A Fractured Journey of Growth:
Making Meaning of a ‘Broken’ Childhood
and Parental Mental Ill-health

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Declaration

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4. The work in this thesis was carried out under the supervision of Dr Lynne
McCormack, Clinical Psychologist and Senior Lecturer.

Signed: _____________________________

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Acknowledgement

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Abstract

Scope:

Research in the area of parental mental ill-health is largely problem saturated, focused on psychopathology risks and other adverse outcomes for the vulnerable children who grow up with an unwell mother or father. This thesis reviews the wealth of literature in the area of parental mental ill-health, including the prevalence of parental mental ill-health and impact on family life. It further discusses the effect of parental mental ill-health on the parent-child attachment relationship and the biological, psychological and social risk factors for children of mentally unwell parents.

What is poorly addressed in the literature and the main aim of this thesis is the subjective interpretations of adult children, reflecting on both the positive and negative ‘lived’ experience of growing up with parental mental ill-health. This phenomenon is explored through semi-structured interviews, analysed and discussed.

Purpose

From the adult child’s perspective, the current study seeks to understand reflections and interpretations related to childhood experiences; and to explore the consequences of parental mental ill-health on the emotional and interpersonal development of these participants. The study aims to explore the subjective ‘lived’ experience from both the positive and negative perspective in order to achieve a rich understanding of the phenomenon of growing up with a mentally unwell mother or father.

Aim

The aim of the current research is to contribute to our understanding of the psychosocial impact of growing up with a parent affected by mental ill-health, and whether positive as well as negative interpretations of childhood experiences are possible. Second, we seek an understanding of the impact of childhood adversity specifically in the area of developmental/betrayal trauma and whether growth is possible out of such adversity.
Methodology

From a phenomenological perspective, semi-structured interviews captured subjective interpretations of seven adult children who grew up with a mother or father affected by mental ill-health. Data were analysed using Interpretative Phenomenological Analysis (IPA). IPA uses a reiterative interpretative framework whereby the researchers strive to make sense of the participant making sense of their experiences. IPA is recommended for investigating unexplored topics where subjective meanings, values and beliefs are important but poorly understood (Smith, 1996).

Results

Analysis of participant interviews revealed one superordinate theme – A fractured journey of growth to adulthood – which overarched six subordinate themes reflecting negative and positive interpretations of growing up with parental mental ill-health. Four themes captured the stigma, shame, social isolation and betrayal experienced by these participants: 1) Who cares, nobody cares; 2) Trauma and betrayal; 3) Transferring the distress, 4) Ducking, weaving and staying safe. Juxtaposed with this, two themes capturing purposeful redefinition of self and psychological growth also emerged: 1) Growing myself up; 2) Transforming a broken childhood.

Conclusions and Implications

This phenomenological investigation has enabled a deeper understanding of the phenomenon of being parented by a mother or father with mental ill-health. It highlights both positive and negative impacts of parental mental ill-health from the adult child’s perspective. The current study found that these children felt shame, experienced betrayal and lived with a heightened vigilance around unmet needs. They were often puzzled by events related to their parent’s mental health difficulties, but instinctively became caretakers when needed. Stigma and social isolation were bedfellows of their young lives.

Conversely, the study also revealed that these participants redefined their distress
when able to form supportive attachment relationships with other significant adults. In doing so, they recognised that autonomy and self-regard could be nurtured through ‘growing myself up’ meaningfully and successfully. Autonomy was sought through distancing themselves from their fear of trans-generational contamination of mental ill-health; and valuing self-determination, goal setting and education for psychological wellbeing and purpose in life. As they experienced their own growth; empathy and a pragmatic but caring distance allowed them to experience a healthy separateness from their parent’s mental ill-health.

These findings build on the growing body of research in the area of parental mental ill-health and highlight the isolation of these vulnerable children and families whose needs are often neglected by current policy and practice. This study captures the debilitating psychosocial distress and sense of betrayal that these participants experienced as children. It also highlights that growth is possible out of such adversity. The ability to redefine the adult self positively despite years of childhood trauma has implications for future research, therapeutic intervention and support.
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Critical Literature Review

Mental ill-health affects many people and the consequences of mental health problems are experienced throughout the wider family system. For many family members and carers of those affected by mental health problems, daily life is marred by challenges and inadequate support. An in-depth understanding of the experiences of these vulnerable families is crucial in informing the development of policies and practices which aim to accommodate their complex and varied needs. The study described in this thesis seeks to understand the subjective ‘lived’ experience of growing up with a parent affected by mental ill-health. This critical review provides a summary of the relevant literature in the area of parental mental ill-health. A brief overview regarding the prevalence of parental mental ill-health is provided. This is followed by consideration of previous research which explores the psychopathology risks and other adverse outcomes for children of parents affected by specific psychiatric disorders. The impact of parental mental ill-health on the parent-child attachment relationship is then considered, followed by examination of the literature regarding developmental trauma and betrayal trauma.

Despite the adversity faced by children who endure parental mental ill-health, many children with a mentally unwell mother or father show no signs of negative outcome. This is less well represented within the literature, as research continues to focus on risks and negative outcomes in offspring of mentally unwell parents. This literature review considers protective factors which potentially mediate risk for vulnerable children, before providing an overview of literature in the area of post-traumatic growth. Finally, a summary of the aims and broad approach of the current study is presented, including a synopsis of the methodological approach employed, and précis of the author’s self-reflexivity and interest in the subject area.
Growing up with Parental Mental Ill-health

Childhood is a critical period of development. Both physical and psychological vulnerabilities in childhood necessitate adult protection (Gladstone, Boydell & McKeever, 2006). Family life for any child who is exposed to a parent’s mental ill-health can be complex and challenging (Mordoch & Hall, 2002). Until part-way through the last century, most individuals diagnosed with severe mental illnesses were confined to institutions where they would remain for much of their lives (Armstrong, 2002). Introduction of community-based mental health care in the 1950’s and improvements in pharmacological treatment afforded individuals affected by severe mental illnesses the opportunity to live in the community. While individuals suffering from an acute exacerbation of mental ill-health may be hospitalised for brief periods of time, the majority of mental health treatment is now community-based and on a voluntary basis. As such, it has become increasingly likely that family members living with a person affected by mental ill-health may be exposed to acute and chronic episodes of mental illness (Armstrong, 2002).

Children growing up with a one or more parents affected by mental ill-health may be subject to a chaotic lifestyle characterised by unpredictable or bizarre behaviour, emotional unavailability, high levels of expressed emotion in the family home, temporary absence due to hospitalisation, marked distress associated with parental self-injury, or parental suicidal behaviour. The multifaceted needs of a mentally unwell parent may outweigh the basic needs of a dependent child, causing children’s needs to be overlooked at times. Parents may become preoccupied by their own symptomatology, lack insight into the needs of self or others, or lack motivation to attend to their children’s needs. Amotivation may occur for several reasons, including as a symptom of psychiatric illness, as an adverse effect of medication, or as a result of frontal lobe impairment or executive dysfunction (Thomas & Kalucy, 2003).

For many reasons, the quality of relationship between parent and child may be
affected in the context of parental mental ill-health. While any disruption to the parent-child relationship is likely pose threat to the child’s wellbeing, research suggests that disturbance during the critical period of infant attachment is of most concern (Cicchetti & Toth, 2005). Disruption to the parent-child relationship during this time may predispose a child to mental health problems throughout childhood, as an adolescent or as an adult.

**Attachment and the Parent-Child Relationship**

Attachment theory (Bowlby, 1969) outlines the importance of caregiver availability, sensitivity and responsiveness during a child’s early life. During the critical attachment period between 6 months and two years of age, an infant’s interaction with their primary caregiver impacts significantly upon their social and emotional developmental trajectory. Caregiver-child interaction during this period provides a foundation for emotion regulation, and has implications for the child’s feelings of security and capacity to form trusting relationships later in life (Berk, 2006). Infants implicitly learn about their importance or worth based on their repeated experience of how their caregivers respond to them during early life.

Infants who have caregivers who are consistently available to them and comforting during times of distress are likely to develop a ‘secure’ attachment to their caregiver. These infants learn that their caregiver is a safe person on whom they can depend. Infants with a secure attachment learn to use their caregiver as a ‘safe base’ from which to explore the world (Bowlby, 1988). These infants also develop effective ‘working models’ (Bowlby, 1969) of their environment, their caregiver and ultimately, of themselves due to their caregiver’s responsiveness to their needs. Based on a representation of a caregiver who is sensitive, responsive and available, securely attached infants come to view themselves as loveable and worthy (Cassidy & Mohr, 2001).

Emotional unavailability or unpredictable behaviour exhibited by a caregiver
interferes with the attachment process between caregiver and child (Duncan & Reder, 2000). Parents affected by mental ill-health may present as emotionally blunt, disinterested or hostile, due to the impact of their symptoms. Parents who are unresponsive, angry or critical towards their children, or parental behaviour which is bizarre or confusing likely threatens the formation of a secure parent-child attachment relationship (Cleaver, Unell & Aldgate 1999). Infants faced with inconsistency or neglect, or infants who build representations of their primary caregiver as unavailable or rejecting, are likely to come to view themselves as unlovable, unworthy and unable to obtain care. These infants are considered to be insecurely attached (Cassidy & Mohr, 2001).

The formation of secure attachment relationships are essential for an individual’s mental well-being, as they provide the foundation for an individual’s developing sense of self and working model for future social relations (Hornor, 2008). Infants who develop attachment relationships characterised by avoidant, resistant or disorganised behaviour are at risk of developing psychopathology; including reactive attachment disorder. Review of the literature suggests that children who have been subject to abuse or neglect during early life are at highest risk of developing reactive attachment disorder. However, children who grow up in chaotic environments where parents are unavailable or unable to appropriately respond to their needs may also be at increased risk of reactive attachment disorder (Minnis, Marwick, Arthur, & McLaughlin, 2006). As such, children of parents who are pre-occupied by their own symptoms of distress or lack motivation to parent due to mental ill-health may be at risk. Despite this, there is evidence to suggest that the presence of parental mental ill-health alone does not equate to attachment difficulties in dependent children. Research shows that some parents are able to build strong and effective relationships with their children, despite enduring mental health difficulties (Aldridge and Becker, 2003).
Prevalence of Parental Mental Ill-Health

Recent research indicates that approximately 45% of the adult population experiences mental health difficulties in their lifetime, with approximately one in five adults affected at any given time (Reupert, Maybery & Kowalenko, 2012). While difficult to ascertain, it is generally agreed that up to 50% of adults accessing mental health services have children in their care and this number continues to rise (Poole, 1996; Falkov, 1998). A recent Australian study demonstrates that the number of parents affected by mental ill-health increased by three per cent every year between 1990 and 2005 (O’Donnell et al. 2013). While most studies have explored prevalence of parental mental ill-health from the adult perspective, more recent research has specifically examined child prevalence and found that up to 20% of young people live in families in which a parent is affected by mental ill-health (Reupert, et al., 2012). This new research indicates that exposure to parental mental ill-health is part of everyday life for a large number of young people, highlighting the need for family support and young carer support services, to assist these vulnerable families.

Consequences of Parental Mental Ill-Health

Over the years, research has explored the consequences of growing up with a parent affected by mental ill-health. Previous research has focused on the psychopathology risk for the child (Rutter & Quinton, 1984) and it is now widely accepted that children of parents with mental ill-health are at increased risk of developing psychiatric problems themselves. Other studies suggest that exposure to parental mental ill-health poses considerable risk to the child's secure attachment (Duncan & Reder, 2000) and places children at a significantly greater risk of social, psychological and physical health problems, than children who grow up with parents without psychiatric illness (Maybery, Ling, Szakacs & Reupert, 2005). Garley and colleagues (1997) note that disturbances in interpersonal relationships and reduced overall adaptive functioning may result from growing up with a mentally ill parent.
Furthermore, studies indicate that children who have grown up with a parent affected by mental ill-health are more likely to require input from mental health services and welfare services as adults (Devlin & O’Brien, 1999). This cycle of disadvantage and dysfunction serves to perpetuate the problem of parental mental ill-health for future generations. Families affected by parental mental ill-health are more likely than other families to experience poverty and social exclusion (Reupert & Maybery, 2007) and are also more likely to have children removed by welfare services (Leschied, Chiodo, Whitehead & Hurley, 2005). In addition to increased risk of developing behavioural or emotional difficulties, children who are parented by someone with a mental illness are also more likely to have poorer cognitive function and a higher incidence of learning difficulties than their peers (Gladstone, Boydell, Seeman & McKeever, 2011).

Research indicates that individuals affected by mental ill-health tend to choose partners who also experience mental health problems (Downey & Coyne 1990). This serves to compound the risk for dependent children, who may find themselves growing up in a household with two unwell parents or carers. Children of parents with mental ill-health are affected in many ways and different risks exist for children based on their parent’s psychopathology. The risks for children growing up with parents affected by specific mental illnesses have been examined and are well documented in the literature.

**Parents with Psychotic Disorders**

Children of mothers diagnosed with schizophrenia are at increased risk of a range of mental health problems: including psychotic illnesses, affective disorders and personality disorders (Dean et al., 2010). Among the risks for children of parents with psychosis is the possibility that a child might become directly involved in a parent’s delusion material. Children may become the subject of a parent’s delusional belief, leading the parent to fear, neglect or harm the child. Alternately, a parent affected by psychosis may harm their child in
the context of a command hallucination or paranoid ideation (Friedman, Hrouda, Holden, Noffsinger & Resnick 2005). Children with a parent affected by a psychotic disorder may also be vulnerable to developing a shared psychotic disorder. Shared psychotic disorder (also known as ‘induced delusional disorder’ or ‘folie à deux’) is characterised by the presence of similar delusional beliefs in two or more people. Review of the literature revealed a number of examples of induced delusional disorder in children of parents affected by psychosis. Most notably is a case of a 12 year old boy who required admission to an adolescent psychiatric unit for in-patient treatment, after developing symptoms mirroring his father’s paranoid disorder (Wehmeier, Barth & Remschmidt, 2003).

In addition, there are strong genetic associations in psychotic disorders such as schizophrenia, increasing the risk of trans-generational transmission (Craddock, O’Donovan & Owen, 2009). Research indicates that first degree relatives of an individual affected by a psychotic disorder have 8-10 times greater risk of developing a psychotic illness than the general population (O’Donovan, Craddock & Owen, 2009). As such, children of parents affected by psychosis are at greater risk of developing mental health problems themselves, due to both biological and environmental risk factors.

**Parents with Affective Disorders**

Children of parents diagnosed with a depressive illness are two to three times more likely to develop a depressive disorder or an anxiety disorder than children of non-depressed parents (Weissman, Wickramaratne, Nomura & Warner 2006). Similarly, children who have a parent affected by bipolar affective disorder are at higher risk for mood disorders and other psychopathologies, including attention deficit/hyperactivity disorder, conduct disorder, oppositional defiant disorder and substance use disorder (DelBello & Geller, 2001). Affective disorders are frequently accompanied by interpersonal difficulties and as a consequence, marital conflict and divorce are common in individuals experiencing depression (Downey &
Children of depressed parents are more likely to grow up in households where marital conflict and family dysfunction are prominent and this may impact on child well-being in several ways. Exposure to family relationship difficulties may influence child attachment, adjustment, stress and coping (Downey & Coyne 1990).

Attachment in affective disorders has been closely examined and increased rates of insecure attachment have been found in children of mothers affected by depression (47%) and bipolar affective disorder (79%), compared to the general population in which rates of insecure attachment are closer to 25% (Radke-Yarrow, Cummings, Kuczynski, & Chapman, 1985). Overall, research indicates that a range of biological factors, including genetic vulnerability, and environmental stressors may interact to influence child adjustment, increasing the risk for children of parents diagnosed with an affective disorder.

**Parents with Personality Disorders**

Numerous studies have evaluated the impact of maternal borderline personality disorder on parenting and attachment. Overall, mothers with borderline personality disorder are less sensitive to their children’s needs, and children of mothers with borderline personality disorder are less attentive and less interested in interacting with their mothers (Newman, Stevenson, Bergman & Boyce, 2007). Individuals with a borderline personality structure most often have difficulties regulating emotions, tolerating distress, controlling impulsivity and negotiating interpersonal relationships. Each of these limitations may impact upon the formation of a secure parent-child relationship. The literature states that attachment relationships in borderline personality disorder tend to be insecure, and fluctuate between extremes of idealising and devaluing others (Newman et. al, 2007).

Many children of parents with borderline personality disorder have disorganised attachment, behavioural difficulties and symptoms of attention deficit/hyperactivity disorder (Reupert et al., 2012). In addition, children’s early understanding of emotions, empathy and
interpersonal relationships may be impacted upon by inconsistent parenting practices and lack of emotional availability in the parent-child relationship. Individuals with borderline personality disorder may experience difficulties with co-morbid anxiety or depression and may also experience difficulties with self-harming behaviour or substance misuse (Reupert et al., 2012). Each of these factors have the potential to impact upon parenting capacity, increasing the risk of psychological harm in dependent children. In addition, there is evidence which suggests both genetic factors and adverse childhood experiences contribute to the development of borderline personality disorder, potentially increasing the risk of trans-generational transmission (Lieb, Zanarini, Schmahl, Linehan & Bohus, 2004).

**Parents with Anxiety Disorders**

Behavioural patterns in anxious parents may contribute to the development and maintenance of symptoms of psychological distress in dependent children, as anxious parents interact with their children differently to non-anxious parents (Woodruff-Borden, Morrow, Bourland & Cambron, 2002). Parents who are diagnosed with an anxiety disorder may have poorer engagement with their children and show their children reduced warmth. In addition, anxious parents typically grant lower levels of autonomy to their children than parents unaffected by an anxiety disorder (Nicol-Harper, Harvey & Stein, 2007). Psychosocial factors contributing to the transmission of anxiety disorders in families have been explored and there is evidence to suggest genetic and environmental factors exists. Research indicates that children of parents diagnosed with an anxiety disorder are seven times more likely to develop an anxiety disorder than children of parents without an anxiety disorder (Woodruff-Borden et al., 2002). This may be due to both genetic transmission and transmission of fear cognitions between generations through social learning.
Parents with Eating Disorders

Parents suffering from an eating disorder may experience difficulties attending to their child due to the completing influence of the eating disorder and preoccupation with body shape, weight and food (Wooley, Wheatcroft & Stein, 1998). Similarly, extreme compensatory behaviours associated with eating disorders (such as excessive exercise, laxative use or self-induced vomiting) may become disruptive to the parent-child relationship. While there is little research evidence to evaluate the impact of paternal eating disorders on children, it is widely accepted that children with mothers who are affected by an eating disorder are vulnerable to a range of emotional difficulties (Hodes, Timimi & Robinson, 1997).

Children are more susceptible to the influence of parental eating disorders at different stages of their development and the possible mechanisms of influence are wide-reaching (Wooley et al., 1998). Parents’ body image dissatisfaction and disordered eating behaviour may impact upon children in both direct and indirect ways. These may influence children and adolescents in their body image attitudes and eating behaviours. The influence of social learning or ‘modelling’ of disordered eating behaviour in a parent has been found to be just as harmful as parental criticism of a child’s weight, shape or eating habits (Wooley et al., 1998). Research indicates that children of parents affected by eating disorders are more vulnerable to developing eating disorders and other psychiatric disorders, such as obsessive compulsive disorder. Prior research suggests psychopathology rates as high as 50% in offspring of parents with anorexia nervosa or bulimia nervosa (Hodes et al., 1997).

Parents with Substance Use Disorders

Children of fathers with substance use disorder are at increased risk of developing emotional and behavioural difficulties, such as attention deficit-hyperactivity disorder,
conduct disorder, major depressive disorder and anxiety disorders (Clark, Cornelius, Wood & Vanyukov, 2004). Furthermore, children of parents diagnosed with substance use disorder are also at increased risk of developing substance use disorder themselves (Biederman, Faraone, Monuteaux & Feighner, 2000). While all children of parents with a substance use disorder are at increased risk of developing similar problems due to genetic vulnerability (Prescott & Kendler, 1999), trans-generational transmission of substance use disorder also likely include an environmental component. Research suggests that adolescence is a critical developmental period for exposure to parental substance misuse (Biederman et. al, 2000). In recognition of this vulnerability, children of parents who are dependent on alcohol or other substances require increased support and assistance throughout adolescence.

**Social Adversity and Stigma**

Psychopathology risks for children of mentally ill parents may differ based on the parent’s presenting problem, however social difficulties are a common experience for these vulnerable families. By and large, children of parents affected by mental ill-health remain at risk of social adversity. Among the risks are family problems such as: poor communication, inconsistent parenting, marital discord and family breakdown (Gladstone et al., 2005). In addition, families affected by parental mental ill-health experience low income, unemployment, substandard housing and poverty more frequently than families unaffected by parental mental ill-health (Hall, 2004). Children growing up with an unwell mother or father may endure frequent disruptions to everyday life, impacting on their social and academic performance (Cogan, Riddell & Mayes, 2005). Furthermore, children may experience difficulties with social exclusion, social isolation and stigma, in the context of parental mental ill-health (Reupert & Maybery, 2007).

Children growing up with a parent affected by mental ill-health have consistently reported difficulties with stigma. Corrigan and Miller (2004) theorise that the primary
stereotypes which maintain stigma are blame (i.e. family members are responsible for their relative’s mental ill-health) and contamination (i.e. close association with a mentally ill person leads to diminished worth). In addition to blame and contamination, shame and discrimination are further avenues for stigma in the area of mental illness. Research has found that up to 50% of family members attempt to conceal their relationship with a person affected by mental illness due to concern about family shame (Corrigan & Miller, 2004). Family shame in mental illness has been compared to shame in families affected by physical illnesses, with research showing family shame was 40 times more prevalent in families affected by mental ill-health than families affected by cancer (Ohaeri & Fido, 2001).

Additionally, the impact of stigma may also deter parents from disclosing information about their mental health difficulties to doctors and other health care providers (Ramchandani & Stein, 2003). Parents may feel frightened about their children being removed by child welfare services due to stereotypes that people with mental ill-health are dangerous or incompetent (Corrigan & Miller, 2004). Identifying vulnerable children and families is crucial in providing assistance and as such, overcoming this stigma and other barriers is essential in the provision of clinical services.

**Children of Parents with Mental Ill-health**

Most studies indicate that children possess inadequate and inaccurate knowledge about their parent’s mental ill-health (Gladstone et. al., 2011). Children often report having little information or explanation for their parent’s symptomatology, which may lead to confusion or difficulty making sense of their experience. Previous research suggests that ambiguity and lack of understanding about a parent’s ill-health may precipitate feelings of guilt or blame in children (Place, Reynolds, Cousins & O’Neill, 2002). Likewise, research indicates that greater knowledge about mental illness may lead to improved child coping and more realistic expectations about their parent’s recovery (Gladstone et. al., 2011).
Parents may refrain from speaking openly and honestly about the subject of parental mental ill-health due to fear of upsetting their child, or because of concerns about the child’s ability to comprehend such adversity. Consideration of age, developmental stage and cognitive ability may play a role, however research indicates that infants, children and adolescents are acutely sensitive to the people with whom they are closest to, and will naturally experience concern if they perceive distress in a loved one (Falkov, 2004). As such, discussion about parental mental ill-health provides an opportunity to address a child’s questions and concerns, and a further opening to provide reassurance, foster strength and build hope for the family’s future.

In addition to a poor understanding of mental health problems, children of parents affected by mental ill-health worry about their own mental health as well as their parent’s mental health (Armstrong, 2002). Some children express concern about their risk of developing a mental illness (Gladstone et al., 2011), drawing parallels between their behaviour and that of an unwell parent and predicting a similar life trajectory for self. Core beliefs of hopelessness may enable a self-fulfilling prophecy, which has the potential to considerably worsen an individual’s outcome (Hinshaw, 2005).

Furthermore, children of parents affected by mental ill-health may feel pressured to maintain stability within the home environment in order to shelter their unwell parent from experiencing undue stress (Armstrong, 2002). This heightened state of arousal and anxiety may evolve into a caring role over time. Studies show that many children accept additional responsibilities in the home to compensate for an unwell parent’s reduced functional capacity.

**Young Carers**

Due to family circumstances, some children who grow up with a parent affected by mental ill-health feel forced to assume care-giving roles or take on responsibilities typically
expected of parents. Young carers (sometimes referred to as ‘parentified children’) are people aged 5–25 who provide physical care or emotional support to someone in his or her family who is affected by illness or disability (Cree, 2003). Presently, more than 150,000 carers in Australia under the age of 18 provide care to an unwell relative (Australian Bureau of Statistics, 2008). Research suggests that identity development and personality, interpersonal relationships and relationships with an individual’s future children may be compromised by a child’s experience of caring for a parent (Earley & Cushway, 2002).

Sadly, research indicates that a young carers own health and wellbeing may be seriously affected without sufficient supports. Studies have revealed rates as high as 75% of young carers experience mental health difficulties in adulthood (Frank, Tatum & Tucker, 1999). Further research has examined specific worries and problems perceived by young carers and found that young carers: worry about the health of the person they care for, worry about their own health, worry about the behaviour of the person they care for, and worry about who will look after them in the future. Problems identified by these young carers include problems at home and school, bullying, difficulties with eating and sleeping, self-harming behaviour and thoughts of suicide (Cree, 2003).

In contrast, many young carers describe a positive reaction to being needed by their parent, which may contribute to a sense of self-worth and importance (Aldridge & Becker, 1993). Other research has found that caregiving children are more aware and understanding of the needs of others (Grossman, 1972), feel proud of their ability to complete complex caregiving tasks (Banks, Cogan, Riddell, Deeley, Hill & Tisdall 2002) and enjoy a sense of satisfaction and selflessness through caring for a loved one (Aldridge & Becker, 1993; Noble-Carr, 2002). While there is the potential for both negative and positive consequences to arise from the experience of caring for a parent, the literature clearly states that adverse outcomes will likely outweigh any benefits of this experience without adequate supports for young
carers. These findings have clear implications for clinical practice, highlighting the importance of financial, emotional and social supports for young carers.

**Post-Traumatic Stress**

Children who have grown up with parental mental ill-health frequently describe a pervasive pattern of emotional neglect or abuse, which poses risk to their physical and/or psychological wellbeing. Research indicates that these traumatic experiences may have deleterious effects on a child, altering their physical, emotional, cognitive and social development (Perry, 2010). For many survivors of traumatic events, post-traumatic stress disorder (PTSD) is a common reaction (Ehlers & Clark, 2000). In addition to isolated traumatic events (such as a motor vehicle accident, assault or home invasion), the accumulation of interpersonal traumas (referred to as ‘complex trauma’) also has the potential to trigger a post-trauma stress response. Symptoms of post-trauma stress consist of three clusters: re-experiencing symptom (such as intrusive thoughts and images, nightmares and flashbacks), avoidance and emotional numbing (including attempts to avoid reminders and feelings of previous traumatic experiences) and arousal symptoms (for example, hypervigilance and sleep disturbance; American Psychiatric Association, 2013).

Research in the area of post-trauma stress has clearly established the importance of cognitive appraisal, personality structure and social support, on stress and coping following a traumatic event (Joseph & Linley, 2005). Briefly, personality traits such as neuroticism may increase vulnerability for developing clinically significant post-trauma stress and attract a diagnosis of PTSD, whereas social support following a traumatic event may offer protection against post-trauma stress (Joseph & Linley, 2005). Similarly, cognitive appraisal during and following trauma is likely to influence stress and coping. Individuals who appraise a traumatic situation negatively (e.g. nowhere is safe, it was my fault, I’ll never get over this) are more likely to attract a diagnosis of PTSD than individuals who appraise trauma as a
time-limited event which does not have negative global future implications (Ehlers & Clark, 2000).

Diagnostically, PTSD in children is widely accepted, however the term ‘developmental trauma’ is often used to describe the experience of multiple or chronic developmentally adverse traumatic events occurring during childhood. Currently within the field, there are strong arguments advocating for the development of a new diagnostic classification which captures the very complex emotional, behavioural and neurobiological sequelae of developmental trauma (Van der Kolk, 2005).

**Developmental Trauma**

Developmental trauma refers to an accumulation of stressful events that occur within specific relationships and contexts, repeatedly throughout childhood (Sar, 2011). Examples of developmental trauma include childhood physical, emotional and sexual abuse and neglect. Additionally, repeated exposure to dysregulated emotions within the family home may also be developmentally traumatising for children and adolescents (Sar, 2011). Research suggests that children who witness domestic violence or who are exposed to parental substance misuse seldom have secure childhoods. These children often present with pervasive and multifaceted vulnerabilities as a consequence. These may include mood disorders, physical health problems and a range of impulsive and self-injurious behaviours (Van der Kolk, 2005).

Children who have endured developmental trauma are at increased risk of medical, forensic, social and mental health difficulties in later life. Research shows that individuals with histories of repeated childhood trauma are over-represented in the criminal justice population (Van der Kolk, 2005) and the mental health system. Repeatedly traumatised children may present with symptoms of emotional distress across the lifespan: including reactive attachment disorder in infancy, conduct disorder during childhood, emotional
disorders during adolescents, and personality, substance use and affective disorders in adulthood (Schmid, Petermann, & Fegert, 2013).

In contrast to isolated traumatic events which may trigger a post-traumatic stress response in children, chronic maltreatment (or repeated traumatisation) has wider-reaching impacts on the developing brain. Chronic trauma interferes with neurobiological development, disrupting the ability to process and integrate sensory, emotional and cognitive information (Ford, 2005). This may lead to difficulties with learning and may impinge on a child’s developmental trajectory. As such, researchers and clinicians in the area of complex trauma continue to advocate for a new diagnostic category (proposed ‘developmental trauma disorder’) despite its exclusion from the latest edition of the Diagnostic and Statistical Manual of Mental Disorders this year.

Research indicates that parents and caregivers are responsible for child maltreatment in approximately 80% of cases (Van der Kolk, 2005). Children who experience interpersonal trauma at the hand of a parent or caregiver are faced with the challenge of learning how to relate to a person who provides for them and also threatens, harms or neglects them. In the context of maltreatment by a parent or caregiver, the child must not only endure the devastating effects of abuse or neglect, they also must contend with the appalling violation of trust that stems from the betrayal of a loved one.

Betrayal Trauma

Betrayal trauma theory (Freyd, 1994) highlights the importance of social relationships in understanding outcome following trauma. Betrayal trauma occurs when a person is violated in a significant way by a person (or institution) on whom they depend for survival. Therefore, childhood physical, emotional, or sexual abuse perpetrated by a caregiver are considered examples of betrayal trauma (Freyd, DePrince & Gleaves, 2007). Betrayal trauma theory attempts to explain why victims of abuse may appear to have no conscious awareness
or memory of a traumatic event, a phenomenon which is referred to as ‘traumatic amnesia’. Betrayal trauma theory states that the degree to which trauma involves betrayal by another person impacts significantly on the way in which the traumatic experience is encoded into the memory of the traumatised individual (Freyd, 1996). Furthermore, betrayal trauma theory posits that traumatic amnesia or ‘betrayal blindness’ may occur in order to preserve relationships, or to attempt to reduce the likelihood of further abuse (Freyd, 1996). For example, a child who is mistreated by a caregiver needs to trust and depend on that person for survival, therefore repression of memories about caregiver abuse may be necessary to ensure their existence. Similarly, a child who attempts to distance themselves from their abusive caregiver may invite further abuse or neglect, therefore betrayal blindness may be an adaptive response in this circumstance.

As previously discussed, children of parents affected by mental ill-health may be exposed to emotional abuse or neglect throughout childhood and these experiences likely constitute betrayal trauma. Betrayal trauma theory states that the closer and more necessary the relationship between the perpetrator and the traumatised individual, the greater the degree of suffering (Freyd, 1996). In this context, both repeated and isolated examples of abuse or neglect by a parent or caregiver have the potential to cause significant harm in dependent children. Research highlights the increasing number of dependent children growing up with parental mental ill-health (O’Donnell et al. 2013), and the likelihood that a child will experience interpersonal or family trauma before age 18 is approximately one in four (Perry, 2010). Consideration of factors which may offer protection in adverse circumstances is warranted, as research shows that not all children who grow up with parental mental ill-health develop psychopathology.
Protective Factors and Resilience

Despite the inherent risks well documented in the literature, not all children who grow up with a parent affected by mental ill-health will experience a negative outcome. Many parents continue to positively contribute to their child’s wellbeing despite suffering from a major mental illness (White, 1996; Aldridge & Becker, 2003) and many children of parents with mental ill-health show no indication of adverse outcomes (Seifer, 2003). Research suggests a number of key factors may help to understand risk and resilience in children of parents affected by mental ill-health. These include the nature of the parent’s illness, the quality of the parent-child relationship and level of external social support (Armstrong, 2002). In addition, numerous predictors, mediators and moderators of risk in children of mentally ill parents have been identified, and researchers agree that single-factor models are insufficient in explaining resilience in these children. Models of resilience emphasise an interaction between child characteristics (such as positive emotions, physiology and secure attachment), parent characteristics (including positive thoughts, positive feelings and self-efficacy) and environmental factors (such as economic resources and social supports; Seifer, 2003).

Parenting sensitivity, quality of parenting and quality of family interaction have been explored and there is evidence that each of these constructs are key mediating variables for risk in children of parents affected by mental ill-health (Ramchandani & Stein, 2003). This suggests that families affected by parental mental ill-health are likely to benefit from family-based interventions which promote emotionally-attuned parenting, improved family communication, strengthened family coping resources and enhanced problem solving skills.

Furthermore, research has identified three key factors which promote resilience in children: a secure base, self-esteem and self-efficacy (Gilligan, 2000). As discussed previously, secure attachment relationships provide a safe base from which infants explore
the world. Without a secure parent-child attachment relationship, children and adolescents may seek out connection from other suitable adults. Studies have explored the role of relationships in vulnerable children and found that auxiliary attachments may take on greater significance when primary attachment relationships are deemed unsatisfactory (Gilligan, 2000). As such, supportive relationships with interested adults (such as a teacher or a mentor) may offer protection for a young person managing family adversity. Similarly, children with higher self-esteem (sense of worth) and higher self-efficacy (belief in ability to succeed) cope better with adversity than do children with lower self-esteem and self-efficacy (Gilligan, 2000). Therefore, interventions aimed at increasing self-esteem and self-efficacy within the context of a secure therapeutic relationship have the potential to assist vulnerable children develop resilience.

Children who grow up in households dominated by parental mental ill-health often have little experience of the outside world. As such, schools may offer a protective role in these vulnerable children’s lives. For children of parents affected by mental ill-health, school may provide a temporary escape from the adversity of home (Gilligan, 2000). Previous research suggests that investment of energy in school or study may occur in adolescents as a constructive form of coping with family adversity (Frydenberg & Lewis 2004). Additionally, Gilligan (2000) outlines the importance of extra-curricular activities for vulnerable children, noting that engagement in sport, cultural activities, part time work and caring for animals all have the potential to build self-esteem and self-efficacy and promote resilience in young people.

**Psychological Growth Through Adversity**

Research examining parental mental ill-health is problem-saturated, largely focused on psychopathology risk for dependent children. Not unlike other stressful and traumatic events, there is the potential for personal gain to be found in the suffering experienced by
children of mentally ill parents. While some individuals may display symptoms of depression, anxiety or post-trauma stress due to their adverse experiences in childhood, others may not be negatively affected. Others still, may show positive psychological changes. Research has examined the individual differences that may contribute to the development of high levels of post-trauma stress, attracting a diagnosis of PTSD in persons following a traumatic event. As previously discussed, psychosocial perspectives suggest that individual variation in post-trauma stress is likely attributable to a complex interaction between personality, cognitive appraisal of the situation and social support factors (Joseph & Linley, 2005). It is therefore likely that a complex interaction of internal and external factors also precipitates psychological growth in adverse circumstances.

Growth through adversity (also referred to as post-traumatic growth (PTG), stress-related growth, thriving, flourishing, positive changes in outlook and positive adaptation) refers to transformative, positive changes that specifically occur in the context of adversity, and are stable and enduring over time (Calhoun & Tedeschi, 2006; Joseph, 2012). Joseph & Linley (2005) suggest that growth through adversity is characterised by three main facets. Firstly, individuals often describe enriched personal relationships, such as a feeling of increased compassion or altruism towards others. Secondly, a changed view of self occurs, often characterised by a heightened sense of resiliency, strength or wisdom. Finally, a change in life philosophy is apparent, with individuals describing a greater appreciation for each new day or changed priorities and personal values (Joseph & Linley, 2005).

While a positive relationship seems to exist between resilience and PTG (Merecz, Waszkowska, & Wezyk, 2012), Joseph (2011) draws a distinction between the two constructs. Resilience describes an individual’s ability to ‘bounce back’ or resume baseline functioning in the face of adversity, while PTG refers to an individual’s capacity to alter their sense of self, views on life, priorities, goals for the future and behaviours in a positive way as
a consequence of trauma. Psychological growth has been reported following a vast range of traumatic events, including: bereavement, accidents and disasters, cancer, sexual abuse, war and conflict, and illness and surgery (see Joseph, 2012). On this background, the current study seeks to explore the potential for psychological growth through the adverse experience of growing up with a parent affected by mental ill-health.

**The Current Study**

The current study seeks to understand the subjective ‘lived’ experience of growing up with a parent affected by mental ill-health. The study captures reflections and interpretations of adult children who grew up with a parent affected by mental ill-health, and aims to explore the participants’ experience of childhood. We seek to understand the impact that growing up with parental mental ill-health may have had on these participant’s emotional and interpersonal development.

Previous research in the area of parental mental ill-health has largely focused on adverse outcomes for children, particularly relating to risk of psychopathology. The current study aims to explore both positive and negative consequences, in order to better understand the ‘lived’ experience of these individuals. Therefore, this study aims to examine whether it is possible to experience positive and negative consequences simultaneously from being parented by a person affected by mental ill-health. The purpose of the current research is to contribute to the literature in the area of parental mental ill-health, enrich our understanding of the impact of adversity and trauma in childhood, and inform the development of interventions for children at risk due to exposure to parental mental ill-health.

Prior idiographic investigations have primarily used child and adolescent participants to understand the consequences of growing up with parental mental ill-health. The current study uses adult participants who identified as children of parents affected by mental ill-health. Adult children were considered to be most appropriate for use in this study, due to the
potential for higher-order reflections and meaning-making from the distance of adulthood. Due to the heavy reliance on rich interpretations and constructed meanings of ‘lived’ experiences in qualitative research, adult children were selected for use in the current study and the data was analysed using Interpretative Phenomenological Analysis (IPA).

**Interpretative Phenomenological Analysis**

Interpretative Phenomenological Analysis is a qualitative research methodology in which researchers seek to understand meaning in events and human interactions, in the context in which they occur. In qualitative research, the focus is on depth rather than breadth and as such, intimate, detailed information is sought from a small group of participants (Ambert, Adler, Adler, & Detzner, 1995). Qualitative research seeks to understand the subjective experience of the participant through exploration of meaning, action and social context (Fossey, Harvey, McDermott & Davidson., 2002). This is in contrast to quantitative research which use larger samples of the population to objectively measure specific hypotheses in order to elicit findings which may be generalisable to a wider population. Despite earlier resistance to methods of enquiry alternate to the quantitative approach, use of qualitative research methodologies in psychology has grown in popularity (Ponterotto, 2005). Qualitative research stands to strengthen our understanding of human experience and has the potential to improve the delivery of clinical services through a deeper, richer understanding of consumer experiences and contribute to the development of theory.

Interpretative Phenomenological Analysis is underpinned by three key areas of philosophy: phenomenology, hermeneutics and idiography (Smith, Flowers & Larkin, 2009) and IPA draws on each of these to inform a distinctive epistemological framework (Shinebourne, 2011). As such, an understanding of the theoretical foundations of IPA is crucial to the integrity of IPA research. Phenomenology is a philosophical approach to the study of human experience which seeks to examine experience in the very way in which it
occurs. In IPA research, attempts are made to understand the meaning that individual’s make of their personally significant experiences, and to objectively analyse the content of conscious experiences of others. Smith and colleagues (2009) describe phenomenological research as a process of ‘systematically and attentively reflecting on everyday lived experience’ (p. 33). Through phenomenological enquiry, the IPA researcher attempts to make meaning of other people’s attempts to make meaning of their own experiences, and as such, an understanding the philosophy of hermeneutics is crucial to IPA.

Hermeneutics is the theory of interpretation. The philosophy of hermeneutics aims to understand the methods and purposes of interpretation, and seeks to explore the original meaning or intentions of an author (or research participant). Central to the philosophy of hermeneutics is an understanding of the context in which meaning is created and an understanding of the dynamic relationship between ‘part’ and ‘whole’. The concept of the hermeneutic circle acknowledges the changeable relationship between part and whole, acknowledging the influence of one on the understanding of the other. For example, the meaning of a word (part) is only clear when examined in the context of a sentence (whole), however, the meaning of a sentence is constructed by the cumulative meaning of individual words (Smith et al., 2009).

As a reiterative process, IPA researchers move back and forth around a ‘hermeneutic circle’ in considering data throughout the stages of analysis, mindful of the context of the researcher’s history and how this influences their interpretation. The philosophy of hermeneutics states that the interpretation of new material is seen within the context of previous experience, and that this history is changed by every encounter of new material (Smith et al., 2009). This process of the researcher making sense of the participant (who is making sense of their experience) is referred to as a ‘double hermeneutic’ (Smith & Osborn, 2003).
Idiography is the third major influence on IPA and is interested in understanding concepts and experience at the particular, or individual level: exploring the personal perspectives of each participant in great detail. As such, IPA research seeks to understand how a particular phenomenon is understood by a particular group of participants (in a particular context), and is not concerned with generalising research findings to a wider population. Despite this, IPA studies have the potential to contribute significantly to the literature and inform the development of theories and interventions.

Interpretative phenomenological analysis is concerned with the detailed examination of ‘lived’ experience (Smith et al., 2009) and the aim of IPA is to highlight generic themes in addition to each participant’s individual story. Ultimately, IPA aims to identify and examine both divergence and convergence in an attempt to better understand the phenomenon being explored (Smith, 2004). Interpretative phenomenological analysis affords close attention to the researcher’s role in influencing the process of co-constructing meaning and as such, self-reflexivity and independent audit are seen as important processes in maintaining transparency throughout the research.

Self-reflexivity

I am a 28 year old Caucasian woman working in the area of child and adolescent mental health. I grew up in regional Australia and have worked in psychology for five years. My training in clinical psychology, my previous work experience in human services, current work experience in child and adolescent mental health and my personal values have shaped my clinical thinking and practice. My understanding of mental health difficulties is informed by a bio-psycho-social model of case formulation, and I adopt a strengths-based approach to my clinical work, favouring a humanistic perspective over a diagnosis-driven, medical model of care.
My interest in the areas of parental mental ill-health, developmental trauma and psychological growth were triggered by my work in child and adolescent mental health. I came to see that many of the young clients presenting to our service had significant family histories of mental ill-health and ongoing difficulties with family dysfunction, likely precipitating and maintaining their symptoms of emotional distress. Through my work in child and adolescent mental health, I began to appreciate the importance of ‘theory before therapy’ and my practice became strongly influenced by concepts central to attachment theory and family systems theory.

Through my work with children, adolescents and families, I have been confronted by the reality of limited support services which currently exist for vulnerable children and families affected by mental ill-health. My personal view is that children growing up with parental mental ill-health have needs which are complex and varied, and sadly, often overlooked. My personal beliefs, assumptions and past experience working with children and families have undoubtedly shaped my thinking and influenced the process of co-constructing meaning throughout this research. It is likely that a different researcher may have elicited different responses from participants at interview, or interpreted the data in different ways.

Throughout my participant interviews, I felt a genuine interest in understanding the ‘lived’ experience of my participants and I conducted the interviews with an open mind and curiosity. I felt enthused by the courage and determination shown by the participants as children, and inspired by their capacity as adults to use the challenges they had faced as motivation to achieve their goals.

I have had no personal experience of growing up with parental mental ill-health and no personal experience of developmental trauma, abuse or neglect.
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A Fractured Journey of Growth:
Making Meaning of a 'Broken' Childhood and Parental Mental Ill-health

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A Fractured Journey of Growth:

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Abstract

The psychosocial risks of parental mental illness on children and families are well known. However, little research explores the positive as well as the negative impact of such experiences from an adult child’s perspective. This phenomenological study explores adult children’s subjective ‘lived’ experience of growing up in a family with parental mental ill-health. Using semi-structured interviews, idiographic interpretations of seven adult children were sought, and data were analysed using Interpretative Phenomenological Analysis (IPA). One superordinate theme, A fractured journey of growth to adulthood, overarched six subordinate themes. Four themes captured stigma, shame, social isolation and betrayal: 1) Who cares, nobody cares; 2) Trauma and betrayal; 3) Transferring the distress, 4) Ducking, weaving and staying safe. Juxtaposed with this, two themes captured purposeful redefinition of self and psychological growth: 1) Growing myself up; 2) Transforming a broken childhood. This study captures the chronicity of psychosocial distress and sense of betrayal experienced by these participants while growing up with a parent affected by mental ill-health. However, inner strengths of empathy and compassion, high resourcefulness, and seeking autonomy through education were seen as domains of growth for redefining adult life positively. Implications for therapy with childhood trauma and future research are discussed.

Key words

Interpretative phenomenological analysis, parental mental illness, cumulative childhood trauma, posttraumatic growth, positive and negative consequences
Introduction

Growing up in a family where one parent is affected by mental ill-health is thwart with anxiety, uncertainty and vigilance. Developmentally, it has the potential to traumatise and stunt emotional and psychological growth. Many of these children are at risk of their own psychopathology in adult life (Rutter & Quinton, 1984; Garley, Gallop, Johnston, & Pipitone, 1997; Duncan & Reder, 2000; Maybery, Ling, Szakacs & Reupert, 2005). For example, children of parents with mental ill-health often present in adult life with psychiatric problems (Rutter & Quinton, 1984) disrupted attachment (Duncan & Reder, 2000), reduced adaptive functioning (Garley et al., 1997), and poorer cognitive ability and learning difficulties (Gladstone, Boydell, Seeman & McKeever, 2011). Additionally, socio-economic disadvantage and social exclusion is common (Reupert & Maybery, 2007). Furthermore, many psychiatric illnesses are considered to have strong genetic associations, with psychotic illness 8-10 times higher in those with a first degree relative diagnosed with a psychotic disorder, than in the general population (O’Donovan, Craddock & Owen, 2009). However, little research explores the positive as well as the negative impact of growing up in a family exposed to parental ill-health from an adult child’s perspective. Therefore, this phenomenological study explores both the positive and negative subjective interpretations of adult children exposed to parental mental ill-health during childhood.

In the context of parental mental illness, family life for a dependent child may be clouded by social adversity and stigma. Many families afflicted by parental mental ill-health face difficulties with low income, unemployment, substandard housing or poverty (Hall, 2004). As a consequence of this adversity, children may experience problems with shame, embarrassment and isolation from peers, and many young people describe difficulties with stigma due to their parent’s mental ill-health (Corrigan & Miller, 2004). The impact of parental mental ill-health is experienced throughout the wider family system, and parental
psychopathology has the potential to influence child well-being in several ways, including impacts on attachment, adjustment, stress and coping in children (Downey & Coyne 1990).

Children with a parent affected by mental ill-health may face strained family relationships, marital problems and family breakdown more frequently than children with non-affected parents. Furthermore, dependent children may be forced to compete with an unwell parent’s symptoms, and as such, children’s basic needs may be left unrealised. Some young children find themselves in care-giving roles or take on responsibilities typically expected of adults, due to parental mental ill-health (Cree, 2003). While some benefits such as increased self-worth and importance may be gained from caring for a parent (Aldridge & Becker, 1993), adverse consequences are likely to overshadow any benefits without adequate supports for young carers.

The risks of exposure to parental mental ill-health are well documented. It is generally accepted that growing up with a parent suffering from mental illness can result in a range of social, psychological, interpersonal and physical health problems for dependent children (Maybery et al., 2005). Such adversity is not restricted to a small population, with up to 20% of young people living in families in which one or both parents are affected by mental ill-health (Reupert, Maybery & Kowalenko, 2012). Literature in the area of parental mental ill-health is problem saturated and continues to focus on psychopathology risks and other adverse outcomes for dependent children. Despite the potential threats, not every child with an unwell mother or father will endure a negative experience or meet an adverse outcome. In spite of mental ill-health, many parents continue to make positive contributions to their children’s well-being (Aldridge & Becker, 2003) and many children with a parent affected by mental illness show no sign of maladjustment (White, 1996). Children who do well despite their exposure to parental mental ill-health are less well represented in the literature, and less
is known about their capacity to overcome the developmental trauma inherent to growing up with a parent's mental illness.

Preliminary research has explored protective factors in children of families affected by parental mental ill-health and identified certain child characteristics, parent characteristics and environmental factors which may offer protection and promote resilience. For example, secure attachment and positive emotional outlook in children, parental self-efficacy, parenting sensitivity, quality of family interaction, economic resources and high levels of social support all have the potential to mediate risk in children of mentally ill parents (Seifer, 2003; Ramchandani & Stein, 2003). As such, although parental mental illness poses threat to the formation of a secure attachment relationship, children may seek out auxiliary connections from other suitable adults when primary attachment relationships are deemed unsatisfactory (Gilligan, 2000). Similarly, schools are well-placed to offer protection for a young person managing family adversity. Children with higher self-esteem and higher self-efficacy cope better with adversity than do children with lower self-esteem and self-efficacy (Gilligan, 2000). Thus, interventions aimed at increasing self-esteem and self-efficacy within the context of a school program or other secure relationship can offset vulnerability and increase resilience skills for life adversity.

Not unlike other stressful and traumatic events, the potential for psychological growth as well as psychopathology may exist from the distress experienced by children of mentally ill parents. Psychological growth through adversity (or posttraumatic growth) has been identified following a range of traumatic events, including: bereavement, accidents and disasters, cancer, sexual abuse, war and conflict, and illness and surgery (see Joseph, 2012; McCormack & Joseph, 2012; 2013). Psychological growth refers to transformative, positive changes that specifically occur in the context of traumatic adversity, and are stable and enduring over time (Calhoun & Tedeschi, 2006; Joseph, 2012). Posttraumatic growth is
characterised by three facets: enriched personal relationships, improved self-perceptions and enhanced life philosophy (Tedeschi & Calhoun, 1996). While a positive relationship may exist between psychological growth and resilience, marked differences exist between the two constructs (Merecz, Waszkowska, & Wezyk, 2012). Resilience describes an individual’s ability to resume baseline functioning following a traumatic event, whereas psychological growth refers to an individual’s capacity to alter their sense of self, views on life, priorities, goals for the future and behaviours in a positive way, as a consequence of trauma. Evidence of growth through adversity is mounting across various stressful and traumatic domains, however there is a dearth of research into the potential for growth from the developmentally traumatising experience of living with parental mental illness.

This study aimed to understand and describe the subjective interpretation of growing up with parental mental ill-health. It is concerned with both positive and negative sense making from an idiographic perspective. It seeks rich data related to the complexity of the parent child dyad impacted by mental ill-health. Further, the study aimed to highlight the participants’ perception of support, family dynamics, sense of self, and impact on adult life. Interpretative Phenomenological Analysis (IPA; Smith 1996) is a particularly relevant analytic method for this study as it is underpinned by the theoretical perspective of symbolic interactionism, i.e. it is concerned with the construction of meaning by the individual within their social and personal world. As a phenomenological qualitative method it provides insight into the hermeneutic possibilities that individuals bring to uniquely traumatic, painful, and chronic life events (Osborn & Smith, 2006; Reynolds & Lim, 2007; Smith & Osborn, 2008). It is relevant to research into complex childhood traumatic experiences related to parental mental-ill-health.

**Method**

**Participants**
All seven participants, six female and one male, aged between 20 and 45 years grew up with a biological parent affected by mental ill health. Parents were, four mothers, diagnosed with major depressive disorder, two fathers who met diagnostic criteria for substance use disorder, and one mother who had a diagnosis of schizo-affective disorder. All participants lived with their parent for part of, or their entire childhood. Four participants had intact nuclear families, two participants lived between the homes of separated parents, and one participant lived with the mentally unwell parent in a single parent family, without regular contact with the non-mentally ill parent. All but one participant had one or more sibling or half-sibling with whom they lived for part of, or their entire childhood. Participants Nathan and Natalie are siblings. Two participants had diagnoses of mixed anxiety and depressive disorders (current), and one participant had a diagnosed anxiety disorder (current). One participant had met criteria for major depressive disorder not current, and another participant had met criteria for post-traumatic stress disorder not current. Two participants reported no formal psychiatric diagnoses over their lifetime. All participants have been de-identified with pseudonyms to protect confidentiality. Please see Table 1 for participant demographic and clinical information.

- Insert Table 1 -

**Data Collection**

Following university human ethics approval participants were sought through the use of advertisements displayed in general medical practices, non-government carer support services, and on university student notice boards. The first seven men and women who made contact with the researchers met selection criteria and were recruited. A semi-structured interview schedule was constructed using a funnelling technique around the phenomena under investigation. The participants were provided with the study information statement and the consent forms after expressing interest in participating in the study. The interview
schedule was provided to each participant the day prior to interview, allowing time for consideration of the questions and reflection upon lived experiences.

Data was collected at a time and place convenient to each participant. Each one-on-one interview was conducted by the second author and took between one to two hours. Interviews were audio-recorded by the second author, providing a data set of approximately 12 hours. During the interviews, time was given for the narrative to evolve followed by a reiterative exploration of meaning making in relation to the ‘lived’ experience of growing up with a parent affected by mental ill health. Each participant was invited to share a detailed account of their childhood experience and to reflect on how these experiences had impacted on their development, family dynamics, and adult lives so far. Throughout the interview the interviewer explored interesting and pertinent aspects of the participant’s experiences, probing for more detailed interpretations and facilitating individual meaning making with each participant. Methodologically, IPA uses a double hermeneutic approach so that rich data can be elicited. As such, the interviewer strove to make sense of the participants making sense of their experiences, ensuring that higher order interpretation was achieved rather than a chronological narrative of events.

Following verbatim transcription of the data set by the second author (see Notations) an initial analysis of the data set was performed independently by both authors. These independently performed audits were conducted to establish validity of themes as required by IPA. This involved independently eliciting themes that were grounded in the text and critically examining each for authenticity in thematic representations (Glaser & Strauss, 1967; Smith 1996). Robust discussion followed between the authors to establish the final set of themes.

Analytic Strategy
Interpretative Phenomenological Analysis is an appropriate methodological approach when investigating a poorly researched phenomenon such as growing up with parental mental ill-health. The primary aim of IPA is to search for subjective meaning making of individual’s unique experiences and provide rich data for analysis (Smith et al., 2009). Therefore, IPA is most often used to bring meaning to experiences which are complex, poorly understood or previously unexplored (Smith & Osborn, 2003). Interpretative Phenomenological Analysis is concerned with homogeneity, that is, participants with a sufficiently similar experiential background, for whom the research question will be meaningful. As children of parents affected by mental ill-health, these participants satisfied the purposive sampling approach of IPA (Smith, 1996).

As a qualitative approach, Interpretative Phenomenological Analysis is concerned with time and place, and the social context of experiences (Smith & Osborn, 2003). By the use of iterative questioning, IPA allows the researcher an opportunity to learn from the participant’s interpreted world and lived experiences, and provide unique insight to inform future research and therapy. This is achieved only when the researcher consciously strives to stay within the participants’ personal/social world though bracketing out their own biases and preconceptions. Thus a narrative account develops that merges the interpretative activity of the researcher and each participant’s interpretation of their experiences.

The seven interviews in this study were treated as one data set. The descriptive analysis/discussion follows. Please see table 2 for the step-by-step stages of the analytic process (Smith, Flowers & Larkin, 2009)

Results

The overarching superordinate theme, *A fractured journey of growth to adulthood* encapsulates the phenomena of a childhood fraught with unpredictable and insecure
relationships and boundaries due to parental mental ill-health. It overarches six subordinate themes: Who cares – nobody cares, Trauma and betrayal, Transferring the distress, Ducking, weaving and staying safe, Growing myself up, and Transforming a broken childhood. These participants described an existence of isolation and abandonment in childhood, where their personal and emotional safety was secondary to others’ needs. This extended to feeling invisible where not only parents but society seemed unaware of their plight and social disconnectedness. They spoke of not feeling secure or valued, with unpredictable parenting. A sense of being betrayed compounded feelings of guilt and sadness. Behaviours learned to hide the truth of family life led to secrecy and shame. Safety and survival absorbed their energy as they navigated their way through reversed-parenting their un-well parent and the ‘never-ending madness’. However these experiences were described as being a double-edged sword. They recognised as adults inner strengths of empathy and compassion and their ability to resource themselves in difficult situations had emerged from their childhood plight. They recognised education as a conduit out of their childhood despair, and made conscious decisions about their own way of being in a world without mental illness.

These following themes capture the array of negative and positive consequences these participants encountered through their experience of growing up with parental mental illness. These themes are presented in Table 3

- Insert Table 3 -

Who cares, nobody cares.

As children, these participants often felt alone, vulnerable and helpless. Without parental nurturing, their needs were overshadowed by those of their mentally unwell parent. Family ties disconnected over time:

‘Once I went into foster care, I did not want to leave … it was just like … If I spend any more time with my mum, she will make me crazy’ (Dominique)
The isolation commonly left them feeling socially inept, disengaged from peers and unsure of their place in a social world:

‘I think one of the hardest thing was … socially she had cut me off … I literally had no experience at social stuff outside of home … Everybody else knows what to do, and I have no idea’ (Dominique)

These adults remembered a desperate sense of nothingness as if their very existence was inconsequential. Love, being cherished, and any sense of being wanted was a void in their child life. They remembered with a sense of despair:

‘There’s nobody in this world that loves me … I don’t have a mother’s love or a father’s love, or, family love, or… so it wouldn’t matter if I disappeared off the face of the earth’ (Wynona)

Being different brought a sense of shame and stigma that left them feeling alienated and inferior:

‘Our family was wrong ... we were just a dysfunctional, broken family, we just weren’t normal like other families’ (Chelsea)

Feelings of inadequacy, humiliation and fearful of being judged or criticised for having a ‘whacko’ father, meant that it took many years for Freya to unravel the mystery surrounding her father. Her meaning making was compromised by gaps in history and censorship:

‘I don’t believe we will ever get the true story. They said dad slipped down some stairs, I actually think he had a fight and was pushed out his bedroom window. Because, I’m older now and you know when you can put pieces together’ (Freya)

Mental ill health in an adult family member brought cumulative problems for these participants as children. The adult relationships in the home were often fractious, dysfunctional and self-centred. Fear and aloneness often co-existed with conflict:
‘I’d get left with my stepdad, who I had a poisonous relationship with. When she couldn’t cope … I was just getting abandoned’ (Chelsea)

**Trauma and betrayal**

Growing up in a family characterised by terror and fear and never-ending madness meant that just surviving each day was a struggle. Their trauma was complex as the indirect neglect and abuse of a mentally unwell parent often collided with another parent’s inability to cope. The inability of those meant to protect and care during crucial developmental stages positioned these participants for a lifetime of being alert. Betrayal was a common thread as parents failed to prioritise safety, love and nurturing. Multiple episodes of abuse and neglect left participants struggling to build self-worth and identity:

‘My dad just got to the point where he didn’t know what to do … so I just went into foster care’ (Dominique)

Passively, they experienced being personally and emotionally disenfranchised. Actively, they experienced personal assault, invasion of privacy, and blame, events that were traumatic and reinforced their sense of betrayal:

‘I came home one day and everything I owned was outside the house’ (Wynona)

The abuse levelled at them at times produced the deepest sense of personal eradication by those very caretakers meant to protect, nurture and provide the foundations of self-regard:

‘… just get out of my life, I hate you, I wish you were never born’ and ‘why don’t you just go and commit suicide’ (Wynona)

Juxtaposed with nothingness was permanent fear, hyper-arousal and anxiety from repeated episodes of violence and vivid memories of thwarted escapes:

‘He would walk in with the starter button, and say things like: “well, you won’t be getting away tonight, I’ve got the button”. So I think it’s that, um, fear. You’re always living in fear and I think that is really hard’ (Freya)
Choosing words carefully and walking around ‘really tip-toey’, participants were ‘conscious of not doing anything to upset’ their parent. They ‘always walked on eggshells with mum, right up to this very day’. Being able to relax evaded their early lives:

‘That switch which could happen very quickly … So I think that unpredictability really made me nervous … cause I never knew what mum was going to do next’

(Wynona)

Family chaos often forced levels of responsibility onto these participants as children setting up inner programs for their own future ‘vicious cycles’. Unable to fulfil the role of caretaker child adequately, guilt became a driving force for self-abuse. For example, Antonia began to turn on herself emulating the lack of regard from her alcoholic father:

‘I decided to move in with dad and that’s when my life turned to hell … I was really, really struggling with the relationship with dad … And the, …the realisation of it, started to really negatively affect me, big time … I started, um, bingeing ’

(Antonia)

A life filled with unpredictability and the ever-present threat of emotional, psychological or physical abuse has left these participants with practiced vigilance, and heightened anxiety. Confidence has been siphoned out of them, anxious attachment is a common thread into adult life:

‘Growing up with dad, I never felt secure … And I know that I have always been anxious, my whole life’ (Antonia)

Transferring the distress.

This theme captures high levels of guilt and sadness associated with self-blame. Aetiology of their parent’s mental ill health was not shared with them hence confusion, shame and secrecy perpetuated anxiety and stress. Many of the participants lived in fear of an intergenerational transmission of psychopathology, which shaped their future family plans.
Without knowledge, childhood fears of trans-generational transmission continue to terrorise adult decisions:

‘I don’t want to have children because I’m terrified that I will pass on my characteristics’ (Chelsea)

Confusion hovered around explanations given by other adults. Without physical signs of illness, there was no sense making for them as children:

‘All I knew was um, my grandparents were telling me that mum’s sick and dad was telling me that mum’s sick and um, I was confused, because she didn’t look sick to me’ (Natalie)

Each participant spoke of their childhood uncertainty with sadness and loss. Dominique spoke of being ‘really withdrawn and crying all the time’ while Wynona rode an ‘emotional rollercoaster’. The pain of remembering overwhelmed Nathan, and he found it hard to articulate the impact of sadness, retreating into repetitions of ‘I don’t know ... It wasn’t very nice’ and ‘I can’t remember’. Feelings of responsibility had dissipated over time, however, guilt and sadness endured:

‘She has lost everything now, I mean, she has lost her relationship, you know, her husband, she, my sister and I left. So, I still have that guilt ... That she is kinda down there on her own and she still has these problems’ (Dominique)

**Ducking, weaving and staying safe.**

For some, surviving and connecting was managed through become a caretaker child. Others developed intuitive behaviours for keeping themselves and other family members safe. With reflection the selfish disregard and minimisation of them as children despite their attempts at caring for their ill parent was expressed with hurt and disbelief:

‘At about 5 or 6 (years) I remember him lying in bed with me, telling me some relationship problem and, he wet the bed (pauses) while I was in bed … he also,
poohed in my bed once, and I think it was just because he was so drunk. I just let
him sleep in my bed and lie in the wet’ (Antonia)

The complexity of seeking regard from a parent unable to give, and finding a reversed
role as caretaker, ‘to be the good girl for him’ and ‘please him, constantly, just to make sure
he was ok’ has left Antonia unable to regard self without doubt:

‘I definitely am a person who always wants that good feedback, always wants that
reassurance … And I know that it comes from … dad …’ (Antonia)

Where they did interpret worth was in their extraordinary ability as children to read
adult situations of threat:

‘I realised, if I slept with my mum every night or I was with my mum, he
wouldn’t hurt her. So I look back now and think, wow, as a 6 year old, you’re
able to comprehend that survival stuff. So I used to sleep in their room every night
… that was my way of ensuring that mum wouldn’t get hurt’ (Freya)

But there was a price to pay staying alert to survival and their young bodies expressed
the traumatic anxiety that was a constant in their lives:

‘I use to wet the bed every night and I look back now, and I think it was only through
fear, because the day dad and mum were no longer together, I stopped wetting the
bed’ (Freya)

Ducking and weaving through the uncertainty of often violent, threatening and fearful
young lives brought skills for ‘fitting in’. Juxtaposed to fitting in however, was the training
ground of seeking to please and modifying behaviours in response to other’s feedback. These
two sides of adaptive vigilance meant the ever alert ‘self’ could never relax into autonomous
self-regard:

‘I become very adaptable in different situations because I was always in such
different environments … People always say oh you fit in so well here and its,
it’s just something that you learn because (laughs) that’s what had to happen’

(Dominique)

Growing myself up

Each of the participants reflected on the positive and negative outcomes associated with their experience of childhood. Recalling the steps taken in re-inventing self, they recognised that growing up with an unwell parent had instilled empathy and compassion, and they described themselves as strong and ‘bounce-backable’. Growing up with an unwell parent was described as a ‘blessing in disguise’, which offered countless opportunities to grow.

Adult life brought time for reflecting back and new meaning making. The struggle has prompted reincarnation, cultivating a self that was ‘so much more stable, healthier ... I just felt better, happier’.

Continuing the passage from self-hatred to acceptance is sensed as sometimes debilitating, but very worthwhile:

‘I still have a lot of problems with myself … whereas I use to just have, crippling self-esteem issues and, um, so much hate for myself just, for not being what everyone else was ... I, kinda like Chelsea (teary) I, I don’t know, she, she has um, admirable qualities’ (Chelsea)

Seeing themselves as ‘non-judgemental’ and ‘tolerant’, participants subscribed to the idea that they possessed a ‘greater understanding of mental illness’. They interpreted their plight as character building; both strengthening and softening at the same time.

‘Bounce-backable’, ‘tough’ and ‘street smart’ were each perceived as a positive consequence and an ‘inner strength’ of childhood trauma:

‘I think it’s made me a very resilient person … I can get knocked down again and again and again and still get up and keep going, even though, sometimes there is nothing to keep going for’ (Wynona)
Capacity for self-reflection matured over time, allowing for meaning-making, personal growth and transition from brokenness to self-acceptance:

‘You work out why you’re doing the things you do and why you act the way you act - the penny drops and you really grow as a person. I’m just really blessed I suppose. Yeah I am, I’m really lucky’ (Freya)

**Transforming the broken childhood**

Participants reflected on the journey from childhood to adulthood. Catching glimpses of other families enabled participants to see a world outside mental illness. Desperate to break free of disadvantage, participants saw freedom in education and employment, which became their focus. Overvalued ideas of achievement and independence became a sword with two edges however, as unreasonable expectation of self and unsatisfactory self-appraisal sat with discomfort.

A sense of another world outside the family home enabled optimism and hope for a different future in participants who were desperate to break free from the cycle of family mental illness:

‘I had two worlds. I had my rich private school friends and then I had my, friends that I met who all had problems as well. And so, I kinda saw a bit of both worlds and I think that probably, not saved me in the end, but I knew that there was other stuff possible’ (Dominique)

Eliciting care from auxiliary attachment figures allowed Wynona to weave together threads of worthiness and empowered her to break free from the web of her mother’s illness:

‘My school became really my carers and that’s what really got me out of the situation’

(Wynona)

Fear of becoming unwell like their parent was a common thread among participants, which saw many of them initiate plans to foster health and wellbeing:
‘I never want to be like mum. I’m going to ensure that doesn’t happen to me ...

Everything she was doing, I’ve tried not to do. So when I have had anxiety
symptoms or depressive symptoms … I want to explore it and make sure I get help
with it and deal with it’ (Dominique)

For these participants school was equated with escapism. Chelsea recalled pressure to
‘prove’ her worth at school. She acknowledged fear of failure as a motivating factor: ‘I would
be like, if I don’t do things right, I’m just going to fail at life’.

Wynona viewed success as her ladder out of a disadvantaged life:

‘One of my mottos is success is the best revenge. I just love learning and bettering
myself and being independent … Also, being proud of what I have achieved and
breaking that cycle of poverty that I was bought up in’ (Wynona)

Participants identified a connection between an anxious temperament and the
uncertainty and chaos which characterised childhood. Bringing balance they conceptualised
anxiety as ‘a good and bad thing’, and acknowledged an underpinning fear of inadequacy:

‘I was always mature, I was switched on, I can see that has been negative in a lot
of ways, because I am so anxious and, that I can’t relax. But I do see it as a big
positive too, that I’ve just never stopped so I have achieved lots’ (Antonia)

Discussion

This study sheds light on the subjective ‘lived’ experience of seven participants who
grew up with a parent affected by mental ill-health. From the adult child’s perspective,
childhood was characterised by debilitating distress, stigma, shame, social isolation and
betrayal, in the context of a mother or father’s mental illness. These participants recalled an
array of unmet needs as children, frequently fading into the background amidst their parent’s
ill-health. Many described repetitive episodes of psychological abuse and neglect. Accounts
of physical abuse were not uncommon. Similarly, the participants in this study talked of
being unable to rely on their unwell parent for emotional support as children. Their remembered experiences included sensing a contagion effect on the other parent where letdown by both parents was common, as the parent with mental ill-health dominated the family and siphoned resources from the wider system. Betrayal blindness (Freyd, 1996) was evidenced in the context of parental maltreatment, characterised by difficulty in recalling details of certain traumatic events and attempts to fill gaps in history in an effort to make meaning of their suffering. The distress of these participants was compounded by an observed lack of support from community health personnel and neighbours, leading participants to wonder who cares? Nobody cares.

Without an adequate understanding of their parent’s mental health difficulties, these participants were left in childhood with confusion, leading to ideas of self-blame and a heightened anxiety response. In this context, participants remembered the responsible child striving to protect and defend their parent’s vulnerability. Misplaced guilt often resulted in additional caring responsibilities being assumed and a retreat from typical adolescent life and in some cases, self-abuse. Over time, enforced isolation bred a norm of social exclusion and was an extension of their family secrecy, shame and stigma. Previous research has found that family members of relatives with mental illness are frequently harmed by stigma, specifically related to blame and contamination (Corrigan & Miller, 2004). Vicarious contamination and stigma were consistently noted by the participants of this study, highlighting the need for whole family intervention with parental mental ill health and greater stigma-reduction efforts for children of such families.

Despite extreme distress as a consequence of growing up with parental mental illness, there was evidence that redefining their lives positively was an important goal as they began to emerge through adolescence. What came through each of these interviews was a commitment to transforming a broken childhood, and a determination to break the cycle of
disadvantage and mental illness. Through auxiliary attachment relationships, education, sporting achievement and employment, each participant sought to overcome adversity, re-define self and build a better life for future generations. Personal gains through the adverse experience of growing up with parental mental illness were recognised and cited as emotional maturity such as responding with greater empathy and compassion to those afflicted by mental illness. Most spoke of striving to unravel damaged relationships with siblings and again, empathise with their sibling’s journey. All retained empathy for their mentally ill parent but recognised boundaries needed to maintain their own mental wellbeing. Where psychologically safe for themselves, limited but self- managed adult contact with the ill parent occurred. In accordance with posttraumatic growth theories, positive and enduring changes were evident across perception of self, world view and interpersonal relationships (Tedeschi & Calhoun, 1996).

The seven participants of this study endured repeated trauma throughout childhood, with wide-reaching impacts. All participants experienced varying degrees of emotional distress at some point in their lives, but spoke in particular of the deep sense of alienation of social neglect, inadequate support and stigma. However, through the process of reflection and meaning-making as adults, each sought to understand how their individual experience had shaped their lives and each came to see themselves as fortunate, giving thanks for the hardship which afforded them the opportunity to grow. Each participant described an ‘inner strength’ and many reflected a deep resolve for ‘perfection’ in order to build an ideal life, free from the clutches of mental illness. For many of the participants of this study, low grade symptoms of anxiety continued into adulthood, though these were conceptualised as helpful and adaptive responses by these participants, who saw the potential benefits to be gained from a life lived with vigilance. Heightened vigilance is often considered a negative response
to trauma, however, future research may consider its role as a positive protective factor as interpreted by these participants.

Limitations

The current study is not without limitations. As a double hermeneutic interpretative process, researcher biases and presuppositions inevitably will influence the co-construction of meaning through analysis. Both authors’ clinical experience has influenced their interest in families impacted by mental illness in parents. However, although it is possible that the authors’ subjective experiences may have influenced interpretation, every effort has been made to bracket these through robust discussion and rigorous independent audit.

This research offers an in-depth examination of how seven adult children of parents affected by mental illness make sense of their subjective lived experiences. As a qualitative study, generalisability is not a desired outcome however the interpretations of these seven participants experiencing childhood distress from living in a family where parents are struggling with mental ill health can inform future research questions and theory. IPA is considered to generate useful insights which may lead to wider clinical implications and ‘theoretical transferability’ (Smith, Flowers & Larkin, 2009). This study identifies avenues for future direction, and contributes to the literature in highlighting both positive and negative aspects in the area of parental mental illness.

Conclusion

The current study contributes to the posttraumatic growth literature, finding evidence of psychological growth through the adverse and developmentally traumatising experience of growing up with a mother or father affected by mental ill-health. Several key implications for clinical practice have emerged from the current study particularly when working with children currently in families with adult mental ill health. These children are not post trauma in any sense of the word. They live it daily. Ongoing betrayal, vicarious, and primary trauma
are the likely lot of such children. Therefore they are at risk of long-term biological, psychological and social risks. As such, children of parents with mental illness require comprehensive psycho-social support systems as part of the family intervention to maximise their developing sense of self and autonomy. Educational programs to inform, reassure and minimise trans-generational fear of contagion are likely to assist in helping them reach their potential. Importantly, despite the longevity of their distress as children the potential to recover and re-write a narrative of growth, alternate to the dominant narrative of distress, pathology and adversity, is possible. Supportive other suitable adults have been shown to offer substitute attachment relationships, positioning children to achieve beyond their expectations. There is a role for early interventions which promote resilience, build self-esteem and develop self-efficacy within the education system.

The primary narrative of these seven participants is one of hope; that, despite years of childhood trauma, it is possible to positively re-define self. Through the development of secure pseudo-attachment relationships, goal orientated behaviour across various domains, and purposeful meaning-making and reflection, these participants deterred adversity, forgave their parents’ betrayal, and fostered a self, worthy of love, acceptance and success.
References


Transcript extract notation

[ … ] indicates editorial elision where non-relevant material has been omitted

( text ) indicates explanatory text added by author

[ - ] pause in speech
<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Demographics</th>
<th>Mental Health History</th>
<th>Parent Affected</th>
<th>Parent’s Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nathan</td>
<td>Male Aged 28</td>
<td>Nil</td>
<td>Mother</td>
<td>Major depressive disorder</td>
</tr>
<tr>
<td>Natalie</td>
<td>Female Aged 32</td>
<td>Anxiety disorder (current)</td>
<td>Mother</td>
<td>Major depressive disorder</td>
</tr>
<tr>
<td>Freya</td>
<td>Female Aged 45</td>
<td>Post-traumatic stress disorder (not current)</td>
<td>Father</td>
<td>Substance use disorder</td>
</tr>
<tr>
<td>Antonia</td>
<td>Female Aged 31</td>
<td>Mixed anxiety and depressive disorders (current), Eating disorder (not current)</td>
<td>Father</td>
<td>Substance use disorder</td>
</tr>
<tr>
<td>Wynona</td>
<td>Female Aged 44</td>
<td>Major Depressive Disorder (not current)</td>
<td>Mother</td>
<td>Schizo-affective disorder</td>
</tr>
<tr>
<td>Chelsea</td>
<td>Female Aged 20</td>
<td>Mixed anxiety and depressive disorders (current)</td>
<td>Mother</td>
<td>Major depressive disorder</td>
</tr>
<tr>
<td>Dominique</td>
<td>Female Aged 35</td>
<td>Nil</td>
<td>Mother</td>
<td>Major depressive disorder</td>
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Table 2. Stages of Interpretative Phenomenological Analytic Process

<table>
<thead>
<tr>
<th>Stage</th>
<th>Process</th>
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<tbody>
<tr>
<td>1</td>
<td>Listening to and transcribing verbatim transcripts.</td>
</tr>
<tr>
<td>2</td>
<td>Thematic analysis of transcript independently both authors to identify positive and negative childhood experiences leading to superordinate and subordinate themes.</td>
</tr>
<tr>
<td>3</td>
<td>Independent interpretation of transcript by paraphrasing and summarising the participant’s phenomenological and hermeneutic experiences through narrative.</td>
</tr>
<tr>
<td>4</td>
<td>Documentation of expected themes followed by exploration of overarching theme of: ‘A fractured journey of growth to adulthood’.</td>
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<tr>
<td>5</td>
<td>Chronological listing of emerging themes for connectedness.</td>
</tr>
<tr>
<td>6</td>
<td>Continuing to assess overarching themes and subthemes and links to meaning making, understanding and redefining self.</td>
</tr>
<tr>
<td>7</td>
<td>Clustering of themes around concepts and theories.</td>
</tr>
<tr>
<td>8</td>
<td>Data from transcript rechecked by the first authors to verify first author’s validity of interpretations from within the text.</td>
</tr>
<tr>
<td>9</td>
<td>Emergent higher order main theme of ‘A fractured journey of growth to adulthood’ reassessed</td>
</tr>
<tr>
<td>10</td>
<td>Subjective analysis of interpretation of themes representing the phenomenon of the lived experience within the context of childhood and parental mental ill health, sense of self, social support, family dynamics, adult redefinition.</td>
</tr>
<tr>
<td>11</td>
<td>Narrative account of theoretical links to themes generated through concise verbatim extracts from transcript.</td>
</tr>
<tr>
<td>12</td>
<td>Development of links from childhood trauma exposure through: Who cares – nobody cares, Trauma and betrayal, Transferring the distress, Ducking, weaving and staying safe, Growing myself up, and Transforming a broken childhood.</td>
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</tbody>
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Table 3. Superordinate theme ‘Fractured Journey of Growth to Adulthood’ with six subordinate themes

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<tbody>
<tr>
<td>1</td>
<td>Who cares – Nobody cares</td>
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<tr>
<td>2</td>
<td>Trauma and betrayal</td>
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<tr>
<td>3</td>
<td>Transferring the distress</td>
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<tr>
<td>4</td>
<td>Ducking and weaving and staying safe</td>
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<tr>
<td>5</td>
<td>Growing myself up</td>
</tr>
<tr>
<td>6</td>
<td>Transforming a broken childhood</td>
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</tbody>
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**Extended Discussion**

The purpose of the extended discussion is to reflect extensively on this research project and its outcome. As well as discussing the findings of this study, this discussion will critique the methodological approach and provide further evidence of the double hermeneutic and interpretative process that led the authors to the thematic conclusions. This is followed by consideration of the study’s strengths and limitations, discussion of the implications for clinical practice and recommendations for future research in the area of parental mental ill-health.

This phenomenological investigation explored the narratives of seven adult participants in order to provide in-depth insight into the subjective ‘lived’ experience of growing up with a parent affected by mental ill-health. This research has enabled a deeper understanding of the phenomenon of being parented by a mother or father with a mental illness, and how individuals interpret this experience looking back as adults. While previous research in this area has focused on the psychopathological risks and other unfavourable outcomes for children of parents with mental ill-health, this study sheds light on the potential for psychosocial growth following such experiences. The current study contributes to the trauma and growth literature and enhances our understanding of individual interpretations of endured repeated family trauma in childhood, and how that can be redefined positively for psychosocial wellbeing.

**A Fractured Journey of Growth to Adulthood**

Interpretative Phenomenological Analysis of data collected from seven participant interviews revealed six major themes relating to the subjective ‘lived’ experience of growing up with a parent affected by mental ill-health. These themes: Who cares – nobody cares; Trauma and betrayal; Transferring the distress; Ducking, weaving and staying safe; Growing
myself up; and Transforming the broken childhood; were overarched by a superordinate theme: ‘A fractured journey of growth to adulthood’.

The participants of this study grew up in an anxious world dominated by their parents’ physical and emotional unavailability through chronic mental ill-health. Many of the participants spoke of being fearful that these experiences contributed to their own experience of mood and anxiety difficulties throughout their lives so far. The elevated risk of psychopathology in children of parents with mental ill-health is well documented in the literature; with depression, anxiety, PTSD and conduct disorder being most prominent (Turner, Finklehor & Ormrod, 2006). Each of these participants described cumulative trauma throughout their childhood. For some this included acute, traumatic episodes such as physical abuse, aggravated assault, threat to life and attempted kidnapping. In the context of chronic family adversity, other hardships commonly experienced by participants included poverty, parental unemployment, parental marital discord, family relationship breakdown, parental imprisonment and unstable or unsuitable accommodation. Research indicates that the accumulation of these ‘non-victimisation adversities’ over a child’s lifetime increases the risk of mental ill-health (Turner et al., 2006).

Despite the impact of the numerous social stressors participants faced in the context of their parents’ ill-health, each participant demonstrated determination in overcoming disadvantage. As adults, the participants demonstrated an insightful and reflective capacity, as they sought to understand the impact of parental mental ill-health on a child’s developmental trajectory. Through the process of meaning making, participants moved away from a self-blaming stance and externalised their understanding of what underpinned their unwell parents’ mental health problem. On this background of psychosocial struggle, tenacity to break the trans-generational cycle of mental ill health was evident among participants. Through a lifetime of hardship, participants learned from modelling aspirations of friends’
parents, recognised the value of education and employment, and sought out avenues of achievement and success. These became their keys to freedom from an isolated world of parental mental ill-health.

**Who Cares? Nobody Cares**

Analysis showed that these participants interpreted their childhood as a crisis situation, often faced with challenges far outside their realm of comprehension. Participants indicated that their own needs were often placed on hold, as their parents prioritised their disabilities, addictions and needs ahead of their children’s basic requirements. The participants of this study described fragmented family relationships, characterised by low levels of interpersonal connection and extreme levels of expressed emotion within the family home. These accounts of cold, unsupportive and neglectful environments during childhood warrant concern, as research indicates that children of families dominated by conflict are at increased risk of developing physical and mental health problems in adolescence and adulthood (Repetti, Taylor & Seeman, 2002).

Furthermore, literature suggests that children who are frequently exposed to expressions of anger or distress during childhood are more likely to experience difficulties relating to their peers, and are less able to successfully recognise emotions in others (Dunn & Brown, 1994). A sense of alienation and difficulty ‘fitting in’ with peers was a common experience among the participants of the current study, who initially described uncertainty in social contexts and lacked both the confidence and appropriate schema to build effective interpersonal relationships.

Participants of the current study recalled family violence, parental self-injury, neglect and unexplained periods of separation due to episodes of parental in-patient treatment. Their parents’ preoccupation with symptoms and sometimes explosive or even ‘poisonous’ parental behaviours were often internalised by the participants and interpreted as examples of
Participants described the impact of repeated dismissal and perpetual disappointment by their parent, associating this with difficulty forming trusting parent-child relationships. As explored in detail in the critical literature review, attachment theory posits that the quality of parent-child attachment varies widely due to the quality of the child’s experiences with attachment figures (Cassidy & Mohr, 2001). Briefly, infants who learn that their caregiver is generally sensitive, responsive and available will come to see themselves as lovable and worthwhile. Infants who experience rejection or feel ignored or belittled by a caregiver will likely learn to view themselves as unworthy of care and unlovable (Cassidy & Mohr, 2001). Participants of this study came to understand the limitations of their parents’ availability and reduced capacity to provide support and security. Many looked to others outside the family for auxiliary care. In addition, these participants cited low levels of community support growing up, and as children, the pain of being overlooked once again compounded their distress: ‘There was no support system, no support system whatsoever’.

The seven participants of this study experienced the shame and stigma of parental mental ill-health. They strongly believed that their families were inferior to others and became secretive in concealing their differences, shamed and fearful that their peers may discover the reality of their home lives. As discussed in the critical literature review, family members of relatives with mental ill-health are frequently harmed by stigma, specifically related to blame and contamination (Corrigan & Miller, 2004). Vicarious contamination and stigma are well described by the participants of this study. Their recollections of shame and stigma comprised of damaged sense of self and worthiness, fear of trans-generational transmission, and an inability to advocate for their own needs.

**Trauma and Betrayal**
Trauma was cumulative and chronic throughout these participants’ childhood. For some, this was further complicated by not only a parent who was mentally unwell, but a second parent overwhelmed or inadequately able to care for the children. They witnessed and experienced repeated exposure to parental abuse and/or neglect, and several of the participants endured constant fear of an unwell, vindictive, addictive, or violent parent. That fear was based around the possibility of parent suicide or homicide. Conversely, they experienced their own innately driven fear that they may become unwell or ‘crazy’ like their parent. Fear of contagion in the area of parental mental ill-health has been well described in the literature (Corrigan & Miller, 2004; Hinshaw, 2005). It is widely recognised that fear of developing psychiatric illness is a common experience for children of mentally ill parents.

Anxiety across their lifetime so far was described; from low grade symptoms to clinically significant anxiety disorders meeting diagnostic threshold (e.g. PTSD, social anxiety disorder). Reflecting as adults, participants associated their symptoms of emotional distress with their experience of growing up in a world dominated by parental mental ill-health. As adults, they came to see how their world views and sense of self had been clouded by accumulative trauma. Learning to be afraid was a dominant discourse of the current study, and participants described ‘walking on eggshells’ and ‘tippy-toeing’ around their unwell parent, fearful of the consequences of upsetting or angering them. This startle response is best understood in the context of hypervigilance and the arousal continuum.

Faced with a threat, a child moves along a continuum of arousal from vigilance through to terror and changes are seen in their cognitive, emotional and behavioural functioning corresponding to their level of arousal (Perry, 2010). If the child is able to move back down the arousal continuum at the conclusion of the traumatic event, their thoughts, feelings and behaviours will return to their baseline level. However, re-experiencing the physiological changes present during the traumatic situation through flashbacks, nightmares
or repeated trauma, may lead to a state of hypervigilance where children exhibit physiological arousal and agitation even at rest (Perry, 2010). This suggests they have not been able to move back down the arousal continuum to a calm state, which poses considerable risk to their long term physical and mental health.

Many of the participants of the current study lived through repeated episodes of trauma and described difficulties with trauma intrusions, hyper-arousal and avoidance mechanisms used to escape reminders of traumatic events. The sense of betrayal underlying the trauma of parental abuse and neglect amplified the suffering of these participants. Participants of this study struggled to integrate the concept that a parent on whom they needed to trust and depend, was not a safe figure in their world and often presented threat or actual harm. In conceptualising the role of social relationships in trauma, betrayal trauma theory (Freyd, 1996) states that “the closer and more necessary the relationship, the greater the degree of betrayal” (p. 9). This indicates that trauma at the hand of a parent perhaps equates to the greatest suffering of all.

**Transferring the Distress**

An array of negative emotions, including guilt, blame, shame, helplessness, sadness and fear were variably experienced throughout the childhood of these participants. Households characterised by extreme expressed emotion, emotional attunement to parental suffering and repeated exposure to disturbing scenes, enabled chronic feelings of distress in participants. A sense of confusion was salient among participants of the current study, who experienced difficulty making sense of parental mental health problems in their youth. Many indicated that limited information had been provided to them by family or external services, leaving participants struggling to make meaning of their parent’s behaviour. Place and colleagues (2002) found that young people are more likely to develop false beliefs about their role in their parent’s problems and may blame themselves when inadequate information is
provided. As previously discussed, systemic shortcomings leave families and carers of those affected by mental ill-health with numerous unmet needs. Further research in this area is needed to inform the development of policy and practices to better meet the needs of these vulnerable families.

The participants of the current study struggled with the limited control they felt over their own lives, growing up in a world governed by parental mental ill-health. Trapped in cycles of worsening parental symptoms and increased social isolation, maladaptive coping behaviours manifested in many of the participants including: disordered eating behaviour, tendency for perfectionism, obsessional thinking and ritualised behaviour. Several hypotheses may shed light on this phenomena. Bowen family systems theory (Bowen, 1978) describes the way in which chronic anxiety in a family is projected onto a child and uses the term ‘child focus’ to describe this. In the child-focused family, a full range of emotional involvements is fixated on one or more children, which results in significant impairment in the child (Donley, 2003). In the current study, several participants described patterns of family functioning which may be consistent with Bowen’s ‘child-focused’ family, which possibly explains the emergence of symptoms of emotional distress in the over-focused child.

Likewise, previous research suggests that disordered eating behaviour may emerge in an individual who is seeking to gain emotional control, regulate overwhelming negative emotions or construct a sense of self from poor internal resources (Rorty & Yager, 1996). In addition, studies have identified childhood emotional abuse as a predictor of eating psychopathology (Kent & Waller, 2000) and suggested that disordered eating behaviour may emerge as mechanism for coping in individuals who lack constructive resources for managing high levels of distress (Troop, 1998). While focusing solely on disordered eating behaviour to demonstrate the emergence of maladaptive behaviour in the context of reduced coping and
control, other obsessive or compulsive traits displayed by participants of the current study may be considered in a similar light.

Common among the participants of this study was a perception that mental ill-health was a ‘family problem’, which led participants to see themselves as more vulnerable to mental ill-health than others. Some participants relied on genetic transmission to explain this phenomenon, which may have helped to externalise their meaning making and reduce personal responsibility for their parents suffering. Other participants concluded that they were unable to escape the family history of mental ill-health, and expressed concern for future generations. The youngest of the seven participants felt ‘terrified’ that she would pass on a genetic loading for mental ill-health to her offspring, leading to a decision to not bear children of her own. Previous research has explored fear of passing mental disorders along to children (Wisdom et al., 2008) and found that individuals with major mental health problems are less likely to have children than other individuals as a consequence (Hansen & Andersen, 2001).

**Ducking, Weaving and Staying Safe**

As children, these participants employed a range of strategies and safety behaviours in order to protect and defend themselves and their loved ones. Family relationships contrary to societal expectation emerged, which saw children adopt a caretaker role within the family. Participants saw themselves as their unwell parent’s ‘carer’ or ‘main confidante’. Others saw their role as the ‘protector’ of a vulnerable parent, defending them from a domestically violent partner or deflecting the criticism or disproval of others. In addition, many of these participants assumed the responsibility of parenting younger siblings as well as themselves. One participant described herself as being ‘parentified’ from a young age, and the idea of ‘growing up quickly’ was echoed by many others in this study. This finding is supported by previous research, which has shown that young people may feel forced to take on an adult
role to support the survival of their family, due to parental ill-health, disability, or substance dependence (Charles, Stainton & Marshall, 2009). More recently, positive aspects of premature caring have been documented, in contrast to previous ideology which rejected the notion of children as carers, and pathologised young children who adopted caring responsibilities.

The reversal of roles within parent-child relationships enabled a sense of connection for many of these participants, who craved attention and love in the context of an emotionally unavailable parent. Likewise, attempts to rear younger siblings helped fill the void of an unsatisfying parental relationship, though this rarely lived up to expectation:

’I took my sister in and I tried to be the mother, which didn’t really go that well, but I tried. But, yeah, she has a lot of resentment for me’

Participants of the current study identified strongly with the idea of being ‘good’ or ‘trying to help’ as children, in an attempt to ameliorate the suffering of their unwell mother or father. For others, escaping the wrath of an unwell parent was best achieved through ‘perfect’ behaviour. Adopting additional caring responsibilities is seen in this light, and many of the participants assumed extra jobs willingly. Research has shown that young carers often derive a great deal of satisfaction through showing their commitment to others (Aldridge & Becker, 1993) and this is consistent with the findings of the current research. Assuming high levels of responsibility for the family’s survival on a background of an anxious temperament, led some participants to self-doubt. Seeking approval and positive regard from others presented as a prominent theme in the current study, and participants endorsed the idea of modifying their own behaviour in order to ‘fit in’ or gain ‘positive feedback’ from others.

Growing Myself Up

Participants of the current study viewed their childhood experience of growing up with a parent affected by mental ill-health as having consequences which were both positive
and negative. Each participant reflected on the devastating assault upon self-worth and identity which occurred repeatedly throughout their youth, and described the struggle to accept self in this context. These participants recalled the deliberate effort to reinvent themselves and recounted their journey from a place of brokenness and self-loathing, to the contentment of self-acceptance. Though the process of reinventing self was seen as an arduous task, each participant expressed satisfaction with the character they had built (or were continuing to build). Many expressed thanks for the difficult experiences they had encountered, seeing these as opportunities for personal growth. Research has examined the role of gratitude in post-trauma presentations, finding that individuals with post-traumatic stress who experience gratitude are more likely to function better than those who do not display gratitude, regardless of post-traumatic stress symptomatology (Kashdan, Uswatte & Julian, 2006).

Post-traumatic growth, (or growth through adversity) has only relatively recently been explored within the empirical literature, though several psychological theories regarding post-traumatic growth have been proposed. It is now widely accepted that traumatic events may precipitate personal growth and positive change in some individuals (Joseph & Linley, 2006), which is in contrast to previous thinking which largely equated significant trauma with marked impairment and resulted in a ‘damaged’ life. As discussed in detail in the critical literature review, PTG is comprised of positive changes in how individuals value their relationships with other people, changes in their self-perceptions and changes in life philosophy (Joseph & Linley, 2005). The results of the current study indicate that the experience of growing up with parental mental ill-health may lead to PTG.

Through adversity, participants saw their values shift and came to appreciate relationships with others in a new light. Shared experiences of pain caused family relationships to strengthen:
'I actually value the relationship that I have now and ... the fact that having that painful experience kind of, helped that relationship form I think, because, we’re so much closer because of it and because we have overcome it, in a sense. I think that that has been something that I have really realised’

While devastating, participants acknowledged that the experience of childhood trauma had bought their personal strengths to the fore, and many described themselves as ‘resilient’ on reflection. This is juxtaposed with childhood beliefs of worthlessness and inferiority. Through the process of meaning making and self-reflection, changes in perceptions of self were apparent among the participants. Each began to see themselves as worthwhile and deserving:

‘I’m as smart as them and I’m not going to miss out on that. So I feel like I have been very driven but probably, to, not, I never wanted to get bogged down from what had happened’

Changes in life philosophy were also salient among the participants of the current study. Many bristled with determination to better themselves and sough to improve their educational, physical, financial and emotional well-being beyond that of their parents. As adults, participants expressed allegiance to other children living with parental mental ill-health and found meaning working in child advocacy roles or other child welfare services.

Previous research in the area of PTG indicates that survivors of trauma are often motivated to share their experiences with others and may seek to help other people in similar circumstances throughout their recovery. This may enable further healing and recognition of the survivor’s own strength, through comparison to other victims who are continuing to struggle (Tedeschi, 1999). A prominent theme throughout the current study was the inadequate provision of services available to vulnerable children living with parental mental
ill-health, and the desire to help and support other vulnerable children in similar situations is seen within this context.

**Transforming the Broken Childhood**

Participants of this study experienced an intense desire to break the cycle of disadvantage which plagued their families. Endorsing the idea of ‘*doing things differently*’ from their unwell parents, they sought out success and achievement to define themselves by. Through glimpses of another world outside the family home, participants saw that ‘*there was other stuff possible*’. Education, employment, achievement and independence were valued highly by the participants, who likened these to insurance policies against personal failure, and a ladder out of a disadvantaged life. There was a tendency among participants to overachieve or ‘*never stop*’ and previous research suggests that high academic achievement (or overachievement) may occur in adolescents as means of coping with elevated stress (Frydenberg & Lewis 2004).

Many of the participants possessed high levels of motivation and goal-orientation; achieving multiple university degrees, or obtaining high-power, sought after positions in their chosen fields. There was also a sense of becoming easily bored by vocations, with several of the participants describing patterns in which they were constantly in pursuit of new and exciting, or more challenging endeavours. This inability to find contentment and inability to relax is seen within the context of chronic low-grade anxiety.

Participants acknowledged the importance of significant others during childhood, whom they felt played an important role in their lives, in lieu of incapable parents. Teachers, nuns, school counsellors and parents of school friends who took ‘*special care*’ of them and ‘*could see there was potential*’ in them were identified. Weaving together threads of worthiness from these discrete encounters formed the basis of identity and seemingly mimicked the ‘*safe base*’ these participants needed from which to explore the world. Mary
Ainsworth (1989) suggests that ‘parent surrogates’ whom children become attached to during childhood may play important roles in their lives. Grandparents, older siblings, or other supportive members of the community (such as a teacher or sporting coach) may potentially act as an attachment figure for a child.

In addition to this, many of these participants sought out support from those belonging to the caring profession as adults, and displayed infinite gratitude for the therapeutic encounters which they saw as an integral part of their healing process: ‘that’s why I am where I am today’. In accordance with Attachment theory, adults may look to a mentor, priest, pastor or therapist to assume the role of an attachment figure to facilitate a safe space for self-exploration and meaning making (Ainsworth, 1989). The current research does not explore the impact of previous psychological treatment on psychological growth as an outcome, and it is possible that PTG is influenced by the experience of psychological intervention. Future research may seek to understand the extent to which psychological growth is influenced by participation in psychotherapy or other supportive interventions. In light of previous research which indicates that students who view teachers as supportive and encouraging are more committed to learning and more successful academically (Becker & Luthar, 2002), further research may seek to better understand the role of auxiliary attachments in the school context, to better support children of vulnerable families.

**Implications for Clinical Practice**

On a background of previous research which highlights an overall increase in prevalence of children living with parents affected by mental ill-health (O’Donnell et al. 2013), the current study sought to understand the ‘lived’ experience of the adult child. Both positive and negative consequences of growing up with parental mental ill-health were gleaned through the subjective interpretations of these seven participants. Several key implications for clinical practice have emerged from the current study.
Firstly, the participants of the current study felt that they were offered inadequate or inaccurate information regarding their parent’s mental health problems. Limiting information of this kind is sometimes conceptualised as a protective mechanism, seeking to shelter children from taking on too much responsibility (Gladstone, Boydell, Seemen & McKeever, 2011). However, misunderstanding of parental mental health difficulties may enable feelings of confusion, self-blame and hopelessness, or lead to fear of contamination. Many young people with unwell parents suspect something is amiss, despite no acknowledgement of this within the family (Morodoch & Hall, 2008). These assertions are usually based on observation of unusual parental behaviour or comparison to other relatives (Gladstone, et al. 2011). Our research found that awareness of parental suffering created unpleasant feelings for these participants as children. As such, we believe that assisting children to make sense of their parent’s mental health difficulties is important.

Parents are most often considered to be the best resource in resolving their child’s distress, and therefore, parents can play a key role in assisting children to make sense of parental mental ill-health. In order to address systemic gaps, some mental health services have implemented family-based psycho-education programs regarding parental mental ill-health. The Australian Infant, Child, Adolescent and Family Mental Health Association has sought to educate and help families who experience parental mental ill-health since the launch of the COPMI (Children of Parents with a Mental Ill-health) program in 2001. This has seen the introduction of early intervention strategies for children of parents affected by mental ill-health, however access to these programs remains limited due to low numbers of ‘COPMI clinicians’ nationally. Increasing awareness and knowledge of the impact of parental mental ill-health through specific training in this area may build clinician confidence and competence in delivering brief interventions to families who are affected by parental mental ill-health. Given that up to 35% of mental health consumers have dependent children (Farrell
et. al, 1999), the need for accessible family focused intervention at the primary care level is apparent.

Reflecting as adults, these participants presented themselves as a vulnerable group of children with an array of unmet needs, overlooked by the mental health system. While some children come to the attention of the mental health system through their parent’s contact with mental health services, many others do not. Children with parents who lack insight into their condition, or children of parents who refuse to accept treatment are likely to be overlooked. Similarly, children of parents who access mental health treatment through the private system rather than public mental health services may miss out on accessing whole of family support, as private providers may lack the resources to effectively support family members and carers. Changes to systems and processes may assist in this area.

For example, clinicians working in adult mental health services are encouraged to carefully assess new clients with the broader family in mind and explicitly ask about dependent children. Where COPMI supports exist, children should routinely be referred for consideration of appropriate supports. Supporting this process however, likely requires a greater COPMI workforce. In the private setting or public services without COPMI support, thoughtful consideration of the family system during the assessment phase will assist the practitioner to identify dependent children of unwell parents. Once identified, children may be referred for support through local counselling services, or through the School Psychologist. However, a service dedicated solely to service provision for children of parents with mental ill-health is likely best-placed to support the complex and varied needs of children with parents affected by mental ill-health.

Many of the participants of the current study saw their child-self in a caring role and described themselves as protective of their unwell parent. The disruption to the family system seen in this type of intense parent-child alliance may impact upon the young person’s ability
to form a trusting relationship with a clinician or prevent them from feeling able to talk openly about their experience of their parent’s difficulties. Young people accessing therapy may feel reluctant to disclose information regarding their parent’s ill-health or behaviour. Anxiety about upsetting or angering their parent, concern about betraying their parent, or fear of being removed from their parent’s care may hinder this process. With this in mind, clinicians are encouraged to attend to the process of joining with, and building rapport with young carers, allowing time for a trusting relationship to develop before entering into a therapeutic intervention or in-depth exploration of the impact of parental mental ill-health.

Furthermore, many young people find the process of talking therapy intimidating and may benefit from a less formal approach to care. Clinicians are encouraged to utilise creativity to engage young people in therapeutic work, and may consider use of art therapy or play therapy to engage young people. Adopting flexibility to join with young clients and tailoring interventions to their individual needs will likely increase the effectiveness of any intervention. In this light, consideration must be given to incorporating parents into therapeutic interventions for children and adolescents. Family-based interventions may help to generate a shared understanding of parental mental ill-health and may also assist in improving family communication and strengthening family coping resources. Research suggests that working with families together may help to normalise the therapy process and provide young people with the opportunity to observe their parents engaging with clinicians in a meaningful way (Falkov, 1998) which may in turn encourage them to do likewise.

The current study found that these participants were affected by stigma as children, and often attempted to limit contact between their peers and their unwell parent. Driven by shame and fear of inadequacy, attempts to conceal parental mental ill-health were seen to perpetuate feelings of difference, loneliness and social isolation. Whole of government and whole of community efforts are required to address the ongoing issue of stigma in mental ill-
health, and further research is required to inform the development of stigma reduction strategies. Furthermore, efforts which encourage participation in community events for children of parents with mental ill-health are required, including: social, recreational, sporting and cultural activities. Children of mentally unwell parents remain at increased risk of social exclusion due to numerous psycho-social factors and research indicates that low levels of community engagement increases the risk of mental ill-health (Evans & Repper, 2000).

The current study found that these participants overcame disadvantage through forming supportive attachment relationships with other significant adults, despite unsatisfying attachment relationships with unwell parents. For many children, this may be best achieved within the school environment. The education system has the potential to help children build coping resources and resilience through the implementation of evidence-based programs which promote psychological growth. For many vulnerable children, school may act as a protective factor. Previous research has identified specific elements which contribute to the development of resilience in children, and models of working with children within the school setting have been developed on this basis. For example, the Resilience Doughnut (Worsley, 2011) has been designed for use by classroom teachers. This model provides children with the tools and resources to manage life stressors and aims to build confidence in self. The findings of the current research support the wide dissemination of resilience-building programs in the school setting.

**Strengths of the Current Study**

The aim of the current study was to explore the subjective ‘lived’ experience of growing up with a parent affected by mental ill-health. After careful consideration of qualitative methodologies, IPA was selected for use in the current study. The advantages and disadvantages of data collection methods (e.g. one-one-one interview, focus groups etc.) were evaluated and the one-one-one, semi-structured interview was selected. The use of IPA was
appropriate for exploration of these participant’s experiences and interpretations, and provided an opportunity to better understand the complexities of this phenomenon. As a flexible and inductive approach (Brocki & Wearden, 2006) IPA accesses the perspective of participants, allowing unanticipated themes to emerge. IPA is considered to be most useful when one is “concerned with complexity, process or novelty” (Smith & Osborn, 2003; p.53). One of the key benefits of IPA, is that this method enables participant’s experiences to return to the forefront (Larkin, Watts & Clifton, 2006) thereby promoting a ‘client-centred’ perspective (Brocki & Wearden, 2006). In keeping with the positive psychology movement, there is the potential for IPA to be less problem saturated, potentially allowing participants an opportunity to express strengths and growth (Reid et al., 2005). Furthermore, the use of verbatim extracts from participant interviews throughout IPA helps to substantiate findings, and allows the reader to conduct their own audit of the analytic process.

A strength of the current study was the use of adult children as participants. In contrast to previous research efforts which have largely used children and adolescents as participants, use of adults accessed a different perspective. This enabled an opportunity to understand this phenomenon more fully. The use of adult participants allowed access to a client population who have potentially had a greater opportunity for reflection and meaning making, than their younger counterparts. Additionally, adult participants were considered to be well-placed to articulate their interpretations of past experiences, and potentially may have felt less worried about revealing ‘family secrets’ than a child or adolescent. As such, we believe that adult participants may have offered a less-censored account of childhood experiences and a thoughtful interpretation of personally significant events, enriching the quality of the data.

The validity and quality of the current study were evaluated against Yardley’s criteria which include: sensitivity to context, commitment and rigour, transparency and coherence,
and impact and importance (Yardley, 2000). From the outset, sensitivity and respect for
children and families affected by mental ill-health was a major consideration. The
opportunity to join with and establish rapport with participants in a meaningful and empathic
way through the one-on-one interview process was a factor which contributed to the rationale
for using IPA in the current study. Similarly, the integrity of the participant’s narrative was
maintained throughout the current study, through the use of verbatim quotes. The benefits of
this are two-fold; allowing the participant a ‘voice’, and allowing the reader to substantiate
findings. Sensitivity to context is further demonstrated through the awareness of and
reference to existing literature in the area and through mindful consideration of the
philosophical underpinnings of IPA.

Commitment and rigour were demonstrated through the thoughtful and thorough
collection of data from a carefully selected sample of participants, thought best to answer the
research question. Additionally, regular supervision during the data collection phase
enhanced the researcher’s learning and reflective practice. This facilitated more thoughtful
probing at interview, which increased access to richer data and therefore enhanced rigour of
the current study. Supervision during analysis similarly encouraged a deeper level of
interpretation, and awareness of the double hermeneutic, reiterative process.

To ensure the principles of transparency and coherence were upheld, a number of
measures were taken. For example, the stages of research have been clearly described in the
manuscript and the interview schedule has been appended to the thesis for review. In regards
to coherence, themes were grouped together and arranged in a logical fashion which enables
the reader to follow the participants’ journey of growth from childhood through to adulthood
systematically. Publication of the final manuscript was achieved through a process of careful,
considered writing which included numerous drafts and edits, prior to submission for peer-
review.
Yardley’s (2000) impact and importance principle mandates that valid research must tell the reader something interesting, important or useful (Smith, Flowers & Larkin, 2009). The current study achieves each of these criteria and has real world policy implications for changing procedure and practices. The implications for clinical practice have been previously discussed in this document.

The current study underwent independent audit at several stages throughout the process, to ensure high quality, valid research was produced. This was made possible by the collection and organisation of research materials into a chain of evidence, which demonstrated systematically and transparently how the particular account had been produced. In the case of the current research, the audit was completed by the research supervisor, and the chain of evidence included initial research notes, the research proposal, the semi-structured interview schedule, interview audio recordings, interview transcripts, annotated transcripts, thematic analyses of individual cases, tables of themes, draft reports and the final manuscript.

**Limitations of the Current Study**

The current study is not without limitations and these should be considered when evaluating the conclusions and clinical implications. As a qualitative, experiential approach to research, generalisability of findings is not a desired outcome. The individual or idiographic nature of IPA is concerned with an in-depth examination of how people make sense of their subjective ‘lived’ experiences, and as such, broad generalisations are not possible. Despite this, IPA continues to grow in popularity and is seen to generate useful insights which may lead to wider clinical implications and ‘theoretical transferability’ (Smith, Flowers & Larkin, 2009). Interpretative Phenomenological Analysis offers a different perspective from other qualitative approaches through the use of the two-stage interpretation process, in which the researcher attempts to interpret the participant’s interpretation of the
experiences in their life. This double hermeneutic process sees the researcher access the participant’s experience through the participant’s recount of it, and the researcher’s sense making is influenced by the researcher’s own prior experiences or ‘experientially-informed lens’ (Smith, Flowers & Larkin, 2009).

As such, IPA mandates close attention to the role the researcher plays in influencing the process of meaning making. Researcher beliefs and assumptions inevitably influence the process of co-constructing meaning with the participants, and therefore awareness and acknowledgement of this is of utmost importance. As a psychologist working in the field of child and adolescent mental health, the researcher has had professional contact with children of parents affected by mental ill-health. It is therefore possible that the author’s subjective experiences and biases may have unintentionally impacted on the collection of data at interview or influenced the interpretation of the data.

While low participant numbers afford a richer depth of analysis in IPA studies, small sample size may be an additional limitation of the current research methodology. The current study captured seven participant voices in an attempt to understand the ‘lived’ experience of growing up with parental mental ill-health. Many more and possibly differing perspectives were not included in the present study and the findings are therefore limited to this particular group of participants. The participants in the study were primarily Caucasian, and so the findings are not inclusive of cultural diversity. Due to the heavy reliance on language in qualitative research and concern that meaning may have become lost in translation, non-English speaking participants were excluded from the study. In addition, the participants of the current study were primarily female and as such, the voice of male children of parents with mental ill-health is not well-represented in the current study.

The recruitment strategy aimed to capture a range of participants from different sectors of the population, however, it is likely that only participants who were most intrigued
by the research would have chosen to participate in the study. As such, self-selection bias may have occurred and potentially influenced the findings of the research. For example, participants with particularly negative or particularly positive interpretations of their childhood experience may have been more likely to volunteer to participate in the current study, than individuals with a less emotionally-arousing interpretation of lived events.

The participants of the current study formed a sufficiently homogenous sample, in the context of the broad definition of parental mental ill-health used in the current study. The study captured 20-45 year old participants who were all children of a parent affected by a range of different mental health difficulties, including: affective disorders, psychotic disorders and substance use disorders. Also, differences between maternal and paternal difficulties were not explored, as the current study recruited children of unwell parents without distinguishing between mothers and fathers. The study may have been strengthened by the use of a homogenous participant group characterised by gender of parent, or by diagnostic category.

As a novice qualitative researcher, there is the potential that the analyses of the current study are too descriptive at the expense of higher-order interpretation. It is possible that inclusion of fewer participants may have enabled a more in-depth exploration of the subjective ‘lived’ experience of participants who grew up with a parent affected by mental ill-health. Smith, Flowers and Larkin (2009) suggest three participants as an optimum number for researchers new to IPA.

**Future Research**

Further research in the area of parental mental ill-health could potentially build on the findings of the current study. This study opted to use adult children, to complement literature which predominantly explores the subjective experience of the child or adolescent participant. Particular areas of focus for future research could include exploring the
experience of adult participants from different social contexts or different cultural backgrounds, or exploring the lived experience of growing up with a parent affected by a particular mental health disorder (such as bipolar affective disorder or schizophrenia).

Similarly, future research may seek to investigate the influence of participant gender, or seek to understand the differences between the impact of growing up with maternal mental ill-health and paternal mental ill-health. Of interest also, is the impact of mental ill-health in primary care-givers and non-resident care-givers, step-parents and separated families as well as the consequences for children of intact, nuclear families.

Furthermore, a longitudinal approach to research could be useful in exploring the experience of parental mental ill-health over time. This may enable an understanding of the impact of parental mental ill-health across developmental stages and help to identify critical periods of vulnerability. Likewise, longitudinal research of this kind may assist in identifying psychological and social factors which may precipitate post-traumatic growth at different ages or developmental stages.

There are also avenues for future research to evaluate the effectiveness of interventions designed to support children of parents with mental ill-health. This may include comparisons between group and individual psychological interventions for children, comparison between family-based, individual therapy and multi-family therapy approaches, and evaluation of psycho-education programs delivered in schools and through non-government family support services.

Previous research has found that families affected by parental mental ill-health are left with an array of unmet needs. Further research seeking to understand the perceived needs of these vulnerable families may assist in developing and tailoring family support services. Research in this area may seek to explore the perceived needs of children, adolescents and adults within affected families.
Another salient issue requiring further research is mental health stigma. Each participant described long-standing difficulties with stigma, which possibly contributed to their experience of social isolation and social exclusion. This points to a clear need for future research efforts in understanding stigma and the development of strategies which aim to reduce mental health stigma within the community.

Finally, further research in the area of post-traumatic growth is required to better understand this construct. Relatively little is known about the precipitants of psychological growth following trauma. Largely unexplored is the influence of psychological intervention or other therapeutic encounters on psychological growth as an outcome for individuals who have experienced significant trauma. Research in this area will enrich our understanding of psychological growth have strong clinical implications in the trauma field.

Conclusion

This research explored the subjective ‘lived’ experiences of seven individuals who identified as adult children of parents affected by mental ill-health. The use of qualitative research methodology generated rich data pertaining to participant’s narratives, which saw distress and psychological growth co-exist in the context of cumulative childhood trauma. The participants of the current study routinely identified systemic gaps in which children of parents with mental ill-health remain vulnerable to, and largely felt that additional supports are required to allow these children to achieve their full capabilities. The participants highlighted the prevalence of stigma and social exclusion and the role that each of these play in perpetuating the isolation characteristic of young people who feel ashamed of their parents ill-health.

Juxtaposed with the pain, however, was the discovery of psychological growth in these participants. Previous research has largely documented the potential for adverse outcomes and psychopathology in children of parents affected by mental ill-health. The
current study captured the resilience of these participants, who frequently exceeded expectation in various domains of life (such as education, employment, interpersonal relationships, physical and mental well-being). Additionally, the current study saw psychological growth out of adversity across all participants, who each described positive changes in views of self, relationships with others and life philosophy, in the wake of their childhood experience.

The findings of the current study build on the growing body of research in the area of parental mental ill-health and outline the need for changes in policy and practice to better meet the needs of these vulnerable families. Additionally, the need for future research is apparent, particularly in the area of mental ill-health stigma reduction, and to inform the development of evidence-based interventions which aim to increase resilience and capacity for psychological growth in children. Despite the pain and grief endured, the key message of the participants of the current study is one of hope, inner strength and capacity for growth and positive redefinition of self, through the adverse experience of growing up with a mother or father affected by mental ill-health.
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Appendices
Appendix A: Ethics Approval
Notification of Expedited Approval

To Chief Investigator or Project Supervisor: Doctor Lynne McCormack
Cc Co-investigators / Research Students: Mrs Sarah White
Re Protocol: Growing up with Parental Mental Ill Health: The Subjective Lived Experience of the Adult Child
Date: 22-May-2013
Reference No: H-2013-0074
Date of Initial Approval: 22-May-2013

Thank you for your Response to Conditional Approval (minor amendments) submission to the Human Research Ethics Committee (HREC) seeking approval in relation to the above protocol.

Your submission was considered under Expedited review by the Ethics Administrator.

I am pleased to advise that the decision on your submission is Approved effective 22-May-2013.

In approving this protocol, the Human Research Ethics Committee (HREC) is of the opinion that the project complies with the provisions contained in the National Statement on Ethical Conduct in Human Research, 2007, and the requirements within this University relating to human research.

Approval will remain valid subject to the submission, and satisfactory assessment, of annual progress reports. If the approval of an External HREC has been “noted” the approval period is as determined by that HREC.

The full Committee will be asked to ratify this decision at its next scheduled meeting. A formal Certificate of Approval will be available upon request. Your approval number is H-2013-0074.

If the research requires the use of an Information Statement, ensure this number is inserted at the relevant point in the Complaints paragraph prior to distribution to potential participants. You may then proceed with the research.

Conditions of Approval

This approval has been granted subject to you complying with the requirements for Monitoring of Progress, Reporting of Adverse Events, and Variations to the Approved Protocol as detailed below.
PLEASE NOTE:
In the case where the HREC has "noted" the approval of an External HREC, progress reports and reports of adverse events are to be submitted to the External HREC only. In the case of Variations to the approved protocol, or a Renewal of approval, you will apply to the External HREC for approval in the first instance and then Register that approval with the University's HREC.

- **Monitoring of Progress**

Other than above, the University is obliged to monitor the progress of research projects involving human participants to ensure that they are conducted according to the protocol as approved by the HREC. A progress report is required on an annual basis. Continuation of your HREC approval for this project is conditional upon receipt, and satisfactory assessment, of annual progress reports. You will be advised when a report is due.

- **Reporting of Adverse Events**

7. It is the responsibility of the person first named on this Approval Advice to report adverse events.
8. Adverse events, however minor, must be recorded by the investigator as observed by the investigator or as volunteered by a participant in the research. Full details are to be documented, whether or not the investigator, or his/her deputies, consider the event to be related to the research substance or procedure.
9. Serious or unforeseen adverse events that occur during the research or within six (6) months of completion of the research, must be reported by the person first named on the Approval Advice to the (HREC) by way of the Adverse Event Report form (via RIMS at [https://rims.newcastle.edu.au/login.asp](https://rims.newcastle.edu.au/login.asp)) within 72 hours of the occurrence of the event or the investigator receiving advice of the event.
10. Serious adverse events are defined as:
   - Causing death, life threatening or serious disability.
   - Causing or prolonging hospitalisation.
   - Overdoses, cancers, congenital abnormalities, tissue damage, whether or not they are judged to be caused by the investigational agent or procedure.
   - Causing psycho-social and/or financial harm. This covers everything from perceived invasion of privacy, breach of confidentiality, or the diminution of social reputation, to the creation of psychological fears and trauma.
   - Any other event which might affect the continued ethical acceptability of the project.
11. Reports of adverse events must include:
   - Participant's study identification number;
   - date of birth;
   - date of entry into the study;
   - treatment arm (if applicable);
   - date of event;
   - details of event;
   - the investigator's opinion as to whether the event is related to the research procedures; and
   - action taken in response to the event.
12. Adverse events which do not fall within the definition of serious or unexpected, including those reported from other sites involved in the research, are to be reported in detail at the time of the annual progress report to the HREC.

- Variations to approved protocol

If you wish to change, or deviate from, the approved protocol, you will need to submit an Application for Variation to Approved Human Research (via RIMS at https://rims.newcastle.edu.au/login.asp). Variations may include, but are not limited to, changes or additions to investigators, study design, study population, number of participants, methods of recruitment, or participant information/consent documentation. Variations must be approved by the (HREC) before they are implemented except when Registering an approval of a variation from an external HREC which has been designated the lead HREC, in which case you may proceed as soon as you receive an acknowledgement of your Registration.

**Linkage of ethics approval to a new Grant**

HREC approvals cannot be assigned to a new grant or award (ie those that were not identified on the application for ethics approval) without confirmation of the approval from the Human Research Ethics Officer on behalf of the HREC.

Best wishes for a successful project.

Professor Allyson Holbrook

Chair, Human Research Ethics Committee

For communications and enquiries:

Human Research Ethics Administration

Research Services
Research Integrity Unit
The Chancellery
The University of Newcastle
Callaghan NSW 2308
T +61 2 492 18999
F +61 2 492 17164
Human-Ethics@newcastle.edu.au


**Linked University of Newcastle administered funding:**
Appendix B: Recruitment Poster
GROWING UP WITH PARENTAL MENTAL ILL HEALTH

20-45 year old children of parents affected by mental ill health are invited to participate in a study, which is looking to explore the positive and negative aspects of growing up with a parent affected by mental ill health.

Participants will be asked to take part in an interview of approximately one hour. During this interview, we will be exploring both the positive and negative aspects of growing up with a parent affected by mental ill health.

If you are currently being treated for psychosis, a dissociative disorder or a personality disorder, you may find talking about your early life experiences difficult at this time.

If you would like more information please contact
Sarah White - Sarah.A.White@uon.edu.au
or Dr Lynne McCormack - 4985 4543

Complaints about this research
This project has been approved by the University’s Human Research Ethics Committee, Approval No. H-2013-0074
Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan.
Appendix C: Participant Information Statement

and Consent Forms
Information Statement for the Research Project:

Growing up with Parental Mental Ill Health

Document Version 4, dated 14/08/2013

You are invited to participate in the research project identified above which is being conducted by Dr Lynne McCormack (Senior Lecturer/Clinical Psychologist) and Sarah White (Student Researcher/ Psychologist) from the School of Psychology at the University of Newcastle. The research is part of Sarah White’s studies at the University of Newcastle, supervised by Dr Lynne McCormack from the School of Psychology.

Why is the research being done?
The general aim of this study is to explore the positive and negative aspects of growing up with a parent affected by mental ill health. In recent years, potentially negative consequences of growing up with a parent affected by mental ill health has been the focus of much of the literature and positive aspects of such experience have been poorly explored. The current study seeks to understand the ‘lived’ experience of the adult child, which likely includes both positive and negative aspects.

Who can participate in the research?
We are seeking people aged 20-45 years who have grown up with a parent affected by mental ill health, to participate in the study. Even if you are currently seeking counselling for your own distress such as anxiety, depression or posttrauma stress, we encourage you to volunteer. However, you may find talking about your early life difficult at this time if you are currently having more intensive treatment i.e. for psychosis or dissociative or personality disturbance.
What choice do you have?

Participation in this research is entirely your choice and only those people who give their informed consent will be included in the project. Whether or not you decide to participate, your decision will not disadvantage you in any way.

If you decide to participate, you may withdraw from the interview at any time without giving any reason and have the option of withdrawing any of your data. Please be assured that if you wish to withdraw your interview, you can do so at any time up until 1 November, 2013.

If you chose to participate in this research, you have the opportunity to access a copy of the audio recording of your interview.

What would you be asked to do?

If you agree to participate in the study, you will be asked to:

- Read and sign an informed consent form
- Ask any questions you have related to the study
- Provide demographic details relating to yourself and your relative
- Partake in an audio recorded interview with the student researcher where you will be asked about the positive and negative aspects of your experience growing up with a parent affected by mental ill health
- Read and sign a consent form at the end of the interview
- Nominate whether you would like to receive a copy of the audio recording of the interview for your own personal records

How much time will it take?

The interview is usually around an hour, it may take less or more depending on how much you would like to share with the researcher. If you need a break at any time, this can be negotiated with the student researcher.
What are the risks and benefits of participating?

Although it is possible that participants in the interview may feel some increase in stress and anxiety as difficult times are recalled, the interviews are not expected to cause significant distress, particularly as the study is interested in positive outcomes and growth. Any normal feelings of distress will be supported and participants will be provided with contact details for counselling services in the local area (such as the University Psychology Clinic and Lifeline telephone counselling service), if additional support is required.

By being part of this research, you will have the opportunity to talk about your experiences of childhood and tell your story. You will also contribute to a more accurate understanding of the needs of and affects on children of parents with mental ill health. Your participation will contribute also to our understanding of the development of resilience and personal growth in children of parents affected by mental ill health.

How will your privacy be protected?

Your data collected from this experiment will be de-identified immediately after collection. All hard data and audio files will be stored in locked filing cabinets or on password protected hard drives within locked rooms, accessible to the research supervisor and student researcher, for the duration of the research and publication of any findings. Furthermore, only those researchers directly involved in this study will have access to these files. The data and consent forms will be disposed of 5 years after all investigations are complete.

How will the information collected be used?

The information collected from this research will form a substantial component of the thesis to be submitted by the student researcher. In addition, the data collected may be published in the scientific literature in paper written by the student researcher and the research supervisor. Individual participants will not be identified in any reports arising from the project.

You will be asked to indicate on the Consent Form if you would like to receive a summary of the results of the research. This brief summary will be mailed or emailed to you at the conclusion of the study. Participants will also be advised of the details of any journal publications arising from this research project.
**What do you need to do to participate?**

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

If you would like to participate, please advise the student researcher by email. The student researcher will then contact you via phone to arrange a time convenient to you for the interview. You will be asked to bring your signed Consent Form to the interview.

**Further information**

If you would like further information about this project please contact Sarah White or Dr Lynne McCormack on the contact numbers listed below.

Thank you for considering this invitation to be part of this valuable research.

Dr Lynne McCormack  
Senior Lecturer/Clinical Psychologist  
School of Psychology  
Faculty of Science & IT  
University of Newcastle  
Ph: 4985 4543

Sarah White  
Student Researcher/Psychologist  
School of Psychology  
Faculty of Science & IT  
University of Newcastle  
Ph: 4925 7800

**Complaints about this research**

This project has been approved by the University’s Human Research Ethics Committee, Approval No. H-2013-0074

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au
Consent Form for the Research Project:
Growing Up with Parental Mental Ill Health

Document Version 2, dated 04/05/2013

- I agree to participate in the above research project and give my consent freely
- I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained
- I understand that I can withdraw from the project at any time and do not have to give any reason for withdrawing
- I consent to attending an interview session as part of this study at the University of Newcastle, as outlined in the Information Statement
- I consent to the interview being audio recorded
- I consent to the data collected being used within a post-graduate research project and possibly also a paper to be published in the scientific literature, presented at conference or for teaching purposes
- I consent to the researchers possibly contacting me in the future for follow up studies
- I understand that my personal information will be de-identified, pseudo-names will be used and I will not be identified in any way
- I have had the opportunity to have all questions answered to my satisfaction

Name: ___________________________  Signature: _____________________

Contact Number: ___________________  Date: ______________________

☐ I would like to have a summary of the results of this research project sent to me at the following address/email address: __________________________________________________________
Post-Interview Consent Form for the Research Project:  
Growing Up with Parental Mental Ill Health

Document Version 2, dated 04/05/2013

- I understand that I can withdraw from the project at any time and do not have to give any reason for withdrawing
- Prior to participating in this study, I was made aware that I would not be able to review or edit the content of my interview
- Having now completed the interview, I re-confirm my consent to the data collected being used within a post-graduate research project and possibly also a paper to be published in the scientific literature, presented at conference or for teaching purposes
- I understand that my personal information will be de-identified, pseudo-names will be used and I will not be identified in any way
- I have had the opportunity to have all questions answered to my satisfaction

☐ I would like to have a copy of the audio recording of the interview sent to me at the following address: ___________________________________________

Name: __________________________________________________ Signature: ______________________

Date: _____________________
Appendix D: Participant Demographic Information
Demographic Information for the Research Project:
Growing up with Parental Mental Ill Health

- What is your age _______
- What is your gender
  - Male
  - Female
- What is your relation to the person with mental ill health (e.g. mother, father, step-mother, step-father) ____________________________________________________
- What is their diagnosis or diagnoses? __________________________
  _______________________________________________________________
- Do you have any diagnosed mental health difficulties?
  - Yes
  - No
- If yes, what is your diagnosis or diagnoses? __________________________
  _______________________________________________________________

Thank you for your contribution to this research.
Appendix E: Semi-structured Interview Schedule
Semi-structured Interview Questions for the Research Project:
Growing up with Parental Mental Ill Health

Project Supervisor: Dr Lynne McCormack
Student Researcher: Sarah White

- Can you tell me generally about your experience of having a parent troubled by mental ill health, for example, when did you first noticed that your parent (mum or dad) had problems and how did that impact on you?

- In what way do you feel your parent’s difficulties affected your life when you were a child?

- Did you have access to support services growing up? Were they helpful?

- What would you have wanted from services if they were available? What would have been helpful and what would have been unhelpful?

- Tell me about a situation in which your parent’s difficulties had an impact on you? (Prompt for school, home, friends, family).

- I am interested in both the positive and negative aspects of such experiences. Could you tell me how you feel your experience as a child of a parent will mental health concerns impacted on you both positively and negatively?

- What have you learnt about yourself that you might not have otherwise known?

- Is there anything else you think that is important for me to know about to understand your experience?
Appendix F: Journal Submission Details
Journal Submission Details

The paper “A fractured journey of growth: Making meaning of a 'broken' childhood and parental mental ill-health” included within this thesis, has been submitted to *Community, Work and Family* for consideration.

Community, Work and Family

Community, work and family are interconnected and central to everybody’s life. The links between community, work and family have generated widespread interdisciplinary interest, which this journal draws together with a focus on theory, research, policy and practice. The Journal provides a forum for social scientists and practitioners to share experiences and ideas and debate current issues and controversies.

Aims and Scope

- To publish theoretical, research-based, policy and practical contributions in the growing area of community, work and family and their interface
- To provide an international forum for debate in the field and reflect the range of approaches to community, work and family in different contexts, by encouraging contributions from academics and practitioners from around the world
- To foster the development of theory, research, policy and practice
- To highlight the experiences of those members of communities, organisations and families whose voices are seldom heard
- To encourage critical examination of existing frameworks and practices to promote research which employs methods with the potential to lead to social action

The Distinctive Nature of the Journal

- Recognises the contested nature of community, work and family
• Highlights the perspectives of multiple stakeholders in communities, work organisations and families
• Explores dimensions of social and organisational change
• Includes voices which are often not heard and are ‘hidden’
• Emphases research and practice
• Targets academics and professionals and is interdisciplinary within the social sciences
• Reports research using diverse methods and with implications for policy and practice
• Encourages new ways of thinking about diversity and equality
• Promotes international debate and collaboration
• Legitimises reflexivity in research in practice

Editors

• Dr Laura den Dulk - Erasmus University Rotterdam, Netherlands
• Professor Jennifer Swanberg - University of Maryland, USA
• Professor Rebecca Lawthom - Manchester Metropolitan University, UK

Manuscript Preparation

• Manuscripts are accepted in English. Any consistent spelling and punctuation styles may be used. Please use single quotation marks, except where ‘a quotation is “within” a quotation’. Long quotations of 50 words or more should be indented with quotation marks.

• A typical manuscript will not exceed 8000 words including tables, references, captions, footnotes and endnotes. Manuscripts that greatly exceed this will be critically reviewed with respect to length. Authors should include a word count with their manuscript.
Manuscripts should be compiled in the following order: title page; abstract; keywords; main text; acknowledgements; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).

Abstracts of 200 words are required for all manuscripts submitted. Authors are also required to submit a translated abstract in either French or Spanish once the manuscript has been accepted for publication.

Each manuscript should have 4 to 6 keywords.

Search engine optimization (SEO) is a means of making your article more visible to anyone who might be looking for it. Please consult our guidance.

Section headings should be concise.

All authors of a manuscript should include their full names, affiliations, postal addresses, telephone numbers and email addresses on the cover page of the manuscript. One author should be identified as the corresponding author. Please give the affiliation where the research was conducted. If any of the named co-authors moves affiliation during the peer review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after the manuscript is accepted. Please note that the email address of the corresponding author will normally be displayed in the article PDF (depending on the journal style) and the online article.

All persons who have a reasonable claim to authorship must be named in the manuscript as co-authors; the corresponding author must be authorized by all co-authors to act as an agent on their behalf in all matters pertaining to publication of the manuscript, and the order of names should be agreed by all authors.

Please supply a short biographical note for each author.
• Please supply all details required by any funding and grant-awarding bodies as an Acknowledgement on the title page of the manuscript, in a separate paragraph, as follows:
  
  o *For single agency grants:* "This work was supported by the [Funding Agency] under Grant [number xxxx]."
  
  o *For multiple agency grants:* "This work was supported by the [Funding Agency 1] under Grant [number xxxx]; [Funding Agency 2] under Grant [number xxxx]; and [Funding Agency 3] under Grant [number xxxx]."

• Authors must also incorporate a Disclosure Statement which will acknowledge any financial interest or benefit they have arising from the direct applications of their research.

• For all manuscripts non-discriminatory language is mandatory. Sexist or racist terms must not be used.

• Authors must adhere to SI units. Units are not italicised.

• When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.

**Manuscript Submissions**

All submissions should be made online at the *Community, Work & Family* Scholar One Manuscripts website. New users should first create an account. Once logged on to the site, submissions should be made via the Author Centre. Online user guides and access to a helpdesk are available on this website.

Manuscripts may be submitted in any standard editable format, including Word and EndNote. These files will be automatically converted into a PDF file for the review process. LaTeX files should be converted to PDF prior to submission.
Appendix G: Evidence of Submission
Evidence of Submission

09-Jun-2014

Dear Dr McCormack & Mrs White:

Your manuscript entitled "A fractured journey of growth: Making meaning of a 'broken' childhood and parental mental ill-health." has been successfully submitted online and is presently being given full consideration for publication in Community, Work & Family.

Your manuscript ID is CCWF-2014-0044.

Please mention the above manuscript ID in all future correspondence or when calling the office for questions. If there are any changes in your street address or e-mail address, please log in to Manuscript Central at http://mc.manuscriptcentral.com/ccwf and edit your user information as appropriate.

You can also view the status of your manuscript at any time by checking your Author Centre after logging in to http://mc.manuscriptcentral.com/ccwf.

Thank you for submitting your manuscript to Community, Work & Family.

Sincerely,
Community, Work & Family Editorial Office