Survivalkid(s): Online support for adolescents and young adults with a mentally ill family member

Drost, L.M.

Citation for published version (APA):
Drost, L. M. (2017). Survivalkid(s): Online support for adolescents and young adults with a mentally ill family member.

General rights
It is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), other than for strictly personal, individual use, unless the work is under an open content license (like Creative Commons).

Disclaimer/Complaints regulations
If you believe that digital publication of certain material infringes any of your rights or (privacy) interests, please let the Library know, stating your reasons. In case of a legitimate complaint, the Library will make the material inaccessible and/or remove it from the website. Please Ask the Library: https://uba.uva.nl/en/contact, or a letter to: Library of the University of Amsterdam, Secretariat, Singel 425, 1012 WP Amsterdam, The Netherlands. You will be contacted as soon as possible.
Online support for children of parents suffering from mental illness: A case study

Abstract

From epidemiologic research, we know that children of parents with a mental illness are at elevated risk of developing a serious mental disorder. Aside from studies based on risk and resilience, there has been little research on the children’s own perceptions.

The aim of this study was to expand our understanding of key variables influencing the seeking of support by children of parents with mental illness and to explore whether a targeted website could help them improve their ability to cope with their circumstances and to find professional help.

This case study illustrates one visitor’s use of a website that was specifically designed for young people living with a mentally ill family member. The visitor was a young adult female whose two parents suffered from mental illness. She participated for 3 years in an intervention delivered through the website. Several things helped to inform us about her perspective on living with parents suffering from mental illness, her use of the website and the benefits she derived from using the website. These included (i) her story as she told it in the exit interview, (ii) her messages to her peers and counsellors, (iii) her user data and (iv) the content of her chat conversations with her peers.

Introduction

One in four people in the world will be affected by mental or neurological disorders at some point in their lives. Treatments are available, but nearly two-thirds of people who are known to have a mental disorder never seek help from a health professional (World Health Organization, 2001). These statistics are comparable to those reported in several western countries (for example see: De Graaf, Ten Have, & Van Dorsselaer, 2010; Maybery, Reupert, Patrick, Goodyear, & Crase, 2009; Nicholson, Biebel, Williams, & Katz-Leavy, 2004; Östman & Hansson, 2002).

Data on the numbers of children living with parental mental illness are not systematically recorded, but Nicholson et al. (2004) pointed out that women and men who meet the criteria for a psychiatric disorder are at least as likely to be parents as those who do not.
According to population estimates, up to one in five young people in Australia live in families with a parent who has a mental illness (Maybery et al., 2009; Reupert, Maybery, & Kowalenko, 2012). Goossens and van der Zanden (2012) reported that at least 405,000 Dutch children under 18 live with a parent who suffers from depression, panic disorder, attention deficit disorder, or alcohol or drug dependence (other diagnoses were not included) on an annual basis. This amounts to approximately 15% of the Dutch population. An earlier estimate, taking into account all parental psychiatric diagnoses and offspring up to 22 years old, estimated that 1.6 million Dutch children are living with a parent who has some kind of psychosocial problem (Bool, Smit, & Bohlmeijer, 2007).

Many epidemiological studies have shown that there is a strong association between a parent’s mental disturbance and difficulties in the development of the offspring (Beardslee, Gladstone, & O’Connor, 2011; Bijl, Cuijpers, & Smit, 2002; Dean et al., 2010; Lieb, Isensee, Höfler, Pfister, & Wittchen, 2002; Ross & Compagnon, 2001). During the past 15 years, prevention programmes targeting the children of parents with a mental illness have been developed in many Western countries (Beardslee, Gladstone, Wright, & Cooper, 2003; Beardslee et al., 2002; Göpfert, Webster, & Seeman, 2004; Hetherington & Baistow, 2001). However, adolescents may not be willing to accept professional help (Gould et al., 2004; Rickwood, Deane, Wilson, & Ciarrochi, 2005; Shaw, 2001; Zwaanswijk, Verhaak, Bensing, Ende, & Verhulst, 2003). Maybery & Reupert (2006) found that adult mental health workers who could bring preventive interventions for the children to the attention of their patients often lacked insight, knowledge, or opportunities to do so.

Researchers seem to overlook the children’s perspective as well. Maybery, Ling, Szakacs, and Reupert (2005) demonstrated that children have different views from parents and practitioners relating to what helps, but only a few studies have examined the children’s own perceptions of what troubled them most or what enabled them to function effectively in difficult situations (Gladstone, Boydell, Seeman, & McKeever, 2011).

The Internet offers the opportunity to provide health support anonymously (Tate & Zabinski, 2004), and most young people in Western societies are familiar with this medium of exchange (Duimel & de Haan, 2007; Lenhart, Rainie, & Lewis, 2005). Young women in particular are known to use the Internet to find information about healthcare (Lenhart et al., 2005) and to communicate with their friends about psychosocial problems (Santor, Poulin, Leblanc, & Kusumakar, 2007; Valkenburg & Peter, 2007). Learning how others deal with similar situations can help reduce feelings of isolation (Lowe, Powell, Griffiths, Thorogood, & Louise, 2009) and being able to assist others can reap benefits for the helper, such as increased self-esteem (Weinstein & Ryan, 2010).

An interactive, password protected, online intervention called Survivalkid (www.Survivalkid.nl) was developed and launched in June 2006 in order to deliver support to young people (aged 12 to 24 years of age) with a mentally ill family member. Examination of the website statistics revealed that with this intervention a larger proportion of the target group was reached: four times the number of individuals who attended face-to-face preventive services at the local mental health centre during the previous 10 years as concluded by Drost, Sytema, and Schippers (2011). Visitors expressed their appreciation for the opportunity to find information and to receive mutual and professional support anonymously. They judged the most helpful features of the website to be, in order, the chat room, the private chat sessions, and the experiences that peers reported (Drost, Cuijpers, & Schippers, 2011). The messages that were exchanged give an indication of the attempts of children from a family with mental illness to cope with their life circumstances and the violence and social isolation that they sometimes experience.

The aim of the present study was to depict one user’s views on her situation and on the online preventive support that was offered to her. It was thought that doing so would (i) expand our understanding of the key variables that influence these children’s attempts to seek support and (ii) determine whether a targeted website could help to improve the ability of children with a parent suffering from mental illness to cope with their circumstances and find professional help. To our knowledge, this is the first study that analyses a visitor’s online behaviour and anonymous written messages in the context of a website designed especially to support this target group.

**Background**

**Experience of Parental Mental Illness**

Despite the strong evidence for a positive relationship between parental mental illness and emotional problems in the children, it is still unclear what factors place a child at risk and the mechanism through which the risk occurs. Models of transgenerational transmission of psychopathology (Goodman & Gotlib, 1999; Hosman, van Doesum, & van Santvoort, 2009) describe a wide range of risk and protective factors which could play a role in the development of psychopathology, including factors attributed to the child (i.e. ...
inherited vulnerability, acquired cognitive and social coping skills), the parents (i.e. problem behaviour, parenting competence), the family context (i.e. marital discord, poverty, competence of the healthy parent), and the support available from the social network and professional help. Hosman et al. (2009) use the concepts ‘equifinality’ (a single disorder can result from many causes) and ‘multifinality’ (a particular risk factor can result in many outcomes; see also Cicchetti & Rogosch, 1996) to explain why a single cause-and-effect relationship cannot be expected. Many studies related to this topic adopt a developmental approach and conclude that achievement of age appropriate developmental tasks is a sign of resilience (Beardslee et al., 2003; Garber & Little, 1999; Manjula & Raguram, 2009; Pargas, Brennan, Hammen, & LeBrocque, 2010).

Growing up in a home with distressed parents has several disadvantages (Brockington et al., 2011). Many children become involved in providing care for their ill parents (Cooklin, 2009), a situation that could adversely affect identity development and interpersonal relationships (Dearden & Becker, 2004; Earley & Cushway, 2002; Thomas et al., 2003). A parent’s psychiatric illness might temporarily or permanently impair his or her parenting and communication skills, resulting in neglect and domestic violence (Dube et al., 2001). Children who witness or are the victims of domestic violence have been reported to have multiple health problems (Kessler et al., 2010). Appleyard, Egeland, Van Dulmen, and Stroufe (2005) make it clear that the more risks are present, the poorer the child’s outcome will be.

**The intervention**

The intervention, which is delivered privately through the Survivalkid website, is intended to provide preventative support for children with a mentally ill family member and, if they need it, to help them find appropriate treatment with, for instance, a school counsellor, social worker, or the community mental health service (Drost, Cuijpers, & Schippers, 2011).

The intervention is based on modules previously used in preventive face-to-face groups for adolescent and young adult children with a mentally ill family member. Like most of these interventions, this one aims to reduce identified risk factors that have been identified (Reupert et al., 2012), such as children’s lack of understanding of their parent’s behaviour, self blame, and loneliness (Hosman et al., 2009). The intervention includes psycho-education and instruction in coping skills (presented as short blocks of text, real-life stories, interactive games, and quizzes), opportunities for peer support via posts on the message board and in moderated chat sessions, and opportunities for users to contact a professional prevention counsellor (‘survival coach’) via a private chat by appointment, or by correspondence via the secure email service. All of the ‘survival coaches’ are trained in counselling for young people. Their job is to moderate the chat sessions, listen, clarify and give advice. The website can be accessed at all times and participation is anonymous. Inappropriate posts can be deleted and visitors who do not comply with the rules can be excluded from the system by the administrator. For evaluation purposes, visitors are asked to report their age, gender and level of education.

**Case study research**

This study was intended to (i) identify characteristics that were specific to a child with mentally ill parents using the website and (ii) provide an in-depth analysis of his or her personal experiences. Case study research was therefore the most suitable strategy to employ (Dale, 1995). Pelham and Blanton (2007) characterize case study research as a “systematic analysis of the experiences of a particular person or group of people” (pp. 398). A major disadvantage of case studies is that they are difficult to generalize. However, case studies can provide details that are easily overlooked or assumed in large-sample studies (Jensen & Rodgers, 2001). Case studies often serve as a starting point for formulating new hypotheses that can then be tested empirically.

A way to improve the interpretative potential of a case study is to use triangulation strategies. This term refers to the combination of two or more data sources, investigators, theoretical perspectives, or methods within the same study. This serves to enhance the validity of the results (Farmer, Robinson, Elliott, & Eyles, 2006) and to increase one’s ability to interpret the results (Thurmond, 2001).

In the present study, two types of triangulation were employed. The first was methodological. Results were compared from three methods of data collection (exit interview, quantitative and qualitative data on website use, analysis of chat content). The second type of triangulation was to use multiple investigators. Three different professionals performed the focused coding of the chat contributions, with the first author serving as auditor.

**Methods**

In the case presented here, we have named the visitor Ann. She was the first user...
of Survivalkid to reach the 24th birthday, and she discontinued her visits in 2009. A year later, she visited Survivalkid again to formally say Goodbye. By then, we had decided to ask departing members some questions during an exit interview, which was conducted on secure pages at the Survivalkid website. Accordingly, we asked Ann to participate in the interview.

The structured email interview was set up according to guidelines that Hunt and McHale (2007) suggested, and it covers the key factors in Hosman et al.’s (2009) developmental model, such as self-esteem, family context, and the availability of sources of support, particularly support from the Survivalkid website. At weekly intervals, three predetermined questions were asked, namely (i) Can you say something about yourself? (ii) Can you tell something about your family situation? (iii) How did you find Survivalkid; was it useful to you? Prompts were used to enable the interviewer to obtain more detailed answers. The first author of the present study completed all of the interviews; at that time she was not familiar with the information that visitors had posted on the website. When the interviews were completed, the participants were provided with the results and asked for their consent. In her correspondence, Ann made it clear that to improve our understanding of children living with a mentally ill parent, she would be happy to share all the confidential information that she had contributed during her visits to the website. We were impressed by her ability to put her thoughts into words, so we asked for and received her permission to analyse her user data, notes on the message board, chat conversations with other visitors, and email messages that she had exchanged with the counsellor. We adopted an ‘ethics as process’ approach (Ramcharan & Cutcliffe, 2001) by making it clear that at any point in the process Ann could withdraw for any reason. The institutional review board granted ethical approval for the study to be conducted. Ann could withdraw for any reason. The institutional review board granted ethical approval for the study to be conducted. Ann sent her written consent for the report that we process Ann could withdraw for any reason. The institutional review board granted ethical approval for the study to be conducted. Ann would be happy to share all the confidential information that she had contributed during her visits to the website. We were impressed by her ability to put her thoughts into words, so we asked for and received her permission to analyse her user data, notes on the message board, chat conversations with other visitors, and email messages that she had exchanged with the counsellor. We adopted an ‘ethics as process’ approach (Ramcharan & Cutcliffe, 2001) by making it clear that at any point in the process Ann could withdraw for any reason. The institutional review board granted ethical approval for the study to be conducted. Ann sent her written consent for the report that we

We first attempted to become familiar with Ann’s personal experiences by gathering relevant facts from the exit interview. All available user data were then collected in order to get an impression of when and how she used the website. Posts on the message board, emails to a counsellor, and chat participation were studied to find out when and how she used the interactive possibilities. The comments that Ann made in the chat room were given most spontaneously; a counsellor neither prompted them nor commented on them. To gain more insight in what she wished to share with peers who were in comparable circumstances, we analysed her interactions in the chat room by following Charmaz’ (2006) coding instructions. During the first phase of the coding-process (‘initial coding’), the first author read and reread the text as a whole, dividing it into meaningful units and adhering closely to the data while she coded them. Next, the most significant codes were used to synthesize and explain larger segments of the written material (‘focused coding’). The first author along with three other professionals (two psychologists and a social worker) each independently conducted this phase of the research. The categories and subcategories that were formed in this manner were grouped together into meaningful other categories by the team of three professionals. They then coded the transcripts with the first author serving as auditor.

Results

The interview

Asked to describe herself, Ann seemed to find it difficult to answer (‘That’s a question I’ve been asking myself, who am I and what do I want?’). She then told us that she lived on her own now, that she had ‘a nice and rewarding job’ as a caretaker for people with dementia, made time for her hobbies and travelling (‘to observe and discover how people live’), and did pleasant things with friends (‘We get along very well, there is a lot of understanding, no quarrels’). Only casually she mentioned that she still suffered from things that happened earlier in her life (‘I am satisfied with my life, really got it made’… ‘Of course, I have my ups and downs’…’I am terribly troubled by re-experiences’).

During the time that Anne made her visits to the website, she apparently lived with her parents and two siblings. According to Ann, both parents had been diagnosed with mental illness, but refused any treatment (‘My parents are convinced that there is nothing wrong with them!’) and had forbidden their children to talk about anything that happened in their home situation (‘They threatened us with all kinds of things, that’s why we kept quiet; we weren’t allowed to say anything’). Reportedly there was ‘always a battle, a lot of aggression’. Hardest to cope with, according to Ann, were her mother’s unpredictable tempers. Ann and her older brother tried to protect their younger sibling from their mother’s rage by taking the responsibility for any mistakes that were made (‘We were always taking the blame, the youngest has been spared all that’). Ann emphasized that there had been no structured help for the family, not even after the mother’s several suicide attempts (‘If she had help, she pretended everything was OK’). In addition to her job in a nursing home, Ann felt responsible for the family’s housekeeping (‘Because my mother didn’t do things as she was in bed, or had disappeared from the face of the earth, I bit by bit took over all the chores at home’).
Ann reported that she had heard about the website from her therapist. Directly after registration, she had started to use it intensively (‘You could find me on the site every day’). Later on, her visits became less (‘That’s because I have been busy what with therapy and other things.’).

Especially she had appreciated the opportunities for contact with peers (‘It ’s been nice to recognise other people’s stories, that way I felt less alone’), and with a survival coach (‘…my counsellor, who has helped me so much, just by listening to me and by responding’). According to Ann, the best thing about the site was visiting it anonymously (‘You know for sure that others don’t know you’). She reported to have ‘a great many good experiences with the site, no bad ones’.

**Frequency of visits**


During the first year Ann visited the website a mean of 38 times per month. Then the frequency of her visits declined. She did not visit in July 2007, but did so again after the school holidays. Ann then remained a regular user until February 2008, when her visits became occasional, but with increased frequency in August/September 2008, January/February 2009, and June 2009. Her visits terminated in the summer of 2009. In February/March 2010 she contacted the website again to say Goodbye, and later when she was interviewed.

**Use of interactive functions**

Message board. Ann used the interactive functions that are available at the Survivalkid website in various ways. Her remarks on the message board were chiefly meant to encourage others; for example, she recited song texts or gave her opinion about a particular statement found on the website. She exchanged one thread of messages with a younger girl who had sent in her life’s story as a contribution to the website. This story, Ann acknowledged, very much resembled her own. She urged the girl to tell her story to a trustworthy person during face-to-face contact.

**Email messages**

Shortly after registration, she sent an email message to one of the counsellors (‘My therapist wants me to share my thoughts with other people. What should I to tell?’). She made it clear that she never talked about her circumstances, but that there was one colleague who had an inkling of her situation: her team leader at work. According to Ann, this person never asked questions, but could see through her defences and offered her a lot of practical support. Reportedly, this team leader had urged her to secretly see a therapist, but Ann had been unable to disclose her difficulties. The therapist then, had introduced Ann to the Survivalkid website.

This first message led to 12 email exchanges with a staff member in which she alternated between talking about ‘this and that’ and about life’s problems. Her writing resembled keeping a diary, for example, she described and re-evaluated her home situation. Immediately after her above mentioned posting for the younger girl, Ann reflected on her own words, acknowledging that she herself had not been able to talk about her troubles for a long time.

The counsellor provided her with information and feedback from a psychological perspective (e.g. ‘Most people need to be loved’; ‘A person cannot always be a carer; he or she needs to be cared for as well’).

Her texts were marked by the empathy she showed for her counsellors (e.g. ‘This is not an easy question, I can imagine’). She often apologised (for being stupid, late, etc.), and was noticeably relieved when a staff member would confirm the validity of a remark she had made or question she had asked (e.g. ‘I am glad that you agree’).

Ann appeared to be in poor health. In March 2007 she sent a new email message to say that she had contracted a spontaneous pneumothorax for which she had been hospitalized. She confessed that she was very disappointed because her mother did not visit her at all while she was ill. She kept the counsellor informed on her situation: when the team leader had taken her to her own home, suggesting that after she had recovered, she could find a place for herself, Ann’s mother had reacted furiously. Ann reported feeling ashamed that she had caused her hostess so much trouble, and therefore had returned home as soon as she was able. In addition, she wrote that she had stopped seeing the therapist. In the next messages, the counsellor tried to encourage her, and to persuade her to seek professional help again.

In January 2008, in her last email correspondence with a survival coach, Ann revealed that she had no hope anymore that her mother would recover. In the spring of 2010 she contact-
ed the website again to say that she had left home for good and finally had sought and obtained proper treatment.

**Chat contributions**

One month after she became a member, Ann started visiting the chatroom. For a year, she participated in 24 thematic chat sessions that lasted 90 minutes each. She read other visitors’ comments and contributed to conversations, disclosing more and more about her situation and her own thoughts. She would often leave a session early (explaining that she had to start cooking). Like most of the participants, she greeted the other people attending when she entered the chat room and said goodbye when leaving, thus conducting herself as a responsible member of a community.

**Themes arising from the chat sessions**

Five themes emerged from the analysis of Ann’s chat sessions: life at home, being with other people, awareness of not leading a normal life, resigning herself to her circumstances, finding a way out. The themes are summarized in Table 1.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Content of chat contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life at home</td>
<td>Unpredictability. Trying to avert aggression. Trying to get control. Trying to be perfect. Guilt. Mother stages the play.</td>
</tr>
<tr>
<td>Being with other people</td>
<td>They can trust me. I will help them. I do not wish to bother anyone.</td>
</tr>
<tr>
<td>The awareness of not leading a normal life</td>
<td>I feel different. I do not dare to think for myself. Still, I have got talents. I suppose something must be done.</td>
</tr>
<tr>
<td>Resignation</td>
<td>Nothing can change my mother’s behaviour.</td>
</tr>
<tr>
<td>Finding a way out</td>
<td>Careful acceptance of help</td>
</tr>
</tbody>
</table>

**Life at home**

Once Ann began talking about herself in the chat room, her home life became a major subject of the sessions. She characterized it as being unreliable. Repeatedly, Ann made it clear how hard it was to predict when and why her mother would be nice or would become cross. She described how she and her brothers ‘were always on the alert’, and how they did not dare to question their mother’s actions for fear of making things worse. She explained that her mother could not function as a parent, so that she herself had assumed adult responsibilities, such as caring for the youngest sibling and taking care of all of the household chores. In case she did not perform these tasks perfectly, she reported how she was made to feel guilty and anxious. ‘I am terrified of my mother when she gets angry’. She made it clear, however, that she would prefer to suffer herself than to know that other people were suffering. She stated, ‘I am the one who knows how to cope’. She explained that her guilty feelings proved to her that she was to blame; there would be no point in disagreeing with her mother’s assessment of the situation. Regarding feeling guilty, she later commented that it was difficult for her to keep her own point of view instead of looking at events from her mother’s perspective. She reported to recognize, nevertheless, that her mother’s view resulted from the illness and to be determined to understand this, even though her mother did not.

**Being with other people**

Ann told her peers that when she was away from her family, she perceived her home life to be normal and she would manage not to think about her problems at home. She called herself ‘a perfectionist’ and explained that she had to be one, because she wanted to avoid having unforeseen disagreements with other people. She stated that she did not want to bother anyone by talking about her own difficulties. Consequently, she reported that no one knew about her situation (‘but playing the happy girl takes lots of energy’). She disclosed that she made an effort to be a trustworthy friend, whatever the circumstances. An example is when she learned about the troubles of a fellow child of mentally ill parents (‘Things can be difficult when you read that someone has a very difficult time and you can’t do much about it’).

**An awareness of not leading a normal life**

Ann let her mates in the chat sessions know that she felt grown-up in comparison to her friends whose parents were healthy. Yet, often she became silent or left the chat room...
when the other people in the chat sessions suggested that she should leave home. She reported that such remarks made her feel uneasy (e.g., ‘It would mean letting my family down’), and that she felt lonely afterwards. She said that, with the purpose of seeking positive energy, she resorted to painting, sometimes even at night. She admitted that she did have talent (‘I do not think much of it, but once one of my paintings was exhibited in the museum’). She could, nevertheless, not think of leading her own life, because ‘there is a difference between what I should do and what I can decide to do’.

**Resignation**

More and more, Ann reflected on the thought that as long as her mother would not acknowledge that she was mentally ill, nothing could be done (‘Nothing can change my mother’s behaviour’). Ann indicated that she thought the reality of the situation was awful; nevertheless, it was inescapable. She reported to feel defeated and thought that she would have to give up fighting.

**Finding a way out**

Eventually, Ann revealed that she had no energy left to continue playing her role as ‘keeper of the home’ and that ‘something had to be done’. Using her own situation as an example, she explained to her peers that, when in trouble, seeking assistance was the right thing to do. Choosing a helper was important, she added. To illustrate this, she explained that her father, her older brother, nor her therapist had been able to support her, because none of these people really seemed to understand her situation, but that her colleague and team leader had been a great help. Being part of the Survivalkid online community had helped her as well; she reported that it gave her the opportunity to reflect on her situation and to realise what was really going on (‘Always someone who listens, always response’).

**Discussion**

The present case report highlights the complexity that can be associated with living with parents who are mentally ill. The following discussion considers Ann’s use of the website and the most prominent themes from the analysis of her chat sessions and places them in the context of related studies in the literature.

Ann’s mother could not fulfil her parental role and Ann was forced to care for the family. This included meeting the needs of her siblings and dealing with her fear of her mother’s tantrums. Under the pressure of her mother’s unpredictability, Ann grew very empathic, acquiring the ability to view circumstances from her mother’s perspective without thinking about her own opinion. This gave her a sense of control. However, apparently being afraid of her parents’ reactions, she dared not assume an adult role and start making her own decisions.

It looks as if Ann lived in two separate worlds. One involved struggling with a hectic home situation and the other was that of a young adult girl mixing with friends and colleagues. In the latter role, she seemed not to have the opportunity to freely exchange thoughts with others, for she always had to be careful not to make the details of her home situation known. Instead, her role was that of an empathic listener and helper, and this allowed her to avoid expressing the differences of opinion that she was afraid of. She reported that even when she saw her therapist, she could not fully disclose what bothered her. It came out to be too difficult for her to give up her defences.

Ann was 21 years old when she got introduced to the website. It seemed to fulfil a need and she started using it extensively. Taking advantage of the opportunity to anonymously associate with peers and a counsellor, she spent the next 3 years gradually writing down the details of her situation. This appeared to help her to reflect on her situation and eventually to give up the idea that she could influence her parents in becoming like other parents. Only when she acquired this insight, did she consider to be able to leave home and begin to develop a life of her own. She was then 24 years of age.

At the time of her site visits, Ann was an emerging adult (Arnett, 2000). She had to accomplish the developmental tasks of (i) seeing herself as a competent person with a future of her own choosing, and (ii) forming meaningful relationships with her peers (Roisman, Masten, Coatsworth, & Tellegen, 2004; Seiffge-Krenke, 2009). Ann, however, as a child of parents with a mental illness had to overcome factors that placed her at risk for having her healthy development thwarted, such as (i) having to cope with a parent who did not want to discuss her inappropriate behaviour, (ii) having to keep her feelings of anxiety, anger, and guilt concealed, and (iii) having to assume an adult role of care-giver that was inappropriate for someone her age (Royal College of Psychiatrists, 2005).

At first, Ann seemed to be resilient in the sense that despite adverse circumstances, she had successfully adapted (Masten, Best, & Garmezy, 1990). That is, in addition to having finished her education and finding a job, she was able to look after her family.
In the interview, Ann let it be known that she was all right and was having a good time with her peers, adding that she had her ‘ups and downs’. Various authors (Fjone, Ytterhus, & Almvik, 2009; Riebschleger, 2004; Thomas et al., 2003) have made it clear that, in order to avoid further stigmatization and chaos in their lives, it is essential for young people living with a parent suffering from a mental illness to be viewed by other people as being well and functioning normally. Cooklin (2009) argued that many children of parents with a mental illness actively avoid ‘placing themselves in a similar category to their ill parent’ [p.18]. Although she had already disclosed her life’s difficulties on the website, Ann concealed them in the interview, might reflect an attitude she had been building up for years.

Ann had not been able to profit from the preventive, face-to-face support that is offered through the Dutch national programme. Clinicians are supposed to inform their patients who are parents about the types of support offered to their children, but Ann’s parents were not in treatment; additionally, because reportedly they did not want to think of themselves as ill, it was unlikely that they would have allowed her to participate. Ann revealed that the family’s general practitioner did not recognize her particular situation. His treatment focused only on the patient and not on her children. Karp (2001) describes not being noticed by their family member’s therapist as a common complaint among care takers.

Because of the parents’ decision not to reveal to outsiders any of the family’s malfunctioning, the only person in her family whom Ann could share her thoughts with was her older brother. Reportedly, he and Ann joined together in an effort to protect their younger sibling from their mother’s aggression. According to Gass, Jenkins, and Dunn (2007), positive sibling relationships can be an important source of support for children who experience stressful events. Bryant (1992), however, states that sibling caretaking cannot be a substitute for parental caretaking, because it lacks the richness and complexity of adult caretaking in terms of the coping strategies provided. Brothers and sisters can differ widely in their coping strategies, consistent with the gender divide that Eschenbeck, Kohlmann, and Lohaus (2007) identified when they found that girls were higher in social support-seeking and problem-solving, whereas boys were higher in avoidant coping. Hoefnagels, Meesters, and Simenon (2007) reported that perceived lack of social support appeared to directly affect the level of self-reported psychopathology among adolescents, regardless of the level of stress that they actually experienced.

Trying to live up to her parents’ expectations and also to protect her younger sibling, Ann took responsibility for the housekeeping. In contrast to Östman’s (2008) findings, she did not seem to have obtained more self-esteem by doing this. This could be related to (i) the fact that she got no recognition for her caretaking (Aldridge, 2006), and (ii) her inclination to take the perspective of any other person she happened to meet, which undoubtedly was inspired by her understandable need to avert any unpredicted aggression. Following 120 young women in their transition from high school to military service, Mayseless and Scharf (2009) found that the young women who reported higher levels of separation anxiety and lower levels of conflictual independence came mainly from families that could be characterized as having inadequate boundaries. These women were preoccupied with conflicts with their parents, but at the same time they were unable to free themselves from their families because of anxiety and a fear of separation. Moral obligation has been documented as a primary theme in families with members who are mentally ill (Karp, 2001). The fear of being disloyal to the parent, especially when this might lead to serious consequences, seems to hinder adolescent children and young adults from exercising their own free will (Abraham & Stein, 2010).

Ann started visiting the Survivalkid website by studying the informational pages on psychiatric illnesses and psychoeducation. Thereafter, she quickly became a participant in the chat sessions. A number of the themes from the chat analysis are consistent with current understanding of children growing up with mentally ill parents, such as experiencing fear and loneliness, blaming oneself, and taking responsibility for the family (Royal College of Psychiatrists, 2005). The second half of Ann’s story includes the report of her personal experiences, which, according to Scherer, Melloh, Buyck, Anderson, and Foster (1996), are important factors that determine a child’s adjustment. Anonymously chatting with peers or communicating with a counsellor while not under her mother’s control, Ann seemed to find empathy and acceptance of her situation. However, sometimes her peers offered advice that she apparently did not want to hear. Since virtual social networks are characteristically easy to enter and leave (Andrews, 2002), she could then simply go away and return to the following chat session without losing face.

At her own pace, she learned to put into words her true circumstances. She was even able to offer advice to others in the same position, which helped her realise that her own way of coping might be to no avail. Her writing in the email messages resembled keeping a diary, which can be beneficial in itself (Pennebaker, 1997). These outcomes support Crutzen and de Noot’s (2011) view that healthcare organisations’ use of online contact might be an appropriate way to reach adolescents by offering them a trustworthy introduction to more formal services.
The Survivalkid website is intended to be an online source of preventative support which is always available for a specific target group. If needed, it can also serve as a trustworthy introduction to more formal services for members of this group. Survival coaches give advice rather than provide therapy. The site is accessible for all (Dutch speaking) children with a mentally ill family member.

If, for example, in a chat session or to a counsellor, participants disclose a problem, they will be encouraged to seek further help. It is noteworthy, however, that disclosing a problem might take considerable time. For instance, even though she had urged a fellow site visitor to seek support, it took Ann a long time to do so herself.

We are aware of the limitations on conclusions that can be drawn from a case study. For instance, Ann’s unique experiences may not reflect those of other children with mentally ill parents. Others might live in less chaotic circumstances or might have more resources for support, such as a healthy parent or adequate treatment. Additionally, Ann might have been handling her problems in a very special, but atypical way. Nevertheless, it became quite clear that Ann, an apparently resilient girl living with a mentally ill parent, might need far more support than she was seeking herself and that she experienced the anonymity and the safety of the accessible online support as beneficial. Although this study is based on the experiences of one particular person, the observations made might lead to further insight into the unique situation of children living with a mentally ill parent. In future, additional analyses should be undertaken to determine how online communication between young people and prevention professionals might influence consultation processes and alter healthcare outcomes (Harvey et al., 2008).

Conclusions

Albeit tentative, the data regarding Ann’s website visits offer insight on issues regarding children with mentally ill parents. Even if many of them adjust well (Gladstone et al., 2006), having a mentally ill parent is strongly associated with difficulties in their children. One implication of these outcomes is that clinicians should be attentive to the risk that apparent resilience can be misleading, particularly if there are reasons why children might want to hide their difficulties. It may take too long for such a child to feel safe enough to dare disclose any problems. Another implication is that if parents with a mental illness remain unseen by healthcare providers, their children may be unable to profit from the preventive face-to-face interventions that have been developed. Online support that is specifically designed for this target group and is anonymously accessible at all hours has distinct advantages. It makes it possible for site visitors to emerge from their hiding and to find information and use support at their own pace. In short, it can be highly empowering.