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The interaction between sense of mastery, social support, and parental distress among mothers with and without serious mental illness

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ABSTRACT

Background: Social support and sense of mastery are considered important resources in coping both with serious mental illness (SMI) and with motherhood-related challenges. However, their interactive effects on the parental stress of mothers with SMI are not clear.
Methods: Scales assessing parental distress, social support, and sense of mastery were administered to 60 mothers with SMI and 60 mothers without SMI.
Results: A main effect of sense of mastery and a lack of main effect of social support were found in both groups. An interaction effect of social support with mastery was found among mothers with SMI revealing that for mothers who had a high sense of mastery, social support was beneficial, whereas for mothers who had a low sense of mastery, social support was harmful.
Conclusions: In practice, attention should be given to the sensitive provision of support, balancing between what is needed and what is requested, with the aim of not harming an individual's sense of mastery.

1. Introduction

The experience of mothers with serious mental illness (SMI) has recently gained increased attention [1,2]. There is growing awareness of the importance of motherhood as part of the recovery process and identity formation of many women with SMI. In addition, there have been efforts to identify facilitators and barriers to a positive experience of motherhood. Barriers include internal factors such as self-criticism and low self-confidence and mastery, as well as external factors such as unsupportive and stigmatizing environments [2]. In contrast, a supportive environment and a sense of mastery has found to contribute importantly to the positive experience of motherhood [3–7]. The current study aimed to explore how these two factors – sense of mastery and social support – interact in their influence on parental distress among mothers with SMI and mothers without SMI. Focusing on an internal factor (i.e. mastery) and an external one (i.e. social support) helps to understand how these two domains interact with one another.

Sense of mastery, similar to constructs such as perceived control, refers to the degree of one's perceived control over one's life; it is considered a major resource in diverse health- and stress-related situations [8,9]. Studies conducted on mastery and perceived control among persons with SMI have shown that it is an important resource for coping with different challenges and influences positive outcomes, such as quality of life and well-being [6,10]. Interestingly, it has been suggested that one effect of mastery on positive outcome is related to the way in which people with a high sense of mastery use social resources effectively when coping with stressful situations [11]. This idea implies that for persons with a high sense of mastery, social support may be more beneficial than it is for persons with a low sense of mastery. In addition, secondary forms of experiencing control – that is, feelings in control by proxy– have been shown to have potentially negative consequences, such as a reduction in one's quality of life [6]. As such, it is possible that people with a low sense of mastery tend to use the support of others as a means for feeling in control, and this in turn might lead to a negative outcome.

The studies reviewed above support the idea that both sense of mastery and social support contribute to a positive experience and outcome for persons with SMI, and further suggest that they interact and influence outcome; in addition, other studies have also shown the relevance of both of these constructs to coping with motherhood-related challenges [3–5]. That is, both mastery and social support appear to be important resources in coping with SMI as well as in coping with motherhood-related challenges.

A recent review on motherhood and recovery [2] reveal some of the challenges and barriers mothers with SMI are confronted with. These challenges include illness related variables (e.g. symptoms)

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environmental variables (e.g. unsupportive family), discriminatory attitudes and variables that are related to the relationship with the children (e.g. intense emotions). Notably, having a supportive social environment was found to be of great importance to motherhood functioning [2]. However, social resources may also create an additional challenge as mothers with SMI often feel pressure to meet social expectations, perceive the social environment as not necessarily supporting and conceal the illness [2].

As mentioned above, the way people utilize social support may be important in determining its outcome. Being able to feel confidence and control over the motherhood role may enable mothers with SMI to use the social support they need. Thus, having a sense of mastery, which is of importance in the context of motherhood and in the context of coping with SMI [3,5,6,10], may assist women with SMI to utilize social support and navigate support from others for their own good [11].

The current study examined the contribution of social support and sense of mastery, and the interaction between them, to parental distress among mothers with SMI and mothers without SMI. Based on the reviewed literature suggesting the importance of both constructs, and based on the idea that persons with a high sense of mastery would utilize social support more beneficially than would persons with a low sense of mastery, we hypothesized: 1) a positive main effect of social support on parental distress, 2) a positive main effect of sense of mastery on parental distress, and 3) an interaction effect of social support and sense of mastery in which the effects of social support on parental distress would be dependent on the level of sense of mastery. For mothers with a high sense of mastery, the associations between social support and parental distress would be positive and stronger than for mothers with a low sense of mastery. We expected that this interaction effect would appear both in mothers with SMI and mothers without SMI, but would be stronger among women with SMI given that they struggle with low levels of mastery and social support. Thus, since women with SMI may experience less social support and lower levels of mastery, we expected the effects of these variables on the outcome to be stronger.

2. Method

2.1. Study design and participants

This study was part of a larger-scale study on the motherhood experience of women with SMI (additional studies from this project are not published yet). SMI is often defined as having at some time, during the last 12 months, a diagnosable mental, behavioral, or emotional disorder that meets the criteria of the DSM-IV-R and results in significant functional impairment [12]. The incidence for SMI in the United States has been estimated as 8.3% [13]. The current sample was a convenience sample of 120 mothers, including 60 mothers with a case-record diagnosis of SMI and 60 mothers who reported not having a SMI. Mothers with SMI had a psychiatric disability of at least 40% (determined by a medical committee, comprising a psychiatrist and other l professionals), and met the criteria for National Insurance Institute of Israel disability benefits (a roughly comparable process to attaining the designation of SMI in the U.S.). With regard to diagnoses, it is likely that most of the mothers with SMI in the current study had a psychotic disorder, as previous research showed that 86% of 16,000 people in Israel who had a psychiatric disability of at least 40% had a diagnosis of a psychotic-related disorder [14]. The control group comprised 60 mothers without any diagnosis of mental disorder (determined via self-report), whose youngest child was between the ages of 1 and 18 years.

Notably, mothers with SMI were significantly older in comparison to mothers without SMI (41.15 vs.36.80) and had a significantly lower level of education. Also, the mean age of the youngest child was significantly higher for mothers with SMI (8.15) than for mothers without SMI (5.37 years). No other differences between groups in the sociodemographic variables were found.

2.2. Measures

2.2.1. Parental stress

Parental Stress. Parental stress was measured via the Parenting Stress Index-Short Form (PSI-SF; [15]) which is consists of 36 items. Participants were asked to rate the extent to which they agreed with each item on a 5-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree). The questionnaire measures 3 dimensions of parental stress: parental distress – the level of distress as perceived by the parent in his/her role as a parent; parent-child dysfunctional interaction – problems that the parent and child have in terms of interacting with one another; and the perception of a child as difficult which is the extent to which the child is perceived by the parent as being difficult to cope with. In the current study a total score of parental stress was calculated with an internal consistency (Cronbach's alpha) of 0.79.

2.2.2. Sense of mastery

Sense of mastery was measured via a scale based on the Pearlin & Schooler questionnaire [16], which was translated into Hebrew by Hobfoll & Walfisch and was found to be reliable and valid [17]. The scale consists of seven items and uses a 7-point Likert-type scale. The sense of mastery score is based on the mean score of the seven items. In the current study, Item 6 ("I have little control over the things that happen to me") was found to have a low correlation with the total score (<0.3) and was therefore removed from the score. In the current research, the internal consistency after excluding this item was found to be satisfactory (Cronbach's alpha = 0.81).

2.2.3. Social support

Social support was measured by the Hebrew version [18] of the MSPSS: Multidimensional Scale of Perceived Social Support [19]. This instrument consists of 12 items (four items for each of the three sources of support: family, friends, significant others) and uses a 7-point Likert-type scale. The original instrument was found to be valid and reliable [19]. The internal consistency (Cronbach's alpha) of the scale in the current research was 0.89.

2.3. Procedure

After receiving ethical approval for the large-scale study on motherhood among women with SMI, of which the current study was part, data collection took place. Data collection among mothers with SMI was conducted after approaching local mental health service centers (in three different central cities in Israel) and presenting the research aims to staff members. These staff members then shared information about the study with potential mothers, and those mothers who were interested in taking part were contacted by the researcher (second author). Out of 70 women who agreed to participate, five could not take part due to language difficulties, two did not agree to sign informed consent, and three did not meet the inclusion criteria. Thus, the resultant total number of participants in the sample of mothers with SMI was 60. The recruitment of mothers without SMI was conducted via use of the snowball method; that is, potential candidates who were in the researcher's general physical proximity and/or in online groups for mothers were approached by the researcher. All of the women from the two groups signed informed consent.

2.4. Data analysis

Background variables (age, education, marital status, number of children, and age of the youngest and oldest child) were compared between the study groups. Variables that were found to be significantly different between the groups were entered as covariates for subsequent analyses.