

WHAT IS THE LIVED EXPERIENCE OF
RESILIENT ADOLESCENTS OF MENTALLY ILL PARENTS

by

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Abstract

The experience of resilient youth living with mentally ill parents is not addressed in the literature. Despite a decade of studies on resiliency, no standardized definition of resilience exists. Hence, one was created, based on research findings in the literature. An open-ended, semi-structured interview format was used to interview five women and one man raised in a home with a mentally ill parent. The experience was found as one of chaos, isolation and pain. The candidates underwent much soul searching as they developed from young to older teenagers. Support of an adult outside the home was cited as significant to their effective coping. In addition, involvement in extracurricular activities, sports and hobbies provided escape from the problems and unpredictable events at home. Acceptance of their parents' illness was associated with maturity. That is during their early teen years the youth experienced anger and frustration at their parents' inability to meet their needs. Nevertheless, while they still experienced pain due to their parents' erratic behavior, in their late teens the candidates developed empathy and understanding for their ill parents. All of the candidates cited understanding of their parents illness as key to their own healing. Unfortunately, schools were not viewed as sources of support for youth nor were mental health professionals. Candidate recommendations of how schools and professionals could support youth of parents with a mental illness are mentioned. Since no studies have attempted to address the lived experience of resilient adolescents of parents with a mental illness this study does. It is hoped the findings can enhance the concept of resiliency and provide suggestions for advancing assistance for youth of mentally ill parents.

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CHAPTER 1

INTRODUCTION

OVERVIEW

This chapter introduces the research problem and explains the rationale for the study and statement of the problem. A definition of resilience is provided. Furthermore, the delimitations and limitations of the study are discussed.

INTRODUCTION TO THE PROBLEM

Growing up in a home with a mentally ill member is synonymous with perpetual loss (Smokowski et al. 1999). Individuals experience shock, chaos, numerous crisis, anger, guilt and possible resentment (Baxter and Diehl, 1998). In addition, to this disruption in life, youth also experience parental neglect due to unpredictable parenting. They may also be subjected to role reversal of the adult child relationship due to parent's difficult coping. Accompanied by emotional neglect is the loss of a significant role model in life (Marsh and Dickens, 1997). Yet, despite these difficulties some youth manage to function well.

Statement of the Problem

Living with a mentally ill parent poses numerous developmental risks for youth. Attachment and trust can be interrupted if the parent becomes ill between the child's birth and age two. This lack of trust has a negative impact on bonding and future relationships (Marsh and Dickens, 1997). In short, if the child does not receive appropriate nurturing he/she will have difficulty maintaining future relationships.

Socialization skills and self-concept can be hindered if the parent becomes ill while the child is age three to five (Marsh and Dickens, 1997). All of the participants' parents became ill during this time, or earlier in their lives.

Academic adjustment can be stifled during the middle childhood years, if the family is in a state of perpetual chaos. In addition, peer relationships can be stifled when youth fear bringing peers to their chaotic home. In addition, this failure to interact with peers can extend into adolescence, resulting in further isolation (Marsh and Dickens, 1997).

In short, the developmental risks of growing up in a home with a mentally ill member are unmet needs, delayed development, growing up too quickly and difficulty separating from home (Marsh and Dickens, 1997).

While the literature discusses the risks associated with growing up with a mentally ill parent, only one study has focused on youth who function well in such a chaotic home environment. Beardslee and Podorefsky (1988) address the experience of adolescents who have grown up in a home with a mentally ill parent. They focus on the significance of self-understanding, not the adolescents overall perspective of their experience and methods of coping.

Rationale for the Study

Individuals who cope well despite adverse circumstances are often termed as resilient. Much of the research in this area has focused on either abused youth or on youth from a large range of adverse living circumstances. These circumstances include: poverty, living with a parent of mental illness, living with an alcoholic or drug dependent

parent or a parent who is absent due to incarceration. While these studies have identified universal characteristics of resilient individuals, they have failed to reflect the lived experience of resilient people or address resilience of youth living with mentally ill parents.

Dekovic (1999) states, "The reflections of young people who have serious affectively ill parents give a clear sense of exactly what experiences are troublesome and difficult for them. Also, given the lack of standardized and validated measures of resiliency, investigation of a subject's own perceptions of what enabled him or her to function effectively provides important information for understanding the psychological processes involved in such adaptive behavior" (p.63). Dekovic's (1999) perspective reflects my own perspective and philosophical stance, in this research study. I wanted to find out what youth found difficult about living in a home with a mentally ill parent. In addition, I wanted to find out how they managed to cope well despite growing up in apparent chaos. I also wanted to determine the influence of school and professionals in the lives of youth with parents of mental illness.

Definitions

In the past twelve years, numerous research studies have been done on resilience in an attempt to discern the characteristics, traits and environment, which promote resilience in individuals. Lists of factors which 'protect' youth in adverse circumstance have been found. These factors are supportive parenting, high intelligence, an easygoing temperament, surrogate parents, positive relationships with adults and active coping strategies (Heller et al. 1999, Marsh & Dickens 1997, Dekovic 1999, Dumont & Provost

1998). In addition, positive child parent bonding experiences during the early developmental years appear to help an individual navigate through difficult life circumstances (Heller et al. 1999, Marsh & Dickens 1997, Dekovic1999, Dumont & Provost 1998).

Despite numerous studies on resilience, no standard or operational definitions of resilience have been established. Nor have there been any standardized or validated measures of resiliency. However, the studies have proved beneficial in determining a holistic view of resilience identified what appear to be universal characteristics of resilient people.

Based on the findings of these studies I have defined resilience for the purpose of this study as functioning well despite adverse life circumstances. This includes an ability to maintain and establish healthy relationships and engage in appropriate developmental tasks: attend school, work, have intimate relationships. Participants were either working, home makers or caring for their ill parent. Many were involved in more than one of these activities.

Since the focus of this study was on resilient youth raised in a home with a mentally ill parent, mental illness was defined. It was defined as any illness diagnosed by a psychiatrist or psychologist based on the Diagnostic and Statistics Manual III or IV criteria.

DELIMITATIONS AND LIMITATIONS OF THE STUDY

I did not enter this study with any preconceived hypothesis. The aim of this study is to describe the lived experience of resilient youth of parents with mental illness. I hope

that new insights and avenues of investigation will emerge from this study. This study was conducted in an open-ended interview format with recordings of the interviews and subsequent transcriptions made. Through inductive strategies, narratives of the interviews were made. These stories were corroborated with each interviewee to ensure that they reflected their lived experience and emphasis was made on the aspects that were important and relevant to each participant involved in this study.

Every attempt had been made to protect against researcher bias. However, it is impossible to be 100% objective. Hence, I reveal my own personal biases in the methodology section – chapter 3, of this study. Furthermore, the participants' memories and personal biases influence the recollection of life events. These influenced the aspects of their lives they described during the interviews.

The experience of growing up with a mentally ill parent, aspects of resiliency and the resilient youth's cognitive processes are addressed in this study. As an educator and school counsellor, I am interested in the influence of the school environment as well as teachers or other personnel on resilient youth, particularly youth with a mentally ill parent. Much of the resilient literature cites academic success as a protective factor in vulnerable or at risk students. Hence, this study also examined the impact, if any, of school on the candidates lived experience.

SUMMARY

This chapter explains the research problem and rationale for the study. That is, the experience of youth living with mentally ill parents is chaotic and bereft of problems and developmental pitfalls. Despite these difficult experiences, many youth adapt well.

They are resilient. Resilience is defined as coping well despite adverse circumstances and manifested as working, attending school and maintaining appropriate developmental relationships. Since few studies have addressed the lived experience of resilient youth of parents with mental illness, this study aimed to do so. The experience of being raised in the home of a mentally ill parent is described as well as aspects of coping and the impact of schools and professionals on youth of parents with mental illness.

CHAPTER 2

LITERATURE REVIEW

OVERVIEW

In this chapter, I discuss the inconsistencies of definitions of resilience and struggles researchers have had in determining a unified definition of resilience. In addition, I explain the results of studies on resilience. Next, I discuss the cognitive characteristics of resilient youth and researcher's understanding of these thought processes. Then I discuss research findings on the impact of being raised in a home of a mentally ill parent. While there is much literature on the impact and developmental risks of growing up in a home of a mentally ill parent, there is minimal literature of resilient youth in such a situation. However, there is a model of the healing process, of family members with a mentally ill member, which appears to replicate findings in the research on characteristics of resiliency.

Defining Resilience

Researchers, in their attempt to define resilience have determined protective factors – individual and environmental factors which protect against risk. Heller and Larrieu (1999) list some of these protective factors, studied by researchers which include intelligence, sense of self-worth, internal locus of control, external attribution of blame and ego-control or ego-resilience. Questions posed about intelligence ask if it leads to more effective coping strategies or do high levels of intelligence lead to academic success, which in turn creates a sense of competence and thus influence an individuals sense of self worth. Also, is self-worth a stable characteristic of resilient individuals, or does it fluctuate? In addition, researchers ask if resilient individuals still display

symptoms that are characteristic of their adverse environments. Finally, they ask if resilient youth are able to maintain a sense of balance in chaotic or adverse situations, or if they overcompensate for difficult circumstances. Unfortunately, studies have difficulty identifying the factors "...related to relatively uncompromised functioning after the experience of childhood maltreatment" (Heller and Larrieu, 1999). In addition, Heller and Larrieu indicate that there are few formal or standard operational definitions of resilience, risk and competence. In addition, advocacy is made for a common theoretical framework of resilience with associated, consistent norms established upon which future research can be based and compared, particularly studies regarding resilience protective factors. In addition, Dumont and Provost (1998) suggest that research include clarification of the role each protective factor plays in the stress-distress relation. They suggest that a more precise definition of resilience would prove beneficial.

Recent studies view resilience as a process (Smokowski et al. 1999, Higgins 1994, Dumont and Provost 1998). One "... that may be an intermediate concept between adaptation and maladaptation (Dumont and Provost, 1998, p.358). That "...resilience best captures the active process of self righting and growth" (Higgins 1994, xii).

Marsh and Dickens (1997) discuss resilience within the context of recommendations made by respondents to others growing up in a home with a mentally ill family member. They describe resilience as "the ability to rebound from early adversity and to prevail over the circumstances of life" (p.63). Dickens and Marsh (1997) believe that it requires courage to face the past, accept early losses without feelings of bitterness or anger, but with a perception of "understanding, compassion and generosity" (p.64). They believe that resilient individuals have gained insight into their

parent or sibling's mental illness and assumed authorship of their lives and responsibility for their actions. Marsh and Dickens (1997) believe that resilient people seek and acknowledge the strengths in themselves and others and are able to seek help and offer support to those who need assistance. Yet, they say that these abilities do not come without a price.

Marsh and Dickens (1997) provide some suggestions for enhancing personal resilience. First, they state that resilient individuals have overcome significant early adversity yet with much difficulty and over numerous years, they emerge as better, stronger individuals. They also state that resilient individuals maintain a sense of hope for their future. "They pursue their goals with energy and determination" (p.138). Yet, they state that those who are resilient are not exceptional, that is they do not have a rare level of competence nor are they invulnerable to misfortune. They are just people who with the challenges they experienced have managed to live fulfilling lives. According to Marsh and Dickens (1997), resilient people do not view themselves as passive victims or survivors, as individuals who are stuck in their early experiences and unable to accept that part of their life. Instead resilient people face their past and have a realistic appraisal of its impact on their current lives. They have acknowledged an imperfect world. It is as if they live by the credo of accepting the things you cannot change, the courage to change the things you can and the wisdom to know the difference. Resilient individuals view themselves and others in a positive yet realistic manner. They acknowledge and are aware of their strengths and the strengths of others. However they also aware of their own and others shortcomings, and the reality of justice and tragedy. Yet when confronted with darkness they continue with their convictions that the world does make

sense and are sustained by their ideals. When faced with challenges in life they seek out the information they need, develop appropriate skills and learn vicariously from the experience of others. In addition, they are able to assist others in their own life journeys, provide support and derive satisfaction from the relationships developed as a result of their assistance. They recognize a need for advocacy and support in our society and subsequently do so in their own realm of their world. Resilient individuals believe in themselves and that they deserve a good life. They will do 'whatever it takes' to resolve their difficulties.

Resilience Results

Maja Dekovic (1999), provides a quantitative, hierarchical, multiple regression analysis of both risk and protective factors. It is an examination of the ways in which multiple sources of risk and protection contribute to the development of both internal external problems in adolescence. Three areas of influence were identified: individual attributes, family attributes and extrafamilial attributes. The aim of this study was to determine if any of these three areas of influence are central in mitigating the effects of risk. As well as whether risk or protective factors have differential influences for internalizing (anxiety, depression, withdrawal) or externalizing (substance use, conduct problems, school problems and juvenile delinquency) problems. Dekovic also attempts to determine if risk and protective factors have a cumulative effect or if their influence is independent of other risk or protective factors. She also attempts to explain whether protective factors mitigate risk behavior.

According to the analysis girls exhibit more internalizing problems, while boys demonstrated more externalizing problem behaviors. Unfortunately, they were unable to

determine whether younger or older adolescents demonstrated more of the behaviors examined. However, association with deviant behavior peers appeared to be a significant predictor of both internalizing and externalizing problems. Also the degree of internal problems was significantly predicted by lack of parental support and low self-esteem. Meanwhile, the following protective factors; monitoring high academic achievement and acceptance by peers had the highest beta's for internalizing behavior and attachment to peers and parents appeared to be important predictors of externalizing behaviors. Individual attributes that were important in mitigating problem behaviors were self-esteem and academic achievement. An important extrafamilial factor was association with peers who displayed deviant behavior; those who maintained such relationships appeared to be the strongest risk for internal and external behaviors. However, family attributes appeared to be less important predictors of problem behavior; yet, support, monitoring and adolescent attachment, were important factors for both types of behaviors, although the effects were relatively small. Subsequently, it was concluded that peers play an important role in the development of both internal and external behaviors examined. Also the amount of risk resulted in a stronger relation to variability in problem behavior with an increased severity with higher levels of risk. It appeared that protective factors did not predict a moderating effect with the exception of predicted better outcomes at both high and low levels of exposure to adversity.

Aspects of this study which are significant to this present study are the author's reference to her previous study, in which she indicates that both the context of development and importance of factors that affect development change with age.

Furthermore, this study emphasizes the significance of the influence and interaction of multiple factors in the influence of risk or resilience of youth.

Another study that addresses the influence of multiple protective factors for resilience is that of Paul R., Smokowski, Arthur J. Reynolds, and Nikolaus Bezuchko (1999). This longitudinal study is a continued prospective study of the scholastic and social adjustment in Chicago Public Schools. Smokowski et al. (1999) have a developmental, interactionist perspective. They believe that “[b]ecause turbulence and uncertainty are often associated with developmental transitions, and can strongly influence established behavioral trajectories positively or negatively, these discontinuities are particularly important when studying risk and resilience” (p. 429). Furthermore they view resilience as a process.

The purpose of their study was to address and identify the complex interaction between risk and resilience in the lives of inner-city minority adolescents; the ‘microprocesses’ youth use in overcoming adversity. Two specific areas of focus are:

- A. how youth describe risk, resilience and protective factors in their lives
- B. influence of individual attributes, family ties, and external support systems on the developmental processes.

Their findings comprised the following:

- Individual attributes included:
 1. ability to overcome adversity was important to youth
 2. resilience was viewed as a process which continues to unfold
 3. persistence, determination, belief in a better future and holding on to dreams or goals
 4. struggles were perceived as temporary
 5. Cognizance of vicarious learning from the experiences of their peers
 6. Internal readiness for external messages of support, motivation and protection of self, as well as strategies or methods for achieving desired goals

- Family Ties
 1. high value on motivational support
 2. straight-forward information regarding environmental risks
 3. members modeled consequences of risk behavior
- External Support
 1. provided motivational support which was lacking in the home
 2. experience of 'surrogate parents'
 3. high discernment and caution re: friendships
 - includes discernment between associates and friends
 - associates were people one would hang out with
 - friends were viewed as people one could rely on
 - true friendships were viewed as rare
 4. adult role models were viewed as caring

There are many other important aspects of this study. First is the method, and qualitative approach. Most studies on resilience are quantitative and while relevant and insightful they are often unable to consider the interrelation of various aspects of resilience and protective factors. In addition, this method permits one to attain adolescent self-reports and personal insights into resilience and their ability to overcome adversity, while undergoing developmental transitions. Why certain individuals are able to "... sustain adaptive functioning under significant duress while other individuals are not able to manifest this level of adaptation" (p.426) is a question asked in my study. As well as the factors that facilitate this process of overcoming adversity, are relevant to this present study. Also, their explanation of resilience as either successful rebounding or overcoming of unfavorable odds does not imply the assumption that individuals had a solid, secure, stable base of which they could return to. Smokowski et al. (1999) recognize that some things cannot be relieved or undone, such as childhood or adolescence. They also acknowledge the loss of the self when one experiences adversity as well as the reformation of self that comes as a result of experiencing life difficulties. Their belief in resilience as a process implies individual authorship of his/her own life as

well as a different interpretation of events and creation of meanings about adversity. This is evident in the interview question posed to the adolescents:

Please stop for a few minutes and picture yourself in a movie about your life. What are some of the events and persons you would want to see in a movie? Naturally, the movie describes what is important to you, how you got where you are today, and where you life is heading in the future. The movie might also include your family or friends and why they mean what they do to you. Finally, the movie might present some of your ideas about people or life. Now, having thought about your life, go ahead and write a story on this sheet of paper" (p. 431).

Furthermore the questions cited from the Berkeley Autobiographical Interview address the issue of meaning making in the interviewed adolescent lives. Specific questions of note are:

Question #1 "... tell the story of your life, whatever you think is most important to tell, starting from as early as you can and going right up to the present time."
Question # 3 "...tell the most important thing you ever did, that ever happened to you" (P.431).

Another author who utilized interviews to discern resilient individual's interpretation of their life events is Carol O'Connell Higgins (1994). She believes resilience can be cultivated and that while genetics play a partial role in the development of resilience, it does not determine behavior, but may influence it. Higgins (1994) postulates that individual motivation and environment play a key role in resilience. She claims that "...resilience best captures the active process of self-righting and growth" (xii).

Higgins (1994) cites the protective function of 'adoptive relationships' during adolescence which permit growth and increase the likelihood of individuals overcoming adversity. The resilient appeared to be determined to focus on the expansion of the self; often this was aided by the recruitment of others that displayed a sincere interest in the

individual's life. These individuals were often surrogate caregivers who demonstrated the following characteristics: they made or had full and rewarding lives, did not shrink from hard work, were not given to spells of self pity, shared what they had and told the truth. She also found that resilient individuals "... construct progressively more elaborate inner meanings, rendering themselves active inner and outer agents in finding a better life" (p.67). One of the areas where individuals perceived themselves as active agents was in their definition of personal growth which was perceived as "... an active process of constructing and defining meaning" (p. 67). This included assumptions these resilient individuals had regarding the construction of new versions of the self, which emphasized learning and development. Two significant components, for Higgins (1994), were:

1. Emphasizing mental health and mental growth throughout the life span
2. Understanding the resilient -- or any client -- on the basis of his or her highest level of functioning

McMillan and Reed (1994), discuss their research findings in conjunction with that of existing literature to explain their model of resiliency. Unfortunately, there is no indication of the quality of the studies cited nor is there any explanation of their selection. In fact, there is minimal discussion of the studies. Any discussion is in relation to those aspects of the studies that support their own research findings. While no data from the studies is mentioned findings of the studies are mentioned. However, their conclusions are relevant to this research.

Individual attributes of resilient youth are cited: positive attitudes, high intrinsic motivation and motivation to succeed. Positive attitudes include respecting others, coming to class prepared, volunteering for in-and-out-of class assignments and knowing how to play the school game. In addition, they are self-starters and accept personal

responsibility for their achievements. Furthermore, they have little spare time and are involved in extracurricular events at school and in other areas of their lives. These activities are an informal source of support that increases school involvement and belonging and help boost self-esteem. In addition, they appear to have numerous hobbies, creative interests and sports. In addition, they appear to become involved in experiences of 'required helpfulness'. That is they become involved in situations where they are required to help others so that they may succeed.

Usually resilient individuals have a close bond with at least one significant adult, either a parent, relative, or close family member. They appear to be adept at finding substitute caregivers when there are none available. McMillan and Reed (1994) believe that teachers "play an important role in the success of resilient students" (139). They created a list of teacher qualities that are important to resilient student success. These characteristics include: caring, having respect for them as people and learners, able to get along with them, listening without being intrusive, and taking them seriously. In addition, being available and understanding, helping and providing encouragement, laughing with them and being able to talk about almost anything as well as professional competence and behavior are important.

Cognitive Processes

Higgins (1994) indicates that adolescents internalize their surrogate parental figures, so that they are with them everywhere they go. These positive surrogate relationships contribute to the youth's vision of 'life' promise, which becomes expanded over the lifespan. Apparently, adolescence is an important time for the development of

resilience; there are several factors during this developmental period, which help, support and protect resilient adolescents:

Ability to negotiate a broader environment

- able to get or take themselves away from complex or chaotic home situations
 - A. actually leave
 - B. baby-sit or work
 - C. spend time at a friend's house, where they attain 'unofficial adoptive status'
 - D. move out and support themselves

Yet, resilient youth have a tendency to 'get out' gracefully; they do not bolt or run madly away into more complex or traumatizing situations. These subtle efforts or behaviors are supported by society's expectation that youth are away from home for long hours. In addition, while participating in these endeavors the youth are able to receive feedback from numerous sources about how they are. Work is rewarded by Calvinist attitudes and subsequently admired and valued by adults.

Higgins (1994) suggests that a resilient individual's ability to ease their way out of difficult home situations is due to their ability to think abstractly. In addition to, the development of an increased perspective taking capacity, they are able to build on internalized surrogate models and develop or create their own 'model of decency and reciprocity' about the world. She proposes that the development of formal operational thought enable youth to see their family modes of interaction as one category of various modes of interaction. Thus they are able to determine their own modes of communication and interaction, from a broad series of categories; specifically those of their surrogates. Resilient youth become aware during adolescence that their families are anomalous. Furthermore, some adolescents are capable of interpersonal hypothetical reasoning. Thus through metacognition of their interactions and relationships they are

able to perceive the perspective of others. Higgins found that resilient individual's used this skill extensively, especially in relation to difficult family interactions. They did this with the aim of not repeating the hurts or mistakes of the past. She also found that resilient youth appeared to be very empathic and devoted to the human model of care.

According to Barankin, T. & Greenberg, M. (1996) mitigating factors on the impact of mental illness on the family are: severity and chronicity of the illness, parent's understanding of their own illness, parental compliance with treatment and co-morbidity. In addition, they indicated that resilient youth of mentally ill parents appear knowledgeable about the parent's illness, but do not retreat from it or fear it. Instead, they perceive the illness as something that needs to be understood. Furthermore, they cite self-understanding as being a paramount characteristic of resilient youth. Self-esteem, mastery, autonomy, flexibility, healthy coping strategies, parental supervision, a positive stable relationship with an adult, ability/power/control over one's environment, and regular and consistent attendance at school are also characteristics cited of resilient youth.

Beardslee and Podorefsky (1988) address the significance of relationships and self-understanding in resilient adolescents. Three components of self-understanding were identified: awareness of parent's illness, specific response to parent's illness, capacity to reflect and observe on the experience of parental illness and other matters. Findings indicated that those who adapted well were doers and problem solvers had a deep sense of pride and effectiveness. Components of self-understanding in those who functioned well include:

1. Accurate cognitive appraisal of the stress to be dealt with.
2. Realistic assessment of one's capacity to act and realistic expectations of the consequences of the action.
3. Actions that reflect understanding or are congruent with it.

Aspects of their results are multi-fold. First is the indication of the importance of constitutional factors or resilient youth, such as:

- temperamental characteristics; easy going
- efficient, effective and mature modes of responding, thinking and acting
- effective coping styles
- positive self-esteem
- sense of being in control.

They cite self-understanding as an essential component to the development of resilience. These youth knew something was wrong with their parents and they were not the cause. They said this knowledge was crucial to their understanding and ability to deal with the ill parent. The youth "... had somehow made peace with or come to an understanding of the experience and this was important to them" (p.66). This understanding was absent in the three youth who had depressive symptoms. Furthermore, when examining the parents' illness and subject's relation to it, the authors found that the youth were:

1. able to reflect on changes in selves and parents over time
2. able to address initial concerns and how they came to see their situation differently from parents' over time
3. able to make clear distinctions between themselves and their experiences and their parents' illness
4. they were not overwhelmed by parents' experiences or difficulties'
5. they did not expect their future lives would reflect or be similar to those of their parents.

Victor Frankl (1984), cites three existential domains: human existence, meaning of existence and trying to find a concrete meaning for existence. He believes that meaning can help an individual survive the worst human conditions and that there are three ways to discover meaning in life. These three ways include creating work or doing a deed, experiencing something or encountering someone – love, or the attitude one can

take toward unavoidable suffering. That when we are met with destiny or fate, which we cannot change, we are forced to change ourselves. We are forced to evaluate and reflect on our difficult situation and transcend it. This can be done by "...turning suffering into a human achievement and accomplishment. Deriving from guilt the opportunity to change oneself for the better [and] deriving from life's transitoriness an incentive to take responsible action" (p. 162). Frankl (1984) believes that "Once an individual's search for a meaning is successful, it not only renders him happy but also gives him the capability to cope with suffering" (p.163).

An expansion of this notion of suffering in meaning making is addressed in 'Selves, Stories and Experiences,' by Norman Denzin. Denzin (1989), believes that meanings are created retrospectively, when individuals re-experience difficult life events. He cites four forms of epiphanies in which meanings are created:

1. Major events – they touch the very fabric of a person's life
2. Cumulative/Representative event – eruptions or reactions to experiences that have been occurring for a long time
3. Minor/Illuminative epiphany – represents a major problematic moment or relationship in a person's life
4. Reliving – meanings are given in the reliving of moments or episodes of a person's life (p. 71).

George C. Purvis, Jr. (1995) in addressing adolescent meaning making, differentiates between essence and existence. Essence is described as perfection while existence is "the reality of being" (p.204). Existence is where the potential of essence is realized and where questions about values and meanings are raised. Apparently these questions as well as the attempt to bridge the gap between essence and existence creates tension. This tension is compounded by youth's struggle to determine between who he 'is' and who he 'ought to be', which is expressed in the question "Who am I?" (p.204)

“That is to say, during adolescence the will to meaning begins to emerge. The adolescent begins to ask questions about the meaning of his life. These questions are usually more emotive than cognitive – another manifestation of his intense identity crisis. This search for meaning is an attempt to make his life ‘livable’. He assumes there must be a purpose in all his turmoil and tension” (p.204). It is at this point that the youth begins to evaluate the world around him. Youth compare themselves to others, observe various lifestyles and values and assess the influence of his family, peers and society (p.205). Meaning is found where the youth ‘finds himself’ – when the tension between what he ‘is’ and what he ‘ought’ to become is a challenge and no longer perceived as a frustration in life.

Crumbaugh (1995) supports this notion of identity formation for youth. He believes that individuals create a ‘framework of meaning’ in which they are ‘somebody’, have a place and function or sense of purpose (p.152). In order to reach this point some youth need to make a ‘leap of faith’ and assume that, despite apparent chaos in their lives, “... there is order in the universe” – what Frankl calls ‘suprameaning’ (p.152).

Crumbaugh (1995) developed six lists that help youth develop meaning in their lives.

1. Life-long aims, ambitions, goals, and interests going back as far as the client can remember, including those he no longer considers important
2. The strong points of personality, physical and environmental circumstances, ‘good luck’
3. The weak points of personality, failures, ‘bad luck’
4. Specific problems that cause his conflicts
5. Future hopes
6. Future plans, immediate and long-range (p.154)

Yet, he warns that finding meaning in life is a dynamic process -- one is perpetually creating meaning in his/her own life. Satisfaction is not in the completion of the process but “... in the experience of progress toward its attainment” (p.158).

Resilience implies that an individual has overcome significant adversity in life. In a sense, these individuals have created a sense of meaningfulness in their lives despite chaos or overwhelming struggles. Growing up with a mentally ill parent is synonymous with perpetual loss. How youth make sense of their experience and maintain a sense of meaning will be explored in this study. The following research studies helps us understand the experience of growing up in the home of a mentally ill parent.

Studies of Mental Illness

Dr. Johnson (2000) engages in naturalistic inquiry in his article. Through semi-structured interviews he attempted to identify the significant areas of concern for families with a member who has mental illness and subsequent areas of importance regarding collaboration of professionals working with these families. He especially focused on gender, ethnic and socio-economic status differences.

The four themes that emerged were: how families deal with mental illness is dependent on ethnic origin, socio-economic status, gender, and position of family members and stage of illness. 2. Members of family need and want to be treated as part of the care giving team by professionals, yet feel excluded. 3. Medication proved significant in its effects for family members. 4. Feelings of competence and meaning were significant factors for ill member's success in the community.

The findings from the analysis of these themes revealed that men had difficulty accepting the illness as biological. It was perceived as lack of motivation. Also, fathers had much difficulty with accepting the illness of their sons particularly in relation to the ill member's productivity and responsibility, which are perceived as essential ingredients of manhood. Siblings who understood the problem as biological were sympathetic toward

the ill member. However, they were rejecting and distancing if they perceived the problem as stubbornness, laziness or manipulation. This was the same for parental caregivers. Most family members, with the exception of the primary caregiver, assumed a peripheral role yet they would take on specific responsibilities. Apparently their reticence was due to fear of receiving the primary caregiver role or the primary caregiver failed to ask for assistance.

Overall, family members had difficulty acknowledging the shift in the ill members functioning. Odd behaviors were attributed to stress association with the wrong crowd or drug use. The precipitating event involved unacceptable or dangerous behavior in which the family reached its threshold or saturation point for the ill member's behavior. It is at this point that the family became involved with the mental health system.

If the ill member experienced a single hospitalization, family members expressed no desire to learn about or understand the illness. However, if there were frequent hospitalizations family members wanted to understand the pattern of hospitalization, discharge, readjustment, early warning signs, decompensation, crisis and re-hospitalization. Unfortunately, families of ethnic origin or of low economic status felt disregarded, dismissed or irrelevant by professionals. Overall families did not feel or perceive themselves are part of the care giving team despite their housing and care management functions for the ill member upon his/her release from the hospital. Decompensation behaviors cited by family members were often ignored by mental health professionals or described as idiosyncratic behaviors. Descriptions of change in speech or talking, pacing or ritualistic behavior, and louder music were responded with a

recommendation for the family members to be 'more accepting of the mentally ill member's uniqueness.'

Differences in experiences with mental illness were found among the various socio-economic and ethnic groups. European-American upper middle class families were identified by NAMI; hence, they had a greater sense of support. Yet, despite perceived competence they experienced feelings of vulnerability regarding interpretation of the illness and dealing with continual dilemmas experienced due to the mental illness. Meanwhile, minority upper middle class families rarely connected with an organized support group. This group was difficult to identify due to their small numbers. Thus, they were less visible to the mental health profession. Middle class families expressed concerns about the stigma and financial burden of mental illness. Apparently middle class families were concerned that the ill member was not functioning according to neighbor standards and felt distanced by neighbors or family members who lacked understanding of mental illness. Upper middle class families often depleted their savings before turning to public hospitals or agencies. However, for lower middle class families and members of low economic status, stigma was only one of many problems associated with the disorder. Of significance was their belief in their ineffectiveness in dealing with professional systems such as: criminal justice, welfare and mental health. The largest population of the study was lower class families. They lived in the city and were more likely to have an extended family network, however this did not appear to be helpful in assisting the family with the problem. It appeared that the primary caregiver needed to use the resources available in the family. Lower class families were difficult to locate and engage.

All families expressed significance of psychotropic medication's ability to stabilize the patients functioning. Families noticed a significant difference in an individual's ability to control problematic behavior. Yet, they were surprised that the treating psychiatrist ignored their observations regarding the medication effects. Despite, overall approval of psychotropic drug use, families expressed disfavor of an ill member's substance abuse. Often substance use resulted in poor functioning of the ill member and involvement with jail. Although there were high scores of substance abuse among all socioeconomic levels, usage was higher among lower class individuals. Families did not perceive the amount of use as problematic for other family members, but found it problematic for ill members. Of concern was the replacement of medication with street drugs, which resulted in dropping out of mental health programs as well as additional problematic behavior that, resulted in either hospitalization or jail.

Often support came from extended family and close friends. However, less than half of the families had any knowledge of others struggles. Those who did experienced increased friendship, support and experienced feelings of competence. In addition, only ¼ of the families had membership or involvement in support groups. Many of them indicated that their motivation to continue came from faith, family and obligation. There was little indication of desire for rejection of the mentally ill family member.

In a national, survey Marsh, D.T. & Lefley-Harriet, P. (1996) address the experience of mental illness in the family. Survey respondents indicated that resources promoting positive change in themselves were: family or relatives, qualities of the family unit of individual members, membership in NAMI, assistance of professionals, assistance of friends, neighbors, co-workers as well as religion and hobbies.

Although family burden was not addressed in the survey 39.7% of respondents provided negative comments about their experience of family burden. They also expressed anger and disbelief that family members were asked about positive consequences of their experience. These respondents also had negative comments about family resilience.

Another article that explains the experience of mental illness in the family is by Barankin, T. & Greenberg, M. (1996). This is a case study embedded in theory with an emphasis on early identification and treatment of the mentally ill patient, particularly for those families with a parent of mental illness. These authors believe that while biology causes the disorder, the influence of environmental factors is important. The case study criteria are supported by the authors' theoretical framework, with an emphasis on clinical practice. This study's reliability is how firmly rooted the case study is in theoretical constructs. It provides support for the positive treatment outcome for the family cited in the case study. Barankin, T. & Greenberg, M. (1996) claim that therapy can counteract the negative effects of living with a mentally ill parent.

Support is provided for the belief that growing up in a home with a mentally ill parent can be chaotic, disruptive with severe neglect and unpredictability of parental care taking methods. Furthermore, it addresses the role reversal that can occur between parent and child, in which the child becomes the caretaker. In addition, Barankin, T. & Greenberg, M. (1996) explain that impaired family functioning, developed during the crisis phase, can sustain or remain after the recovery of the ill parent.

Mothers with depression apparently exhibit the following characteristics when depressed: reticent communication, submissive and therefore dependent, less

affectionate, argumentative with spouse and children, increased hostile behavior, negative tension and numerous attempts at controlling people. In addition, communication appears to remain an issue, as well as problem solving in families of a depressed spouse.

In contrast, children of parents with bipolar disorder endure the following experiences: loss and separation from a caregiver, insecure and ambivalent attachments, hostility, poverty and an unstable environment. Manic depressive parents exhibit the following characteristics: take but refuse to give, little awareness for other people, minimal ability for empathy, diminished capacity for fostering stable connections in child due to their own infantile dependency needs. In addition, they have difficulty overcoming or coping with loss, grief, rage and developed 'defensive' maneuvers to avoid conflict as well as problems initiating and sustaining relationships outside their own family.

Marsh et al. (1993) discuss the results of two surveys administered to children and siblings of the Siblings and Adult Children Network of the National Alliance for the Mentally Ill (NAMI). The aim of this study was to determine the impact of serious mental illness on adult siblings and children of parents with a mental illness.

Through document analysis, the researchers determined that those who experience mental illness in their home as a child or adolescent endured a wide range of adverse consequences. These included disruption of normal development due to lack of a model of normal development and subsequent difficulty determining normalcy in personal life. In addition, their appeared to be a subjective burden. That is members experienced grief and loss as well as empathic pain of other family members; that is they felt the suffering of other family members. They also experienced an objective burden. Family members

had to deal with the 'symptomatic' behavior of the illness and crisis associated with these symptoms. Accompanied by this was the stigmatization of living with a mentally ill sibling or parent. Many of the respondents indicated that they experienced altered roles and relationships such as parentification – assuming responsibility for their parent; or 'replacement child syndrome' – striving for perfection to prevent further parental anguish. They also experienced identity issues such as being afraid of becoming mentally ill and an impaired sense of self. Many endured personal risks such as depression and anxiety. Further, there were familial consequences such as familial disruption, stress and the façade of normalcy. Often there were impaired relationships with those outside the family, social isolation and discomfort. Accompanied by this was either poor school performance or becoming a super achiever at the expense of a personal life. Despite these struggles "...no resource was rated as helpful during the first ten years of the parent's or sibling's illness" (p. 16). It was not until adulthood that respondents cited external resources – professional, as being helpful. Adolescents appeared to attribute their own personal qualities to their coping.

Adults experienced a personal legacy of poor self-esteem or emotional anesthesia, arrested development. As well, there was the interpersonal legacy, which included a fear of rejection or an extreme desire to please others. In addition, respondents experienced intimacy problems such as avoidance of intimacy, and inability to trust or make a commitment. Often those who married feared procreation due to the genetic risks associated with mental illness and experienced difficulty balancing the responsibilities of family with those of the mentally ill family member. Those who assumed care-giving responsibilities perceived this as a life time task. Often they would sacrifice their

personal life to meet the needs of others or lose familial relationships in their quest for self-preservation. In addition, many of the respondents experienced unfulfilled career potential.

Marsh et al. (1993) derived the following themes from their second survey:

1. Care giving concerns
2. Family disruption
3. Trouble balancing needs
4. Needs not met
5. Grew up too fast
6. Guilt
7. Helplessness and Hopelessness
8. Perfectionism
9. Low sense of self
10. Chronic sorrow

In light of these experiences, Marsh et al. (1993) reported needs cited, by the respondents, for both the family and the individual. Family needs included satisfactory services for the relatives of the mentally ill patient, satisfactory services for working through personal reactions to the illness, skills to cope with the illness and personal support. Of most importance was information about mental illness and its related issues. Individual needs included personal psychotherapy, validation of personal needs and plans constructive relationships outside the family and open communication with the family.

Because of this study Marsh (1997) and one of her co-authors, Rex Dickens (1997) wrote a book, presenting their findings and discussing the implications for healing. Attachment and basic trust are cited as the basic tasks from birth to age two. Attachment involves bonding and affects future relationships while basic trust requires nurturance and security. Socialization and self-concept are the developmental tasks of three to five year olds. Socialization is when children "acquire knowledge, skills, values and behaviors that will enable them to participate in their society" (p.46). Self-concept

entails "a sense of being a valuable and competent person" (p.46). Marsh and Dickens (1997) suggest that basic trust may have been shattered if a mentally ill parent was either unable to meet the young child's needs. Also, if the parent was busy contending with the needs of the other parent who was mentally ill. In addition, they suggest that due to the misconceptions of the mentally ill parent the child may not have a clear sense of reality. In addition, accompanied by a lack of energy or time for the child, due to the mental illness, a low self-concept may result.

During middle childhood, children are expected to acquire academic adjustment and establish peer relationships. Academic adjustment is considered as a basic building block for life while peer relationships help youth establish a social network outside the family. If either of these tasks are not achieved the youth will lack the necessary skills for coping with the outside world. Marsh and Dickens (1997) indicate that youth may have difficulty with academic adjustment because of an inability to concentrate at school, due to problems at home.

Adolescence is cited as a time for "preparing for an independent and productive adulthood" (p.50). The tasks associated with this age range are:

- establishing a personal identity which can serve as an internal compass when life situations change
- emerging sexuality with changing sex roles, standards and behaviors
- determining educational and vocational plans and goals
- separating and departing, from the family

Marsh and Dickens (1997) suggest that the accomplishment of these tasks may have been hindered if an adolescent was living with a mentally ill family member. They indicate that an adolescent may have feared becoming mentally ill also. Feelings of loss and isolation were cited and the authors suggest these feelings may have hindered peer

relationships or dating. Furthermore, Marsh and Dickens (1997) suggest that family responsibilities may have altered the adolescent's ability to separate from home and subsequently changed career and educational goals.

Marsh and Dickens indicate that there are a number of developmental risks associated with growing up in a home with a mentally ill parent or sibling, these include:

1. personal needs neglected or not met
2. hindered development
3. growing up too quickly
4. difficulty separating from home

If individuals experience unmet needs they often fail to develop appropriate resources for coping effectively with the adult world. Also, if the family depended on the youth there is often significant guilt associated with leaving. Furthermore, there are often 'distorted' roles and relationships the home of mental illness, as everyone attempts to compensate for the "disruptive force of mental illness" (p.53). In addition, youth of a parent with mental illness often experience parentification; that is, they assume the parental role as a child.

Mental illness in the family can have a significant effect on an individuals academic life. Often youth experience poor school performance due to disruption at home. Marsh and Dickens (1997) suggest that low academic achievement may further erode youth's self esteem. In addition, teachers and counselors who recognized inconsistencies in academic performance but were unaware of the cause may reinforce this low sense of self. However, some youth become super achievers at school, in an attempt to escape from their feelings of hopelessness and helplessness. Marsh and Dickens (1997) believe "this is a constructive reallocation of energy that offers opportunities for growth and satisfaction." (p.56). However, they caution that this may

prevent youth from confronting the mental illness and subsequently becoming dependent on external validation. Marsh and Dickens (1997) suggest that mental illness in the family may have an adverse effect on youth's involvement in extracurricular activities. Many youth refuse involvement in extracurricular activities due to feelings of social alienation and isolation. Failure to do this results in a lack of opportunity to enhance social skills and self-esteem, expand activities and relationships outside home, obtain reinforcement for normal developmental experiences and identify with healthy, constructive role models. In addition, they reinforce the notion of altered educational and career plans due to responsibilities at home or lack of financial and emotional resources. In addition, there may have been minimal encouragement from parents and an individual may have difficulty focusing on his/her own future when the family is in disarray.

Peer relationships are very important in youth. Many children of parents with mental illness have difficulty with peer relationships. Youth may feel estranged from their peers due to the stigma of mental illness and lack of understanding of the family. In addition, youth may have difficulty juggling two different worlds – inside and outside the family. Furthermore, youth may avoid peer relationships in the absence of a secure home base, due to the unpredictable and disruptive presence of mental illness. As well, the skills youth developed to cope and survive in the home situation may have a negative impact on external relationships; for example, avoidance that may result in the loss of friends and further alienation.

Baxter and S. Diehl (1998) address the recovery process for both family members and mentally ill individuals. Baxter and Diehl (1998) have a pedagogical didactic approach of the mental illness recovery process. Their aim is to provide information for

both those who have mental illness and their families so that they can make sense of their experience. They provide a theoretical comparison of the two conceptual models of the recovery process.

The tables on the following page reveal the results of the study.

Table 1 – Emotional Stages of Recovery

Event 1: CRISIS: psychosis, suicide attempt, mania, or panic attack

Stage 1: RECUPERATION A stage of dependence

Emotions: Denial, confusion, despair, anger

Needs: Safe place, food, lots of sleep,
A caregiver
Medications (probably)

Event2: DECISION: "TIME TO GET GOING."

Stage 2: Rebuilding: Rebuilding independence

Emotions: Grief, self-doubt, hope, anxiety, frustration, pride

Needs: To be heard and accepted, I
Learning about mental illness,
people & work skills
to live

Event3: AWAKENING "I AM SOMEBODY. I LOVE A DREAM."

Stage 3: Recovery/Discovery: Building healthy interdependence

Emotions: Acceptance of self & others,
Confidence, anger injustice,
helpfulness to others

Needs: A dream to strive for, appreciative people
Intimacy: someone to love
Meaningful work
Fun and physical activity
Advocate for self & others

Table 2 – The stages of Emotional Response Among Family Members

I. HEADS OUT OF THE SAND

Crisis/chaos/shock

Denial: "normalizing"

Hoping against hope

Needs: Support – Comfort – Empathy for confusion – Help finding resources

Crisis Intervention – Prognosis – Empathy for pain

II. LEARNING TO COPE

Anger/guilt/resentment

Recognition

Grief

Needs: Vent feelings – Keep hope – Education – Self-care –

Networking – Skill training – Letting go – Co-op from system

III. MOVING INTO ADVOCACY

Understanding

Acceptance

Advocacy/action

Needs: Activism – Restoring balance in life – Responsiveness from
system

In conjunction with the stages of recovery for both consumers and families, acknowledgment of recovery from mental illness as a sense of mastery that it is not synonymous with cure was significant. Instead, recovery implies the development of new meaning and purpose in one's life as one overcomes the trauma of mental illness. As well, it incorporates a change in attitudes, values, feelings, goals, skills or roles.

To make these changes individuals and family members need the support of the community, schools and professionals. Following are recommendations, of researchers, for developing resilience in youth and providing support for families with a mentally ill member.

Recommendations for Schools and Professionals

McMillan and Reed (1994) discuss the implications for schools. According to them, "The challenge to schools is to provide the relationships and involvement that can foster self-efficacy, goals, personal responsibility, etc." (139). McMillan and Reed (1994) make some recommendations for schools. They suggest that instruction and climate promote a sense of locus of control, self-efficacy, optimism and personal responsibility. In addition, they recommend that schools establish reference points for achievements and relate student success to ability. Schools set goals, particularly long-term goals, which can help youth, see beyond their immediate future. Stress high academic achievement while also building self-esteem and confidence. Create a classroom environment that has time-on-task, student interaction, student success and positive reinforcements for appropriate classroom behaviors. Expand extracurricular activities, especially where there is a large at-risk population with personal invitations for the at-risk students to join. In addition, provide support groups for relevant issues of at-

risk populations. McMillan and Reed (1994) also suggest training teachers and encourage them to develop relationships that can benefit at-risk youth. In addition, they recommend seminars for education students and classroom students on working with at-risk students. According to McMillan and Reed (1994) at-risk youth need teachers who are respectful, caring, honest, patient, open minded, firm, understand different learning styles, expect positive results and recognize cultural norms and differences.

Werner (1984) discusses some of the data in the research findings. Her conclusions for adults working with youth are important. Werner (1984) suggests that adults learn to accept children's idiosyncrasies and enable them to have challenging experiences, but not ones that will overwhelm the youth. She suggests that children be rewarded for helpfulness and co-operation and that adults relay a sense of responsibility and caring to the youth. In addition, encouraging children to develop special interests, hobbies or activities because they can be a source of gratification and self-esteem. She also suggests that adults model a conviction to life despite its adversities. In addition, she wants us to encourage children to reach out beyond the nuclear family for support. Furthermore, Werner (1984) believes that acts of 'required helpfulness' result in enduring and positive changes in young people. That is a socially desirable task helps prevent others in the family, neighborhood or community from experiencing distress or discomfort. This can instill a feeling of confidence or faith that things will work out reasonable well.

(Marsh et al. 1996) suggest that professionals apply competency-based models to theory, research and practice and emphasize the positive qualities of families. They advocate for information services of mental health, illness and treatment. They also

indicate the need to address individual needs as well as those of the family. Furthermore, they recommend that therapists acknowledge individual and family potential for resilience.

Respondents made suggestions for both family members and professionals.

Suggestions for family members were:

1. learn as much as possible
2. join a support group
3. start a support group
4. become involved in activities outside home
5. do not let the mental illness take over your life
6. find a good therapist
7. divest or rid yourself of the stigma and shame associated with the mental illness
8. become active in education and advocacy

Suggestions made for professionals include:

1. become knowledgeable about the experiences and needs of all family members
2. visit existing support groups
3. form a collaborative partnership with family members
4. include adult siblings and children as members of the treatment team if they are interested and available
5. avoid blaming and pathologizing family members
6. address the needs of all family members as early as possible
7. be available to answer the questions of family members and respond to their concerns
8. make referrals to existing support and advocacy groups
9. assist families in achieving a balance that meets the needs of all family members
10. offer services for family members in clinical settings
11. serve as a resource and consultant to existing family support and advocacy groups

In addition, the author's provide information and advice for best practice of professionals, which include:

1. Include family members
2. Five components of services for children and siblings
 - a. didactic information about mental illness and resources

- b. skills training in communication, conflict resolution, problem solving, assertiveness, behavioral management and stress management
- c. emotional support – for grieving, sharing and mobilizing resources
- d. family process – focus on the impact of mental illness on the family system, family subsystems, and individual family members
- e. social component – offer support, reinforcement for normal development, experiences and goals, constructive role models, opportunities for advocacy

Summary

The numerous recommendations of researchers and study participants for schools and professionals reveal a discrepancy between consumer family needs and those of service providers. Thus, further research needs to identify the needs of children of parents with mental illness. We need to determine what youth find difficult and how we as adults and professionals can help them cope. Furthermore, the difficulty experienced by research, in defining resilience suggests lack of understanding of how youth cope with difficult life experiences and their perception of it. To determine how they make sense of chaos, and create structure for themselves, in an unstructured and unpredictable world.

In an attempt to do this, this study asked the following questions:

1. When did youth first realize their mother/father was ill?
2. When someone in a youth's family gets sick, there may be changes.

What changed?

3. Who, in their lives was helpful?
4. How youth managed to get through the difficult times?
5. What advice youth would give to other youth in their situation/position.

6. What influence, if any did school or school personnel have on youth's experience as a child of a parent with mental illness?

CHAPTER 3

METHODOLOGY

Overview

This chapter explains my rationale for using a qualitative research design for this study. Procedures for ensuring credibility are discussed. In addition, I address my personal biases in reference to this study of resilient youth. Next, the procedures of the study, candidate selection, data analysis and the interview process are outlined. Details of participant criteria and particulars are provided.

Rationale

Quantitative research has focused on adolescent coping styles (Dumont and Provost, 1998) and assessment and identification of risk and protective factors (Heller et al. 1999). Although most of these studies are exploratory in nature, researchers enter the studies with preconceived hypotheses, thus eliminating the opportunity to address the lived experience of resilient individuals. In addition, a lack of norm references of resiliency resulted in an inability to generalize results of one study to that of other studies and populations (Heller et al., 1999). Furthermore, a need for multiple sources of data to determine internal and external influences on behavior inhibited researcher's ability to consider the interrelation of various aspects of resilience and protective factors (Heller et al. 1999). In short, the essence of the lived experience of resilient individuals is absent.

Smokowski et al. (1998) used adolescent self-reports and personal insights into resilience and their ability to overcome adversity. Yet, their study focuses on various risk factors of youth, in numerous adverse situations, not youth of parents with mental illness. Higgins (1996) interviewed resilient adults, who had been physically abused as children,

and translated their interviews into narratives. While this study is insightful regarding resiliency it does not provide accounts of, or explain the lived experience of children who have mentally ill parents.

Beardslee and Podorefsky (1988) conducted the only study that focuses on resiliency and the experience of living with a mentally ill parent. It has elements of a qualitative research approach. The author's interest in this area developed because previous studies had not been done on children whose parents had serious affective mental illness and adapt well. Yet, numerous studies exist on the risk factors associated with being raised by mentally ill parents. Beardslee and Podorefsky (1988) chose to assess the stability of adaptive functioning of a sample population with characteristics of adaptive individual's explanation of their own experiences. Their aim was to add to clinical interventions and prevention programs for children who have parents with affective disorders, determine how affective illness seriously impairs relationships and the protective factors utilized by resilient offspring.

Beardslee and Podorefsky (1988) chose to interview adolescents because: "The reflections of young people who have seriously affectively ill parents give a clear sense of exactly what experiences are troublesome. Also, given the lack of standardized and validated measures of resiliency, investigation of a subject's own perceptions of what enabled him/her to function effectively provides important information for understanding the psychological processes involved in such adaptive behavior" (p.63). Their rationale reflects my own. The issues Beardslee and Podorefsky (1988) mentioned regarding resiliency, thirteen years ago, have remained the same. Subsequently the aim of this study is to explain the lived experience of adolescents of mentally ill parents.

This study attempted to make sense of the lives of adolescents with mentally ill parents. The assumptions associated with this are that a pivotal event occurred in the youth's lives and that this event provides the "meaning structure that organizes other activities in a person's life" (Berg, 1995, p.65). This was a study of how mental illness infiltrated the lives of youth. How the youth's understanding and subsequent interpretation of the experience of living with a mentally ill parent changed with their development. As well as the role of school and professionals in the lives of youth with mentally ill parents.

Phenomenology is how one orients to lived experience (Van Manen 1992, Lieblich et al.1998, Berg 1995, Colazzi 1978). This phenomenological study views how youth orient themselves to the lived experience of having a mentally ill parent. It describes the participants' experience, interprets their resilience and suggests practices for schools and professionals. According to Lieblich et al. (1998), "... the mission of psychology is to explore and *understand* the *inner world* of individuals. One of the clearest channels for learning about the inner world is through verbal accounts and stories presented by individual narrators about their experienced reality. In other words, narratives provide us with access to peoples identity and personality" (p.7). Since no previous studies, have addressed the lived experience of resilient adolescents with mentally ill parents this study aimed to do so.

Study Outline

The following flow chart outlines the study.

- Topic of Investigation: Resilient Adolescents of Mentally ill parents
- Process:
- A. Interview Participants
 - B. Transcribe Interviews & identify significant statements
 - C. Develop meaning units around the following topics:
 - 1. Experience of living with a mentally ill parent
 - 2. Coping mechanisms of youth
 - 3. Helpful adults
 - 4. Influence of schools and professionals
 - D. Create narratives based on meaning units
 - E. Consult with each participant about appropriateness of narrative
 - F. Modify narratives according to participant recommendations
 - G. Repeat E & F until participants are satisfied
 - H. Cluster themes of narratives
 - I. Summarize narratives

Credibility

“Working with narrative material requires dialogical listening to three voices (at least); the voice of the narrator, as represented by the tape or the text, the theoretical framework, which provides the concepts and tools for interpretation; and a reflexive monitoring of the act of reading and interpretation, that is self-awareness of the decision process of drawing conclusions from the material. In the process of such a study, the listener or reader of a life story enters an interactive process with the narrative and becomes sensitive to its narrator’s voice and meanings” (Lieblich et al., 1998, p.11).

To ensure trustworthiness of the narratives the participants were consulted about the construction of their life stories. They ensured the correctness of the stories as well as the

meaningful events in their lives. This consulting process occurred continually until the participants were completely satisfied with the narratives.

Researcher's Bias

Van Manen (1992) suggest that we try to come to terms with our assumptions. “[N]ot in order to forget them again, but rather to hold them deliberately at bay and even turn this knowledge against itself... thereby exposing its shallow or concealing character” (p.47). He recommends that the researcher explain his/her own understandings, beliefs, biases, assumptions, presuppositions and theories. This researcher comes from the perspective of a teacher/educator, school counsellor and someone who has been termed ‘resilient’. As a teacher and clinician I have noticed that resilient youth have presented as mature individuals who perceive their difficult life circumstances from a different perspective than other youth at risk. Instead of perceiving their adversity as a roadblock or hindrance in their lives they approach it as a challenge. They assume responsibility for their lives and those of others. In addition, youth of abusive, seriously ill or mentally ill parents did not view their parent’s behavior as reflective of themselves; they appeared capable of separating themselves from their parents. Furthermore, they seem to have a strong sense of purpose in their lives with clearly defined goals. This led me to ask why these youth approached life differently from their at risk cohorts.

In addition, as I read literature on the characteristics and traits of mentally ill parents, I began to suspect that my mother was mentally ill. While, she was never diagnosed as having a mental illness she did demonstrate some of the traits of a mentally ill parent. Although we do not know that she was mentally ill, I found the accounts of youth with mentally ill parents resonated with my own experience as a child. My

childhood was very painful and confusing. I often could not comprehend my mother's motives for her actions. This pain remains today, and at times seems as raw as the painful experiences I endured in youth. It required much energy and strength while writing the narratives and listening to the participants' accounts of their experiences not to become too involved in their stories. To remain objective and remain remote, while not impossible, proved at times to be a challenge. Hence, the candidate's perceptions were the focus of this study. The biographical narratives were not included in this study, without the consent and approval of the participants.

PROCEDURE

Participant Selection and Recruitment

Consumer agencies and counselling psychologists within the Greater Vancouver Region were consulted for assistance in recruiting candidates. (Please see Appendix A for letter to colleagues). I decided to consult psychologists and consumer organization leaders for candidates because they would be able to identify individuals who demonstrated characteristics of resiliency. In addition, they could locate candidates who were able to discuss their parent's mental illness and reflect on its impact on their adolescent lives. (Please see Appendix B for recruitment notice). Upon identification of candidates, a preliminary interview occurred to ensure that they met the study's selection criteria and understood the nature and purpose of the study.

Candidates met the following criteria:

1. Age 19+
2. Have an awareness of their parents mental illness
3. Capable of discussing this experience and it's impact on their lives
4. Demonstrate resilience as defined at the beginning of the study

5. Lived with the mentally ill parent for at least six years and may still be residing with their mentally ill parent.

Study Sample

Of the six candidates, five were female and one was male. Their age range was 29-50+. Five had a mentally ill mother and one had a mentally ill father. All are Caucasian and living, working or attending school within the Greater Vancouver area. Two candidates live with their mentally ill parent and are responsible for their care. All of their parents became mentally ill after their birth, with the exception of one whose parent had a psychotic episode during birth. All parents became ill when the participants were very young. Education range for the candidates was high school graduation to attendance in graduate school. Two were attending post-secondary schools and one was involved in graduate school training at the time of this study. Of the candidates interviewed, two have bachelor degrees, one is presently pursuing a bachelor degree in psychology with hopes of attending graduate school, and another is attending post secondary school.

Marital status of the participants ranged from being single to married. Two of the participants were single. One candidate was married with children, one had been married with a child, and one was co-habiting while the other three were single. All of them live within the lower to upper middle class income range. Four of the six candidates revealed that they had received therapeutic support as adults regarding their experience of having a mentally ill parent. The other two candidates indicated that they sought the help and assistance of friends and family for support.

Interviews

A preliminary contact interview was made to ensure the participants understood the aim and purpose of the study and determine that they met the participant criteria. At this time, candidates decided on the location and time of the interview. The focus was both convenience and comfort for the candidates. Before the interview, I engaged in establishing rapport with the candidates and further assurance of their understanding of the study and its goals. A semistandardized interview style was used. That is a series of predetermined questions were asked in a systematic way, yet the interviewee was free and able to digress (Lieblich, et al. 1998). I probed beyond the candidate's answers to the standardized questions to draw out stories that are more complete. The wording of the questions was made so that the candidates could understand my intent and focus of the story. The questions posed to the candidates addressed both the positive and negative aspects of their experiences. Every effort was made to create and promote a non-biased atmosphere.

All candidates were ensured of the confidentiality of their interviews and subsequent biographical narratives. Random numbers were assigned to the recorded interviews and subsequent narratives to guarantee confidentiality. All interviews were recorded and transcribed.

Please see Appendix D for the list of interview questions.

Data Analysis

Holistic content analysis of the interviews was used. According to Berg (1995), holistic analysis is the preferred approach when individual's development to a situation is being studied. Since this study addresses the development of youth living with mentally

ill parents the holistic approach seemed to be most suitable. The narratives were constructed from an "... interpretive reading of symbolism underlying the physically present data" (Berg 1995, p. 176). That is, the themes of the interviews and significant meaning units were used to create the narratives. These themes were derived from a process of induction. I immersed myself in the interviews and transcripts to identify the themes and concepts that appeared meaningful to the interviewees. Then narratives were created. The candidates verified these narratives. When all of the candidates were satisfied with the narratives, the stories and themes of each were compared against each other to determine the common themes of the life stories. These themes associated with significant experiences of the candidates are discussed in the narrative summary in chapter four of this study.

Narrative Construction

Narrative construction was based on basic story format with a beginning, middle and end. In addition, they followed the format of the interview questions with emphasis on the following: the experience of living with a mentally ill parent, support and coping, advice to other youth as well as the influence of schools and professionals. Whenever possible the candidate's language and terminology was used in the text. My words are used to add clarity to events and to discern connections between events and explicate explicit meanings identified in the interviews. Every effort was made to emphasize the important aspects of the candidate's lives and experiences in the text. Once the stories were constructed they were verified by the candidates and modified according to their concerns and desired emphasis of content and the description of their experiences.

Summary

Since there have been no studies on the lived experience of resilient adolescents of parents with mental illness this was the focus of this study. The phenomenological research design permits the exploration of the participants' experiences and perceptions of living with a mentally ill parent. Emphasis is on the themes common to all of the participants to gain a sense of similarities of experience, coping mechanisms, support and influence of schools and professionals. Their stories are provided in chapter four.

CHAPTER 4

RESULTS

Overview

This chapter contains the narratives of each of the candidates. At the end is the narrative summary, which identifies the commonalities of the narratives. It also mentions areas of significance for the candidates that are not common with all of the other candidates.

The narrative summary follows the basic flow of the biographical stories and the interview format. The order of discussion is not reflective of significant aspects in the study. The focus areas are: the experience of living with a mentally ill parent, resiliency – coping strategies and support and influence of schools and professionals. Advice for schools, youth and professionals was important for the candidates of this study. Hence, their recommendations are cited.

Narrative 1

I began to realize that my mother was mentally ill when I was about nine or ten years old. She would say that she was hearing things that I never heard. I spoke to my grandparents about this, they were aware of her condition. Unfortunately, I did not quite understand what was happening, I just knew that there was definitely something wrong. Although her condition remained quite stable, while she did have times when her condition became worse she never had to be hospitalized. Usually when her condition became worse. It resulted in moving to another town. This was quite difficult for me, because as a shy child it was difficult for me to make friends, usually by the time I had just established friendships we would have to move again. Losing friends frequently resulted in my choosing to be alone. It hurt too much to lose friends. This resulted in increased isolation, as I had no contacts and my mother usually kept to herself. The frequent moves also made it difficult for anyone who may have been helpful, or detect my situation to intervene and provide support. In short, nobody ever knew about my mother's condition and I was too afraid to tell. Thus, until I was an adult and became aware of my mother's mental illness and support systems for her and myself, my mother and I were basically on our own without any supports.

Aside from the loneliness and isolation, I was frequently frustrated about my mother's illness. I did not understand why she behaved the way she did, at times I wished that I had a different mother, yet I struggled with feeling responsible for her and wanting to help. However, in time I learned that she was a wonderful person, despite her illness. I resent not being able to do anything for her, for waiting so long to help her. However, when I was young I did not know what to do or how to help her, who I could

talk to or go to for help. After all, it is not usual for a child to take his mother to a doctor. It was very hard to watch her suffer. For years I always comforted my mother, tried to make her understand and for the longest time I tried to rationalize with her, but was not successful. I wish that I had of had somebody else to talk to about our situation. I think that would have helped.

To cope I read a lot. I have probably read more than most kids. I also used to draw; I was a good artist. I spent time collecting comics and playing video games. "I just kept on going to school and doing my thing. There was nothing I could do to change things... I had no power". Thus, I would engage in activities that would take my mind off my troubles.

For other youth in my situation, I would advise that they not wait as long as I did to seek help or to talk to people about your situation. Even if you cannot do anything for your parents, at least you will have someone whom you will be able to talk with about your situation. Do not keep it to yourself. When I was a teenager, I never thought that I would find someone, who understood my mother, especially when I had so much trouble understanding her. Seek help, do not wait, and keep asking until you get it.

As for professionals, I would recommend that you acknowledge and recognize that a schizophrenics link with reality is and can be non-existent. Take more of an active role in the mentally ill patient's care. Do not leave it up to the patient to take care of him or herself, often they are incapable of doing so and are not aware of what is best for them. For example, my mother hates doctors. Thus it is extremely hard for her to show up to a site where there are numerous doctors who are constantly telling her there is something wrong with her when she believes that she is healthy. Often people with mental illness

will have little insight into their condition. It is the responsibility of the professional to help the patient gain insight. When this is not possible to take an active role in the patient's care.

In schools, I would advocate for education of youth, teachers and school personnel about mental illness. To teach acceptance and tolerance about mental illness to all individuals involved in the education system. Present the information with an open attitude, understanding and compassion. Also, establish a means of communication for youth of parents with mental illness, help them realize that it is okay to talk about it and seek help. Ensure that any awareness of the parent's condition remains confidential because high schools are mine fields for gossip and rumor. Perhaps a crisis line for youth that have mentally ill parents would be beneficial. Yet, do not forget to remind youth that while things are difficult now, there is hope and things will get better.

Narrative 2

When I was twelve, my father was hospitalized for pneumonia; this was my first introduction to his mental illness. I was not formally introduced; I just became aware in listening to my mother's discussions of my father's illness that he had other medical issues. The other time, when I was the same age, I witnessed my father having a panic attack. My brothers and I had purchased a couch, as a gift for my mother, while the movers were transporting the couch from the truck to the house my father arrived home. He believed that we were moving out of the house, no amount of reasoning, explaining or rationalizing changed his perception. He had a big blow out and appeared to 'totally lose it'. This was the first time that I made the connection between his behavior and mental illness.

Since my father was the primary wage earner, his illness had a significant financial impact. Also, due to his illness my father had difficulty managing the finances of the home. He also had a tendency to participate in various financial schemes, which were unsuccessful. Hence, my mother had to assume responsibility for household finances. Another change was the family dynamics. In time, I began to feel that I could not trust my father. Hence, I would turn to my mother for support. This affected change in my relationship with my father. The relationship between my father and brothers also became strained, especially since he began to deal ineffectively with them. The most significant was the lack of security, inconsistency, and unpredictability of life. Also my father began drinking and would frequent the bars my male, high school friends, visited. I found his behavior very embarrassing when I was in high school.

Fortunately, I learned to be very flexible. This helped me get through the difficult times. In addition, my mother was “sort of the rock, you know the person that kept things going”. Also, my brothers were very good. Yet, like many families with a parent of mental illness, we kept it a secret. Although we were a very small community, the belief was that my father was an alcoholic. We were secretive because not only would nobody understand what schizophrenia was, but also they had never heard of the illness. Yet, the people who helped made an impact by their small gestures. For example, a lady up the street mentioned that not all relationships were like my parents and it was possible to find a happy loving, peaceful relationship. For me, this was tantamount. I had essentially sworn off any possible relationships because what I perceived from my parents experience was far too complicated and hurtful for my mother. For example, when we visited my father in the hospital for pneumonia my mother had to come at a specific time so that she would not be there at the same time as my father’s girlfriend. When this lady told me she was happily married, “it was just a silly thing, you know but it, it somehow comforted me to know that sometimes things don’t work out well, but sometimes they do.” In addition, my godmother’s would send little notes every once in a while or call to show they cared. This made me feel as if I had support. I also had a tendency to spend a lot of time with my friends so that I could avoid home. Often many of these families would adopt me as their own, surrogate child. Fortunately it was a small community and our family remained there throughout my childhood years. This enabled me to establish some strong and lasting friendships. I also enjoyed school. “A few of my teachers were excellent”. I particularly remember my grade 10 Drama teacher. As part of our mark she expected us to write a journal entry each day explaining what we had learned. For me the

contents of this journal extended far beyond the classroom. Religiously after school each day I would come home, sit at the kitchen table, and immediately begin writing. I feel that there was a special bond between my Drama teacher and I. For me, this journal was my saving grace. My mother had left for Florida that year, in an attempt to promote a crisis and subsequent change in my father – that is force him to bottom out and obtain the necessary medical treatment and help. Thus an essential member of my support system was gone and things were exceptionally chaotic at home. Through this journal writing, my teacher “became that person that listens to you”.

The unpredictability of the experience was most difficult to deal with as well as not having a relationship with an adult male. However, having two older brothers helped. As a teenager, I found my mother’s pain and suffering to be the most difficult to watch. She was a lady who never complained and would never reveal that she was in pain, but it was there. There was a lot of sadness, which was never discussed because we were all in survival mode.

Often I would, when things became too difficult, go for a jog or walk to clear my head, take a deep breath, acknowledge that it was not the end of the world and feel ready to go back. By the end of my walk or run, I would feel as if I could deal with it again. When I reached high school, particularly in my last two years I used goals and certain things I wanted to do in life, to help me march forward. Near the end of high school, I had decided that I wanted to attend university and then teacher’s college. In order to attain marks high enough to enter university I would rise at 4:00 a.m. each morning to study, because that was the only time our household was quiet, calm and peaceful. This became my ritual during my last two years of high school. I needed to work hard, not

because I was unable to do the work, but because in grade nine, my father was very ill and since things were too hectic at school, I was unable to focus. Finally, my mother had requested that I decrease my workload, in grade nine because I was failing half of my subjects. I remember thinking that I was unable to do the work, at that time, but this self-doubt about my academic abilities did not last long.

I guess what surprises me about school, when I was struggling academically, is that nobody ever spoke to me about it. While I know that my mother often came to the school to discuss matters, and was very open about my father's illness, I also had a physically handicapped brother, thus most of her visits were regarding him. Hence, I do not know if the school personnel were aware of our home situation or not. However, it would have been nice if somebody had discussed it with me and explained "you know you're not stupid, you're just dealing with a lot". This would have prevented a few years of my feeling that I was not bright enough to do well in school. Fortunately, even when I doubted my academic abilities I had a positive self-esteem. My mother was "fairly instrumental in keeping my self-esteem fairly positive".

When I think of what I would tell youth, I think of how three brothers and myself coped and dealt with the situation. In my family, there were four children and four separate ways of dealing with the experience. One brother used fantasy, I feel a little too much, but he would write to a pen pal and make up a completely different life for himself. For me goal setting helped. "To have goals, to have things that I wanted to do in my life, that was really important. So that I could distance myself." As well, to take some time from the situation, get yourself out of the house; find something you enjoy which will give you a sense of reprieve. An activity, club or hobby that will take your

mind off things, so that when you return you feel as if you can handle things again. To day, I think you could access counselors, teachers or adults in the neighborhood for guidance and assistance. I think there is more awareness and support out there now than there was twenty years ago. It is hard for me to make recommendations because I think the parent's illness and symptoms can have a huge impact. For example, my father is schizophrenic but he was always very gentle, the biggest problem we had was trying to bring him back to reality. He was never violent and rarely mean. However, mentally ill people can be violent. I think you would deal with a violent person much more differently than they would deal with a nonviolent person. Thus, it would be necessary to know what the illness was and how it presented for the ill person, in the family and its effects on the dynamics in the family as well as the youth. In addition, an assessment of the youth's self-esteem would be important, because a positive self-esteem can help you move through the difficult aspects of life in more healthy ways. I would recommend that if you have a low self-esteem to seek help so that you may build yourself back up again.

As for teachers, I would recommend the use of journals no matter what grade you teach. I as a teacher of elementary school use journals, and although they are just pictures they can be very telling. I do believe that schools are very good about catching things and consulting with parents regarding matters.

Despite my mother's involvement in the school, due in large part to my brother, and her openness about our situation, I did not have too many positive experiences with staff. This, I think, in high school, was because while I was struggling I was not a model student. However, I also think that when I was having difficulty focusing in class and on my schoolwork, it could have been dealt with in a different, more constructive way. For

example, I remember in grade nine sitting in one of my classrooms and always staring out this window. Right outside the room, there was a large tree. While I credit my teacher for noticing, out of his thirty-one students, that one was not listening, I do not feel that asking, "Is your boyfriend up in the tree out the window?" was very helpful. While this may have resulted in my looking out the window less, it did not get to the heart of the matter, which was what was bothering me. Also, in grade eight, I remember walking past the vice principal's office and hearing him say, "Oh, that Mrs. X, she's always here I wish she'd just go away." I was really hurt when I heard this and felt that he could do more to help us especially since he knew our family was struggling. I wanted to defend my mother; the small amount of respect I had for this man was eroded at this point. In light of my experiences, I would recommend that teachers and professionals display more compassion to struggling families and try to be supportive.

Narrative 3

My mother became ill when I was very young. My first recollection of her illness was when I was four years old, nothing in particular stands out, except my awareness that my mother did not cope very well, cried easily and was paranoid. I remember being isolated, from social contacts because of her illness, particularly her paranoia, she always seemed to believe that people were out to get her or against us. In addition, she had great difficulty making friendships and sustaining them. Unfortunately, my father died when I was very young, in a trucking accident, and my mother never remarried, which left us in a very disadvantaged situation.

My mother seemed to have great difficulty overcoming the loss of her husband. She seemed to dwell on his death. Often she would identify a child, from a particular war song on the radio and discuss at length the similarities between the child in the song and myself. I remember being heartbroken as she would speak of our loss and wondered why my mother would continue to discuss this issue; despite the obvious pain that it would bring me. She appeared to be amiss of my pain. In fact, affection or comfort from her was meted out according to her personal whim, not whether I needed or deserved to be nurtured or comforted. It was hard to predict how my mother would behave or interact with me on any given hour. Hence, life as a child was synonymous with walking on eggshells.

When my mother became ill, many people – both family and friends pulled away from us, in addition, my grandfather worked diligently at covering up my mother's illness and keeping it under wraps. He would often tell me, particularly when I reached school age, not to tell anyone of my mother's behaviors because either my mother or I would be

removed from the home. When my grandfather informed me, that my new living circumstances may actually be worse than those I endured at home, I was sufficiently silenced about my home situation. In fact, I was afraid of my peers asking questions at school, hence I would not socialize with them, thus isolating me more. Yet, when I did make friends it was hard to realize how different the mother's of my friends were from my own, how predictable and understanding they were. They would not assume that everything their child did was purposeful, or rage because you looked at them wrong or broke a glass. Unfortunately, we were unable to visit these families or many others because my mother would become uncomfortable and irritable when she was out of the house for a short period. This resulted in a lack of significant social contacts. Furthermore, my mother's lack of knowledge and comprehension about many world concepts and events hindered her from assisting me with my schoolwork. Not only was my mother unavailable emotionally, supportively and academically, she was also often 'unavailable' – that is, physically present, but off in another world by herself. It was at these times that she was the most hardest to reach and if I did connect with her, while in a trance, my mother would be very angry when I would vie for her attention. In addition to the trance like states, my mother appeared to be devoid of emotion; her affective responses were blunted. Periodically, she would display a burst of emotion, but not very often.

Fortunately, my grandfather lived with us. When my mother would have her difficult moments, I would run to him for solace and comfort, particularly as a young child. He also had a friend, who would speak with me and explain my mother's condition to me as best, as he could. When I became a teenager, I found some teachers at

school whom I could speak to about my mother. They ran the Interschool Christian Fellowship, would comfort me, listen and pray with me. My faith has always been very important to me. I feel it has helped me cope a lot with the difficult times. In our church, there was also a priest who permitted me to call him when things became difficult, he would also check in to see how my circumstances were and make sure that I was okay.

Despite this adult support in my life, I found it difficult to trust adults and never felt secure or cared for, I did not feel loved. Not feeling loved or nurtured was the most difficult for me. I believe I felt this way because my mother would choose when to display affection of any kind, when it suited her. In addition, as a young child, when I tried to tell people what was happening, they did not believe me, hence I did not feel validated. In fact, those who spoke to my mother regarding my disclosure labeled me as a bad or rebellious child. This made me believe that my feelings and needs were minimized and insignificant to adults. Since I could not rely on adults, I learned to depend on myself. I had to look after me. When my grandfather was around, I would seek affection from him or anyone else who was willing to pay attention to me.

Somehow, through God I was given the inner strength to depend on myself. I believed that I was a good person, that I could overcome this obstacle in my life, that it was not my fault and that it was not about me. Each time, an issue arose; I reminded myself that I was a deserving and worthwhile individual. In addition, I watched some television shows that had good family values, such as: The Waltons and Little House on the Prairie. These shows helped me realize that my mother's illness was not about me, that there was not something wrong with me and that it was all right to reach out for what I needed. I learned to recognize people who validated me, respected my needs;

“...people who were interested in me and what I had to say, respected my opinions and wanted to know what it was that I needed, wanted to know how I felt and didn’t get mad...” I learned to avoid people who were condescending or did not give me positive feedback.

I would recommend that other youth in my situation look for their own inner strength, your inner voice. This, I feel is the most important thing to do for survival. This voice will be an excellent source of encouragement. It is reassuring and protective. Also, look for healthy, supportive adults who can give you the support and validation you need. Remember, “there is help out there, there are people you can trust in life”. “And you can succeed in life, it might not seem like it at the time, but you can”.

Professionals are good source of support, but I would recommend that they listen to the youth, validate their feelings and let them know that their feelings and opinions are important. Furthermore, I would recommend that teachers try to understand students’ behavior and actions not assume that they are inherently bad. Recognize that behavior has a purpose and, in the case of children with mentally ill parents, it may be the only way for the child to let others know that there is something wrong. Also, do not treat the children of mentally ill parents as if they are also ill, this is very degrading and does not engender confidence in youth. In fact, it leads to mistrust of adults and professionals.

Narrative 4

My mother, I believe, had her first psychotic episode when I was four or five years old. I remember that I was really young and my mother was away from home for awhile. After this, our family united, in a sense, to protect my both my mother's image and that of the family. We did our best to present as a normal family and look good. Often this meant that my older sister and I had to assume responsibility for the managing and running of the household as well as duties involved in the maintenance of the home. We did this, because we wanted people to believe that our mother was taking good care of her children.

Fortunately, my older sister, who is five years my senior, not only assumed much of the care taking responsibility but also enjoyed taking care of me. When we were little, I was her little doll. We each benefited from our respective roles, her as the responsible older sister and me as someone who had a caregiver that accepted responsibility for me. In addition, I had an aunt whom I adored, loved and respected. This aunt took care of us when our mother first ended up in the hospital and explained what was happening to our mother. She was like a grandmother to me not only because she was older than my mother was but because she was a very loving, caring, social, religious person. In addition, she had a very nice family. I spent a lot of time at her home, as a child, during weekends and holidays because my mother could not cope.

For me, what made it difficult to cope was the worry and fear of what would happen to my siblings and me if my mother became more ill. The uncertainty of our future scared me. Yet, as a young teenager I experienced a great deal of anger at my

mother's inability to function or complete tasks which I deemed to be simple. I remember yelling and banging doors because I was upset that my mother was unable to meet my needs. However, in my mid to late teens I came to understand my mother and stopped spending a lot of energy on wishing that things could be different. I began to learn that there are some things that you cannot change. Some things you learn to accept. I began to recognize her positive attributes such as her gentle spirit and how hard my mother really tried to be a good mother. I recollect seeing her "go down into her depths and just dragging herself up so that she could help us make our lunch or something..." Such insight came after much soul searching which I believe was spurred by my observations of my mother's life, her illness and consequent marital history. I began to realize that some of her difficulties were due to the person she married, that she was doing the best she could and that she had a lot of really good qualities. With this awareness came an inability to be angry with my mother and her illness. Yet, that did not make life less difficult.

My sister helped make it less difficult, as well as the weekend visits and summer vacations with my aunt. Of most importance was the awareness that somebody loved me. I was certain that my aunt loved me, knew my sister and mother loved me, but was never quite sure whether my father loved me. I remember being certain and comforted by the thought that my aunt would be there for me when my mother could not be. In addition, my sister and I were very close, even throughout our teen years. In fact, we parented each other regarding make-up, appropriate dress, social behavior and dating rituals. In addition, despite my father's frequent absences, he had a love of life and knowledge, which we truly admired. Furthermore, despite my mother's illness, she was a very

empathic listener. She was the type of person you could talk to about anything.

Unfortunately, she was unable to assist me with setting boundaries, but I learned to speak with her and then set my own boundaries.

Recognizing your own boundaries are important, particularly the boundaries between yourself and your parents illness. In addition, finding someone who can support you, in the absence of your parent can be helpful. Use other sources, such as school, clubs, church or family to help you attain the skills you need to develop and emotional support necessary for your growth. After all, when your parents' not there, "the bottom line is what are you going to do?" Acknowledging your strengths and skills taking stock of your strengths and supports in life, is the first step in achieving the nurturing and love you need.

In addition, adults, teachers and professionals can help youth in taking stock by reminding them of the power and authorship youth have over their own lives. For me, a pivotal moment was when a teacher mentioned, when I was in grade seven, "You know you're going into grade eight, and it's a new start, you can decide how your life's going to go from here, you need to take stock." This statement helped me determine the steps and strategies I would take and use to navigate myself through my teenage and high school years. Also, it helped me realized that if a person is unhappy with his/her situation in life, steps can be taken to change his/her circumstances from negative to positive. It helped me realize that I can change my life. I feel this is an important message for teenagers because many young people, I think, feel as if somebody else is in control, when it is the youth that is in charge of his/her life.

Despite this inspirational statement, by a teacher in grade seven, I had an unremarkable experience with school in my youth. For me, the elementary school years were most difficult because there was a heavy reliance, on the part of the teachers, for my mother's input and parental responsibility. This was very discouraging; particularly when marks were deducted because we could not perform a task, which required my mother's assistance, one such example, is starching and bleaching an apron. In addition, I found that the teachers seemed to take my absences personally. I could not understand why my teacher would be angry about my absence from school. Some of my absences were due to taking care of my mother, but many of them were due to an illness I experienced as a child, which was finally corrected after a series of operations. While, I was not keen on school, my sister was. She excelled at school and acquired much of her sense of self through her marks attained at school. When I would see her upset about not attaining, a high mark for something beyond her control – the apron – I would feel upset at the unfairness of the teachers' marking system.

Another area of support, which I feel my sister and I missed, was involvement in clubs. This was because we often felt pushed out of any clubs we would enjoy because of their reliance and high expectations for parent involvement. Obviously, we had no such involvement with a mentally ill mother and an absentee father. Hence, because we felt shamed that our parents were not what teachers and club facilitators expected we learned to adopt the persona of a highly functioning child of society and present the image of a healthy, happy family.

Fortunately, I found the teachers in high school to be more fair minded, open and accepting. Furthermore, it was in high school that I found a good group of girls to

socialize with and be friends. It was here that I learned how to make school a nice environment for myself, expand my systems of support and acknowledge both my own personal strengths and those of my mother. I think this is an important part of survival – acknowledging your strengths and support systems and remaining in school. It is important, to recognize what you and your parent are capable of and not to blame yourself or your parent for his/her illness. In addition, it is important to not do anything harmful to yourself, find surrogate parents and if your not able to do this, develop relationships with others, were from each person you get something you need to keep you healthy, happy, feeling connected, supported, needed and loved in life.

Narrative 5

My mother became ill shortly after I was born. Although she had schizophrenia all of her life, my mother became much more ill, when I was a teenager, and had to leave home. However, she did have periods when she was better, during this time she seemed normal, except that she was quite depressed. Her depression had a whole other effect on the household and family than her psychotic attacks. The psychotic episodes were frightening but only periodic, while my mother's depression was part of our everyday life and left me feeling responsible for her well being. My whole family had difficulty understanding my mother's depression; in fact, my brother and father were a bit hard on her. I remember my mom slept a lot. Thus, with her depression and schizophrenia we went from periods of stress to more stress. When my mother was very ill she would have to go to the hospital, and if my father was working out of town, someone would have to come and take care of us.

Fortunately, I was a good student. School was a real refuge for me. I loved school, especially in elementary school. I remember I went for years without even missing a day of school. This helped because my teachers really liked me. In addition, I was involved in Brownies, Girl Guides, softball and swimming. Keeping active helped me cope. Unfortunately, none of the adults at school or in my clubs was aware of my situation; thus, they never offered support that way. Yet, although my father was an alcoholic and my mother was mentally ill I knew and felt that they loved both my brother and I. Furthermore, as a child I always felt that I had everything I needed. Although there was emotional neglect and a lack of support, our physical needs were met. Also, my father is a very resourceful man. He taught me how to be resourceful and generate

opportunity from a difficult situation, mostly in a practical sense and I learned to apply this resourcefulness to personal areas of my life.

However, I did not feel as if I had much of a support system for coping with my mother's illness. My brother, who is older, had pulled away from the family. He left home as soon as he could. He had a lot of anger about the situation. In my adolescence, I tried to reach out to a school counselor, but when I explained my situation, he told me, "If you don't pull yourself together, what man is ever going to want you?" I was devastated by his response and I never sought help again as an adolescent. This was unfortunate because by the time I was a teenager I had internalized a lot of shame associated with my mother's illness. Our whole family had internalized this shame. I think this shame even prevented me from telling my friends about my home situation. Despite the fact that I had numerous friends, I never felt like I could talk to them about my family, although they did help me to keep busy and away from the tension at home. In addition, I began dating, from the time I was thirteen. This relationship lasted for about three to four years, on and off. For me it was an odd relationship, quite controlling, he was older than I was also. I think I became involved in this relationship because I was unable to look at relationships in a healthy way. I think that if things had been okay at home I would have realized that I did not have to be interested in that type of relationship. Another area of struggle for me when I entered high school was that I perceived myself to have poor social skills. Perhaps this was due to the chaotic dynamics at home and also due to my dwindling self-confidence; however I did manage to make a lot of friends. In addition, although I bounced back easily as a child, I experienced immense struggles as a teenager. First, I was hypersensitive, to the point where I would

burst into tears if I had to discuss a tense matter with someone. Also, I had significant regret about not pursuing post-secondary education, especially when my peers, who had lesser abilities than I, had gone on to college or university.

Despite my own personal struggles, what I found to be the absolute most difficult experience for me was how my mother was treated. I found it very hard to reconcile how our world treated people with a mental illness. When I was approximately seventeen my mother was residing in a home, that paralleled that of the East End. I felt powerless about her circumstances, but I did not know how to help her. While I knew that my mother was ill, I did not have a lot of insight or knowledge about her illness, yet I knew that it was not her fault. This led to feelings of guilt when I would become angry with her while I was a teenager. I also felt guilty and upset about how my father and brother would treat my mother as well as the world at large. This awareness, of how cruel our world can be, made the transition from adolescence to adulthood a very difficult one for me. I think this was also due, in part, to some hidden fear that I could also become ill like my mother.

If school had not been such a pleasurable experience. Throughout my childhood and teen years I remained in survival mode and used achievements at school as my focus, outlet. School was my 'saving grace'. "If I hadn't had that, I wouldn't have had anything." Despite school's anchorage, with its structure and normalcy, there is no one that stands out as being particularly helpful; that is, there is no one who became involved with or expressed interest in my personal life or problems. This is surprising for me, in a way, because in high school I missed numerous classes due to the stresses experienced at home. In fact, in my final year of high school I missed more classes than I actually

attended. I would often attend a class then go home and come back later. I would write my own notes and sign my mother's signature regarding my absences. My homeroom teacher became aware of this when he called my home and found out that my mother was not living there at the time. He told me that he knew about the notes and let me continue - he told me that as long as I continued to do well in school there would be no hassles. I wish he had asked me what was going on, not to get me into trouble, but at least to try to steer me toward some help. However, this flexibility helped me to cope when my world was falling apart and at the time, there may not have been any real help that he could steer me toward anyhow. Also, I had a math teacher who would take the time to sit with me, at the end of the day, to explain the lessons I had missed, without any pressure about my missing classes. I think my strong academic performance – ability to remain an honors student – despite my lack of attendance, encouraged my teachers to give me this leeway. I do not think that I would have received the same treatment if I had been a weak student. Hence, I feel my ability to do well in school was a gift, it encouraged teachers to give me the necessary leeway during difficult times, engendered their pride and gave me a focus, sense of stability in an unstable world. The one thing that would have made my experience better would have been to have someone who I could talk to about what was happening at home.

That is one of the key pieces of advice I would give to youth of parents with a mental illness, find some one to talk to because "...the sooner you get okay about talking about things, the sooner you'll be healthier." Seek out support and possible support groups. Meeting others who have been through a similar experience can be very helpful; it helps you realize that you are not the only one. What helped me, as an adult was

becoming more open and accepting of my mother's mental illness as well as "being okay to talk about it, to learn about it". Yet, be careful whom you talk to about your parent's illness. After all your friends may not be the most open or educated people about this situation.

As for adults, teachers and professionals I would recommend that they become educated about mental illness, gain some insight into what mental illness is and how it impacts each family member as well as the family unit. Furthermore, be aware of your own hang-ups about mental illness, because if you have closed attitudes this will reflect on how you cope and deal with family members and mentally ill individuals. In short, you will not be very helpful. "I think that if we view mental illness as negative per se, it makes it harder for the child, because the child came from the parent" – who is mentally ill. Hence, if you have negative attitudes about mental illness or people who are mentally ill, what message are you sending to the children? That not only is the parent defective, but they are too? Where is the hope in that? Positive attitudes and acceptance are where the hope lies for the youth and family members of people who are mentally ill.

Remember that the healing process is about acceptance, for all parties involved and identifying the positives that came from the experience. If you do have issues surrounding mental illness, it would help to address them before trying to help someone else find acceptance around these same issues. Helping people to reframe experiences and attitudes is necessary for assisting families with a mentally ill parent. Also, listen. Hear what it is that the individual and family members have to say. Usually family members do not seek help until either they or the whole unit has reached its breaking point, thus being aware of the impact of mental illness on the family and providing

subsequent support is essential. When the family is in crisis, it is too difficult, and sometimes too late to intervene. Introduce support and assistance when the family is not in chaos and things are reasonably calm.

As for school personnel, I would encourage school counselors to present with a more open, collaborative and supportive attitude than what I received as a youth. Be available for youth to speak with you. "You know, we never, ever talked about it, in my family or anyone. Yet there was, like this you know super crisis that was happening in our home all the time but nobody ever talked about it. Well that didn't make it less; it made it so much heavier, scarier and bigger. If we had of just talked about it, it would have diffused it. But nobody ever knew how." Teach youth how to talk and communicate about the difficult things and issues in life. This is a valuable skill to have. Counselors, share your skills and training with youth. Also, if personnel are aware of mental illness in the family, provide flexibility, like what I received, when necessary. Flexibility in life is important, as is structure. Help the youth find a suitable balance between both. Also, talk about mental illness, be open about it, educate youth about it, and be available for discussions of it. Do not forget the importance of compassion and acceptance of both the youth and the mentally ill parent. This is what will instill hope in youth. Recognize the courage in someone who is mentally ill yet makes a life for him or herself. Sometimes it helps to put your self in the other person's shoes, assist youth in doing this, regarding their mentally ill parents, if they are ready. Also, help dispel the myths about mental illness, particularly those portrayed in the media. Furthermore, acknowledge the childhood fantasy of wanting to rescue the ill parent, cure him or her – to save the ill parent. This fantasy can hinder personal growth in youth. Help youth

realize that while they cannot cure the illness they can be 'there' for the ill parent. Help youth come to terms with life and its limitations, accept life as it is and stop thinking that it should not be the way it is. In addition, provide guidance for youth when it is needed, that is when they are so overwhelmed that they are unable to determine the correct path for themselves. Please remember that the final year of high school marks a significant life transition, from childhood to adulthood. It often involves the confrontation of childhood issues. Navigating this transition is difficult but it is even more so when one is raised in a chaotic home with little or no supports. Watch for those who are struggling.

Narrative 6

My father had his first psychotic episode during my birth. I feel this must have been quite distressful for my mother at the time, because a mother wants her husband's support. However, my father was not available because he was on the psychiatric ward. Perhaps, this episode happened because he was scared and worried about becoming a father.

Although my father was mentally ill throughout my childhood, adolescence and adulthood I was never privy to the nature of his illness until I was 18 years old. At this time, I pressed my mother for information. She broke a promise to my father, in which they would always keep his illness a secret between themselves. It was when I inquired about the possibility of hereditary influence that she acquiesced. Finally, my father's illness had a name – Schizophrenia. When I asked my mother to explain his illness, she was unable to do so. She had lived almost her entire life with a man who was mentally ill and never attempted to understand his disease.

Life with my mentally ill father was not violent. In fact, he was not a violent man. The only time we worried about our safety, was when I was approximately nine years old. My mother woke my sister and I up in the middle of the night because my father was hallucinating that there was a bear in the living room and feared that it would harm us. It seems my mother was unable to pull my father out of his hallucination. Thus, she had sought the assistance of us children. She had hoped that seeing and interacting with us would bring my father back to reality. Both my sister and I tried, however we were not successful and my father went to the hospital a few days later. In

addition, at this time he began to store knives under his bed because he believed the bear was in the back yard. At this time, my mother disposed of all of the knives in the house. Aside from this one of the most difficult components of having a mentally ill parent was the stigma and shame associated with his illness. Often my sisters and I would be asked "What's wrong with your dad? Why does he seem out of it? Oh, did he just have a nervous breakdown?" "Is he on drugs?" Obviously, without any explanation of what my father's illness was or anyone to talk to, we could only feel shame and the negative stigma associated with his illness.

Overall, my father was a kind, caring and competent man. He ran his own landscaping business, sent his three daughters to private school, kept us clothed, fed, and ensured that we had a home. In a sense, he was quite resilient for a man with mental illness. In addition, he was the only wage earner in the family. Unfortunately, this meant that there were times when my mother was hesitant to take my father to the hospital, because this would mean that she would be left without a means to provide for her children. Yet, when he was a patient in the hospital I was permitted to visit him. The visits of my father in the hospital began when I was nine. Before this, he would go away, but nothing was ever explained to me. Despite the lack of explanation, I was able to discern that his behavior was not normal – it was weird. The characteristics which I found weird were that he slept a lot more than normal, rarely communicated or raged when he did, cry for days and see things that none of us were able to see.

The experience of having a mentally ill parent, led me to have difficulty trusting people, perhaps this was due to the unpredictability of his behavior. Also, I recall being sensitive at school whenever I would be bullied or teased. What I struggled with most

was my parents fighting a lot when I was little. I believe this had a lot to do with their communication with each other. In addition, my father's negative and positive, primarily the negative effect of illness affected his communication. He seemed to have difficulty with empathy toward my mother; he did not appear to understand her struggle. Their fighting affected my safety.

As a child, I coped with my father's illness by becoming involved in sports. I remember being involved in every sport, possible at school. Unfortunately, none of my teachers knew about my father's illness. This was because our family put up a good front. It was the extracurricular activities, and being involved in them that helped the most. Yet, when I was a teenager I acted out. I was angry, but did not know why. Now I know that it was because he had a mental illness, but at the time, I only knew that there was something wrong with him, but his illness did not have a name. Actually, until I reached puberty, I excelled in school. I think the change in my behavior began when I attended summer school, for a class I failed, despite my best efforts. At summer school, I found teenagers who were different from any I had ever known at private school. I befriended a girl, whose mother, I believe, had schizophrenia. We would talk about our parents and compare their behaviors and medications – unfortunately, my friend could not name her mother's illness, and thus we remained in the dark.

The incidents in my adolescence that stand out for me include being caught for shoplifting and becoming pregnant at age 15. I gave the child up for adoption, because I knew I was not prepared to raise a child. My probation officer reached out to me, but I did not trust her. Unfortunately, my parent's were unavailable for me during my

adolescent struggles – my mother had to contend with both a mentally ill husband and two small children. Despite this, I survived.

To get through the difficult times, I believe I dissociated. That is I would go through the motions in life, be in survival mode. In addition, whenever I did something I put 110% effort into any activities I became involved with at school. I think the extreme amount of effort I put into my activities was an attempt to avoid, or hide from my feelings.

Everyone in my family compensated for my father's illness. My mother was the caregiver. Since there was a large age gap between my sisters, and me, I became a little parent to them. In a way, this gave me a sense of purpose, identity, a sense of belonging. Yet, my mother's illness has affected my family members in different ways. My mother did not have the support or companionship of her spouse. Because she was care taking for my father, she had little time or opportunity to become involved in my sister's lives or activities. Fortunately, I received a lot of attention from my father when I was younger. However, when I moved out of home, there was more money available for gifts that were more expensive and special trips.

The advice that I would give other teenagers would be to seek counseling, find somebody that you can trust outside your home to talk to about your experiences. Find a professional, who is willing to listen and can provide you with the empathy you cannot experience at home. Furthermore, do not do things that are going to hurt you! In addition, although there is a lot of shame and stigma associated with mental illness, please remember that your parent's illness does not define you, it is not who you are. It is also important not to blame yourself, because you do not have control over your parent's

illness. It is not your fault. Also, try not to get too involved in the drama. Allow yourself to have fun, be yourself and do not let yourself be consumed by your parent's illness.

In addition, educate yourself about your parent's illness. An awareness of the illness, its effects on your parent and symptoms can lead to an increased understanding of your parent's behavior. This will also enable you to realize that you are not the cause or influence of your parent's behavior. Once you understand why your parent's are behaving in a certain way, you will stop feeling responsible for their behavior. Furthermore, educate yourself about resources available to yourself, your family, your parent and youth. Keep seeking until you find the help you need, it is out there.

Since family members are in frequent contact with the ill member, they are better able to recognize indications of the ill member's relapse. Unfortunately, professionals do not always acknowledge the family's awareness and help is often provided too late. After much pain has occurred in the home. Hence, professionals need to listen to families when they cite the progress of the ill member, acknowledge both their role, and support in the ill member's care.

As for adults, teachers and professionals, educate yourself about mental illness its impact on the family, the various types, as well as the different roles family members play. Furthermore, do not forget the family, or leave them out. Be compassionate to both the ill member and the rest of the family. Become informed and adept at detecting the various behavior patterns of children who have a mentally ill parent. If someone reaches out to you, talk to him/her. Furthermore, help the child become aware of the mental illness, especially since there is a genetic predisposition to the illness or becoming mentally ill. Please watch the children of the mentally ill parent, for symptom of mental

illness and help them get treatment. Help families educate themselves, to become a support system for each other and have the opportunity to communicate with each other about the illness. Do not let family members go through the experience alone or isolated, like my family. If the family acknowledges the illness, they can have better relationships with each other, pull together and be a supportive unit. In addition, offer support groups for teens that have the same struggles. Furthermore, provide outings for teens and children of parents with mental illness such as: horseback riding, hiking, trips to Science World or the museum. Living with a mentally ill parent can make life isolating. Help bring the kids out of this isolation. Advocate for and establish an intake protocol for dealing with mentally ill patients and their families when they are diagnosed or admitted to hospital. Find out about the marital history of the patient, family structure, economic factors and number of children. Have a system that permits the provision of resources, childcare, counseling, clothing, home care, etc. for all family members. In short, do not focus solely on the treatment of the patient. Mental illness is a familial issue, treat and support the whole family.

Narrative Summary

All of the candidates grew up in homes where their mentally ill parent became ill in the candidates' early childhood years. For most, the onset of their parent's illness occurred prior to their attendance at school. Hence, for them the onset of the illness was not reflective of change, mental illness was a way of life, one that they cannot remember living without.

Despite the predominance of mental illness in their lives, all of the youth knew, from early childhood, that there was something wrong with their parents and their parents' behavior was not typical of other caregivers. However, they did not make the connection between their parents' chaotic, erratic, predictable behavior and mental illness until their preteen years – age 10-12. Although they became aware, in their preteens, that their parents were mentally ill the majority of the candidates did not have a name for their parents' illness nor were they educated about it. One participant's mother was very open about her father's illness, but for all of the other candidates, their parent's illness was couched in secrecy and silence. This lack of knowledge about their parents' illness resulted in intense internal struggles, of the candidates, in their youth as they struggled to make sense of a chaotic, unpredictable world at home.

All of the participants experienced anger. This anger was directed either at themselves or toward their mentally ill parents. Not understanding their parents' illness seemed to fuel this anger. Frustration was experienced by all of the participants at their parents' inability to meet their needs. Candidates experienced neglect even in homes with both parents. This was because the healthy parent was forced to compensate for the ill parent's lack of support and assist the ill parent through their psychotic episodes. Lack

of parental support often resulted in siblings assuming the caretaking role of each other or the youth becoming responsible for the care of their ill parent. Often these youth felt frustrated and isolated from the community. This isolation was due to the stigma and shame associated with mental illness. Also, a lack of awareness of their parents' illness resulted in an inability for the youth and family to access systems of support. This experience of isolation was reinforced by their parents' inability to maintain social contacts. In addition, the youth were unwilling to introduce peers to their family due to the fear of being further stigmatized.

Perpetual pain accompanied by isolation and chaos was cited as a family experience by all of the participants. Many of them revealed that this experience of pain was synonymous with living with a mentally ill family member. To cope with this pain the participants sought help and assistance where it was available. Most had a significant adult who adopted them; they became surrogate children of other families. For one person, her aunt was an important, supportive, constructive role model. Another revealed that she became a surrogate member of her friends' family. Those who had surrogate care givers in their lives found them to be anchors. They helped them escape the chaos of their homes and learn alternative methods of coping and care. Unfortunately, not all of the candidates had surrogate caregivers. Although they knew their parents loved them, they felt as if something was missing in their lives. An essential element of support was missing in their lives.

Having external supports or the lack of them did not hinder the candidates from finding alternative methods of coping with the chaos in their homes. The methods used involved various forms of distraction or diversion; the aim was to escape from their

chaotic home environments. Escape was in the form of hobbies – reading and drawing or athletic endeavors. Extracurricular activities were also important for the majority of the candidates. Involvement in school clubs, teams and sporting events provided an alternative focus in their lives. Most of the participants mentioned putting 110% effort into all of their academic and extracurricular endeavors. Many mentioned that this ability to divert their energies into other endeavors was an important element of their ability to cope. The establishment and completion of personal goals was cited as an important coping strategy. Many said that without goals they might not have survived as well as they did.

School seemed to provide normalcy and structure in their lives. Academic achievements were also important for many of the participants. Half of the candidates mentioned their academic focus as a diversion strategy for coping with the mental illness in their home. The remainder of the participants revealed that they enjoyed school. Having a place to attend where normalcy and structure were the norm was comforting for the participants.

However, despite the importance of school for the youth, few cite teachers or school personnel as being helpful. Those who do mention the influence of school personnel mention experiences or support that, for them, was peripheral to their experience; this included classroom assignments, leniency regarding truancy or involvement in clubs. None of the participants believed that teachers or school personnel were aware of their home life. This lack of awareness was due in part to the candidates' fear of others finding out about their parents' mental illness. Many mentioned an attempt by them and their families to present the image of a normal family. Yet, many believed

that their behavior at school or poor academic performance were indicative of personal struggles and problems at home. The candidates felt that there was a lack of involvement and interest in their lives as students. Actually, most of the participants cited incidents or comments by teachers and staff, which stifled their attempts for gaining assistance and support. They did not feel validated by the staff. Instead their needs, sentiments and perceptions were undermined or ignored. Consequently, the candidates did not view schools as sources of support for children of parents with mental illness.

In addition, the candidates felt betrayed, rejected and ignored by mental health professionals involved in their care of their ill parent. They mentioned the humiliation experienced by them and their other family members at the treatment of their parents. Furthermore, they seemed angry that the family needs were not addressed. For them, the system provided the same neglect experienced at home. However, at home their ill parent was unable to provide the necessary support, the system just appeared unwilling to do so. Until they were adults, the candidates were left on their own to cope with the impact of being raised by a mentally ill parent.

Due to the lack of support received in their youth, the candidates are strong proponents for advocacy of youth and families with parents with mental illness. They have numerous suggestions for coping for other youth. In addition, they provide definitive recommendations for schools, consumer agents and mental health service providers.

For youth, they recommend that they talk about the experience and not remain in silence. To seek the help of professionals and not stop asking for assistance. They also suggest that they find healthy means of escape from their home situation. To establish

goals and strive for them. That they learn and educate themselves about their parents illness. Recognize boundaries between their parent's illness and themselves. Moreover, not do anything harmful to them.

Schools are asked to educate staff, teachers and students about mental illness. To teach acceptance and tolerance of mental illness and debunk the myths reinforced in the media. They ask that schools provide the means, skills and opportunity to talk about their experience and offer hope. They ask that personnel be supportive of youth with mentally ill parents and compassionate of their struggles. Furthermore, they ask that schools work to empower youth.

Professionals are asked to listen and be open to what the youth and family members have to say. Recognize behaviors that are reflective of youth with parents who have mental illness. In addition, they ask for validation, compassion and assisting youth in determining their strengths. Furthermore, they ask that professionals educate themselves, youth and family members about mental illness that they demystify it. They ask that professionals become more aware of the impact mental illness has on the family unit and each member. They want professionals to provide opportunities for healing, empowerment and establishment of boundaries for all family members. They ask that professionals be proactive in their involvement with mentally members and their families – ask them about the type of support they need and help them acquire it.

Summary

The biographical stories of the candidates provide personal accounts of their experience growing up in a home with a mentally ill parent. Their stories reveal the pain, chaos and confusion the participants experienced in their youth. In addition, they reveal how the youth came to terms with their parents' mental illness. Of importance is the difficulty of the experience and lack of support the youth and their family members received. Their personal accounts reflect the gaps in our system and recommendations a framework for closing this gap. Their personal accounts reveal that mental illness is a family illness. It seems that we need to not only treat the ill member, but also provide treatment, support and opportunities for healing for all family members.

CHAPTER 5

DISCUSSION

OVERVIEW

This chapter begins with an outline of the common themes derived from the personal narratives. A brief explanation of these themes is provided. Next, a comparison of the themes with literature findings is discussed. The following categories for this discussion are 1. The experience of living with a mentally ill parent.

2. Aspects of Resiliency

3. Cognition's

4. Influence of schools, professionals, and recommendations for both.

The studies limitations are cited and finally, the implications for future research and practice are addressed.

THEMES

Experience

Theses themes are divided according to internal and external struggles. Internal struggles are those which occurred inside the individuals – feelings, thoughts and worries. External struggles are difficult life experiences, due to the parent's illness, that the candidates had no control over. These include additional responsibilities and changes to their immediate environment.

Internal Struggles

Isolation: loneliness due to lack of relationships either because of the parents' inability to maintain friendships or stigmatization associated with mental

illness.

Frustration: due to unmet needs – physical and emotional

Confusion: not understanding parents irrational, unpredictable behavior, or lack of emotional support as well as not knowing what was wrong.

Feeling Responsible: believing and wanting to do something to help the mentally ill parent. Wanting to alleviate either their ill parents' pain, or that of someone else in the family.

Shame: the stigmatization associated with mental illness. Also, secrecy in the family about the illness accompanied by fear and worry that others might find out and the other family members would be poorly treated. This hindered the youth from speaking about their experience.

External Struggles

Illness: dealing with symptoms of the illness such as unpredictable and inconsistent behavior, psychotic episodes, panic attacks and embarrassing public behaviors.

Pain: continual pain of unmet needs as well as the unmet needs of other family members as well as economic hardship.

Role reversal: assuming care taking responsibilities for either self or siblings as well as becoming responsible for the ill parent's care.

Resilience

These themes come under the following headings: escape – for a while from the

experience of living with a mentally ill parent, support of others in their lives and goals set to give them a life focus.

Escape: This involved participation in sports, school events, clubs or hobbies in a effort to divert attention from the worries, concerns and fears of living with a mentally ill parent. Hobbies, academic studies and athletic endeavors were cited as suitable distractions.

Support: This involved a close bond with an adult other than the youth's parent(s). These adults provided emotional support, opportunities for weekend and summer holidays and encouragement.

Goals: Personal achievements and academic pursuits provided a focus and means to channel energy. Goals were self-imposed guidance and structure in their lives. Activities ranged from Girl Guide leadership to pursuits of attending university.

Cognition

As the youth matured their perceptions of their mentally ill parent changed, in addition many of them mentioned experiences that were pivotal moments in their understanding of their lives and their world.

Transition: change from anger and frustration to understanding and empathy for their ill parents.

Epiphanies: acknowledgment of comments, which proved to be turning events in their perception of life and sense of personal power.

Schools and Professionals

While the normalcy and structure of schools was appreciated the participants advocated for more involvement and education. Meanwhile, professionals were viewed as having failed youth of parents with a mental illness. Recommendations for a change in perceptions of mental illness and acknowledgment of family members and their needs were suggested as a starting point for change.

OVERVIEW OF THE RESULTS

In this study, six adults raised in homes with a mentally ill parent discussed adolescent experiences. Each separate transcribed interview resulted in six separate narratives addressing the themes of each individual's personal experience and a comprehensive narrative identifying the group themes. Each of the narratives discussed the age of onset of the illness, subject's awareness of the illness and consequent struggles of living with a mentally ill parent. In addition, they addressed coping methods and areas of resiliency for each of the participants. Furthermore, the role of school and school personnel was discussed, followed by recommendations, of the candidates for youth, school personnel and professionals working in the mental health field.

Isolation was a predominant theme for all of the participants. The feeling of having to endure chaos, alone appeared overwhelming. Stigmatization and shame seemed to reinforce feelings of isolation accompanied with frustration. A lack of knowledge about mental illness hindered the participant's ability to help but did not prevent them from feeling responsible. Many were thrust into parental or care taking

roles because of lack of support and their parent's inability to cope. Parental neglect was a common theme; with it was pain and sorrow.

Coping involved methods of diversion, distraction or escape. Often this took the form of hobbies, athletics, extracurricular activities or academic pursuits. Goals, both short and long term, were significant. Achieving personal goals was paramount. In addition, significant bonding with the healthy parent, extended family member or another adult resulted in receiving support, comfort, encouragement and having basic needs met. Often these adults became surrogate parents. They played an important role in participant's lives when they were young. The participants never forgot the efforts of their 'adoptive' parents.

While many of the participants were aware that their parents were ill, they did not know what the illness was. They felt that knowledge of the illness would have helped them establish clear boundaries between themselves and their parent's illness. It would have mitigated feeling responsible. In addition, they advocate for opportunities to talk about the experience and opportunities to connect with others having the same experience. As adults, they found that talking helped promote the healing process. In, addition, since goal setting and involvement in outside activities helped them cope, the participants recommend doing so. Furthermore, the participants suggest that youth reinforce their self-esteem and not do anything harmful.

Participants indicated liking school because of its structure and normalcy. However, they did not feel that teachers or school personnel were particularly helpful to them, as children of parents with a mental illness. Subsequently they had many

recommendations for schools. The common themes in their recommendations are support, education, compassion and advocacy for youth of parents with a mental illness.

All of the participants experienced little or no involvement of professionals. As adults, they acknowledge the lack of resources and support for children of parents with a mental illness. Subsequently, they have numerous recommendations for mental health professionals. The themes of their recommendations include acknowledgment and respect of family members and their role in the mentally ill person's life. In addition, they advocate for support, resources and healing services for all family members involved. Education of family, professionals and the ill member was a significant theme for all of the participants.

COMPARISON OF THEMES WITH LITERATURE

Experience

"The mental illness of a family member is an unexpected event that disrupts the usual sense of continuity and rhythm in the life cycle, with a profound impact on young family members" (Marsh & Dickens, 1997 p.51).

The candidates' experience of living with a mentally ill parent had both internal and external influences on their lives. Due to the early onset of the illness in their lives all of the candidates experienced confusion at their parents behavior. While they all recognized, at an early age that there was something wrong with their parents, they did not make the connection between mental illness and their parents disorder until age 10-12. Often they did not have a name for the illness, nor were they educated about it. According to Beardslee and Pordorefsy (1988), knowledge was crucial to youth's

understanding and ability to deal with the ill parent. Marsh et al. (1993) indicated that, in their survey, the respondents did not rate any resources as helpful in the first ten years of the family member's illness. Baxter and Diehl (1998) indicate that after a crisis – psychotic episode, suicide attempt, mania or panic attack the mentally ill member experiences a stage of dependence. During this time, they experience denial, confusion, despair and anger. They need a safe place, food, and a lot of sleep and medication. Meanwhile members of the family are trying to get their 'heads out of the sand'; they experience crisis, chaos and shock. In addition, they undergo a process of 'denial', an attempt at normalizing the experience and hoping against hope that another crisis will not occur or the ill member will be healed. In addition, family members experience a great deal of confusion.

Beardslee and Podorefsky (1988) reveal that the youth's descriptions of their experience were done in terms of changes in personal behavior and outlook, irritability, sadness, lack of energy, excessive drinking for some. There was a focus on the disruption of their lives associated with the consequence of the parent's illness such as economic hardship, change of home or residence and lack of parental awareness or involvement. These experiences were described as full of disillusionment, confusion and feeling of helplessness as well as the loss of a role model. In addition, with confusion is a great deal of frustration. Beardslee and Podorefsky (1988) state that important themes in their adolescent narratives were anger and frustration of not knowing what was happening as well as parent unavailability. Baxter and Diehl (1998) indicate that in learning to cope with the mental illness family members experience anger, guilt or

resentment. Much frustration, anger and resentment were experienced due to the unmet needs of this study's participants as well as their inability to help their ill parent.

Beardslee and Podorefsy (1988) indicate that many of the youth in their study assumed a care-taking role. Often they were responsible for managing major family functions, finances or living situations. They often found themselves caring for younger children and bringing attention to their parent's illness. Furthermore, they were often peacemakers, supporters of younger siblings and cheered up depressed mothers. Marsh et al. (1993) describes this role reversal, of child assuming an adult role or accepting responsibility for the ill parent as parentification. Each of the participants in this study assumed a care taking role of either themselves, their ill parent or siblings. In addition, to roles of practical responsibility subjects experienced subjective burden. According to Marsh et al. (1993) subjective burden is the experience of grief and loss as well as empathic pain of other family members; that is they felt the suffering of other family members. Marsh and Dickens (1997) indicate that adolescents may experience difficulty and feelings of guilt associated with leaving home if their family or some of its members depend on them. In addition, they indicate that there are often distorted roles in the home of mental illness because everyone attempts to compensate for the "disruptive force of mental illness" (p.53).

When children do not bond with their parents, they feel very alone and isolated. Marsh et al. (1993) states that there are often impaired relationships outside the home. This results in social isolation and discomfort. For the candidates in this study social isolation was significant. Marsh and Dickens (1997) state that many children of parents with a mental illness have difficulty with peer relationships. Youth may feel estranged

from their peers. Because of the stigma of mental illness as well as people's lack of understanding of the family. Furthermore, youth may avoid peer relationships in the absence of a secure home base, due to the unpredictable and disruptive presence of mental illness. As well, skills youth developed to cope and survive in the home situation may have a negative impact on external relationships; for example, avoidance may result in the loss of friends and further isolation. This experience of isolation is compounded when parents do not have any external contacts.

Accompanied with isolation, often, is the stigma of living with a mentally ill family member. Dr. Johnson, (2000) found that middle class families had concerns about the stigma and financial burden of mental illness. Apparently middle class families were concerned that the ill member was not functioning according to neighbor standards and felt distanced by neighbors or family members who lacked understanding of mental illness. Dr. Johnson found that for lower middle class families stigma was only one of the many problems associated with the illness. Often this stigma and shame will prevent youth from speaking out or seeking assistance with the problems associated with the disorder.

Marsh and Dickens (1997) suggest that basic trust may have been shattered if a mentally ill parent was either unable to meet the child's needs. Alternatively, if the parent was busy contending with the needs of the other parent who was mentally ill. In addition, they suggest that due to the misconceptions of the mentally ill parent the child may not have a clear sense of reality. In addition, accompanied by a lack of energy or time for the child, due to the mental illness, a low self-concept may result. All of the

candidates expressed concern and struggle with the inconsistency and unpredictability of their parent's behavior.

Barankin, T. and Greenberg, M. (1996) suggest that impaired family functioning, developed during the crisis phase, can sustain or remain after the recovery of the ill parent. Based on the recovery process described by Baxter and Diehl (1998), the family would remain in a constant state of crisis and experience perpetual feelings of anger, guilt, resentment and grief. Subsequently, many families remain in perpetual state of pain or loss. Marsh et al. (1993) cites chronic sorrow as one of the theme of the survey study. They use the term objective burden to describe the perpetual dealing, of family members with the 'symptomatic' behavior of the illness and crisis associated with the disorder.

Resilience

Marsh and Dickens (1997) perceive resilience as synonymous with the recommendations made by their study respondents to others growing up in a home with a mentally ill family member. The advice of this study's participants include:

1. Talk about it
2. Establish and set goals for yourself
3. Find means of escape
4. Learn and educate yourself about the illness
5. Seek the support and help of professionals
6. Reinforce your self-esteem
7. Do not do anything harmful to you
8. Recognize boundaries between your self and your parent's illness

Findings in the current studies are similar to those of Marsh et al.'s (1993) study. Their respondents advocated for education, support groups, involvement in outside activities, therapy, getting rid of the stigma and shame and preventing mental illness from taking over your life. Since many of the current study's candidates did not feel as if they had

the opportunity to discuss their parent's illness with someone when they were young they feel this is most important. Even those who came from close knit, supportive communities were unable to speak of the mental illness because of the lack of education and understanding of this type of illness. Hence, they suggest that youth ... *not wait as long as I did to seek help or to talk to people about your situation*. Yet, they do not advocate for speaking with friends about problems, as they may not be the best or most reliable resource. All of them reveal that high school can be a rumor mill and suggest seeking out confidential professional support. Smokowski et al. (1999) indicate that the resilient youth in their study demonstrated high discernment and caution of friends. They appeared to have distinct categories for friends and associates. Associates were people one could hang out with, but not get close too while friends were viewed as people one could rely on. However, true friendships were perceived as being very rare.

Smokowski et al. (1999) found that resilient youth have persistence, determination, belief in a better future and hold on to dreams and goals. Higgins (1994) also found that resilient individuals are active agents in creating, for themselves, a better life. For many of the candidates, establishing and working hard toward achieving goals was important for them. Often they would put 110% effort into their achievements. Many said that having goals and putting their heart and soul into their endeavors helped take their minds off their home life.

Having some form of diversion, distraction or escape from dealing with the mental illness was important for all of the study participants. While each had their own means of escape, they all said that it was important for coping. They read, collected comic books, jogged, went to visit friends, or engaged in extracurricular activities. This

is an essential piece of advice that the respondents made for youth of parents with a mental illness. Higgins (1994) states that resilient adolescents appear to be able to get or take themselves away from complex or chaotic home situations. She said that these efforts are subtle and often supported by society's expectations. In addition, these other activities enable youth to receive opinions from various sources about who they are. Furthermore, Beardslee and Podorefsky (1988) cite effective coping styles as one of the characteristics of resilient youth.

Beardslee and Podorefsky (1988) indicated that understanding of their parents' mental illness was a significant factor for resilient adolescents. All of the candidates in this study reinforce the importance of understanding of the illness. They feel it helps one make sense of his/her world.

In addition to educating themselves about mental illness, the participants in the current study recommend that individuals seek support and the help of professionals. Since none of them received professional help when they were young, the candidates learned to rely on the support of those adults around them, either from immediate family at home, extended family or friend's parents. Higgins (1994) addressed the importance of these adoptive relationships. Such adoptive relationships assisted youth in the expansion of themselves. Characteristics of these surrogate caregivers include full and rewarding lives, do not shrink from hard work, not given to spells of self pity, shared what they had and told the truth. Higgins (1994) indicates that adolescents internalize their surrogate parental figures, so that they are with them where ever they go. She suggests that these positive surrogate relationships contribute to the youth's vision of 'life' promise, which

expands over the life span. Smokowski et al. (1999) also found the experience of surrogate parents to be one of the themes of external support for resilient youth.

Marsh and Dickens (1997) indicate that socialization and self-concept are the development tasks of toddlers – age 3 to five. Socialization involves the acquisition of skills, values and behaviors that will enable them to be a competent member of society. Self-concept entails “a sense of being a valuable competent person” (p. 46). They suggest that if the mentally ill parent was unable to meet the child’s needs, or if the healthy parent was busy contending with the ill parent, basic trust may have been shattered. In addition, they suggest that this lack of time or energy for the child, due to the mental illness, may result in a low self-concept. Yet, Dumont and Provost (1998) found personal satisfaction and self-confidence to be the best predictors of resilience. They suggest that adolescents with high self-esteem seldom use avoidance techniques, they prefer to problem solving strategies. These individuals appear to be less bothered by stress because they perceive that they have control and are able to be active in their environment. In addition, they indicate that increased self-esteem correlated positively with youth’s involvement in the community and their family where as lower self-esteem predicted avoidant coping strategies such as possible drug or alcohol use. In addition, Heller and Larrieu (1999) indicate, in their review, that other resiliency studies attempt to explain self-worth: identified as high self-esteem or positive self-regard, as a stable characteristic of resilient individuals. Dekovic (1999) determined individual attributes that were important in mitigating problem behaviors were self-esteem and academic achievement. Furthermore, Beardslee and Podorefsky (1988) cite positive self-esteem as one of the constitutional factors of resilient youth. Although self-esteem was not directly

addressed in this study, it was cited by many of the participants as something to either maintain or build on. In addition, one candidate revealed that her mother's efforts to ensure that she had a high self-esteem were important in helping her get through the difficult times. One candidate describes this positive sense of self as an inner voice. Others spoke of feeling loved, despite the neglect and unpredictability at home.

In addition, the candidates mentioned the importance of not doing anything harmful. Dumont and Provost (1998) suggest that vulnerable adolescents appeared to score higher on involvement in antisocial or illegal peer activities, despite the availability of support.

Cognition

The participants of this study emphasized the importance of recognizing the boundaries between themselves and their parents' illness. Beardslee and Podorefsky (1988) cite self-understanding as an essential component to the development of resilience. The youth knew something was wrong with their parents and they were not the cause. All of the candidates in this study were aware that they were not the cause of their parent's illness and that there was something wrong. Beardslee and Podorefsky (1988) believe this knowledge was crucial to their understanding and ability to deal with the ill parent. They said that the youth "...had somehow made peace with or come to an understanding of the experience and this was important to them" (p. 66). The candidates of this study indicated that once they understood their parent's illness they had increased understanding and empathy toward their ill parent. However, some of the candidates in this study developed empathy and understanding of their parent's ill illness without understanding. All of the candidates went through a process of movement anger and

frustration to empathy and understanding. Yet, their ability to differentiate themselves from their parents did not erode the pain. Smokowski et al. (1999) acknowledge the loss of the self when one experiences adversity as well as the reformation of the self that comes as a result of experiencing life difficulties. Their belief in resilience as a process implies individual authorship of one's life as well as a different interpretation of events and creation of meanings about adversity than those who appear unable to overcome their life struggles. All of the candidates had a different understanding of their parent's illness, in late adolescence, than they had in their early adolescence. For some, with this understanding came a fear of becoming mentally ill themselves.

Higgins (1994) states that one of the areas where resilient individuals perceived themselves as active agents was in their definition of personal growth which was an active process of constructing and defining meaning for themselves. This meaning making included assumptions they had regarding new versions of themselves, this often emphasized learning and development. Victor Frankl (1984) believes that meaning can help an individual survive the worst human conditions. He postulates three ways of discovering meaning: creating work or doing a deed, experiencing something or encountering someone – love, or the attitude one can take toward unavoidable suffering. All of the candidates derived meaning from their lives from one of the three ways mentioned. Some became involved in activities, others committed themselves to their parents care or the care of others they loved or changed their perceptions of their situation. Frankl (1984) states that when we meet with destiny or fate, which we cannot change, we are forced to change ourselves. We are propelled to evaluate and reflect on our difficult life situation and transcend it. Many of the candidates mention significant

moments, epiphanies, they experienced in conversations with other adults in their lives, or from comments made by teachers which resulted in a re-evaluation of themselves and their beliefs. One candidate's perception of relationships changed from fear and avoidance to hope, when a surrogate mother informed her that there were other alternatives to that of her parents. Another candidate mentioned how she changed her after a comment by a teacher, who told her class, upon leaving grade seven that they decided how their lives went. His suggestions to take stock and change those aspects of your life you are not comfortable with remained with her throughout her life. Purvis, Jr. (1995) states that "during adolescence the will to meaning begins to emerge. The adolescent begins to ask questions about the meaning of his life. This search for meaning is an attempt to make his life 'livable'. He assumes there must be a purpose in all his turmoil and tension" (p.204). Crumbaugh (1995) poses that youth create a 'framework of meaning' in which they are 'somebody', have a place and function or sense of purpose (p.152). In order to reach this point some youth need to make a 'leap of faith' and assume that, despite apparent chaos in their lives, "...there is order in the universe" – what Frankl calls 'suprameaning'. In their goal setting, the youth created meaning in their lives. Some of the candidates effectively, reinvented themselves in striving toward their goals. One candidate wanted to attend university, despite a poor academic record in her early high school years she was successful. Smokowski et al. (1999) as well as Higgins (1994) feels that resilience is a process: one in which individuals accept authorship over their own lives and create new meanings about adversity. The candidate's transition from anger to acceptance of their parent's mental illness is reflective of this process, as well as their understanding of their own sense of purpose in

life. In addition, Marsh and Dickens (1997) believe that when faced with challenges in life, resilient individuals, seek out information, develop appropriate skills and learn vicariously from others. When confronted with darkness they continue with their convictions that the world does make sense. For these candidates, their goals helped them make sense in a world of chaos. They gave their lives meaning, structure and focus. Marsh and Dickens (1997) believe that resilient individuals are sustained by their ideals. For these candidates their goals were synonymous with their ideals. Furthermore, Marsh and Dickens (1997) state that resilient people recognize a need for advocacy and support in our society and subsequently do so in their realm of the world. They state that resilient individuals believe in themselves and that they deserve a good life. While these candidates did believe in themselves, their ability to do so was overshadowed by the experience of living with a mentally ill parent. Baxter and Diehl (1998) cite the final stage of recovery as 'moving into advocacy'. During this stage family members gain understanding and acceptance of the mental illness. Also, recovery is not synonymous with a cure for the mentally ill family member. Instead, recovery implies the development of new meaning and purpose in one's life as one overcomes the trauma of mental illness. In addition, it incorporates a change in attitudes, values, feelings, goals, skills or roles. All of this study's participants are supportive of and advocates of youth with parents of mental illness.

Schools and Professionals

Participants of this study believe that schools and school personnel can be instrumental in helping youth develop a change in attitudes, values, feeling, goals, skills and roles. They make the following recommendations for schools:

1. educate personnel, staff and students about mental illness
2. teach acceptance and tolerance
3. help youth, and give them the opportunity to talk about their experience in a confidential manner
4. be supportive
5. empower youth
6. be compassionate
7. offer hope

While many of the candidates indicated that they liked school because of its' structure and normalcy, most did not feel supported by staff. One candidate felt rejected when she went to a school counsellor for help. McMillan and Reed (1994) believe at-risk youth need teachers who are respectful, caring, honest, patient, open-minded, firm, understand different learning styles, expect positive results and recognize cultural norms and differences. Apparently, they believe that teachers "play an important role in the success of resilient students" (p. 139). This does not appear to be the case with this study's participants. Yet, the list of characteristics of 'good' teachers, comprised by resilient students is supported by this study's participant suggestions for educators. These include: caring, having respect for them as people and learners, able to get along with them, listening without being intrusive. As well as, taking them seriously, being available and understanding, helping and providing encouragement, laughing with them and being able to talk about almost anything. In addition, professional competence and behavior are important.

Marsh and Dickens (1997) state that mental illness in the family can have a significant effect on an individuals academic life. Often youth experience poor school performance due to disruption at home. They state that low academic performance may erode youth's self esteem. In addition, Marsh and Dickens (1997) state that teachers and

counselors who recognize inconsistencies in academic performance but are unaware of the cause may reinforce this low self-esteem.

In contrast, some youth are super achievers at school, in an attempt to escape their feelings of hopelessness and helplessness. Marsh and Dickens (1997) believe "this is a constructive reallocation of energy that offers opportunities for growth and satisfaction" (p. 56). However, they caution that this may prevent youth from confronting the mental illness and subsequently becoming dependent on external validation.

In addition, they suggest that mental illness may have an adverse effect on youth's involvement in extracurricular activities. Many youth refuse involvement in extracurricular activities due to feelings of social alienation and isolation. One candidate, in this study, explains how she and her siblings were unable to become involved in activities outside the home due to high expectations of parental involvement. Marsh and Dickens (1997) feel that failure to become involved in any extracurricular activity results in a lack of opportunity to enhance social skills and self-esteem. In addition, they miss the chance to expand activities and relationships outside home, obtain reinforcement for normal developmental experiences and identify with healthy, constructive role models. McMillan and Reed (1994) believe that extracurricular activities are an informal source of support that increases school involvement and help boost self-esteem. Yet, they appear to believe that resilient youth become involved in extra-curricular activities and have numerous hobbies, creative interests and sports.

In addition, to the recommendations made for schools and school personnel, the participants made recommendations for professionals and adults working with mental illness. These are:

1. Listen and be open
2. Recognize behaviors that identify children of parents with mental illness
3. Validate youth
4. Be compassionate
5. Help youth acknowledge their strengths
6. Educate yourselves, family members and others
7. Be aware of the impact of mental illness on both the family and each of its members
8. Help heal and members establish personal boundaries
9. Empower
10. Demystify mental illness
11. Provide support; determine the needs of the family and assist in the provision of them

Marsh et al. (1993) had similar recommendations from their study respondents. Family members want professionals to play a more active role in the healing of both the mentally ill member and their lives. They want professionals to be pro-active, to treat the whole family, not just the patient. They want to be acknowledged and recognized as important players in the mentally ill person's life.

SUMMARY

The themes of this study reflect the findings of previous studies. The experience of isolation, pain and chaos of living with mental illness is revealed in the personal stories of the candidates. Meanwhile their resilience shines through. It appears that their resilience is associated with developing healthy means of escape such as hobbies, academic pursuits and extracurricular activities. Many of the participants had surrogate parents who provided the support and affection their parents were unable to give them. Yet, their lives were not devoid of subjective and objective pain. That is their parents mental illness caused much hardship and pain in their lives and for the family. These candidates were sensitive to the pain of other family members as well as that of their ill

parent. They felt responsible for the care of their parents and struggling family members. Their goals and new understandings obtained through many struggles and soul searching helped sustain them and move them through their adolescence. Unfortunately, all of the candidates felt that this journey through adolescence was a lonely one, with minimal or no support from schools or outside agencies. In short, nobody guided them through the healing process or recovery of living with a mentally ill parent. They healed themselves. With this healing came the acknowledgment of their limitations in helping their ill parent as well as their personal power in their own lives.

LIMITATIONS OF STUDY

Although this study is about the adolescent experience of growing up in a home with a mentally ill parent, it is retrospective. Adults reflected on their youth and discussed relevant points about their adolescence. Often when we reflect on the past, we view people and events from a different perspective than we did in the past. Subsequently, it is difficult to separate the past from the present. Furthermore, the definition of resiliency is broad and open to interpretation. In addition, this study's methodology means that it is impossible to generalize the results of this study to the population at large. In addition, this study's sample was primarily female, white, middle class. No ethnic or cultural representation occurred. Recruitment of candidates was from consumer groups in the Greater Vancouver Region. Thus, candidates selected are committed to recovery and health. Subsequently their perceptions may not reflect those of all youth raised in homes with a mentally ill parent.

Multiple reviewers of transcripts as well as multiple raters of themes could be utilized in future studies, to provide additional assurances of prevention of researcher bias.

IMPLICATIONS FOR THEORY

There appears to be a connection between the recovery process of living with a mentally ill parent, the change of perception from confusion and anger to understanding and empathy and resilience. While many studies cite resilience as a process (Smokowski et al., Beardslee and Podorefsky, Higgins, Marsh et al.) they fail to explain this process. Perhaps the resiliency process is similar to the healing process. This is an aspect of future study that might shed light on the concept of resiliency. The chart below outlines the experience of the resilient youth, compared against the stages of recovery, identified by Baxter and Diehl 1998, associated with living with a mentally ill family member.

Resilience	Recovery
Awareness of illness, connection between parent's strange behavior and mental illness. Study participants made this connection from age 10-12	<i>Stage 1:</i> <i>Heads out of Sand:</i> Acknowledgement of illness
Shame, anger and frustration of illness and due to unmet needs	<i>Stage 2:</i> <i>Learning to cope:</i> anger, guilt, resentment
Transition of perception to empathy and understanding of ill parent's struggle.	<i>Stage 3:</i> <i>Advocacy:</i> understanding and acceptance

IMPLICATIONS FOR RESEARCH

In addition, the use of personal goals to escape, provide structure and create meaning in the lives of youth with parents of mental illness is not addressed in studies of resilient youth or resilient youth of parents with mental illness.

Also, the significance and intensity of the pain, due to isolation, associated with parents mental illness is not recognized. While studies do cite isolation as one of the problems associated with living with a mentally ill parent, they do not address the all-ominous impact it has on youth and family members. All of the candidates in this study cited isolation and lack of contacts as huge obstacles in their lives.

Furthermore, numerous studies describe the characteristics of teachers and staff required to encourage resiliency in youth, but they do not explain how the staff might do this. Nor do they address the magnitude of the influence of negative responses, by staff or teachers, on youth. At least half of the candidates cited comments made by staff or teachers, which led the youth to believe that schools were not a source of support. How to create an atmosphere of support needs to be addressed and youth should be consulted about their needs at school. Furthermore, studies of the impact of school and school personnel on youth of parents with mental illness could prove informative.

IMPLICATIONS FOR SCHOOLS

It appears as if youth have high expectations of schools and their staff. They expect schools to pick up where their struggling parents leave off; to help fill the gaps and ease struggles. In addition, students seem to expect schools to address their

emotional needs not just their academic needs. Consequently, education of youth about mental illness and provision of support or the appropriate connections with outside agencies is recommended. After all, while this study's youth felt safe in school they did not feel safe enough to talk about their parent's mental illness. Education and awareness are the first steps to healing. In addition, teachers can display empathy toward students who appear to be struggling. Many of the candidates indicated that feeling supported was important to them. Having an adult outside of home, recognize when they are struggling is significant for a child whose needs are unmet at home. Inquiring when youth seem tired or are struggling can pave the pathway to communication, support and understanding.

IMPLICATIONS FOR COMMUNITY PROFESSIONALS

As indicated in the literature, family members with mental illness feel betrayed and ignored by the system (Marsh and Dickens, 1997). In short, they feel the system has failed them. It appears that support, education and empathy from professionals to family members are needed. There appears to be some movement in the Mental Health field toward identification of the needs of family members with mentally ill members. Such initiatives include "Supporting Families with Parental Mental Illness", in British Columbia and "National Scoping Initiative for Children of the Mentally Ill" in Australia. These initiatives appear to be the first steps of a long journey toward support and assistance of family's with mentally ill members.

REFERENCES

Barankin, T. & Greenberg, M.(1996). Impact of Parental Affective Disorders on Families. In B. Abosh & A. Collins (Ed.), Mental Illness in the Family: Issues & Trends (pp. 105-119). Toronto: University of Toronto Press.

Baxter, E.A., & Diehl, S.(1998). Emotional Stages: Consumers and Family Members Recovering From the Trauma of Mental Illness. Psychiatric Rehabilitation Journal, Spring '98, 21, 4 349-356.

Beardslee, W.R., & Podorefsky, D. (1988). Resilient Adolescents Whose Parents Have Serious Affective and Other Psychiatric Disorders: Importance of Self-Understanding and Relationships. American Journal of Psychiatry, 145, January 63-69.

Berg, B.L. (1995). An Introduction to Content Analysis. Qualitative Research Method for the Social Sciences (pp.174-199). Massachusetts, Simon & Schuster.

Colaizzi, P.F. (1978). Psychological Research as the Phenomenologist Views It. Existential Phenomenological Alternatives for Psychology (pp. 48-71). New York, Oxford University Press.

Crain, W.C. (1980). Erikson and the Eight Stages of Life. Theories of Developmental Concepts and Applications, 2nd ed. (pp. 160-180)

Crain, W.C. (1980). Piaget's Cognitive Developmental Theory. Theories of Developmental Concepts and Applications, 2nd ed. (pp. 88-117)

Crumbaugh, J.C. (1995). Exercises of Logoanalysis. In J.B. Fabry, R.P. Bulka & W.S. Sahakian (Eds.), Finding Meaning in Life: Logotherapy. (pp. 151-159). Northwale, NJ: Jason Aronson Inc.

Dekovic, M. (1999). Risk and Protective Factors in the Development of Problem Behavior During Adolescence. Journal of Youth and Adolescence, 28, 6 667-685.

Denzin, N.K. (1994). The Art and Politics of Interpretation. In N.K. Denzin & Y.S. Lincoln (Eds.), Handbook or Qualitative Research. (pp.500-515). Thousand Oaks, CA: Sage.

Denzin, N.K. (1989). Selves, Stories & Experiences. Interpretive Biography: Qualitative Research Methods Series, 17 (pp. 69-78). California: Sage University Press

Dumont, M. & Provost, M.A. (1998). Resilience in Adolescents: Protective Role of Social Support, Coping Strategies, Self-Esteem, and Social Activities on Experience of Stress and Depression, Journal of Youth and Adolescence, 28, 3 343-363.

Frankl, V. (1984). Man's Search for Meaning New York, Washington Square Press.

Heller, S.S., Larrieu, J.A., D Imperio, R., & Boris, N.W. (1999). Research on Resilience to Child Maltreatment: Empirical Considerations, Child Abuse & Neglect, 23, 4 321-338.

Johnson, E.D. (2000). Differences Among Families Coping With Serious Mental Illness: A Qualitative Analysis. American Journal of Orthopsychiatry, 70(1), January 126-134.

Inoff-Germain, G., Dr. Nottelmann, E., & Dr. Radke-Yarrow, M. (1997). Relation of Parental Affective Illness to Family Dyadic and Individual Functioning: An Observational Study of Family Interaction. American Journal of Orthopsychiatry, 67(3), July 1997 433-448.

Lieblich, A., Luval-Mashiach, R., & Zilber, L. (1998). A New Model for Classification of Approaches to Reading, Analysis and Interpretation. Narrative Research Reading, Analysis and Interpretation: Applied Social Research Methods, 47 (pp.1-19). California, Sage Publications.

Loncaric, M.A. (1998). What is the Meaning of Disengagement as Lived by Students Who Left School Without Graduating. (p.226). Vancouver, BC: University of British Columbia.

Marsh, D.T., Dickens, R.M., Yackovick, N.S., Wilson, J.M., Leichliter, J.S., & McQuillis, V.A. (1993). Troubled Journeys, Siblings and Children of People with Mental Illness. Innovations & Research, 2(2), 17-28.

Marsh, D.T., Dickens, Rex, M. (1997) Reclaiming Your Childhood. Troubled Journey: Coming to Terms with the Mental Illness of a Sibling or Parent (pp. 45-66). Jeremy P. Tarcher, Putnam.

Marsh, D.T., Dickens, Rex, M. (1997) Revising the Legacy. Troubled Journey: Coming to Terms with the Mental Illness of a Sibling or Parent (pp. 138-140). Jermey P. Tarcher, Putnam.

Marsh, D.T., & Lefly-Harriet, P. (1996). The Family Experience of Mental Illness Evidence for Resilience. Psychiatric Rehabilitation Journal, Fall 96,20, 2 3-10.

McMillan, J.H. & Reed, D.F. (1994). At Risk Students and Resiliency: Factors Contributing to Academic Success. The Clearing House, 67, 3 (pp. 137-140).

O'Connell Higgins, C. (1994). The Later Loci of Hope: Adolescent Adoptive Relationships as Developmental Opportunities. Resilient Adults: Overcoming a Cruel Past (pp. 125-169). San Francisco: Jossey-Bass.

O'Connell Higgins, C. (1994). The Locus of Hope: A Developmental Approach to Early Love. Resilient Adults: Overcoming a Cruel Past (pp. 65-124). San Francisco: Jossey-Bass.

Plucker, J.A. (1998). The Relationship between school climate conditions and student aspirations, Journal of Educational Research, 91,4 (pp.240-247).

Purvis, Jr. G.C. (1995). A Philosophy of Youth. In J.B. Fabry, R.P. Bulka & W.S. Sahakian (Eds.), Finding Meaning in Life: Logotherapy. (pp. 203-212). Northvale, NJ: Jason Aronson Inc.

Smokowski, P.R., Reynolds, A.J., Bezruczko, N. (1999). Resilience and Protective Factors in Adolescence: An Autobiographical Perspective from Disadvantaged Youth. Journal of School Psychology, 37, 4 425-448.

Van Manen, M. (1992). Researching Lived Experience: Human Science for an Action Sensitive Pedagogy Ontario, The Althouse Press.

Werner, E. (1994). Resilient Children. Research in Review. Young Children.

Yin, R.S. (1994). Case Study Design and Methods Research, 2nd edition. Applied Social Research Methods Series, 5 Beverly Hills: Sage Publications.

Appendix D

Interview Questions

1. When did you first realize your mother/father was ill?
2. When someone in your family gets sick, there may be changes. What changed for you?
3. Who, in your life was helpful to you?
4. What did you find most difficult?
5. How did you manage to get through the difficult times?
6. What advice, if any would you give to other youth in your situation/position?
7. What advice would you give to adults, teachers or professionals?
8. Since we usually spend a lot of time in school during our youth, what influence, if any did school or school personnel have on your experience as a child of a parent with mental illness?