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Understanding parenting responsibilities as a challenge to mental healthcare access for mothers with a mental illness in Tyrol, Austria

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A B S T R A C T

It is estimated that one out of three individuals will experience a mental illness at some point in their lives. Parenting with a mental illness can be particularly challenging and often requires additional support and resources to navigate through it. One of the challenges is accessing mental healthcare while also having parenting responsibilities. This study aims to explore how mothers with a mental illness in Tyrol, Austria, experience the impact of their parenting responsibilities in terms of accessing mental healthcare, and which processes contribute to such challenges. We draw from 20 semi-narrative interviews with mothers with a mental illness which were conducted in the context of a larger research project, focusing on developing and evaluating support for families with a parent with a mental illness. We identified three main findings affecting access to mental healthcare services: (1) organisational issues with mental healthcare services, (2) socio-cultural norms around family and care work, and (3) identity-related expectation of being a 'good mother' who is always there for her children. The concern for the children's wellbeing was also closely linked to these aspects. It is important, however, to consider the ways in which these findings are interwoven, and that social support could mitigate challenges. The findings of this study contribute to understanding childcare responsibility as a significant challenge to accessing mental healthcare for mothers with a mental illness and recognising it as a structural, socio-cultural, and identity-related phenomenon.

1. Introduction

This study explores how mothers with mental illnesses in Tyrol, Austria, experience the impact of their parenting responsibilities on accessing mental healthcare and identifies the processes contributing to these challenges. Having children can be a central incentive for mothers with mental illnesses to try to recover and remain well (Blegen et al., 2012; Diaz-Caneja and Johnson, 2004). The role of motherhood often motivates women to actively participate in hospital treatment or use psychiatric services to prevent relapse (Diaz-Caneja and Johnson, 2004; Mowbray et al., 2001). In Awram et al., 2017's study, for example, interviewed mothers expressed that the wellbeing of their children was a motivating factor for seeking support. In this context, caring for children can facilitate mothers in seeking mental health support.

However, being a mother can also present significant challenges for those with a mental illness. Aside from care work-related demands, which can negatively impact mental health (Gebrande, 2021; Halla et al., 2024), as well as feelings of guilt towards their children and worries about children's wellbeing (Law et al., 2021; Montgomery et al., 2011; Perera et al., 2014), specific aspects of parenting can inhibit mothers from accessing mental healthcare. The stigma of being perceived as a 'bad mother' (Halsa, 2018) and the fear of losing custody of their children (Ackerson, 2003; Schamp et al., 2021) are notable barriers. Additionally, the responsibility of caring for children can be one factor that makes it challenging for mothers to access mental healthcare services.

Mental healthcare support often requires regular appointments, flexible work or childcare hours, or extended hospital stays, which may conflict with parenting responsibilities. In Goodman's (2009) study conducted in the USA, 33 % of women surveyed reported that childcare was a barrier to accessing treatment. The systematic review of studies from the UK by Sambrook et al., 2019 recognises childcare responsibilities as a structural barrier due to limited childcare facilities and insufficient resources and organisational requirements on the part of mental healthcare facilities (for example, the difficulty of integrating babies into therapy sessions). Slaunwhite (2015), in a Canadian study, also points out that mothers often raise the need to care for their children, or the lack of childcare facilities, as barriers. Krumm et al., 2013 systematic review refers to one German study (Koelch and Schmid, 2008) and one from the UK (Khalifeh et al., 2009), noting that maternal

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reluctance to seek mental health services often stems from concerns about finding suitable childcare during hospital stays. Stewart et al., 2007 have similar findings, citing childcare as one challenge to accessing support services for parents with drug addiction in the UK. According to them, "parents, and especially women, who looked after children, were less likely to receive residential treatment" (p. 1657). Their study mentions gender as a significant parameter, as women were frequently responsible for caring for children. It was more difficult for women than for men with children to seek treatment, as they were less likely to have a partner "who was actively involved in the care of the children" (2007, p. 1665). The systematic review by Barnett et al. (2021) of studies conducted in regions of the USA and Canada highlights that mothers often reported the importance of providing childcare during appointments. For intensive day treatment or residential settings, mothers needed programs that allowed their children to stay with them. Lastly, Barnett et al. (2021, p. 9) argue that fathers "traditionally have fewer fathering demands […] than […] mothers, which places an unfair burden on mothers".

From a gender-theoretical perspective (Krüger-Kirn, 2021; Possinger, 2017; Thiessen, 2019), we seek to further investigate mothers' challenges in accessing mental healthcare due to childcare responsibilities and to look at the underlying processes and the different dimensions of this challenge. Most previous studies have been conducted in English-speaking countries such as the USA, Canada, and the UK. Our study, however, focuses on mothers with mental illness in the rural area of Tyrol, Austria. At this point, it is important to consider that Austria is characterised by traditional gender roles regarding the distribution of (unpaid) care work within families (Göltl & Berghammer, 2023). Although women's labour force participation has significantly increased in recent decades, mothers still predominantly bear the responsibility for care work (Setz, 2023). Children further reinforce this gendered distribution (Geserick & Wernhart, 2023). In Austria, mothers are responsible for an average of two-thirds of childcare duties (Statistik Austria, 2023). Particularly, couples with children aged two to twelve often adhere to traditional gender norms in organising caregiving duties (Geserick et al., 2023). The younger the child, the more time-intensive childcare is required (Statistik Austria, 2023).

In addition, there is still a considerable lack of (affordable) childcare facilities in Tyrol (Weiss, 2010, 2020), as in the whole of Austria (Auer and Welte, 2009). Outside the capital city of Vienna, only two out of ten childcare facilities are open long enough to allow full-time work. This means that only one in five kindergarten places is compatible with full-time employment outside Vienna (Achleitner, 2022).

Moreover, the traditional belief that the mother should be the primary caregiver for children remains widespread in Austria. A comparison of European countries shows, for example, that the proportion of those who believe that young children are likely to suffer if the mother works in a paid labour is highest in Austria (compared to Germany, Switzerland, Denmark, Sweden, Finland, Poland, the Czech Republic, and Hungary; state 2008) (Pfau-Effinger & Euler, 2014). From the understanding that mothers are primarily responsible for childcare and that childcare facilities often do not offer full-day services, it can be assumed that the gendered distribution of care work and the lack of suitable childcare facilities, especially full-day options, pose challenges for mothers seeking mental healthcare support.

Based on 20 semi-narrative interviews with mothers with a mental illness, we analyse childcare responsibilities as a challenge to access mental healthcare in more detail, a finding that emerged from the initial analysis of the experiences of mothers with a mental illness. We aim to investigate the difficulties that mothers encounter when seeking mental healthcare services due to their childcare responsibilities. Therefore, our focus is on the *processes* of *how* childcare becomes a challenge for accessing mental healthcare. We ask the following research questions: How does childcare responsibility challenge mental healthcare accessibility for mothers with a mental illness? What aspects influence the level of difficulty in overcoming this challenge?

To explore how mothers with a mental illness in Tyrol, Austria, experience the impact of their parenting responsibilities in terms of accessing mental healthcare, we use a gender-theoretical/feminist approach that considers motherhood and care work as cultural and normative phenomena (Hungerland, 2018; Malich & Weise, 2022; Toppe, 2022). The ways in which parental practices, such as childcare, are carried out, are constructed through culturally embedded expectations, discourses, and economic, as well as political frameworks (Dolderer et al., 2016; Dreas, 2019). However, parental practices are not fixed and are constantly negotiated within the family (Schier and Jurczyk, 2008). This approach enables us to interrogate the challenge of childcare for mental healthcare access and analyse the underlying processes that lead to these challenges.

2. Method

2.1. Data and participants

This qualitative study is part of a larger research project (see Christiansen et al., 2019; Goodyear et al., 2022), a pilot project developed to strengthen social support for children of parents with mental illness.

Each family was recruited by adult mental health practitioners. Their respective adult mental health specialists determined participants' eligibility through screening, which included assessing their ability to give informed consent. The families were involved in the project for approximately half a year. The first author conducted semi-narrative interviews with each parent ($n = 22$) who elected to participate after six months of participation in the project. The Human Research Ethics Committee of the Medical University of Innsbruck) approved the interview guide (Approval No. ESC 1197/2019). Before the interviews were conducted, parents signed an informed consent form and were also informed they could stop the interview at any point, take breaks, and choose to not answer questions as they preferred. The interviews were conducted at the research offices or via mobile phone, depending on participant preference and COVID-19 related regulations, from 2020 to 2022. Twenty mothers and two fathers were interviewed. The average interview time with the parents was 88 min (Range = 29–178 min), with 17 participants interviewed within one day ($n = 4$ with breaks) and three interviewed over more than one day.

Every interviewed mother was over 18 years old themselves, lived in Tyrol (Austria), spoke German proficiently, had at least one child over the age of two in their care, and participated in the larger project. The sample provides some heterogeneity in terms of diagnoses, level of education, number of children, and family circumstances (see Table 1).

The interviews were audio-recorded, transcribed, pseudonymised (all identifying features have been removed), and translated into English. To ensure accurate translation, external employees first performed the translations, which were reviewed by German-speaking researchers fluent in the Tyrolean dialect. For the coding process (see Analysis process), documents containing both the original language transcript and the English translation were used, allowing for the identification and discussion of potential linguistic inaccuracies or misunderstandings. Finally, the sequences used for detailed analysis were reviewed for readability and comprehensibility by the first author (a native German speaker) and the senior author (a native English speaker).

The interview transcripts served to evaluate the larger research project (seeBauer et al., 2024) and to understand the general experiences of the child and the parents in everyday life (see Supplementary Material 1 for a translation of the interview schedule). The aim was to examine parents' perspectives on their situation with a mental illness and how families with a parent with a mental illness can be supported. In the context of general experiences, a recurring topic in the mothers' interviews was the responsibility for childcare.

Table 1
Participant information as provided by the parents during the interviews.

parent	parent and care constellation		number of children
mother $n = 20$ father $n = 2$	parents together $n = 11$ parents are main carer $n = 8$ shared custody $n = 1$ limited visitation $n = 1$ not specified $n = 1$		one child $n = 6$ two children $n = 11$ three children $n = 4$ four children $n = 1$
age group of the youngest child	**employment situation**	**highest level of education**	**type of mental illness** (most women described having more than one diagnosis)
early childhood (2–5) $n = 10$ school age (6–13) $n = 10$ adolescence (14–18) $n = 2$	self-employed $n = 1$ part-time employment $n = 10$ unemployed $n = 6$ sick leave $n = 4$ maternity leave $n = 1$	does not finish high school $n = 4$ apprenticeship $n = 4$ high school or diploma $n = 7$ university degree $n = 5$ not specified $n = 2$	depression $n = 11$ post-traumatic stress disorder $n = 7$ anxiety disorder $n = 5$ addiction $n = 4$ borderline personality disorder $n = 3$ dissociative disorder $n = 2$ obsessive compulsive disorder $n = 1$ bipolar disorder $n = 1$ eating disorder $n = 1$ social phobia $n = 1$ adjustment disorder $n = 2$ combined personality disorder $= 1$

2.2. Analysis process

The interview transcripts ($n = 22$) were coded using thematic analysis (Braun & Clarke, 2021). Analysis was performed by the first author, a sociologist specialising in the field of gender studies. This process was discussed and supported by supervision and reflective meetings with senior researchers, including a senior qualitative researcher and a social scientist specialist in maternal mental health (co-authors), to check assumptions and understandings until themes were confirmed. The coding process was supported by the computer program QSR International NVivo 12.

At the beginning of the analysis process, the entire data set was read several times. By repeatedly reading the data set, an understanding of the content was developed, and recurring patterns and particularly interesting passages on the experiences of parents in the context of a mental illness were coded. The coding process was carried out inductively. At first, the code closely followed the literal wording, but became more abstract later. Codes and themes were repeatedly renamed, differentiated, or combined during the coding process and were then combined into thematic blocks. Two central thematic blocks were *challenges to accessing mental healthcare* and *care work* (see Fig. 1), with care work being primarily central in the interviews with the mothers. The theme *childcare responsibilities as a challenge to accessing mental healthcare* was assigned to both thematic blocks. Consequently, this theme bridges the two identified thematic blocks. Recognising that childcare emerges as a central motif in mothers' interviews and seems to play a pivotal role in understanding their experiences with mental illness, the research team decided to ask *how* childcare might impact access to mental healthcare and which role gender and parenthood play.

To deepen our understanding of *how* childcare responsibilities can

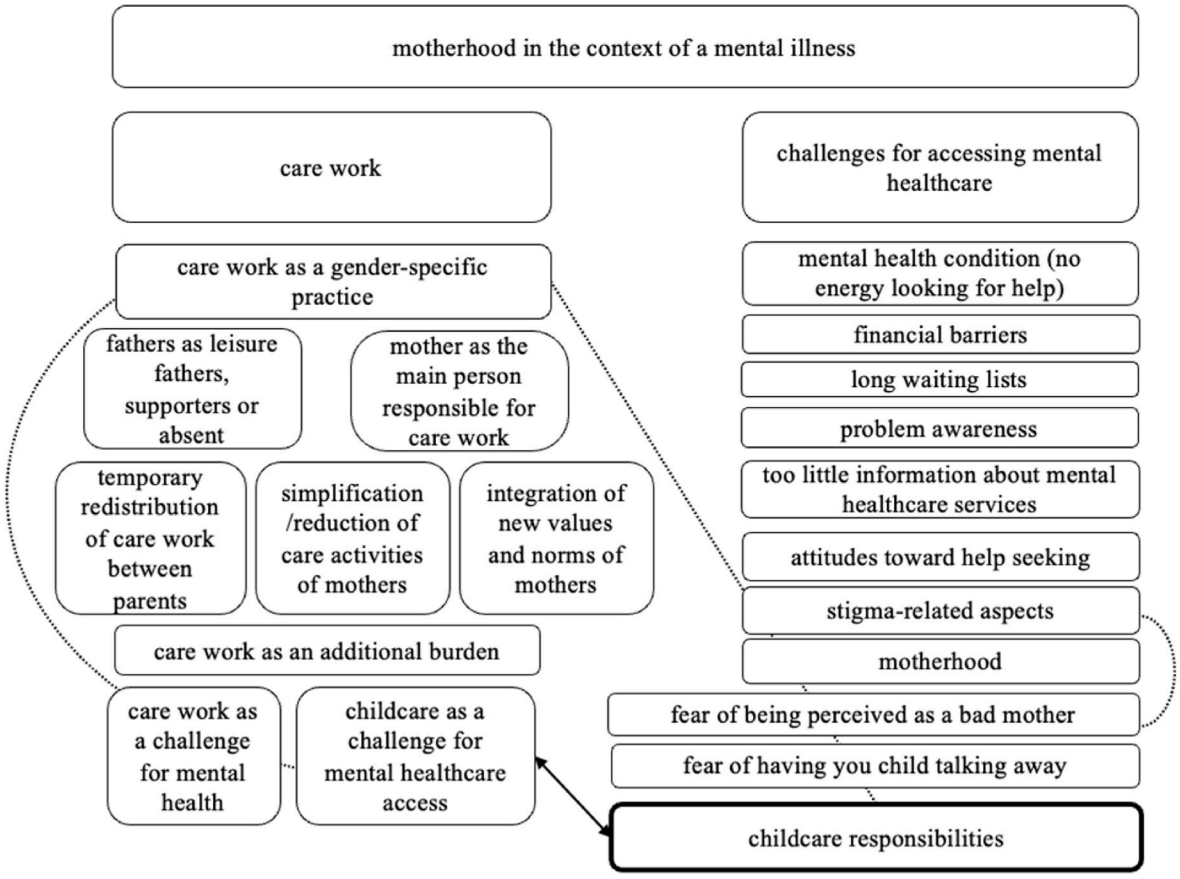

Fig. 1. Overview of the topic and themes on mothers' general experiences to understand childcare as a challenge for mental healthcare access as a link between significant themes.

challenge access to mental healthcare, we extended our coding process with sequential analysis. Building upon initial coding stages (Braun & Clarke, 2021), we sequentially analysed segments where childcare emerged as a challenge to accessing mental healthcare (see Fig. 2), focusing on gendered narratives and structures. In this analysis step, the coded sequences were broken down into smaller units, focusing on how information was conveyed, and which actions were presupposed to be self-evident. Throughout the analysis, connections and contradictions were explored by continually referencing the entire interview. This additional analysis step (Angehrn, 2005; DeVault & Gross, 2021) was guided by a methodological research approach rather than a rigid procedure. This approach involves analysing what is explicitly said during the interviews, as well as what remains unsaid or not explicitly raised by the participants, to identify the underlying assumptions and beliefs that shape actions, interpretations, and experiences. If, for instance, a mother discusses childcare responsibilities without mentioning the child's father, the absence of this information is just as important as what was shared. By incorporating the unsaid or self-evident elements into the analysis of the coded sequences, we aimed to gain a deeper understanding of the processes that render childcare a challenge for mothers with mental illness, as well as the gendered structures and narratives underlying these challenges.

3. Results

In our data, some mothers describe their role and responsibilities as a challenge to mental healthcare access. Our coding suggests that this challenge can be attributed to the following factors: (1) an organisational lack of provisions in mental healthcare facilities to accommodate mothers together with their children, (2) the prevalence of gendered family structures and norms that place caregiving predominantly as a 'woman's job', and (3) identity-related expectations of being a 'good mother' who is always there for her children. However, through the more detailed sequential analysis step, in which we also linked the individual coded passages back to the overall interview, it becomes visible that none of the three factors can be analysed in isolation; rather, they are interwoven (see Fig. 2). Although we will provide a case for each aspect, we will highlight the complex nature of mothers' challenges in accessing mental healthcare due to childcare responsibilities.

Furthermore, our research indicates that having a social network can assist mothers in overcoming obstacles stemming from societal and cultural structures. Mothers who were able to access help with childcare from their social network seemed, in some instances, more likely to be able to access mental healthcare, while those without support faced more challenges. This will be shown with one example respectively.

3.1. Mental healthcare facility regulations as a challenge for mothers

We identified that mothers lacked the opportunity to stay with their children when admitted to mental healthcare facilities for rehabilitation. In one interview, a mother explicitly states that this regulation leads to a reluctance or inability to access mental healthcare services:

> M09: They offer you rehabilitation, which is not possible if you have a family […]. If someone has a family, you can't do the whole rehab program, […]. If I have children …, the family should be considered (by the health professionals) […]. Because admission for rehabilitation is (only) possible without children, and you're away for three weeks somewhere. That doesn't work. And taking them along isn't really an option. […] What do you do with the children? For me, it's not well-organised yet.

This mother has two children aged five and ten. In this sequence, the connection between childcare duties and the reluctance to access mental healthcare is evident. The mother's decision to forgo an inpatient stay in rehabilitation seems to be mainly driven by the impossibility of bringing her children along. One central contributing aspect as to why this mother does not see herself as able to pursue rehabilitation, therefore, seems to be the "*not well-organised*" situation of the mental healthcare facility that prevents her from undergoing rehabilitation with her children.

On closer examination of this interview, it becomes clear that societal expectations of motherhood and gender norms within the family contribute to the problem. Despite the father living in the same household, it seems difficult for the mother to attend a rehabilitation centre without her children. We interpreted this to mean that the mother feels she cannot be absent for a certain period – regardless of whether another caregiver is present, which, in her case, there is. The use of the term "*family*", which in this context can be assumed to refer to dependent children (and seemingly exclude her partner and father of the children), implies a strong sense of exclusive responsibility on the part of the mother towards her (and her partner's) children. This choice of terminology may indicate a prioritisation of the mother-child relationship over other family dynamics. As a result, it seems the mother feels a strong need to stay with her children.

A later part of the interview provides a clearer understanding of this perception:

> M09: … and not taking the children away from their parents. Because that's the 'nice' (said sarcastically) option from the youth welfare office […], (then) have to go to therapy or rehab alone. […] And why I think that many parents who have a psychological burden somewhere don't even apply for help, because they are perhaps under pressure, or fear […] if they say, 'You go to some therapy/

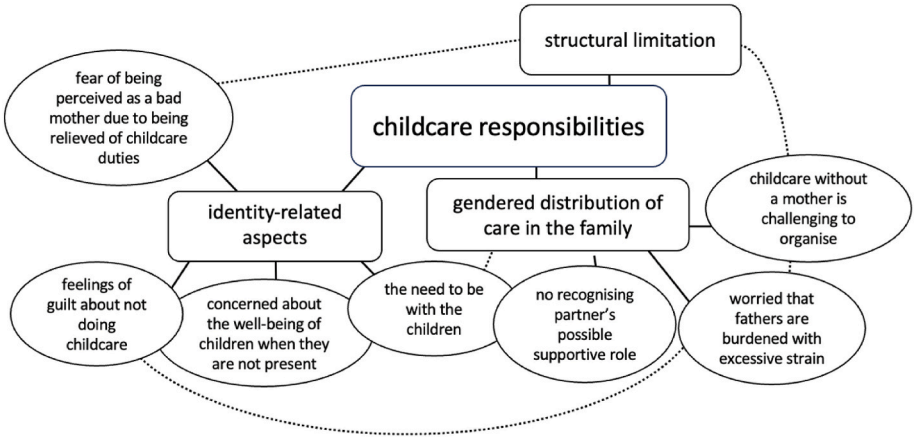

Fig. 2. Overview of the codes of challenges in accessing mental healthcare through childcare responsibilities.

rehab, and we take the children while you're there. […] (in my view) it should be possible to manage getting [the therapy] while still caring for your family.

The statement "*you should manage [the therapy] with the family*" again indicates that the structural restriction of bringing the child along is one aspect as to why the mother does not feel able to take part in an inpatient rehabilitation program. However, this sequence shows that the stigma associated with mental health in the context of parenting and the fear that their children will be cared for by others also influence her decision.

The fear in this quote that someone else will take over her parenting responsibilities for her children if she is absent implies the mother's view that the father is not able (or is not seen as someone able) to take on the role of primary caregiver. For example, at another point in the interview, the mother indicated that the father does not usually participate in childcare or household duties, explaining it as follows: "*that's just how it is. So, in that sense, I believe men are pretty much the same internationally; […] and we women, well, do a lot with the children and take care of the household*".

While the first sequence initially seems to focus on the structural limitations on the part of the mental healthcare facility as to why the mother does not go to a rehabilitation centre, a deeper analysis of the interview highlights that gender-specific expectations within the family, elements of the mother's identity, and concerns about the wellbeing of her children while she is away, also play a role. These complex issues contribute to the mother's reluctance and eventual denial to seek mental healthcare support. If there were an opportunity to participate in a rehabilitation program with her children, and if there were not the fear that the children would be "*tak[en] [away] […] in the meantime*", she may be more inclined to consider a stay in a rehabilitation facility.

3.2. Childcare as a socio-cultural challenge

Our data show that gendered family structures and norms in which mothers bear the primary responsibility for their children prevail, which poses a challenge for delegating childcare tasks from the mother to other people (seeSchamschula, 2024). Compared to the previous challenge of taking the child into adult mental healthcare facilities, which focused on the structural dimension on the part of mental healthcare facilities, childcare as a socio-cultural challenge underscores norms and practices within the family. The following quote illustrates how gendered norms within the family influence access to mental healthcare:

M19: I should have gone [as an inpatient to a psychiatric hospital] a few times. But it is not so easy, because I am alone with the children. My partner is there, but I cannot just go to a clinic for a week or two and leave the children with him … because he also has to go to work.

Similar to the previous example, this one also shows how a mother is recommended inpatient treatment by professionals, but does not consider it because of her responsibility for her nine- and two-year-old children. In contrast to the first example, where the mother (M09) emphasises the structural dimension on the part of the rehabilitation centre, in this example, the gendered organisation of childcare within her family emerges as *the* reason why accessing mental healthcare is not possible for her.

The statement "*because I am alone with the children*" gives the initial impression that the mother lives alone with her children and that this circumstance is the reason why she cannot commit to an inpatient stay. However, the mother lives together with the children's father in one household. Although the person the mother mentions in the sequence is not only her partner but also the children's father, the mother has the feeling that she is "*alone with the children*" and cannot 'leave' the children for a week or two. The statement "*I cannot just go to a clinic for a week or two and leave the children with him*" shows how childcare, or "physical availability" (Tolasch, 2015, p. 234), is seen as the unquestioned responsibility of the mother and how this does not allow the mother to stay away from her children for a certain period. In this context, the gendered division of care work, therefore, prevents the mother from receiving the treatment recommended to her.

The argument in the interview, "*because he also has to go to work*", signals that it is difficult to organise childcare differently due to the father's employment and gives the impression that the situation is hardly changeable. During the interview, there was no mention of the possibility of the father of the children taking a week or two off, applying for carer's leave, or similar options. However, no interview questions covered this aspect. Hence, it is impossible to determine whether the father was asked or suggested this by the mother. Various factors could contribute as to why a father may not take time off work to care for his children. These include structural obstacles within the job, societal expectations regarding work, and stigma-related elements on mental health. However, gendered socio-cultural ideas influence these various dimensions, as gendered narratives shape who is responsible for the family's finances, who cares for the children, and who does (not) take time off work for care work. These gendered norms may have their "full effect", so to speak, when treatment must be carried out without children.

3.3. Childcare as an identity-related challenge to mental healthcare

While identity-specific factors cannot be looked at in isolation from socio-cultural elements, we believe it is crucial to discuss identity as a challenge in its own right. Numerous quotes in our data illustrate how the identity-specific fear of being seen as a 'bad mother' due to mental illness and the related consequence of losing their children inhibits accepting help. The following quote illustrates how a mother sees her identity as a 'good mother' threatened by external observers, not because of the mental illness per se, but if she does not take the primary responsibility for childcare for a certain period of time due to mental healthcare.

M15: I was afraid at first. […] When I say, 'I'm going to psychosomatic treatment', […] it sounds like, 'Wow, you're going there now, and you'll be there for five weeks, leaving your child alone at home'.

A significant concern for this mother is what others might think of her leaving her four-year-old child "*alone at home*" while being in treatment. This concern illustrates how the identity of a mother, and the associated notion that childcare must be provided primarily by the mother, makes an inpatient stay (without children) a challenging decision.

In particular, the knowledge that the woman's husband, who is also the children's father, is present in the family, reinforces the gendered notion of who should care for the child. The phrase "*leaving [her] child alone at home*" here expresses that the child is perceived as left alone without a mother – regardless of whether another caregiver is present, which, in her case, there is.

Although this quote clearly states her concern that by accessing mental healthcare, she will be seen by others as a 'bad mother' who leaves her children alone at home, the mother was nevertheless 'daring' to take the step of accessing mental healthcare. Even though the fear of being perceived by others as a 'bad mother' did not prevent the woman from accessing mental healthcare, the quote makes it clear that identity-related aspects of motherhood can make this desicion difficult. The mother's struggle to agree to an inpatient stay is further illustrated through the following quote:

M15: In December, I had an appointment (with the psychiatrist). And I said, I would like [to have my inpatient stay] in February, since I knew there would be holidays and my mother-in-law would have more time […]. So, from January, we said, let's do [kindergarten] every day so that he (=son) gets used to it. He (= her son) was already prepared, […] my partner (= father of the child) had a week holiday […], my mother-in-law had another week holiday, and I

think my mother also had a few more days (of holidays). And I said […], I want the contact person to remain my partner and a main grandmother, so his mother was also there a lot. My mother […] often took him to kindergarten in the morning when Florian (=father of the child) was on night duty and slept in the morning. That's how it was divided up. And he (= her son) also visited me every second or third day […]. We were […] at the zoo, […] we went to the playgrounds […], and that's how we resolved it in those five weeks […]. I [also] was allowed to go home at the weekend. Normally, you're not allowed to do that, but that was my condition. I said I would only do it if allowed to go home.

This quote emphasises the need for meticulous planning and organisation of childcare when a mother is admitted to the hospital, a situation frequently observed in the data. To maintain consistency and familiarity in her child's care, this mother strategically plans and ensures that the child's father, her mother-in-law, as well as her mother, are all available to provide care. It is worth noting that only through the interaction of three people plus kindergarten (before the mother's planned inpatient stay, the son had attended kindergarten three times a week, increasing to five times a week thereafter), it was then possible to shift the responsibility from the mother (who otherwise works part-time) to others for the child. The quote also suggests that the question of how childcare can be managed when a mother is an inpatient is largely an internal family matter.

In addition, the mother organises continuous activities between her and her son during her inpatient stays. Even at a time when she is, in a way, 'excused' of childcare duties, she nevertheless continues to do so. The statement "*I was allowed to go home at the weekend. Normally you're not allowed to do that, but that was my condition. I said I would only do it if I would be allowed to go home*" signals how the mother chose mental healthcare because of an organisational exception that enabled her to be with her child at weekends. She might not have agreed to a five-week inpatient stay if she had not been allowed to do so. This quote illustrates the intricate interplay between the mother's identity as the primary caregiver for her child and the family norms, according to which the mother usually bears the primary responsibility for the child. Both circumstances make it difficult for this mother to stay away from her family for a certain period.

Additionally, this sequential analysis indicates that this quote can also be attributed to the first theme of *organisational issues with mental healthcare services*. Only with an exception to the regulations did the mother agree to an inpatient stay. The interview shows that concerns about the child's wellbeing make these exceptions crucial for the mother's agreement to an inpatient stay. Concerns about the child and feelings of guilt towards the child also appear in other interviews. Occasionally, feelings of guilt towards the husband are also mentioned when childcare responsibilities temporarily shift from the mother to the father due to an inpatient stay.

3.4. The influence of a supportive social network

"*When I was in the psychiatric (hospital) […], for nine weeks, Maya (= her daughter) was with my mum*" (M07), one mother says in the interview. Although, according to this mother, her mother "*[has] no idea at all about mental illnesses. That doesn't exist in [her] world*", her mother is willing to care for the child when her daughter has an inpatient stay due to her illness. The interviewed mother stated that her mother immediately took over the care responsibility for her child when she was absent: "*there was never any discussion […] my mum was always there for her (= her child) without any ifs and buts*" (M07). In the data, many mothers mentioned receiving support with childcare primarily from the children's grandmothers. However, other individuals from their social environment, such as neighbours or volunteer babysitters, also appear as supporters in the interviews.

According to M07, the child's father is not supportive regarding childcare responsibilities. However, even though the father is not present for the nine-year-old child, the mother was still able to access mental healthcare with the support of her own mother. So, even if the mother is the person primarily responsible for the child and the father does not play a role in the child's daily life, responsibility could be transferred to another person. If the grandmother had not cared for her grandchild while her daughter was an inpatient, it might not have been possible for the mother to accept this formal help.

The difficulty often experienced to be able to attend regular appointments without a social support network is shown in the following example. Here, even a fortnightly appointment is challenging:

M05: There is this skills group for borderline (personality disorder) at the clinic. And I probably will not do that because it does not work out with the children (she has to care for them those days), but I think it// I got myself this book now that works with this therapy. […] and I think it's enriching that you can perhaps control something yourself and name it a bit more clearly.

This mother lives separately from the children's father. Her children are four and six years old. The mother states that care responsibilities are shared between her (60%) and the father (40%) of the children. The appointment at the clinic seems to fall on one of the four days a week when she is responsible for caring for the children.

Upon examining the interview, the challenge of attending this skills group cannot solely be attributed to the gendered division of care between parents but also to stigma and the lack of a support system available to the mother. According to the mother, she has a strained relationship with her mother and ex-husband, and her friends have distanced themselves from her. The interviewed mother mentions having acquaintances and friends but describes these relationships as superficial. She tends to avoid talking about her mental illness due to previous negative experiences. This reluctance also influences her ability to build a network as the following quote, for example, expresses: "*it's difficult to build a network, so to speak, with regard to my mental illness, um, because I can't confront anyone with it*". The absence of a low-stigma environment within her social network, where she feels comfortable discussing mental health issues, may also hinder her ability to seek support for childcare due to mental health concerns.

Getting "*this book […] that works with this therapy*" represents an opportunity for the mother to take action and have some control over her mental health. Despite childcare duties, she can still learn specific tools or ideas from the book. At the same time, this act highlights how her parenting responsibilities force her to seek alternative mental healthcare methods that fit her situation.

4. Discussion

The objective of this study was to explore the challenges faced by mothers with a mental illness in Tyrol, Austria, in accessing mental healthcare due to childcare responsibilities and to identify the underlying processes that contribute to these challenges. We identified several reasons why and how parenting responsibilities can challenge mothers' abilities to access mental healthcare. Similar to previous studies (Sambrook et al., 2019; Slaunwhite, 2015; Stewart et al., 2007), we found that mental healthcare facilities' inadequate resources and organisational factors can create logistical barriers. In this context, mothers refrain from utilising mental healthcare services, as they are unable to take their children with them. However, among the mothers interviewed, logistical barriers were rarely mentioned, with only one mother explicitly citing this as a reason for not undergoing treatment.

We also found that gendered structures and norms can challenge mothers' access to mental healthcare. In this context, little consideration is often given to the father's parenting role. While numerous studies discuss how childcare responsibility in families is organised in a gendered manner (Achleitner, 2024; Geserick & Wernhart, 2023) and the difficulties this creates for mothers (Halla et al., 2024; Xue and

McMunn, 2021), only a few explicitly address gendered norms (Barnett et al., 2021; Stewart et al., 2007) within families in the context of accessing mental healthcare for mothers with a mental illness.

For some women, a supportive social network has mitigated this internal family barrier. Studies have suggested that social connectedness is an important support source (Reupert et al., 2022) and that a social network can positively influence help-seeking behaviour (Vogel et al., 2007). Our study also observed the importance of social networks with regard to the redistribution of childcare during a mother's stay in mental healthcare facilities. We furthermore found that stigma can impede the development of social networks, making it challenging for affected individuals to delegate childcare responsibilities due to mental health treatment temporarily. Numerous studies have identified stigma as a barrier to accessing mental health treatment (Aguirre Velasco et al., 2020; Clement et al., 2015; Knaak et al., 2017). Our study extends this understanding, suggesting that stigma also prevents mothers from seeking help with childcare responsibilities within their social network, thereby hindering their ability to attend mental healthcare appointments.

However, in cases where the distribution of childcare could be reassigned from the mother to other individuals, often thorough planning was necessary to guarantee the care of children by others in the mother's absence. In this context, our data also indicates that childcare is interpreted as a 'private issue'. Mothers who wanted to receive *inpatient* treatment had to negotiate with their partner, the children's grandmothers, or other members of their social network whether they could look after their children for a certain period. Without their support, there hardly seemed to be other options to access *inpatient* mental healthcare. This shows how illness or care issues must often be negotiated within the family (Reuter, 2004). Childcare being treated as a 'private issue' seems to intensify the challenge of accessing mental healthcare. It can be especially difficult for those who are reluctant to disclose their mental illness in private due to stigma.

In families where childcare was delegated to others during an inpatient stay, concerns about the child's wellbeing, and sometimes the partner's wellbeing, were prevalent. This, in turn, emphasises that mothers are expected to be the primary caretakers of their children (Hays, 1996; Krüger-Kirn, 2021; Swift, 2015) and that a child's wellbeing is inherently tied to the mother's involvement (Campanello, 2018; Diabaté, 2018; Speck, 2016). This demonstrates that childcare encompasses not only practices but also gender identities and the gendered attributions associated with them (Dreas, 2019; Krüger-Kirn, 2021). In this context, it also seems necessary to discuss childcare as an identity-related challenge to accessing mental healthcare. The literature on the identity conflict between being a 'good mother' and 'being a person with mental illness' found that this conflict can deter mothers from seeking help due to fears of stigma and judgment regarding mental illnesses (Baldisserotto et al., 2020; Goodman, 2009; Halsa, 2018; Jones, 2019). Our study explored this relationship further by showing the ways in which an identity-related idea that a 'good mother' should always be the primary caregiver for the child shapes the organisation of childcare practices and how this can complicate access to mental healthcare. Consistent with (Hine et al., 2019), our findings show that motherhood profoundly influences women. In this context, we agree with Hine et al., 2019 that while women with mental illness can benefit from claiming a normative maternal identity, adapting to gender norms can also lead to psychological stress and the acceptance of an oppressed social status. Cultural expectations around motherhood can lead mothers with mental illness to feel that they must put their own needs on hold until their children are older (Hine et al., 2017). Additionally, we found that the fear of being seen as a 'bad mother' is not only due to the mental illness itself but also because of the temporary delegation of childcare responsibilities by accessing mental healthcare.

Moreover, it is important to consider that we cannot rule out that there are also other reasons contributing to delayed treatment for the interviewed mothers who mentioned childcare as a barrier. For instance, they might be apprehensive about the treatment process, concerned about its potential discomfort or unfamiliarity. Childcare responsibilities might be perceived as a socially acceptable reason for declining treatment.

Understanding social and cultural attitudes towards family and political conditions seems crucial in understanding the link between access to mental healthcare and parental responsibilities. Cultural factors play a significant role in shaping the experiences of mothers with mental illness (Chen et al., 2021). Austria's conservative welfare state regime, with its long history of the "housewife model", where women are primarily responsible for childcare and household tasks (Pfau-Effinger, 2005) is likely to influence the experiences of the interviewed mothers. In addition, the gap in full-day childcare options (Achleitner, 2022) and the lack of (affordable) childcare facilities (Auer and Welte, 2009; Weiss, 2010, 2020) may make it more difficult for mothers to be absent for a certain period – especially if there is no social network to look after their children.

Moreover, mothers who live in the same household as the children's fathers and who mentioned the challenge of childcare in accessing mental healthcare in our study had at least one child in early childhood (2–5 years of age). This suggests that it is more difficult for mothers with younger children to delegate childcare for a certain period than mothers with older children or teenagers. These results align with the observation that the younger the child, the more care work is required (Statistik Austria, 2023) and that childcare in Austria is especially organised in a gendered way in families where children are aged two to twelve (Geserick et al., 2023).

Furthermore, the research question of this study arose from the observation that during an interview about general experiences with a mental illness, some mothers talked about how mental healthcare was sometimes difficult to combine with taking care of their children. However, no explicit question in the interview guide included childcare responsibility as a challenge to accessing mental healthcare services. This study primarily offers an initial impression that childcare poses a challenge and advocates for further research to explore this issue comprehensively. Even though they were not directly asked about it, mothers mentioned this challenge. Future research should include specific questions about the challenges of childcare responsibilities and mental healthcare access. The belief that mothers are inherently responsible for childcare (Dreβler, 2018; Hungerland, 2018; Swift, 2015; Thiessen, 2019) can lead to essentialism, making recognising childcare as a complex socio-cultural and identity-specific issue more difficult. This is why we continue to advocate exploring the issue of childcare as a challenge using methods that engage the unsaid and the elements that seem self-evident.

Ethics approval

The study is performed according to the Declaration of Helsinki and was approved by the Ethics Committee of the Medical University of Innsbruck (Approval No. ESC 1197/2019). All participants provided informed consent to participate in the study, including those who participated in the optional qualitative interview.

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CRediT authorship contribution statement

Monika Schamschula: Writing – original draft, Visualization, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Annette Bauer:** Writing – review & editing, Supervision, Investigation, Funding acquisition, Conceptualization. **Jean Lillian Paul:** Writing – review & editing, Supervision, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ssmqr.2024.100490.

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