Survivalkid(s): Online support for adolescents and young adults with a mentally ill family member
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Self-expressed strengths and resources of children of parents with a mental illness: A systematic review

Abstract

The aim of this review was to explore the strengths children reported to have acquired while coping with their parent’s illness, and the external factors these children indicated had facilitated their coping process.

A systematic literature search was conducted of peer-reviewed papers that focussed on self-reported experiences of children with parents who had mental illness, and revealed their strengths and resources. The search included the following databases: MEDLINE, PsycINFO, and CINAHL. Results were filtered according to whether search terms appeared in the title or abstract. Fifty-seven full-text papers were reviewed; 26 of them met the inclusion criteria and were included in the review. The statements were analysed using content analysis. The search identified 160 relevant statements, 38 (24%) of which could be described as self-reported strengths and 122 (76%) as self-reported resources. According to these statements, the children described themselves as more mature, independent, and empathic than their peers who did not have a parent with a mental illness, and as having acquired several abilities. The statements about resources indicated that the children regarded social support, information, and particularly the support of mental health-care professionals as helpful when living with a parent with a mental illness. Recommendations for nursing actions to support children’s ability to cope with their parents’ illness are outlined.

Introduction

It has long been acknowledged that children of parents with a mental illness run a higher risk of having negative mental health outcomes compared to children of healthy parents. Despite the higher rate of behavioural, developmental, and emotional problems in these children (Beardslee, Gladstone, & O’Connor, 2011; Brockington et al., 2011; Dean et al., 2010; Falkov & Lindsey, 2002; McLaughlin et al., 2012), the majority remain healthy. It is thought that between 25%-50% of children whose parents are affected by mental illness will experience some level of psychiatric symptoms compared with 10%-20% of children whose parents are not affected (Maybery, Ling, Szakacs, & Reupert, 2005).

Many studies have tried to identify the factors that influence the trans-generational transmission of psychopathology. In the construction of theoretical models, such as those...
developed by Goodman and Gotlib (1999) and Hosman, van Doesum, and Van Santvoort (2009), results from epidemiological research are integrated to give an overview of risk and protective factors that have been found to influence transmission. Examples of risk factors are: the child’s inherited vulnerability, parental problem behaviours, and poverty in the family. The impact of risk factors might, however, be buffered by protective factors. Examples of protective factors are: the child’s stress reactivity, the competence of the healthy parent, and the support available from the broader social network and from professionals involved. If a child of a parent with a mental illness remains healthy despite being exposed to many risk factors, he or she might be described as less vulnerable or resilient (Hosman et al., 2009). Current preventive interventions generally comprise modules that have been developed to counteract or reduce identified risk factors and increase protective factors (Reupert et al., 2012; Riley et al., 2008).

Gladstone, Boydell, and McKeever (2006) emphasize that the definition of risk is often determined by the view of health professionals. It has, for instance, been considered a risk factor (an unhealthy reversal of roles) when children provide care for their parents who have a mental illness. This, however, could just as easily be interpreted as a protective factor in that it provides children with a means to help their parents and to have a sense of control over their situation (Aldridge & Becker, 2003). Gladstone et al. (2006) also emphasize that children might offer alternative - perhaps even conflicting - descriptions of what it means to respond in a healthy manner to parental mental illness. These authors suggest, that professionals’ views about risk and protective factors be complemented by the children’s own perspective. This is especially important when studying the impact of parental mental illness on children as well as how children experience intervention programs.

Placing greater emphasis on the positive learning experiences that children have had growing up with a parent with a mental illness might inform future interventions. Identifying ways to successfully adapt to stressful situations can increase children’s sense of competence and increase their resistance to later adversity (Masten & Tellegen, 2012). In fact, when children are required to deal with a parent’s symptomatic behaviour, they might develop adaptive characteristics that enable them to function effectively and to be able to adapt to adverse conditions generally (Kinsella & Anderson, 1996). Rutter (2012) makes it clear that exposure to stress or adversity might either increase vulnerabilities through a sensitization effect or decrease vulnerabilities through a steeling effect. According to Rutter, people can be reinforced through the experience of doing well in difficult circumstances. That is, when children of parents with a mental illness find ways to successfully cope with their situation, they might acquire new strengths. Recognizing that children are able to take positive strides in dealing with their difficult situation can be empowering for families who are coping with a mental illness (Foster, O’Brien, & Korhonen, 2012).

A few authors have, in fact, taken into account the self-reported experiences of children of parents with a mental illness (Gladstone, Boydell, Seeman, & McKeever, 2011; Mechling, 2011; Murphy, Peters, Jackson, & Wilkes, 2011). These reviews identified how children described their daily life when their parent was ill. Themes that were reported in the studies were as follows: the impact on children’s lives, how children had coped with their circumstances, and their understanding of the mental illness. These reviews did not, however, identify children’s self-identified strengths. Accordingly, the present review of the literature on the experiences of children whose parents had a mental illness gives special attention to self-reported strengths that children developed during the course of their coping with their circumstances. The present study explored the strengths children themselves identified when coping with or adapting to their parent’s mental illness, and the external factors they indicated were important for enabling them to do so. In order to achieve these goals, two categories of statements on experiences were analysed: the experiences of young people currently living with a parent who had a mental illness and those of adult children who were asked to reflect on their childhood.

**Methods**

**Search strategy**

We conducted a systematic search of the literature from the MEDLINE, PsycINFO, and CINAHL databases from January 1993 to October 2014 using the following search terms: child of impaired parents, copmi (child of a parent with a mental illness), parent* AND mental* OR psych*,ill* OR disorder*, and these terms were crossed with qualitative research OR self-report OR perceiv* OR perceptr* OR impact* OR experience*. We specified free text words and MESH terms. The search criteria included the presence of a search term in the title or the abstract of the paper. Reference lists in retrieved articles were searched for additional relevant studies. The search was limited to references in English. The principles named in the statement on Preferred Reporting Items in Systematic Reviews and Meta-Analyses (PRISMA) were used to guide the systematic review. The PRISMA statement is a checklist of items to include when reporting a systematic review or meta-analysis, formulated by Moher, Liberati, Tetzlaff, Altman, and the PRISMA Group (2009).
Definitions used in the review

The term ‘parents with a mental illness’ was defined as parents who in the original study were reported to have been affected by at least one psychiatric disability (i.e. having a diagnosis of depression or mood disorder, anxiety disorder, obsessive-compulsive disorder, schizophrenia, attention deficit disorder, or borderline personality disorder) or who were reported to receive or to have received psychiatric treatment. Therefore, a criterion for including a paper was that it specified the parent’s diagnosis or that the parent, child or family was receiving support for the parent’s mental illness.

To define ‘strengths’ and ‘resources’, we used the descriptions that Fergus and Zimmerman (2005) introduced. These authors define ‘strengths’ as an individual’s positive characteristics; they are assets that young people acquire while they are coping with their situation. In the case of parental mental illness, children’s strengths might be their enhanced adaptive coping skills. Fergus and Zimmerman also define resources as positive factors that enable young people to learn to overcome difficulties, but they are external to the individual. Resources might include, for example, parental support, adult mentoring, or community organizations that promote positive youth development.

This review analysed statements on self-expressed strengths, that is, assets that children of parents with a mental illness describe using when they are coping with the situation. The term ‘self-expressed’ refers to the subjective perspective of the children. To be included in the review, eligible papers had to report on opinions about strengths and resources that were clearly those of children who had lived with a parent with a mental illness; they could not be the view of parents, professionals, or the authors of the paper.

Study selection criteria

The search included references to qualitative research published in peer-reviewed, English-language journals. The search criterion was the presence of the search terms in either the title or the abstract. A study protocol was developed before particular studies were selected. The full search strategy is available from the corresponding author upon request.

The protocol was refined on a sample of five studies. Articles were included if they described a study that focused on self-expressed experiences of young children living with a parent with a mental illness or on the experiences of adult children reported retrospectively. Studies were excluded that did not report that at least 50% of the respondents were living or had lived with parents with a psychiatric disability. Consequently, all studies of children of parents suffering from addiction, a brain injury, dementia, an intellectual disability, or a somatic illness were excluded. Studies were also excluded that did not include information about (i) children reporting on abilities that they had developed while coping with their situation, or (ii) resources they reported had helped them overcome the difficulties that they had experienced in connection with their parent’s illness. Finally, studies were excluded that had evaluated an intervention for children whose parents have a mental illness.

Selection of studies

A flowchart showing the procedure by which studies were selected is shown Figure 1.
Fifty-seven studies were initially identified and selected because of their titles and abstracts. These papers were then reviewed to ascertain that children’s self-identified strengths or resources had been included. Statements on self-identified strengths or resources were found in 26 papers, including 16 articles that described the daily experiences of young children and 10 articles that reported on the experiences of adult children. The studies that were included are summarized in Tables 1 and 2. A list of studies that were excluded is available from the corresponding author on request.

Table 1: Studies of young children

<table>
<thead>
<tr>
<th>Studies (n = 16)</th>
<th>Country</th>
<th>Setting</th>
<th>No. participants</th>
<th>Age [years]</th>
<th>Parental psychiatric diagnosis</th>
<th>Recruitment method</th>
<th>Study design</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drost &amp; Schippers 2015</td>
<td>The Netherlands</td>
<td>Online support</td>
<td>1/0</td>
<td>24</td>
<td>Not specified</td>
<td>Regular visitors of the intervention was invited to give her views</td>
<td>Case study</td>
</tr>
<tr>
<td>Fraser &amp; Pakenham 2009</td>
<td>Australia</td>
<td>Community</td>
<td>44/17</td>
<td>12-18</td>
<td>Anxiety disorder: Bipolar disorder, Depression disorder, Eating disorder: Personality disorder, Psychosis: Schizophrenia</td>
<td>Through parents who were participants in a treatment study</td>
<td>Questionnaires</td>
</tr>
<tr>
<td>Fudge &amp; Mason 2004</td>
<td>Australia</td>
<td>Targeted support programs</td>
<td>8</td>
<td>13-20</td>
<td>Not specified</td>
<td>Children were recruited from support groups</td>
<td>Interviews and focus groups</td>
</tr>
<tr>
<td>Garley et al. 1997</td>
<td>Canada</td>
<td>Psychiatric outpatient facility</td>
<td>6/3</td>
<td>11-15</td>
<td>Mood disorder</td>
<td>Participants were children of patients in an outpatient facility</td>
<td>Videotaped focus groups</td>
</tr>
<tr>
<td>Griffiths et al. 2012</td>
<td>UK</td>
<td>Community</td>
<td>10/5</td>
<td>13-19</td>
<td>OCD</td>
<td>Through parents using mental health services</td>
<td>Semi-structured interviews</td>
</tr>
<tr>
<td>Maybery et al. 2005</td>
<td>Australia</td>
<td>Community</td>
<td>12, Sex not recorded</td>
<td>6-16</td>
<td>Anxiety disorder: Mood disorder, Personality disorder: Psychotic disorder</td>
<td>Through parents with a mental health diagnosis</td>
<td>Focus groups</td>
</tr>
<tr>
<td>Mearus &amp; Johnson 2000</td>
<td>Canada</td>
<td>Community</td>
<td>3/0</td>
<td>17</td>
<td>Mood disorder</td>
<td>Through parents using mental health services</td>
<td>Individual interviews</td>
</tr>
<tr>
<td>Mordoch &amp; Hall 2006</td>
<td>Canada</td>
<td>Community</td>
<td>22/14</td>
<td>6-16</td>
<td>Bipolar disorder, Depression, Schizophrenia</td>
<td>Through parents using mental health services</td>
<td>Individual interviews</td>
</tr>
<tr>
<td>Mor doch 2010 2nd analysis</td>
<td>Canada</td>
<td>Community</td>
<td>22/14</td>
<td>6-16</td>
<td>Bipolar disorder, Depression, Schizophrenia</td>
<td>Through parents using mental health services</td>
<td>Individual interviews</td>
</tr>
<tr>
<td>Östman 2006</td>
<td>Sweden</td>
<td>Psychiatric hospital</td>
<td>8/3</td>
<td>10-18</td>
<td>Affective disorder: Schizophrenia</td>
<td>Through parents admitted to a psychiatric hospital</td>
<td>Interviews</td>
</tr>
</tbody>
</table>

Table 2: Studies of adult children

<table>
<thead>
<tr>
<th>Studies (n = 9)</th>
<th>Country</th>
<th>Setting</th>
<th>No. participants</th>
<th>Age [years]</th>
<th>Parental psychiatric diagnosis</th>
<th>Recruitment method</th>
<th>Study design</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stoddart et al. 2004</td>
<td>UK</td>
<td>Community</td>
<td>26-16</td>
<td>6-17</td>
<td>Affective disorder: Borderline personality disorder, Chronic fatigue disorder, Depression disorder, Eating disorder: Psychosis</td>
<td>Via parents receiving outpatient help from a community mental health service</td>
<td>Interviews with both parents and children</td>
</tr>
<tr>
<td>Trousdale 2013</td>
<td>Norway</td>
<td>Online self-help group</td>
<td>More than 4/1</td>
<td>15-18</td>
<td>Several severe mental illnesses: e.g., bipolar disorder and psychosis</td>
<td>Through a targeted online group</td>
<td>Participant observation</td>
</tr>
<tr>
<td>Valiakalayil et al. 2004</td>
<td>Canada</td>
<td>Adult in-patient clinic</td>
<td>13/4</td>
<td>15-18</td>
<td>Schizophrenia</td>
<td>Through parents who were in-patients at the hospital</td>
<td>Questionnaires and individual interviews</td>
</tr>
<tr>
<td>Van Parys &amp; Rober 2013</td>
<td>Belgium</td>
<td>University hospital</td>
<td>14/5</td>
<td>Mean age 10</td>
<td>Depression</td>
<td>Through parents who were in-patients at the hospital</td>
<td>Family interviews</td>
</tr>
</tbody>
</table>
As indicated, only statements on the self-experienced strengths and resources of children of parents with a mental illness were selected for analysis. One of the authors (LD) identified statements on self-experienced strengths and resources, and a second author (SS) randomly checked 20 statements to confirm the accuracy of the selections. Altogether, 160 statements were identified and included in the subsequent analysis.

**Analytical procedure**

After identifying the statements, conventional content analysis was used to more closely examine the findings of the study. Conventional content analysis allows categories to emerge from the data with the goal of answering the research questions (Hsieh & Shannon, 2005). After initial coding by the first author, decisions were made about which codes would be most meaningful. In turn, three coders (LD, LvdK, and SS) independently coded the transcripts. Interrater reliability, calculated with an online kappa calculator (Randolph, 2005), was 0.82 for strengths and 0.85 for resources; the two results indicate adequate interrater reliability (Burns, 2014; Randolph, 2005). Disagreements among the coders were discussed until a consensus was reached.

**Results**

**Study characteristics**

The number of respondents in the different studies varied between three and 60. Studies with children and young people included respondents between the ages of six and 20 years; studies with adults included respondents between the ages of 18 and 77 years. Most of the studies included both males and females. However, in two of them only females were recruited. The majority of the studies used individual interviews or focus groups to examine the experiences of children whose parents had a mental illness. Other research methods included structured and open-ended questionnaires and online content analysis (Tables 1 and 2). Young children were usually recruited via mental health services that offered treatment or support for parents or interventions for the children of patients; adult children were recruited via posters, flyers and advertisements in local papers.

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**Table 2: Studies on grown-up children**

<table>
<thead>
<tr>
<th>Studies on grown-up children (n = 10)</th>
<th>Country</th>
<th>Setting</th>
<th>No. participants/ No. males</th>
<th>Age (years)</th>
<th>Parental diagnosis</th>
<th>Recruitment method</th>
<th>Study design</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baik &amp; Brown 2006</td>
<td>USA &amp; Australia</td>
<td>Community</td>
<td>5/2</td>
<td>26-50</td>
<td>Depression</td>
<td>Flyers</td>
<td>Individual interviews</td>
</tr>
<tr>
<td>Dunn 1993</td>
<td>USA</td>
<td>Community</td>
<td>9/4</td>
<td>21-41</td>
<td>Psychosis</td>
<td>Ads in newspapers, notices in newsletters, and referrals by mental health providers</td>
<td>Individual interviews</td>
</tr>
<tr>
<td>Foster 2010</td>
<td>Australia</td>
<td>Community</td>
<td>10/2</td>
<td>25-57</td>
<td>Bipolar disorder Schizo-affective disorder Schizophrenia</td>
<td>Via print and radio media</td>
<td>Interviews</td>
</tr>
<tr>
<td>Herbert et al. 2013</td>
<td>India</td>
<td>Community</td>
<td>45/27</td>
<td>18-50</td>
<td>Schizophrenia</td>
<td>Through the parents who used mental health services</td>
<td>Questionnaires</td>
</tr>
<tr>
<td>Kinnella &amp; Anderson 1996</td>
<td>USA</td>
<td>Community</td>
<td>10/5 + 10 siblings</td>
<td>27-56</td>
<td>Bipolar disorder Schizophrenia</td>
<td>Through notices in newsletters and through referrals.</td>
<td>Demographic questionnaires, Individual interviews</td>
</tr>
<tr>
<td>Knutsson-Medin et al. 2007</td>
<td>Sweden</td>
<td>Community</td>
<td>36/15</td>
<td>19-38</td>
<td>Several clinical diagnoses</td>
<td>Through participants/ parents who themselves had been participants in a study of children of psychiatric patients.</td>
<td>Questionnaires</td>
</tr>
<tr>
<td>Marsh et al. 1995</td>
<td>USA</td>
<td>Community</td>
<td>I: 60/13 32 children and 28 siblings</td>
<td>21-67</td>
<td>Several clinical diagnoses</td>
<td>Two surveys were conducted through the Siblings and Adult Children Network of the National Alliance for the Mentally II: 75/17 25 ch. and 48 siblings</td>
<td>I Questionnaires II: Open-ended questions</td>
</tr>
<tr>
<td>Mauru &amp; Stein 2010</td>
<td>USA</td>
<td>Community</td>
<td>9/3</td>
<td>18-22</td>
<td>Several clinical diagnoses</td>
<td>Not recorded</td>
<td>Individual interviews</td>
</tr>
<tr>
<td>O’Connell 2008</td>
<td>USA</td>
<td>Community</td>
<td>40/5</td>
<td>18-70</td>
<td>Bipolar disorder Schizo-affective disorder Schizophrenia</td>
<td>Through electronic, print, and verbal recruiting methods.</td>
<td>Questionnaires</td>
</tr>
<tr>
<td>Williams 1998</td>
<td>Australia</td>
<td>Private psychiatric practice</td>
<td>4/0</td>
<td>Not recorded</td>
<td>Bipolar disorder Schizophrenia</td>
<td>Through parents who were patients in the practice</td>
<td>Recorded group sessions</td>
</tr>
</tbody>
</table>

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**Data extraction**

As indicated, only statements on the self-experienced strengths and resources of children of parents with a mental illness were selected for analysis. One of the authors (LD) identified statements on self-experienced strengths and resources, and a second author (SS) randomly checked 20 statements to confirm the accuracy of the selections. Altogether, 160 statements were identified and included in the subsequent analysis.
CHAPTER 2

Statements on self-reported strengths

Through the literature search, 160 statements that met the inclusion criteria were identified; 38 (24%) of them were related to self-reported strengths, and 122 (76%) of them were related to self-reported resources. Comparable results were obtained for young and adult children.

The statements related to self-reported strengths described the children as experiencing themselves as more mature, independent, and empathic than their peers and as having acquired several abilities, such as the ability to accomplish difficult tasks and to be creative. The statements on self-reported strengths that were identified are summarized in Table 3.

<table>
<thead>
<tr>
<th>Final codes</th>
<th>Example subthemes</th>
<th>References related to young children</th>
<th>Number of statements</th>
<th>References related to adult children</th>
<th>Number of statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independence</td>
<td>Independent</td>
<td>Drost &amp; Schippers 2015</td>
<td>1</td>
<td>Foster 2010</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Self-reliant</td>
<td></td>
<td></td>
<td>Kinsella &amp; Anderson 1996</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Responsible</td>
<td></td>
<td></td>
<td>Maunu &amp; Stein 2010</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Personal stability</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disciplined</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maturity (in comparison with peers)</td>
<td>Stronger</td>
<td>Drost &amp; Schippers 2015</td>
<td>6</td>
<td>Kinsella &amp; Anderson 1996</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>More mature</td>
<td>Fraser &amp; Pakenham 2009</td>
<td></td>
<td>Maunu &amp; Stein 2010</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ability to differentiate between the person and the illness</td>
<td>Fudge &amp; Mason 2004</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Mondosh &amp; Hall 2006</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Ochman 2008</td>
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<tr>
<td></td>
<td></td>
<td>Valiakalayil et al. 2004</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to accomplish</td>
<td>Expertise in caring experience</td>
<td>Fudge &amp; Mason 2004</td>
<td>3</td>
<td>Marsh et al. 1993</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Garley et al. 1997</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trondsen 2012</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to Create</td>
<td>To be creative</td>
<td>Drost &amp; Schippers 2015</td>
<td>1</td>
<td>Kinsella &amp; Anderson 1996</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Expressing themselves through fine or performing arts</td>
<td></td>
<td></td>
<td>Marsh et al. 1993</td>
<td></td>
</tr>
<tr>
<td>Empathy/tolerance</td>
<td>Tolerance, compassion, understanding of suffering</td>
<td>Garley et al. 1997</td>
<td>5</td>
<td>Baik &amp; Bowers 2006</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Valiakalayil et al. 2004</td>
<td></td>
<td>Kinsella &amp; Anderson 1996</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Van Parys &amp; Rober 2013</td>
<td></td>
<td>Marsh et al. 1993</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Maunu &amp; Stein 2010</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Williams 1998</td>
<td></td>
</tr>
<tr>
<td>Resiliency</td>
<td>Ability to manage problematic situations, to assess the safety of disclosing, capable of managing adversity, assurance that you can live through anything</td>
<td>Meadus &amp; Johnson 2000</td>
<td>1</td>
<td>Baik &amp; Bowers 2006</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Kinsella &amp; Anderson 1996</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Marsh et al. 1993</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Maunu &amp; Stein 2010</td>
<td></td>
</tr>
<tr>
<td>Assertiveness</td>
<td>Ability to advocate on behalf of their relative with mental illness</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Kinsella &amp; Anderson 1996</td>
<td>1</td>
</tr>
<tr>
<td>Total reported strengths</td>
<td></td>
<td></td>
<td>38</td>
<td></td>
<td>23</td>
</tr>
</tbody>
</table>

References related to young children:
- Drost & Schippers 2015
- Fraser & Pakenham 2009
- Fudge & Mason 2004
- Mondosh & Hall 2006
- Ochman 2008
- Valiakalayil et al. 2004
- Fudge & Mason 2004
- Garley et al. 1997
- Trondsen 2012
- Drost & Schippers 2015
- Garley et al. 1997
- Valiakalayil et al. 2004
- Van Parys & Rober 2013
- Meadus & Johnson 2000
- Baik & Bowers 2006
- Kinsella & Anderson 1996
- Marsh et al. 1993
- Maunu & Stein 2010
- Williams 1998

References related to adult children:
- Kinsella & Anderson 1996
- Marsh et al. 1993
- Maunu & Stein 2010
- Baik & Bowers 2006
- Kinsella & Anderson 1996
- Meadus & Johnson 2000
- Marsh et al. 1993
- Maunu & Stein 2010
- Williams 1998
**Discussion**

The responses of young and adult children were quite similar. Representatives of both groups were reported to have acquired several abilities when coping with their circumstances, such as the ability to accomplish difficult tasks and to be creative. Statements such as ‘I grew up faster and am more mature’ (Fudge & Mason 2004, p. 7) and ‘I know I’m a very strong person’ (Mauu & Stein, 2010 p. 652) seem to refer to a ‘steeling effect’ (Rutter, 2012) that had changed their self-perceptions in a positive way. These findings appear in line with Rutter’s understanding of resilience, which implies that people might acquire new strengths when they find ways to successfully cope with difficulties. Rutter emphasizes the importance of mental phenomena such as ideas, attributions, and self-reflection that constitute the ‘meaning’ of experiences for individuals in response to stress and adversity.

In nearly one-third of the studies, respondents indicated that they had assumed adult caring responsibilities. Remarkably, not all children introduced the ability to care as one of their special capabilities. Maybe they took it for granted or simply felt obliged to do it. The children mentioned several specific factors when they referred to resources that helped them or could help them in learning to overcome the difficulties they had experienced while living with a parent with a mental illness. They included having support from mental health services, having social support, being provided with information, and, in a few cases, being able to get away from their home situation.

### Table 4: Reported resources

<table>
<thead>
<tr>
<th>Final codes</th>
<th>Example subthemes</th>
<th>References related to young children</th>
<th>No. statements</th>
<th>References related to adult children</th>
<th>No. statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information and explanation</td>
<td>Importance of being informed early enough about the mental illness in the family</td>
<td>Fraser &amp; Pakenham 2009</td>
<td>15</td>
<td>Baik &amp; Bowens 2006</td>
<td>7</td>
</tr>
<tr>
<td>Social support</td>
<td>Receiving comfort from pets</td>
<td>Fudge &amp; Mason 2004</td>
<td>23</td>
<td>Baik &amp; Bowens 2006</td>
<td>16</td>
</tr>
<tr>
<td>Professional support</td>
<td>Better care for parents</td>
<td>Davidson et al. 1998</td>
<td>34</td>
<td>Baik &amp; Bowens 2006</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Recognition of a child's position</td>
<td>Foster 2010</td>
<td></td>
<td>Dunn 1993</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inclusion of parent in the treatment process</td>
<td>Dunn 1993</td>
<td></td>
<td>Foster 2010</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Practical support</td>
<td>Dunn 1993</td>
<td></td>
<td>Kimura &amp; Anderson 1996</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Treatment</td>
<td>Dunn 1993</td>
<td></td>
<td>Knodges &amp; Meden et al. 2007</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dunn 1993</td>
<td></td>
<td>Marsh et al. 1993</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dunn 1993</td>
<td></td>
<td>O’Connell 2008</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Opportunities to get away</td>
<td>Outings</td>
<td></td>
<td>O’Connell 2008</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Having fun with parents, family, friends</td>
<td>Fudge &amp; Mason 2004</td>
<td>5</td>
<td>Kimura &amp; Anderson 1996</td>
</tr>
<tr>
<td>Total reported resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>77</td>
</tr>
</tbody>
</table>
It is noteworthy that nearly one-half of the respondents indicated that as part of the customary adult mental health treatment, they could have profited from having more support from mental health professionals. From the results, it appeared that children hoped for positive recognition as a family member and to be a participant in the therapeutic process of their parent, and for well-timed advice (e.g. more information about the parent’s diagnosis and what this meant for the family’s daily life) and encouragement that would be provided while they were trying to tackle the various problems caused by the parents’ symptoms.

The children, however, did not specifically seek such help themselves. A girl cited in Trondsen’s (2012) study expressed this as follows: ‘In general, I feel like I’m bothering people when I begin talking about my problems or what’s wrong. I have a sort of feeling like it’s not a good enough reason to be sad, even though other people say it is’ (p. 181). Some children expected that their parents’ counsellors would offer unprompted psychosocial support to them while they were dealing with the effects of their parent’s mental illness. This expectation is visible in the following comment: ‘I’m a very independent person. I would never ask for help, cause I assume that people should come in, that’s my assumption, they should come in and offer’ (Foster 2010 pp. 3147-8). It is important to note that, in some cases, the autonomy children have developed can make it difficult for them to ask for help.

There seems to be a large gap between the expectations of these children and the psychiatric services that are actually offered (Maybery, Goodyear, O’Hanlon, Cuff, & Reupert, 2014). Even when legislation mandates that patients be assessed to determine whether or not they have children and to provide them with necessary support, implementation of new procedures in adult mental health services proceeds with difficulty (Lauritzen, Reedtz, Van Doesum, & Martinussen, 2014). Mental health professionals are often concerned that they will be disloyal to their adult patients or insufficiently equipped to offer the care that their patients’ children need (Houlihan, Sharek, & Higgins, 2013; Korhonen, Pietilä, & Vehviläinen-Julkunen, 2010; Maybery & Reupert, 2006). Their reluctance might be eased if they could embrace a family-focussed approach to prevent problems for children and their families (Falkov, 2012; Foster et al., 2012). Foster et al. recommend that nurses identify consumers’ parental status and children on admission/intake, and check for children’s current status and well-being. They advise nurses to remain attentive to parents’ and children’s needs to maintain contact and to provide appropriate information and resources on mental illness. Goodyear et al. (2015) present similar guidelines for family-inclusive practice, such as viewing the primary client in the context of their family system; the identification of dependent children, and assessment of their strengths and vulnerabilities. Next to mental health professionals, general practitioners are in a good position to support children as next of kin. Gullbrå et al. (2014) collected many examples of how these professionals might support children, including identifying children at risk, counselling the parents, and taking part in collaboration with other healthcare professionals and social workers.

Children do not expect highly-specialized services. They would merely like for their parent’s caregiver to introduce himself or herself (Bilsborough, 2004) and enquire about their well-being as the child of a parent with mental illness (Foster, 2010). Mental health workers need to take time to help children understand what is happening. They might explicitly appreciate their roles within the family and assist children in finding ways to further improve the coping skills that they have already developed (Bilsborough, 2004). Brochures to guide such a conversation can be downloaded from the Internet (e.g. www.copmi.net.au).

The core components across existing preventive programs for the target group are psycho-education and social support (Reupert et al., 2012). However, the impact of the given information might be different for each child (Grove, Reupert, & Maybery, 2015a) and not all children are comfortable sharing confidential information in a special group (Grove, Reupert, & Maybery, 2015b). Moreover, preventive interventions are able to reach only a proportion of the children and their families (Cooklin, 2013). A close and continuous collaboration between research and practice is essential to find out how knowledge and social support can be offered in a way that ‘might result in power’ (Grove et al., 2015a, p. 2).

The outcomes of the present study suggest that existing preventive interventions might be enhanced by including modules based on positive psychology, which focuses on what is right about people (Kobau et al., 2011). Current views about how people learn suggest that educating health-care professionals about how to cope with their patients’ symptoms should be constructive, self-directed, and contextual (Dolmans, De Grave, Wollhagen, & Van Der Vleuten, 2005). These principles might also be beneficial for this target group to learn in order to be able to better tackle the difficulties caused by their parents’ symptomatic behaviour.

Another opportunity for mental health services to reach these children might be through the use of electronic devices, such as a DVD that provides psycho-education (Grove, Reupert
for reaching out to these young people and promoting their contact with professional services.

Limitations

This study extends previous reviews of the literature through its unique focus on the self-reported ability of children of parents with a mental illness to acquire special strengths. Nevertheless, several limitations must be acknowledged. First, most of the studies reviewed were not specifically designed to identify strengths or resources as they are defined in this paper. Instead, they focused more generally on children’s experiences in living with a parent who had a mental illness. Additionally, the methods of data collection varied widely across the studies, and most studies did not include control groups and did not indicate the proportion of children who reported strengths or resources. Furthermore, we cannot be absolutely sure that the parents had all been formally diagnosed or had received treatment. Finally, the self-expressed experiences of some respondents cannot be simply generalized to the entire population of children who live with a parent with a mental illness.

Conclusions

Despite its limitations, the present study did identify some children who reportedly acquired strengths while living with a parent with a mental illness. Moreover, a number of them expressed well-defined ideas about how the support they received helped them learn to overcome difficulties at home and improve their ability to cope with them. The study has clear implications for further research and how clinical practice might be improved.

The current emphasis on the negative effects of having a parent with a mental illness could be changed by giving more attention to the ‘steeling process’ and by identifying optimal ways of supporting it. Research is needed to identify the factors that promote children’s successful coping, and for this, reliable and valid measures of resilience are required (Windle, Bennett, & Noyes, 2011).

Electronic and online interventions could be valuable for coaching children to acquire better coping skills. They provide easy access and the option of remaining anonymous. Research, however, is necessary to identify the particular strategies that are optimal