Mental Illness as a Family Constructed Object: The Reciprocal Relationship Between Individuals With A Mental Illness and Their Families

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On my honor
I have neither given nor received
unauthorized aid on this thesis.

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ABSTRACT

This paper researches the reciprocal relationship between individuals with a diagnosed mental illness and their families. I interviewed fourteen college students who were diagnosed with depression, anxiety or bipolar disorder and asked them about their relationships with their families. I used a symbolic interactionist perspective to interpret the social construction of mental illness. I found that individuals who were not the only family member diagnosed with a mental illness defined mental illness as a normalized object. As a result, these individuals had a higher perceived sense of self and higher self-esteem. However, individuals who were the only family member diagnosed defined mental illness as an abnormality and therefore, the individuals sense of self was lower.

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Mental illness has a lasting impact on an individual with a mental illness as well as his or her family. There have been a great number of studies on how a parent's mental illness affects a child. However, there has been a lack of research on how individuals with mental illnesses perceive their family to affect their illness and in turn, how they feel their mental illnesses affect the family. This dual relationship has yet to be analyzed while looking at the social construction of mental illness within the families.

Using interviews, I attempt to explore the reciprocal relationship between individuals with mental illnesses and their families and how the construction of mental illness affects the individuals' perception of self. The shaped meaning of mental illness will be reflected in the tradition of symbolic interactionism through the theories of George Herbert Mead, Herbert Blumer, Erving Goffman and Charles Cooley. I will use their understanding of the self to highlight the relationship between the families' social construction of mental illness and the individual's perception of self.

REVIEW OF LITERATURE

Symbolic Interaction Theory

Mead ([1934] 1962), Blumer (1969), Goffman (1959) and Cooley ([1909] 1983) argue that groups form around social interactions. Within these interactions, people learn to share common understanding and learn what to expect from one another. They do this through the use of symbols, such as language, or verbal and/or nonverbal communication to interpret interactions with others. Symbolic communication helps people create a meaningful world. Herbert Blumer (1969:12) argues, "Humans are not passive agents but are actively engaged in creating their own meaningful social world based on their

construction and interpretations of the social reality." In other words, people modify meanings and symbols as they struggle to make sense of situations and events. George Herbert Mead ([1934] 1962) states that the outcomes of symbolic interactions are physical, social or abstract objects. This paper will view mental illness as an object that is defined and shaped by social interactions. Mead argues, "The nature of an object consists of the meaning that it has for the person whom it is an object for and this meaning sets the way in which he sees the object, the way in which he is prepared to act towards it, and the way in which he is ready to talk about it." (Blumer 1969:11). Therefore, a family's social construction of mental illness affects how an individual with mental illness interacts with it as an object and, consequently, how the individual views him or her self in relation to the object.

Charles Cooley ([1909] 1983) and Mead [1934] 1962) believe that the self is a social product shaped by the interactions we have with others from the time we are born. For Cooley, there are three principle elements. First, we imagine how we appear to others; second, others make judgments and respond to us; and third, we react to that feedback based on our interpretations (Cooley [1909] 1983). Within this process that Cooley calls the "looking glass self," an individual's sense of self-esteem is determined ([1909] 1983:24). Our feelings about ourselves emerge from a process of imagining how we appear in others' eyes. He states, "the thing that moves us to pride or shame is an imputed sentiment. This is evident from the fact that the character and weight of that other, in whose mind we see ourselves, makes all the difference with our feeling" (Cooley [1909] 1983:152). Individuals base their self-esteem on how they believe others view them. Mead refers to this process as taking the role of the other.

Mead argues that the self is created through this process by taking the role of the other ([1934] 1962). "Role-taking allows humans to view themselves as objects, as though they were looking at themselves from outside themselves" (Mead [1934] 1962:207). As a result of seeing one's self as an object, an individual may gain insight in how others view him or her and that insight allows for either high or low self-esteem. How a family constructs mental illness to be interpreted will affect how individuals with mental illness perceive their sense of self. Additionally, the process of taking the role of the other is vital to symbolic interaction because it allows for meaning making within interactions (Mead [1934] 1962). Interactions rely on symbols for communication; however, as Mead asserts, there is a possibility for the "process of interpretation" to go awry (Mead [1934] 1962:62). When a child and parent construct different meanings for objects and symbols, there will be a failure in interpretation and communication. In other words, the child and parents will not understand one another, particularly if they have different construction of mental illness as an object and this in turn affects the child's sense of self. Thus, Mead ([1934] 1962) argues that the individual must take the role of the other to try and interpret his or her meaningful action.

The process of socialization plays a key role in an individual's understanding of self and the meaning of objects (Hewitt & Shulman 2011; Mead [1934] 1962). This process begins with the family and continues with peer groups. The central product of the socialization process is the self, or the perception individuals have of their selves (Hewitt & Shulman 2011). Meanings of objects and one's perception of self are modified as an individual grows up and moves through the stages of life (Mead [1934] 1962; Blumer 1969). Socialization agents work by communicating messages to

individuals at various stages of their lives (Hewitt & Shulman 2011). Some examples of these agents are parents, peer groups, educational institutions, religion, and the media. Moreover, television and computers are informal agents of socialization that shape individuals' meaningful world of objects.

Individuals' interpretation of objects changes as different agents of socialization influence them. Therefore, an individual's understanding of mental illness as an object will first be shaped by his or her parents and later by other agents of socialization. The individual's perception of mental illness affects how the individual perceives him or her self by taking the role of the other. That perception of mental illness and self affects the individual's self-esteem. For individuals with a mental illness, their perception of mental illness as an object plays a crucial role in their perception of self and sense of esteem that will be analyzed in this paper.

Mead argues that the primary socialization unit for young children is the family, but as they become teenagers, the other socialization groups become increasingly important in shaping their norms, values, and attitudes (Hewitt & Shulman 2011; Mead [1934] 1962). Norms play an important role in the socialization process of an individual because norms help guide interactions, meanings, and a sense of self (Mead [1934] 1962). Children originally define normal as what their parents socialized them to understand. However, this definition changes as the individual grows and becomes influenced by other social groups that affect how the individual creates meaning. Therefore, while a child's perspective of the world would be parallel to his or her parents, a student in college will have shaped a different meaning of the world and perceived a sense of self through other social groups besides his or her parents (Hewitt & Shulman

2011; Mead [1934] 1962). Thus, while the child's sense of self is changing, the parent's sense of self stays largely the same because they are no longer as exposed to new agents of socialization and their meanings of objects stay relatively the same (Blumer 1969). Mead argues that it becomes more difficult to change adults' meaningful make up of the world as opposed to a young adult because young adults encounter new roles and social groups more frequently, thus challenging their sense of self (Hewitt & Shulman 2011; Mead [1934] 1962). Therefore, a child's interpretation of mental illness will reflect their family's construction of norms, but as other agents, such as peers, socialize the child, his or her understanding of mental illness will expand. However, an adult's construction of mental illness stays largely the same because they are less exposed to new agents of socialization that would affect their norms and values.

Mental illness has a socially constructed meaning that is formed through interactions. Those interactions take part in socializing an individual and creating his or her norms, values and meaning. Within those interactions, the individual takes the role of the other to see them selves as an object and learn how others view them. How individuals feel the world perceives them is their perception of self and in turn affects their self-esteem. Therefore, interactions with those who view mental illness as normal will allow the individual to have a healthier sense of self. However, it is first important to understand the diagnosis that will be used in this paper to identify symptoms that will later be used as symbols and objects within interactions.

Overview of Diagnosis: Depression, Anxiety, and Bipolar

The rates of Depression, Anxiety, and Bipolar are on a continual rise among individuals with still many unanswered questions about their affects on the family.

Depression is multiple genes of small effect interacting with environmental and developmental factors (Moskivina et al. 2008; Sullivan et al. 2000). Symptoms of depression include increased appetite, hypersomnia, weight change, feelings of worthlessness and guilt (Moskivina et al. 2008; Angst et al. 1984). Rates of depression in adolescents are the highest of all psychological disorders in that age group (Hammen 2009). This disorder affects millions of adolescents and their families (Hammen 2009). Depression is associated with problems such as school difficulties, unwanted pregnancies, health problems, drug abuse, partner violence, and problematic peer and family relationships, as well as anxiety and suicide (Hammen 2009). Women are at a greater risk than men for major depression (Moskivina et al. 2008; Kendler et al. 2001) and women are at a greater risk for comorbid anxiety and depression (Guberman et al. 2011; Moskivina et al. 2008).

The co-occurrence of anxiety and depression in youth is frequent (Guberman et al. 2011; Masi et al. 2004; Compas and Oppedisano 2000) and has been associated with worse impairment and increased suicidal tendencies than either symptom in isolation (Guberman et al. 2011). Compared to either diagnosis alone, comorbid diagnoses in youth are associated with more severe internalizing symptoms (Guberman et al. 2011; Bernstein, 1991; Berstein and Garfinkel 1986) and impaired family function (Guberman et al. 2011; O'Neil et al. 2010; Stark et al. 1990). Anxiety alone is a mental illness with symptoms such as feelings of fear, worry, fatigue, and, concentration problems. Anxiety takes the form of: phobia, social anxiety, obsessive-compulsive, and post-traumatic stress. Anxiety is often accompanied by panic attacks (Lindhout et al. 2009) and eating disorders (Swinbourne and Touyz 2007).

Bipolar-I, Bipolar-II, and Bipolar NOS is a disorder is characterized by extreme mood fluctuations between mania and symptoms of depression (Carolan et al. 2011). Bipolar-I is characterized by one or more manic episodes. Manic episodes are defined as causing severe social or occupational impairment. Bipolar-II is having no manic episodes but one or more hypomania episodes and one or more major depressive episode. Hypomania episodes do not go to the full extremes of mania and can be more difficult to diagnose. Bipolar NOS is used as a diagnosis when the symptoms and disorder do not fall within a specific subtype (Doughty et al. 2004).

Family Function And Support

Family dysfunction leads to mental illness

Park et al. (2008) found that family environments characterized by high levels of negativity, conflict, disengagement, or otherwise adverse relationships have been found to be associated with higher levels of depression in youth (Park et al. 2008; Sheeber et al. 2001). The study found that perceptions of a negative family milieu (unsupportive) were associated with more depressive symptoms (Park et al. 2008; Cumsille and Epstein, 1994). Second, studies that assessed the family environment have shown a significant relationship between low-quality parenting (low levels of supportive or high levels of harsh parenting behaviors) and greater levels of depressive symptoms in the children (Park et al. 2008; Dallaire et al. 2006).

The effect of parents' mental illness on ego

Studies have found that family relationship quality and parenting practices are often compromised when a parent is depressed (Bohnert et al. 2007; Goodman and Gotlib 1999). Parental depression has been associated with poorer parenting skills (Herr et al.

2007; Goodman and Gotlib 1999; Gelfand and Teti 1990), increased rates of child and adolescent depression (Herr et al. 2007; Beardslee et al. 1998; Weissman et al. 1997), and poorer interpersonal functioning among the offspring (Herr et al. 2007; Lewinsohn et al. 2005). Children of depressed parents have reported lower self-esteem (Hirsch et al., 1985), and lower perceived self-worth (Bohnert et al. 2007; Goodman et al. 1994). Bohnert (2007) suggested that negative parenting behavior characterized by rejection and punishment is related to children's development of negative self-perception.

Depressed mothers have difficulty nurturing and supporting their children's interests (Bohnert et al. 2007; Goodman and Gotlib 1999; Webster-Stratton and Hammond 1988), tend to be more hostile, and are more likely to engage in conflicting and coercive interactions with their children than are non-depressed mothers (Bohnert et al. 2007; Conger et al. 1995). Maternal rejection and verbal criticism relate to negative cognitions in children and adolescents (Bohnert et al. 2007; Garber and Flynn, 2001; Goodman et al. 1994; Jaenicke et al. 1987). Finally, offspring of depressed mothers are at an increased risk for experiencing depression and anxiety (Goodman and Gotlib 1999; Beardslee et al. 1998). Studies suggest that 50 percent of the children of depressed mothers will experience their own depression by the time they reach adulthood (Foster et al. 2008). The familial transmission of psychopathology from parents to children is likely the result of both genetic and environmental factors, particularly in the maternal context (Park et al. 2008).

Depressed fathers have been shown to be more critical and emotionally over-involved with their children than non-depressed fathers, but only when the child's mother was also depressed (Brennan et al. 2002). Fathers' depressive symptoms have been

shown to be associated with higher father–child relationship stress (Jones et al. 2001) and father–child conflict (Kane and Garber 2004). Herr et al. (2007) found that current parental depression was associated with poorer parent–youth relationships. Additionally, currently depressed men experienced similar problems as women in relationships with their adolescent children.

Siblings' social support helps mental illness

Besides parents, siblings have the most contact with an ego, the child of focus, and they affect his or her linguistic, cognitive, and emotional development, and behavioral outcomes (Wu et al. 2012; Brody 2004). Ji-Yeon et al. (2007) found that social support enhances youth adjustment (Ji-Yeon et al. 2007; Reddy et al. 2003; Scholte et al. 2001; Dubow et al. 1991) and buffers the effects of negative life experiences on well-being and mental health (Ji-Yeon et al. 2007; Flouri and Buchanan 2002; Cohen & Wills 1985). Social support (affection and nurturance) has the potential to alleviate youths' stress burden during life events (Luthar et al. 2000), reducing their risk for maladjustment and depression (Thoits 2010). Gass et al. (2007) found that children with high levels of maternal stress from negative life events and high sibling warmth had relatively fewer internalizing symptoms (Gass et al. 2007). Waldinger et al. (2007) also found a link between poor childhood sibling relationships and adult depression (Waldinger et al. 2007).

Further Research Needed

These studies have indicated that dysfunctional family environments have detrimental affects for a child. The research found that parents with a mental illness harm a child's mental health. Parental mental illness has been shown to produce a high

likelihood of mental illness in the child. However, a strong social support and family closeness have been found to counteract a child's symptoms of mental illness. These studies have not researched the social construction of mental illness and how that construction affects the relationships between family members. I will seek to fill the gap in the literature by addressing the social construction of mental illness in families through a sociological lens.

METHODS

This paper seeks to understand the reciprocal relationship between individuals with mental illnesses and their families, and how that relationship affects the family's social construction of mental illness and the individual's sense of self. This question was answered through fourteen interviews (see appendix for interview schedule). I used convenience sampling to gain my participants. I emailed members of a mental health group at a selective liberal arts college in the United States. I explained my research topic and asked for interested individuals to contact me via email. Once contacted by a potential participant, I arranged a meeting the following week at a mutually agreed upon time and location.

All of the participants were within the age range of 18 to 22 years old. In addition, all of the participants self-identified as Caucasian except for one participant, who identified as biracial. Additionally, only three of the fourteen participants were male. Of the fourteen participants, two were diagnosed with bipolar disorder, three with depression, six with anxiety, and three with comorbid anxiety and depression. Each interview was conducted either at the participants' house, my house, or a private common

area such as the library. The interviews were recorded on my computer and took on average about 55 minutes. The shortest interview was 40 minutes and the longest interview was one hour and ten minutes. One interview was conducted over Skype and the rest were done in person using a recording device. The participants received no compensation for their time. Prior to beginning each interview, the interviewees signed a consent form and were made aware of the possible risks and benefits of their participation.

My research has several limitations. First, I gathered my participants based on convenience sampling; therefore, I only recruited individuals who were in college, were stable enough to be in school, lived away from home, and were comfortable enough with their mental illness to be members of a mental illness group on campus. Moreover, the participant demographic includes a lack of racial and gender diversity. Therefore, my results are unable to be generalized.

ANALYSIS

The analysis for this research paper can best be understood by using a symbolic interactionist lens. Symbolic interactionists such as Mead ([1934] 1962), Blumer (1969), Goffman (1959), and Cooley ([1909] 1983) assume that social groups create shared meanings regarding symbols and events and then interact based on those meanings. Through interactions, people share common understandings and learn what to expect from others. Individuals actively engage in creating their own meaningful social worlds based on their constructions and interpretations of the social reality ([1934] 1962). However, people modify meanings and symbols as they struggle to make sense of their

situations and the events they experience. Membership to different social groups depends on how they define the meaning of symbols and influences the way we define our "self" ([1934] 1962). Humans define what is normal by what others around them accept as ordinary.

Norms are learned through the process of socialization that begins from childhood. These norms are originally defined by parents and later influenced and changed by social groups such as peers, academic institutions, religion affiliations, and the media. It is through the understanding of norms that an individual learns what is accepted and that acceptance affects the individual's sense of self and self-esteem. This paper looks at the difference between an individual being the only family member diagnosed as opposed to having a family member who is also diagnosed. Having another family member diagnosed affects the individual's construction of mental illness and the family's norms. As a result, the individual's self-esteem is affected by that construction.

Ego As Only Family Member Diagnosed

Eight of the fourteen interviewees said they are the only family members who have a diagnosed mental illness. These interviewees identified five common themes. First, family members did not notice the ego's symptoms of mental illness because the family members were not socialized to identify symptoms of a mental illness. Second, family members were unable to identify the symptoms because they did not have experience with mental illness and therefore, mental illness was not discussed or understood by the family members. This lack of understanding about mental illness led to stigma around having a mental illness and many interviewees tried to hide their mental illnesses from their families because of the perceived stigma. The family's use of

language to convey norms to the ego allowed the ego to interpret having a mental illness as being outside the scope of what is normal.

Third, the interviewees tried to change their families' shared meaning of what is normal to encompass having a mental illness by changing their families' views on mental illness. Fourth, the interviewees' parents had a variety of responses to trying to understand and help their children. Mead ([1934] 1962) argues that it was difficult for many parents to change their shared meaning because their social groups had already defined what a mental illness meant and reshaping that view is challenging later in life. Finally, it was because of their family's lack of understanding and experience with mental illness that most of the interviewees liked being away from home. This can be understood through a Meadian interpretation that the interviewees liked spending time with their social groups at school that had the same-shared meaning of what having a mental illness means and allowed the interviewees to have a more positive sense of self.

Ego's symptoms not recognized by the family

Family members of the interviewees did not notice their early symptoms of mental illness either because the families assumed their moods were due to angst or because the interviewees hid their mental illnesses. Mead argues that as an individual is socialized through family and later peers, an individual learns values, norms, and the meaning of symbols (Hewitt & Shulman 2011:64). Therefore, I extrapolate that the interviewees' family members were socialized to identify symbols such as mood swings and child separation to be identified as adolescent angst and not symptoms of a mental illness. Four interviewees said their parents did not notice the symptoms because they hid them so well. One interviewee said, "I honestly just did a really great job of hiding my

depression from my mom. My emotions around her really fluctuated and I think they just thought that was grumpy teenager stuff. I was particularly moody around her because I wanted her to notice what was going on with me." This quote mirrors similar thoughts of other interviewees that they not only successfully hide their mental illness but their mood swings were associated with teenage angst.

Additionally, Mead argues, "Defining the situation is a process in which we create meaning. Human beings author the meanings that form the basis on which they act" (Hewitt & Shulman 2011:123). The parents used the interviewees' non-verbal and verbal communication to interpret the interviewees' sadness, anger, and frustration, to mean teenage angst to define the situation and acted based on that meaning. This frustrated the interviewees because they hoped their parents were able to identify their mental illness.

It became apparent that many family members did not pick up on the symptoms because it was not part of their shared construction of mental illness. Mental illness as an object gains its construction through interactions that form and shape its meaning. However, mental illness was never discussed in these families and therefore, the family's construction of it was based on socialized messages from the media. One interviewee said, "I can't think of any family member who had it so it was never talked about. I could only draw together what I thought mental illness was from TV, movies, and media." Mead states that one socializing agent is the media and it instills its own values and norms around the construction of objects ([1934] 1962). This interviewee explained how his parents' original understanding of mental illness came from socially constructed ideas of mental illness portrayed in movies. I argue that because his and seven other

interviewees' families had never directly been exposed to mental illness, media served as a socializing agent to define their understanding of a mental illness.

Stigma around mental illness

Media portrays mental illness as abnormal, and the interviewees' families interacted with mental illness as an object using that definition. Consequently, misconceptions and stigma regarding mental illness easily arose. As Blumer and Mead argue, groups define what the norms are and interact with one another based on those assumptions (1969; [1934] 1962). Chris said that his mother looked to the news to understand what a mental illness is. "My mom will say there are crazies and who knows what crazies will do. They will break down your door and shoot your whole family. I definitely had a lot of the stigmatized views of what mental illness was and what it was to be crazy." Blumer and Mead say that a child is first socialized by his or her parents and through the socialization process gain ideas of norms and values (1969; [1934] 1962). These values and norms are conveyed to the child through symbolic communication (Mead [1934] 1962; Blumer 1969). I argue that Chris's mother was using verbal communication such as, "crazies", to convey norms to him that forced Chris to interpret a mental illness as being crazy. In other words, Chris's interaction with his mother about mental illness socially constructed its definition to mean crazy and not a norm.

Mead states, "as children move through elementary school and beyond, peer influence becomes stronger as the amount of time a child spends with peers increases" ([1934] 1962: 67). One interviewee said his friends defined what mental illness was for him. He said, "I received really stigmatizing messages from my friends that perceived mental illness as negative. To talk to anyone about it or to seek help meant you were

crazy." Consequently, I argue that the interviewee was socialized through his friends to view mental illness as a negative quality.

Ego keeps mental illness a secret

These stigmatized notions of mental illness were the reason three interviewees tried to hide their mental illness from their families. The families constructed mental illness as a deviant object and therefore, the interviewees were reluctant to tell their families they were not "normal." One interviewee said she has kept her anxiety a secret because "we didn't talk about emotional things and my mom would be hurt because she thinks that I am very well adjusted, which I am, but I have also dealt with anxiety. I would hate to break her image and wreck her peace of mind." Mead states that learning the meaning of an object is not enough but "meaning lies in the actions that people take, are prepared to take, or can imagine taking towards the object" ([1934] 1962:63). The interviewee knew the meaning of mental illness was being poorly "adjusted" and the proper way to interact with mental illness as an object was to not talk about it. Therefore, it was not enough that the interviewees knew that mental illness meant being abnormal; they also had to know that it was equally as bad to interact with mental illness or tell their families they had a mental illness.

However, five of the interviewees eventually said they had to tell their families about their mental illness. Mead argues, "the self is a stable object defined by a strong sense of social identity grounded in and certified by the community" ([1934] 1962:111). The family is a crucial part of an individual's community and a family's acceptance affects how the individual thinks of his or her self and self-esteem. I argue that individuals with mental illnesses construct their sense of self-based largely on their

family's ascribed meaning of mental illness. Therefore if a family defines mental illness as abnormal, individuals will have poorer self-esteem and attempt to rectify that by changing their family's meaning of mental illness so they feel accepted within their family.

Ego tries to changes family's view on mental illness

Eight interviewees tried to change their family's construction of mental illness. They explained that their families' understanding of mental illness changed because they were gaining firsthand experience with someone who has a mental illness. Blumer (1969) states "meaning is anchored in behavior. The meaning of an act is neither fixed nor unchanging, but is determined in conduct as individuals act towards objects. As acts, proceed, meaning can transform" (1969:52). As a result, families' meaning of mental illness had the opportunity to change through their interactions with the interviewees. Ben said,

> My mental health has forced them to change their ideas about mental health because before they didn't have first-hand experience and I am demanding them to support me. The way they think about depression has changed because I have explained to them that it is not something you choose.

Many of the interviewees described how they made mental health a large part of their lives and brought it closer to their families. Therefore, by the interviewees interacting with their parents with a different meaning of mental illness it allowed the parents to alter their meaning of mental illness as well. However, there is a possibility of failure of interpretation.

Mead argues that humans are creatures of habit and "during socialization, we learn a large number of definitions, along with rules for applying them to the concrete

repetitive situations we encounter" ([1934] 1962:120). That implies that people do not learn all possible definitions, nor does each interaction merely require the application of a pre-established definition. A characteristic of humans is their ability to create new meanings, face unexpected events, and consider the possibility that one interpretation of a situation might be wrong. However, unexpected meanings within interactions facilitate misunderstandings, conflicts over interpretations, and resistance to change within an individual's established routine of meaning (Mead [1934] 1962). I extrapolate that families may resist change in their social meaning of mental illness because it goes against their socialized meaning and habits of interaction.

Family's reaction to ego's mental illness

The interviewees described different reactions from their parents once they tried to change their family's socially constructed definition of mental illness to be within the family's norms and values. There were four main reactions from the parents. First, the parents were able to expand their understanding of mental illness as an object and incorporate a new definition of mental illness as normal. Second, when confronted by the new meaning in an unfamiliar interaction, parents turned to religion. Third, the parents wanted to interact with their children based on the new meaning of mental illness but did not know how to. Fourth, the parents were unable to change their construction of mental illness and became angry when forced to interact in the new situation.

Two interviewees said that when their parents were confronted with the new construction of mental illness, the parents tried to change their understanding of mental illness to properly interact with their child. One interviewee described how her family had been against therapy but "my mom went to a therapist to talk about what to do with

my eating disorder because she didn't want her comments to make me upset." The interviewee said that even though her parents did not understand anxiety, they were reaching out to different resources. When the interviewee's mother went to therapy, she was deliberately inserting herself in an interaction that was based on mental illness having a meaning that was normal and not stigmatized. I argue that the mother did this so she could interact with her daughter based on this new meaning of mental illness in the hopes of helping her daughter.

Alternatively, this can be interpreted as the mother trying to maintain social order by changing the meaning of mental illness. The family's original social order had the daughter within the family's constructed ideas of norms and values but once the daughter said she had a mental illness the social order was out of balance. Mead states, "when a person behaves 'strangely,' the natural appearance of order is broken, and observers become agitated. They create interpretations to make sense of any breaches and they resent violations of the 'invisible' order in which they are embedded" ([1934] 1962:156). I argue that the mother was agitated that her daughter was no longer within her defined bounds or norms, and to rectify that social imbalance she changed her constructed meaning of mental illness so that social order would be restored.

Two interviewees' parents attempted to regain social order through the use of religion. Logan said she comes from a very religious family and the "mentality is that you can receive help from the church and you will be good. They use religion to understand things they don't have the answers to. This is not the type of support that I want, but for them it is the best type of support they think they can offer me." Logan's parents were using one of their social groups, religion, to try and provide support for Logan and use

religion to help them understand Logan's mental illness. Mead argues, "We assume that an event has a cause, and to act appropriately or effectively we must first establish the cause. Many use religious teachings to explain and interpret conduct" (Hewitt & Shulman 2011:130). I argue the interviewees' families turned to religion to try to understand their child's newly developed mental illness and find a cause or solution. However, the interviewees did not want religion as a "support" or an answer to their mental illness.

Many interviewees expressed that although their parents wanted to understand, they didn't know how to help. Ben described his father as wanting to "hear about issues that I was having, but [didn't] really know how to help me. He [didn't] really have the tools that he can use to address problems with anxiety or depression because that has never been an issue in his life before." Mead states, "people must form definitions of situations and interpret others' conduct in order to construct their acts, but they are usually limited in what definitions they can consider and in the interpretations that they can make" (Hewitt & Shulman 2011:143). These definitions of a situation are formed through taking the role of the other. Within a child-parent relationship, definition of situations has been routinized. However, when the child has changed the definition of a situation or interaction, parents may fail at taking their child's role. I argue that not having the proper "tools" to help could also be seen as the father's inability to take the role of his son and, therefore, fail to properly interact and create shared meaning around mental illness.

Additionally, a parent's inability to take the role of their child can leave the parent feeling frustrated from the failed interactions. Two interviewees said their parents reacted in anger and vexation when they did not understand the new meaning of mental

illness from their children. One interviewee stated her parents "didn't understand why I didn't have a handle on it yet. I think they both just felt a little angry." The parents failed at grasping the new construction of mental illness and therefore were unable to take the role of their daughter in their interactions around mental illness. Part of the reason the parents could not take the role of their daughter was because they "didn't understand." Mead argues that "successful role taking depend on an individual's capacity to share and understand feelings" (Hewitt & Shulman 2011:126). I posit that because the interviewee's parents could not understand her mental illness, they were unable to take her role because of their lack of empathy for mental illness.

Ego prefers not being home

Overall, the parents' lack of ability to take the role of their child made six out of eight interviewees prefer not being at home. One interviewee, Ben, said, "on this winter break, I was drinking more and getting into more fights with my parents and just angry with them for not understanding what was happening to me." This interviewee was describing frustration with his parents' failure to interpret his interactions because they did not share the same meaning of mental illness. Ben was frustrated with his parents for their inability to take his role and see mental illness from his perspective. Mead states, "by attempting to grasp the perspective of the other, one identified with that perspective. Role taking can generate empathy in the sense that people try to assess what feelings others have that are appropriate in that situation" (Hewitt & Shulman 2011: 126). I argue that Ben was angry with his parents because they did not share his construction of mental illness and therefore could not understand mental illness from his perspective. Since the

parents could not understand mental illness, they could not empathize and therefore, could not take the role of their son.

Additionally, six interviewees felt more comfortable interacting with their social groups at college than at home with family. As previously stated in my methods, all interviewees were recruited through a mental health group on campus that met once a week. Therefore, all interviewees had peers diagnosed with a mental illness and social interactions at school were smoother because they shared the same meaning of mental illness as normal. The interviewees' college mental illness peer group was able to empathize with having a mental illness and therefore, have successful interactions with the interviewees. Erving Goffman (1959) says the importance of interactions being successful and both individuals ability to take the role of the other when interpreting symbols should not be understated.

Goffman emphasizes the importance of the presentation of self and defines it as what "people do in order to enhance or protect their conceptions of themselves and their status in other's eyes" (Hewitt & Shulman 2011:144). The college mental illness peer groups were able to see mental illness through the interviewees' perspective because they all have a mental illness and therefore, did not judge or think the interviewees were abnormal. The families, through socialization, originally defined the norms for the individual. However, the individual's college mental illness peer group changed the social construction of norms to incorporate mental illness. These interactions at school allowed the interviewees to have high self-esteem and a positive perception of their self. Consequently, the interviewees prefer spending time at school with social groups that share their meaning of mental illness.

Ego With Other Diagnosed Family Member

Mead ([1934] 1962), Blumer (2969), Goffman (1959), and Cooley's ([1909] 1983) understanding of symbolic interaction can also be used to interpret the seven common themes expressed by interviewees who had at least one other member of their family with a mental illness. The family plays a large part in socializing the interviewees and creating the accepted norms when the interviewees were children. Since other family members besides the ego have a mental illness, having a mental illness is incorporated into what is normal. This is crucial for the mental health of the interviewees and how they perceive their sense of self. Six out of the fourteen interviews conducted had an immediate family member who was also diagnosed with a mental illness. The first of the seven common themes is the identification of the early symptoms of the ego's mental illness by siblings or parents. Second, the family became worried about the ego's symptoms of mental illnesses. Third, all parents took steps to address the ego's mental illness by pushing therapy and the ego's initial response was reluctance, followed by appreciation for family's efforts. Fourth, the ego's initial reluctance to receive help was suppressed after talking to another family member with a mental illness. Fifth, the ego eventually did not feel abnormal for having a mental illness. Sixth, the ego described family members without a mental illness having three responses to the ego's mental illness. Finally, four of the six interviewees said they felt healthier and happier at home.

Family notices symptoms

When the interviewees first started developing symptoms of their mental illness, five out of six interviewees' family members noticed. The parents of the ego noticed because they either had personal experience with a mental illness or they were the

spouses of individuals who have a mental illness and therefore, learned the signs. One interviewee said, "Both my parents noticed my depressive symptoms. My dad has had a history of depression and I think they just noticed similar symptoms." The parents who had experience with mental illness had already learned the shared meaning and proper forms of interaction around mental illness. This interviewee's parents were able to identify the symptoms of a mental illness because her parents learned when they were addressing the father's depression. Parents with a mental illness were able to correctly interpret the non-verbal symbols the egos were expressing. They had already developed meaning around symbols of mental illness and became concerned for the ego's mental health.

Family expresses concern for ego

After the families had become aware of the ego's symptoms of mental illness, the interviewees described the family's concern and support. The support came from family meetings about the ego's mental health. One interviewee said that after her depression forced her to leave school,

> We had a family meeting about my depression. Everyone was a little concerned with what was going on with me. I remember my brother crying and I have never seen him cry for emotional reasons. It was kind of awkward for me but I was glad my family was supporting me.

The family's meetings around the ego's mental illness were crucial in forming interactions with the ego to develop meaningful ways of understanding mental illness. Mead states, "a definition of the situation is an organization of perception in which people assemble objects, meanings and others and act toward them in a coherent, organized way. When people are in a familiar situation and its configuration of meaning

is known, they can organize their own conduct in relation to its definition" (Hewitt & Shulman 2011:49). I argue that family meetings around mental illness allowed the ego to formulate the family's constructed meaning of mental illness and apply those meanings to future interactions around mental illness. Since the family's social construction of mental illness was positive, the interviewee was able to have a positive sense of self.

Ego's desire to not seem abnormal

Once the parents had defined the situation of mental illness as nothing to be ashamed of, they were able to interact with their child about mental illness in a slightly established manner. The parents pushed their children to seek help because their own experience had taught them that therapy helps mental illnesses. One interviewee said,

> My mom suggested that I may be depressed and I should go see somebody. I really didn't want go to at first because my friends made fun of students who went to the school counselor. That caused some fights with my mom and me because she wanted me to go and I was reluctant. So after I saw the therapist she wanted me to start taking medication. I was really reluctant because I didn't want to feel not normal. Now I am glad I went on them and my mom pushed me to get help.

Five of the interviewees indicated they were reluctant to receive help because they did not want to feel abnormal. These messages about not wanting to feel abnormal were based on norms created within the interviewees high school peer groups. One interviewee said, "My friends in high school made fun of students who were sent to counseling and said there was something wrong with them."

As previously stated, Mead and Cooley argue that young adults are influenced and socialized from peer groups while in lower school and high school and their peers contribute to the individuals' values and norms (Hewitt & Shulman 2011; Mead [1934] 1962; Blumer [1909] 1983). Therefore, even if the interviewees were not receiving

stigmatizing messages about therapy and mental illness from their parents, their peer groups were creating those messages. Additionally, Mead states, "When humans mind themselves, they constitute the self as an object" and humans sense of self and worth are based on what they think others think of them (Hewitt & Shulman 2011:46). Consequently, I argue that the interviewees were taking the role of their peers and perceived their peers to view them as abnormal because of their mental illness. The interviewees' high school peer groups constructed mental illness to not be a norm or something valued.

Both groups, individuals with a diagnosed family member and individuals without one, describe hearing stigmatizing messages about mental illness from their high school peer groups. Mead states, "The integrationist approach to socialization emphasizes that children are active interpreters of their world and not merely passive sponges that mindlessly absorb lessons" (Hewitt & Shulman 2011:65). Therefore, even though individuals with a diagnosed family member were socialized to see mental illness as a norm, the individuals were still affected by the messages they heard at school. The individuals with a diagnosed family member were actively interpreting the mixed messages about mental illness from their high school friends and family. However, what truly made the difference for the individuals with a diagnosed family member was their ability to talk to their family about having a mental illness.

Ego feels normal because of parent

Blumer describes norms as "rules or behavior shared by members of a social group that are rooted in the value system" (Blumer 1969:13). Having a family member describe mental illness as normal and nothing to be ashamed of affected how the

interviewees perceived their sense of self and relieved some of the messages of abnormality expressed by high school peer groups. One interviewee said, "I remember feeling abnormal when my psychologist suggested I go on medication. My dad told me he had been on anti-depressants for years and said it really helped him. I felt more comfortable going on medication after talking it through with him. Since my dad was on medication it felt more normal to me." Five interviewees indicated that having a parent to talk to about their mental illness made them feel more normal and comfortable with the idea of medication and therapy. The parents allowed the interviewees to modify the meaning of normal and mental illness so they were able to make sense of their situation.

Ego has family member to talk to

Having a parent with a mental illness also allowed the interviewees to have an adult who empathized with their situation. As previously stated, Mead argues that successful role taking requires the individual to be able to perceive the other person's situation and interact based on that understanding (Hewitt & Shulman 2011). Consequently, having a family member who understands having a mental illness allows the individuals and their parents to share the same meaning of mental illness and the interviewees believe their feelings are understood. One interview said,

> My relationship with my mother was probably the only close relationship I had at the time because I knew she had been through this and knew what I needed. One time I was really upset after dinner and she went and grabbed this old kitchen towel out of our drawer and told me to 'rip this up, rip it up into a million pieces.' She just knew that those kinds of things helped me.

This sense of shared understanding with a parent was common among the interviewees. It allowed the parents to correctly interpret non-verbal symbols, such as frustration,

anger, or sadness that the interviewees were using to communicate with their parents. The parents were then able to successfully interact with them.

Ego struggles talking to parent without a mental illness

Four interviewees stated that they appreciated having someone within their family with a mental illness to talk to but struggled to communicate with their parent without a mental illness. Similar to testaments by interviewees who had no family members with a mental illness, two interviewees indicated that their parents without a mental illness had a hard time understanding and knowing how to interact. Four interviewees described that what mattered was not whether their parent without a mental illness understood, but if they validated the interviewees' feelings.

Two out of the six interviewees said their parent without a mental illness did not know how to interact with them because they did not have the same-shared meaning of mental illness. The interviewees described their parent without a mental illness as unsure of how to handle the ego's mental illness. One interviewee admitted that because her mother didn't understand her mental illness or how to deal with it, the interviewee was resistant to talk to her about it. She described a situation in which she would talk to her mother "about what I [was] feeling and she [would] say how my problems are small. That makes me feel pathetic because it makes my problems not real and I feel weaker. I don't know that she recognizes that and I think that is why I go to my dad to talk."

I argue that the mother was failing to properly take the role of her daughter because her response to her daughter's depression made the interviewee feel worse. Mead asserts that all interaction go through a "process of interpretation" (Mead [1934] 1962:62). The mother's failure to interpret what response her daughter wanted through

her inability to take the role of her daughter had detrimental effects on the interviewee's sense of self-esteem. Since the mother did not understand having a mental illness, she was unable to take the role of her daughter. Both interviewees demonstrated their frustrations with their parents who did not have a mental illness because they did not understand having a mental illness and, therefore, failed at taking the role of the other.

Four of the interviewees indicated that even though one of their parents may not understand having a mental illness, they validated the interviewees' feelings and made them feel supported. Sylvia expressed feelings about needing to feel validated by her father who does not have a mental illness. Sylvia asked her mother what it is like to be married to a man who does not have a mental illness. Her mother said, "It doesn't matter if they don't understand as long as they validate your feelings and take them as real." Sylvia added, "I always feel like my feelings are validated by my parents." Therefore, even though the interviewee felt her parent without a mental illness did not understand what it was like for her, as long as her parent was empathetic and validated her feelings, she was able to talk to that parent about having a mental illness. In the process of taking the role of the other, the interviewees were able to tell if their parents validated and understood their mental illness. Those feelings of validation played a large role in how the interviewees perceived their sense of self.

Similarly, another interviewee said, "I never felt that my step-dad understood but I always felt like he was really supportive by reading the books about mental illnesses. He was always encouraging through things he didn't understand sometimes." The interviewee was emphasizing how important it was that her stepfather supported her even when he did not understand what it was like to have a mental illness. Her stepfather was

able to take the role of the interviewee because he was able to, in Mead's words, "grasp the perspective of the other… [and] generate empathy in the sense that people try to assess what feelings others have that are appropriate in that situation" (Hewitt & Shulman 2011: 126). The stepfather was able to shape his understanding of mental illness to fit his daughter's construction because he was able to empathize and validate her feelings through seeing mental illness as real.

Four of the interviewees' parents were able to empathize and validate the interviewees' feelings because they constructed mental illness to be real. Blumer argues the "Status of being real becomes an issue of what people choose to believe and/or agree to believe under particular circumstances: there are not objective real facts" (Blumer 1969:19). Although there are no real facts, the parents of the four interviewees constructed mental illness to be real. Therefore, I argue that because four out of the six interviewees' parents constructed mental illness to be real, they were able to empathize with their child's mental illness, take the role of their child, and validate the child's feelings. Consequently, two interviewees' parents did not see mental illness as real and could not validate the interviewees' feelings. Overall, it was more important to the interviewees that the parent without a mental illness saw the mental illness as real and was able to validate their feelings.

Ego happier at home

Four interviewees said they were happier at home because their families' interactions around mental illness were based on the same understanding that mental illness was normal. One interviewee described being home as being "surrounded by people who love you even when you don't like yourself and it is very reassuring. My

parents are my best friends and I love being around people who care so much about me." The interviewee described how her family validated her mental illness because they were able to take her role in interactions regarding mental illness. Many interviewees described their homes as stress-free places where they can be themselves around supportive people. Home was a mentally healthy place for the interviewees because their families made the ego feel normal and accepted with their mental illness. The interviewees had a positive sense of self-esteem because through the process of role taking, they internalized messages of being normal and having their symptoms validated and understood. Consequently, individuals who are the only family member diagnosed prefer to be at school interacting with social groups that make them feel normal because when interacting with their families and taking the role of the other, they have a poorer sense of self.

CONCLUSION

Mental illness has a socially constructed meaning that is formed through interactions. Those interactions socialize an individual and create his or her norms, values and meanings. Within those interactions, the individuals take the role of the other to see themselves as an object and learn how others are viewing them. How individuals feel the world perceives them is their perception of self. Therefore, interactions with those who view mental illness as normal will allow the individual to have a healthier sense of self and higher self-esteem.

Interviewees who were the only family member with a mental illness did not like being home and interacting with their family members because they had a lower sense of

self and self-esteem. Their interactions with their families were shaped around the meaning of mental illness as abnormal. These interviewees were socialized by their parents through non-verbal and verbal communication to perceive those with a mental illness to be crazy and abnormal. However, even after the interviewees attempted to interact with their parents based on a new understanding of mental illness, the interviewees still felt their parents were unable to change their views. Therefore, when interviewees are interacting and taking the role of their parent their sense of self is lower because of how they think their parents perceive them. This makes the interviewees with no other diagnosed family member unable to enjoy being home. Consequently, they enjoy being at college interacting with peers who also have a mental illness.

Six interviewees identified as having at least one other family member diagnosed with a mental illness. The interviewees' definition of mental illness was shaped through their interactions with their parents and later by their high school peers. The interviewees received contradicting messages about mental illness from their family and high school peers. However, once the interviewees were diagnosed with a mental illness and began talking to their parent with a mental illness, their construction of mental illness mirrored their parents, not their peers. Their interactions with their parents around mental illness indicated that having a mental illness was normal. Hence, when the interviewees were taking the role of their parents to gain a perspective of self, they felt their feelings were validated and treated as normal even with a mental illness. This allowed the interviewees to gain higher self-esteem and enjoy being home and interacting with their parents.

The importance of a parent without a mental illness validating the individual's mental illness emerged in the second section. It originally appeared that the difference in

the interviewees' sense of self and self-esteem was associated with whether the parents without a mental illness understood the interviewees' mental illnesses. However, it later became apparent that the difference was not whether they understood but whether they validated their feelings arising from the mental illness. Both groups, the only diagnosed family member and not the only diagnosed family member, described their parent(s) without a mental illness as not understanding. The difference was whether the parent validated their mental illness and treated it as real. That phenomenon only occurred when the parent without a mental illness was married to a spouse with a mental illness. When the interviewees were the only family members with a mental illness, they said neither of their parents validated their feelings or treated their mental illness as real.

Overall, proper interpretation of interactions, higher self-esteem, and positive perception of self are due to the families shaping the definition of mental illness to be normal. The interviewees without another diagnosed family member shared a different understanding of mental illness that made the interviewees have lower self-esteem and perceived self. The application of Mead, Cooley, Goffman, and Blumer's symbolic interactions framework allowed these patterns to emerge between interviewees with and without other diagnosed family members.

These findings provide a new framework for thinking about the relationship between individuals with a mental illness and their families. Most researchers, psychologists, and psychiatrists that work and think about mental illness interpret the family relationship on a more individualized basis. The research on mental illness and its relationship with family has predominantly painted a negative picture of parents with mental illnesses. The research shows that parents with mental illnesses are worse parents

and have dysfunctional families. These types of environments and parenting lead the child to develop a mental illness. The research also demonstrates that supportive family members are those without a mental illness and family members who do have a mental illness only create further problems for the child. My findings directly contradict the research that has been done on mental illness. However, studying the reciprocal relationship through a sociological lens allowed me to take fourteen interviewees' personal stories and find commonalities to make a statement about the socially constructed meaning of mental illness and its applications to the individuals' perceived sense of self.

This project had some shortcomings that must be addressed. First, the sample size of interviewees was small and therefore makes it hard to be a study that can be generalized to a larger population. Additionally, the sample did not contain an equal number of male and female participants, which may have skewed the data. The sample also had majority Caucasian interviewees and therefore the findings only studied the reciprocal relationship between Caucasian individuals with a mental illness and their families and therefore could not be generalized to other racial groups. Additionally, the study did not take socio-economic status into account when selecting participants and that may have also skewed the data. Finally, the study is biased because all participants were mentally stable enough to be in college, could afford college, and attended an institution that provided resources for the mentally ill. If this study were to be repeated I would use a larger sample size to encompass more racial groups, an equal gender ratio, a diversity of socio-economic statuses, and participants that are not all in college.

Additionally, there were several interesting findings within this study that could be pursued in the future. My findings indicated that individuals with another diagnosed family member had shaped a positive definition of mental illness and a higher sense of self. However, two of the interviewees described a sibling as having a more severe and debilitating mental illness. When that was the case, the interviewees expressed higher feelings of guilt for being healthier than their siblings, increased pressure to be perfect for their parents, and an overall lower self-esteem and sense of self. I would like to pursue this line of research with only a sample of interviewees who believe their sibling has a more severe mental illness. Also, twelve out of fourteen of my interviewees said they had a relative who committed suicide. That relative was an aunt, uncle, or great-grandfather. This high rate of suicide in the family could be due to a variety of reasons that could be addressed in future research.

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APPENDIX

Interview Schedule:

History of Mental Health:

When did you first start noticing symptoms?
Who else noticed?
How did you feel?
Who did you talk to?
Did you tell your family/Did they notice/How did they respond?
Could you describe a typical "good" day and a typical "bad" day?

How did you manage your mental health (meds, counseling, group therapy, ect)?
What kept you trying to get better?
Did your family understand?

How Family Affects Your Mental Health:

Can you tell me all about your family (who is in it, what they are like, how you get along with them, how they get along with each other)?
How did your family respond to your mental health issues?
Can you explain if they were supportive and if so, in what ways did they support you?
If they were not supportive, what ways were they not supportive?
How would you have liked them to handle your mental health issues?
How do you feel your family affects your mental health? Can you give some examples?

How are mental health issues seen in your family (pre and post your own mental health awareness)?

Other Family Members with Mental Health Issues:

Does anyone in your family have mental health issues? (diagnosed or in your opinion)

If so, how is that seen/portrayed in your family?

Was that person or people supportive of you or where you supportive of them?

Is there a history of mental health issues in your family?

Do you see mental health as being a genetic, situational or cumulative issue?

How You Think Your Mental Health Affects Your Family?

How do you feel your mental health affects your family?

How do you think your parents and siblings understand it?

Has it changed your family's perspective on mental health?

Has your mental health changed any dynamics or family relationships?

Describe what kind of role you play within your family in terms of explaining your mental health, talking or not talking about your mental health, helping other members of your family who may struggle with their mental health?

Do you have anything you would like to add?