**Discrimination and support from friends and family members
experienced by people with mental health problems: Findings from an
Australian national survey**

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Abstract

Purpose

To investigate the scope and nature of discrimination and positive treatment experienced by adults with mental health problems from their friends and family in a population-based survey.

Methods

An Australian telephone-survey of 5220 adults included 1381 individuals who reported a mental health problem or scored high on a screening questionnaire. Respondents were interviewed about their experience of discrimination and positive treatment from their friends, spouse and other family members. Descriptions of experiences were content-analysed to identify key characteristics.

Results

Mental health diagnoses were primarily depression or anxiety disorders, and just over half had received treatment in the last 12 months. Positive treatment from family and friends was far more common than discrimination, reported by 74.1% of respondents. This was primarily characterised by providing emotional support and maintaining contact, as well as checking on their mental health and being a good listener. Nevertheless, discriminatory behaviours from friends and family were reported by 25.8% of respondents, with reducing or cutting contact being by far the most common. Friends and family also commonly dismissed that mental illness was real or caused suffering and showed a lack of understanding about mental health problems or treatments and how they can impact behaviour and functioning.

Conclusions

This nationally representative study of real life experiences highlights the potential for harm or benefit from a person's social support network. Despite positive experiences being common, there is an ongoing need to reduce mental illness stigma and improve understanding of how to support a loved one with a mental health problem.

Key words

Mental disorders, stigma, discrimination, social support

Background

Stigma and discrimination have a negative impact upon the lives of people with mental disorders. It is a key deterrent of help-seeking [1], interferes with personal relationships and work and educational opportunities [2], and contributes to lower self-esteem and feelings of hopelessness and suicide [3,4]. A great deal of research has investigated attitudes towards people with mental health problems, particularly beliefs that they are dangerous and unpredictable, that they are responsible for their problem due to personal weakness, and that they should be avoided [5-7].

More recently, research has turned to understanding the behavioural aspect of stigma – discrimination – by directly asking people with mental health problems about unfair treatment they have experienced from others. This is in recognition of the limitations of survey research assessing stigmatising attitudes towards hypothetical situations [8]. People with mental health problems have reported being discriminated against in a range of settings, including within personal relationships, workplaces, health care and housing [9]. Several large-scale surveys of individuals in contact with mental health services, which have used the same measure of discrimination [the Discrimination and Stigma Scale; 10], have found that discrimination is most commonly experienced within personal relationships. Reported rates vary between 40-54% from family members, 33-50% from friends, and 21-39% in dating or intimate relationships [11,12,2,9,8].

Friends and family members are an important source of mental health support, and unfair treatment from loved ones may be particularly damaging [13]. Qualitative research can aid understanding of what is perceived as unfair or discriminatory treatment from others. There are a growing number of interview studies conducted with people who have mental health

problems to explore what types of behaviours are perceived as discriminatory, with much of this work focusing on schizophrenia [14]. Several types of behaviours have been identified in this literature [15-19]. The most common is that of social distancing, particularly from friends. This ranges from a reduction in social contact or exclusion from invitations, through to losing relationships altogether. Another consistent finding is friends and family not understanding mental health problems and how they impact behaviour, or making stereotypical judgements such as the person lacks credibility or is “crazy”. Overprotective behaviour from family members, involving protection from stressors or a reduction in autonomy, is perceived as unfair or discriminatory despite being well-intentioned. Mistreatment, including verbal and physical abuse, has also been reported from friends and family.

These studies offer insight into the types of behaviour from others that are perceived as discriminatory by adults with mental health problems. However, research thus far has included samples of convenience, participants who were already in touch with treatment services or who were selected for reporting the most discrimination [16]. An epidemiological survey may show different findings, by reducing the likelihood of recruiting participants who have experienced particularly severe discrimination, and including people who have not sought treatment. This may provide more accurate estimations of the most common experiences of discrimination, which could then be used to inform the design of anti-discrimination campaigns.

An important counterpoint to anti-discrimination messages in education campaigns would be to provide information on alternative supportive behaviours in which people might engage. Social networks are well-placed to facilitate early help-seeking for mental health

problems, and support from friends and family can increase the likelihood of recovery [20,21]. Yet, there has been scant research into the *types* of positive behaviours that friends and family can engage in to best support their loved ones with mental health problems. In one study of individuals with schizophrenia, supportive treatment was perceived as merely being treated with kindness and respect [18]. More detailed accounts of supportive behaviours for people with bipolar disorder have been reported by Doherty and MacGeorge [22], including emotional or conversational support, support managing the illness, and help with activities, housing, finance or transport. Some of these would apply to people with other mental health problems, but some may be more specific to bipolar disorder. However, no population-based studies have systematically assessed experiences of positive treatment related to mental health problems from friends and family members.

In light of the research gaps identified above, this national population-based survey aimed to investigate the scope and nature of discrimination and positive treatment experienced by adults with mental health problems from their friends and family.

Methods

The data are from a large national survey of Australians about mental health discrimination in a variety of settings [23]. This paper reports on discrimination from friends, family, and spouses experienced by adults with a recent mental health problem. Discrimination experienced in other settings is reported elsewhere (workplace and education settings [24]; health professionals [25]). The survey involved computer-assisted telephone interviews (CATI) with a national sample of 5,220 members of the general community aged 18 years and over. The sample was contacted by random-digit dialling of both landlines and mobile phones (dual frame design). Interviews were conducted between October and December

2014 by the Social Research Centre survey company. Ethics approval was obtained from the University of Melbourne Human Research Ethics Committee.

Survey interview

Initial questions covered sociodemographic information, including age, gender, marital status, postcode, country of birth, language spoken at home, level of education and Aboriginal and Torres Strait Islander status. Respondents completed the 12-month version of the Kessler 6 (K6) mental health symptom screening questionnaire [26] and were asked whether they had experienced any sort of mental health problem in the last 12 months. Respondents who answered 'yes' to this question were then asked what they thought the problem was. For the purposes of the study, respondents were considered to have a mental health problem if they either scored in the high range on the K6 (≥ 19) or specified any of the following mental health problems: depression/major depression, attempted suicide or self-harm, anxiety/anxiety disorder, post-traumatic stress disorder/PTSD, agoraphobia, panic disorder, obsessive-compulsive disorder/OCD, social phobia, generalised anxiety disorder/GAD, eating disorder/anorexia/bulimia, schizophrenia/paranoid schizophrenia, schizoaffective disorder, psychosis/psychotic, bipolar/bipolar disorder/manic-depressive disorder, mental illness, personality disorder/borderline personality disorder, attention deficit-hyperactivity disorder/ADHD, Autism/Asperger's and nervous breakdown.

These respondents were then asked a series of questions about their experiences of discrimination and positive treatment over the past 12 months in a range of domains, including from friends, spouses and family members. Respondents were told "*discrimination occurs when people are treated unfairly because they are seen as being different from others*". In relation to friends, respondents were first asked, "*Have any of your friends*

avoided you because of the emotional or mental health problems you have told me about?”.

Next they were asked *“Have any of your friends discriminated against you in other ways because of these problems?”* and *“Have any of your friends treated you more positively because of these problems?”*. If respondents answered ‘yes’ to either of the latter two questions, they were then asked, *“Can you please describe what happened?”*. The same questions were then asked in relation to family members and spouses. Answers were transcribed verbatim by interviewers.

Content analysis

Respondent descriptions of discrimination and positive treatment from their spouse, family, and friends were content analysed to identify key characteristics [27]. A coding framework was developed which included instructions with examples and counter-examples for each code. This was developed in an iterative process, whereby an initial coding system was created and refined through discussion and double-coding of a sample of approximately 10% of responses by three authors (AM, AJ, NR). Sampled responses were selected in order to represent the full range of codes. Coding discrepancies were discussed until consensus was reached for both the coding system and the response in question. Once the coding framework was finalised, one of the authors (AM or RB) coded the remaining discrimination and positive treatment responses. A response could be coded into more than one category. Discussion with a second author was necessary for some responses. Responses that could not be interpreted, did not make sense, or required very strong assumptions about the respondent’s meaning were not coded. Only categories with at least 4% frequency in at least one domain are presented.

Statistical analysis

A pre-weight was applied to adjust for the dual frame design and the respondent chance of selection. The achieved sample was close to the Australian national population in terms of geographic distribution, however, there was an under-representation of males and of younger adults, and an over-representation of university-educated individuals and people with an English-speaking background. These biases were adjusted for by 'raking' (also known as rim weighting or iterative proportional fitting) to account for known population proportions of gender, age, education level, region and telephone status. Raking is the preferred approach for overcoming non-response biases in telephone surveys, as it can incorporate a wider range of sociodemographic variables into the weighting formula [28]. Analyses were performed using Intercooled Stata 13 (StataCorp LP, Texas, USA).

Results

Out of 5220 interviews conducted, 1381 (28.8%) respondents were classified as having a mental health problem and were asked the questions about their experiences of discrimination and positive treatment. Most of these (1159) reported an in-scope mental health problem and the remaining 222 respondents had K6 scores of 19 or above. The most common mental health problem was depression (55.6%), followed by anxiety disorders (including PTSD and OCD; 45.2%), bipolar disorder (4.6%), psychotic disorder (2.7%), eating disorder (2.3%), and personality disorder (1.2%) (multiple diagnoses were possible). Over half (57.5%) of the sample had received treatment for a mental health problem in the last 12 months. The sample age distribution was: 18-29 years (29.2%), 30-59 years (58.0%) and 60 years or older (12.8%). There were more women (56.4%) than men (43.5%) classified as having a mental health problem.

A quarter of respondents (25.8%) reported discrimination from their friends, spouse or other family members, and there were 424 descriptions of how respondents were treated unfairly by them. Twelve categories of discrimination were identified, and the most common experience was friends and family **reducing or cutting contact** with respondents (see Table 1). This included avoidance, exclusion, distancing, and even losing friendships because of the respondent's mental health problem. See Table 2 for examples of each type of discrimination experience. Respondents also reported friends and family were **dismissive** that their mental illness was real or caused suffering; **lacked understanding** about the respondent's illness, including how the illness affects them, its causes, and the impact of treatment on functioning; and **judged** them because of their behavior (e.g. worthless, stupid, lazy, dangerous). Reports of others **expressing anger or frustration or getting into arguments** with the respondent were more commonly reported from spouses than friends and other family members, as was **being teased or experiencing verbal abuse**. Less frequently reported behaviors were being **stereotyped** as 'crazy' or having their behavior always interpreted through a mental health lens; being **treated as incompetent** or a bit **differently or strangely**; **telling others** about their mental health problem without their permission; being **overprotective** by removing potential stressors; and being **physically abusive**.

Experiencing positive treatment was more common than discrimination, as 74.1% of respondents reported this from their friends, spouse or other family members. There was no association between being discriminated against and being treated more positively by friends and family (Cramer's $V = .06$, $p = .088$). Being treated more positively from friends

and family was reported by 78.6% of respondents who reported discrimination, versus 73.1% of respondents who reported no discrimination.

There were 1745 responses that were coded into 9 categories of positive treatment. Most respondents reported that their friends and family were **emotionally supportive** in general terms, such as being caring, understanding, nice, or helpful (see Tables 3 and 4). The second most common positive treatment was friends and family **maintaining or increasing contact** with respondents. Respondents also reported friends and family **checking on them** to see how they are going and whether they are ok, **trying to cheer them up**, and **talking or listening** to the respondent about their issues or sharing their own experiences related to mental health. Some types of positive treatment were more commonly reported from spouses than friends or other family members. These included **adjusting expectations** of what the respondent can do in acknowledgment of their problem, or providing **practical assistance**, such as helping with household chores, childcare, housing, financial support, or taking them to appointments. A small proportion of respondents reported friends and family **encouraging engagement in positive activities**, such as getting out of the house or being more social, or encouraging **healthy habits** relating to diet, sleep, exercise, or substances. Some responses were infrequently reported and were coded under **Other**. These, included giving advice, sending gifts, encouraging professional help-seeking, making an effort to avoid negative interactions with the respondent, and an improved relationship with their friend, family member, or spouse.

Discussion

This study investigated the frequency and types of discriminatory or supportive behaviours people with mental health problems reported experiencing from their loved ones.

Discriminatory behaviours were reported by 25.8% of the sample, with social distancing (reducing or cutting contact) being by far the most common. Also common were dismissive treatment and ignorance about mental health problems or treatments and how they can impact behaviour and functioning. There was some variation in frequency of experience across relationship type, as reports of social distance were more common from friends, and spouses tended to engage in more verbal abuse and arguments than friends or family members. This may reflect the closeness or proximity of the relationship, as spouses would be less able to reduce contact than friends. In contrast to the minority who reported discrimination, most respondents (74.1%) reported some form of positive treatment from family and friends related to their mental health problem, which was primarily emotional support and contact, as well as checking on their mental health and being a good listener. Positive treatment was common even in respondents who reported discrimination, which may be due to different responses from multiple people in a person's social network, or different responses over time from the same individual. This nationally representative study of real life experiences shows that friends and family are sources of both discrimination and support.

Contextualizing these findings in the prior literature, the types of discrimination experiences reported here are generally consistent with those reported in other studies. For instance, social distancing from friends and family was the main form of discrimination reported by adult mental health service users [15,16], and others not understanding their experiences or showing any empathy was also common. The desire to reduce social contact may be to avoid the risks (e.g., violence) associated with people with mental illness [29], but avoidance may also be due to friends and family not being able to cope with the person's mental

illness, particularly when they are most unwell [16]. Respondents identified overprotection and physical abuse as discriminatory behaviours, but they were less commonly reported in our sample compared to previous research focused on schizophrenia [18].

In contrast, the prevalence estimates of discrimination from friends and family were lower in our study than in other surveys, where up to half of respondents reported discrimination from family or friends [e.g., 12,9]. There may be several reasons for this difference, including the use of a different interview measure (which had a focus on discrimination in the past 12 months only) and sampling of the public rather than mental health service users. Moreover, most respondents reported a depressive or anxiety disorder and few reported psychotic illnesses, which tend to be more highly stigmatised [6,7]. Alternatively, Australian national campaigns to reduce stigma may be a factor, as there is evidence that the desire for social distance from those with depression has decreased over time in Australia [30], but has remained unchanged in other countries [31].

Results suggest that the level of stigma and mental health literacy in the community could still be improved. Respondents thought that a lack of knowledge or understanding about mental health problems from their friends and family led to them being treated unfairly. Although mental health literacy has improved in Australia in recent years [32], a minority still believe that mental health problems are not real or are due to personal weakness, and would be unwilling to interact socially with a person affected [30]. Programs such as Mental Health First Aid (MHFA), which educates community members on mental health problems and how to assist a loved one to seek help, have been shown to improve mental health knowledge, reduce stigma, and increase helping behaviours [33]. Alongside community education initiatives, there is a role for health professionals to educate carers about their

loved one's mental illness and how to provide ongoing support. Consumers and carers agree on the importance of active carer participation in mental health care, with carers desiring not only information about mental illness but also how to cope as a carer and provide practical day-to-day support [34,35]. This information and support can range from basic psychoeducation to more intensive skills-based family interventions, which have shown benefits in preventing relapse and reducing hospitalisation [36]. These community and family education initiatives recognise the pivotal role that a person's social networks play in supporting them towards obtaining treatment and achieving recovery.

The study's main limitations were its relatively low response rate, which may affect the generalizability of the results, and the use of an unvalidated measure of discrimination experiences. Although raked weighting was used to improve the representativeness of prevalence estimates, this method can only compensate for sociodemographic biases and not for biases in other variables like discriminatory or supportive experiences. Another limitation is that in a general community sample, more severe mental disorders have a low prevalence, so that the results may not adequately represent the experiences of people with these disorders. The study design also meant that follow-up questions to clarify responses were not possible, and information about the context of each experience was not obtained. This would be possible in a smaller, 'richer' qualitative study that used longer or more detailed interviews, but was not feasible with the large sample size obtained.

Furthermore, whilst the study identified a range of behaviours from friends and family perceived as supportive, it did not investigate which types of positive treatment are thought to be *most* useful to people with a mental health problem. The study's main strength was its use of interviews to ascertain the experiences of people with a wide range of mental health

problems, rather than assessing stigmatising attitudes towards hypothetical vignettes. The large, population-based sample may also have reduced the likelihood of recruiting respondents who wanted to participate due to experiencing particularly severe discrimination. Furthermore, as the sample included a mix of service-users and non-users, results are less likely to be biased towards underreporting of discrimination from people who have experienced very high levels discrimination avoiding treatment services.

In conclusion, this study found that friends and family engaged in a variety of behaviours that were perceived to be discriminatory by people with mental health problems, particularly social rejection and the enactment of negative or judgemental attitudes. Correspondingly, providing emotional support and maintaining contact were the main positive behaviours reported by respondents from their loved ones. These findings highlight the potential for harm or benefit from a person's social support network, and the ongoing need for efforts to reduce mental illness stigma and improve understanding of how to support a loved one with a mental health problem.

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Conflict of interest

The authors declare that they have no conflict of interest.

Ethical standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008.

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Tables

Table 1. Frequency of type of discrimination experienced by respondents from their spouse, family members, and friends

Type of discrimination	spouse		family		friends	
	n	%	n	%	n	%
Reduced / cut contact	24	34.3	63	43.2	88	54.7
Dismissive	6	8.6	30	20.5	23	14.3
Lacked understanding	13	18.6	30	20.5	21	13.0
Being judged	10	14.3	17	11.6	22	13.7
Teasing / verbal abuse	10	14.3	9	6.2	13	8.1
Stereotyped	3	4.3	4	2.7	7	4.3
Treated as incompetent	5	7.1	6	4.1	0	0.0
Treated a bit differently / strangely	0	0.0	5	3.4	8	5.0
Told others	0	0.0	4	2.7	7	4.3
Expressed anger / frustration / arguments	14	20.0	11	7.5	3	1.9
Overprotection	3	4.3	3	2.1	3	1.9
Physical abuse	3	4.3	3	2.1	1	0.6
Could not be coded	21	23.1	20	12.0	6	3.6

Table 2. Example responses for each type of discrimination reported by respondents from their spouse, family members, and friends

Type of discrimination	Examples	Domain	Disorder
Reduced / cut contact	A couple of my friends stopped talking to me. [Male, 35-39]	friends	Schizophrenia
	In terms of not making the regular contact, discrimination as to social events as well. Non-invitations. [Female, 35-39]	family	Depression, anxiety disorder
	Doesn't want to be physical, doesn't want to have a physical relationship while I'm going through this / withdrawing communication wise, not knowing what to say to me [Female, 35-39]	spouse	Panic disorder, GAD
Dismissive	Basically they don't believe mental illness. They just tell me I'm basically failing at life, or I'm just too negative [Female, 20-24]	family	Depression, anxiety disorder
	They just tell you it's all in your head [Female, 25-29]	friends	Depression, anxiety disorder
	They say pull yourself together, or there's other people worse off which you don't need to hear when you're feeling bad. [Female, 60-64]	family	No disorder
Lacked understanding	Only because of the non-understanding of the illness sometimes makes it hard and we're going through something at the moment where I'm on heavy medications and I'm very drowsy and I've been housebound for a long time, and my family have been saying get out and do things and I just haven't got the energy, so trying to explain to them is hard enough [Male, 45-49]	family	Schizoaffective disorder
	They just reckoned I shouldn't be taking antidepressants because it's no good for me. [Female, 45-49]	friends	Depression
	Doesn't understand the disorder the illness responds with anger thinking is more of a situation where you're just being difficult not a disorder [Female, 60-64]	spouse	Anxiety disorder, PTSD
Being judged	Being judgmental. Looked down upon for being weak. [Female, 35-39]	friends	Depression, anxiety disorder
	My father said that I was a disappointment to him and my mother. [Male, 55-59]	family	Depression, anxiety disorder, PTSD
	Put a lot of blame on me for things I couldn't help at the time. Calling me lazy because I had no energy [Male, 30-34]	spouse	Stress

Teasing / verbal abuse	They've belittled me and put me down [Female, 45-49]	family	Depression, PTSD
	Sometimes he in the past he would tease me for having a mental problem, I don't like having it but sometimes my spouse would tease me about it, he doesn't do it now, it's just the stigma attached to it and that teasing can hurt me [Female, 45-49]	spouse	Schizoaffective disorder
	Being taunted all the time about it. They would make smart-arse jokes and * like that [Male, 35-39]	friends	Nervous breakdown
Stereotyped	My friends didn't want to visit me because they were scared of crazy people [Female, 30-34]	friends	Depression, psychosis
	Their perceptions of you are then very different, and how they interpret your behaviour. Everything would be seen with a mental health lens on it. [Female, 30-34]	spouse	No disorder
Treated as incompetent	Took all responsibility away from me [Female, 30-34]	family	Bipolar disorder
	Can't trust me to make decisions [Male, 55-59]	spouse	Depression, anxiety disorder, PTSD
Treated a bit differently / strangely	Some people are unsure of how to act around me [Male, 50-54]	friends	Depression, anxiety disorder, schizophrenia
	They would treat you differently or withhold information [Female, 30-34]	family	No disorder
Told others	They just told others, and stuff [Female, 18-19]	friends	Depression, anxiety disorder
	Probably just a breakdown in family ties, mostly with my mother. When I tried to discuss it with her she hung up on me and then phoned other siblings and talked about me. [Female, 35-39]	family	PTSD, GAD
Expressed anger / frustration / arguments	General attitude, general way of being treated, apart from avoidance: anger, frustration, all those negative words [Female, 60-64]	family	Depression
	When he gets frustrated he'll make comments and make me sound like a raving lunatic. It's more when he's frustrated and angry that he'll focus on my problems rather than a solution to what we're dealing with [Female, 35-39]	spouse	Anxiety disorder
Overprotection	if something could have a potential for me to be a stressor for me I won't be invited out or they change what's going on [Female, 18-19]	friends	PTSD, borderline personality disorder

	Thinking that I couldn't do my normal job and wanting me to do less stressful jobs [Female, 35-39]	spouse	Bipolar disorder
Physical abuse	I was assaulted by my brother for no particular, because he thought I was vulnerable and took it out on me.[Female, 50-54]	family	Depression
	I was attacked [Female, 50-54]	spouse	No disorder

Table 3 Frequency of type of positive treatment experienced by respondents from their spouse, family members, and friends

Type of positive treatment	spouse		family		friends	
	n	%	n	%	n	%
Non-specific emotional support	372	81.2	392	68.2	477	72.3
Maintained or increased contact	64	14.0	195	33.9	205	31.1
Checked on them	26	5.7	84	14.6	101	15.3
Talked or listened	47	10.3	38	6.6	84	12.7
Tried to cheer up	40	8.7	32	5.6	55	8.3
Adjusted expectations	40	8.7	25	4.3	22	3.3
Practical assistance	57	12.4	42	7.3	28	4.2
Encouraged positive or healthy activities	20	4.4	11	1.9	36	5.5
Other	49	10.7	65	11.3	44	6.7
Could not be coded	12	2.6	13	2.2	27	3.9

Table 4. Example responses for each type of positive treatment experienced by respondents from their spouse, family members, and friends

Type of positive treatment	Examples	Domain	Disorder
Non-specific emotional support	They are supportive and understanding [Male, 65-69]	family	PTSD
	When they see you're going through a rough time they rally around you and support you with word or offering to help or just by being there. [Female, 35-39]	friends	Anxiety disorder
	Just being a bit more thoughtful [Female, 65-69]	spouse	Depression
Maintained or increased contact	Trying to stop over as often as they can [Female, 20-24]	family	Depression, anxiety disorder
	Just spent more time with me I guess [Male, 65-69]	spouse	Stress
	Try to catch up more [Male, 25-29]	friends	Anxiety disorder
Checked on them	Phone calls to check on me [Female, 45-49]	friends	Depression, anxiety disorder
	Just a lot more monitoring [Female, 25-29]	family	Depression
	Constantly making sure I'm ok [Female, 20-24]	spouse	Depression, anxiety disorder
Talked or listened	Given me the opportunity to talk about how I'm feeling [Female, 65-69]	family	Anxiety disorder
	They also share their stories of mental health problems [Female, 45-49]	friends	Depression, anxiety disorder
	He listens and lets me vent [Female, 45-49]	spouse	Depression, anxiety disorder
Tried to cheer up	They try to cheer me up [Male, 40-44]	friends	Depression, schizophrenia
	They try to make me happy, take me out and cheer me up [Male, 20-24]	spouse	Depression, anxiety disorder
	Always making me look at the brighter side of things and the future [Female, 55-59]	family	Depression, anxiety disorder

Adjusted expectations	They understand that some days I can do things and some days I can't [Male, 65-69]	friends	No disorder
	Degree of forgiveness of not being as productive as I normally am [Male, 45-49]	spouse	Depression, anxiety disorder
	My daughter is 13 years old but she is not disappointed when I cannot do things with her she doesn't make me feel bad about letting her down [Female, 45-49]	family	Agoraphobia
Practical assistance	Helping, offer to do housework or vacuuming [Female, 50-54]	friends	No disorder
	They've helped me out by taking me to appointments [Female, 50-54]	family	Depression
	He's happy to take the kids to school in the morning and to pay for afterschool care [Female, 35-39]	spouse	Borderline personality disorder
Encouraged positive or healthy activities	Just making sure that I am getting out of the house even if I don't want to but you have to get out and do things [Female, 40-44]	family	Depression, attempted suicide or self-harm
	Encourages healthy habits, good sleeping practices. [Female, 45-49]	spouse	Depression