Stigma among Parents with Serious Mental Illness: Internalised Mental Illness Stigma in Mothers and Externalised Gender Stigma in Fathers.

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Statement of Originality

The thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to the final version of my thesis being made available worldwide when deposited in the University’s Digital Repository**, subject to the provisions of the Copyright Act 1968.

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Abstract

Scope: The numbers of people with serious mental illness (SMI) who are parents have increased in the last decade (Campbell, et al., 2012). These parents encounter discrimination and stereotypes that they are unfit to provide adequate parenting due to their illness (Ackerson 2003a). Public stigma among people living with SMI is extensive and can significantly impact on a person’s self-esteem and quality of life (Corrigan & Watson 2002a). Furthermore, parents may experience additional stigma associated with their gender due to traditional stereotypes and societal expectations and standards relating to parenting (Biernat, Mains, & Nelson, 1999; Bird, 1997, Wood & Eagly, 2012). Very little is currently known regarding the specific experiences of stigma that mothers, and in particular fathers with SMI face.

Purpose: The current study aimed to explore and compare the experiences of stigma for mothers and fathers with SMI relating to mental illness and gender and the associated impact of stigma on parenting experiences. The purpose of the study was to provide insights regarding the specific impact of stigma on mothers and fathers with SMI and directions for tailored interventions to support mothers and fathers and their families.

Methodology: Participants (N = 93) who previously identified as parents in the Second Australian National Survey of Psychosis (Morgan et al., 2012) from the Hunter, Orange and Adelaide regions of Australia completed a telephone survey which consisted of three main sections: (1) demographic, clinical and child-care information; (2) three subscales from the parenting domain of the Parenting Stress Index (3rd ed.; Abidin, 1995) including Competence, Role Restriction and Isolation and; (3) stigma items based on the Self-Stigma of Mental Illness Scale (Corrigan, Watson, & Barr, 2006), as well as items relating to perceived sources of discrimination. Relevant clinical and demographic information previously collected in the national survey was also included. Data were
analysed using two-step Multiple Hierarchical Regression models to explore gender differences on stigma variables and parenting variables, as well as similarities and differences between mothers and fathers in the relationship between stigma variables and each of the parenting variables. Chi-squared tests were also used to explore sources of perceived discrimination for mothers and fathers.

**Results:** Mothers were more likely than fathers to perceive and internalise stigma associated with the impact of their mental illness on their parenting. Conversely, fathers were more likely than mothers to perceive stigma associated with their gender on their parenting, however, rather than internalising this stigma, they were more likely to externalise, and hold stigmatising attitudes towards others. Mental illness stigma was associated with poorer perceived parenting competence and increased role restriction for mothers; gender stigma was associated with greater perceived isolation for fathers. Irrespective of gender, however, stigma of all forms investigated (public/self-stigma; associated with mental illness/gender) predicted poorer self-reported parenting experiences among all parents. Additionally, mothers were more likely to experience mental illness discrimination and family members were cited as the most common source of discrimination by both mothers and fathers.

**Conclusions:** Perceived stigma and discrimination is common among both mothers and fathers with SMI; however, mothers may experience greater perceived detrimental impacts of mental illness stigma relative to fathers, demonstrating greater tendency to *self-stigmatise*. In contrast, fathers may be more likely than mothers to *perceive* stigma associated with their gender on their parenting and may be more likely to exhibit greater stigmatising attitudes towards other fathers.

**Implications:** Interventions focusing on self-stigma and internalised negative stereotypes may assist mothers with SMI to improve perceived parenting competence
and reduce the impact of parenting burdens. Interventions for fathers with SMI addressing perceived gender stereotypes regarding parenting and externalised negative attitudes towards others may aid in improving social relationships for fathers and decrease isolation. Further research regarding stigma among parents with SMI is needed to continue to explore these concerns among parents and provide additional insights regarding tailored interventions to better support mothers and fathers and their families.
An Introduction to Stigma among Parents with Serious Mental Illness

Stigma has been defined as a discrediting attribute that makes a person flawed, dissimilar from the majority and undesirable (Goffman, 1963); ‘serious mental illness’ (SMI) includes persistent and chronic mental illnesses that most often refer to psychotic disorders and major affective disorders, combined with use of intensive mental health treatment over a prolonged period of time (Mowbray, Oyserman, Zemencuk, & Ross, 1995). Stigma for people with SMI is common, and has been described as a ‘second illness’, as these individuals are faced with managing not only the symptoms of their illness, but also a range of negative reactions from their social environment (Schulze & Angermeyer, 2003). These social responses can often have a more harmful impact on the person than the difficulties arising from the symptoms of the illness itself (Rusch, Angermeyer, & Corrigan, 2005). Behaviourally, stigma can inhibit help-seeking, impede a person’s opportunity to gain and maintain employment, access fair and adequate legal support, and negatively impact on a variety of relationships. Internally, stigma may result in poor self-esteem and confidence, low mood and potentially exacerbate psychiatric symptoms (Hocking, 2013).

Numerous efforts have been undertaken that aim to reduce negative public attitudes and discrimination towards people with mental illness (Hart & Phillipson, 1999; Jorm; Pinflo et al., 2003; Tanaka, Ogawa, Inadomi, Kikuchi, & Ohta, 2003). Despite these anti-stigma initiatives, however, research indicates that stigma associated with SMI, unlike stigma relating to other mental illnesses, have increased over time (Phelan, Link, Stueve, & Pescosolido, 2000). Further research is therefore required to better inform interventions to reduce stigma and its impact. More recently, treatment approaches have focused on targeting the impact of stigma on the individual. An
important step in this area should be carried out with a group whose experiences have largely been overlooked in the literature: parents with SMI.

Parenting, irrespective of gender or mental illness, is a valuable part of one’s identity and can contribute to one’s self-esteem and confidence (Ackerson, 2003b). Being a parent can create purpose and meaning in one’s life and is a role many members of society strive to attain (Ackerson, 2003b). Parents with SMI however, experience stereotypes regarding their inability to not only look after themselves, but also their failure to adequately care for their children (Ackerson, 2003a). The terms ‘multiple stigma’ and ‘double stigma’ apply to individuals who experience more than one stigmatising condition (Conner & Rosen, 2008; Daftary, 2012). Given gender stereotypes associated with parenting as a predominantly female domain, and the potentially higher expectations of mothers in society, both fathers and mothers with SMI are faced with multiple stigma associated with not only their illness, but also their parenting capacity and their gender.

Despite many individuals with SMI being parents (Matthew Gray, Lixia Qu, & Ruth Weston, 2008), and these more serious disorders being the most stigmatised of the mental illnesses (Świtaj, Wciórka, Smolarska-Świtaj, & Grygiel, 2009), very little research has thus far investigated stigma associated with parenting experienced by individuals with SMI. Further, fathers with SMI have been largely excluded in the research pertaining to parenting, and limited attention has focused on how the experiences of stigma may differ between genders. Increased knowledge regarding the experiences of stigma for parents with SMI will aid in efforts to reduce the impact of stigma on parents, and assist to inform tailored intervention programs to more appropriately support mothers and fathers and their families.
Due to the limited current knowledge related to stigma among parents with SMI, this study aims to provide insights regarding the experiences of stigma to parents living with SMI, as well as the potential differences between, and impact of, stigma for mothers and fathers. The purpose of this critical review is to summarise and critically evaluate recent empirical evidence surrounding stigma as it relates to SMI, gender and parenting and to highlight the gaps in current knowledge in these areas.

The review is organised in four main sections. Firstly, it will provide an overview of the types and components of stigma and critically discuss stigma associated with SMI, the experiences of stigma for individuals with SMI and how stigma may differ between genders. Secondly, it will assess research investigating gender and parent stigma and the potential impact of gender stereotypes on mothers and fathers with SMI. Thirdly, it will critically examine the current literature regarding stigma relating to parents with SMI, the experiences of stigma for mothers and fathers and the impact and implications of stigma for parents. Lastly, it will provide a summary of the gaps in the research to date, and an overview of the aims and hypothesis of the current study.
Stigma among Individuals with Serious Mental Illness

The aim of this section is to introduce stigma as it relates to SMI. This section provides an overview of contemporary theories of stigma and the functions of stigma. This section introduces public stigma and self-stigma associated with SMI. The components of stigma, including stereotypes, prejudice and discrimination are described to help illustrate the different mechanisms in which stigma may be applied to people with SMI. This section discusses the interrelationship between public stigma and self-stigma, and critically evaluates the research regarding the experiences of these two types of stigma for people with SMI, generally, and how the experiences of stigma may differ between genders.

Serious Mental Illness in Australia

Mental illness is a significant social and public health issue in Australia. An estimated 20% of Australian adults meet criteria for a mental illness at some point in their lives (Australian Bureau of Statistics, 2008). Mental illness can have a significant psychological and emotional impact on the individual and their family. Many people with mental illness require extended inpatient or outpatient health care, assistance with housing, or are unable to engage in employment (Morgan et al., 2012). Further, mental illness also incurs a substantial societal financial burden (Morgan et al., 2012).

As noted earlier, serious mental illness (SMI) refers to persistent and chronic mental illnesses that cause significant functional impairment and are combined with use of intensive mental health treatment over a period of more than one year (Dickey, Normand, Weiss, Drake, & Azeni, 2002; Mowbray, et al., 1995). Serious mental illnesses most commonly consist of psychotic disorders; however other diagnoses such as major affective disorders are also often included. (Dickey, Normand, Weiss, Drake,
This review will mostly focus on people living with a psychotic disorder.

Psychotic disorders are a diverse group of mental illnesses that are believed to originate through biochemical imbalances in the brain, as well as the experience of significant psychosocial stressors over time (Broome et al., 2005). Symptoms associated with psychotic disorders may include delusions, hallucinations, disorganised thinking, abnormal motor behaviour, as well as negative symptoms such as decreased emotional expression and motivation (World Health Organization, 1993).

Schizophrenia is the most common of the psychotic illnesses. Other psychotic illnesses according to the International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10; World Health Organization, 1993) include schizotypal disorder, schizoaffective disorders, delusional disorders, acute and transient psychotic disorders, other nonorganic psychotic disorders and unspecified non-organic psychotic disorder.

Psychotic disorders are a significant concern in Australia. The 2010 second Australian national survey of psychosis (Morgan et al., 2012) covered 1.5 million people aged 18-64 years. The survey identified that approximately 63,500 adults with psychotic disorders received treatment from public mental health services in a 12 month period in Australia. Males were more likely than females to be in contact with public services over 12 months, with estimates of approximately 38,800 (61%) and 24,600 (39%) for males and females respectively (Morgan et al., 2012).

Psychotic disorders have also been shown to incur a substantial financial burden on Australia. Annual societal costs are estimated to be over $46,000 for the average patient with psychosis, comprising in lost productivity, inpatient mental health care costs as well as costs associated with community mental health care (Carr, Neil, Halpin,
Holmes, & Lewin, 2003). Overall, psychotic illnesses are estimated to costs the Australian government at least $1.45 billion per annum, while societal costs are at a minimum of $2.25 billion per annum (Carr et al., 2003).

Despite some individuals with SMI experiencing debilitating symptoms, many people can also recover and function well in society. Treatment approaches for SMI are often focused on symptom reduction aimed at improving quality of life. However, an often over-looked aspect of recovery relates to the experience of stigma. Research has shown that stigma can exacerbate psychiatric symptoms, reduce quality of life and decrease help seeking behaviour (Carr & Halpin, 2002).

**Stigma and its Functions**

Conceptualisations of stigma originated in the early 1960’s. Erwing Goffman defined stigma as a discrediting attribute that makes the stigmatised person undesirable, different from others and unaccepted by the majority (Goffman, 1963). Current definitions have extended this, describing stigma more broadly as a phenomenon that functions to devalue those who deviate from societal norms (Heatherton, Kleck, Hebl, & Hull, 2000; Hocking, 2013).

Stigmatising others may be a practical and effective response to perceived threats, real danger, or fear of the unknown (Leary, 2001; Yang et al., 2007). Stigma is believed to have three main functions: Disease avoidance, exploitation or domination and norm enforcement (Phelan, Link, & Dovidio, 2008). Disease avoidance is described as having evolutionary origins, and relates to one’s natural instinct to avoid those with diseases that may potentially harm the individual in some way. According to Phelan and colleagues, stigma associated with mental illness has most often been found to be associated with this function. Exploitation or domination, on the other hand, occurs when control is exercised on members of the stigmatised group, so that the dominant
group may maintain power (Phelan et al., 2008). Lastly, norm enforcement involves efforts to maintain social conformity, to clarify the boundaries of social behaviour and identity and the consequences of non-conformity (Phelan et al., 2008).

Hence, there are a variety of different reasons for why stigma may arise. Irrespective of its function, there are two main forms in which stigma occurs: Public stigma and self-stigma (Brohan, Slade, Clement, & Thornicroft, 2010; Corrigan, 2005).

**Public Stigma of Serious Mental Illness**

Public stigma is the reaction that the general population has to a stigmatised group (Corrigan & Watson, 2002b). It encompasses the attitudes, emotional reactions and behavioural responses of the public towards marginalised others. Public stigma consists of three main components including stereotypes, prejudice and discrimination (Corrigan et al., 2002).

Stereotypes are widely held knowledge structures which encompass beliefs about certain characteristics and qualities regarding a particular social group that are learned by members of society (Corrigan, Larson, & Rusch, 2009). Numerous stereotypes exist concerning people with mental illness. For example, common public views include that people with mental illness are dangerous or incompetent (Corrigan et al., 2002). Other stereotypes include beliefs such as people with mental health problems are to blame for their illness and are undeserving of help (Corrigan & Watson, 2002a). Theses stereotypes can be triggered by direct observation of behaviour or symptoms associated with mental illness, by being informed that a person has a psychiatric diagnosis or by inaccurate and negative depictions of mental illness in the media (Rusch et al., 2005).

The stereotype content model (Fiske, Cuddy, Glick & Xu, 2002) poses that there are two fundamental dimensions of social stereotypes: warmth and competence. Studies
have indicated that people with mental illness are stereotyped as low warmth and low competence (Sadler, Meagor, & Kaye, 2012). Stereotypes of coldness and incompetence have been shown to be associated with negative attitudes such as contempt and disapproval. Hence, according to this model, people with mental illness may experience stigma as a result of these social stereotypes.

Psychotic disorders are regarded as the most stigmatised of the mental illnesses (Świtaj et al., 2009). While other mental illnesses, such as depression, anxiety disorders and eating disorders, have seen increasing public interest and acceptability, psychotic illnesses remain associated with negative stereotypes, such as poor prognosis, dangerousness, unpredictability and incompetence (Angermeyer & Matschinger, 2004; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Reavley & Jorm, 2011). Phelan and colleagues (2000) found that despite improvements in attitudes regarding other mental health diagnoses over the past 40 years, in 1996 compared to 1950, the general public were 2.5 times more likely to perceive those with psychosis as dangerous. Given that psychotic disorders are generally less common, more chronic in nature (Jääskeläinen et al., 2012), and are less publicised in mental health media campaigns compared to other disorders (Wesley Mission, 2007), the public may have less knowledge and understanding about psychotic illnesses and this may therefore promote greater undesired public stereotypes.

Prejudice is the negative emotional response that occurs when a person endorses negative stereotypes associated with a stigmatised group (Corrigan et al., 2009). Common public responses towards people with mental illness include anger, fear and disgust. Prejudice may subsequently result in discriminatory behaviours towards people with mental illness. These behaviours may vary from verbal abuse, avoidance, or limiting a person’s opportunities (Alexander & Link, 2003; Link & Phelan, 2001; Wahl,
Public attitude surveys indicate that discrimination occurs for people with SMI in the workplace (Wesley Mission, 2007; Reavley & Jorm, 2011), as well as in a variety of social relationships (Angermeyer & Matschinger, 1995).

For the individual, public stigma may be perceived or experienced (Corrigan & Watson, 2002b). Perceived stigma is the fear or awareness of stigma by those with the stigmatised condition (Verhaeghe & Bracke, 2011). It includes what an individual thinks most people believe about the stigmatised group in general and how the individual thinks society views him/her personally as a member of the stigmatised group (LeBel, 2008). Vorauer (2006) has used the terms ‘meta-stereotypes’ and ‘meta-prejudice’ to denote group members’ beliefs about attitudes and responses to their group by others.

The term ‘stigma consciousness’ extends this, and is the degree to which one expects to be stigmatised by others (Pinel, 1999). Research suggests people with higher stigma consciousness are more likely to perceive discrimination from others towards them and their group compared to those with lower stigma consciousness (Crocker & Major, 1989; Pinel, 1999).

Experienced stigma on the other hand, refers to the experience of actual discrimination and/or participation restrictions on the part of the stigmatised individual (LeBel, 2008). People with SMI may perceive others to hold stigmatising attitudes or expect to be discriminated against by the public, however, may not necessarily experience discrimination (Gerlinger et al., 2013). Individuals with SMI may adopt numerous strategies in an effort to cope with stigma associated with their illness.

**Behavioural responses to stigma.** Many people with mental illness report concealing their diagnosis and/or their contact with mental health services in attempt to avoid cueing stereotypes that are known to attract prejudice and discrimination.
Parents with Serious Mental Illness (Oyserman & Swim, 2001; Schulze & Angermeyer, 2003). Some studies indicate that less than a third of people feel at ease to talk about their illness (Karidi et al., 2010). In a study in Poland by Świtaj and colleagues (2009), with about 150 individuals with schizophrenia, more than 80% reported avoiding telling others outside of their immediate family about receiving psychiatric treatment for fear of rejection from others.

There may be both practical and unhelpful outcomes to concealing one’s mental illness. For some, concealing their illness may allow a person to retain their rights and continue to have access to the same opportunities as others. However, for others, on-going attempts to hide their illness may have a significant impact on relationships and subsequently result in withdrawal and social isolation (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2002; Wahl, 1999). In the second Australian national survey of psychosis (Morgan et al., 2012), participants reported that in the previous 12 months both the fear of stigma (23%) and actual experience of stigma (21%) had hindered their participation in desired life activities.

People with mental illness may also refrain from accessing psychological treatment in an effort to avoid being given a diagnostic label (Corrigan & Wassel, 2008; Link et al., 2002). Label avoidance subsequently may protect the individual from stigma; however, restricting access to treatment can result in further deterioration of mental health and limit opportunities to gain social supports of others who share their stigmatised experiences (Andrews, Issakidis, & Carter, 2001; Corrigan & Wassel, 2008). Further to the aforementioned behavioural responses, people also tend to experience a range of internal emotional reactions to stigma.

**Self-Stigma of Serious Mental Illness**

Self-stigma is agreement with and internalisation of public stigma by individuals with the stigmatised condition (Corrigan & Watson, 2002b). Similarly to public stigma,
self-stigma also encompasses stereotypes, prejudice and discrimination. However, when a person self-stigmatises, they direct negative stereotypes towards themselves. For example “I am dangerous and incompetent because I have a mental illness”. When a person perceives these beliefs as a true reflection of themselves, this may also be associated with thoughts regarding lack of personal competence, beliefs that they are undeserving of the rights provided to others or that they are personally to blame for their illness (Boyd-Ritsher, Otilingam, & Grajales, 2003; Corrigan & Watson, 2002b; Wahl, 1999).

Prejudice in self-stigma involves negative emotional reactions towards oneself. These reactions may include shame, guilt and humiliation, and can result in poor self-esteem and low self-efficacy (Corrigan & Watson, 2002b). Subsequently, personal acts of discrimination such as failure to access treatment, or to pursue employment or social opportunities, are also common (Corrigan & Watson, 2002b). The detrimental impact of self-stigma on a person’s life goals has been termed the ‘why-try’ effect (Corrigan et al., 2009). Self-stigma in mental illness has also been shown to be associated with increased suicide risk and depression (Sharaf, Ossman, & Lachine, 2012), less trust of mental health services and reduced satisfaction with mental health treatment overall (Verhaeghe & Bracke, 2011).

Research suggests that there is an interrelationship between perceived stigma and self-stigma: Studies indicate that the greater the level of perceived stigma the more likely one is to self-stigmatise. These co-variations are typically interpreted as due to perceived stigma causing self-stigma. For example, some people with mental illness who expect to be discriminated against have been found to be more likely to confirm negative stereotypes about their group and are more likely to have reduced self-esteem (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001) and higher levels of
depression (Link, Struening, Rahav, Phelan, & Nuttbrock, 1997). Research has also
found that people with mental illness who expect stigma are less likely to engage in
employment and social opportunities (Lee, 2002) and are less likely to comply with
treatment (Sirey et al., 2001).

On the contrary, other research has suggested that the extent of perceived stigma
may be dependent on, and be caused by one’s internal experience of self-stigma.
‘Identity threat theory’ (Steele, 1998; Steele, Spencer, & Aronson, 2002) posits that
when someone is high in self-stigma (i.e. more likely to agree with and internalise
negative stereotypes about themselves and their group), the more likely they are to
perceive ambiguous behaviours from others as negative, and therefore the more likely
they are to elicit and experience public stigma and thus expect to be stigmatised from
others in the future (Crocker & Major, 1989; Crocker, Major, & Steele., 1998; Major &
O’Brien, 2005; Major, Quinton, & McCoy, 2002). More recent accounts acknowledge
the possibility of a bidirectional link between perceived stigma and self-stigma, where
one feeds the other in an iterative process over time (Major & O’Brien, 2005).

Although the majority of the research presents stigma as typically resulting in
negative outcomes, other research has demonstrated that the expectation of, or
perception of stigma does not necessarily lead to self-stigma or the internalisation of
negative stereotypes. Some people with mental illness perceive public stigma as
unreasonable or unjustified and choose to reject it. Research suggests that rejecting
public stigma can result in numerous positive outcomes including greater personal
resilience, higher self-esteem and self-efficacy, empowering people to seek and
maintain treatment, and even encouraging people to take proactive action to advocate
against stigma (Corrigan & Wassel, 2008; Corrigan & Watson, 2002b).
Crocker and Major (1989), argue that people who are stigmatised may use a variety of techniques to protect their self-esteem and reduce the potential negative impact of stigma. For example, people may attribute negative responses they receive from others to prejudice against their group (vs. the self); they may compare their outcomes with those of the stigmatised (vs. dominant) group. They may disregard negative characteristics, and instead value more positive qualities of their group (Crocker & Major, 1989). In line with this, Wang, Stroebe, and Dovidio (2012) found that women in a high stigma consciousness condition tended to attribute failures at receiving a desired job to the perceived gender prejudice of a male interviewer, rather than to themselves. As a result, they protected their self-esteem and engaged in positive coping strategies in response to perceived prejudice.

In summary, it is evident that there is a relationship between the degree to which one expects to be stigmatised by others and the extent to which one internalises stigma. Findings are however mixed regarding whether perceived stigma results in greater self-stigma or whether the reverse occurs—one’s own perception of themselves distorts their view of their interactions with others through a stigmatised lens (Major & O'Brien, 2005). Research findings are also not clear regarding the exact nature of associated responses to perceived stigma: Research suggests that people may internalise stigma resulting in mostly negative outcomes, or choose to reject it, and alternatively adopt strategies to protect their self-esteem and cope with stigma in a positive way.

This mixed and complex evidence may reflect the fact that the determinants of perceived stigma, self-stigma, and their associated reactions are all individually and contextually dependent. Irrespective of their exact place in the causal chain of events, there is obviously a need for both of these two sides to individuals’ experience of stigma.
to be explored further and to be studied together to gain deeper insights into how each dimension contributes to stigmatised individuals’ overall stigma experience.
Public and Self-Stigma Experiences for Individuals with Serious Mental Illness

The large majority of research has focused on public attitudes towards people with SMI. Little research attention has thus far been paid to the actual experiences of stigmatised individuals. For individuals with SMI, both perceived and experienced stigma is common. A recent meta-analysis by Gerlinger and colleagues (2013) found that on average 65% of people with psychotic illnesses perceive stigma and 56% report experiencing stigma. People with SMI report the perception of, and the experience of both public and self-stigma in a variety of forms and contexts.

One study in Germany investigated the experiences of stigma among 25 individuals with schizophrenia (Schulze & Angermeyer, 2003). Focus group discussions indicated that stigma was present in interactions with neighbours, family members, mental health professionals, medical staff and in the media (Schulze & Angermeyer, 2003). Participants in this study described a variety of negative public stereotypes associated with their illness, including being ‘crazy’, irresponsible and untrustworthy. They believed that the media portrayed people with schizophrenia as violent, dangerous and incompetent. The ‘schizophrenia label’ was described as shaping people’s perception of their identity, regardless of whether they were currently experiencing acute symptoms of their illness. Perceived discrimination experienced by this group included being ignored, or alternatively carefully watched over, by neighbours and family members; perceived limited interest in their person by mental health professionals; lack of tolerance from health care staff for re-current inpatient hospital admissions; and beliefs that physical health complaints were minimised by medical staff.

Another study in the United States by Dickerson and colleagues (2002) investigated the experiences of stigma for 70 individuals with schizophrenia receiving
community care. All but one participant reported having at least one experience of stigma. About 70% of participants reported concerns about being viewed unfavourably by others due to their psychiatric illness. Around half indicated having heard offensive statements from others and negative media accounts about people with psychiatric disorders. The most common sources of stigma for this group included general community members (61%), employers (36%), mental health professionals (20%), family members (19%) and friends (14%).

Many individuals with SMI also report internalising the public stigma they experience. In the meta-analysis by Gerlinger and colleagues (2013), self-stigma was found to be a common occurrence for people with psychotic disorders. On average, approximately half of people with psychotic illnesses across the studies reviewed reported the experience of shame as being the most common impact of self-stigma.

Some research has also found evidence of the interrelationship between self-stigma and perceived discrimination. A 14 country study conducted in Europe with over 1,200 people with psychotic disorders receiving community mental health treatment found that 42% reported moderate or high levels of self-stigma (Brohan, Elgie, Sartorius, & Thornicroft, 2010). Self-stigma was found to be less common than perceived discrimination, however, with almost 70% reporting discrimination. The authors noted that there was a significant positive association between self-stigma and perceived discrimination, with perceived discrimination being more common among those who reported high self-stigma.

Together, these studies suggest that both perceived stigma and self-stigma may be a common occurrence for people with SMI. Further, research suggests the positive association between self-stigma and perceived discrimination for these individuals. Although research is beginning to provide insights regarding the experiences of stigma
for people with SMI, there is currently limited research investigating gender differences in these experiences.

**Stigma Experiences for Men and Women with Serious Mental Illness**

Research thus far conducted on the stigma experiences of men and women with SMI returns mixed findings. Some studies have found no significant associations between mental illness stigma and gender (Dickerson et al., 2002; Świtaj et al., 2009). Other research however suggests that the gender of the person with mental illness may affect the extent of perceived stigma and self-stigma experienced (Cechnicki, Angermeyer, & Bielańska, 2011; Farina, 1998; Jenkins & Carpenter-Song, 2008; Karidi et al., 2010; Morgan et al., 2012).

According to Farina (1998), men with mental illness are generally more likely to be viewed by others as aggressive or dangerous compared to women, and therefore may be perceived more negatively. Interestingly, although public attitudes may be generally more favourable overall for women (Eagly, Mladinic, & Otto, 1991; Farina, 1998), women with SMI tend to report perceiving greater stigma compared to men. The second Australian national survey of psychosis found that females with psychosis were more likely than males to report experiencing mental illness stigma, with almost half of females reporting that they had experienced discrimination on the basis of their mental illness in the past year compared with a third of males (Morgan et al., 2012). Similarly, in Poland, Cechnicki and colleagues (2011) found that women with schizophrenia were more likely to experience structural mental illness discrimination compared to men, reporting that they were more likely to have rehabilitation applications rejected because of their mental illness.

There is some evidence to suggest that there may also be gender differences with regards to self-stigma for people with SMI (Jenkins & Carpenter-Song, 2008; Karidi et
al., 2010). This evidence however is mixed in nature. For example, in a study with 90 people with psychotic illnesses receiving community treatment in North America, Jenkins and Carpenter-Song (2008) found that women (32%) were more likely than men (10%) to apply mental illness stigma to themselves. On the other hand, a European study by Karidi and colleagues (2010) with 150 outpatients with schizophrenia found that men were more likely to report that their medication affected their social status and that the term ‘schizophrenia’ was an insult. Furthermore, in this study men were also more likely to have negative attitudes towards other people with mental illness in comparison to women.

Karidi and colleagues (2010) highlighted that men may be more sensitive to the social impact of mental illness due to (male-dominated) societies’ higher expectation for its male members (Karidi et al., 2010). This may be true for men with regards to social roles such as employment for example; however, when considering the role of parenting, the opposite may be true, and women may suffer higher standards’ expectations and display greater stigma sensitivity (Eagly & Carli, 2003; Wood & Eagly, 2012). To date and to best of our knowledge, however, no research has specifically explored the impact of gender and gender stereotypes with regards to parenting for people with SMI.

There is also evidence to suggest that there may be gender differences in regards to disclosure of mental illness. Research indicates that women may be more likely to self-disclose their mental illness in comparison to men (Dindia & Allen, 1992). Women also tend to score higher than men on measures indicating more intimate and informal relationships, such as having a confidant and receiving social support from friends and family (Umberson, Chen, House, Hopkins, & Slaten, 1996). Given that disclosing mental illness has been associated with improvements in quality of life and can promote
a sense of empowerment and control (Corrigan et al., 2010), men may be more
vulnerable to the negative impact of concealing one’s diagnosis.

In summary, the literature regarding gender differences in stigma for people
with SMI is currently mixed and incomplete. Although public attitudes may be more
favourable towards women with SMI compared to men, women may perceive greater
stigma from others. Moreover, it is currently unclear whether self-stigma is more
common for men or women, with evidence thus far indicating that both genders may
self-stigmatise. Although these differences may exist between men and women in
general, the experience of stigma may be different again for men and women who are
parents.
Parent and Gender Stigma for Mothers and Fathers with Serious Mental Illness

As noted earlier, individuals with more than one stigmatising condition may experience ‘double stigma’ or ‘multiple stigma’ on a variety of different bases (Conner & Rosen, 2008; Daftary, 2012). For parents with SMI, stigma may be compounded, based not only on their mental illness but also their gender. This section discusses research relating to the importance of parenting for mothers and fathers with SMI and critically evaluates research regarding stigma associated with gender and parenting for mothers and fathers.

The Importance of Parenting for Individuals with Serious Mental Illness

Parenting is one of the most highly valued roles in many human societies and cultures (Ackerson, 2003b). Parenting encompasses a range of positive emotions such as love, joy, hope and fulfilment. For people with SMI, parenting is an equally meaningful role and a desired life goal (Nicholson & Miller, 2008; Sands, 1995). In a study of 24 mothers with SMI, Mowbray and colleagues (1995) found that more than 80% of women reported that the role of motherhood was a positive experience which promoted personal growth and development. Likewise in other studies, mothers with SMI report that having children provides a sense of purpose and increases self-esteem (Diaz-Caneja & Johnson, 2004). Similarly, fathers with SMI also describe fatherhood as being inextricably linked to their identity (Reupert & Maybery, 2009). Fathers with SMI express pride in their roles as fathers, and desire to provide a positive upbringing for their children (Evenson, Rhodes, Feigenbaum, & Solly, 2008).

Hence, the literature suggests that parents with SMI tend to have comparable feelings and aspirations regarding parenting as do non-mentally ill parents. In addition, research suggests that, as well as experiencing the general rewards and challenges of
parenting, parents with SMI also enjoy unique benefits, and face unique barriers to achieving a sense of normalcy in the role of parenthood.

Studies indicate that parenting may have a positive impact on one’s mental health. For example, having a child can provide parents with a sense of competence, purpose, and may be a key incentive for mental illness recovery (Diaz-Caneja & Johnson, 2004; Evenson et al., 2008). In a study of around 380 mothers with SMI, more than 20% described positive behavioural consequences of motherhood, including discontinuing unhelpful relationships and ceasing drug use (Mowbray, Oyserman, Bybee, MacFarlane, & Rueda-Riedle, 2001). In addition, both mothers and fathers with SMI have been shown to demonstrate higher levels of functioning in the community in comparison with people with SMI who do not have children (Nicholson, Nason, Calabresi, & Yando, 1999; White, Nicholson, Fisher, & Geller, 1995).

Although there are numerous benefits of parenting, having children is also associated with potential burdens or restrictions. For example, parenting increases financial hardship, limits opportunities for some forms of social engagement, may increase marital discord, and can introduce stress associated with caring for children (Bird, 1997). Hence, parents with SMI are often faced with added challenges. For example, due to the impact of their illness, some parents may experience difficulties providing adequate care for their children and many experience temporary or permanent custody loss as a result (Nicholson, Biebel, Hinden, Henry, & Stier, 2001; Park, Solomon, & Mandell, 2006). Parents with SMI are also more likely to experience divorce or separation, are more likely to be isolated, and are less likely to have access to material and emotional supports in comparison to parents without mental illness (Nicholson & Miller, 2008).
Mothers and fathers appear to differ with regards to social support. Fathers tend to be more socially isolated in comparison to mothers (Reupert & Maybery, 2009). In interviews conducted by Reupert and Mayberry, 10 of their 11 fathers had separated from the child’s mother. Fathers with SMI are also less likely than mothers to report having support from a confidant (Campbell et al., 2012). Help-seeking behaviours of mothers and fathers with SMI appear to also differ. Many men do not seek help until times of crisis. Fathers, contrary to mothers, also tend to be more inclined to rely on professionals as opposed to family or other informal sources of support (Reupert & Maybery, 2009). In summary, research thus far suggests that parents with SMI may experience a variety of benefits as well as challenges associated with parenting. However, research on parenting experiences for people with SMI remains sparse.

Gender and Parent Stigma for Parents with Serious Mental Illness

Gender stereotypes are prominent in most societies and cultures. Early research on stereotypes indicated that women are often judged more communal (e.g., warm, caring) and less agentic (e.g., assertive, achievement-oriented) than men (Deaux, 1984). Research has also shown that perceivers expect men and women to differ with regards to assertiveness, with the expectation that men will behave more assertive in work and sport situations and women will behave more assertive in home and health situations (Mendoza-Denton., Park, & O’Connor, 2008).

Gender stereotypes with regards to parenting traditionally associate parenting with being a predominantly female domain (Bird, 1997). Mothers tend to be associated with the ‘homemaker’ and ‘child-carer’ role, with responsibilities to perform household tasks and more direct child care duties in comparison to fathers (Bird, 1997; Wood & Eagly, 2012). Fathers on the other hand, have been traditionally associated with the ‘provider’ or ‘breadwinner’ role, with less direct child-caring responsibilities, and
alternatively, expectations to earn an adequate income to supply for the family (Bird, 1997; Wood & Eagly, 2012). Although there has been growing recognition of the importance of fathers in child’s lives in recent years (Baxter & Smart, 2011), fathers are currently significantly underrepresented in the literature pertaining to parenting.

Stereotypes of men and women overlap with stereotypes of people with mental illness to differing degrees. As noted earlier, people with SMI are often stereotyped as low in both warmth and competence; the two fundamental dimensions of social stereotypes according to the social content model; (Fiske, et al. 2002; Sadler, et al., 2012). Traditional women, such as stay-at-home mothers, are typically stereotyped as warm, but less competent. Contrary to this, working fathers are often stereotyped as competent, but lower in warmth (Eckes, 2002). Hence, parents with mental illness may experience stigma both based on their mental illness and their gender in different ways.

Similarly, role congruity theory (Eagly & Karau, 2001) states that stigma arises from an incongruity between group stereotypes and social role characteristics. When individuals belong to multiple social categories, stereotypes associated with either or both of these categories may be incongruent with a social role. For example, the parenting or care-giver role is typically associated with communal (warmth) but less agentic (competent) traits. Therefore, being a mother is generally more congruent with this role; however, having a SMI (and therefore having low perceived warmth) is incongruent with aspects of this role. Consequently, because parents with SMI belong to multiple social categories, the experience of stigma is complex and is associated with the interrelationship between mental illness, gender and parenting.

Gender stereotypes associated with parenting may have important implications for mothers and fathers. However current research is inconsistent regarding whether mothers or fathers experience greater adversity due to gender stereotypes. Bird (1997)
suggested that one consequence of traditional gender stereotypes regarding parenting may be that mothers become more involved with their children and, as a result, receive more of both the psychological burdens and benefits of parenting in comparison to fathers. Given traditional stereotypical gender roles, and the underrepresentation of fathers in the parenting literature, it may be that fathers with SMI experience greater stigma compared to mothers, not only due to their mental illness but also their parenting capacity as men.

Alternative accounts suggest that mothers may fare worse than fathers. The Shifting Standards Model (Biernat, Mains, & Nelson, 1991; Biernat & Manis, 1994) proposes that individual members of stereotyped groups are judged based on within-category standards. Therefore, judgement standards may lead the same behaviour to be interpreted differently for people from different groups. For example, when applying this model to parents with SMI, parenting may be judged on different standards for mothers and fathers. Given traditional gender stereotypes that parenting is predominantly a female role, mothers may in fact be judged against a higher and harsher standard in comparison to fathers and, thus, be less likely to meet the expected gender-based standard and may experience additional stigma as a result. While its implications are poignant, this model has been yet to be empirically tested with parents with SMI. However, there is some indirect evidence of the Shifting Standards phenomenon for parents in research on gender and parent stigma in the workplace.

Gender and Parent Stigma in the Workplace

Whilst little is known regarding the impact of gender stereotypes for mothers and fathers with SMI, for non-mentally ill parents, research on gender and parent stigma in the workplace setting provides important insights. Much of the research on stigma
towards parents has focused on this setting and suggests that stigma may differ for mothers and fathers.

Stereotypes associated with the ‘ideal worker’ and ‘ideal parent’ are often at odds. Research suggests that this may be more so for mothers than for fathers. The ‘ideal mother’, according to cultural expectations, spends most of her time caring for her children even if she has a professional career (Ridgeway & Correll, 2004; Wood & Eagly, 2012). By contrast, the ‘ideal worker’ and the ‘ideal father’ are more similar, and cultural expectations of fatherhood tend to coincide with men’s work roles. A ‘good’ father is often considered one who works to support his family (Etaugh & Folger, 1998; Wallace & Young, 2008).

These stereotypes may encourage discriminatory behaviours in the workplace. For example, despite evidence suggesting that mothers, fathers and non-parents all perform similarly on pro-work behavioural outcomes (such as work effort, job engagement, work intensity and impact of home life on work) (Kmec, 2011), studies have found that individuals may be judged according to both their gender and their parenting status with regards to employment decisions. Parents may be judged as being poorly suited to the workplace compared to non-parents, and mothers may be disadvantaged relative to fathers. Fuegen and colleagues (2004), for example, found that parents were judged as less agentic and less committed to employment than non-parents. In addition, fathers were held to more lenient standards than mothers and to childless men. These results provide indirect evidence of the Shifting Standards Model regarding the perceptions of mothers and fathers in the workplace. In the work setting, parental status may increase gender differences in competence judgements such that mothers are required to do more, or meet higher standards than fathers to prove their competence (Fuegen et al., 2004). Furthermore, these results also suggest that
occupation roles may conflict with parental roles for women but not men (Etaugh & Folger, 1998). Because a working mother violates stereotypes regarding the care-taker role, contrary to a working father who represents the provider-role, employers may set stricter standards for hiring mothers compared to fathers (Fuegen et al., 2004).

With regards to stereotypes relating to parenting efficacy of working parents, research has indicated that stay-at-home mothers and fathers are regarded as equally effective parents; however stay-at-home mothers are judged to perform more physical and emotional care-giving than stay-at-home fathers (Bridges, Etaugh, & Barnes-Farrell, 2002). With regards to employed parents, employed mothers tend to be judged as providing greater physical care compared to employed fathers; however, employed fathers are regarded as better parents compared to employed mothers (Bridges et al., 2002).

Consequently, evidence suggests that the workplace setting appears to promote gender stereotypes regarding parenting in relation to mothers as care-givers and homemakers and fathers as providers. There is some indication that, both in the workplace and home settings, mothers tend to be judged more harshly. In the workplace, mothers tend to be viewed as less competent in comparison to fathers and to childless women. With regards to parenting efficacy, employed mothers tend to be judged more harshly in comparison to employed fathers and to stay at home mothers. The next section focuses on the little research regarding stigma for parents that extends beyond the workplace setting and discusses how this stigma may impact further on parents with SMI.
The Experience of Stigma for Mothers and Fathers with Serious Mental Illness

Research on parents with SMI has been overshadowed by a focus on parents’ pathology, subsequent deficits in parenting abilities and potential impact on the child. Little research has considered the parents’ perspective or investigated their experiences and needs as parents. The aim of this section is to critically review the relatively limited literature regarding the experiences of stigma for parents with SMI, and the potential differences in the experiences of stigma for mothers and fathers.

Stigma for Parents with Serious Mental Illness

Prior to the 1960’s, individuals with SMI were treated in inpatient psychiatric facilities. During this time, people with SMI were denied the right to parent a child. Treatment with anti-psychotic medication often resulted in disabling side-effects including conception problems. Having children was not only discouraged, many people with SMI were sterilised, or had their child removed from their care following birth, as it was believed that their illness alone determined their parenting capacity (Krumm & Becker, 2006).

In contrast to the decline in parenthood in the Australian general population (Gray, Qu, Weston, 2008), the number of parents diagnosed with a SMI has increased in recent years. Of approximately 1,800 adults interviewed in the second Australian national survey of psychosis, over half of all women and a quarter of men were parents (Campbell et al., 2012). This was an increase for both mothers (from 50.5% to 56.2%) and fathers (from 21.3% to 25.9%) following the previous national survey a decade earlier (Jablensky et al., 1999).

A variety of factors may account for the increase in the number of parents with SMI. For example, following the deinstitutionalisation epoch of the 1960’s,
significantly more people with SMI are now cared for in the community and are living independently; therefore also increasing their opportunities for romantic relations and child rearing. Further, with continued improvements and advances in anti-psychotic medication, fewer individuals now experience conception difficulties resulting from this class of medications (Seeman, 2002; Serretti, Ronchi, Lorenzi, & Berardi, 2004). As a result, many individuals with SMI are now able to become parents. Given the limited current knowledge regarding the growing number of parents with SMI, and the frequency of stigma for individuals with these diagnoses, the experience of stigma for parents with SMI is an important and timely area of investigation.

Stereotypes relating to people with SMI who are parents are often associated with expectations about not only their inability to care for themselves, but further their failure to provide adequate parenting for their children (Ackerson, 2003a). Stereotypes often include that parents with SMI abuse or neglect their children, that they will pass on their illness to their child, or that they are unfit to be a ‘good-enough’ parent (Boursnell, 2007). Therefore, parents with SMI often experience multiple stigmas not only due to their illness but also their parenting capacity.

Given the highly stigmatised public view of people with SMI generally, it is not surprising that parents with SMI are more likely to experience stigma in comparison to parents with other disorders (Nicholson & Miller, 2008). A possible explanation for this greater stigma may be the tendency of parents with SMI to actually display greater deficits in parenting abilities compared to parents with other mental illnesses (Nicholson & Miller, 2008). Symptoms such as lack of insight, which may be common in psychotic disorders, may inhibit parents’ awareness of their functioning and when psychiatric treatment is needed. Consequently, this may impact on their ability to care for
Parents with SMI tend to report greater stigma in comparison to people with SMI who do not have children. Data from the second Australian national survey of psychosis found that mothers were slightly more likely to have experienced stigma (47.2%) compared to childless women (46.4%) and that fathers were also more likely to have experienced stigma (35.4%) compared to childless men (30.8%) (Campbell et al., 2012). However, no specific details were gained in this study regarding whether these stigma experiences related to public stigma or self-stigma, or the different contexts in which stigma occurred.

Responses to Stigma by Parents with Serious Mental Illness

Avoidance of public stigma. Parents may respond to stigma in a variety of ways. As discussed earlier, responses to stigma may be behavioural and externally focused, or internally directed. Numerous studies have found that parents with SMI may attempt to avoid public stigma by concealing both their illness and their parenting status in order to avoid stereotypes that they are inadequate parents, and due to fear of removal of their children from their care (Ackerson, 2003a; Diaz-Caneja & Johnson, 2004). In a survey conducted by SANE Australia in 2012 (SANE, 2012), 40% of parents reported that they had not sought help for their mental illness because of this fear, and only approximately a third had disclosed their illness to their child’s school.

There are significant implications for parents with SMI and their children when parents do not disclose their illness. For example, avoidance of treatment may result in parents becoming isolated from material and emotional supports, and their mental health may subsequently decline. This then creates a vicious cycle for parents, as the initial strategy adopted in an effort to maintain access to their children may ultimately
result in the reason for loss of custody (Ackerson, 2003a). On the other hand, parents who do disclose their mental illness may experience discrimination from others. In the survey conducted by SANE (2012), of parents who informed their child’s school of their mental illness, half found the disclosure unhelpful, leading to discrimination from other parents and in some cases bullying of their child.

Hence, the choice to disclose one’s mental illness and seek treatment and support may be a difficult dilemma for parents. Disclosure, although potentially resulting in gaining often necessary treatment, also encompasses the risk of child custody loss and potential discrimination. Regardless of whether they choose to disclose their illness, self-stigma may be an even greater concern for parents with SMI.

Self-stigma. There is currently limited knowledge regarding self-stigma for parents with SMI. Evidence from small scale qualitative studies indicate that some parents may internalise public stereotypes and social expectations that their illness prevents them from being a ‘good-enough’ parent or that they will pass on their illness to their child, either biologically or due to deficits in parenting associated with their illness (Boursnell, 2007; Nicholson & Miller, 2008).

In a study of 32 mothers with SMI, Montgomery and colleagues (2011) found that many mothers questioned their parenting competence. Similarly, in a study with fathers with SMI, although some men described anger regarding custody disputes, many were resigned to not being the residential parent, and viewed themselves as ‘being undeserving’ of living with their children (Reupert & Maybery, 2009). Both mothers and fathers also describe a sense of shame and guilt at being hospitalised for their illness and their children witnessing their suffering (Evenson et al., 2008; Montgomery et al., 2011). In addition, fears that children will inherit their illness are also common for both mothers and fathers (Diaz-Caneja & Johnson, 2004; Evenson et al., 2008).
In sum, evidence suggests that both mothers and fathers may internalise stigma based on the impact of their mental illness on their parenting. It is also evident that self-stigma may have significant impact on both mothers and fathers; however, to our knowledge the literature to date has not compared the stigma experiences of mothers and fathers and the associated impact of stigma on parenting. Current research instead tends to use single gender samples, mostly focusing on mothers.

**Stigma for Mothers with Serious Mental Illness**

Mothers with SMI report experiencing stigma in a variety of forms and contexts. For example, mothers describe being overly criticised about their parenting from partners and family members (Ackerson, 2003a). Ackerson (2003a) conducted interviews with 12 mothers and one father in the United States. Parents had a diagnosis of psychotic disorder or a severe mood disorder and were parents of young children as well as adolescent children. Mothers in this study described a limited understanding of mental illness from partners, and partners leaving the relationship because they believed the mothers diagnosis meant that they were ‘crazy’.

The legal system and the child welfare system in relation to child custody disputes are regularly cited by mothers as being main sources of stigma. Research with mothers with SMI consistently reports mothers’ experiences of their illness being used against them in custody decisions and an emphasis on their pathology by services, rather than on their individual parenting ability (Ackerson, 2003a; Boursnell, 2007; Montgomery et al., 2011; White et al., 1995). Estimates of maternal custody loss are high and range from 30 to 80% (Nicholson et al., 2001). Furthermore, parents who retain custody often live in fear that they will lose access to their children if they become unwell (Ackerson, 2003a; Boursnell, 2007; Montgomery et al., 2011; White et al., 1995). Mothers with SMI are almost three times as likely as mothers without SMI to
be involved with child welfare services or to lose custody of their children (Park et al., 2006).

The subjective experiences of mothers in relation to stigma associated with child custody decisions have been rarely explored. In Ackerson’s (2003a) study seven of the 13 parents interviewed reported having lost custody of their children, and 11 expressed concerns about losing their children through either divorce or child welfare. Similarly, in Australia, Boursnell (2007) interviewed seven mothers and three fathers with SMI and found that parents described living in fear of losing custody of their children, either to the other parent, family members or to welfare services. In a more recent larger scale study with around 300 parents of school-aged children, 84% of whom were mothers, half of the parents reported that they lived in fear of losing custody of their child because of their mental illness (SANE, 2012).

Evidence suggests that stigma may also occur in interactions with mental health professions. Negative stereotypes about the unsuitability of women with SMI to become parents are still prominent among many mental health service providers (Corrigan, Markowitz, & Watson, 2004; Wahl, 1999). Indeed, some women with SMI may be at risk to their child; however, research indicates that with appropriate support many parents with mental illness can adequately care for their children (Howard, 2000; Oates, 1997). Mothers report that mental health professionals rarely ask in detail about their experiences of parenting, offer support with parenting or with the grief associated with losing custody of their children (Diaz-Caneja & Johnson, 2004). In interviews with 35 mothers with SMI and mental health care workers in the United Kingdom, Howard and Hunt (2008) found that mothers identified specific needs relating to caring for their children that were not recognised by mental health care providers. These included both practical and emotional aspects of child care responsibilities, as well as intimate
relationships, self-care and the provision of parenting information. Therefore, stigma may be maintained through mental health services emphasis on potential risks to children, and the perceived lack of support for the specific parenting needs of mothers with SMI.

Mothers with SMI also report experiencing stigma from the general public. Mothers describe perceived negative stereotypes associated with being ‘bad mothers’ because of their illness and being selfish for having children because of the risk of passing on their illness to their children (Boursnell, 2007). Interviews with 22 mothers with psychotic illnesses by Diaz-Caneja and Johnson (2004) in the United Kingdom revealed negative stereotypes for mothers whether they were living with or without their children. Mothers who were living with their children described perceived beliefs from the general public that they were inadequate mothers, and those that did not have custody described stigma associated with having inadequate parenting skills. Discriminatory behaviours are also evident from the general public: Mothers report experiences of being excluded by people in their local community and particularly by other parents when people become aware of their illness (Bassett, Lampe, & Lloyd, 1999). Altogether this suggests that mothers with SMI may experience stigma from a range of different contexts. In the following section the environments in which fathers report stigma are discussed.

**Stigma for Fathers with Serious Mental Illness**

Fathers have thus far been rarely included in research on parents with SMI. Hence, while research regarding the experiences of stigma of mothers with SMI is growing, very little is currently known about the experiences of fathers with SMI. Limited is also research investigating gender differences in parenting experiences of individuals with SMI (Campbell et al., 2012).
Only two studies were located that specifically investigated the subjective experiences of fathers with SMI (Evenson et al., 2008; Reupert & Maybery, 2009) and one that explored and compared characteristics of fathers with SMI using clinician-rated measures (Nicholson et al., 1999). These studies suggest that fathers report similar concerns to mothers; however, differences also exist.

Fathers with SMI have been found to have an earlier age of illness onset and more often have co-morbid substance abuse, compared to mothers with SMI (Craig & Bromet, 2004). They are also at a greater risk of losing custody of their children in comparison to mothers (Reupert & Maybery, 2009). The second Australian national survey of psychosis found that almost a quarter of women but only 5.5% of men had dependent children living in their care (Campbell et al., 2012).

Similarly to mothers, fathers also tend to report experiencing stigma from partners and family members. In Australia, Reupert and Mayberry (2009) conducted interviews with 11 fathers with both dependent and non-dependent children. Fathers had a diagnosis of schizophrenia, bipolar disorder or depression. Fathers in this study described experiences of being spoken about by the child’s mother in a derogatory manner in front of their children, and the subsequent negative impact this had on their relationships with their children.

Like mothers with SMI, fathers also tend to report stigma from the legal system and the child welfare system in relation to child custody loss. In Reupert and Mayberry’s (2009) study, none of the fathers interviewed were living full-time with their children and none reported voluntarily relinquishing care. Many fathers described lengthy and difficult custody disputes, an over-emphasis on their pathology from services, and a belief that their mental illness was a way of keeping them away from their children.
Other studies however have failed to find evidence of stigma of this kind for fathers. In the United Kingdom, the ten fathers with psychosis interviewed by Evenson and colleagues (2008) did not report fears about child custody loss. Living arrangements in this study however uniquely differed, with many fathers in this sample reporting that they lived with their children, and did not have current difficulties with child-care arrangements.

Research also suggests that mental health service providers may hold a gender bias favouring mothers. In a study in the United States of primarily non-Caucasian fathers with psychosis, Nicholson and colleagues (1999) found that service providers rated parenthood as being less important to fathers than mothers and that mothers as opposed to fathers would be more likely to benefit from parenting support. The authors also noted that service providers felt less confident in the accuracy of the information they provided about fathers in comparison to mothers. Similarly, in Reupert and Mayberry’s (2009) study although none of the fathers were living full-time with their children, fatherhood was still considered an important part of their self-image, and a factor that was perceived as being often unrecognised and unacknowledged by services. Altogether, these findings demonstrate that clinicians may be less aware of the experiences and needs of fathers with SMI. The results also may reflect gender stereotypes of service providers that mothering is primarily a female domain.

Fathers with SMI also report stigma from the general public. Fathers report feeling as though the general community are overly focused on their pathology rather than their individuality (Reupert & Maybery, 2009). Fathers also describe perceiving negative judgements from the general community once their illness is disclosed and as though any variations in their emotions or behaviours are assumed as being due to their illness or being non-compliant with their medication (Reupert & Maybery, 2009).
To summarise, it is evident that stigma is a significant concern for both mothers and fathers with SMI. In comparison to mothers, there is a lack of research on the experiences of stigma for fathers. Research so far relies on small sample sizes, and therefore has been unable to adequately explore gender comparisons. The literature currently available tends to suggest that, on the one hand, fathers may be at greater risk of stigmatisation not only due to greater custody loss and isolation, but also due to traditional gender stereotypes that associate parenting as being a primarily female domain. However, on the other hand, there is also research demonstrating that mothers may be judged more harshly as parents based on higher parenting standards for women, and tend to report experiencing greater discrimination. Due to these inconsistent findings, and the lack of quantitative studies with mothers and fathers with SMI, this is currently an area that is unclear and requires further investigation.
Parents with SMI may experience stigma associated with the impact of both their mental illness and their gender on their parenting. No research to date has focused specifically on comparing the experiences of stigma for mothers and fathers with SMI, the degree to which parents internalise (vs. externalise) the different forms of stigma they may be exposed to, or the associated impact of these stigma experiences on parenting.

The present study aimed to explore and compare the experiences of stigma associated with mental illness and gender for mothers and fathers with SMI and the perceived impact of stigma on parenting. The study also aimed to investigate the relationship between these dimensions of stigma with parenting characteristics for both mothers and fathers to isolate similarities and differences on the impact of stigma on parenting between genders. Finally, the study aimed to explore and compare the sources of discrimination for mothers and fathers with SMI.

Although the study was exploratory in nature, based on previous research, we hypothesised that 1) mothers with SMI, in line with research suggesting that women may be more likely to perceive and internalise mental illness stigma, will experience greater perceived stigma and self-stigma associated with the impact of their mental illness on their parenting compared to fathers, and subsequently stigma associated with mental illness will also have a greater impact on parenting outcomes for mothers in comparison to fathers; 2) fathers with SMI, in accordance with traditional gender stereotypes associated with parenting, will experience greater perceived stigma and self-stigma associated with the impact of their gender on their parenting compared to mothers, and subsequently stigma associated with gender will also have a greater impact on parenting outcomes for fathers in comparison to mothers.
Strengths of the current study in contrast to previous research include the adoption of a quantitative approach, the use of a larger sample size in comparison to many previous qualitative studies with parents with SMI, and the inclusion of parents of both genders. Identifying the specific experiences of stigma for mothers and fathers with SMI will assist in developing a better understanding of the impact of stigma on parents and their families. Such findings may be useful in better understanding and reducing the stigma associated with being a parent with SMI so that parents feel more able to discuss their parenting role and seek support. This research may also assist in developing appropriate and targeted rehabilitation and support programs for parents with SMI and their families.
Parents with serious mental illness: Differences in internalised and externalised mental illness stigma and gender stigma between mothers and fathers

Abstract

Research demonstrates that people living with serious mental illness (SMI) contend with widespread public stigma; however, little is known about the specific experiences of stigma that mothers, and in particular fathers, with SMI encounter as parents. This study aimed to explore and compare the experiences of stigma for mothers and fathers with SMI inferred not only by living with a mental illness but also potential compounding gender effects, and the associated impact of stigma on parenting. Telephone surveys were conducted with 93 participants with SMI who previously identified as parents in the Second Australian National Survey of Psychosis. Results indicated that mothers were more likely than fathers to perceive and internalise stigma associated with their mental illness. Conversely, fathers were more inclined to perceive stigma relating to their gender and to hold stigmatising attitudes towards others. Mental illness and gender stigma predicted poorer self-reported parenting experiences for both mothers and fathers. These findings may assist in tailoring interventions for mothers and fathers with SMI.

Key Words: self-stigma; perceived stigma; gender differences; discrimination; psychosis
1. Introduction

It is well established that stigmatising attitudes towards people affected by serious mental illness are extensive; however, the actual lived experiences of those stigmatised has received less attention. Serious mental illness (SMI) refers to persistent and chronic mental illnesses that are subject to intensive mental health treatment for one year or longer (Mowbray et al., 1995). Public stigma about people with SMI involves negative stereotypes (e.g., dangerousness or incompetence), prejudiced reactions (e.g., fear or disgust), and discrimination by means of avoidance or restricting opportunities generally available to others (Alexander and Link, 2003; Corrigan et al., 2009; Fiske et al., 2002; Link and Phelan, 2001; Sadler et al., 2012; Wahl, 1999). In addition, people with SMI also experience self-stigma (i.e., they agree with, and internalise, public stigma; Corrigan and Watson, 2002) and, as a result, may suffer from lower self-esteem and self-efficacy, and overall poorer mental health outcomes (Corrigan et al., 2009; Corrigan and Watson, 2002; Sharaf et al., 2012; Verhaeghe and Bracke, 2011).

The majority of people with SMI become parents (Dolman et al., 2013; Howard et al., 2001). Biological parents include parents with a biological or genetic bond to their children. Non-biological parents consist of those parents involved in care-taking responsibilities for a child or who assume a parenting role, however are not biologically related to the child. These parents may include foster, adoptive or step parents (DiFonzi et al., 2013). Non-biological parenthood is common (Meyer et al., 2011; DiFonzo et al., 2013), with cross cultural studies indicating that more than one in ten school-aged children live apart from at least one of their biological parents (Chapple, 2009).

Stigma may occur for parents with SMI due to incongruences between stereotypes associated with people with SMI and the perceived social role characteristics of parents (Eagly and Karau, 2002). Stereotypes regarding parents with
SMI are often associated with expectations about not only their presumed inability to look after themselves, but also their inability to adequately care for their children (Ackerson, 2003; Jeffery et al., 2013; Nicholson et al., 1998). Similar to other parents, however, people with SMI identify parenting as a meaningful role and a desired life goal (Nicholson and Miller, 2008; Sands, 1995), with parenting providing a sense of purpose, and also an incentive for recovery (Diaz-Caneja and Johnson, 2004; Evenson et al., 2008).

A focus on deficits in parenting abilities, and the subsequent impact on the child, has overshadowed attention to research on the perspectives of parents with SMI. Subsequently, the experiences of stigma for this population have rarely been investigated (Jeffery et al., 2013). Currently, information regarding stigma for parents with SMI is provided by small, typically qualitative studies, mostly focusing on mothers. For example, Boursnell (2007) interviewed seven mothers and three fathers with SMI who reported encountering negative attitudes, such as being seen to fail to fulfil the role as “good-enough parents”. Parents with SMI describe experiencing such stigma from child welfare services and the legal system in relation to child custody disputes, with their pathology being emphasised in custody decisions, rather than their parenting ability (Ackerson, 2003; Boursnell, 2007; Montgomery et al., 2011; White et al., 1995). In addition, mothers and fathers with SMI experience stigma from mental health professionals (Diaz-Caneja and Johnson, 2004; Howard, 2000; Jeffery et al., 2013; Oates, 1997; Reupert and Mayberry, 2009), who rarely ask about parenting experiences, offer support with parenting, or assist with the grief associated with child custody loss (Diaz-Caneja and Johnson, 2004). As a consequence, many parents with SMI avoid treatment or fail to disclose parenting concerns, due to fears of stigma or child removal (Ackerson, 2003).
Although research in this area is limited, some studies suggest that both mothers and fathers with SMI internalise negative public attitudes and thus experience self-stigma. For instance, in a study with 32 mothers with SMI, Montgomery and colleagues (2011) found that many mothers questioned their parenting competence due to their mental illness. Similarly, Reupert and Mayberry (2009) found fathers residing with their children described themselves as ‘being undeserving’ of this right. Both mothers and fathers with SMI report feelings of shame and guilt about being hospitalised and their children witnessing their suffering (Davies and Allen, 2007; Edwards and Timmons, 2005; Evenson et al., 2008; Montgomery et al., 2011). Research to date is yet to compare the self-stigma experiences for mothers and fathers; however, some evidence from non-parent populations suggests that women may be more likely to perceive and internalise stigma compared to men (Jenkins and Carpenter-Song, 2008).

People may also externalise stigma and thus hold stigmatising attitudes towards others with the stigmatised condition (Karidi et al 2010). Little research has explored the perspectives of people with SMI towards others with SMI or investigated possible differences in externalised stigma between men and women. Some evidence suggests that men with SMI are more likely than women to hold negative attitudes towards others with SMI (Karidi et al., 2010). Given that the potential psychological consequences of internalising and externalising stigma are varied, it is important to investigate each of these responses to stigma separately.

In addition to mental illness stigma, both mothers and fathers with SMI may also experience stigma associated with the impact of their gender on their parenting. For example, for fathers, stigma may occur due to the traditional gender stereotype that parenting is a predominantly female domain (Bird, 1997) and that men are less warm and nurturing compared to women (Eckes, 2002). Indeed, Nicholson and colleagues
PARENTS WITH SERIOUS MENTAL ILLNESS

(1999) reported that service providers rated parenthood as being less important to fathers than mothers and that mothers would be more likely to benefit from parenting support. Some evidence suggests that fathers with SMI internalise such gender stereotypes with regards to parenting (e.g., men being ‘breadwinners’ rather than ‘caregivers’) and suffer in silence rather than asking for help with parenting (Reupert and Mayberry, 2009).

Conversely, some theories suggest that mothers may experience greater parenting stigma than fathers. The Shifting Standards Model (Biernat et al., 1991; Biernat and Manis 1994), for example, proposes that individual members of stereotyped groups are judged based on within-group standards. Hence, given traditional gender stereotypes that women are more warm and nurturing than men (Eckes, 2002), and that parenting is predominantly a female role, mothers may in fact be judged against a higher and harsher parenting standard in comparison to fathers. Therefore, mothers, may be less likely to meet their respective gender-specific standards, and may experience greater stigma as a result. Although this model is yet to be empirically tested with parents with SMI, indirect evidence from healthy controls indicates that, in both the workplace and home settings, mothers indeed tend to be judged more harshly as parents (Bridges et al., 2002; Fuegen et al., 2004).

To summarise, parents with SMI may experience stigma related to both the impact of their mental illness and their gender on their parenting and may perceive stigma externally (public stigma), or internally (self-stigma). To date, there is little research regarding the specific impact of stigma for mothers and fathers with SMI.

To identify differences and similarities in stigma experiences for mothers and fathers with SMI, the present study explored and compared a sample of mothers and fathers with SMI with regards to (a) their experiences of perceived stigma and self-
stigma associated with mental illness and gender, and (b) the impact of these types of stigmas on their parenting experience. Firstly, based on evidence suggesting that women may be more likely to perceive and internalise stigma, we expected mothers with SMI to experience greater perceived stigma and self-stigma associated with the impact of their mental illness on their parenting, and to experience a greater negative impact of mental illness stigma on parenting experiences compared to fathers. Secondly, due to traditional gender stereotypes associated with parenting, we expected fathers with SMI to experience greater perceived stigma and self-stigma associated with the impact of their gender on their parenting, and to display a greater negative impact of gender stigma on parenting experiences compared to mothers.

This study also initiated an exploration onto the possible determinants of these stigma experiences by testing the relationships between these dimensions of stigma and parenting characteristics of both mothers and fathers, as well as the perceived sources of stigmatising behaviours (or discrimination) for mothers and fathers with SMI. Due to lack of previous research into this area, we had no explicit a-priori hypotheses about this portion of the results.

2. Methods

2.1. Participants

Participants with severe mental illness (N = 93) from the Hunter (N = 54), Orange (N = 17) and Adelaide (N = 22) regions of Australia were recruited from the database of the Second Australian National Survey of Psychosis (for comprehensive information about the survey design and participants, see Morgan et al., 2012). All participants had previously completed the Survey of High Impact Psychosis (SHIP) interview (Morgan et al., 2012). Participants had previously screened positive for a
psychotic disorder using the psychosis screener (Morgan et al., 2012), but not everyone
met full criteria for a psychotic illness as per the International Statistical Classification
of Diseases and Related Health Problems, 10th Revision (ICD-10; World Health
Organization, 1993). For information regarding diagnoses, see Table 2S. Participants
were included if they were a parent (biological or non-biological) of at least one child of
any age. Parents were excluded if they were assessed by the interviewer as not having
the necessary cognitive capacity to participate in research or provide informed consent
at the time of contact.

Potential participants who had provided re-contact consent in the national survey
were mailed a letter informing them about the study and providing them with the
opportunity to withdraw from being re-contacted. Participants who agreed to be re-
contacted were provided with study information and informed written consent was
gained. Human research ethics approval was obtained at institutional levels at each site.

Approximately 80% of participants who originally provided re-contact consent
agreed to be re-contacted for the current study. The remainder were unable to be re-
contacted. Of those who agreed to be re-contacted, 65% consented to participate.
Reasons for refusals were not sought in accordance with ethics approval. Two
participants had died following the initial study and two participants were excluded on
the basis of their cognitive functioning (see Table 1S in the supplementary material for
numbers of participants at different stages of the recruitment process).

Table 1 displays descriptive statistics for parents’ current age, age at becoming a
parent, and age at mental illness onset. Additional information about parents’
demographic and clinical characteristics; the numbers of parents with dependent
children (≤18 years), non-dependent children (>18 years), biological children (own
children), and non-biological children (step, foster or adoptive children); and the living
situation of parents with dependent children, non-dependent children and biological children, can be seen in Tables 2S to 4S, respectively.

Table 1

*Parent demographic characteristics*

<table>
<thead>
<tr>
<th></th>
<th>Range</th>
<th>Mothers</th>
<th>Fathers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years)</strong></td>
<td>23-66</td>
<td>45.9(10.2)</td>
<td>44.1(10.5)</td>
<td>45.2(10.3)</td>
</tr>
<tr>
<td>Age became a parent</td>
<td>15-35</td>
<td>22.8(5.0)</td>
<td>24.9(4.9)</td>
<td>23.6(5.0)</td>
</tr>
<tr>
<td>Age mental illness onset</td>
<td>5-49</td>
<td>21.5(9.1)</td>
<td>24.3(11.1)</td>
<td>22.5(9.9)</td>
</tr>
</tbody>
</table>

(Median = 19)

2.2. *Measures*

Relevant clinical and demographic data previously collected in the national survey was utilised in the analyses, including age, gender, diagnosis, marital status, highest qualification, interviewer-rated quality of caring for children, interviewer-rated global performance, and participant-rated overall mental health. These variables were chosen using a hypothesis-driven method by which variables suggested by the literature to be potentially related stigma and parenting were tested.

Interviewers in the national survey based their ratings on observation and information provided by participants at the time of the interview. Inter reliability for each interviewer-rated item was obtained through national training workshops for each of the interviewers, onsite training, and weekly inter-site teleconferences for the duration of the testing phase in which participants responses were discussed.

In addition, structured telephone surveys were conducted between August 2012 and February 2013 by professionals with mental health training. Each survey took
approximately 30 minutes to complete and consisted of three main sections as outlined below.

2.2.1. **Demographics and child care**

This section consisted of: Age entered parenthood, age at mental illness onset, number of children (total, biological, non-biological, dependent and non-dependent), living situation of children (biological, dependent and non-dependent), and whether the parent had a current mental health case manager.

2.2.2. **Parenting**

Three subscales from the parenting domain of the Parenting Stress Index (3rd ed.; PSI-3; Abidin, 1995) were used: Competence (13 items), Role Restriction (7 items), and Isolation (6 items). These subscales aim to assess perceived parenting ability, impact of parental responsibilities and level of social support, respectively. Each item is rated on a five point Likert scale (1 = strongly disagree, 5 = strongly agree). A summarised version of these items are listed in Table 6S. In addition, four items from the Competence subscale required participants to elect a response based on a series of statements. The subscales have been shown to have good internal consistency (α = .79-.93), test-retest reliability, and validity (Abidin, 1995). As the PSI-3 was developed for parents of children ranging in age from one month to 12 years, parents were asked to consider their youngest child when responding to these questions. Questions were also screened for suitability for use with parents of children of all ages; one Competence subscale item was adapted accordingly (from “When my child came home from hospital…” to “When my child was born…” [Abidin, 1995]).

2.2.3. **Stigma**

This section included questions based on the Self-Stigma of Mental Illness Scale (SSMIS) (Corrigan et al., 2006). The SSMIS is a 40 item self-report measure of
stereotype awareness, stereotype endorsement, stereotype self-concurrence, and self-esteem decrement. Nine items were adapted to suit a telephone interview and to specifically address perceived stigma and self-stigma/internalised stigma and externalised stigma associated with mental illness and gender related to parenting. These items are listed in Table 2. Each item was rated on a five point Likert scale (1 = strongly disagree, 5 = strongly agree). This section also included questions regarding perceived sources of mental illness discrimination for parents. If participants agreed that they had experienced discrimination they were provided with six possible sources of discrimination (family, friends, mental health services, legal services, child welfare services, and work colleagues) and asked (yes or no) whether they had experienced mental illness discrimination from each source in the preceding 12 months. See Table 7. Participants were able to cite as many sources of discrimination as applicable.

2.3. Data analysis

2.3.1. Preliminary Analysis

Descriptive statistics were extracted using IBM SPSS statistical software (version 21; SPSS, Chicago, IL, USA). Missing values were excluded prior to analyses. Normality checks were undertaken on metric variables. Non-normal variables (Skew/SE Skew ≥ 2.58) were rectified by computing square root or logarithm transformations.

Overall PSI-3 subscale scores for each of the three subscales were calculated. More than half of parents (64.5%; 60.3% mothers, 71.4% fathers) reported that their youngest child was dependent; however, children’s ages varied considerably (range = 0.25-38 years; \(M = 15.1\) years, S.D. = 10.4). Therefore, to gain a more informative picture of parenting experiences with younger children, PSI-3 subscale scores were also computed separately for parents with dependent children.
We also investigated differences between those parents with an ICD-10 diagnosis of depression without psychosis and the remainder of the sample who met criteria for a psychotic disorder.

To check for selective attrition, a Multivariate Analysis of Variance (MANOVA) was performed separately with participants from the Hunter and Orange sites who were eligible and consented to participate (vs. those who did not consent); the Adelaide subsample was excluded from these analyses because the majority of eligible participants (85%) consented to participate. We compared the consenting and non-consenting participants on socio-demographic variables including age, English vs. non-English as a first language, age at leaving school, number of own children, number of stepchildren, number of dependent children, net fortnightly income; as well as clinical variables including overall global functioning, participant-rated overall mental health, and participant-rated overall life satisfaction.

Overall, there was no evidence of systematic differences between the two subgroups of eligible participants in either sample, Hunter multivariate $F = 1.84$, $p = .069$; Orange multivariate $F = .749$, $p = .674$. We still inspected univariate effects and found two significant effects in the Hunter subsample and no significant effects in the Orange subsample (all $ps > .146$).

In the Hunter subsample, eligible participants who did not consent were more likely to have fewer stepchildren, ($M = .00 \ SD = .00$ vs. $M = .31 \ SD = .69$) $F (1, 82) = 7.18$, $p = .009$, and reported a lower net fortnightly income ($M = 2.00 \ SD = .87$ vs. $M = 2.44 \ SD = 1.01$; with values ranging between 0 = less than $300 per fortnight and 4 = more than $1000 per fortnight ) $F (1, 82) = 4.25$, $p = .042$ than those who did consent. All other univariate tests for the Hunter subsample were non-significant (all $ps > .131$),
meaning that there was no systematic difference on these other variables between the eligible participants who consented vs. those who did not consent.

The interviewer-rated child-care variable provided an overall clinical assessment of quality of general child-caring in the past 12 months. This was based on a scale ranging between 0 = no dysfunction and 2 = severe dysfunction. This variable contained valid cases for only a small subset of variables (i.e. in the Hunter and Orange subsamples 30 and 18 responded ‘uncertain’ respectively and were therefore classed as missing values). As MANOVA uses listwise deletion, including this variable in the analysis would have resulted in a substantial decrease in the overall N across the analyses. Therefore, to ensure the small N on this variable did not make the MANOVA tests unduly conservative, we excluded this variable from the MANOVA and compared the two groups on this variable using independent samples t-tests. No significant difference was found between those who consented vs. those who did not consent in the Hunter subsample ($M = .29 \ SD = .463$ vs. $M = .55 \ SD = .688$) $F = 4.67, p = .278$. A t-test was not performed for the Orange subsample as all valid cases for this subsample stated ‘no dysfunction’ for both groups and therefore there was no sufficient variance to run the test.

Hence, overall, there appeared to be no obvious problems stemming from sampling biases and uneven participant drop out in our data. The individuals who were eligible and agreed to take part in the study were similar in characteristics to the individuals who were eligible and declined to participate, thus, adding confidence to generalizability of our findings to the broader population of parents with a serious mental illness in the sampled areas.
2.3.2. Extended analysis

Correlations were conducted overall and within gender across all variables. As expected, four stigma attitudinal items demonstrated significant gender differences. These included: (1) perceived mental illness stigma on parenting (“I think that other people believe that having a mental illness means that I cannot be a good parent”); (2) mental illness self-stigma/internalised stigma on parenting (“Having a mental illness means that I cannot be a good parent”); (3) perceived gender stigma on parenting (“I think that other people believe that being male/female [as applicable to participant’s own gender] makes it harder to be a good parent”); and (4) gender self-stigma/internalised stigma on parenting (“Because I am male/female [as applicable to participant’s own gender] I believe I am not a very good parent”).

Correlations were conducted for both mothers and fathers between the four stigma attitudinal items and the PSI-3 subscale scores as well as with individual items from each of the three PSI-3 subscales. Those variables with significant associations ($p = <0.05$) were included in two-step multiple regressions. Correlations were also performed for both mothers and fathers between the four stigma attitudinal items and the variables from the national survey, and the demographic and child care variables. Similarly, those variables with significant associations were included in the two-step multiple regression.

Two-step multiple regression models were utilised to explore gender differences in stigma variables and parenting variables. This approach was instrumental to pursue several research objectives in an integrated and parsimonious way. First, it allowed us to investigate our hypothesis one (mothers) and two (fathers) in relation to gender differences in perceived stigma and self-stigma associated with mental illness and gender. Gender differences on the variables treated as outcomes would result in
significant gender effects; conversely, gender invariance on these variables would result in non-significant main effects of gender. Second, this analytical approach was also used to explore relationships between stigma variables and parenting variables and the differences between genders in the relationship between stigma variables and parenting variables (across gender). Significant effects of the stigma ‘predictor’ would indicate the existence of significant relationships between the stigma variable and the parenting outcome variable across fathers and mothers; non-significant effects of the predictor would indicate the lack of a reliable relationship between the stigma variable and the parenting outcome. Third, this analytical approach allowed us to test for differences between the genders in the relationship between stigma variables and parenting variables. Hence, this allowed us to investigate the second part of hypothesis one (mothers) and two (fathers) in relation to providing information about how each of the stigma items was associated with parenting experiences uniquely across gender. A significant interaction between the stigma predictor and gender would indicate that the relationship between stigma and parenting is statistically different for father and mothers; a non significant interaction would indicate that the relationship between stigma and parenting is statistically invariant across the genders (i.e., the relationship found between stigma and parenting applies equally to both fathers and mothers). Simple effects analysis would clarify in what way the relationship between stigma and parenting differs between the genders. Also, although our analysis allowed the opportunity to show dissociations between different bases for stigma, this was beyond the scope of the current investigation and was therefore not explored.

Aiken and West’s (1991) method was used to test for the interaction between gender and each stigma type in predicting parenting variables. For these two-step multiple regression analyses, gender was first dummy coded (-1 = fathers, +1 =
mothers), each stigma variable centered, and multiplicative terms representing gender by stigma interaction computed. Step 1 included gender and each one of the stigma variables in turn as predictors; hence, this step informed gender differences on each parenting variable and associations between the stigma variable and the parenting variable across mothers and fathers. Step 2 included the multiplicative gender by stigma term and, thus, tested for gender (i.e., mothers vs. fathers) differences in the association between stigma and the parenting variable. Simple slope analysis followed significant or marginally significant interaction effects. These analyses provide separate slopes/beta coefficients for the two genders capturing the stigma-parenting relationship. Bonferroni corrections (Rice, 1989) were not performed as the study was exploratory in nature and relatively under-power (Moran, 2003; Nakagawa, 2004).

Chi-squared tests were performed to explore sources of perceived discrimination for mothers and fathers. To interpret the chi-squared tests, adjusted residuals were inspected to ascertain how far the observed count was from the expected count; a cut-off value of 2 was utilised. To measure the strength of association among the levels of the row and column variables, Cramer’s V is reported (>0.5, high association; 0.1-0.3, low association; 0-0.1, little if any association).

3. Results

3.1. Parents’ experiences of stigma

Table 2 describes parents’ agreement with stigma-related issues. Perceived stigma relating to mental illness was the most common form of stigma among parents. Parents were more likely to perceive stigma relating to mental illness or gender than internalise these attitudes. Despite high proportions of parents who perceived stigma, the majority of all parents reported that being a parent had helped them try to better manage their mental illness.
Table 2

*Parents’ agreement with stigma-related variables*

<table>
<thead>
<tr>
<th>Stigma-related variables</th>
<th>Mothers N(%)</th>
<th>Fathers N(%)</th>
<th>Total N(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think that other people believe that having a MI means I cannot be a good parent (Perceived MI/parent stigma)</td>
<td>46(79.3)</td>
<td>18(51.4)</td>
<td>64(68.9)</td>
</tr>
<tr>
<td>I think that others people believe that (my gender) makes it harder to be a good parent (Perceived gender/parent stigma)</td>
<td>11(19.0)</td>
<td>16(45.7)</td>
<td>27(29.0)</td>
</tr>
<tr>
<td>Having a MI means that I cannot be a good parent (MI/parent self-stigma / internalised stigma)</td>
<td>6(10.3)</td>
<td>1(2.9)</td>
<td>7(7.5)</td>
</tr>
<tr>
<td>Because I am (my gender) I believe I am not a very good parent (Gender/parent self-stigma / internalised stigma)</td>
<td>6(10.3)</td>
<td>3(8.6)</td>
<td>9(9.7)</td>
</tr>
<tr>
<td>I think that most people with MI are not very good parents (Externalised MI stigma)</td>
<td>11(37.9)</td>
<td>7(20.0)</td>
<td>18(19.4)</td>
</tr>
<tr>
<td>I think that most (parents of my gender) are not very good parents (Externalised gender stigma)</td>
<td>7(12.1)</td>
<td>9(25.7)</td>
<td>16(28.0)</td>
</tr>
<tr>
<td>Being a parent has helped me try to better manage my mental illness</td>
<td>52(89.7)</td>
<td>32(91.4)</td>
<td>84(90.3)</td>
</tr>
<tr>
<td>I feel that I have been treated unfairly by others because I have a MI (MI discrimination)</td>
<td>51(87.9)</td>
<td>25(71.4)</td>
<td>76(81.7)</td>
</tr>
</tbody>
</table>

*Note:* MI = mental illness. Table includes parents who responded 3-5 on five point Likert scale anchored at 1 = strongly disagree, 2 = disagree, 3 = not sure, 4 = agree and 5 = strongly agree.
Table 2 continued

<table>
<thead>
<tr>
<th>Stigma-related variables</th>
<th>Mothers N(%)</th>
<th>Fathers N(%)</th>
<th>Total N(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel that I have been treated unfairly by others</td>
<td>21(36.2)</td>
<td>21(60.0)</td>
<td>42(45.2)</td>
</tr>
</tbody>
</table>

Note: MI = mental illness. Table includes parents who responded 3-5 on five point Likert scale anchored at 1 = strongly disagree, 2 = disagree, 3 = not sure, 4 = agree and 5 = strongly agree.

3.2. Differences in stigma experiences between mothers and fathers

Table 3 summarises gender differences on stigma variables (see significant beta coefficients for Step 1’s gender predictor). Mothers were significantly more likely than fathers to report greater perceived mental illness stigma and greater mental illness self-stigma on parenting. In addition, mothers were significantly more likely than fathers to experience mental illness discrimination overall. Conversely, fathers were significantly more likely than mothers to report greater perceived gender stigma on parenting and were significantly more likely to hold stigmatising attitudes towards other fathers generally.
Table 3

*Multiple hierarchical regression analysis: Differences in stigma experiences between mothers and fathers*

<table>
<thead>
<tr>
<th>Outcome Variables</th>
<th>Step 1</th>
<th>Step 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gender β</td>
<td>Predictor β</td>
</tr>
<tr>
<td><strong>MI/parent self-stigma / internalised stigma</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceived MI/parent stigma</td>
<td>0.257*</td>
<td>0.195(*)</td>
</tr>
<tr>
<td>Externalised gender stigma</td>
<td>-0.299**</td>
<td>0.341**</td>
</tr>
<tr>
<td>Externalised MI stigma</td>
<td>-0.173(*)</td>
<td>0.327**</td>
</tr>
<tr>
<td>Gender/parent self-stigma / internalised stigma</td>
<td>-0.162(*)</td>
<td>0.551***</td>
</tr>
</tbody>
</table>

**Perceived gender/parent stigma**

|                                                        |        |          |               |
| Perceived MI/parent stigma                             | 0.374*** | 0.264**  | -0.162 (N=35) |
| Less MI discrimination                                 | -0.298** | -0.227*  | 0.140 (N=35)  |
| Gender discrimination                                  | -0.173(*) | 0.272**  | -0.069 (N=35) |

**Gender/parent self-stigma**

|                                                        |        |          |               |
| MI/parent self-stigma / internalised stigma            | 0.266** | 0.515*** | -0.114 (N=35) |
| Perceived gender/parent stigma                         | -0.247* | 0.291**  | 0.037 (N=35)  |
| Externalised gender stigma                             | -0.201* | 0.491*** | -0.050 (N=35) |

*Note:* Values are standardized regression coefficients. Fathers = -1; Mothers = 1. MI = mental illness. N = smallest number of cases for analyses after gender split and after missing cases excluded. (*)p < 0.10; *p < 0.05; **p < 0.01; ***p < 0.001.
3.3. Differences in parenting experiences between mothers and fathers

As summarised in Table 4 (see significant beta coefficients for Step 1’s gender predictor), mothers reported a significantly more negative parenting profile than fathers on the following parenting dimensions: (1) Parenting Competence, including poorer overall parenting competence, feeling less capable when caring for their child, more parenting concerns, a greater self-reported need for parenting assistance, feeling less able to manage parenting responsibilities, and a poorer view of themselves as parents; and (2) Role Restriction, including greater overall role restriction and greater perceived lack of personal space. Interestingly, despite more negative self-reported ratings of their parenting experience by mothers, interviewers were more likely to rate fathers as poorer compared to mothers on overall quality of care for their children. Several other marginal effects were also identified and can be found in Table 4.
Table 4

*Multiple hierarchical regression analysis: Differences in parenting experiences between mothers and fathers*

<table>
<thead>
<tr>
<th>Outcome Variables</th>
<th>Step 1</th>
<th>Step 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gender β</td>
<td>Predictor β</td>
</tr>
<tr>
<td><strong>Gender/parent self-stigma / internalised stigma</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Competence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poorer overall parenting competence</td>
<td>0.238*</td>
<td>0.430***</td>
</tr>
<tr>
<td>Parenting capability</td>
<td>-0.240*</td>
<td>-0.240*</td>
</tr>
<tr>
<td>Less parenting concerns</td>
<td>-0.329**</td>
<td>-0.154</td>
</tr>
<tr>
<td>Less parenting assistance required</td>
<td>-0.235*</td>
<td>-0.285**</td>
</tr>
<tr>
<td>Managing parenting responsibilities</td>
<td>-0.200*</td>
<td>-0.369***</td>
</tr>
<tr>
<td>Poorer perception of parenting ability</td>
<td>0.189(*)</td>
<td>0.238*</td>
</tr>
<tr>
<td><strong>MI/parent self-stigma / internalised stigma</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poorer overall parenting competence</td>
<td>0.119(*)</td>
<td>0.433***</td>
</tr>
<tr>
<td><strong>Perceived MI/parent stigma</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less parenting concerns</td>
<td>-0.263*</td>
<td>-0.204*</td>
</tr>
<tr>
<td><strong>Perceived gender/parent stigma</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managing parenting responsibilities</td>
<td>-0.252*</td>
<td>-0.238*</td>
</tr>
<tr>
<td>Poorer view of self as parent</td>
<td>0.235*</td>
<td>0.223*</td>
</tr>
</tbody>
</table>

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Table 4 continued

<table>
<thead>
<tr>
<th>Outcome Variables</th>
<th>Step 1</th>
<th>Step 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gender β</td>
<td>Predictor β</td>
</tr>
</tbody>
</table>

**Perceived gender/parent stigma**

**Role Restriction**

Greater overall role restriction | 0.289** | 0.321** | 0.014 (N=35)

**Gender/parent self-stigma/ internalised stigma**

**Role Restriction**

Greater overall role restriction | 0.216* | 0.383** | 0.032 (N=35)
Lack of personal space | 0.235* | 0.337** | 0.069 (N=35)

**MI/parent self-stigma/ internalised stigma**

Parental focus on child | 0.198(*) | 0.178(*) | -0.070 (N=35)

**Clinical/Demographic**

Poorer quality of care for children | -0.303(*) | 0.399* | -0.033 (N=35)

**Perceived gender/parent stigma**

**Isolation**

Greater loneliness | 0.202(*) | 0.304** | -0.111 (N=35)
Disinterest in social events | 0.170(*) | 0.373*** | -0.109 (N=35)

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3.4. Clinical/demographic and parenting correlates of stigma related to mental illness and gender on parenting

3.4.1. Stigma-related issues shared by mothers and fathers

Table 5 summarises clinical/demographic and parenting correlates of the four stigma attitudinal items found to be equally relevant to mothers and fathers (see significant beta coefficients for Step 1’s stigma predictor and non-significant beta coefficients for Step 2’s gender-stigma interaction). Among both mothers and fathers, perceived mental illness stigma on parenting was associated with those parents’ with an ICD-10 diagnosis of depression without psychosis and being more likely to have a case manager. In addition, equally among both mothers and fathers, gender self-stigma on parenting was significantly predicted by lower-level educational qualifications. For the parenting variables, in all cases greater stigmatising attitudes were consistently associated with more negative parenting experiences on the Competence, Role Restriction, and Isolation subscales of the PSI-3.
Table 5

*Multiple hierarchical regression analysis: Stigma-related parenting issues shared by mothers and fathers associated with mental illness and gender stigma on parenting*

<table>
<thead>
<tr>
<th>Outcome Variables</th>
<th>Step 1</th>
<th>Step 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gender β</td>
<td>Predictor β</td>
</tr>
<tr>
<td><strong>Perceived MI/parent stigma</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical/Demographic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis of depression without psychosis</td>
<td>0.063</td>
<td>0.242*</td>
</tr>
<tr>
<td>Less likely current case manager</td>
<td>-0.159</td>
<td>-0.235*</td>
</tr>
<tr>
<td><strong>Gender/parent self-stigma/internalised stigma</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Higher qualification</td>
<td>0.002</td>
<td>-0.230*</td>
</tr>
<tr>
<td><strong>Competence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poorer overall parenting competence (Dep)</td>
<td>0.201</td>
<td>0.399**</td>
</tr>
<tr>
<td>Confidence in parenting ability</td>
<td>-0.136</td>
<td>-0.367***</td>
</tr>
<tr>
<td>Decision making</td>
<td>-0.107</td>
<td>-0.391***</td>
</tr>
<tr>
<td>Poorer perception of self as parent</td>
<td>0.184</td>
<td>0.295**</td>
</tr>
<tr>
<td><strong>Perceived gender/parent stigma</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poorer overall parenting competence (Dep)</td>
<td>0.222</td>
<td>0.295*</td>
</tr>
<tr>
<td><strong>Perceived MI/parent stigma</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poorer overall parenting competence</td>
<td>0.134</td>
<td>0.310**</td>
</tr>
<tr>
<td>Poorer overall parenting competence (Dep)</td>
<td>0.023</td>
<td>0.287*</td>
</tr>
<tr>
<td>Confidence in parenting ability</td>
<td>-0.072</td>
<td>-0.183(*)</td>
</tr>
<tr>
<td>Ease of parenting</td>
<td>-0.032</td>
<td>-0.283**</td>
</tr>
</tbody>
</table>

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Table 5 continued

<table>
<thead>
<tr>
<th>Outcome Variables</th>
<th>Step 1</th>
<th>Predictor β</th>
<th>Interaction β</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gender β</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceived MI/parent stigma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decision making</td>
<td>-0.033</td>
<td>-0.215*</td>
<td>0.056 (N=35)</td>
</tr>
<tr>
<td>Less parenting assistance required</td>
<td>-0.172</td>
<td>-0.185(*)</td>
<td>-0.013 (N=35)</td>
</tr>
<tr>
<td>Managing parenting responsibilities</td>
<td>-0.104</td>
<td>-0.286**</td>
<td>-0.146 (N=35)</td>
</tr>
<tr>
<td>Poorer perceived parenting ability</td>
<td>0.097</td>
<td>0.281**</td>
<td>-0.079 (N=35)</td>
</tr>
<tr>
<td>MI/parent self-stigma/ internalised stigma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poorer overall parenting competence (Dep)</td>
<td>0.048</td>
<td>0.451***</td>
<td>-0.033 (N=25)</td>
</tr>
<tr>
<td>Less confidence in parenting ability</td>
<td>-0.042</td>
<td>-0.339**</td>
<td>0.031 (N=35)</td>
</tr>
<tr>
<td>Parenting capability</td>
<td>-0.139</td>
<td>-0.376***</td>
<td>-0.013 (N=35)</td>
</tr>
<tr>
<td>Decision making</td>
<td>-0.014</td>
<td>-0.332**</td>
<td>0.017 (N=35)</td>
</tr>
<tr>
<td>Less parenting assistance required</td>
<td>-0.138</td>
<td>-0.356**</td>
<td>-0.093 (N=35)</td>
</tr>
<tr>
<td>Managing parenting responsibilities</td>
<td>-0.065</td>
<td>-0.498***</td>
<td>-0.067 (N=35)</td>
</tr>
<tr>
<td>Perceived gender/parent stigma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greater overall role restriction (Dep)</td>
<td>0.196</td>
<td>0.283*</td>
<td>-0.096 (N=25)</td>
</tr>
<tr>
<td>Underestimated parenting obligations</td>
<td>0.114</td>
<td>0.259*</td>
<td>0.043 (N=35)</td>
</tr>
<tr>
<td>Lack of novel experiences</td>
<td>0.155</td>
<td>0.309**</td>
<td>0.084 (N=35)</td>
</tr>
</tbody>
</table>

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Table 5 continued

<table>
<thead>
<tr>
<th>Outcome Variables</th>
<th>Step 1</th>
<th>Predictor β</th>
<th>Interaction β</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender β</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Predictor β</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interaction β</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Gender/parent self-stigma/ internalised stigma**

**Role Restriction**

Difficult to escape parenting obligations 0.114 0.308** -0.013 (N=35)
Lack of control 0.117 0.253* 0.144 (N=35)
Lack of novel experiences 0.085 0.400*** -0.010 (N=35)
Cannot engage in enjoyable activities 0.186 0.285** 0.005 (N=35)

**Self-stigma MI/parent/ internalised stigma**

Difficult to escape parenting obligations -0.006 0.444*** -0.027 (N=35)
Lack of control 0.033 0.310** 0.115 (N=35)

**Perceived MI/parent stigma**

Greater overall role restriction 0.140 0.222* 0.032 (N=35)
Difficult to escape parenting obligations 0.034 0.241* 0.042 (N=35)
Lack of control 0.044 0.220* -0.021 (N=35)
Lack of novel experiences -0.041 0.296** 0.066 (N=35)
Cannot engage in enjoyable activities 0.120 0.194(*) 0.067 (N=35)

**MI/parent self-stigma/ internalised stigma**

Greater overall role restriction 0.111 0.380*** -0.024 (N=35)
Greater overall role restriction (Dep) 0.033 0.406** -0.128 (N=25)
Lack of novel experiences -0.005 0.320** 0.000 (N=35)
Lack of personal space 0.144 0.328** 0.028 (N=35)

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### Table 5 continued

<table>
<thead>
<tr>
<th>Outcome Variables</th>
<th>Step 1</th>
<th>Predictor β</th>
<th>Interaction β</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender/parent self-stigma/ internalised stigma</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Isolation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greater overall isolation</td>
<td>0.136</td>
<td>0.357***</td>
<td>-0.029 (N=35)</td>
</tr>
<tr>
<td>Greater overall isolation (Dep)</td>
<td>0.184</td>
<td>0.408**</td>
<td>-0.022 (N=25)</td>
</tr>
<tr>
<td>Greater loneliness</td>
<td>0.131</td>
<td>0.296**</td>
<td>-0.005 (N=35)</td>
</tr>
<tr>
<td>Disinterest in social events</td>
<td>0.083</td>
<td>0.348**</td>
<td>-0.067 (N=35)</td>
</tr>
<tr>
<td>Fewer parenting supports</td>
<td>-0.019</td>
<td>0.232*</td>
<td>-0.103 (N=35)</td>
</tr>
<tr>
<td><strong>Perceived MI/parent stigma</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greater overall isolation</td>
<td>-0.001</td>
<td>0.421***</td>
<td>0.108 (N=35)</td>
</tr>
<tr>
<td>Greater loneliness</td>
<td>0.039</td>
<td>0.280*</td>
<td>0.001 (N=35)</td>
</tr>
<tr>
<td>Disinterest in social events</td>
<td>-0.028</td>
<td>0.339**</td>
<td>0.124 (N=35)</td>
</tr>
<tr>
<td>Disinterest in others</td>
<td>0.024</td>
<td>0.316**</td>
<td>0.015 (N=35)</td>
</tr>
<tr>
<td>Others dislike spending time with me</td>
<td>-0.068</td>
<td>0.356**</td>
<td>0.099 (N=35)</td>
</tr>
<tr>
<td>Fewer friends</td>
<td>0.067</td>
<td>0.264*</td>
<td>0.096 (N=35)</td>
</tr>
<tr>
<td><strong>MI/parent self-stigma/ internalised stigma</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greater overall isolation</td>
<td>0.060</td>
<td>0.270*</td>
<td>0.104 (N=35)</td>
</tr>
<tr>
<td>Greater loneliness</td>
<td>0.022</td>
<td>0.404***</td>
<td>0.155 (N=35)</td>
</tr>
<tr>
<td>Disinterest in social events</td>
<td>0.010</td>
<td>0.257**</td>
<td>0.074 (N=35)</td>
</tr>
<tr>
<td>Others dislike spending time with me</td>
<td>-0.025</td>
<td>0.260**</td>
<td>-0.038 (N=35)</td>
</tr>
</tbody>
</table>

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3.4.2. Stigma-related issues different for mothers and fathers

Table 6 summarises clinical/demographic and parenting correlates of the four stigma attitudinal items found to have unique or different connotations for mothers and fathers (see significant beta coefficients for Step 2’s gender-stigma interaction and beta coefficients for simple slope analysis’ gender split). Exclusively among mothers, perceived mental illness stigma on parenting was associated with a younger age of mental illness onset, and was a significant predictor of feeling less capable when caring for their child, poor perceptions of themselves as mothers, and having greater perceived lack of personal space. Contrary to this, exclusively among fathers, this type of stigma was associated with having experienced mental illness after becoming a parent, having a greater number of non-biological children, and greater severity in interviewer-rated global performance.

Exclusively among mothers, mental illness self-stigma on parenting was more likely to present among those not living with their biological children and predicted poor perceptions of themselves as mothers and their parenting ability. Interestingly, this type of self-stigma was more prevalent among mothers with depression without psychosis, whereas for fathers, although marginal, mental illness self-stigma on parenting was more common among those with a psychotic disorder.

Although mothers generally, and mothers with dependent children only, were more likely than fathers to report greater overall isolation, perceived gender stigma on parenting was a significant predictor of isolation exclusively, or to a greater extent, among fathers generally, and fathers with dependent children only. Furthermore, only among fathers, did perceived gender stigma on parenting predict stronger beliefs that other people dislike spending time with them and being disinterested in others.
Exclusively among mothers, gender self-stigma on parenting was again significantly more likely for those not living with their biological children. Conversely, only among fathers, was gender self-stigma on parenting associated with poorer overall self-rated mental health and stronger perceptions that others dislike spending time with them. Interestingly, gender self-stigma was also associated with perceptions of more opportunities to spend time with friends since becoming a parent for fathers, but fewer of such opportunities for mothers.

Table 6

*Multiple hierarchical regression analysis: Stigma-related parenting issues different for mothers and fathers associated with mental illness and gender stigma on parenting*

<table>
<thead>
<tr>
<th>Outcome Variables</th>
<th>Step 1</th>
<th>Step 2</th>
<th>Simple Slope</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gender β</td>
<td>Predictor β</td>
<td>Interaction β</td>
</tr>
<tr>
<td>Perceived MI/parent stigma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical/demographic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older age of MI onset</td>
<td>-0.107</td>
<td>-0.101</td>
<td>-0.203(*)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MI after becoming a parent</td>
<td>0.012</td>
<td>-0.084</td>
<td>0.268*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More NBio children</td>
<td>-0.249*</td>
<td>0.204(*)</td>
<td>-0.212*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greater severity on global performance rating</td>
<td>0.084</td>
<td>0.152</td>
<td>-0.254*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

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Table 6 continued

<table>
<thead>
<tr>
<th>Outcome Variables</th>
<th>Step 1</th>
<th>Step 2</th>
<th>Simple Slope</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gender β</td>
<td>Predictor β</td>
<td>Interaction β</td>
</tr>
<tr>
<td><strong>Perceived MI/parent stigma</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Competence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parenting capability</td>
<td>-0.177 (*)</td>
<td>-0.188 (*)</td>
<td>-0.267*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(N=35)</td>
</tr>
<tr>
<td>Poorer perceived view of self as a parent</td>
<td>0.077</td>
<td>0.331**</td>
<td>0.216*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(N=35)</td>
</tr>
<tr>
<td><strong>Role Restriction</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of personal space</td>
<td>0.141</td>
<td>0.283**</td>
<td>0.175(*)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(N=35)</td>
</tr>
<tr>
<td><strong>MI/parent self-stigma/ internalised stigma</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clinical/demographic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not living with Bio children</td>
<td>-0.168</td>
<td>0.139</td>
<td>0.324*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(N=24)</td>
</tr>
<tr>
<td>Depression without Psychosis</td>
<td>0.105</td>
<td>0.128</td>
<td>0.303**</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(N=35)</td>
</tr>
<tr>
<td><strong>Competence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poorer perceived view of self as parent</td>
<td>0.091</td>
<td>0.342**</td>
<td>0.226*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(N=35)</td>
</tr>
<tr>
<td>Poorer perceived view of parenting ability</td>
<td>0.120</td>
<td>0.247*</td>
<td>0.181(*)</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>(N=35)</td>
</tr>
</tbody>
</table>

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Table 6 continued

<table>
<thead>
<tr>
<th>Outcome Variables</th>
<th>Step 1</th>
<th>Step 2</th>
<th>Simple Slope</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gender β</td>
<td>Predictor β</td>
<td>Interaction β</td>
</tr>
<tr>
<td><strong>Perceived gender/parent stigma</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Isolation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greater overall isolation</td>
<td>0.233*</td>
<td>0.413***</td>
<td>-0.170(*)</td>
</tr>
<tr>
<td>(N=35)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others dislike spending time with me</td>
<td>0.104</td>
<td>0.248*</td>
<td>-0.312**</td>
</tr>
<tr>
<td>(N=35)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disinterest in others</td>
<td>0.193(*)</td>
<td>0.285**</td>
<td>-0.207*</td>
</tr>
<tr>
<td>(N=35)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Gender/parent self-stigma/ internalised stigma</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical/demographic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not living with Bio children</td>
<td>-0.122</td>
<td>0.228</td>
<td>0.335**</td>
</tr>
<tr>
<td>(N=24)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poorer overall self-rated mental health</td>
<td>.005</td>
<td>0.169</td>
<td>-0.212(*)</td>
</tr>
<tr>
<td>(N=34)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Isolation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others dislike spending time with me</td>
<td>0.046</td>
<td>0.216*</td>
<td>-0.190(*)</td>
</tr>
<tr>
<td>(N=35)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Role Restriction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fewer friends</td>
<td>0.152</td>
<td>0.201(*)</td>
<td>0.215*</td>
</tr>
<tr>
<td>(N=35)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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3.5. *Experiences of stigmatising behaviours and sources of mental illness discrimination*

Fewer parents reported experiencing gender discrimination compared with mental illness discrimination and, unlike mental illness discrimination, differences between mothers and fathers regarding gender discrimination did not reach significance (see Multiple Hierarchical Regression Table 4). Therefore, results about perceived sources of discrimination are reported exclusively for mental illness discrimination and are summarised in Table 7. Overall, mothers were more likely than fathers to report mental illness discrimination across all sources; although gender differences between sources of discrimination did not reach significance.

The most common sources of discrimination cited by all parents were family members, followed by friends. Mothers were more likely than fathers not to have experienced mental illness discrimination from family members in the preceding 12 months. About half of all parents who had experienced mental illness discrimination during this time reported that they had been discriminated against by friends. Of services, mental health services were the most frequently cited source of discrimination by mothers, whereas legal services were most common for fathers.
Table 7

Chi-squared analyses: Perceived sources of mental illness discrimination for parents

<table>
<thead>
<tr>
<th>Sources of discrimination</th>
<th>Mothers N(%)</th>
<th>Fathers N(%)</th>
<th>Total N(%)</th>
<th>Cramer’s V</th>
<th>Fisher’s exact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discrimination</td>
<td>36(70.6)</td>
<td>13(52.0)</td>
<td>49(64.5)</td>
<td>0.112</td>
<td>0.132</td>
</tr>
<tr>
<td>No discrimination</td>
<td>15(29.4)</td>
<td>12(48.0)</td>
<td>27(35.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>51</td>
<td>25</td>
<td>76</td>
<td>0.112</td>
<td>0.132</td>
</tr>
<tr>
<td><strong>Friends</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discrimination</td>
<td>25(52.1)</td>
<td>12(50.0)</td>
<td>37(51.4)</td>
<td>.868</td>
<td>1.00</td>
</tr>
<tr>
<td>No discrimination</td>
<td>23(47.9)</td>
<td>12(50.0)</td>
<td>35(48.6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>48</td>
<td>24</td>
<td>76</td>
<td>.868</td>
<td>1.00</td>
</tr>
<tr>
<td>NA</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental health services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discrimination</td>
<td>17(36.2)</td>
<td>4(21.1)</td>
<td>21(31.8)</td>
<td>0.233</td>
<td>0.262</td>
</tr>
<tr>
<td>No discrimination</td>
<td>30(63.8)</td>
<td>15(78.9)</td>
<td>45(68.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>19</td>
<td>76</td>
<td>0.233</td>
<td>0.262</td>
</tr>
<tr>
<td>NA</td>
<td>4</td>
<td>6</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Legal services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discrimination</td>
<td>9(39.1)</td>
<td>7(58.3)</td>
<td>16(45.7)</td>
<td>0.279</td>
<td>0.311</td>
</tr>
<tr>
<td>No discrimination</td>
<td>14(60.9)</td>
<td>5(41.7)</td>
<td>19(54.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>12</td>
<td>76</td>
<td>0.279</td>
<td>0.311</td>
</tr>
<tr>
<td>NA</td>
<td>28</td>
<td>13</td>
<td>41</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: NA = Not applicable; work colleagues were excluded as more than 90% of the sample stated that this source of discrimination was not applicable.
Table 7 continued

<table>
<thead>
<tr>
<th>Sources of discrimination</th>
<th>Mothers N(%)</th>
<th>Fathers N(%)</th>
<th>Total N(%)</th>
<th>Cramer’s V</th>
<th>Fisher’s exact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child welfare services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discrimination</td>
<td>9(47.4)</td>
<td>6(54.5)</td>
<td>15(50.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No discrimination</td>
<td>10(52.6)</td>
<td>5(45.5)</td>
<td>15(50.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>11</td>
<td>76</td>
<td>0.705</td>
<td>1.00</td>
</tr>
<tr>
<td>NA</td>
<td>32</td>
<td>14</td>
<td>46</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: NA = Not applicable; work colleagues were excluded as more than 90% of the sample stated that this source of discrimination was not applicable.

4. Discussion

The aim of this study was to explore and compare the experiences of stigma related to mental illness and gender for mothers and fathers with SMI and the perceived impacts of stigma on parenting. Our findings indicated that parents overall were more likely to perceive stigma rather than self-stigmatise and that there were generally low rates of self-stigma among parents. Perceived stigma and self-stigma associated with the impact of gender and mental illness on parenting occurred differently for mothers and fathers. However, irrespective of gender, each of these different types of stigma is likely to contribute to poor self-reported parenting experiences.

In accordance with our first hypothesis, mothers were more likely than fathers to perceive and internalise stigma associated with the impact of their mental illness on their parenting. Furthermore, mothers were also more likely to report poorer overall parenting outcomes compared to fathers. Mothers’ tendency to self-stigmatise and to be more critical of themselves as parents may be reflective of their greater likelihood to be living with their children, and to, therefore, be more associated with direct parenting
responsibilities compared to fathers. These results may also be interpreted in the context of the Shifting Standards Model (Biernat et al., 1991; Biernat and Manis, 1994) that is, similar to previous research conducted with working parents, mothers in this study may have placed their parenting competence at higher standards compared to fathers and, therefore, judged themselves more harshly. Results regarding mothers’ tendency to self-stigmatise in comparison to fathers however, must be interpreted in the context of overall low levels of self-stigma among mothers.

In line with our second hypothesis, fathers were more likely than mothers to perceive stigma associated with the impact of their gender on their parenting. This may be indicative of fathers’ awareness of traditional gender stereotypes that associate parenting with being a predominantly female role (Bird, 1997). Contrary to our second hypotheses, however, no significant effects were found for fathers regarding gender self-stigma. Rather, fathers were more likely than mothers to externalise, and hold stigmatising attitudes towards other fathers. These results are consistent with research indicating that females are generally more emotionally sensitive and are more likely to internalise concerns, whereas males tend to cope with emotions in a more external manner (Else-Quest et al., 2006; Zlomke and Hahn, 2010). Results regarding fathers’ greater likelihood to externalise stigma in comparison to mothers however, must be interpreted in the context of overall low levels of externalised stigma among fathers.

In line with the second part of hypotheses one and two, there was some evidence of mental illness stigma having a greater impact on self-reported parenting experiences for mothers and, likewise, gender stigma having a greater impact on parenting experiences for fathers. For mothers, stigma associated with mental illness predicted poorer self-reported parenting competence and increased role restriction. For fathers, stigma related to gender predicted greater self-reported isolation. However, it was
evident that both mental illness and gender stigma predicted poorer self-reported parenting experiences overall for both mothers and fathers. Therefore, it appears that although there may be some unique impacts of specific types of stigma on parenting experiences for mothers and fathers, stigma tends to have a negative impact on parenting overall.

4.1. Implications

Our findings have important implications for parents with SMI. For example, it may be that mothers and fathers who are less educated may be more vulnerable to gender self-stereotyping and internalising this form of stigma. Therefore, it may be particularly important for interventions to target these parents. Mothers and fathers with depression and those with a mental health case manager may have greater insight compared to those with psychosis and, hence, greater awareness of mental illness stereotypes (Mak and Wu, 2006; Staring et al., 2009). This increased insight, too, might lead to these parents being more aware of their own limitations and more focussed on lack of competence rather than on strategies to overcome weaknesses. Also, these parents may be more likely to be open regarding their illness, engaged in mental health treatment and, therefore, potentially exposed to others with stigmatising attitudes.

Discrimination from family members may be a particular concern for both mothers and fathers. Therefore, it may be important for interventions to focus on helping parents to develop better relationships with their families and/or providing family education and support regarding discrimination and its potential impacts. As opposed to family and friends, parents were less likely to report mental illness discrimination from services. Although this may be accurate, parents may have also been less inclined to disclose this form of discrimination due to concerns regarding potential consequences, or in an attempt to provide more socially acceptable responses.
Despite professionals being cited less frequently as a source of mental illness discrimination compared to family members, a substantial proportion of parents also reported experiencing discrimination from mental health services, legal services and child welfare services. Interventions for professionals from these services, such as psychoeducation or ‘social contact’ through personal testimonies by parents with SMI, may assist to increase understanding and empathy and promote more positive interactions with parents with SMI.

Mothers with a younger age of mental illness onset may be more inclined to perceive mental illness stigma on their parenting, as these mothers may be more likely to experience chronic mental illness and hence be greater exposed to potentially stigmatising environments over a longer period of time. Mothers who did not reside with their biological children were at greater risk of self-stigma. Because biological children included children of all ages, this may be indicative of disconnected relationships with children of any age as well as issues related to child custody loss. Therefore, interventions for mothers with SMI may target self-stigma and improving relationships with children. Research regarding interventions for self-stigma is currently lacking (Gerlinger et al., 2013); however, some studies have found that interventions can reduce self-stigma and improve self-esteem and self-efficacy (Davidson et al., 2006; Hauser et al., 2009). Self-stigma interventions may be tailored for mothers to assist with improving their perceived competence as parents and decrease perceived burdens associated with parenting.

Fathers who had a greater number of non-biological children, who experienced mental illness after parenthood and those poorer in global functioning, were more inclined to perceive stigma associated with their mental illness on parenting. Therefore, it may be important for stigma interventions with fathers to target those with these
particular vulnerabilities. Interventions for fathers should address perceived gender stereotypes associated with parenting and focus on more externalised responses to stigma to reduce isolation for fathers associated with stigma of this kind and improve social relationships.

Despite high proportions of parents who perceived stigma, the large majority of all parents also reported that parenthood had encouraged them to better manage their mental illness, demonstrating that although stigma occurs in a variety of forms, for most parents with SMI, parenthood is valuable incentive for recovery for both mothers and fathers. It would benefit in future research to explore the strategies used by these parents to better manage their mental illness, if those strategies are effective, and if they can be generalised to non-parents.

4.2. Limitations

Although the current study adds significantly to research on stigma and parents with SMI, there are some limitations that are important to acknowledge. For example, although the study utilised a larger sample size than many prior (qualitative) investigations in this area, the sample size was still relatively small and, therefore, the findings cannot be generalised to all parents with SMI. Furthermore, although a novel aspect and strength of our study was the inclusion of fathers, the majority of our sample was female. While this gender division was relative to the general population from which the sample was recruited, and is also comparative to the general population of mothers and fathers with psychotic disorders (Campbell et al., 2012), more research is required with larger numbers of fathers to gain more representative findings for fathers with SMI.
Although ethnicity was not analysed in this study, this information was collected in the Second Australian National Survey of Psychosis, and rather than exploring stigma due to ethnicity in this smaller subset, it could be investigated in the larger cohort.

Additionally, because of the cross-sectional design of the study we cannot make inferences about the direction of the relationships between stigma experiences and parenting. Further, due to the multiple statistical tests undertaken, the results must be interpreted with caution of a possible Type 2 error.

The subscales used from the PSI-3 provided important information regarding a variety of parenting issues relevant to parents with SMI. Although screening measures and amendments were undertaken, it is possible that some of the items were less appropriate for parents with older children and this may have affected the results. In addition, some of the stigma items were worded in a complex way and may have been cognitively challenging for some parents with SMI. Furthermore, although our measure of stigma was based on the SSMIS (Corrigan et al., 2006), more research is required and replication is needed to validate the current tool for the types of stigma explored.

Finally, although we explored general sources of mental illness discrimination, the study did not investigate the specific types of discrimination for parents as cited by Jeffrey et al 2013 e.g. perinatal professionals (midwives, obstetricians, health visitors), schools, and physical health professionals (family physicians, emergency departments). Future research may explore the discrimination experiences of parents with SMI with these potentially more relevant services. As well as comparing the differences in the stigma experiences of parents with and without SMI.
5. Conclusion

Mothers and fathers with SMI experience stigma differently. Mothers are more likely to perceive and internalise stigma associated with the impact of their mental illness on their parenting. Conversely, fathers are more likely to perceive stigma related to the impact of their gender on their parenting and are more inclined to hold stigmatising attitudes towards others. Although stigma appears to impact on parenting in unique ways for mothers and fathers, irrespective of gender, stigma of all forms explored in the current study predicted poorer self-reported parenting experiences. This is the first quantitative study to compare the stigma experiences of mothers and fathers with SMI and to provide initial insights regarding tailored stigma interventions for parents. It is hoped that future research may continue to investigate this area to provide further knowledge to better support parents, to promote help-seeking, and reduce the impact of stigma for mothers and fathers with SMI.

Acknowledgements

This publication is based on data collected in the framework of the 2010 Australian National Survey of High Impact Psychosis. The members of the Survey of High Impact Psychosis Study Group are: V Morgan (National Project Director), A Jablensky (Chief Scientific Advisor), A Waterreus (National Project Coordinator), R Bush, V Carr, D Castle, M Cohen, C Galletly, C Harvey, B Hocking, A Mackinnon, P McGorry, J McGrath, A Neil, S Saw, H Stain. Ethics approvals for the study were obtained from relevant institutional human research ethics committees. The original study was funded by the Australian Government Department of Health and Ageing. This report acknowledges all the effort and hard work by the local site coordinators. We would also like to thank the hundreds of mental health professionals who participated in the
preparation and conduct of the survey and the many Australians with psychotic disorders who gave their time and whose responses form the basis of this publication.
General Discussion

Over the last decade there has been an increase in the numbers of parents living with SMI in Australia (Campbell et al., 2012). Whilst it is well established that people affected by SMI contend with widespread public stigma impacting on their quality of life (Corrigan & Watson, 2002b), little is still known about the specific experiences of stigma that parents with SMI encounter. Hence, the current study aimed to explore and compare the experiences of stigma for mothers and fathers with SMI with regards to the stigma they experience related to their mental illness, as well as potential compounding gender effects, and the associated impact of stigma on parenting.

In the following section, I will elaborate on the discussion in the previous section by providing a more in-depth analysis of the research and clinical implications of the findings of the current study. Firstly, I will provide a summary of results and implications regarding issues shared by mothers and fathers with SMI. Secondly, issues and implications specific to mothers with SMI will be discussed. Finally, results regarding fathers with SMI will be described in reference to clinical implications specific to fathers. This section also provides a summary of the limitations of the study and considerations for future research.

Issues Shared by Mothers and Fathers with Serious Mental Illness

Our findings indicated that multiple issues were equally relevant among mothers and fathers. Prior research demonstrates that individuals with SMI without children are more likely to perceive stigma rather than self-stigmatise (Brohan, Elgie, et al., 2010; Gerlinger et al., 2013). In accordance with this finding, parents in the current study were more likely to perceive stigma associated with the impact of their mental illness and their gender on their parenting rather than internalise these negative attitudes. However, unlike previous studies demonstrating rates of self-stigma around 40% for
non-parents (Brohan, Elgie, et al., 2010), less than 10% of parents in our study reported self-stigma.

There are a variety of reasons which may account for lower rates of self-stigma among parents compared to non-parents with SMI. It is possible that having children may act as a protective factor against self-stigma. Many parents with SMI value the role of parenthood and having children has been shown to have a positive impact on mental health outcomes (Diaz-Caneja & Johnson, 2004; Evenson et al., 2008; Nicholson & Miller, 2008; Sands, 1995). Indeed, in the current study the majority of all parents agreed that being a parent had encouraged them to better manage their mental illness. Subsequently, these parents may be more likely to adopt positive coping strategies to deal with stigma compared to people with SMI without children; they may be more likely to reject negative public attitudes, therefore reducing self-stigma and protecting their self-esteem (Corrigan & Wassel, 2008; Corrigan & Watson, 2002b; Crocker & Major, 1989). Interventions with parents with SMI therefore could build on positive coping strategies, such as embracing their parental role, to help minimise the impact of self-stigma.

For both mothers and fathers, stigma generally predicted more negative self-reported parenting experiences. Further, among all parents, those who internalised mental illness stigma associated with their parenting achieved poorly on interviewer-rated quality of child care. Therefore, irrespective of gender, our results show that stigma appears to have detrimental effects on subjective experiences of parenting for all parents. In addition, parents who self-stigmatise regarding the impact of their mental illness on their parenting may be particularly prone to not only poorer self-reported parenting experiences, but also to (objective) difficulties providing adequate care for their children. Hence, this finding provides evidence for the negative impact of stigma
on parents with SMI, and highlights the need for interventions to address stigma to better assist mothers and fathers in their parental role.

All parents reported experiencing discrimination based on their mental illness in a variety of contexts. Both mothers and fathers were most likely to report mental illness discrimination from family (or friends) compared to external support services. Although previous research has found that parents with SMI experience discrimination from family members (Ackerson, 2003a), most qualitative studies tend to cite child welfare services and the legal system in relation to child custody disputes as a key source of discrimination for parents with SMI (Ackerson, 2003a; Boursnell, 2007; Montgomery et al., 2011; White et al., 1995). Because family members may be a main source of both practical and emotional support during times of crisis for some parents (Ackerson, 2003a), discrimination from family members may impact on parents’ ability to access parental support or child care assistance from family when most needed. Furthermore, because parents may have closer personal relationships with family members as opposed to external services, perceived discrimination of this kind may be more likely to promote self-stigma and have longer-term negative impacts on quality of life.

Our findings add to prior research in this area also by demonstrating that discrimination from external services may potentially be less concerning for parents with SMI than as previously suggested by smaller qualitative studies in this area. Interventions may therefore wish to pay greater attention to more proximal sources of discrimination for parents, such as family members. Interventions for parents with SMI may aim to promote family engagement and improve relationships within the family system. Strategies such as family education and support regarding discrimination and its impact may help to increase social support for parents, improve parenting efficacy and reduce self-stigma.
For all parents, those with lower-level educational qualifications were more inclined to internalise gender based stigma on their parenting. Because low education has been shown to be associated with poorer mental health outcomes (Belle, 1990), it is possible that parents who are less educated may be more vulnerable to experiencing poorer self-esteem and self-efficacy and therefore may be more likely to internalise negative gender stereotypes regarding parenting. However, it is important to note that due to the correlational nature of our data, it is also possible that the reverse occurs; and poor self-esteem and self-efficacy contribute to a decrease in motivation to engage in vocational opportunities, thus resulting in lower educational attainment. Irrespective of the direction of causality in the stigma-educational levels relationship, our finding suggests that service providers may well target parents who are less educated or lower in functioning and who may be more vulnerable to internalising gender related stereotypes regarding parenting.

Parents with a mental health care worker were found to be more likely to perceive mental illness stigma associated with their parenting. Although disclosing one’s mental illness and accessing support may allow a person to gain often necessary treatment, it also risks exposing oneself to the stigmatising attitudes of others (SANE, 2012). Hence, it is likely that parents in our study with a mental health care worker were more likely to have disclosed their illness, to be engaged in mental health treatment, and thus more exposed to negative attitudes of others within mental services and/or in the community. To reduce the risk of parents’ avoiding mental health treatment due to perceived stigma (Ackerson, 2003a; Diaz-Caneja & Johnson, 2004), education and support for mental health care providers is needed to help increase awareness of the impact of their stigmatising attitudes on parents with SMI. Furthermore, to help parents maintain engagement in mental health treatment, collaborative assessment and regular
monitoring of parenting goals by mental health care providers may assist to reduce perceived stigma and promote a sense of safety to encourage parents to disclose their parenting concerns and feel more in their parenting role.

Whilst previous literature has demonstrated higher levels of public stigma towards people with psychosis in comparison to other psychiatric illnesses (Świtaj et al., 2009), in our study, parents with depression without psychosis were more likely to perceive mental illness stigma compared to parents with a psychotic illness. Research has shown that insight is a predictor of increased perceived stigma for people with SMI (Mak & Wu, 2006; Staring, Van der Gaag, Van den Berge, Duivenvoorden, & Mulder, 2009). Therefore, those parents with depression without psychosis, and hence, with potentially greater insight, may be more aware of negative public attitudes associated with the impact of their mental illness on their parenting and thus may be more likely to perceive stigma as a result. It is important therefore for service providers to target parents with depression and those with greater insight who are likely to be more vulnerable to perceived mental illness stigma. Interventions could explore parents’ awareness of mental illness stigma, ways in which parents with depression respond to this form of stigma and build on positive coping strategies to help protect their self-esteem and self-efficacy.

In summary, stigma interventions focusing on the aforementioned issues may assist to reduce the negative impact of stigma on both mothers and father with SMI. Some issues identified in the present study were particularly relevant to mothers vs. fathers. These results and implications are discussed in the following sections.

**Issues for Mothers with Serious Mental Illness**

This study investigated two main hypotheses specific to mothers and fathers. Firstly, we predicted that mothers would experience greater perceived stigma and self-
stigma associated with the impact of their mental illness on their parenting compared to fathers, and additionally, that mental illness stigma would have greater impact on parenting outcomes for mothers compared to fathers.

Our results were consistent with this hypothesis, indicating that mothers were significantly more likely to be aware of stigmatising public attitudes regarding being a parent with a mental illness, to internalise these views and; this form of stigma in turn impacted more negatively on specific areas of mothers’ parenting relative to fathers.

Our findings support the suggestions by Jenkins and Carpenter-Song (2008) that females with SMI may be more likely to experience mental illness self-stigma compared to males. Besides corroborating this empirically, this study has the merit of being the first to our knowledge to have demonstrated this pattern with parents with SMI. This finding is important because parents with SMI, opposed to non-parents, encounter multiple stigma not only due to their mental illness on their parenting ability (Ackerson, 2003a) but also the compounding impact of gender stereotypes regarding parenting (Bird, 1997; Wood & Eagly, 2012). In addition, little research has thus far compared whether mothers or fathers are more adversely affected by stigma. Hence, given that mothers were found to be more likely to self-stigmatise, this result provides evidence that, subjectively, mothers may be more negatively affected by mental illness stigma compared to fathers. Results regarding mothers’ tendency to self-stigmatise in comparison to fathers however, must be interpreted in the context of overall low levels of self-stigma among mothers.

There are a number of possible explanations that may account for mothers to be more likely to self-stigmatise compared to fathers. For example, as mentioned previously, the Shifting Standards Model (Biernat et al., 1991; Biernat & Manis, 1994) proposes that people are judged based on within group standards or dimensions.
Therefore, parents may be judged differently according to their gender. Given traditional gender stereotypes which tend to associate parenting with being a predominantly female domain, mothers with SMI may have and perceive higher expectations of themselves as parents compared to fathers. Hence, mothers with SMI may be more inclined to perceive negative public judgements regarding (inadequate) mothering, may be less likely to meet high standards of motherhood and therefore be more likely to internalise stigma and be self-critical of their parenting.

Mothers were also significantly more likely to perceive discrimination based on their mental illness relative to fathers. This supports earlier findings that women with mental illness are more likely to perceive discrimination compared to men (Cechnicki et al., 2011). However, this study is the first to our knowledge to demonstrate this finding in a parent specific population which contend with additional stigma associated with being a mentally-ill parent as well as gender stereotypes and expectations regarding parenting. Research indicates that those who are more likely to perceive stigma and self-stigmatise are also more inclined to perceive discrimination (Brohan, Elgie, et al., 2010; Crocker & Major, 1989; Pinel, 1999). As described earlier, ‘identity threat theory’ (Steele, 1998; Steele et al., 2002) states that when someone is high in self-stigma, the more likely they are to perceive ambiguous behaviours from others as negative and due to their prejudiced views, the more likely they are to experience discrimination (Crocker & Major, 1989; Crocker et al., 1998; Major & O’Brien, 2005; Major et al., 2002). Therefore, given that mothers are more likely to internalise mental illness stigma, mothers may also be more inclined to interpret potentially ambiguous behaviours from others as discrimination.

Our results significantly add to the current literature on the stigma experiences of mothers with SMI. Considering the adverse effect of self-stigma on mothers, it is
worthwhile further investigating the possibility of implementing specifically designed interventions for mothers with SMI targeting this form of stigma associated with the impact of mental illness on parenting.

Our findings indicate that it may be important for intervention programs to target mothers with a younger age of mental illness onset who may be more likely to perceive mental illness stigma. Additionally, our results show that mothers who do not live with their biological children and those with depression without psychosis may be at greater risk of mental illness self-stigma. Research regarding interventions for self-stigma however is currently sparse. A recent meta-analysis undertaken by Gerlinger and colleagues (2013) found that of 54 studies reviewed, only two studies specifically focused on interventions for self-stigma (between the years of 1994 and 2011). Yet, the limited research on treatments for self-stigma demonstrates that psycho-education, peer support and cognitive behavioural interventions may help to reduce self-stigma and ameliorate associated impacts on mental health, such as reduced self-esteem and self-efficacy and poorer quality of life (Davidson, Chinman, Sells, & Rowe, 2006; Garety, Fowler, & Kuipers, 2000; Hauser et al., 2009; Larson & Corrigan, 2010). Therefore, interventions such as these should be tailored for mothers and incorporated in to parenting programs to improve issues identified by mothers to be associated with mental illness self-stigma including parenting competence and parenting self-efficacy.

**Issues for Fathers with Serious Mental Illness**

We also predicted that fathers would experience greater perceived stigma and self-stigma associated with the impact of their gender on their parenting compared to mothers, and subsequently that stigma associated with gender would have a greater impact on parenting outcomes for fathers compared to mothers.
Consistent with this hypothesis, fathers were more likely than mothers to perceive gender stigma, and gender stigma was also found particularly important in predicting parenting-related experiences of isolation for fathers. However, unlike mothers who reported greater mental illness self-stigma and discrimination, there were no significant effects identified for gender based self-stigma or discrimination for fathers. Rather, our study found that fathers, as opposed to mothers, reported greater stigma towards other fathers in general and towards other parents with mental illness. This suggests that although fathers may be aware of traditional gender stereotypes regarding parenting, fathers may be more likely to direct negative attitudes externally towards others, rather than internalising these views. This is in agreement with findings from Karidi and colleagues (2010) who found that men with SMI were more likely to have negative attitudes towards others with mental illness in comparison to women. Results regarding fathers’ greater likelihood to externalise stigma in comparison to mothers however, must be interpreted in the context of overall low levels of externalised stigma among fathers.

Research relating to gender differences in coping and locus of control may account for this finding. Studies in this area demonstrate that women tend to favour more emotion-focused or internal styles of coping, aimed to reduce emotional stress. Men, alternatively, tend to exhibit behavioural or external means of coping, aimed at altering the situation or environment (Lazarus & Folkman, 1984; Lengua & Stormshak, 2000; Matud, 2004). According to the socialisation hypothesis, gender differences in coping styles may be reflective of traditional gender roles, with expectations that women are more emotional and dependent, whereas men are more autonomous and assertive (Ptacek, Smith, & Dodge, 1994). Gender differences in coping styles also relate to variations in locus of control for men and women. Following Rotter’s (1966)
initial findings that men and women exhibited little differences in locus of control, more recent research indicates that women are less likely to perceive their efforts to address a problem as effective, and therefore respond to situations in a more emotion-focused or avoidant manner. Men, alternatively, tend to view themselves as having greater personal control over situations, and thus display more behavioural and problem-focused coping strategies (Sherman, Higgs, & Williams, 1997).

Altogether, it may be possible that mothers who are more emotionally orientated, and perceive less control over their situation, may be more likely to agree with and internalise negative attitudes associated with their parenting. Conversely, fathers, who are more externally focused and perceive greater control over their environment, may be more likely to direct stigmatising attitudes towards others rather than themselves. This approach may therefore potentially protect fathers’ self-esteem and self-efficacy relative to mothers, however may also impact on their social relationships, on their access to appropriate parenting supports and result in greater isolation.

Our findings suggested that it may be important for intervention programs to particularly target poorer functioning fathers, those fathers who experience mental illness after becoming a parent and fathers who may come from separated families, and hence have a greater number of non-biological children, as these fathers were more likely to perceive mental illness stigma. In addition, despite self-stigma being less concerning for fathers, treatment interventions may target fathers with poorer perceived mental health who were found to be more inclined to internalise gender-based stigma associated with their parenting.

Interventions aimed at fathers with SMI may target perceived gender stereotypes associated with parenting and negative attitudes towards others to help reduce the risk
of social isolation and poorer social relationships associated with this form of stigma for fathers. Furthermore, interventions may explore the specific coping strategies adopted by fathers and build on their strengths as fathers.

Interestingly, although mothers were more likely than fathers to report a more negative perception of their parenting competence, interviewers were more likely to rate fathers as poorer with regards to the quality of care they provided for their children. These ratings may be accurate, indicating that fathers experience difficulties providing adequate care for their children, and therefore highlighting the need for support for fathers in this area. Alternatively, these ratings may also reflect a gender bias from clinicians favouring mothers; this bias has been demonstrated in previous studies (Nicholson et al., 1999). Consequently, it is important also for clinicians to be aware of these parenting stereotypes and the potential impact they may have on engaging fathers in treatment. Our results indicated that almost 90% of fathers, as opposed to 81% of mothers, reported that being a parent had helped them try to better manage their mental illness. This suggests that children are just as important in the lives of fathers with SMI as they are to mothers. Moreover, based on our results, fathers may be equally, if not more likely than mothers to be motivated to better manage their mental health for their children.

In addition, in accordance with the literature regarding parents with SMI (Reupert & Mayberry, 2009), fathers in this sample were less likely to reside with their children in comparison to mothers (see Table 4S for further details). This factor is likely to impact on fathers’ parenting experiences and perceptions of stigma based on their gender, as fathers may perceive their gender as a factor that may be used against them in child custody decisions.
Limited attention has been paid in the literature to the experiences of fathers with SMI. The current study adds significantly to prior knowledge in this area. Our results have a variety of important implications for clinical practice: Although many areas of stigma experiences are shared by all parents, there are also a number of unique concerns for mothers and fathers. Consequently, these results can help to improve service delivery to better adapt and tailor treatment approaches to target the particular concerns faced by mothers and fathers with SMI and reduce the associated impact of stigma on parenting.

**Study Limitations**

While the present research adds significantly to current knowledge on stigma and parents with SMI, there are some limitations that are important to acknowledge. For example, as highlighted in the previous discussion section, although the current study utilised a larger sample size than many other qualitative investigations in this area, our sample was still relatively small ($N = 93$), and therefore the results cannot be generalised to all parents with SMI. In addition, although this study included fathers, the majority (62%) of the sample were still female. While this gender division maps onto the general population in which the sample were recruited from, and to the gender division of mothers and fathers with psychotic disorders (Campbell et al., 2012), more research is required with larger numbers of fathers to gain more representative findings for fathers with SMI.

The results were based on self-report measures. Although participants were encouraged to provide honest responses and assured that their information would be kept confidential, participants may have been disinclined to fully disclose sensitive issues, such as self-stigma or parenting difficulties due to shame or humiliation, fears regarding potential consequences, or in an attempt to comply with perceived desired
social standards. Also, the majority of our sample had a psychotic disorder. Common symptoms experienced by these individuals such as poor insight, paranoia, low mood (Broome et al., 2005), as well as potential side effects related to medication, may have resulted in parents minimising or failing to provide accurate responses. Further, although all participants who completed the interview were assessed as being psychologically stable at the time of contact, research suggests that parents with SMI often conceal their symptoms (Ackerson, 2003a; Diaz-Caneja & Johnson, 2004). In addition, some of the stigma items were worded in a complex way and may have been cognitively challenging for some parents with SMI. Consequently, all of these factors may have impacted on the data obtained and may account, for example, for the smaller proportion of parents who reported self-stigma in our study in comparison to previous studies with individuals with SMI (Brohan, Elgie, et al., 2010; Jenkins & Carpenter-Song, 2008).

Both mothers and fathers were more likely to report discrimination from family or friends as opposed to support services. While this may have been accurate, it is possible that parents associated the interviewer with these support services and were therefore less inclined to disclose discrimination of this kind due to similar concerns regarding potential ramifications, embarrassment, or social desirability. Furthermore, we asked about parents experiences of discrimination during the preceding 12 months. This provided an indication of the extent of discrimination in a short and recent period; however, some individuals may have experienced discrimination outside of this time frame. It is therefore possible that discrimination from support services, as well as other sources, may be even greater than the results obtained.

Limitations of the measures used in the study may have also impacted on the results. As reported in the previous discussion section, the subscales from the PSI-3
(Abidin, 1995) allowed us to gain important information regarding a variety of issues relevant to parents with SMI. Questions were screened regarding their suitability for use with parents of children of all ages and one item was adapted accordingly. In addition, parents were asked to consider their youngest child when responding to the questions. Despite this, however, we acknowledge that some of the items may not have been as appropriate for parents with older children and this may have therefore affected some of our results. Furthermore, although the tool used to explore stigma was appropriate for our study design, and items were based on the SSMIS, a valid and widely used measure (Corrigan, Watson, & Barr, 2006), further investigation is needed to provide evidence that the adapted and single- items used in the current study targeted the particular domains of stigma intended. We were unable to locate a validated instrument that explored stigma specifically for parents at the time of development of the study; this further highlights the need for additional psychometric work in this area to better evaluate and understand the stigma experiences of mothers and fathers with SMI.

Variables from the second Australian national survey of psychosis were gained two years prior to the current study. We cannot exclude the possibility that parents’ characteristics may have changed during this time (e.g. education, quality of child care and general functioning). Furthermore, as acknowledged by Campbell and colleagues (2012), interviewers in the second Australian national survey of psychosis based their ratings of quality of child care and overall functioning on participants’ self-reports rather than on observational data, which may have increased the accuracy of these ratings. Consequently, although this information provided valuable insight regarding parents, these issues must be taken into account when interpreting results related to the clinical and demographic issues associated with stigma for parents.
Lastly, because of the cross-sectional design of our study we cannot make inferences about the direction of the relationships between stigma experiences and parenting. It seems reasonable to speculate that poor quality of parenting experiences may be a result of stigma, but it is also possible that parents with SMI who are experiencing parenting difficulties are inclined to perceive their social environment and the way they are treated by others more negatively and reflecting stigma (Świtaj et al., 2009). Hence, the results of the study must also be viewed in light of these limiting factors. However, although some limitations exist regarding the representativeness of the sample utilised and the study design and methods adopted, the current research adds significantly to the literature regarding the experiences of stigma for parents with SMI.

**Further Considerations for Future Research**

This study provides a first insight into gender differences associated with stigma experiences for parents with SMI and the associated impact of stigma on parenting for both mothers and fathers. It requires replication with a larger sample size and with parents from different social contexts. There is a large amount of further work in this area which warrants attention. We will not attempt to list all of these in detail, but rather provide a few specific recommendations for further investigations with parents with SMI.

For example, many parents in the current study talked about how different their responses may have been at different time periods in their lives (e.g. when their children were younger, or during an acute phase of their illness). Consequently, it may be important for future research to explore the unique experiences of stigma for mothers and fathers across the child’s life-span and during both acute and non-acute illness phases as parents’ experiences and needs may be very different during these times.
Given the depth of the data in the original survey, there was scope to investigate a range of issues relevant to stigma and parenting. For the purpose of the current study, a small subset of variables from the previous study which explored parenting and child care as well as demographic and clinical variables previously suggested to be related to stigma we included. We recommend however, that future research investigate the relationships between stigma, parenting and other potentially relevant variables from the Second Australian National Survey of Psychosis to gain further insights regarding the issues that may be associated with stigma for parents with SMI. This may include, for example, additional clinical and socio-demographic issues such as symptoms of depression and anxiety, substance use and socioeconomic status. In addition, research may also investigate the relationship between parenting experiences as measured by the PSI-3 and mental health symptomology.

The two-step multiple regression analyses used in the study allowed the opportunity to show dissociations between different bases for stigma. This was not explored in the current study however, as it was beyond the scope of the aims of the present work. We recommend that future research further investigate the relationships between different forms of stigma explored in the current study and how gender may moderate those relationships.

Although the current study explored general sources of mental illness discrimination, we did not investigate the more specific areas of discrimination parents often encounter such as perinatal professionals (midwives, obstetricians, health visitors), schools, and physical health professionals (family physicians, emergency departments) (Jeffrey et al., 2013). Future research may explore the discrimination experiences of parents with SMI with these more specifically relevant services.
To better determine the unique issues experienced by parents with SMI, it is recommended that future studies explore and compare the differences in the experiences of stigma and discrimination for parents with and without SMI. For example, investigating the distinct characteristics associated with the way in which fathers with SMI (as opposed to fathers in general) experience parenting stigma based on their gender.

As opposed to general expectations of parents without SMI, few parents overall in this sample were currently living with their dependent children; and fathers were even less likely to reside with their children. Although this study commenced some exploration regarding how living situation may be associated with differences in stigma experiences between mothers and fathers, this could also be investigated further.

Similarly to studies with non-specific parent samples of individuals with SMI, perceived stigma was common among all parents and parents were less likely to self-stigmatise. Future research should explore the similarities and differences in the responses to stigma by parents and non-parents and compare the specific stigma experiences between parents and non-parents with SMI to test whether parents are in fact less likely to self-stigmatise due to the positive impact of parenting on mental health. Furthermore, to provide additional insights regarding specific treatment approaches for parents, it would be important for research to investigate ways in which parents, particularly fathers, respond to and cope with perceived stigma to assist parents to develop and strengthen these strategies.

Lastly, given the dearth of current research evaluating the effectiveness of self-stigma interventions for people with SMI generally (Gerlinger et al., 2013), further to the development of appropriate and tailored treatment and support programs for mothers and fathers with SMI, it is important for future studies to explore the effectiveness of
these approaches for parents using validated measures and to investigate the associated impact of these interventions on parenting experiences.

Conclusion

To conclude, this study is the first, to our knowledge, to explore and compare the experiences of subjective mental illness and gender stigma associated with parenting for mothers and fathers with SMI and the perceived impact of these stigmas on parenting experiences. This study demonstrated that both mothers and fathers with SMI perceive stigma and, to a lesser extent self-stigmatise. In addition, for all parents, irrespective of gender, each of the areas of stigma explored in this study was associated with poorer self-reported parenting experiences. Therefore our results provide empirical evidence regarding the detrimental impact of stigma specific to men and women with SMI who have children.

Although there were some similarities between mothers and fathers, it was clear that the experience of stigma differs between genders. Specifically, mothers were more likely to perceive and internalise stigma associated with the impact of their mental illness on their parenting. Conversely, fathers were more inclined to perceive stigma associated with their gender on their parenting and to display stigmatising attitudes towards others. Despite overall negative influences of stigma on parenting experiences, there was also evidence of particular impacts of certain types of stigma on parenting that were unique between genders, thus allowing for recommendations to be made on gender specific treatment approaches.

In spite of the negative consequences of stigma identified, perhaps the most uplifting finding of this study was that the majority of both mothers and fathers reported that being a parent had encouraged them to better manage their mental illness. Hence, despite decades of public stigma towards parents living with SMI and stereotypes that
they are unfit to parent a child (Krumm & Becker, 2006), this study indicated that many parents do not internalise public stigma and, instead, view parenthood as a key incentive for mental illness recovery.

Notwithstanding the aforementioned limitations of the study, the present research has provided a unique contribution to current knowledge on stigma and parents with SMI. The study offers insights regarding tailored treatment interventions for mothers, fathers and their families. These insights will help provide further support for parents with SMI to reduce the impact of stigma on parenting, and help individuals living with SMI enjoy and benefit more from their parental role.
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Appendices
Appendix A: Supplementary tables to methods and results sections

Table 1S

Sample representation of parents

<table>
<thead>
<tr>
<th>Location</th>
<th>Total national survey</th>
<th>Total agreed to be re-contacted for current study</th>
<th>Total participated in current study</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Hunter</td>
<td>97 (52 Mothers)</td>
<td>77 (41 Mothers)</td>
<td>54 (31 Mothers)</td>
</tr>
<tr>
<td>Orange</td>
<td>54 (28 Mothers)</td>
<td>43 (23 Mothers)</td>
<td>17 (11 Mothers)</td>
</tr>
<tr>
<td>Adelaide</td>
<td>26 (17 Mothers)</td>
<td>24 (16 Mothers)</td>
<td>22 (16 Mothers)</td>
</tr>
<tr>
<td>Total</td>
<td>177 (97 Mothers)</td>
<td>144 (80 Mothers)</td>
<td>93 (58 Mothers)</td>
</tr>
</tbody>
</table>
### Clinical and demographic characteristics

<table>
<thead>
<tr>
<th></th>
<th>Mothers</th>
<th>Fathers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N(%)</td>
<td>N(%)</td>
<td>N(%)</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married/de facto</td>
<td>21(36.2)</td>
<td>10(28.6)</td>
<td>31(33.3)</td>
</tr>
<tr>
<td>Single</td>
<td>37(63.8)</td>
<td>25(71.4)</td>
<td>62(66.7)</td>
</tr>
<tr>
<td><strong>Qualifications</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary school/below</td>
<td>23(41.8)</td>
<td>18(51.4)</td>
<td>41(45.6)</td>
</tr>
<tr>
<td>TAFE/ trade</td>
<td>27(49.1)</td>
<td>15(42.9)</td>
<td>42(46.7)</td>
</tr>
<tr>
<td>Diploma/university</td>
<td>5(9.1)</td>
<td>2(5.7)</td>
<td>7(7.8)</td>
</tr>
<tr>
<td><strong>ICD-10 Diagnosis</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>15(25.9)</td>
<td>17(48.6)</td>
<td>32(34.4)</td>
</tr>
<tr>
<td>Schizoaffective Disorder</td>
<td>13(22.4)</td>
<td>6(17.1)</td>
<td>19(20.4)</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>15(25.9)</td>
<td>4(11.4)</td>
<td>19(20.4)</td>
</tr>
<tr>
<td>Depression without psychosis</td>
<td>13(22.4)</td>
<td>4(11.4)</td>
<td>17(18.3)</td>
</tr>
<tr>
<td>Delusional Disorder</td>
<td>1(1.7)</td>
<td>3(8.6)</td>
<td>4(4.3)</td>
</tr>
<tr>
<td>Depressive Psychosis</td>
<td>1(1.7)</td>
<td>1(2.9)</td>
<td>2(2.2)</td>
</tr>
<tr>
<td><strong>Current case manager</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>37(63.8)</td>
<td>14(40.0)</td>
<td>51(58.4)</td>
</tr>
</tbody>
</table>
Table 3S

**Number of children per parent**

<table>
<thead>
<tr>
<th></th>
<th>Range</th>
<th>Median</th>
<th>Mean(S.D.)</th>
<th>N(%)</th>
<th>Mean(S.D.)</th>
<th>N(%)</th>
<th>Mean(S.D.)</th>
<th>N(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependend Children</td>
<td>0-6</td>
<td>1.0</td>
<td>1.3(1.4)</td>
<td>60(64.5)</td>
<td>1.1(1.1)</td>
<td>35(60.3)</td>
<td>1.7(1.7)</td>
<td>25(71.4)</td>
</tr>
<tr>
<td>Non-Dependent</td>
<td>0-6</td>
<td>1.0</td>
<td>1.4(1.6)</td>
<td>54(58.1)</td>
<td>1.6(1.6)</td>
<td>39(67.2)</td>
<td>1.1(1.7)</td>
<td>15(42.9)</td>
</tr>
<tr>
<td>Biological Children</td>
<td>0-7</td>
<td>2.0</td>
<td>2.3(1.3)</td>
<td>91(97.9)</td>
<td>2.4(1.2)</td>
<td>58(100)</td>
<td>2.2(1.4)</td>
<td>33(94.3)</td>
</tr>
<tr>
<td>Non-Biological</td>
<td>0-6</td>
<td>.</td>
<td>0.5(1.0)</td>
<td>23(24.7)</td>
<td>0.3(1.0)</td>
<td>9(15.5)</td>
<td>0.7(1.0)</td>
<td>14(40.0)</td>
</tr>
<tr>
<td><strong>Total Children</strong></td>
<td>1-10</td>
<td>2.0</td>
<td>2.8(1.8)</td>
<td></td>
<td>2.7(1.7)</td>
<td></td>
<td>2.9(1.9)</td>
<td></td>
</tr>
</tbody>
</table>

*Note: 21 parents had both dependent and non-dependent children and 21 parents had both biological and non-biological children.*
Table 4S

Living situation of parents with dependent, non-dependent and biological children

<table>
<thead>
<tr>
<th></th>
<th>Mothers</th>
<th>Fathers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N(%)</td>
<td>N(%)</td>
<td>N(%)</td>
</tr>
<tr>
<td><strong>Dependent Children</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living with</td>
<td>16(51.6)</td>
<td>5(29.4)</td>
<td>21(43.8)</td>
</tr>
<tr>
<td>Living without</td>
<td>15(48.4)</td>
<td>12(70.6)</td>
<td>27(56.3)</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>17</td>
<td>48</td>
</tr>
<tr>
<td><strong>Non-Dependent Children</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living with</td>
<td>4(12.9)</td>
<td>.</td>
<td>4(9.8)</td>
</tr>
<tr>
<td>Living without</td>
<td>27(87.1)</td>
<td>10(100)</td>
<td>37(90.2)</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>10</td>
<td>41</td>
</tr>
<tr>
<td><strong>Biological Children</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living with</td>
<td>13(33.3)</td>
<td>5(20.8)</td>
<td>18(28.6)</td>
</tr>
<tr>
<td>Living without</td>
<td>26(66.7)</td>
<td>19(79.2)</td>
<td>45(71.4)</td>
</tr>
<tr>
<td>Total</td>
<td>39</td>
<td>24</td>
<td>63</td>
</tr>
</tbody>
</table>

*Note: Parents with more than one child in each category who cited a different living situation within the dependent children (N = 12), non-dependent children (N = 13) or biological children groups (N = 28) are excluded from this table. Non-biological children were not included due to the small sample size in this category.*
Table 5S

Means and standard deviations for stigma-related variables

<table>
<thead>
<tr>
<th>Stigma-related variables</th>
<th>Mothers</th>
<th>Fathers</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I think that other people believe that having a MI means I cannot be a good parent</strong> (Perceived MI/parent stigma)</td>
<td>3.76(1.30)</td>
<td>2.91(1.25)</td>
<td>3.44(1.34)</td>
</tr>
<tr>
<td><strong>I think that others people believe that (my gender) makes it harder to be a good parent</strong> (Perceived gender/parent stigma)</td>
<td>2.09(.81)</td>
<td>2.74(1.27)</td>
<td>2.33(1.05)</td>
</tr>
<tr>
<td><strong>Having a MI means that I cannot be a good parent</strong> (MI/parent self-stigma / internalised stigma)</td>
<td>1.90(.85)</td>
<td>1.51(.66)</td>
<td>1.75(.80)</td>
</tr>
<tr>
<td><strong>Because I am (my gender) I believe I am not a very good parent</strong> (Gender/parent self-stigma / internalised stigma)</td>
<td>1.81(.93)</td>
<td>1.80(.76)</td>
<td>1.81(.86)</td>
</tr>
<tr>
<td><strong>I think that most people with MI are not very good parents</strong> (Externalised MI stigma)</td>
<td>1.95(.93)</td>
<td>2.03(.71)</td>
<td>1.98(.85)</td>
</tr>
<tr>
<td><strong>I think that most (parents of my gender) are not very good parents</strong> (Externalised gender stigma)</td>
<td>1.81(.83)</td>
<td>2.17(.92)</td>
<td>1.95(.88)</td>
</tr>
<tr>
<td><strong>Being a parent has helped me try to better manage my mental illness</strong></td>
<td>4.05(.98)</td>
<td>4.09(.92)</td>
<td>4.06(.95)</td>
</tr>
</tbody>
</table>

Note: MI = mental illness. Table includes parents responses on five point Likert scale anchored at 1 = strongly disagree, 2 = disagree, 3 = not sure, 4 = agree and 5 = strongly agree.
Table 5S continued

<table>
<thead>
<tr>
<th>Stigma-related variables</th>
<th>Mothers ($N=58$)</th>
<th>Fathers ($N=35$)</th>
<th>Total ($N=93$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel that I have been treated unfairly by others because I have a MI (MI discrimination)</td>
<td>3.93(1.12)</td>
<td>3.34(1.28)</td>
<td>3.71(1.21)</td>
</tr>
<tr>
<td>I feel that I have been treated unfairly by others because of my gender (Gender discrimination)</td>
<td>2.60(1.24)</td>
<td>3.26(1.36)</td>
<td>2.85(1.32)</td>
</tr>
</tbody>
</table>

Note: MI = mental illness. Table includes parents responses on five point Likert scale anchored at 1 = strongly disagree, 2 = disagree, 3 = not sure, 4 = agree and 5 = strongly agree.
<table>
<thead>
<tr>
<th>Parenting-related variables</th>
<th>Mothers (N=58)</th>
<th>Fathers (N=35)</th>
<th>Total (N=93)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Competence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confidence in parenting ability</td>
<td>2.62(1.51)</td>
<td>2.23(1.44)</td>
<td>2.47(1.49)</td>
</tr>
<tr>
<td>Ease of parenting</td>
<td>3.52(1.31)</td>
<td>3.20(1.26)</td>
<td>3.40(1.30)</td>
</tr>
<tr>
<td>Parenting capability</td>
<td>3.48(1.07)</td>
<td>3.97(1.86)</td>
<td>3.67(1.01)</td>
</tr>
<tr>
<td>Decision making</td>
<td>2.50(1.20)</td>
<td>2.26(1.20)</td>
<td>2.41(1.20)</td>
</tr>
<tr>
<td>Parenting concerns</td>
<td>3.62(1.30)</td>
<td>2.71(1.27)</td>
<td>3.28(1.35)</td>
</tr>
<tr>
<td>Parenting satisfaction</td>
<td>4.40(.79)</td>
<td>4.46(.85)</td>
<td>4.42(.81)</td>
</tr>
<tr>
<td>Child listens to my requests</td>
<td>3.59(.97)</td>
<td>3.74(.78)</td>
<td>3.65(.91)</td>
</tr>
<tr>
<td>Parenting assistance required</td>
<td>2.57(1.24)</td>
<td>2.00(1.09)</td>
<td>2.35(1.21)</td>
</tr>
<tr>
<td>Poor management of parenting responsibilities</td>
<td>3.07(1.36)</td>
<td>2.54(1.25)</td>
<td>2.87(1.34)</td>
</tr>
<tr>
<td><strong>Role Restriction</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parental focus on child</td>
<td>3.79(1.20)</td>
<td>3.17(1.25)</td>
<td>3.56(1.25)</td>
</tr>
<tr>
<td>Underestimated parenting obligations</td>
<td>3.29(1.30)</td>
<td>3.17(1.15)</td>
<td>3.25(1.24)</td>
</tr>
<tr>
<td>Difficult to escape parenting obligations</td>
<td>2.43(1.22)</td>
<td>2.17(1.10)</td>
<td>2.33(1.17)</td>
</tr>
<tr>
<td>Lack of control</td>
<td>2.72(1.25)</td>
<td>2.46(.98)</td>
<td>2.62(1.16)</td>
</tr>
<tr>
<td>Lack of novel experiences</td>
<td>2.40(1.12)</td>
<td>2.23(.97)</td>
<td>2.33(1.07)</td>
</tr>
</tbody>
</table>

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### Table 6S continued

<table>
<thead>
<tr>
<th>Parenting-related variables</th>
<th>Mothers $(N=58)$</th>
<th>Fathers $(N=35)$</th>
<th>Total $(N=93)$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Role Restriction</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannot engage in enjoyable activities</td>
<td>2.40(1.08)</td>
<td>2.09(.95)</td>
<td>2.26(.99)</td>
</tr>
<tr>
<td>Lack of personal space</td>
<td>2.67(1.37)</td>
<td>2.09(.95)</td>
<td>2.45(1.26)</td>
</tr>
<tr>
<td><strong>Isolation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greater loneliness</td>
<td>3.07(1.40)</td>
<td>2.71(1.34)</td>
<td>2.94(1.38)</td>
</tr>
<tr>
<td>Disinterest in social events</td>
<td>2.81(1.16)</td>
<td>2.63(1.20)</td>
<td>2.74(1.17)</td>
</tr>
<tr>
<td>Disinterest in others</td>
<td>3.31(1.30)</td>
<td>2.97(1.47)</td>
<td>3.18(1.37)</td>
</tr>
<tr>
<td>Others dislike spending time with me</td>
<td>2.72(1.07)</td>
<td>2.63(1.24)</td>
<td>2.69(1.13)</td>
</tr>
<tr>
<td>Fewer parenting supports</td>
<td>3.09(1.17)</td>
<td>3.03(1.22)</td>
<td>3.06(1.19)</td>
</tr>
<tr>
<td>Fewer friends</td>
<td>2.72(1.24)</td>
<td>2.37(1.00)</td>
<td>2.59(1.16)</td>
</tr>
</tbody>
</table>

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Appendix B: Telephone Survey

Participant ID number: __________________
Participant gender: _____________________
Date of Interview: ______________________

This study is about parenting. Being a parent can sometimes be difficult, and can sometimes be a rewarding experience. These questions ask about your experiences and needs as a parent.

The questions will take about 30 minutes to complete over the phone. You will receive $20 as reimbursement for your time. Would you be willing to participate in this questionnaire now, or would you prefer for us to contact you at another time?

Yes – Complete questionnaire
No – When would be another appropriate time to contact you?

Part A: Demographics and Child Care

I am going to ask you some questions about your mental health

1. Can you tell me at approximately what age you first started to experience mental health problems? _________yrs

2. Do you currently have a Mental Health Care Worker (includes Case Worker/Care Coordinator/Case Manager, as applicable) from a Community Health Service or NGO? YES / NO

I am now going to ask you about your children.

1. How many children do you have? __________

2. Do you have any non-biological children? (i.e., stepchildren, foster children, adopted children) YES/NO
If yes, please indicate how many:
Stepchildren __________
Foster children __________
Adopted children __________

3. How old were you at the birth of your first child? ________yrs
I am now going to ask you some questions about your child(ren). Please do not provide any names to protect their confidentiality.

4. Could you please provide the ages of each of your children from eldest to youngest?

Child 1: ____ years  Child 4: ____ years  Child 7: ____ years  Child 10: ____ years
Child 2: ____ years  Child 5: ____ years  Child 8: ____ years  Child 11: ____ years
Child 3: ____ years  Child 6: ____ years  Child 9: ____ years  Child 12 : ____ years

I would first like to ask you some questions relating to your eldest child (repeat the following question for each child)

5. If previously indicated has non-biological children: Is this your own child stepchild / foster child / adopted child (as applicable)? ________________

6. Who does this child live with?

1 = With you and your partner/spouse
2 = With you only
3 = Child’s other parent - Query care arrangements (option 7 below)
4 = Child’s grandparent(s)
5 = Other relative(s)
6 = Foster/adoptive parent(s)
7 = Shared care between parent and other (specify arrangements e.g. alternate weeks, weekend care etc) ____________________________
8 = Other (Specify) ____________________
9 = Child has moved out of home/live with own family or friends etc
88 = Not known

For the next questions, I am going to read a series of statements. For each statement please choose the option that best suits you

SA = Strongly Agree
A = Agree
NS = Not Sure
D = Disagree
SD = Strongly Disagree

(Participants were provided with the option to write these responses down to aid in answering this section)
Part B: Parenting

While there may not be a response that exactly states your feelings, please choose the closest that describes how you feel. Your first reaction to each question should be your answer. For each statement, please focus on your youngest child (if more than one child). ¹

Part C: Stigma

The next statements are about your own and others views about being a male/female (as applicable to participant), and parents with mental illness. I would like to ask you to please refer back to the response options you wrote down before. Please choose your most appropriate response to the statements.

Gender

1. I feel that I have been treated unfairly by others because of my gender

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not Sure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

2. I think that other people believe that being a male/female (as applicable to participant) makes it harder to be a good parent

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not Sure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

3. Because I am a male/female (as applicable to participant) I believe that I am not a very good parent

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not Sure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

¹ Participants were read questions from the Competence, Role Restriction and Isolation subscales of the Parenting Stress Index (3rd ed.; Abidin, 1995). This section has not been included due to copyright restrictions.
4. I think that most males/females \( (\text{as applicable to participant}) \) are not very good parents

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not Sure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**Mental illness**

5. I feel that I have been treated unfairly by others because I have a mental illness

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not Sure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

*If the participant answered ‘strongly agree’, ‘agree’ or ‘not sure’ to the above question:*

I’m going to read a list of different people. Please indicate whether you feel that you have been treated unfairly by these people in the last 12 months because of your mental illness?

6. Firstly, do you feel that you have been treated unfairly by ‘legal services’ in the last 12 months because of your mental illness?

YES  NO  N/A

*(Repeat for child welfare services etc)*

<table>
<thead>
<tr>
<th></th>
<th>Yes / No</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child welfare services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work colleagues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Please refer back to the response options you have written down for the next questions.

7. I think that other people believe that having a mental illness means that I cannot be a good parent

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Not Sure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

8. I think that most people with mental illness are not very good parents

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Not Sure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

9. Having a mental illness means that I cannot be a good parent

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Not Sure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

10. Being a parent has helped me try to better manage my mental illness

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Not Sure</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Thank you for the time you have taken to complete this questionnaire.

I will also send $20 to thank you for your participation with a receipt. Could you please sign the receipt and return it in the reply paid envelope?

If completing this questionnaire has caused you any distress, you are welcome to contact the University of Newcastle Psychology Clinic (02) 49215075, Lifeline (13 11 14) or Relationships Australia (1300 364 277).

If you have any questions or would like any further information about the study, please contact Dr Linda Campbell (Ph: (02) 43494490, Email: linda.e.campbell@newcastle.edu).
Appendix C: Self-stigma of Mental Illness Scale (Corrigan et al., 2006)

Name or ID Number __________________________________ Date ________________

There are many attitudes about mental illness. We would like to know what you think most of the public as a whole (or most people) believe about these attitudes. Please answer the following items using the 9-point scale below.

I strongly Disagree neither agree I strongly
Disagree nor disagree agree

1  2  3  4  5  6  7  8  9

Section 1:
I think the public believes…
1. _____ most persons with mental illness cannot be trusted.
2. _____ most persons with mental illness are disgusting.
3. _____ most persons with mental illness are unable to get or keep a regular job.
4. _____ most persons with mental illness are dirty and unkempt.
5. _____ most persons with mental illness are to blame for their problems.
6. _____ most persons with mental illness are below average in intelligence.
7. _____ most persons with mental illness are unpredictable.
8. _____ most persons with mental illness will not recover or get better.
9. _____ most persons with mental illness are dangerous.
10. _____ most persons with mental illness are unable to take care of themselves.

Section 2:
Now answer the next 10 items using the agreement scale.

I strongly Disagree neither agree I strongly
Disagree nor disagree agree

1  2  3  4  5  6  7  8  9

I think…
1. _____ most persons with mental illness are to blame for their problems.
2. _____ most persons with mental illness are unpredictable.
3. _____ most persons with mental illness will not recover or get better.
4. _____ most persons with mental illness are unable to get or keep a regular job.
5. _____ most persons with mental illness are dirty and unkempt.
6. _____ most persons with mental illness are dangerous.
7. _____ most persons with mental illness cannot be trusted.
8. _____ most persons with mental illness are below average in intelligence.
9. _____ most persons with mental illness are unable to take care of themselves.
10. _____ most persons with mental illness are disgusting.
Section 3
Now answer the next 10 items using the agreement scale.

<table>
<thead>
<tr>
<th></th>
<th>I strongly agree</th>
<th>neither agree</th>
<th>Disagree</th>
<th>nor disagree</th>
<th>I strongly disagree</th>
<th>neither agree</th>
<th>nor disagree</th>
<th>I strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td>3</td>
<td></td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td>7</td>
<td></td>
<td>8</td>
<td></td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>

Because I have a mental illness…

1. _____ I am below average in intelligence.
2. _____ I cannot be trusted.
3. _____ I am unable to get or keep a regular job.
4. _____ I am dirty and unkempt.
5. _____ I am unable to take care of myself.
6. _____ I will not recover or get better.
7. _____ I am to blame for my problems.
8. _____ I am unpredictable.
9. _____ I am dangerous.
10. _____ I am disgusting.

Section 4
Finally, answer the next 10 items using the agreement scale.

<table>
<thead>
<tr>
<th></th>
<th>I strongly agree</th>
<th>neither agree</th>
<th>Disagree</th>
<th>nor disagree</th>
<th>I strongly disagree</th>
<th>neither agree</th>
<th>nor disagree</th>
<th>I strongly agree</th>
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<td>1</td>
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<td>9</td>
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</tr>
</tbody>
</table>

I currently respect myself less…

1. _____ because I am unable to take care of myself.
2. _____ because I am unable to get or keep a regular job.
3. _____ because I am dangerous.
4. _____ because I cannot be trusted.
5. _____ because I am to blame for my problems.
6. _____ because I will not recover or get better.
7. _____ because I am disgusting.
8. _____ because I am unpredictable.
9. _____ because I am dirty and unkempt.
10. _____ because I am below average in intelligence.
Appendix D: Scope and author guide for journal submission
(Retrieved from: http://www.elsevier.com/journals/psychiatry-research)

Psychiatry Research: Scope

The journal provides very rapid publication of short but complete research reports in the field of psychiatry. The scope of the journal encompasses:

(1) Biochemical, physiological, genetic, psychological, and social determinants of human behavior;
(2) Assessment of human behavior and subjective state;
(3) Evaluation of somatic and non-somatic psychiatric treatments.

In addition, reports of clinically related basic studies in the fields of neuropharmacology, neurochemistry, neuroendocrinology, electrophysiology, psychology, genetics, and brain imaging are published. Significant methodological advances such as instrumentation, clinical scales, and assays directly applicable to psychiatric research are also appropriate. Brief reviews, theoretical contributions, and letters to the editor will be considered.

Psychiatry Research: Guide for Authors

Preparation of manuscripts

Title page

The title page should be included in the main body of the text, along with the abstract and keywords.

Title of paper (only the first letter of the first word of the title should be capitalized), and authors' full names (do not use initials and academic degrees) and complete mailing addresses, including zip codes (USA) or country codes should be provided for the corresponding author (more simplified addresses may be provided for co-authors but should at least provide department, institution, city, state and country). An asterisk should be placed after the name of the author to whom correspondence and reprint requests should be addressed. Superscript letters (a, b, c, etc.) should be used to indicate the departmental and institutional affiliation of each author. If all authors are in the same department at the same institution, superscript letters are not required. The corresponding author's fax, telephone, and e-mail numbers should be supplied.

The Abstract should be 150-200 words for full-length articles and 50 words for brief reports, summarizing the reason for the study, the methods used, the results and the major conclusions. Do not include a summary at the end of the paper. The abstract should be followed by up to seven key words should be listed which accord with the indexing conventions of Index Medicus. Note that the keywords should not duplicate words used in the title of the article, which will be automatically indexed.

Text

Although exceptions will be considered, manuscripts should not exceed 5000 words, and shorter manuscripts (e.g., 3000 words) are preferred. Each article should contain the following major headings: Introduction (preceded by arabic number 1.), Methods
Introduction
The introduction should be brief and explain the purpose of the study; an extensive review of the literature should be avoided, but directly relevant articles by other investigators, as well as by the authors themselves, must be cited. If the paper includes subjects who have been included in previous reports, references should be provided and the number of subjects whose data have been included elsewhere should be specified.

Methods
The Methods should contain sufficient detail to enable others to repeat the procedures without studying the references directly.

Results
The Results should summarize the most important data and statistical correlations should be included. Tabular data should not be duplicated, important points and trends should be pointed out. The final sentence should emphasize the importance attached to the observations.

Discussion
The discussion should relate directly to the study being reported and give perspective to the adequacy of the materials and methods for the purpose of the study. Results should be interpreted to lend meaning to the observations. Any discrepancies with previously published results should be explained. The paper should conclude with a brief statement regarding the significance of the study.

Acknowledgement
The Acknowledgement section is an optional section and should also be used for grant-support information.

Funding body agreements and policies
Elsevier has established agreements and developed policies to allow authors whose
articles appear in journals published by Elsevier, to comply with potential manuscript archiving requirements as specified as conditions of their grant awards. To learn more about existing agreements and policies please visit http://www.elsevier.com/fundingbodies

**Statistical reporting**
Study group variability should be reported as the standard deviation, not the standard error. In addition to the probability value, be sure to specify full details of the statistical analysis performed (e.g., name of statistical test used, test value, one-tailed or two-tailed test used, degrees of freedom or number of subjects, and probability level). Authors should also explicitly state what hypothesis is being tested. Probability values should be presented as upercased, italicized P; r, t, F, df, and n should also be italicized. Leading zeroes should be used throughout.

**References**

**Literature citations.** References in the text to literature cited should be given by the name of the author(s), followed by the year of publication in parentheses, e.g.: Smith and Smith (1994) or (Allen et al., 1952; Smith, 1966a, 1966b; Jones and Jones, 1993). For three or more authors, the name of the first author followed by et al. should be used. References listed within parentheses should be in chronological order. Articles published by the same author(s) in the same year should be designated "a," "b," etc. (note that the a/b designation corresponds to the order in which each article appears in the reference list, not to the order of first citation within the manuscript). All references cited in the text must be included in the reference list. Check carefully to insure that the spelling of names in the text matches that in the reference list and that the date in the text matches the date in the reference list.

**Reference list:** References should be arranged in alphabetical order by first author and should not be numbered. For single-authored articles, if more than one article by the same author is included, list each reference in chronological order. If both articles were published in the same year, alphabetize by the first major word of the article title and designate the first listed article as "a," the second as "b," etc. For multi-authored articles, list in alphabetical order by (1) last name of first author, (2) last name of second author, etc. If the names of all authors are identical, list in chronological order. If both authors' names and year of publication are the same, alphabetize by the first major word of the article title.

Provide the last names and first initials of all authors (do not use et al. in the reference list). Journal titles should not be abbreviated; provide the journal's full name. Do not italicize journal or book titles. Be sure that all references are complete: Journal articles should include authors, year of publication, article title, full journal name, volume number, and beginning and concluding page numbers. Book chapters should include authors, year of publication, chapter title, name(s) of volume editor(s), volume title, volume number (if any), name of publisher, city of publication, and page numbers. Books should include author(s) or editor(s), year of publication, book title, publisher, and city of publication. Include only references that have been cited in the text.

**Tables and Figures**

**Tables:** Tables should be typed with double spacing and should be uploaded separately, numbered consecutively with Arabic numerals, and should contain horizontal lines.
only. A short descriptive heading should be provided above with any footnotes and/or explanations below.

Figures: Figures and Photographs of good quality should be submitted online as a separate file. Please use a lettering that remains clearly readable even after reduction to about 66% (lettering should be no smaller than 2 mm after reduction). In preparing figures, bear in mind the dimensions of the page and columns (typesetting area 15.8 x 20.8 cm and 7.4 x 20.8 cm, respectively). For every figure or photograph, a legend should be provided.

All authors wishing to use illustrations already published must first obtain the permission of the author and publisher and/or copyright holders and give precise reference to the original work. This permission must include the right to publish in electronic media.

Footnotes: These should be avoided; when essential, these should be numbered consecutively and typed at the foot of the appropriate page.
For further information regarding artwork, visit the website: http://authors.elsevier.com/artwork/psychres
Appendix E: Evidence of manuscript submission to peer-reviewed journal
(Email correspondence to Corresponding Author/Principal Supervisor, Dr Linda Campbell)

-----Original Message-----

From: ees.psy.0.2769a6.8749d611@eesmail.elsevier.com
[mailto:ees.psy.0.2769a6.8749d611@eesmail.elsevier.com] On Behalf Of Psychiatry Research

Sent: Friday, 21 February 2014 5:55 PM

To: Linda Campbell

Subject: Editor handles PSY-D-14-00155

Ms. Ref. No.: PSY-D-14-00155

Title: Stigma among parents with serious mental illness: Internalised mental illness stigma in mothers and externalised gender stigma in fathers Psychiatry Research

Dear Dr Linda Elisabet Campbell,

Your submission entitled "Stigma among parents with serious mental illness: Internalised mental illness stigma in mothers and externalised gender stigma in fathers" will be handled by Editor-in-Chief Monte Buchsbaum, M.D..

You may check on the progress of your paper by logging on to the Elsevier Editorial System as an author. The URL is http://ees.elsevier.com/psy/.

Your username is: lec444

If you need to retrieve password details, please go to: http://ees.elsevier.com/PSY/automail_query.asp

Thank you for submitting your work to this journal.

Kind regards,

Elsevier Editorial System

Psychiatry Research
Information Statement for the Research Project:
Parenting with mental illness: Experiences and Needs

Document; dated 20/03/2012, HREC 0911185.10

You are invited to participate in the research project identified above. It is being conducted by Ms Melanie Stone who is doing the research as part of her Doctorate of Clinical and Health Psychology at the University of Newcastle. She is being supervised by Dr Linda Campbell and Dr Stefania Paolini from the School of Psychology at the University of Newcastle.

Why is the research being done?
The purpose of the research is to explore the differences in experiences and needs of mothers and fathers with mental illness and whether these differ to those of parents without mental illness. Research on parents with mental illness has primarily focused on their pathology and the potential risk for their children, rarely considering the parents perspective. There is currently limited research comparing the experiences and needs of parents with and without mental illness. Furthermore, very little research has compared the experiences and needs of mothers and fathers with mental illness. Identifying the specific experiences and needs of parents with mental illness will assist in developing a better understanding of the impact of mental illness on parents and their families. Such findings may be useful in developing appropriate rehabilitation and support programs for parents with mental illness and their children.

Who can participate in the research?
We are inviting mothers and fathers over the age of 18 years who previously completed the Australian National Survey of High Impact Psychosis (SHIP) to participate in this research. Your name was selected from this participant pool as you previously identified that you were a parent and you consented to being contacted for research purposes within two years of your interview for SHIP.

We are also inviting mothers and fathers over the age of 18 years without a mental illness to participate in this research. You have been invited to participate in this study because you are listed on the Hunter Medical Research Institute’s Volunteers register or have seen the study advertised on the noticeboards at the University of Newcastle, Hunter New England Health Services or your local GP office, and have no known mental health conditions and have not had FACS (DoCS) intervention as a result of child protection incidents.
What choice do you have?
You are not required to participate in this project. Participation in this research is entirely your choice. Only those people who give their informed consent will be included in the project. Whether or not you decide to participate, your decision will not disadvantage you.

If you do decide to participate, you may withdraw from the project at any time, without giving a reason and without any penalty. If you decide to withdraw from the study, you have the option of withdrawing any data which identifies you.

What would you be asked to do?
If you agree to participate, you will be asked to complete either a telephone interview, or if you prefer we can post a questionnaire to you. The interview/questionnaire will ask questions about your experiences and needs as a parent.

The telephone interview will be conducted by the student researcher or another member of the study team.

Will it cost anything to participate in the study?
No. Participating in this project is free. All costs associated with the interview will be reimbursed. You will be reimbursed $20 for your time and expenses to participate in the interview.

How much time will it take?
The telephone interview should take about 20 minutes to complete.

What are the risks and benefits of participating?
We can’t promise you any direct benefit as a result of participating in this project, however you will help us better understand the experiences and needs of parents. Generally, the questions used for this project have not been found to be distressing, however during the interview you will be asked to talk about your parenting experience, which may be a little bit upsetting for some people. You can choose not to answer any questions that you do not wish to reply to. In the event of any participant becoming distressed as a result of the interview appropriate support will be made available.

If for any reason you feel distressed following the questionnaire, you may contact the following services which can provide counselling and support: The University of Newcastle Psychology Clinic ((02) 49215075), Lifeline (13 11 14) or Relationships Australia (1300 364 277).

How will your privacy be protected?
Information obtained as a result of this project will remain confidential, subject to mandatory legal requirements (i.e., if concerns about the safety and welfare of infants or others arise during the course of your participation, or if any information relating to illegal activity is revealed, the relevant legal body must be notified by research staff and hence confidentiality cannot be maintained in these circumstances). If you choose to participate, we ask that you please maintain the confidentiality of you children when answering questions by providing initials rather than names Otherwise information obtained is confidential and all information you supply that may potentially identify you will be removed prior to any coding or data analysis. Only the above mentioned Principal Investigator and the student researcher will have access to your personal information in its identifiable form. All information will be held securely at the University of Newcastle’s Ourimbah campus with information collected only being released to researchers directly involved in this project.
How will the information collected be used?
When all the information has been collected, it will then be analysed. The results will then be published in scientific journals and presented at conferences. The results will also be used in a thesis to be submitted to the University of Newcastle for Ms Melanie Stone’s degree. Any information obtained from you will only ever be reported in its de-identified form, therefore individual participants will not be identified in any reports or presentations arising from the project.

If you would like a summary of the results following the completion of the research project, please contact Dr Linda Campbell by telephone or email

What do you need to do to participate?
Please read this Information Statement and be sure you understand its contents before you consent to participate. If there is anything you do not understand, or you have questions, please contact the researcher.

If you would like to participate, please complete the attached Consent Form and return it in the reply paid envelope provided. A researcher will then contact to arrange a time convenient to you to complete the telephone questionnaire or if you prefer, send the questionnaire to you via mail for you to complete at your own convenience.

Further information
If you would like further information, please contact

Dr Linda Campbell:             Telephone: (02) 43494490
                           Email: linda.e.campbell@newcastle.edu.au

Thank you for considering this invitation.

Dr. Linda Campbell             Dr Stefania Paoloini             Ms Melanie Stone
Associate Lecturer             Senior Lecturer                 Student Researcher

Complaints about this research
This research has been approved by the Hunter new England Human Research Ethics Committee, reference number 09/11/18/5.10. Should you have any concerns about your rights as a participant in this research, or have a complaint about the manner in which the research is being conducted, it may be given to the researcher, or if an independent person is preferred, to Dr Nicole Gerrand, Manager Research Ethics and Governance, Hunter New England Human Research Ethics Committee, Hunter New England Health, Locked Bag 1, New Lambton NSW 2305, telephone (02) 49214950, email Hnehrec@hnehealth.nsw.gov.au.
Appendix G: Consent Form

Consent Form for the Research Project: Parenting with mental illness: Experiences and Needs

Researchers: Ms Melanie Stone, Dr Linda Campbell & Dr Stefania Paolini,

Document; dated 20/03/2012, HREC 0911185.10

I, (please print name) ___________________________________ agree to participate in the above research project and give my consent freely.

• I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.

• I understand that I may keep a copy of this Consent Form

• I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing.

• I consent to completing a telephone questionnaire (or being sent a questionnaire via mail to complete at my own convenience) about my experiences as a parent.

• I agree that if I previously participated in the Survey of High Impact Psychosis (SHIP), additional research data can be gathered from the information I earlier provided in this survey.

• I understand that my personal information will remain confidential to the researchers.

• I have had the opportunity to have questions answered to my satisfaction.

In addition:

• I give permission for a Researcher from this group to recontact me again within the next 2 years regarding my possible participation in further research YES / NO

Print Name: __________________________________________________________

Signature: ___________________________________ Date: ____________________
Appendix H: Copyright Permission Information

Sent Via Email: melanie.stone@uon.edu.au

November 11, 2014

Melanie Lacey
School of Psychology
University of Newcastle
Newcastle, NSW 2300
Australia

Dear Ms. Lacey:

In response to your recent request, permission is hereby granted to you to include a brief description for each item of the Parenting Stress Index (PSI) in your thesis titled, *Stigma Among Parents With Serious Mental Illness: Internalised Mental Illness Stigma in Mothers and Externalised Gender Stigma in Fathers*. If additional material is needed, it will be necessary to write to PAR for further permission.

Permission is also granted for inclusion of the brief item descriptions in the article titled, “Parents with serious mental illness: Differences in internalised and externalised mental illness stigma and gender stigma between mothers and fathers,” by Melanie Lacey, Stefania Paolini, Mary-Claire Hanlon, Jessica Melville, Cherrie Galletly, and Linda Campbell to be published in the journal, *Psychiatry Research* in 2014.

This Agreement is subject to the following restrictions:
(1) Any and all materials used will contain the following credit line:

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(3) Payment of a permission fee of $50.00 USD.
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TWO COPIES of this Permission Agreement should be signed and returned to me, along with your payment for $50.00 USD for the permission fee, to indicate your agreement with the above restrictions. I will then sign it for PAR and return a fully executed copy to you for your records.

Sincerely,

Permissions Specialist
vmark@parinc.com
1-800-331-8378 (phone)
1-800-727-9329 (fax)

ACCEPTED AND AGREED:
BY: ___________________________
MELANIE LACEY
DATE: ________________________

ACCEPTED AND AGREED:
BY: ___________________________
VICKI M. MCFADDEN
DATE: ________________________

PAYMENT RECEIVED:
PAR CUSTOMER No.: