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# Young Adults and their Parents: The (Mis)understandings that Construct Mental Illness

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## ABSTRACT

While public awareness about young people's mental health has been on the rise, the context in which it is studied has many gaps. Adolescent mental health is often studied within the context of family relationships but the same is not true for young adults over 18 years old. Drawing on interviews with young adults who have mental illness and their parents, I found that the parent-child relationship is a relevant context in which ideas about what mental illness is are constructed. Through the conscious presentation of self within the unique expectations of this relationship and the feedback from parents or children, young adults construct definitions of mental illness which guide their ideas of self and actions in the relationship. By considering this specific relationship and life stage, I hope to contribute to a more specific understanding of the social construction of mental illness and to highlight its practical implications in the lives and relationships of young adults.

Keywords: mental illness; family; young adulthood

When I was fifteen, I was diagnosed as bipolar. To me, this meant that there were days when I felt on top of the world, incapable of focusing on any one task, and days when simple things like being awake felt impossible. To psychiatrists, this meant I experienced mania and depression, requiring medication and therapy. To my parents, it meant they had a teenager who was always doing either something irresponsible and impulsive or locked in their bedroom, requiring disciplinary responses to ensure they grew up to be responsible. My relationship with my parents and the result of seeing my experience through two different lenses—as a profound emotional struggle and as problematic behaviours—impacted how each of us understood what mental illness was.

As I have transitioned into adulthood, my relationship with my parents has shifted and so has my experience of mental illness. Without parents functioning as gatekeepers for things like appointments and medications and having never had the kind of relationship where I shared much about my feelings, my mental health is not something we talked about. Because I perceived relationships with friends, roommates, and partners as more relevant to my mental health, I found that my experience of mental illness changed. Without any authority figure trying to raise me, the interactions around my symptoms and emotions were different. Additionally, as my parents were, in a way, released from being responsible for my actions, our interactions (or lack thereof) around my symptomatic behaviour also changed both of our understandings of mental illness.

Noticing how my parents and I each understood mental illness, and how those understandings changed with age, made me want to further investigate the links between young adulthood as a life stage, parent-child relationships, and mental illness. Approaches to the study of mental illness have focused on coping and support strategies between young people and their parents with most of the focus directed towards adolescence (Armitage et al, 2020; Draucker, 2005; Griffiths et al., 2011; Heerde et al., 2014; Honey et al., 2013; Moses, 2010). Family studies have considered the interactions of parents and children, but generally overlook the role of mental illness within that relationship. For mentally ill teens, parents are often both an immediate source of support in crisis and the gatekeepers to professional help. Though they are not usually the first line of support as their children become adults, parents do still provide material and emotional support. The relationship can become ambivalent in this transitional period as both parties negotiate new levels of independence and closeness. As young people enter adulthood, neither their mental illness nor the influence of parental relationships dissipate. Understanding how this relationship informs each party's understanding of the young adult's mental illness has implications for personal coping, parenting strategies, and their relationship moving forward. Taking a symbolic interactionist approach, I sought to explore the construction of mental illness in young people's relationships with their parents by interviewing both young adults with a mental illness and their parents.

## Diagnosing the Situation: Symbolic Interactionism, Ambivalence, and Mental Illness

### Relationships as symbols

I used symbolic interactionism to frame my thinking about the project and analysis of my interviews. This framework fits best with my goal of deriving how interactions between parents and adult children influenced each other's perspectives on what mental illness is. 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 (2009, 135) posit that social interactionism "focuses on the connection between symbols (i.e., shared meanings) and interactions (i.e., verbal and nonverbal actions and communications)." 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 non-tainting (Link and Phelan, 2014). Link and Phelan (2014, 25) 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.

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 et al. (2015) define a specific type of stigma as "symbolic interactionist stigma": the perceptions 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 of youth self-stigmatization, finding both higher stigmatization by parents and higher self-stigmatization by youth when parents attempt to conceal youth mental health symptoms. 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 it is 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.

## Ambivalent Apples from Ambivalent Trees

The central task of parenting is to prepare children for independence, though in the 2000's, the age of independence is later than in previous decades (Gitelson et al. 2006). In "emerging adulthood," roughly ages 18-25, parents continue to provide emotional and financial support and pass on family values (Gitelson et al. 2006; Vassallo et al. 2009). Emerging adulthood is thus a transitional period of being "less dependent rather than independent" (Gower and 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; studies rarely address both perspectives (Gitelson et al., 2006; Gower et al., 2008; Pejlert, 2001; Pillemer et al., 2012). By interviewing both young adults and parents, I attempted to address this gap in the specific context of young adult mental illness and young adult perspectives.

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 (Bengtson et al. 2004; van Gaalen et al. 2006). It represents the tensions between parenting and growing up, dependence and independence, closeness and distance (Pillemer 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 et al. 2006). Solidarity has many specific dimensions such as intimacy, agreement, dependence, integration,

opportunities, and familism (Bengtson et al. 2004). Few relationships are entirely harmonious or 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 et al. 2012; Bengtson et al. 2004).

While it is a common trope that adolescents engage in lots of parental conflict, meta-analysis also show that conflict generally peaks early in adolescence and decreases thereafter (Arnett, 1999; Laursen et al. 1998). The initial rise in conflict may not be entirely the adolescent's fault. Adolescents and their parents both express more contempt toward the other through avoidance behaviours in the teen years. Listening 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 et al. 1994; Beaumont, 1996). Interestingly, Kahlbaugh and Haviland (1994) found from their in-home observations that while avoidance increases, teens do not hesitate to approach their parents to engage with them socially, indicating that the development of ambivalence in parent-child relationships is a complex process and not one solely defined by teen-initiated avoidance.

## Familial Façades and Mental Illness

The family can be a place of both support and stress for people with mental illness (Griffiths et al. 2011). Heerde et al. (2015) discuss how 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. 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 (Pejilert 2001; Muhlbauer 2002; Wedig et al. 2007; Song et al. 2014; Armitage et al. 2020). 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 regarding mental illness. Just as parents and their children engage in mutual avoidance in the teenage years, the process of opening up about mental illness is also mutual. Draucker (2005) used interviews with 18–21-year-old youths who experienced depression as teens, and interviews with their parents to investigate parent-child interaction patterns in adolescence. She found that both parents and adolescents engaged in active behaviours whereby the adolescent hides and the parent chooses not to see evidence of the adolescent's depression. As the adolescent begins to hint at their experience, the parent too is in an active state of 'kind of' knowing, figuring out what to do with the knowledge while maintaining some ignorance. Finally, when the adolescent opens up, the parent is again in an active role of asking questions and making use of their new knowledge. Draucker (2005) termed these behaviours "maintaining the façade," "poking holes in the façade," and "breaking down the façade." Each of these stages requires active participation from both sides, and I am curious about how interactions at each stage construct "the problem."

Honey et al. (2013) address interaction again, this time interviewing mentally ill youth on their perceptions of how parents influence their behaviour. The youths in this study identified their parents as either facilitating behaviours (making desired behaviours easier), persuading to behave certain ways (encouragement), or controlling (forcing), and that they responded differently depending on how they viewed their parent's motives, their own autonomy, and their acceptance of parental authority (Honey et al. 2013). This is of relevance to my study because how the teens respond depends on their perception of adult motives, demonstrating that youths might construct their mental illness differently whether they feel

that they are being excessively controlled or being cared for. The relationship between young people and their parents regarding mental illness is under-studied, but deeply valuable in assessing congruences and incongruencies in experience and perception, and contextualizing understandings of mental illness within familial relationships.

Most literature on parent-young adult relationships is one-sided, researching either parents' or young adult's impression 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. Furthermore, studies of mental health in the context of parent-child relationships have often focused on teens, excluding young adults (Draucker 2005; Honey et al. 2013). As neither mental illness nor the parental relationship immediately dissolves when a person turns 18, and parents see their role as continuous, it is important to critically consider how both parties impact each other's experience and understanding of mental health.

## Methodology

I conducted 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. Due to COVID-19 it was not always possible to meet participants face-to-face, so six of nine interviews were completed via Zoom, two in person, and one by phone. As for mental illness, I did not require any proof or confirmation of diagnosis, only self-disclosure from the young adult. I did not want to exclude those who were not professionally diagnosed. Similarly, I asked parents to disclose what mental illness their child has and how they knew to confirm that there was more than mere suspicion.

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. Interviews also allowed me to ask participants to reflect on multiple memories. I was able to discover overarching narratives of mental illness and relationships that people constructed over time through these interviews. The purpose of using these qualitative methods was to identify recurring narratives and ideas across participants as a start towards filling the gap of research on parent-young adult relationships and mental health.

I recruited via snowball sampling, beginning with posting my recruitment ad 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. Though the only demographic I intentionally sought was people who are 18-30 and have a mental illness or parents of this group, I recognize that 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 yield more illuminating data, but this is beyond the scope of this study.

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.

I audio-recorded the interviews and transcribed them afterward. 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. 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 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 is submitted. When participants became upset during the interview, I offered to stop recording, give them a break, stop completely, and withdraw any responses they have already given if they wish. 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. I kept my participant's identities anonymous, and in case any parent-child dyads participated I did not identify any relationships between participants in this document nor confirm participation or discuss others' responses during interviews.

This study is limited by a small sample size, specifically by the small number of parents I was able to interview. I interviewed seven youth and two parents. I had hoped to interview an equal proportion of youth to parents to address both parties' involvements in constructing mental illness, however due to the timeline and interest, I was unable to recruit additional parents. The perspectives of the two parents interviewed gives a small glimpse into what could be learned from the parent's side but does not represent parents of mentally ill youth more generally. I argue that this research is still valuable as it addresses the gap by which young adult mental health has rarely been considered in a familial context at all, and the two parent interviews revealed similar themes both to each other and the youth interviews, encouraging the usefulness of including parents in this research topic. Through these interviews, I attempted to answer how the parent-child relationship shapes both parties' understanding of what mental illness is. I found that mental illness is a site where the parent-child relationship is re-negotiated in young adulthood.

## Making Messes, Cleaning Up: Stigma, Worry, and Façade

The people I spoke to have a range of relationship types with their parents or young adult children. Of the young adults that I interviewed, none identified as men, some identified as cisgender women and others as non-binary. Both parents were mothers. Some parent-child relationships were extremely uninvolved, with one young adult even describing their parents as more "like acquaintances" than parents, while others considered their parents their best friends. There were a host of factors that contributed to the closeness of the relationship. Most young adults indicated that their relationship stayed more or less the same since they were in their early teens while many young adults described coming to better understandings of their parents with age and maturity. None described their relationship as going from very distant to very close or vice versa.

One commonality across interviews is that all participants had working theories to describe why they thought their parent or child behaved in certain ways, and they attributed value and meanings to those actions. For example, beyond asserting that a parent did not want their child to use their diagnosis as an excuse, participants often expanded to more general statements about their parent's experience of

mental illness and resulting belief that it should not prevent them from normal functioning. One young adult, Charlie, said that their father did not 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 was depressed and managed it without therapy or medication by "just pushing through it." Though their father revealed that he had been depressed to Charlie, Charlie independently made the connection between his experience of depression and his expectations of them. Every interviewee made attributions about why their parent or child felt and behaved in certain ways and used that knowledge to inform their choices about how to manage that relationship.

## Young Adulthood Exposes Stigma

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," elucidating a common sentiment that most participants were as open about mental health as was already normal for their families. 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 in arguments when behavioural symptoms caused issues. 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.

In young adulthood, symptoms of mental illness became primarily the young adult's responsibility, and the parent's levels of knowledge and involvement decreased, in a way affirming mental illness as a normal part of life that the youth gains independence and autonomy over with age. From a parent's perspective, Jennifer struggled with accepting that her two adult daughters did not want to talk about some topics with her, but did not 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 is difficult for her, mental health is a topic that she believes her daughters have authority over how and when they chose to discuss it. Lisa, the other mother with whom I spoke, 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 also conveys that mental illness is better heard about than seen. Behavioural expressions of mental health issues were considered the cause of relationship difficulties for some participants. As adolescents, multiple 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 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 mental health concerns also recalls Link and 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. Beyond surface level ideas of stigma — the undesirability or abnormality of certain traits — it 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 and Phelan, 2014). Eliott was unsure whether their parents have disclosed their diagnosis to their sister or not; they did not know if their parents wanted to give them autonomy over disclosure, or if they did not want to talk about it. They could have been trying to conceal the diagnosis, or they could be granting Eliott the freedom to craft their identity through conscious disclosure. Regardless of intention, the uncertainty 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, influencing Eliott's actions, and in turn, other's reactions.

Boundaries and stigma intertwine 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. According to Rebecca and other participant's stories, 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. Hunter described some of the reasons they would or would not talk to parents, saying "my dad is really good at talking me down from anxiety," but also noting that when they were having anxiety about money troubles, phone calls home would create more stress. They resolved that "if it's something that's not involving them [Hunter's parents], [my dad] is really good at keeping me level-headed." Robin also stated that they would share almost anything with their mother, except "anything related to [their] struggles with eating disorders [...] that is something where I just think she couldn't hear without totally breaking down over it." Young adults described their parents as worrying about them, leading them to "nag," become anxious, minimizing, or taking control. Though they each expressed sympathy for their parents' situations, expecting these outcomes led young adults to consciously manage how, when, and if they would 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 is 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, 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 are 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," or "do you need serious help?" when Hunter expresses to them that they are 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 et al. 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 to avoid causing anxiety.

The relationship between having responsibility for another person, the amount one worries about them, and being compelled to act 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), this results in worry, and they may thus 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 — especially in young adulthood, while their children are only slowly transitioning toward independence. This complicates the findings of Vassallo et al. (2009) who suggest that parents of young adults primarily see their role as listening and giving advice, rather than providing material and financial goods. 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 these two 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 worried.

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 do not 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 did not approve of what she considered 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 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 the idea of parents as a safety net. While we can understand it negatively in terms of parents as a last resort, some young adults expressed this idea positively in terms of knowing that when their mental health is at its poorest or there is a situation they cannot 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 act.

The two mothers I interviewed certainly represented the concept of a guaranteed long-term support in their interviews. Before even beginning to ask questions, Lisa let me know she was going to get herself a box of tissues because she knew she was likely to cry when speaking about her daughters. She described a very close relationship with each of her daughters from a young age, and still wanted to support them as much as possible as adults. She noted that the greatest change to her relationship with her children was that, now that they are adults, she does not "have to be superwoman all the time" and can be more reciprocally vulnerable. She described a vulnerable situation with one daughter in which she acted "regrettably" by dismissing her mental health concerns, but after reflecting on what her daughter said and her own perspective on parenting, she concluded that her role was to "constantly [be] the student where [her] daughters are concerned," to

always learn from them about their needs and experiences. She was able to move forward better supporting her daughter after re-affirming her commitment to always listening and learning — something that seems unique to the parental commitment and biographical knowledge of a child. True to her statement at the beginning of the interview, Lisa began to cry early on as she described each of her daughter's accomplishments and her love for them.

These young adults consciously decided what to tell their parents about their mental illness based on how helpful they thought disclosure would be, as well as a consideration of 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 would not 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 started taking medication for their mental health, had to talk about it with their mother so she could help with the assessment process, but knew they would have to approach her in a specific way. They described their mother as preferring natural alternatives to pharmaceuticals and trying to avoid them 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. 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 explained why their parents behaved the way they did, often alluding to generational lack of awareness or their own mental health struggles, potentially helping them make peace with the things they could not discuss.

## Façades: From "False Front" to Tidying Up

For Draucker (2005), the façade refers to an active and mutual process that parents and adolescents engage in to conceal evidence of the adolescent's depression, and the slow tearing down of this false front to reveal the truth. While the concept of façade was a helpful starting point, it did not perfectly fit with my findings. In Draucker's (2005) 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 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 maintained semi-façades; 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 engaged in was more akin to tidying up an apartment that is usually ridden with beer cans and takeout containers when they know parents are coming over. Their parents knew about their diagnoses, past histories, and 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 several 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 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.

In sum, the relationship between young adults and their parents constructs both parties understanding of mental illness through ambivalence. In my research, I found complex tensions between closeness and distance specifically related to dimensions of support and independence surrounding mental illness. The transitional processes of young adults self-directing their own mental health care exposes many tensions as young people attempt to manage the positives and negatives of increased independence and re-negotiate the parental relationship. Not enough parents were interviewed to say how parents feel

categorically, however in future research I would love to investigate this further, exploring the emerging themes of this study as the mothers I interviewed described the unique challenges of parsing their place in caring for a young adult with mental illness.

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 area of research.

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. 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 have 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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## References


Armitage, Sarah, Monika Parkinson, Sarah Halligan, and Shirley Reynolds. 2020. "Mothers' Experiences of Having an Adolescent Child with Depression: An Interpretative Phenomenological Analysis." *Journal of Child and Family Studies* 29, no. 6: 1617–29. https://doi.org/10.1007/s10826-020-01705-5.

Arnett, Jeffrey Jensen. 1999. "Adolescent Storm and Stress, Reconsidered." *American Psychologist* 54, no. 5: 317–26. https://doi.org/10.1037/0003-066x.54.5.317.

Beaumont, Sherry L. 1996. "Adolescent Girls' Perceptions of Conversations with Mothers and Friends." Journal *of Adolescent Research* 11, no. 3: 325–46. https://doi.org/10.1177/0743554896113004.

Bengtson, Vern, Roseann Giarrusso, J. Beth Mabry, and Merril Silverstein. 2002. "Solidarity, Conflict, And Ambivalence: Complementary or Competing Perspectives on Intergenerational Relationships?" *Journal of Marriage and Family* 64, no. 3: 568–76. https://doi.org/10.1111/j.1741-3737.2002.00568.x.

Draucker, Claire Burke. 2005. "Interaction Patterns of Adolescents with Depression and the Important Adults in Their Lives." *Qualitative Health Research* 15, no. 7: 942–63. https://doi.org/10.1177/1049732305277859.

Gitelson, I B, and D McDermott. 2006. "Parents and Their Young Adult Children: Transitions to Adulthood." *Child Welfare* 85, no. 5: 853–66.

Gower, Myrna, and Emilia Dowling. 2008. "Parenting Adult Children - Invisible Ties That Bind?" *Journal of Family Therapy* 30, no. 4: 425–37. https://doi.org/10.1111/j.1467-6427.2008.00438.x.

Griffiths, Kathleen M, Dimity A Crisp, Lisa Barney, and Russell Reid. 2011. "Seeking Help for Depression from Family and Friends: A Qualitative Analysis of Perceived Advantages and Disadvantages." *BMC Psychiatry* 11, no. 1. https://doi.org/10.1186/1471-244x-11-196.

Handberg, Charlotte, Sally Thorne, Julie Midtgaard, Claus Vinther Nielsen, and Kirsten Lomborg. 2014. "Revisiting Symbolic Interactionism as a Theoretical Framework beyond the Grounded Theory Tradition." *Qualitative Health Research* 25, no. 8: 1023–32. https://doi.org/10.1177/1049732314554231.

Heerde, Jessica A., John W. Toumbourou, Sheryl A. Hemphill, and Craig A. Olsson. 2014. "Longitudinal Prediction of Mid-Adolescent Psychosocial Outcomes from Early Adolescent Family Help Seeking and Family Support." *Journal of Research on Adolescence* 25, no. 2: 310–27. https://doi.org/10.1111/jora.12113.

Honey, Anne, Vikki Fraser, Gwynnyth Llewellyn, Philip Hazell, and Simon Clarke. 2013. "Parental Influence on the Mental Health-Related Behaviour of Young People with Mental Illness: Young People's Perceptions." *Advances in Mental Health* 12, no. 1: 63–74. https://doi.org/10.5172/jamh.2013.12.1.63.

Kahlbaugh, Patricia E., and Jeannette M. Haviland. 1994. "Nonverbal Communication between Parents and Adolescents: A Study of Approach and Avoidance Behaviors." *Journal of Nonverbal Behavior* 18, no. 1: 91–113. https://doi.org/10.1007/bf02169080.

LaRossa, R., Reitzes, D.C. 2009. Symbolic Interactionism and Family Studies. In: Boss, P., Doherty, W.J., LaRossa, R., Schumm, W.R., Steinmetz, S.K. (eds) *Sourcebook of Family Theories and Methods.* Springer, Boston, MA. https://doi.org/10.1007/978-0-387-85764-0_6

Laursen, Brett, Katherine C. Coy, and W. Andrew Collins. 1998. "Reconsidering Changes in Parent-Child Conflict across Adolescence: A Meta-Analysis." *Child Development* 69, no. 3: 817–32. https://doi.org/10.1111/j.1467-8624.1998.00817.x.

Link, Bruce G., and Jo Phelan. 2014. "Stigma Power." *Social Science & Medicine* 103: 24–32. https://doi.org/10.1016/j.socscimed.2013.07.035.

Link, Bruce G., Jennifer Wells, Jo C. Phelan, and Lawrence Yang. 2015. "Understanding the Importance of 'Symbolic Interaction Stigma': How Expectations about the Reactions of Others Adds to the Burden of Mental Illness Stigma." Psychiatric *Rehabilitation Journal* 38, no. 2: 117–24. https://doi.org/10.1037/prj0000142.

Moses, Tally. 2010. "Adolescent Mental Health Consumers' Self-Stigma: Associations with Parents' and Adolescents' Illness Perceptions and Parental Stigma." *Journal of Community Psychology* 38, no. 6: 781–98. https://doi.org/10.1002/jcop.20395.

Muhlbauer, Susan A. 2002. "Navigating the Storm of Mental Illness: Phases in the Family's Journey." *Qualitative Health Research* 12, no. 8: 1076–92. https://doi.org/10.1177/104973202129120458.

Pejlert, Anita. 2001. "Being a Parent of an Adult Son or Daughter with Severe Mental Illness Receiving Professional Care: Parents' Narratives." *Health and Social Care in the Community* 9, no. 4: 194–204. https://doi.org/10.1046/j.0966-0410.2001.00301.x.

Pillemer, Karl, Christin L. Munsch, Thomas Fuller-Rowell, Catherine Riffin, and J. Jill Suitor. 2010. "Ambivalence toward Adult Children: Differences between Mothers and Fathers." *Journal of Marriage and Family* 74, no. 5: 1101–13. https://doi.org/10.1111/j.1741-3737.2012.01004.x.

Song, Jieun, Marsha R. Mailick, and Jan S. Greenberg. 2014. "Work and Health of Parents of Adult Children with Serious Mental Illness." *Family Relations* 63, no. 1: 122–34. https://doi.org/10.1111/fare.12043.

van Gaalen, Ruben I., and Pearl A. Dykstra. 2006. "Solidarity and Conflict between Adult Children and Parents: A Latent Class Analysis." *Journal of Marriage and Family* 68, no. 4: 947–60. https://doi.org/10.1111/j.1741-3737.2006.00306.x.

Vassallo, Suzanne, Smart, and Price-Robertson. 2009. "The Roles That Parents Play in the Lives of Their Young Adult Children." *Family Matters* 82, no. 8.

Walker, Michael T. 2006. "The Social Construction of Mental Illness And Its Implications for the Recovery Model." *International Journal of Psychosocial Rehabilitation* 10, no. 1: 71–87.

Wedig, Michelle M., and Matthew K. Nock. 2007. "Parental Expressed Emotion and Adolescent Self-Injury." *Journal of the American Academy of Child & Adolescent Psychiatry* 46, no. 9: 1171–78. https://doi.org/10.1097/chi.0b013e3180ca9aaf.