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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:

Making Meaning of a 'Broken' Childhood and Parental Mental Ill-health

Abstract

The psychopathological impact of parental mental ill-health on children is well known. However, little research explores positive and negative interpretations of such exposure in childhood, from the adult child's perspective. Using Interpretative Phenomenological Analysis (IPA) this study sought subjective interpretations of the 'lived' experiences of growing up in a family with parental mental ill-health. A purposive sample of seven adult children provided data for analysis through semi-structured interviews. One superordinate theme: *A fractured journey of growth to adulthood*, overarched six subordinate themes. Four themes captured stigma, shame, social isolation and betrayal. Juxtaposed with this, two themes captured purposeful redefinition of self and psychological growth. This study captures the chronicity of traumatic distress and sense of betrayal experienced by these participants in childhood through unrelenting exposure to parental mental ill-health. However, despite unpredictability, fear, and neglect in childhood, they identified the emergence of inner strengths in adult life: unexpected growth in empathy and compassion, high resourcefulness, and personal authenticity through higher education. Findings highlight that positively redefining 'self' in adult life is possible in the aftermath of childhood trauma associated with parental mental ill-health. Implications for therapy include: a) moving forward from childhood trauma; b) managing ongoing family dynamics in adult-life.

Key words

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

Un Viaje Fracturado de Crecimiento:

Dándole sentido a una infancia '*fracturada*' y a la Enfermedad Mental Parental

Resumen

El impacto psicopatológico de la enfermedad mental parental en los hijos es bien conocido. Sin embargo, pocos estudios exploran las interpretaciones positivas y negativas de la experiencia infantil, desde la perspectiva del hijo adulto. Mediante un análisis fenomenológico interpretativo (AFI), este estudio examinó las interpretaciones subjetivas de las experiencias 'vivas' al crecer en una familia con enfermedad mental parental. Una muestra intencional de siete hijos adultos proporcionó datos para ser analizados mediante entrevistas semiestructuradas. Un tema de orden superior: *un viaje fracturado de crecimiento hacia la adultez*, abarcó seis temas subordinados. Cuatro temas capturaron estigma, vergüenza, aislamiento social y traición. Junto con esto, dos temas capturaron la redefinición decidida de uno mismo y el crecimiento psicológico. Este estudio captura la cronicidad del malestar traumático y la sensación de traición que experimentaron los participantes en su infancia a través de la exposición constante a la enfermedad mental parental. Sin embargo, a pesar de la imprevisibilidad, miedo y abandono de la infancia, los participantes identificaron el surgimiento de fuerzas internas en la vida adulta: un crecimiento inesperado de la empatía y compasión, alta capacidad para solucionar problemas y originalidad personal a través de la educación superior. Los resultados destacan que tras el trauma infantil asociado a la enfermedad mental parental, es posible redefinir el 'self' positivamente en la vida adulta. Implicaciones para la terapia incluyen: a) mejoría del trauma infantil; b) manejo de la dinámica familiar en la vida adulta.

Palabras clave

Análisis fenomenológico interpretativo, enfermedad mental parental, trauma infantil acumulativo, crecimiento postraumático, consecuencias positivas y negativas

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 traumatised and stunt emotional and psychological growth. This article considers the psychopathological risks and other adverse outcomes for children of parents affected by specific psychiatric disorders. Similarly, it provides a summary of the relevant literature in the area of parental mental ill-health including the prevalence of parental mental ill-health. The impact of parental mental ill-health on the parent-child attachment relationship is also discussed followed by examination of the literature regarding developmental trauma and betrayal trauma in children. However, while the psychopathological and psychosocial implications of exposure to adverse events are well known, there is a paucity of research exploring both positive and/or negative interpretations of adult children exposed during childhood to parental mental ill-health. Therefore, this phenomenological study seeks the subjective interpretation of the 'lived' experience. It is particularly interested in whether individuals exposed to parental mental ill-health during childhood perceive the opportunity for psychological growth out of such adversity despite the inherent distress and difficulties currently recognised.

Many children exposed chronically to parental mental-ill-health are at risk of their own psychopathology in adult life (Garley, Gallop, Johnston, & Pipitone, 1997; Duncan & Reder, 2000; Maybery, Ling, Szakacs & Reupert, 2005). For example, in adult life they may present 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). Many psychiatric illnesses are considered to have strong genetic associations, with psychotic

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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).

In the context of parental mental illness, family life for a dependent child may be clouded by social adversity and stigma. Many families impacted by parental mental ill-health face difficulties with low income, unemployment, substandard housing or poverty (Hall, 2004). As a consequence of this adversity, children within these households 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). Similarly, within the wider family system, parental psychopathology has the potential to influence child well-being in several ways, including impacts on attachment, adjustment, stress and coping (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 (Cree, 2003). 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. For some, the burden of care-giving roles or taking on responsibilities typically expected of adults, is common (Cree, 2003). While some benefits such as increased self-worth and importance may be gained from caring for a parent (Aldridge & Becker, 1993), further research is needed into how better to support young carers to increase benefits and reduce the impact of adverse outcomes.

The risks of exposure to parental mental ill-health in childhood are well documented across developed countries. As yet there is a paucity of research documenting the impact of parental mental ill-health on children in countries exposed to chronic civil unrest or war. Therefore, 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. For those in first world countries, up to 23.3% of children have been reported to be living in a family with a parental mental illness (ABS, 2009) and 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; Maybery, Rupeart, & Patrick et al., 2009). This presents societal challenges for supporting and caring for the many children affected.

Despite the potential threats, not every child with an unwell mother or father will experience long term consequences. 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 wellbeing as well as psychopathology may exist from childhood distress experienced from parental mental ill-health. Positive outcomes have been variously known as perceived benefits (McMillen & Fisher, 1998), thriving (Abraido-Lanza, Guier, & Colon, 1998), stress-related growth (Park, Cohen, & Murch, 1996) and positive changes in outlook (Joseph, Williams, & Yule, 1993). However the term most commonly used in the research literature is posttraumatic growth (Tedeschi & Calhoun, 1995). Research exploring adverse responses to direct and indirect trauma have often revealed a paradox in which many of those who report negative outcomes following their trauma exposure also report areas of positive growth (Seligman & Csikszentmihalyi, 2000). Psychological growth refers to transformative, positive changes that are stable and enduring over time, directly related to a traumatic event that shatters our world view, or are complex (Calhoun & Tedeschi, 2006; Joseph, 2011). Such 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).

There are currently three broad dimensions of growth. These changes over-arch: positive re-evaluation of self worth, greater appreciation of interpersonal relationships, changed life values and beliefs (see Helgeson, Reynolds & Tomich, 2006; Joseph & Linley, 2008; Prati & Pietrantoni, 2009; Tedeschi & Calhoun, 1996, 2004). Positive changes in self-perception include personal resiliency, wisdom, and strength, and conversely, increased acceptance of vulnerabilities and limitations (Tedeschi & Calhoun, 1996). Similarly, changes in life philosophy can promote new appreciation of the very nature of existence, often leading

to a re-evaluation of what is important in life (Joseph & Linley, 2005). More recent studies have described domains of growth to include an increase in gratitude, humility, empathy and altruism following complex traumatic experiences (McCormack, Hagger & Joseph, 2011; McCormack & Sly, 2013; McCormack & Joseph, 2013).

Helgeson et al (2006) conducted a meta-analytic review of 87 studies concluding that benefit finding was related to lower depression and more positive well-being, but also more intrusive and avoidant symptomatology posttraumatic experiences. This latter finding has caused some confusion, leading some to question the adaptive utility of growth. However, others propose that posttraumatic stress should be viewed as the cognitive process that gives rise to growth. From this perspective, growth is seen to arise out of the chaos of trauma and the resultant cognitive – emotional struggles (see Joseph 2011). More recent evidence suggests a curvilinear relationship between growth and stress exists (Joseph, Murphy & Regal, 2012) whereby to cognitively incorporate traumatic information with previous world views, stress levels from intrusive thoughts and avoidant behaviours no longer overwhelm the individual but are purposeful allowing active engagement in cognitive processing of the traumatic material (Joseph et. al., 2012). Therefore, growth is an unlikely outcome in the early, reactive stages following traumatic exposure.

It is not only primary exposure to traumatic events that is attracting research interest. Personal benefits and positive changes has been demonstrated in several studies including adult children exposed vicarious to combat trauma during childhood, and therapists exposed to complex childhood trauma narratives (Arnold et al, 2005; Dekel, 2007; Linley et al, 2005; McCormack, Hagger & Joseph, 2011; McCormack & sly, 2013; McCormack and Adams, 2015; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). As evidence of growth accumulates following both primary and secondary exposure to traumatic life events, the

potential for growth from the developmentally traumatising experience of living with parental mental illness is a phenomenon of interest in the present study.

This study aims 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 aims 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 alcohol dependence, and one mother who had a diagnosis of schizo-affective disorder. Those with alcohol dependence and schizo-affective disorder exhibited cycles of severe and unpredictable symptoms followed by a period of improvement, with less severe symptoms. 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, and one participant had a diagnosed anxiety disorder. One participant had met criteria for major depressive disorder not current, and another participant had met criteria for post-traumatic stress disorder not current. One participant reported no formal psychiatric diagnoses over their lifetime. All participants have been de-identified with pseudonyms to protect confidentiality.

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. Prior to the interview, the participants were provided with the schedule for reflection, the study information statement, and the consent forms

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, a complex subject area such as growing up with parental mental ill-health can be understood and interpreted. Through the use of double hermeneutics, the interviewer seeks to make sense of the participant's interpretations through a process of critical reflection, clarification and seeking understanding. Therefore, the interviewer strives to make sense of the participant who in turn is striving to make 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 credibility 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 (Smith 1996). Although many interpretations of phenomenological data are possible, the authors sought the richest data that addressed the research question. Where the authors differed in thematic interpretation, collaborative examination of the text and in-depth discussion to evaluate the textual evidence for thematic interpretations ensued, before consensus was reached regarding the final set of themes derived for this study.

Analytic Strategy

Interpretative Phenomenological Analysis (IPA) is concerned with time and place, and the social context of experiences (Smith & Osborn, 2003). As such, IPA is an appropriate methodological approach whereby the topic under investigation, growing up with parental mental ill-health, holds relevance and personal significance for the participants in the

here and now. It seeks homogeneity and purposeful sampling in that participants will share similar demographic and experiential backgrounds. The primary aim of IPA is to search for subjective meaning making through the use of reflexive questioning teasing out individual thought, word and action (Smith et al., 2009). Through the use of iterative questioning, the researcher has the opportunity to learn from the participant's interpreted world and lived experiences, while at the same time critically engage with their own presuppositions and biases. For this to occur, the researcher must consciously strive to stay within the participants' personal/social world. Thus a narrative account develops that merges the interpretative activity of the researcher and each participant's interpretation of their experiences. By the use of a funnelling process from broad to specific questioning, complex, and often previously unexplored but significant events in an individual's life can be explored (Smith & Osborn, 2003).

Credibility

Credibility and trustworthiness of findings were considered in a number of ways (Smith, Michie, Stephenson, & Quarrell et al., 2002; Spencer & Ritchie, 2012; Yardley, 2008). Unlike nomothetic research, IPA seeks individual interpretations, authenticity of data and creditability through audit trails and robust discussion (Smith, Flowers, & Larkin, 2009). As such, biases and presuppositions were acknowledged and scrutinised to guard against overshadowing interpretation with author biases, yet recognises the knowledge and experience both brought to interpretation. Both authors independently analysed the data and then debated their independent interpretations until convergent and divergent themes were agreed upon substantiated by rich data extracts. Causal evidence or inter-rater reliability was not sought. Instead, independent auditing delivered one account of the data that achieved internal coherence and presentation of evidence. A detailed audit trail included audio

recordings, transcripts, description of theme development, notes, diagrams and thematic definitions.

The seven interviews in this study were treated as one data set. The descriptive analysis/discussion follows. Please see table 1 for the step-by-step stages of the analytic process (Smith, Flowers & Larkin, 2009).

- Insert Table 1 -

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.

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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 2

- Insert Table 2 -

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.

Foster care brought challenges for remaining engaged with family ties:

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)

Feelings of socially ineptness appeared to be in the present, interwoven with past memories of disengagement from peers. Their remained an erosion of surety 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 seemed to leave participants thinking dichotomously, believing that other families were 'right' while theirs was always 'wrong'. There was a sense of shame and stigma associated with a conviction of alienation and inferiority:

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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, left Freya struggling to unravel the mystery surrounding her father. Her meaning making seemed 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 was interpreted as co-existing 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 simply surviving each day was a struggle. There was a sense of never ending negativity compounding the ever present indirect neglect and abuse of a mentally unwell parent. Juxtaposed with such loss was the helplessness and lack of coping often recognised in the other parent. The unavailability of those adults meant to protect and care during crucial developmental stages positioned these participants for a lifetime of being alert. Betrayal was a common thread in their reflections as they remembered parents who failed to prioritise safety, love and nurturing. Multiple episodes of abuse and neglect left memories of a childhood struggling to build self-worth and identity but equally confused by the absent, stuck or fearful 'other' parent:

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

Such passivity or parental unavailability brought invisibility and numbness. Living within an emotionally disenfranchised space made walking away possible. For others, acts of personal assault, with privacy invaded, self-blame became an intrinsic response reinforcing their sense of betrayal:

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

Abuse produced the deepest sense of personal eradication. Words were indelibly etched 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)

A sense of nothingness was juxtaposed with permanent fear, hyper-arousal and anxiety as repeated episodes of violence and vivid memories of thwarted escapes were recalled:

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 ... conscious of not doing anything to upset*' their parent are deep seated learned responses which inform current adult relational interactions. Similarly, '*always walked on eggshells with mum, right up to this very day*' has inhibited a natural progression of trust and safety within adult relationships:

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

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caretaker child adequately, guilt became a driving force for self-abuse. Antonia mirrored her father's abuse turning on herself:

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 practiced vigilance, and heightened anxiety has become their normal response to the world. Confidence siphoned out of them, anxious attachment is their common thread into adult relationships:

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 transgenerational 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, they mused that 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)

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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*'. Despite the dissipation over time of feelings of responsibility, 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 kind of 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 becoming a caretaker child. Others developed intuitive behaviours for keeping themselves and other family members safe. Observing these participants reflect on the selfish disregard and minimisation of them as children despite their attempts at caring for their ill parent, hurt and disbelief could find no eloquence:

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, poo-ed 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 battle for unconditional regard seemed ever present in Antonia. Still unable to make sense of the complexity of a parent unable to give, the need to take responsibility, '*to be the good girl for him*' and '*please him, constantly, just to make sure he was ok*' still hovers as personal 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)

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Strengths were valued 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 survival demanded a price to pay. Staying alert, their young bodies expressed the traumatic anxiety that was a constant in their lives whereas as young adults they connected the dots between their bodily responses and the fear of childhood powerlessness:

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*'. However, fitting in was the training ground for 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

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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, kind of 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

Growing up with parental mental ill health

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 came to recognise freedom in education and employment. It 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 of success.

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 kind of 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 empowering 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 and anxious thread among participants. Distancing, generalising, their counterbalance was to position themselves proactively, seek help, and 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)

Growing up with parental mental ill health

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 brought up in. (Wynona)

The fear of genetics and repeating history loomed heavily for these participants as they identified a connection between an anxious temperament and the uncertainty and chaos which characterised childhood. Their inner voices of doubt tended to drive their anxiety, yet they were able to recognise that it was both ‘*a good and bad thing*’, and acknowledge an underpinning fear of inadequacy that gave buoyancy to success:

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

Growing up with parental mental ill health

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*.

These participants experienced a wider sense of betrayal in 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 et al, 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, assisting children to make sense of their parent's mental health difficulties is an important finding of this study. Without an adequate understanding of their parent's mental health difficulties, these participants remember confusion, leading to ideas of self-blame and a heightened anxiety response during childhood. 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.

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. Despite the unpredictable, the fear, sadness, and traumatic neglect during childhood associated 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. In accordance with posttraumatic growth theories, positive and enduring changes were evident across perception of self, world view and interpersonal relationships (Tedeschi & Calhoun, 1996; see Joseph, 2012) for these participants. 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.

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 that boundaries are needed to maintain their own mental wellbeing in adult life. Where psychologically safe for themselves, limited but self-managed adult contact with the ill parent occurred.

Limitations

The current study is not without limitations. This research offers an in-depth examination of the interpretative experiences of seven adult children of parents affected by mental illness and how they make sense of their subjective lived experiences. As a qualitative study, it is not concerned with generalisability nor does it seek cause and effect. Similarly, it does not seek saturation of thematic interpretation as an IPA study but focuses on providing one possible narrative of many, giving value to divergent and convergent themes where rich data is evident. As such it contributes to the extant literature in this field identifying avenues for future direction, while contributing to the literature by highlighting both positive and negative insights into the childhood experiences of parental mental illness.

Through clinical experience, it is possible that the authors' subjective experiences and biases have unintentionally impacted upon the collection of data at interview or influenced the interpretation of data. This was discussed at every level of the analysis to reduce bias yet enhance the co-constructed process of meaning making with the participants. Further, the participants in this study were Caucasian and predominantly female and therefore, the findings are not inclusive of cultural diversity and the voice of male children of parents affected by mental ill-health is not well represented in the study.

Conclusion

The current study contributes to the growth literature, describing how distress from the adverse and developmentally traumatising experience of growing up with a mother or father affected by mental ill-health can also facilitate growth in adult life. In addition the study supports growth theory (see Joseph, 2011) revealing that meaning making and distress can co-exist particularly in complex life journeys such as these. Importantly, the study highlights that adult children traumatised during childhood through parental mental ill health, though able to identify growthful domains to facilitate adult life, remain engaged with difficult family dynamics that will continue to challenge them and place them at risk of ongoing vulnerability. This offers several key implications for clinical practice when working with children currently in families with adult mental ill health, and those who confronting that history in adult life. Redefining self as separate to a mentally ill parent is an important goal of therapy as is hope for future adult self. Furthermore, while supporting the journey many children are trapped within, a therapeutic focus on developing strengths to move forward positively can be an adjunct to trauma therapy. In essence psychological support for both distress and growth, should be equal goals of therapeutic intervention in adult survivors of such difficult childhoods.

The study highlights that ongoing betrayal, vicarious, and primary trauma are the likely lot of children living with parents experiencing mental ill-health. Therefore many 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 transgenerational 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.

Declaration of Conflicting Interests

The authors declare no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

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Transcript extract notation

[...]	indicates editorial elision where non-relevant material has been omitted
(text)	indicates explanatory text added by author
[-]	pause in speech

Table 1. Stages of Interpretative Phenomenological Analytic Process

Stage	Process
1	Listening to and transcribing verbatim transcripts.
2	Thematic analysis of transcript independently both authors to identify positive and negative childhood experiences leading to superordinate and subordinate themes.
3	Independent interpretation of transcript by paraphrasing and summarising the participant's phenomenological and hermeneutic experiences through narrative.
4	Documentation of expected themes followed by exploration of overarching theme of: 'A fractured journey of growth to adulthood'.
5	Chronological listing of emerging themes for connectedness.
6	Continuing to assess overarching themes and subthemes and links to meaning making, understanding and redefining self.
7	Clustering of themes around concepts and theories.
8	Data from transcript rechecked by the first authors to verify first author's validity of interpretations from within the text.
9	Emergent higher order main theme of 'A fractured journey of growth to adulthood' reassessed
10	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.
11	Narrative account of theoretical links to themes generated through concise verbatim extracts from transcript.
12	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.

Table 2. Superordinate theme '*Fractured Journey of Growth to Adulthood*' with six subordinate themes

<ol style="list-style-type: none"> 1. Who cares – Nobody cares 2. Trauma and betrayal 3. Transferring the distress 4. Ducking and weaving and staying safe 5. Growing myself up 6. Transforming a broken childhood
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