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“Just Breaks My Heart” *A Mother’s Narrative*

In this paper the authors present a story of a mother living with a serious mental illness in the context of poverty. Her personal narrative illustrates her affection for her child with whom she has never lived, a perspective that is not typically addressed in professional discourse. Claire’s story of sacrifice compels health care providers to look at the world differently; to question traditional assumptions about what it means to be mother: an identity that endures even in illness and all its debilitating implications. For this woman, motherhood is an experience that transcends the face-to-face relationship and hands-on carework. Even though she is marginalized because of illness and poverty, Claire continues to understand herself as the mother. On the periphery, her carework changes, but it is still present. Most importantly, Claire’s narrative articulates how the suffering that is brought about by the lack of acknowledgment of her mother status is more devastating than the symptoms of her illness.

Women with serious mental illness are as likely as women without illness to become parents (Brunette and Dean, 2002: 154; Nicholson and Biebel, 2002: 168). Mothers typically aspire to establish meaningful and mutually enriching relationships with their children; however, women with mental illness often mother under adverse circumstances. In addition to the physical and emotional demands of delivering and learning how to care for their children, mothers with mental illness also must typically persevere against other formidable challenges including poverty, insecure housing, victimization, and isolation, knowing that any one of these factors may jeopardize their ability to maintain custody of their children (Gopfert, Webster and Seeman, 2004: 163; Sands, Koppelman and Solomon, 2004: 322).

A number of Canadian studies consistently report that women with enduring mental illness tend to be poor and insecurely housed (Nelson 2006:

250-260; Wilton, 2004: 26). Indeed, women's personal narratives about the experience of mental illness regularly highlight poverty as a complicating aspect of mothering in illness (Montgomery, Tompkins, Forchuk and French 2006: 7). For example, women relying on Ontario Disability Support receive financial assistance that is almost 40 percent below the poverty line (Schizophrenia Society of Ontario, 2006: 1). Although low income does not cause mental illness, poverty exacerbates the challenges of coping with and recovering from illness or is a consequence of having been ill (Nelson, 2006: 259; Wilton, 2004: 36). First person narratives can explicate how women living with illness and poverty care for their children. Personal narratives "recount past attempted solutions to how they should live and are part of their ongoing attempts to seek present ways of living" (Frank, 2002: 3). Frank asserts that they are accounts of a lived life, a telling about *things that matter* to individuals.

As Leslie Doty Hollingsworth (2004) observes, the presence of maternal mental illness is "used to 'fast track' the termination of parents' rights to the custody of their children" (199). In addition, as Alan W. Leschied and colleagues (2006) found, "[t]he percentage of children who are in the care of the CAS [Children's Aid Society] increased from almost half of the children in care coming from poor families in 1995 to eight of ten children in 2001 coming from families who are on some kind of social assistance" (41). Children who become involved with child protection services are predominantly poor; lack of appropriate housing, poor diet and inadequate provision of the necessities of life often make them as vulnerable to negative outcomes.

By association poverty makes mental illness visible as mothers rely on numerous social services. In fact, an in-depth study of the perception of parents involved with child protection services, in British Columbia, identified poverty as their greatest obstacle to parenting (Russell, Harris and Gockel, 2008: 87). Temporary and often permanent removal from their child's life becomes a common outcome for mothers with mental illness who do not have access to the personal, financial and social welfare resources required to raise a child in our society. Considering the dominant cultural narratives that contextualize the lives of this group of mothers, there seems to be little hope of a 'happily-ever-after' ending to their stories as mother.

Sara Allen, Shirley R. Klein, and E. Jeffrey Hill (2008) offer a process-oriented conceptualization of traditional family carework. Their resultant model delineates daily caring processes typically engaged in by women and shaped by the family's dynamic situational contexts. These pragmatic processes are significant to influencing individual, familial and social outcomes. The utility of this model can be found in the interplay among a family's contexts, carework processes and outcomes in illuminating the often invisible components of carework.

This paper shows how a mother, Claire, living in the context of enduring serious mental illness and poverty, undertook both tangible and intangible carework processes for her child, at a distance. Although Allen and colleagues

acknowledge that their model’s applicability in nontraditional or marginalized family units has not been fully explored, it does offer a framework for discussing elusive carework processes. Three sequential periods of this mother’s perceived carework are identifiable as: 1) I am Claire, I am Becoming Mother; 2) I am Claire, I am Mother; and 3) I am Auntie Claire, I am still Mother. In each of these phases, the context, processes and outcomes will be described and illustrated through this mother’s personal narrative. Efforts have been made to maintain the integrity of Claire’s story by refraining from interrupting the narrative to the fullest extent possible.

I am Claire, I am becoming mother – the context

Claire’s account provides a description of her individual, familial, and social contexts over the course of her experience of becoming a mother. Her narrative is personal. There is an absence of explicit connection to structural influences impacting this experience: income security, access to work or educational opportunities and other community supports apart from mental health services.

Claire is a woman residing in her home community in Northern Ontario with her partner of over ten years. She talks about having a lifelong desire to “be a mother,” and in her late thirties she became pregnant. Being pregnant was not an impetus for marriage despite her partner’s numerous offers:

Well, I wanted to be a mother because I wanted to experience the pregnancy and the whole thing ... I wanted to be a mother to a baby. I wanted to know how it felt, the whole thing. But once it became real I, I didn’t want to be pregnant, and then I, I was just fighting it. It was too much for my mind to take that I was really pregnant you know, and when I was seven months I landed in the hospital. I had to be hospitalized and I had to be, I had to take the medication ... I had to keep taking the medication, ahh ... and I was thinking this would affect my baby for sure. You know, all the drugs I have to take. It was just too much. I really prayed and everything so that umm, because I had never been pregnant before. It scared me. It scared me a lot. But I wanted to know how it felt to be a woman, to go through the pregnancy and ahh, ahh ... have the baby and take care of the baby and see how it really was in life. I’d heard about it all my life, and I wanted to experience it.

Claire makes reference to her need for an inpatient psychiatric hospitalization during her pregnancy. Her worry for her unborn baby is typical of most expectant mothers, but it also reflects her insight into the implications of serious mental illness and treatment that was initially diagnosed in her late teens.

She recounts that she graduated from high school with an academic average high enough to earn her admission to a competitive university program. During her studies, however, she found herself overwhelmed: “[I] didn’t know

what was going on.” The sudden, unexpected presence of illness shifted her contextual reality. During the formative years of her early womanhood, she was “hospitalized almost every six months.” Her persistent illness was intrusive in its degree of severity, duration and its disabling affects. By the time of her pregnancy, Claire identifies her illness as “mostly manic but sometimes depressive.” In addition, as Claire describes:

The illness always, always . . . and I could, I could blame things on my illness, but it's true. I mean you get all confused and, you know, I stopped taking my pills, and then I wouldn't sleep at night, and I'd end up in hospital every time almost, except when [a family member] died. I needed shock treatment to get out of that rut. I tried to go to university. I'd, I'd have a degree. And I still, I don't even know how I managed really because I was sick in my second year [of university]. Very hard to do something with, when you have this illness. Very hard and to keep your morale up and to keep everything um, stable and balanced.

Claire acknowledges that the presence of her illness and frequent hospitalizations has impacted her relationship with the father of her baby. She shares that he also lives with a chronic condition and, like her, receives a meager disability pension. Early in their relationship she experienced what she describes as unpredictable domestic violence. Over time, however, Claire suffered less frequent “sucker punches,” and she characterizes her current relationship with her partner as more positive. “He is very good to me, he thinks of me, you know, he is in my life and I really love him.” She discusses the dynamics of their relationship within the context of coping with illness, poverty and her preparations for motherhood.

Claire’s following description illustrates the limiting nature of her social location that created structural barriers in doing the planning and personal preparation for becoming a mother. Circumstances of poverty interfered with her desire “to be responsible as a mother.”

We were just living in a boarding room at the time. He had a room and I had a room beside him. So it was a very difficult time because we were living in just a little room and we had nothing. We didn't have any money you know only our disability pensions.

In addition to her severely disabling poverty, Claire received troubling messages that called her ability to mother into question. “Everyone else was telling me I couldn’t take care of the baby when I found myself pregnant. Even my mother was telling me things like that.” Illness thus interrupted the transmission of support and wisdom that prospective mothers look for from other women in their lives. Even the experience of delivering her child was shaped by her illness.

It took me about eight hours, and not too bad; I didn't feel the normal pains that I'd always heard about all my life, you know—it hurts, and this and that, and it didn't hurt me because I'm always drugged ... ah, I'm always ah, under medication, ah ... I had to be induced and ah, everything like that. It didn't come naturally ah, because of the medication I'm on.

I am Claire, I am becoming mother – the processes

Claire's description of becoming mother focused on two of the central carework processes undertaken by families as described by Allen, Klein and Hall (2008) to achieve the outcome of having a healthy baby. These include elements of interfacing and provisioning processes. With respect to interfacing processes, Claire accessed the health care system not only to protect her mental well-being, but to ensure safety for her baby in pregnancy. The treatment and counsel she received from her trusted mental health care professional was comforting and reassuring:

I had to keep taking the medication and I was thinking this would affect my baby for sure ... you know all the drugs I have to take. I didn't want any damage to the baby. That was upsetting, worrisome for me. The doctor said I should stay on my medication and he said he knew of other babies and that they were doing well you know. But, I said to myself, “the doctor knows best.”

Claire identified less success during this period with provisioning processes given her extreme poverty. She described attempts to promote her health and that of her baby by quitting smoking, but “it was very hard.” Although Claire demonstrates insight to the emergent family needs as a result of pregnancy, Claire could not consistently engage in processes to affect a successful outcome:

All though the pregnancy, [my partner] was wanting to get his truck in working order so that when it came time to bring me to the hospital his truck would work. See, a man doesn't think like a woman. And, and all that time we should have been looking for an apartment. We should have been looking for an apartment for the baby and stuff for the baby, you know, and things like that so when it came time to leave the hospital with the baby I have a place to bring her.

I am Claire, I am becoming mother – the outcomes

Claire's context and carework processes during her experience of becoming mother influenced individual outcomes, and contributed to emerging self-doubt about the ability of her partner and herself to fulfill the imminent obligations of parenthood. Claire's increasing self-doubt about being competent to mother in illness and poverty were validated by others' verbalized concerns. “Everyone else was telling me you know, taking care of a baby is more than

your think. Even my mother was telling me things like that.” Her self-doubt was compounded by the stress of an uncertain co-parenting dynamic that she hoped to develop with the child’s father.

I wasn't sure of him as a father, even if we should be a couple and all that. I was living with him, but, it was all these problems that I had that made me sick at seven months, I guess, which made me sick.

Still despite ambivalence regarding her relationship with her partner, Claire addressed the impact of poverty and the lack of supports as the most significant barriers in her transition into motherhood. To become mother under such vulnerable circumstances was overwhelmingly stressful. Her description depicts a sense of personal powerlessness:

Nobody could have helped us out of this, I don't think. It would have, it would have been useful if we would have had a place for her when it was time, you know, and then maybe we would have had a chance.

I am Claire, I am mother – the context

The actualization of her goal of becoming a mother begins with the hospitalized birth of a “healthy child”:

Oh I loved [my child] the minute I saw [my child] and [my child] was healthy, and that's what worried me, you know, with all these pills I'm taking ... if this is going to affect [my child's] health in some way, but [my child] was healthy and that was all that matters.

This event, however, is punctuated by her awareness of impending personal loss, and family vulnerability marked by the disparity between the transition to motherhood that she had anticipated all her adult life, and the actual birth experience. She perceives her family vulnerability as related to her inability to secure suitable accommodations prior to the birth of her child:

Nobody could have helped us out of this, I don't think. It would have, it would have to be us that would have had a place for her when it was time, you know, and then maybe we would have had a chance, but still I don't think I could have taken care of her. I think it would have happened anyway because everyone was telling me, you know, you will never be able to take care of that baby.

For Claire, this perceived lack of support was not unfamiliar. She typifies her past experiences as being continually ‘judged’.

People don't understand mental illness. As soon as you mention you are

mentally ill, that kind of closes the door. That is what I've found. People don't understand.

As a result of the judgment that Claire and her partner were unable to parent, her partner's sister and husband became the temporary primary caregivers to the child following discharge from hospital. During this "separation" from her child, she engaged in processes to demonstrate her responsibility as a mother, even from a distance. As she asserts "I put this baby into the world, and [the child] was my responsibility."

I am Claire, I am mother – the processes

Claire's description of being a mother continues to focus on the previously identified carework processes, interfacing and provisioning. Additionally, she incorporated sparsely detailed attempts at leading, nurturing and renewing processes. Consistency with maintaining these processes was undermined at least partially because she was limited to weekly supervised visits with her child.

Early intervention by child welfare services resulted in what Claire perceived to be temporary custody of her child to extended family members. This arrangement relocated Claire to the periphery of her child's life. Inherent in the interfacing and nurturing processes is the need for contact between mother and child. Although the Claire is unclear of the legal nuances of the custody arrangement, she reports having supervised weekly visits during her child's first few months of life:

My child had a foster mother, a foster parent. The foster parent would bring my child to Children's Aid and we would go see our baby. I have pictures of that. Like we have her for about an hour or so every week. I got to hold the baby. I got to talk to the baby. But I never took care of the baby just by myself. I told them when they took the baby, "I don't think I could take care of this baby." ... Staying up at night, I don't think I could go without sleep because it's my major thing ... if I go without sleep for two nights in a row, then I get sick. So I didn't feel that I could do that, and I had heard that this baby, she probably would have cried at night.

This verbalized recognition of "knowing my limits" communicates her recognized need to care for self as a woman with an enduring illness (renewal) attempting to balance the responsibility to care of her child (interfacing). Claire captures the challenges of balancing self-care with care for other, as follows:

If I had a baby at home, and I'd had to go to hospital, who would take care of my baby? There's a dad there, but that would put a lot of pressure on him, and I usually stay about a month when I go to the hospital. This

would tear me apart just to think that I'm not there for my baby. That's why I'm saying that I can't take care of her totally, you know, because I can't even take care of myself sometimes.

Claire provided for the temporary delegation of daily mothering processes to another woman by working cooperatively with child welfare services. Claire's involvement with this service was compelled by a lack of viable alternatives. This "difficult" relationship, in part, demonstrates her personal sacrifice and central commitment to her meeting her child's basic needs of suitable shelter, nutrition, and attachment. In light of her impoverished circumstances together with her understanding of her illness triggers, and her commitment to responsibilities as mother, she temporarily entrusted her partner's sister to undertake the daily carework processes. Sacrificing the desire to have her child with her can be seen to demonstrate profound selflessness by a mother trying to look after the best interests of her child:

We went to court, two or three times, and about the third time, it was decided that my sister-in-law was granted custody. And we signed something. I wish I could remember what it is that we signed, but it wasn't that they [partner's sister and spouse] could adopt her or anything like that. It was just something like that they could take care of her.

I am Claire, I am mother – the outcomes

Claire's context and carework processes over the course of her experience of becoming a mother influenced the emergence of her individual outcome, and the personal realization that "I never had a chance" to become competent as a mother. This realization was characterized by remorse and self-blame. Although she acknowledges agreeing with the views of others that the daily child care tasks required for her baby was best provided by others on a temporary basis at no time did she envision relinquishing her place as mother. The involvement of child welfare services in concert with her partner's extended family ultimately had a more substantial affect on Claire's mother role than she initially anticipated: she was moved from the centre of the care circle to the periphery. This phase ended with the establishment and sanctioning of a parallel family carework context and processes in which Claire was not recognized as an active participant. Claire's place of mother at a distance equates with a loss of agency.

I am Auntie Claire, I am mother – the context

This last segment of Claire's account is predominantly a description of her child's new familial context, in which Claire and her partner became increasingly inconsequential and marginalized. Soon after signing legal documents that Claire seems, at least in hindsight, to not have fully understood, "the supervised visits stopped." Claire's child was now residing with and cared for by

her partner's sister, brother-in-law, and their three children. Over time, Claire received increasingly fewer invitations to family gatherings, such as barbeques and her child's birthday. When Claire and the baby's father did participate in family visits their attendance was often initiated and mediated by her partner's mother. This lack of inclusion was rationalized by the baby's foster father on the grounds that his family is "busy, busy, busy."

Contributing to an increasingly strained relationship between Claire and the baby's foster mother were differences in access to social and economic resources. Claire's situation of poverty limited the ways she could provide for her child, while the baby's surrogate parents were employed and could provide more, materially, for the child.

I didn't really see her grow up ... now she's getting taller ... she is growing. They are all worried about her teeth, and she is going to have to wear braces. But, if she has [her father's] teeth, they'll have to be pulled. He has beautiful dentures now.

This demonstrates the significance of the family's economic context shaping what provisioning carework processes are possible. As Marilyn Callahan and Karen Swift (2006: 211) suggest, poverty is closely correlated with neglect which in turn is the greatest contributing factor to child protection involvement with a family.

Despite her cautious efforts to continue to be involved as mother, conflict often arose between Claire and her child's daily surrogate caretakers, becoming another barrier and a source of personal turmoil. Another indication of Claire's shifted place as mother is the way in which her child, now school-aged, refers to the biological aunt as "Mommy," and her as "Aunt Claire."

I can't talk to [the foster mother] because she'll, she'll get mad or she'll hang up the phone, or she's not very, very welcome to taking new suggestions... So I don't know what ... it's sad. I guess stuff happened and they just, she just can't get over that, you know; and because of that she doesn't care who she hurts.

I am Auntie Claire, I am mother – the processes

Claire's assigned role as Auntie did not diminish her commitment to the tangible and intangible carework attached to her mother identity. Even at a distance, she was steadfast in her perception of herself as mother, fulfilling the acts of carework to the extent she was able and permitted. Although contact with her child became sporadic and limited, she describes her interfacing efforts to create a space for her child in her now suitable home.

We have a [media recording] for her ... I bought it ... and [my child] just loves that tape ... wants to play it all the time and sings along. And we

have books for [my child] and I bought a colouring book, and I finally got some crayons for so that when [my child] comes abh, but we never get to see [my child], not as often as we want...

Because she wants the best for her child, and because her input is not valued by the foster parents, Claire questions the surrogate family's ability to ensure her child's well-being; however, when pressed, Claire does acknowledge the capability of the surrogate family:

I don't really interfere. I wouldn't interfere unless I saw that my child was being hurt or [the sister-in-law] was making a bad decision. I think she is a good mother to her kids because everything seems to be going well... I'm very seldom there, and what I see sometimes, is how she is treated. Is that how she is treated all the time? ...Do they give [my child] the attention she needs and everything?

Claire's distancing appears to give others the opportunity to protect, provide, nurture and lead the carework of her child on her behalf. Her decision to be self-silencing suggests a degree of sacrifice:

I know that I am [my child's] mother, but how could I exercise that, that... I can't just say "I'm your mother." Would she understand? I know she knows we are part of her life somehow... She doesn't realize totally why we have her pictures here and all that, but in her little mind she knows that there is something here and she asks "why do we come here?" So I think she is questioning in her mind.

I am Auntie Claire, I am mother – the outcome

Despite Claire's peripheral involvement in her child's life and her limited opportunities to actualize her carework intentions, she is adamant that her child "will always be [her] child."

I am her mother. I'll never deny that. I'm a mother. I know how it feels to be a mother, and to be denied seeing my own flesh and blood. I know how that feels. I like to see her more often, and maybe she will understand easier, more easily ... [my child] has a place there with us. It takes a long time. You have to be patient.

Accepting that her child was "still in the family" contributes to her hope that her child will eventually understand how she mothered in illness, and the contributing factors that determined the nature of her role as mother.

Indeed, as Claire makes clear, there is no ending to this personal narrative. For the rest of her life, regardless of access and her physical presence in her daughter's life, Claire is mother.

Conclusion

Claire's first person account tells a story that is determined by the effects of financial deprivation and illness that exacerbated anxieties associated with becoming a mother, and her ability to care for her child. She feared that the toll that mental illness took on her health and social welfare would undermine her ability to provide the day-to-day care that a child requires. Her narrative lends an important perspective to the discourse on relations between mental illness, poverty and mothering. Her expertise as a mother and a person with serious mental illness requires mental health and child welfare experts to reflect upon the professional assumptions that we bring to our roles. Women in Claire's position are compelled to make life changing decisions under incredible stress. It is typical of new mothers to feel insecure about their ability to assume the demands of a mothering role. With few personal and structural supports, most will not succeed. In Ontario, the Child and Family Services Act obligates all human services professionals to practice in a manner that makes the best interests of the child a priority outranking the desire of the mother and even client confidentiality. Claire's story does not call that obligation into question. Poor health was the explicit reason for Claire surrendering custody of her child. What is worth reflecting upon, however, is what might have been possible if Claire wasn't poor in a global sense: financially, and in terms of other informal and structural supports.

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