This article uses qualitative research and narrative analysis to examine the experience of women age 55 and older who are parents caring for adult children with mental illness. Knowledge about the conflicts of older parents with dependent children is underdeveloped. In this study, analysis of women’s stories about parenting in later life reveal that the women have two sets of feelings: wanting to be free from the responsibility of caregiving and feeling responsible to continue the support and protection of their adult vulnerable children. The women’s conflicts are palpable and are found in the ideational themes of the narratives, as well as the structure of how the narratives are spoken. The discussion highlights the relevance of the theory of ambivalence for clinical practice when working with older women who are caregivers for their adult dependent children.

KEYWORDS chronic mental illness, ambivalence, elder abuse, older adult caregivers, intergenerational relationships

This article investigates how older women make sense of parenting an adult child with psychiatric problems and the strategies women use to manage family conflict that may ensue. The combined demographics of older adults living longer and deinstitutionalization of people with psychiatric illness has resulted in many older people assuming responsibility for care of their adult children with mental health needs for long periods of time. Prevalence data of older adults caring for adult children with mental illness is hard to locate. The National Alliance for Caregiving (2009) conducted a survey of caregivers of younger adults, which they defined as persons between ages 18 and 49,
and estimated that at least 11.1 million caregivers provide unpaid care to an adult family member or friend. Caregivers reported that the main problem or illness for which they provided care to an adult child was for emotional illness (23%). Clearly these numbers would not include older parents whose “children” could be age 50 to 70 years. Kelly and Knopf (1995) identified two groups of older adult caregivers: those who have cared for their disabled children from birth (perpetual parents) and parents of adult children with psychiatric or substance abuse problems who return home in early adulthood. They call the later group of parents “stigmatized parents,” as they are often blamed for the condition of their sons or daughters. Few studies have examined how older family caregivers make sense of the ongoing responsibility of caring for an adult child with mental illness.

A large body of literature documents the negative consequences of interpersonal stress on psychological well-being across the life course (Krause, 1994; Newsom, Mahan, Rook, & Krause, 2008; Schuster, Kessler, & Aseltine, 1990; Thoits, 2010). Several authors have documented how older parents are affected by their children’s success or failure (Cohler & Grunebaum, 1981; Greenfield & Marks, 2006; Hagesstad, 1986; Koropeckyj-Cox, 2002; Peters, Hooker, & Zvonkovic, 2006; Pillemer & Suitor, 1991; Ryff, Schmutte, & Lee, 1996; Silverstein & Bengston, 1991). Poor health outcomes among older low-income adults have been shown to be explained by financial and parental stress (Lantz, House, Mero, & Williams, 2006). Research has demonstrated that parents experience heightened ambivalence when their adult children are “off time” in their achievement of self-sufficiency (Hagesstad, 1986). Adult children who have mental illness are less likely to have achieved self-sufficiency in employment or marriage that is expected of young or middle-age adults.

The vulnerability of older parents living with adult children who are financially and emotionally dependent upon their parents has been identified by researchers within the field of elder abuse (Lachs & Pillemer, 2004; Pillemer & Finkelhor, 1989). Although social workers and police offers have reported that family interventions are the most effective way to intervene with older parents who are victims of family elder abuse (Brownell, Berman, Salamone, & Welty, 2002; Nahmiash, 2002), very little is know about how older parents experience the caregiving role of a dependent adult child nor were any evidence-based models found that could inform social work practice with older parents and their mentally ill adult children.

Ambivalence

Few models describe parenting in later life. Rossi (1968) and Galinsky (1997) created a scheme for analyzing stages of parenthood. The last stage is called “disengagement” by Rossi and “departure” by Galinsky. Rossi also pointed out that there is no socially accepted way of becoming an ex-parent and that
parenting in later life includes “an attenuated process of termination with little cultural prescription about when the authority and obligations of a parent end” (Rossi, p. 30). Later life parenting is not guided by legal or social norms, as is parenting relationships for children younger than age 18. Scholars have begun to use the theoretical lens of ambivalence to study intergenerational relationships in later life (Connidis & McMullin, 2002; Fingerman, Chen, Hay, Cichy, & Lefkowitz, 2006; Luscher & Pillemer, 1998; Peters et al., 2006; Pillemer et al., 2007; Suitor, Gilligan, & Pillemer, 2011).

The theoretical construct of ambivalence allows researchers to study how parents and adult children manage the conflicting poles of autonomy and dependence. Older parents can hold conflicting feelings of wanting to support and protect their adult children, while also wanting their adult children to be self-sufficient. The lens of ambivalence allows for the examination of adults’ feeling personally responsible to care for one’s adult children, while also wanting to “live one’s own life.”

Due to the limited body of research on caregiving for adult children with psychiatric problems in later life, qualitative research is appropriate to inform future research and clinical work. This research project explored how older women who were caregivers of adult children or grandchildren with mental illness perceived their parenting role. The research had two phases: a series of focus groups with service providers examining the barriers to service provision for older parents and their adult children with mental illness and in-depth interviews with older women who were providing care for a young adult who had mental health problems and reported experiencing family conflict. This is the first study to use qualitative methods to study older parents’ perceptions of their parenting role among a sample of parents with adult children with mental health problems.

A QUALITATIVE STUDY: NARRATIVE ANALYSIS

This study examined how older women made sense of parenting dependent children in later life using narrative analysis, which allowed the researcher to enter the perspective of the subject. “Persons give meaning to their lives and relationships by storying their experience” (White & Epson, 1990, p. 13). I used Riessman’s (2008) definition of narrative: a bounded segment of talk that is temporally ordered and recapitulates a sequence of events.

Several researchers have used qualitative methods to examine the “meaning-making function of narrative” (Riessman, 2008, p. 10) when individuals experience biographical disruptions, such as chronic illness or divorce (Charmaz, 1991, 2006; Frank, 1995; Riessman, 1990, 2000, 2003). This study focused on the biographical disruption of parenting a child who is “off-time” in his or her development in terms of economic and behavioral self-sufficiency.
Sample

Four older women who were responsible for the care of their adult children were interviewed. All lived in Rockland County, New York, United States of America, and each was referred to me by a social service or health care provider who had participated in a series of focus groups I held about services for older women caregivers of dependent children with mental illness. Participants were recruited by health and social service professionals who received information about the study from the researcher. Service providers were asked to help recruit research participants who were older women caregivers and had experienced family conflict and/or violence with their adult children who had mental illness. The women who were contacted by the service providers and who then expressed interest in the study gave permission for me to contact them. All the women were older than age 55 and low income. Two were African American, two were Hispanic. Each of the women interviewed had adult children who were dependent on them for financial, emotional, and/or behavioral health management. Their children had not achieved the expected Western trajectory of self-sufficiency.

This article focuses on the stories of two of the women, Mrs. Lewis and Mrs. Thomas. Although four women were interviewed for the study, only two are reported on in this article. The omitted cases had caregiving situations that included extenuating circumstances, over and beyond the child’s psychiatric problems. One mother was caring for her adult child who also had a severe physical disability that developed in early adulthood, and the other woman was living in a shelter to escape her granddaughter’s violent behavior toward her.

Mrs. Thomas was age 56, African American, the mother of three children, two sons and a daughter, and two grandchildren. At the time of the interview she was living with her youngest child, her 21-year-old daughter, who had had several psychiatric hospitalizations and placements in residential treatment centers since age 9. Mrs. Lewis was age 69, African American, the mother of four children, with nine grandchildren and two great-grandchildren. At the time of the interview she was living with and caring for her grandson, Gerald, age 27, who she had raised since he was age 1. Gerald had had several psychiatric hospitalizations starting in late adolescence.

Procedure

The women who were contacted by the service providers and gave permission for me to contact them, and I set up an appointment at a community agency near their home. Each woman signed an Institutional Review Board consent form that stated that the research study was about parenting in later life and conflicts that can arise when negotiating with one's adult children about their economic, emotional, psychological
and housing needs. The researchers hope to learn from women like yourself about obstacles to getting help for yourself and your adult child. You were recommended to participate in this study because of your direct experience with family conflict.

I used a semistructured interview protocol that asked open-ended questions about the women’s parenting experiences with all their children, beginning when their children were young. Mothers were then asked to shift their focus to their experience with their child who had had emotional difficulties and who was currently living with them. In the introduction, I stated that I was doing a research study about parenting in later life and the idea that for many of us, including myself, parenting keeps going and I am interested in trying to understand what that experience is like for you... I’m interested in learning about the positive and stressful aspects of parenting and what you want at this point from your older adult children. I will have some questions but really I’m here to learn from you.

I interjected focused questions when and if the interviewee had difficulty exploring the topic in a focused manner. One question I used to focus the interview was asking the woman to identify the high points and the low points at the different stages of caregiving that she described (McAdams, 1985).

The interviews lasted between 1 and 3 hours. The women received an honorarium for participation in the study. Interviews were tape recorded and transcribed. I listened to the audio recordings many times over for tone and meaning and amended the transcripts to reflect the way in which the narratives were spoken.

Positionality

As a qualitative researcher, I understand the importance of acknowledging my influence on the interview, rather than seeing myself as a neutral objective recorder. I come from a very different world than my participants. I am a White, middle-class professional woman, who interviewed low-income African American and Hispanic women. Yet, as I prepared for this study, I discovered that there were significant personal ways in which my parenting experience overlapped with the experience of the women I would be interviewing. I, too, have an adult child who is “off-time” in his development. I used this shared experience to build a bridge with the women, by including myself in the phrasing of some of the questions, for example, “as I think of my own life and as I talk to other people, there are times in our lives when we have a lot of pleasure in being a parent and there are times when there’s real low points.” I also was aware of possible boundary issues that could arise from my incorrectly overidentifying with the stories I was hearing, so
after each interview I kept memos of my personal reactions and how my experiences were different and the same from what I was learning from the women in the interviews. Although I used a semistructured interview protocol, I allowed the women to take the lead in the conversation.

Analysis

Sections of the verbatim transcript were organized using an adaptation of Gee’s model of breaking the text into stanzas, with each unit focusing on a particular consciousness of mind. Stanzas are “clumps” of tone units that deal with a unitary topic or perspective. Interpretation of meaning was done by my listening carefully to the audio recordings of the interviews many times over and then presenting the speech in units based on how the narrative was spoken (Gee, 1985, 1991).

I discovered narratives that could be grouped into two separate types. The first addressed times in the women’s lives when there was congruence between the woman’s personal developmental needs and her children’s capacities, which were classified as “high points” by both women. The second group of stories was about the stresses of caring for their adult children now, when the mother believed she should be “done” with caregiving responsibilities yet was unable to put her child out.

As I analyzed these interviews, I saw that the two groups of stories were different not only thematically but structurally. The structure of the stories about the “high points” of their parenting career were straightforward narratives, told in the first person, describing the mothers’ pleasure that was present during the period when there was synchrony between her and her children’s needs. In contrast, the structure of the stories that addressed the current stresses in their current parenting lives was very different. These narratives did not have a traditional structure. Instead, they included in vivo ongoing conversations, spoken in the present, directed to the adult child, or her other children. The narratives also contained internal dialogues the women have had and continue to have with themselves. These narratives were structured without any grammatical lead-ins introducing who was speaking what, and to whom. The manner or structure in which the stories were told allowed me to witness the unresolved and ongoing conversations that constitute the older parents’ daily experience of parenting an adult child with mental illness.

RESULTS

The High Points of Parenting

I: So, in terms of when your kids were little, was that high points or low points?
Mrs. Lewis: Well, with my own children?
They were my high points because you know, we were close. We had... I guess by me being still young <laughs>
when we were growing up and together
so I really had a good time with them... growing up.
You know, I had no problems really and they were good kids.
I mean they were...
everybody has one thing or another
but through it all I mean at that point
I had no problems with them.
I had no problems with anybody:
who was in school, they were going to school,
who was working after school you know and
they all was responsible for themselves.
They were my high points, because you know, we were close.

The above narrative meets Labov’s criteria (1982) for a narrative that is
temporally structured and begins with an orientation that introduces the participants in the actions: the time, the place, and the initial behavior. Mrs. Lewis introduced the story with “We were close.” She then oriented the listener to the time and place, “I guess by me being still young when we were growing up and together.” She ends the orientation with the behavior, ” so I really had a good time with them... growing up.”

Mrs. Thomas’ narrative of her early positive parenting experiences was also temporally coherent. She told a story that followed a linear path. “When I put them out, they was able to stand on they feet and do what they had to do.... They was able to... go up instead of going down.” Mrs. Thomas’s narrative of her positive parenting experiences described the time when her sons were young adults and she successfully “put them out” because they were not contributing to the household. The positive part of this experience for her, retrospectively, was that her sons were able to meet her request for self-sufficiency and did not “hate her” for her demand that they grow up.

I: When you think of being a parent, what comes to your mind in terms of what was the most satisfying time for you?
Mrs. Thomas: Um, with the boys I can say. <laughs>
When I put them out.
I put it like that cause I’m blunt what I say.
When I put them out
they was able to stand on they feet and do what they had to do...
So, that’s very important to me
that they was able to fall, you know,
go up
instead of going down.
The Stresses of Parenting an Adult Child With Mental Illness

The content and manner in which the women spoke to me about the stresses of parenting their adult child with psychiatric problems were very different than the stories they shared about the high points in their parenting careers. In presenting the narratives related to the stress of parenting, I use italicized formatting to delineate the embedded conversations that I discovered upon analysis.

Mrs. Thomas began the interview by speaking nonstop for more than 10 minutes about the problems she has with her daughter. Small bounded stories from the much longer monologue are presented. In these narratives, the listener receives no orientation to time and place. Instead, Mrs. Thomas seemed to be acting out her endless attempts to get her daughter “to listen,” so that the daughter could become self-sufficient. As Mrs. Thomas spoke, I became the audience watching her unsuccessful attempts to get through to her daughter.

I’m like, you know what, I’m stressed, I’m tired, you’re 21 now, you need to go ahead do whatever you want to do. I said cause I know I gotta do what I has to do to keep a roof over MY head. You know what I’m saying? . . . and I’ve gotten to point where, <pause>. you know . . . I’m tired <laughs>, you know what I’m sayin? I’m frustrated . . . I said cause it seems like you’re not paying me no attention, you’re not listening to me. You do good for a couple of months or whatever and then you fall backwards. You need to stop falling backwards and go forwards because see, can’t nobody can do for yourself but yourself. You understand what I’m sayin? So it just seems like it goes in one ear and out the other one and I’ve gotten to point where, to the point now where <pause>. you know . . . I’m tired <laughs>, you know what I’m sayin? I’m frustrated . . . and anything she needs I try givin’ it to her but now that she’s 21, I’m sorry, baby; you gotta do it yourself. I can’t do it no more.
The last line of this narrative is the coda of the story “you gotta do it yourself. I can’t do it no more.” In Labov’s model (1982) for analyzing narratives, the coda is a statement that ends a narrative and returns the temporal setting to the present and answers the question “and what happened then?” In the above narrative, the coda “I can’t do it no more” ends the story, returning us to the present, where Mrs. Thomas wishes she was free, but she is not.

Later in the interview, Mrs. Thomas tells another story that allowed me to witness her in vivo internal dialogue about when and if to push her daughter out or whether to continue to support her. The coda of the story is “I know she not ready.” I use italics underlined to indicate her internal conversations with herself.

I think about it all the time and
I’m like o.k. give her another year,
try to deal with it for another year...
and then if you can’t, things will change with her;
hopefully in another year she’ll be o.k.
“mommy I’m ready to be out there on my own.”
I just can’t get her out,
I just can’t kick her out like that,
there,
cause I know she not ready.

Mrs. Lewis told a story in similar overlapping voices that included (1) her conversation to her grandson, (2) her dialogue with her other adult children or the adult children’s reported dialogue with their sibling, (3) her internal dialogue, and (4) information to orient me to her situation.

but I want him to be able to stand on his own ya know?
I know it’s not going to be easy
And once he makes up his mind that
this is my life...
this is how I have to live my life.
I can’t...
the outside.
I can’t do those things...
like I used to.
I have to either give it up or if this is what I choose to be...
I told him
if you chooses to be in another hospital that’s what’s gonna happen.
I can’t do it for you
I’ve done enough already
I mean my children is
Like... enough
When are you gonna live your?
I mean my husband’s gone eighteen years already.
I should be able to go and come as I please
And not have to worry ABOUT HIM
But I DO because you know sometimes <laughs>,
as he got older...he,
he wasn’t that bad
but now
he got older.

The body of the narrative relates her ongoing strategies to get her adult child with psychiatric problems to take responsibility for himself. In both narratives, I was in the position of listening to the mothers’ conversations with their children. Mrs. Lewis’s narrative included what she had told her son he must tell himself in order to change: “this is my life...this is how I have to live my life. I can’t...the outside, I can’t do those things...like I used to.” Mrs. Lewis also brought into the narrative the voices of her other children who were putting pressure on her to focus on herself and not on her grandson. The coda of the narrative brings Mrs. Lewis into the present: he got older. Her grandson’s problems seemed “not that bad” when he was younger, but now they do not seem to be going away.

The last narrative begins with “keep the peace.” In this story, Mrs. Lewis allowed me to witness the ways in which she tried to make herself invisible to maintain her safety when her grandson (Gerald) was out of control. She also addressed another way she “keeps the peace” by keeping secrets from her other children about Gerald’s behavior; they would be aggressive toward Gerald if they had evidence that he was threatening her well-being.

Same thing, you try to keep the peace.
I,
cause you know,
I feel,
I don’t try to put fire to anything,
especially when I see he’s excited.
And what do I do?
I’m not gonna put myself in danger to, to or
I’m gonna get in his face and tell him oh you know so and so.
No.
Because I don’t know what he’s thinking.
I don’t know what he was smoking or whatever it was.
And I’m not...you know I’ve seen so many things happen.
Uh, my friend got her son, her son just lost it and beat it...and...I, no,
listen...
I: What happened?
Mrs. Lewis: A friend of mine, her son came and beat her up terribly.
I: Oh, my.
Mrs. Lewis: But see, my, my thing is....
I try to keep peace because I have...
my youngest son, that’s the one in Vegas.
He’ll, he’ll call up and he’ll,
he’ll talk to Gerald.
And he’ll say
*Listen. I’m only gonna say this ONCE.*
*If I ever hear anything about YOU or anybody else doing anything to MY mother, he says,*
*I’ll tell you, there’s nothing and NO ONE will be able to, to you know keep me away.*
Well then my oldest son, is like,
he’s quiet, too;
but he says,
*Not havin’ it,*
*not havin’ it,*
*that’s all we have is my mother,*
*our mother,*
*and she’s good to you so there’s no reason for you to…*
*I’m not havin’ you be disrespectful to her.*
My daughters are the same.

**DISCUSSION**

This qualitative research project examined how two older low-income women make sense of their ongoing parenting responsibilities with adult children who have mental health problems. Qualitative research was used to explore a topic that has been understudied: the experience of later life caregiving of adult children. The use of narrative analysis allowed discovery of the lived conflicts of older parents who are providing direct care for their adult children, at a time of life when they could be focusing on their own self-care instead of parenting responsibilities. Social workers working with adults with chronic psychiatric illness who are being cared for by their families may be familiar with Mrs. Thomas and Mrs. Lewis. Often in mental health settings a social worker seeking a safe discharge plan will assume that living with a patient’s mother will be best. This study looks at the caregivers of patients and their conflicts about continuing to be the safe haven for their adult dependent children.

The use of structural analysis, focusing on how the narratives are spoken, highlights how the women are continually negotiating with themselves and their adult children about when and how their support can come to an end. Although each woman speaks about wanting more time for herself in her later years and wishing that she did not have to be tied down to ongoing caregiving, both mothers were committed to supporting their dependent adult child “for a little longer.”

Analysis of the women’s narratives demonstrates undigested conflicts regarding self-care versus maintaining the parental role. The ways in which
the conflict can not be spoken about and are, instead, being relived through
the stories suggests that the women are balancing conflicting feelings that
have not been analyzed in an objective manner. The identification of these
conflicts supports consideration of using the theory of ambivalence to under-
stand the experience of older women who are caring for adult children with
psychiatric problems. Ambivalence has been defined as simultaneously held
opposing feelings or emotions that are due in part to countervailing expecta-
tions about how individuals should act. Researchers have developed several
different methods of measuring ambivalence within intergenerational rela-
tionships (Suitor et al., 2011). This study introduces narrative qualitative
analysis as a means of examining older parents’ ambivalence about their
ongoing role as caregiver.

Both women express wanting to be free of their adult children’s prob-
lems; “I’m tired,” said Mrs. Thomas. Mrs. Lewis said, “I mean, my husband’s
been gone eighteen years already, I should be able to go and come as I
please and not worry about him.” Yet, along with the expressed wish for
independence from parenting responsibilities, both women expressed a con-
tinuing commitment to protect their adult children, at least for the present.
The conflict is so palpable that it is not expressed objectively but instead
enacted in the women’s narratives, which include ongoing dialogues with
their adult children, internal conversations about their dilemma, and the
words of their other adult children who want to protect them from the adult
child with mental health issues.

Family research or clinical work that relies on either/or descriptions of
intergenerational relationships (filial responsibility vs. self-interest or indi-
vidualism vs. collectivism) are simplistic and unrealistic (Pyke, 1999). The con-
cept of ambivalence allows social service providers and researchers to address
the balance of solidarity and conflict within families and attend to ways in
which caregivers balance their dual feelings over time. Teaching social work
students and clinicians to identify and empathize with family members’
ambivalence can be an important part of training social workers to work with
older families. Understanding ambivalence can help social workers overcome
simplistic idealization of family relations. Helping older parents who are care-
givers acknowledge their feelings of ambivalence can support the develop-
ment of personal identity and effective problem solving, including risk
management when they are in danger of abuse from their child with psychi-
atric problems or when their own health is being compromised.

The analysis presented in this article supports a life course perspective
on ambivalence. The stories reported by both women on the “high points” of
their parenting reveal a congruence of parents’ well-being and their feelings
about their role as parent when they and their children were young. The nar-
ratives become laden with ambivalence when addressing parenting in later
life, when the woman herself wishes time for self-care and leisure. The
context of available services for adults with chronic mental illness must be
considered when viewing the situation of older caregivers with adult children with psychiatric problems. Understanding ambivalence as a sociological concept as well as a psychological concept is illustrated. Although Mrs. Lewis and Mrs. Thomas may be personally ready to focus on their own lives, and feel burdened by their children’s lack of self-sufficiency, they are also cognizant of the vulnerability of their adult offspring in a society that offers few safe settings for people with psychiatric impairments. Clinicians working with families with dependent adult children with limited capacity for self-sufficiency can help older parents sort through their conflicts, with knowledge of available services to make an informed decision that addresses the health and well-being of parent and child. Further research with larger samples of older parents who are caring for their adult dependent children is needed. Future work could investigate the adult child’s experience of continuing to live with and be cared for by their older mothers.

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