can take place in a public location such as a cafe. If you are not comfortable or able, interviews can take place over a video-calling platform of your choice such as Zoom or Skype. During the interview, you will be asked a series of questions which you may answer or skip as you choose.

Possible benefits, risks, and discomforts

Participating in this study might not benefit you directly, but we might learn things that will benefit others.

There may be risk or discomfort associated with participating in this study. The interview questions will ask about mental illness and family relationships, which may be sensitive or troubling to discuss. I will ask participants to invite other qualified people to participate in my study, including your own parent or child. This may lead to discomfort in bringing up a sensitive topic. I will mitigate these risks by encouraging you to only give as much information as you feel comfortable, including skipping questions or withdrawing from the study completely. You are also welcome to choose not to invite others to participate in this study. All information from your interview will be kept completely private from other interviewees, and in the case of interviewing both a parent and child, neither will have access to the other's answers during their

interview. All results in the final paper will be anonymized and I will not indicate relationships between participants in this paper.

Videochat interviews will take place via Skype or Zoom, so you can choose to do them from a private place where no one will overhear you. If you do an interview by videochat, there is a risk of loss of personal privacy from the use of internet-based communications. The risk is no greater or lesser than when using applications such as Skype and Zoom for other purposes.

Videochat interviews will be recorded using a computer program such as Zencastr, Cleanfeed, or Audiohijack. A handheld recorder and/or the recording feature within Zoom or Skype may also be used as a back-up. I will tell you exactly how I will be recording the interview prior to the start.

The information that you provide to me will be kept confidential. Only my supervisor and I will have access to it. The interview will be audio-recorded, and the recording will be stored on a password-protected, encrypted laptop, with a backup saved on OneDrive, a Canadian encrypted cloud storage service, as well as on an encrypted external hard drive. I will transcribe the interview, and the transcription will be stored on the password-protected, encrypted laptop. Once the interview is transcribed, I will delete the audio. A back-up of the transcription will be saved in OneDrive, as well as on the external hard drive. The transcription and any associated notes will be kept indefinitely in the above-named locations, and may be referenced in future research I conduct.

Compensation:

There will be no compensation for participating in this study.

How your information will be protected

Your participation in this research will not be shared outside of the research team (myself, Sydney Patterson, and my supervisor, Dr. Martha Radice). If you choose to share my study with others for recruitment purposes, you may choose to disclose or not disclose whether you have personally participated- I will not share that information under any circumstances. If you choose to complete the interview at a cafe, there will likely be low privacy, but if you choose to complete the interview via video call, I will be alone in a room and wearing headphones so that nobody but myself can hear your answers.

With your permission, I will audio record the interviews and transcribe them afterward. Once transcribed, audio files will be deleted. I will change all names to pseudonyms and alter or leave out any identifiable details. Transcripts and the legend of pseudonyms will be kept in password-protected documents on my computer which only I have access to.

In my thesis, I will only use direct quotes if you give me permission to do so. Quotes will have identifying information removed or altered to protect your privacy.

Transcripts and the legend of pseudonyms will be destroyed once the study is complete.

If you decide to stop participating

You are free to stop participating in this study at any time until March 1st. After March 1st, it will be impossible to withdraw you from the study because the final thesis will already be submitted. You may withdraw before, during, or after the interview up until that point.

How to obtain results

If you wish, I can email you a copy of your transcript and/or the final thesis when it is completed. You can request this by emailing me or telling me during your interview. My thesis will also be publicly available on the Dalhousie library website after March 1st.

Questions

I am happy to talk with you about any questions or concerns you may have about participating in this study. You are welcome to contact myself, Sydney Patterson, at sy229646@dal.ca, or my supervisor, Dr. Martha Radice, at MARTHA at any time.

If you have any ethical concerns about your participation in this research, you may also contact Research Ethics, Dalhousie University at (902) 494-3423, or email: ethics@dal.ca (REB file # 20XX-XXXX).

Signature Page

Project tile: Young Adult Mental Illness and Parent Relationships

Lead researcher: Sydney Patterson, Dalhousie University, sy229646@dal.ca

I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I understand that I have been asked to participate in one interview of roughly an hour, and that the interview will be audio recorded. I understand that direct quotes may be used from my interview without identifying me. I agree to take part in this study. My participation is voluntary and I understand that I am free to withdraw from the study at any time until March 1st.

Name Signature Date

Please provide an email address below if you would like to be sent a copy of your transcript and/or a copy of my thesis, and indicate which:

Transcript

Thesis

Email address: _____

Appendix C- Interview Guide - Parents

1. Can you tell me a bit about your family?
2. Do you currently live with your child?
    a. When did you last live together?
3. How often do you see each other or talk?
4. What's your relationship like?
5. Do you think your child is closer with you or your partner? Why do you think that?
6. Do you know a lot about what's going on in your child's personal life? Do they tell you a lot about their life?
    a. Has that changed over the last few years, since they were a teenager? Have you gotten closer or more distant? Or has it changed in other ways?
7. Do you know what mental illness your child has?
    a. How did you learn that? Was it from your child, a doctor, a mental health professional?
8. Can you tell me more of the story of when you noticed that your child might have a mental illness or be struggling somehow?
    a. What was your relationship like then?
9. And now, do you talk about their mental health? What kind of things do you talk about?
    a. Who initiates those conversations, you or them?
    b. What is that like for you? How does it feel to talk about what they're going through? (or not talk about it)
10. Do you think their mental illness changed your relationship at all?

11. If they were struggling with their mental health, do you think they would turn to you for help? why/why not?
12. How would you describe your parenting style in general?
13. What is it like to parent them now that they're a young adult?
14. Do you think their mental illness has influenced at all your responsibilities, worries, or priorities as a parent?
15. Are you happy with the way your relationship is right now with regards to their mental health? Would you like to change anything?
16. Is there anything you wish you knew years ago when they started to struggle that would've helped you support them better?
17. Did learning about their mental illness change your relationship?
18. Did it change how you envisioned their future?
19. Are there any distinctive moments that stand out to you with regard to their mental illness? (Like a time they reached out to you for help, a time you worried for them, anything at all that stands out)
20. What advice would you give to a friend if their child was struggling with a mental illness?
21. Is there anything else that you think I should know?

Appendix D- Interview Guide - Young Adults

1. How old are you?
2. Can you tell me a bit about your immediate family? How many parents are relevant in your life, is there anyone you're particularly close to or less close to?
    a. Can you tell me a bit about why you feel more close to that person?
    b. And why would you say you're not as close with the other one?
3. Who do you live with? If not parent(s), when did you last live with them?
    a. (If not living together) How often do you see or talk to your parent(s)?
    b. What are they like?
4. In general, what's your relationship with your parent(s) like?
    a. When you talk or visit, do you share a lot about your personal life?

   b. Do you look forward to talking to them/ how do you feel when you have a visit planned?
   c. Has that changed at all from when you were in your teens to now? How so?

5. Can you tell me about your mental health history?
   a. Can you tell me more about when you first realized your symptoms or thought something might be wrong? (*ask follow ups)
   b. What has it been like for you since then? How have you managed?
   c. If i asked you to give me a definition of what your mental illness is, what would you say?
   d. FOR ADHD- there's some disagreement about whether it's a mental health issue or not, because it's technically a developmental disorder, what do you think about that and why?
   e. Do you talk to anybody about your mental health? Who?
   f. Does/do your parent(s) know about your mental illness? What's your sense of what they know?
   g. Have your parents been involved in any way in your treatment or in supporting your mental health?
      i. Do they help you in any way to access therapy or doctor's appointments?
      ii. Do they emotionally support you in some way?
      iii. Do they give advice?
6. If you were struggling with your mental health, or in times where you do struggle, are either of your parents people you would turn to for help?
   a. Do they ever seem to notice if you're struggling and check in with you?
   b. What about if things are going well or just in general, do you mention things like going to therapy, your medication, having a bad day or doing well- are those things you feel comfortable bringing up with them? why/why not?
   c. Are there specific things that are easier to talk about? Parts that are harder or that you avoid?
   d. Are there ever times you might choose not to tell your parents about your mental health, or have you hidden your symptoms or feelings in the past?

7. Has your relationship changed or stayed the same in the last few years with regards to mental health? Do you find that you talk about it with them more or less or is it the same?
8. Can you tell me how, if at all, your mental illness affects your relationship with your parent(s)?
9. Are there any distinctive moments you can recall with regards to your mental illness and your parent(s)? (Like a memory of a time they helped you out, maybe time they weren't so helpful, anything at all that stands out to you)
10. What do you want your relationship with your parent(s) to be like?
11. How do you want your parent(s) to support your mental health now, if at all?
12. What advice would you give to a younger person with your same mental illness on communicating with their parents?