

**Interventions for Children of Parents with a Mental Illness: Children's
Experiences and Outcomes.**

**PhD Candidature
CONFIRMATION REPORT**

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EXECUTIVE SUMMARY

Children of parents with a mental illness experience various difficulties throughout their lives, sometimes beginning in their early years. These difficulties can impact on the child's wellbeing and can lead to their own mental health problems. Although a genetic contribution is important in the transmission of a parent's mental illness to children, so are environmental influences, including parenting competence and family relationships, and these are malleable. Considering this, children of parents with a mental illness should have access to interventions which aim to impede the trans-generational transmission of mental illness, as well as foster healthy development and positive relationships with family members and others outside the family. Although there are several interventions available in Australia to support children of parents with a mental illness, research regarding their efficacy and effectiveness is limited.

While there are different types of supports and interventions available, there has not been a systematic study conducted to examine interventions regarding how and through what mechanisms positive outcomes can be encouraged and sustained for children of parents with a mental illness. Given this, a trial study has been conducted to test the efficacy of the selected methodology. The findings of this study have informed the selection of measures to be used in subsequent research. It is proposed that this research will examine how different types of intervention work and impact on children of parents with a mental illness. Further research will investigate the key ingredients and the mechanisms of change across interventions, which appear to be effective for children of parents with a mental illness. Concurrent research will examine the experiences for children as they are involved in these interventions as well as outcomes.

To achieve the overall research aim, three studies have been defined. The first study has already been conducted, and examined the impact on children of a DVD intervention for families where a parent has an affective disorder, called 'Family Focus'. The second study will examine children's experiences of a peer support program, such as Children And Mentally ill ParentS (CHAMPS), and the outcomes of this type of intervention on children. Similarly, the third and final study will identify children's experiences and outcomes as a result of their parent's involvement in another intervention called, 'Let's Talk about Children'. Throughout these three studies the outcomes, impacts and the mechanisms for positive change that potentially make interventions effective for children will be investigated. To guide the research efforts, a proposed schedule detailing the time to be spent for each of the tasks identified in the three stages of work has been developed. Finally, the contribution value and avenues to communicate results of this research are presented.

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1 INTRODUCTION

All children need physical and emotional care from their primary caregiver to develop emotionally and socially. A child of a parent with a mental illness may experience a home environment different from many other children. This environment can, at times, be intimidating and frightening for the child (Falkov, 2004; Jacobsen & Miller, 1998), and the parent with the mental illness may not be available to support or nurture their child/ren (Oyserman & Mowbray, 2000). A child whose parent has a mental illness shared her experience of living in this environment:

“My mum had a mental illness and I felt like everything was going to crumble. I had to care for Mum. She was so sad she didn’t even look at me or say a word to me for days. It hurt, most of the time I believed she didn’t care or love me.”

Lily aged 10, retrieved from Australian Children of Parents with a Mental Illness (COPMI) national initiative website, (2012)

Lily’s experience is common; one epidemiological study found that 21-23% of children have been found to have, or have had, a parent with a mental illness (Maybery, Reupert, Goodyear, Patrick & Crase, 2009). Research consistently reports higher rates of behavioural, developmental, and emotional difficulties in such children, compared with those in the general community (Oyserman & Mowbray, 2000; Reupert & Maybery, 2010), with long-term effects including social and occupational dysfunction (Shiner & Marmorstein, 1998). In addition, several studies report increased rates of psychiatric disorders in children from homes with ill parents, compared to other children, through an interplay of both genetic and environmental factors (Beardslee, Keller, & Seifer, 1996; Jacobsen & Miller, 1998).

It might be said that children of parents with mental illness are a substantial and marginalised group within society. Whilst extensive research has been conducted into their risk of adverse psycho-social and developmental outcomes as well as the potential for resilience, there has been relatively little focus on their personal experiences of the supports available to them, and their understandings of such experiences. Therefore this research is the first attempt to capture children's experiences, perspectives and the outcomes of such interventions.

This document consists of six sections, with the first section being this introduction. The following section outlines a literature review and highlights key findings from previous research regarding interventions for children of parents with mental illness. In section three, the

main aims and objectives of this research will be presented. Along with these are the proposed key research questions. Section four describes the methodology, and sets out the tasks ahead in this PhD candidature. This includes a schedule which defines the timeline that is allocated for each of the tasks identified earlier. Finally, this report concludes in section six with an outline of contribution value and expected publications for this research work.

2 LITERATURE REVIEW

This literature review will begin by considering the setting for a child living with a mentally ill parent. An empirical theoretical framework related to this area will be considered with a focus on the child's development and social environment. It must be noted that in each title the personal experience of a child living with parental mental illness is italicized and is used to reflect the content of the section (retrieved from the COPMI website, 2012).

2.1 Parental Mental Illness: *“Accept your parent – they are still a person, just ‘unique’*

Mental illness is a diagnosable illness that significantly affects or impairs a person's cognitive, behavioral or social capabilities (Mental Health Branch Victoria, 1998). Commonly recognized categories of mental illness includes mood disorder (major depression, bipolar disorder), or anxiety disorders (panic disorder, generalized anxiety disorder), psychotic disorders (schizophrenia) or personality disorders (antisocial, borderline, histrionic or narcissistic personality disorders) (Mental Health Foundation, 2002). These disorders affect around one in five people throughout their lifetime (Australian Bureau of Statistics, 2007). More specific to children whose parents have mental illness, the Australian Bureau of Statistics (ABS) estimates that 34,666 children live in 18,502 Victorian families where the parent has a severe mental illness requiring assistance from mental health services. Further the ABS report that around 250,000 children live in a household where the parent has mental health difficulties. The most common parental mental illness in Australia is postnatal depression, which affects around 14% of women around the time of childbirth (ABS, 2007).

It is important to note that it is not the mental illness of the parent per se which causes difficulties with the child. Rather it is the complex conditions which interplay within the home context, parent and child/ren. This complexity relates to a disconcerted living environment or from social instability and turmoil among the family which is the main risk for children (Kraemer Tenes, Kaufman, Adnopo & Racusin, 2001; Hiddle, 1998). On this point a number of studies have found that it is challenging to identify the effects of mental illness on children, compared to the effects of family breakdown (Dunn, 1993), unemployment, parental use of drugs and/or alcohol (Reupert, Goodyear & Maybery, 2012) and a dysfunctional parent child relationship and connection (Hiddle) as it can be an amalgamation of these direct and indirect effects (Cowling & McGorry, 1995) that adversely impact on the child.

Having examined the context of parental mental illness it is now necessary to consider the risk and resilience factors for children of parents with mental illness, which follows.

2.2 Risk and Resilience Factors for Children of Parents with Mental Illness: “It’s easy to push yourself into drugs or down a dark path”

Clearly exposure to such an environment has the potential to significantly influence and impact on a child’s development. This type of environment can lead to various associated risk factors and possible negative outcomes for children whose parent has a mental health difficulty. Issues related to this situation will now be considered, beginning with a focus on the transmission of parental mental illness to the child, across diagnostic groups.

Research suggests that mental illness can have a genetic contribution. Hosman, van Doesum and van Santvoort (2009) report that children whose parents have an affective disorder are at heightened risk of acquiring an anxiety and/or a depressive disorder themselves, when compared to other children in the community. For example, children whose parent has an anxiety disorder (e.g. generalised anxiety, panic disorder, social anxiety) there is twofold risk of developing an anxiety disorder themselves (Biederman, Petty, Faraone et al., 2006). Similarly, in a 20 year longitudinal study, Weissman and others (2006) found a threefold increase of depression, anxiety and substance dependence in the children of those with a depressed parent, compared to those whose parent had no psychiatric diagnosis. Moreover, several twin, family, adoption and high risk cohort studies indicate a genetic contribution to the transmission of serious mental illness in offspring (including schizophrenia, major depression, bipolar disorder) (as reviewed by Dean, Stevens, Mortensen, Murray, Walsh, & Pedersen, 2010). At the same time, it has also been found that the offspring of mothers with schizophrenia were found not only to have elevated risks of schizophrenia, but also a range of psychotic, affective and personality disorders (Dean et al., 2010). Such a result suggests that the general vulnerability to the development of a mental disorder in offspring is mediated by both genetic and environmental factors.

Accordingly, children face other risks as well; this includes environmental influence, family and individual characteristics, and parent functioning. More specifically, the child may, at times, experience rejection (Murray, Cooper & Hipwell, 2003), hostile responses (Cowling & McGorry, 1995), and a lack of reaction or maltreatment from the ill parent (Elgar, Mills, Waschbusch, Brownridge & McGrath, 2007). Hosman et al (2009) suggest that parenting competence can mediate psychiatric risk through the parent and child relationship or, conversely, through poor parenting skills over a long-standing period, such as emotional binge eating or substance use. Further, family risk factors can include violence or break down (Reupert, Cuff et al., 2012; Shipp, 1999), stigma linked with parental mental illness (Koschade

& Lynd-Stevenson, 2011), and hospitalisation of the ill parent (Maybery, Ling, Szakacs & Reupert, 2005).

These risk factors are usually determined by the parent's mental illness diagnosis, and depend on the chronicity of the illness, its severity, and co-morbidity with other illnesses (Reupert, Cuff et al., 2012), as well as the quality and availability of support, including social and professional support (Reupert, Green & Maybery, 2008).

Outcomes for children vary as well, with some outcomes common across diagnostic groups and others more specific to the parent's diagnosis. An example of an outcome that can be disorder is that children of parents with bipolar disorder are at heightened risk of acquiring inattention disorders (such as ADHD) and conduct/oppositional defiance disorder; or the child of a parent with psychosis is more likely to behave in a disruptive or disorderly manner. Across diagnostic groups children might assume onerous caring responsibilities of their parent and/or siblings, a process that Gardner, Richard and Lorandos, (2006) termed parentification. Other general outcomes for children include lower academic achievement, poor communication skills and social functioning, poverty and, as previously reported, the child possibly acquiring a mental illness themselves (Reupert, Maybery & Kowalenko, 2012).

Not all children will be adversely impacted by parental mental illness, nor will all children in the same family be affected in similar ways (Nicholson & Sweeney, 1998; Reupert et al., 2012). Children show different levels of success in their ability to cope with the environment (Silverman, 1989). Researchers agree that some children with a mentally ill parent can cope well (Sheehan, 1997), acquire and practice effective problem solving skills (Cowling et al., 1995) and access functional social supports external to the mentally ill parent (Rutter & Quinton, 1984). Goodman and Gotlib (1999) reported that children need protective factors, for example adequate community support, to reduce the impact of negative risk factors. While children have been a focus in this literature review it is important to note that some adults, who were once children of parents with a mental illness, report that they managed through difficult times without experiencing such adverse outcomes, reporting that protective factors played a large role in creating a 'buffer' (Colom, Vieta, Sanchez-Moreno, Palomino-Otiniano et al., 2006; Phares & Duhig, 2002).

Protective factors can 'buffer' the impact of the associated risk factors or reduce the vulnerability of a child acquiring a mental illness. Protective factors include: warm and nurturing care by other the parent, the child's own functional problem-solving skills in response to stressors and social support by peers, teachers or family members, such as aunts, uncles, grandparents or siblings (Hosman et al., 2009; Polkki, Ervast & Huupponen, 2005). Good

relationships with family members or friends are often the child's safeguard from risk and provides the child with a safe haven. A qualitative study by Polkki et al. (2005) found that children obtain strength and hope from visiting friends or other family, which help the child to view a normal household.

While social support has been reported as a protective for children of parent's with a mental illness, researchers agree that developing resilience is essential for children to cope well and manage their situation.

Resilience is a person's ability to rebound from stressful events or 'bounce back' (Masten, 2009; Rutter, 2008) to their level of normal functioning, resulting in the person showing minimal damaging effects. Important to note, resilience is a process rather than a personality type or trait. Resilience consists of two forms, an inner strength and relational strengths (Goodyear et al., 2009; Fuller, McGraw & Goodyear, 1999; Werner, 1995). An inner strength is a child's optimism, positive self-image, and adaptive coping strategies (Werner) and a relational strength is the quality of the support from health care or family/friends (Goodyear et al.). It is thought that children of parents with a mental illness develop resilience that is an inner and relational strength (Rayner & Montague, 2008). Consequently, it is commonly acknowledged within the literature that some children of ill parents are 'Super Kids (Karlsson, 1968; Kauffman & Grunebaum, 1979). This means that these children are able to 'bounce back' from adversity quickly and become remarkably resilient. Though this term can be perceived as misleading (considering the associated implications and risks of living with parental mental illness) Beardslee and colleagues (1996; 1988) have rather defined the term 'the resilient child' in reference to those living with parental mental illness, in terms of:

- has knowledge and an accurate understanding of the parent's mental health;
- can share their experience with others;
- has the ability to separate the self from the potentially emotive situation that is their parent's mental illness;
- has a resilient support, family member or teacher; and
- has attained confidence and positive self-image from outside the household.

This summary regarding resilience was based, in part, from a qualitative, interview based study which found that children whose parents have a mental illness and who are considered resilient had a sound knowledge of their parent's mental illness, were able to differentiate the parent's mental illness from themselves (i.e. they did not blame themselves for their parent's illness) and were able to understand the fluctuating nature of mental illness over time (Beardslee et al., 1996; 1988).

Overleaf is a summary of some the aforementioned risk and protective factors developed by Foster, 2006.

Individual	<ul style="list-style-type: none"> • Genetic predisposition for developing mental disorder: one parent 10-16 %, both parents 40% • Temperament: 'easy' = less risk, 'difficult' = higher risk • Age: younger = higher risk (6 mths – 4 yrs = highest risk) • Gender: male = at higher risk than female • Self-esteem: lower = higher risk • Intelligence: lower = higher risk • Birth defects and physical illness = higher risk • Learning disabilities = higher risk
Social and Environmental	<ul style="list-style-type: none"> • Poverty, poor housing, lack of transport = higher risk • Poor educational history = higher risk • Social isolation and lack of support = higher risk • Parental unemployment = higher risk
Family	<ul style="list-style-type: none"> • Marital conflict = higher risk • Chronic family stress = higher risk • Difficulty with communication = higher risk • Family functioning: lower = higher risk
Parental	<ul style="list-style-type: none"> • Psychosis = higher risk of child folie a deux, language delays, relationship difficulties, sleeping and eating problems • Hostility, conflict and violence = higher risk • Abusive behaviours = higher risk of infanticide and homicide • Incapacitation/role reversal = higher risk of child parentification • Warm parent/child relationship = lower risk

Figure 1. Risk and protective factors for children whose parents have a mental illness (Foster, 2006).

In summary, various individual, family and community protective factors are important buffers that enable a child to become resilient and cope with their parent’s mental illness, and manage the associated risks for living in such families.

2.3 Developmental Theoretical Model: *“Is it just me growing up? Or is Mum actually sick?”*

There are several theoretical models which integrate and summarise the extensive research conducted within this area. For example, Hinden, Biebel, Nicholson, Henry and Stier’s (2002) presented a model that can be used for developing interventions for families affected by parental mental illness. This model examines the various influencing factors in the family

context and the desired outcomes of interventions. Another theoretical framework is Falkov's (1998) *Crossing Bridges: The Family Model*. This model examines the reciprocal relationship of mental health on parent and child interaction, as well as the impact of family stressors and vulnerabilities, and protective factors (strengths, resilience and resources) on this relationship.

While these models tend to focus on a family systems approach, a developmental theoretical model developed by Hosman, van Doesum and van Santvoort (2009) integrates the extensive knowledge from the growing number of studies in this field regarding the mechanisms of risk for children specifically. An underlying assumption of this model is that effective approaches and interventions are implemented at different points (namely, the child, parent, parent-child bond, the family) and times (across the lifespan) to reduce the risk of mental illness and improve the social emotional development for the child. Figure 2, below, summarises the domains of risk and protective factors in the transmission of mental illness to children of a parent with mental illness. This model differentiates between interacting domains and influences specific to children and examines the mechanisms of trans-generational risk factors (Goodman & Gotlib, 1999; Hosman et al.).

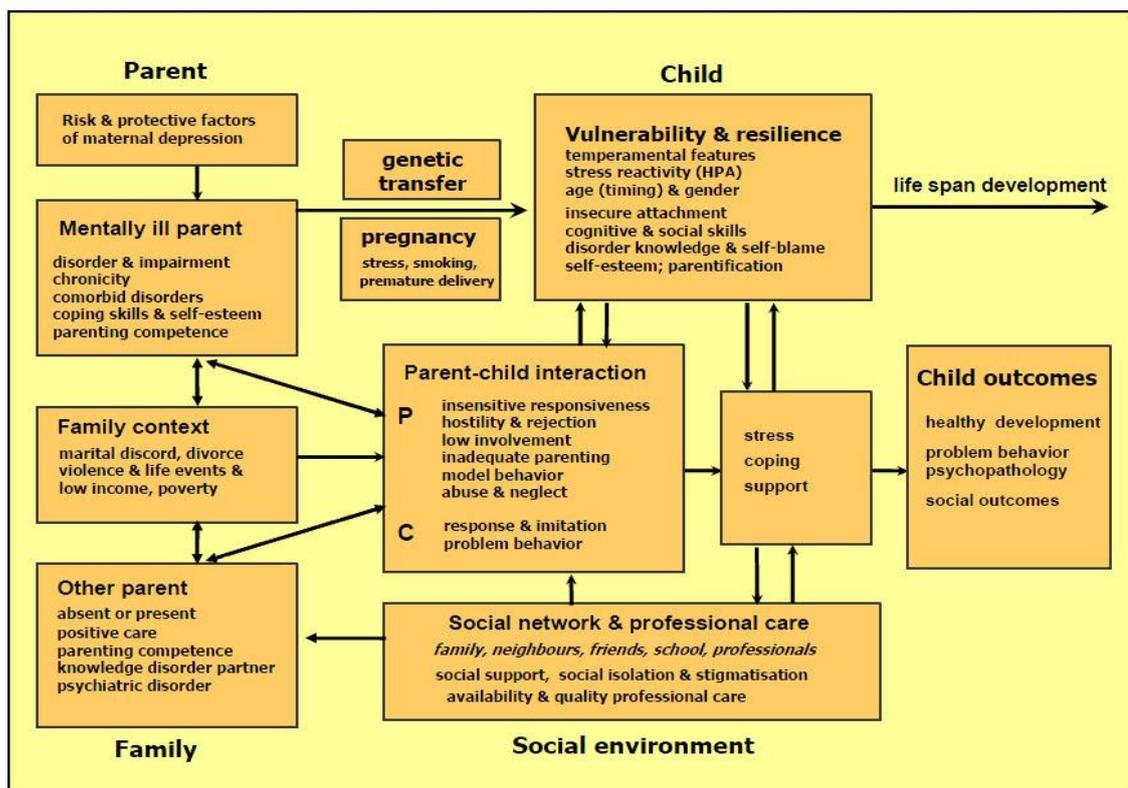


Figure 2. Hosman et al. (2009) theoretical model

An important aspect of this framework is that it distinguishes between the developmental stages in a child's life, beginning at pregnancy and progressing through age-related risk factors and mental illness disorders. Specifically, this model highlights the need to develop interventions along the life span tailored to the developmental needs and risks of specific stages of child development. While there are multiple points of intervention (the child, the parent, the parent-child bond, and the family) each aims to improve outcomes for the child. This model is suited to this area of research, surpassing Falkov's (1998) and Hinden et al. (2002) frameworks, based on a number of factors. Hosman's et al. (2009) model is child focused, has synthesis of numerous child related factors, and was developed as a theoretical base for interventions for children of parents with mental illness. The following section will explore interventions in more detail.

2.4 Interventions for Children of Parents with a Mental Illness: “*Staying closed up never helps.*”

To this point the focus has been on the context of and associated risks for children whose parents have mental illness. It is important however to also examine the interventions and supports available that attempt to alleviate the negative outcomes for children and halt the transmission of psychiatric disorders in families.

Firstly, Siegenthaler, Munder and Egger (2012) reported that the transmission of mental illness in families can be prevented. A systematic review of 13 randomised controlled trials studies of interventions for parents with mental illness, which included cognitive, behavioural and psycho-educational components, was conducted with approximately 1500 children, regarding the impact of family interventions where the parent had a diagnosis of depression, anxiety and/or substance. Siegenthaler and colleagues found that family interventions decreased internalising behaviours in children with a subsequent 40% reduced chance that children would develop a similar mental illness as their parent. Thus, given these findings, it is of great significance that effective interventions are developed and used to impede the transmission of mental illness in families.

Secondly, there are several interventions currently available for parents and a child living through mental illness, all with varying foci therefore the emphasis of this literature review is regarding interventions and programs that are aimed at children who have a parent with mental illness. The points of intervention include supports directed to:

(i) the child, for example peer support programs (such as *Children And Mentally ill Parents*, CHAMPS). Reupert and colleagues (2012) reported that there is an emerging

evidence base for the effectiveness of peer support programs. Another child specific intervention is online interventions and information websites. While there are no online interventions available for Australian youth, there are two internet-based interventions developed in the Netherlands for young people aged 16 – 25 years old (Woolderink, Smit, van der Zanden et al., 2012) with little evidence available of its effectiveness (Drost, Sytema & Schippers, 2010; Woolderink et al.).

(ii) the family as a unit, most of the research in this area has come from Beardslee and colleagues who have developed Family Talk, which targets families where a parent is diagnosed with a major depressive disorder or bipolar disorder, with children aged between 8 and 15 (Beardslee, Wright, Gladstone & Forbes, 2009). Family Talk employs a cognitive psycho-educational approach, of between six to ten sessions, some of which are directed to parents, the children and the whole family (Beardslee et al.). Evaluation data collected four years post intervention demonstrate significantly more gains in children's understanding of parental disorder, children's functioning increased and internalizing symptoms decreased.

(iii) the workforce in terms of their responsiveness to the needs of families (Reupert & Maybery, 2012). Examples of workforce programs include Keeping Children and Families in Mind, an evaluation of which found significant knowledge, skill and attitude changes once workers have completed the training (Reupert, Foster, Maybery, Eddy & Fudge, 2010).

More specifically, the following interventions will be examined in detail and are the centre of this research:

2.4.1 Peer support program: *Children And Mentally ill ParentS (CHAMPS)*

CHAMPS (*Children And Mentally ill ParentS*) is a peer support program for children aged 8-12 and whose parent is diagnosed with a mental illness (Cuff & Pietsch, 1997; Cuff & Purdey, 2003). It is offered as either after-school weekly program or a three to four day holiday program. The aim of CHAMPS is to prevent social isolation by providing a sense of belonging and connectedness through peer support (Goodyear et al.; Cuff & Purdey). It is a structured program which provides psycho-educational groups with activities about parental mental health (Cuff & Purdey). Family participation is also required. CHAMPS was evaluated four weeks post intervention (n = 69) using a within-group research design (Goodyear, Cuff, Maybery & Reupert, 2009), and employed the Kids Connections, Kids Problems and Kids Coping scales in its evaluation (Goodyear et al.). Evaluation data demonstrated an increase in children's self-esteem, confidence, and coping; while a reduction in relationship problems and emotional issues were reported from children who attended CHAMPS (Goodyear et al.).

Though there are many positive outcomes of this program, it is important however to also examine some potential disadvantages. Firstly, behavioural changes found in this study were not compared to a control group; the authors argued that this decision was based on ethical reasons, such as at risk children not receiving an intervention as early as needed (Goodyear et al., 2009). Goodyear and colleagues noted that the lack of control or wait list group may affect the study's rigor and generalisability.

Also, it is also important to acknowledge that no researcher (to the author's knowledge) has examined children's personal experience and their perception of the support provided by CHAMPS, and whether they perceive this support as beneficial. There are other peer support programs, such as PATS: Paying Attention to Self (Hargreaves, Bond, O'Brien et al., 2008) and SMILES: Simplifying Mental Illness + Life Enhancement Skills (Pitman & Matthey, 2004) which are implemented across Australia; however children's experiences have not been examined or evaluated regarding their perception of these programs.

A potential concern with peer support programs, which has been raised in the literature, is that the child is not supported within the context of the family, as instead the focus is on peer relationships with other children whose parents have a mental illness (Reupert & Maybery, 2010b). Another problem is that children cultivate relationships and connections with peers whose parents have a mental illness perhaps at the expense of developing relationships and connections with other children from school or their own communities (Reupert et al., 2012; Hargreaves et al., 2008).

2.4.2 Let's Talk about Children

Let's Talk about Children (Let's Talk) is a Finnish based parent focused intervention originally developed for parents with an affective disorder with children aged 8 – 16. The intervention consists of two to three sessions conducted by a clinician in collaboration with the parent with the mental illness. This program was based on an intervention, called Family Talk, developed by Professor William Beardslee and colleagues that has been shown to promote resilience in children of parents with depression (Beardslee et al., 2009). Let's Talk will be implemented across selected sites in Victoria, in 2013. You have already started to talk about this above – restructure this so it flows better

A study was conducted by Solantaus, Paavonen, Toikka et al. (2010) to evaluate the effectiveness of Family Talk and Let's Talk about Children interventions. In total a 119 families participated and the children were between 8 to 16 years old. Parents completed standardized questionnaires of their children's symptoms and pro-social behaviour at 4, 10 and

18 months after the intervention. Both interventions reduced children's emotional symptoms, worry and hyperactivity, and improved pro-social behaviour (Solantaus et al.). Interestingly, Family Talk was more effective on emotional symptoms directly post intervention, while the effects of Let's Talk about Children emerged after a period of time. Though, Solantaus and colleagues report that Let's Talk is efficacious in treating parents with depression, a concern was the refusal rate (approximately 60%) and dropout rate (25%) of parents. Solantaus et al. argue that this is common (as per Braver & Smith, 1996; Niemela, Hakko & Rasanen, 2010; Olds, Sadler & Kitzman, 2007) considering the difficulty associated with participant's involvement in preventative rather than treatment pilot studies. The authors also reported that parental depression may have impacted on participation due to parents' lack of motivation or energy to attend.

Once again, children's experience of this intervention was not examined, or their perception of the benefits and positive consequences of attending such a program.

2.4.3 Psycho-educational tool: 'Family Focus' DVD

A "Family Focus" DVD was developed by the Australian Children of Parents with a Mental Illness (COPMI) national initiative, with Australian Government funding. The DVD is based on the principles of an intervention developed by Professor William Beardslee and colleagues that has been shown to promote resilience in children of parents with depression (Beardslee et al., 2009; Beardslee, Gladstone, Wright, & Cooper, 2003). Beardslee's Family Talk intervention promotes family communication and an understanding about the impact of parental depression on each family member. Specifically, the 'Family Focus' DVD provided children with developmentally suitable information about parental depression and anxiety. The DVD comprised of age-appropriate explanations about parental depression and anxiety as well as exposing children to accurate knowledge about mental illness. The DVD included information about how the child can respond to their parent, and also provided coping and help seeking strategies for the child. Currently, an article examining children's experience of the DVD has been submitted by Grove, Reupert and Maybery, 2012 for peer review. The article is described in the methodology section of this document and can be viewed in Appendix A.

2.5 Outcomes across Interventions

It is commonly acknowledged within the literature that 'knowledge is power' (Reupert & Maybery, 2010a). This means that when people become educated and knowledgeable about something of which they were previously ignorant that they are then able to change and

improve their circumstances. Most critically this has been suggested as a significant factor that impedes the transmission of mental illness in families (Beardslee & Podorefsky, 1988). “Knowledge” about a parent’s mental illness is thought to provide “power” to their children and the subsequent reduction in the likelihood of getting the illness themselves (Reupert & Maybery, 2010a). In a review of online interventions, peer support groups and family interventions, Reupert and Maybery (2010a) indicate that one of the main constant ingredients across programs was psycho-education, in which children were provided with age appropriate information about mental illness. The authors suggest that providing children with information about mental illness and the opportunity to share their experiences has a significant contribution in supporting their present and future emotional health. Additionally, Beardslee and colleagues (2003) conducted a longitudinal efficacy study of a family based intervention, which included a psycho-educational component. They reported that by increasing children's understanding of parental mood disorder, resilience-related qualities were promoted while a significant reduction in associated risk factors was found. Though research has reported psycho-education as a key component of interventions few studies have explored the mechanisms of how knowledge might be utilised or empower children. Also, it is important to examine children’s experiences and perceptions of these mechanisms and how positive development might be promoted.

Finally, the conditions through which children’s outcomes can be improved, particularly regarding mental illness knowledge and with appropriate help-seeking behaviours, is imperative for the prevention of the transmission of psychiatric disorders and to reduce the aforementioned risk factors and negative outcomes for children (Goodman & Gotlib, 1999; Ramchandani & Psychogiou, 2009; Nicholson & Henry, 2003). As mentioned previously, there is large area of research in child and adolescent development regarding resilience and protective factors, which contributes to the framing of help seeking behaviours but does not directly provide an evidence base on the impact of programs or interventions in increasing help seeking type of behaviour (World Health Organisation, 2007). Therefore this will study to add to the literature, further, regarding children seeking help during difficulties and the impacts this has on children.

Though there are constant ingredients across the various types of programs and/or interventions that have been reported in this discussion, there is little to no research that has identified the “active” ingredient/s that makes interventions effective or in other words, promotes positive change for children of parents with mental illness. For that reason, this will be one of the primary aims of this research project.

3 RESEARCH AIM AND OBJECTIVES

3.1 Overall Research Aim

This research will examine how different interventions work for children of parents with a mental illness. Specifically, this research will examine how children experience different interventions and through what mechanisms positive outcomes in children can be encouraged and maintained.

3.2 Research Objectives

The objectives of this project are as follows:

- (a) Study 1 – Examine the impact of a DVD intervention for children and children’s experiences of the DVD;
- (b) Study 2 – Explore children’s experiences of a peer support program, such as CHAMPS, and children’s outcomes; and
- (c) Study 3 – Examine children’s experience and outcomes as a result of their parent being exposed to ‘Let’s Talk about Children ’
- (d) Study 4 – Comparison analysis will be conducted between all three studies (above) to examine the similarities and differences across interventions.

3.3 Research Questions

The following research questions will be applied to this area of study respectively:

- (a) What are the key ingredients across interventions which are effective for children of parents with a mental illness?
 - What are the mechanisms for positive change?
- (b) How do different interventions impact on children? In terms of
 - Intervention outcomes, such as help seeking behaviours and mental illness knowledge.
- (c) What are the experiences of interventions for children?
 - How do children react and respond in regard to different interventions?

3.4 Overview of Study

Figure 3, below, is an overview of the major variables in this research project.

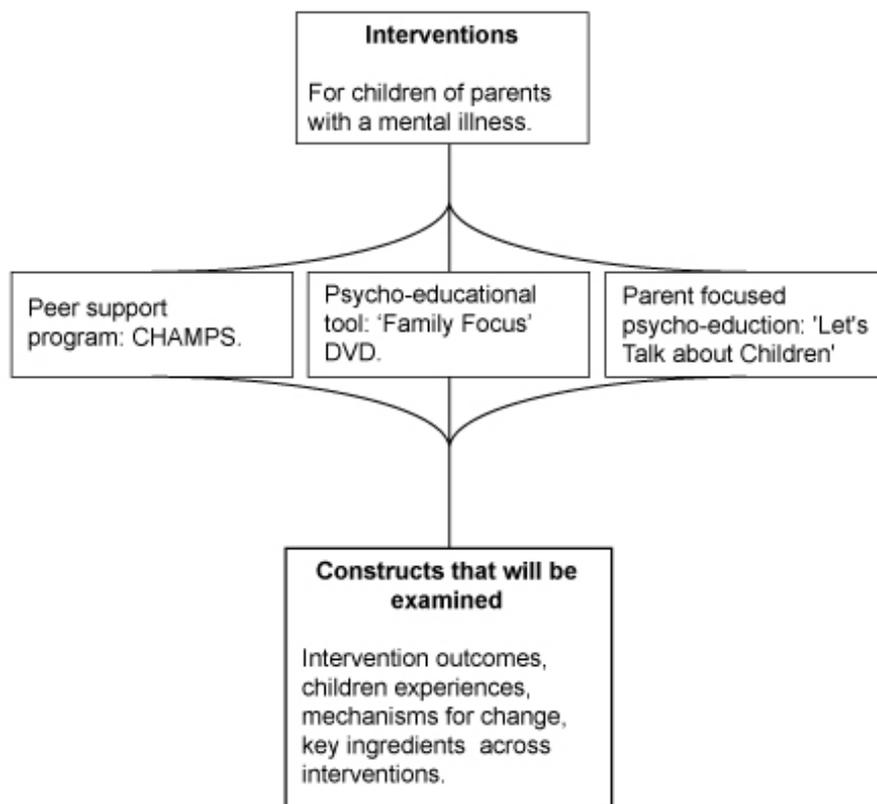


Figure 3. Overview of the Constructs in this Research.

4 METHODOLOGY

Figure 4, below, outlines the methodology that will be implemented in this research project.

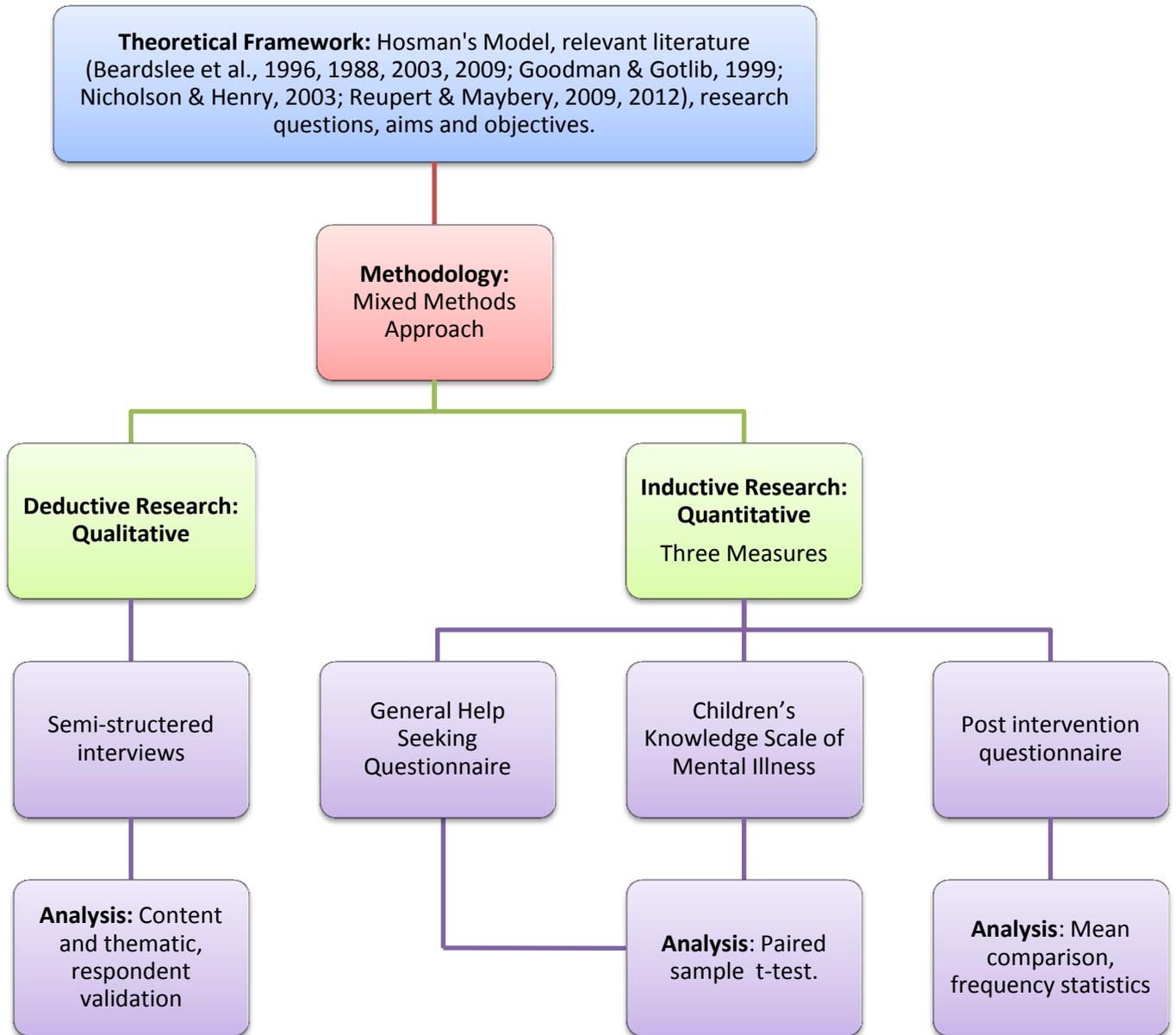


Figure 4. Framework of Research Methodology

An outline of the research design and methodology is explained in detail below, beginning with the procedure for each study followed by the questionnaires and data analysis that will be implemented across the three studies.

4.1 Study One – DVD ‘Family Focus’ Intervention

The first study examined the utility of a DVD intervention, designed to educate children, whose parents have depression and/or anxiety. This study was completed mid-2012 and as a result a journal article was prepared. This article was sent for peer review to the Journal of Child & Family Social Work on 1st October 2012. This journal is reported by ERA 2010 Journal List as an A ranking journal, with an impact factor of 0.883. See Appendix A for the article, titled: *Gaining knowledge about parental mental illness: How does it empower children?*

This study examined the impact of the DVD on families and particularly in regard to how the intervention empowers children. Specifically, this study examined:

1. Children’s mental health knowledge and help seeking behaviour pre and post exposure of the DVD;
2. Children’s perspectives regarding the DVD;
3. The ways in which the DVD had been employed by families and particularly children.

The following research questions were applied in this study:

- What happened after children watched the DVD?
- How was the DVD used by families?
- What are children’s experiences of watching the DVD?

4.1.1 Participants

In study one a total of 29 children participated in the pre and post DVD intervention questionnaires and 18 took part in a telephone interview. All children involved were aged between 8 to 12 years and had parent/s with a diagnoses of depression and/or anxiety. Table 1 (overleaf) summarises the demographic characteristics of the children who completed the questionnaires and in the telephone interview (also see Table 1).

Table 1. Demographics of participants involved with the questionnaires and interviews

Demographic Characteristics	Number Questionnaire Participants (n=29)*	Number of Interview Participants (n=18)*
Age (years)		
Mean	10.4	10.1
Range	8 – 12	8 – 12
Gender	Male 18 (62.0%) Female 11 (38.0%)	Male 10 (56.0%) Female 8 (44.0%)
Parental Diagnosis		
Depression	13 (45.0%)	11 (61%)
Depression/ Anxiety	10 (35.0%)	4 (21%)
Depression/Anxiety/ Schizoid	2 (7.0%)	1 (6%)
Depression /PTSD	1 (3.0%)	1 (6%)
Anxiety (Schizoaffective)	3 (10.0%)	1 (6%)

* Some participants are siblings

4.1.2 Procedure

Ethics approval was obtained early 2012. Children were engaged in the study through their parents who were recruited via various consumer online platforms in Australia, such as through the COPMI initiative website using the discussion board; another recruitment method was via health care professionals. To be eligible for inclusion, one or both parents needed to have recently or be currently experiencing depression and/or anxiety, and to be receiving or have recently completed mental health treatment. The DVD was designed specifically for children aged 8-12 years.

Interested parents were invited to contact the research team, who were provided with a verbal explanation of the study. Their eligibility for inclusion was established at this point. A pack containing the explanatory statements and consent forms, the pre and post questionnaires for children, and the “Family Focus” DVD was then sent out to eligible families. Parents were informed that consent from themselves and from their child/children was necessary (See Appendix B for Explanatory Statement and Consent Forms). All participants were informed that they could select to complete the pre and post questionnaires only, or complete these in conjunction with an individual telephone interview.

Participants completed the General Help Seeking questionnaire and Children’s Knowledge Scale of Mental Illness questionnaire before watching the DVD and were instructed to complete the same questionnaires approximately one week after, including an additional intervention evaluation (see below in section 4.4 for information regarding these measures). The post questionnaires included a separate document inviting participants to the interview.

Telephone interviews were conducted approximately two to four weeks after exposure to the DVD. Children received a \$10 gift voucher for completion of the pre and post questionnaires and a further \$10 gift voucher for the interview.

Parents were also instructed to watch the DVD. Their own experiences and reflections are part of a broader project; the purpose of this research is to report on the data collected from children who participated.

4.2 Study Two – Peer Support Program: CHAMPS

4.2.1 Participants

In study two, children attending CHAMPS program will be invited to participate in the study. CHAMPS facilitators will be approached and participants will be recruited via the key informants in the COPMI initiative and Victorian FaPMI (Families where a Parent has Mental Illness) field. These informants will be contacted through the COPMI webpage and from this publically available site, via email and telephone contact. CHAMPS is for children aged between 8 – 12 years old and is offered in the form of after-school, school holidays or camp programs.

4.2.2 Procedure

Participants will complete the General Help Seeking questionnaire and Children's Knowledge Scale of Mental Illness questionnaire before participating in the peer support program and will be instructed to complete the same post questionnaires, including an additional post intervention evaluation, approximately one week after the final session of the intervention. The post questionnaires will include a separate document inviting participants to take part in an interview over the phone. Telephone interviews will be conducted around two to four weeks after attending the peer support group. Children will receive a \$10 gift voucher for completion of the pre and post questionnaires and a further \$10 gift voucher for the interview.

Parents will be informed that consent from themselves and from their child/children is necessary. All participants will be informed that they can select to complete the pre and post questionnaires only, or complete these in conjunction with an individual telephone interview.

4.3 Study Three – Let's Talk about Children

4.3.1 Participants

Let's Talk about Children will be implemented at selected sites in Victoria in 2013 (supervisors' project). As a part of this broader project, families will be recruited to take part in

the program. Specifically, the current PhD project will recruit children of parents involved in Let's Talk.

To partake in this research project, all participants will be between 10-12 years of age. Also, participants are required to have a parent who is diagnosed with a mental illness, which is not specific to a certain type of mental illness diagnosis.

4.3.2 Procedure

Identical to study one and two, participants will complete the General Help Seeking questionnaire and Children's Knowledge Scale of Mental Illness questionnaire before their parent attends the Let's Talk about Children sessions and will be invited to complete the post intervention evaluation and questionnaire approximately one week after the parent has completed the intervention. The post questionnaires include a separate document inviting participants to take part in an over the phone interview. Telephone interviews will be conducted approximately two to four weeks after exposure to Let's Talk. Children will receive a \$10 gift voucher for completion of the pre and post questionnaires and a further \$10 gift voucher for the interview.

Parents will be informed that consent from themselves and from their child/children is necessary, and will be informed that they can select to complete the pre and post questionnaires only, or complete these in conjunction with an individual telephone interview.

4.4 Study One, Two and Three: Measures and Data Analysis

The measures and data analysis used in study one will be implemented in study two and three. This is to ensure consistent measures are used throughout the research project to identify what outcomes, similar or different, may be found through these three interventions.

4.4.1 Measures

In order to operationalize the constructs identified in this research, study one trialled the measures and questionnaires. In total three questionnaires were employed (See Appendix C for Questionnaires):

4.4.1.1 Children's Knowledge Scale of Mental Illness

The Children's Knowledge Scale of Mental Illness was developed to determine children's understanding of mental health and illness (Goodyear, Maybery & Reupert, unpublished measure). The scale contains seven items asking participants to circle whether a statement is true, false or don't know. Correct scores indicate greater knowledge and positive attitude about mental illness, while incorrect answers are indicative of stereotypes or incorrect

beliefs about mental illness (Goodyear et al.). While the measure is reported to have good face and content validity (Goodyear, personal communication) other psychometric data has not been reported. We have not been able to locate a children's knowledge of mental illness scale (with reported psychometric characteristics) in the literature.

4.4.1.2 Help Seeking Behaviour

The General Help Seeking Questionnaire measures prior help seeking experience and future help seeking intentions (Wilson, Deane, Ciarrochi & Rickwood, 2005). Wilson et al., (2005) found the questionnaire to be a reliable and valid measure of help seeking behaviours, reporting a Cronbach alpha of .85. The measure includes items such as "If you were having a personal or emotional problem, how likely is it that you would seek help from the following people?" in regard to a range of various family, friendship, religious and professional supports, with responses ranging from extremely unlikely through to extremely likely (seven point scale). The post questionnaire posed questions such as "If you were having a personal or emotional problem, how likely is it that you would seek help from the following people in the next month?"

4.4.1.3 Post Intervention Questionnaire

A post questionnaire was constructed to gauge children's impressions of the intervention. Items will ask children about their use and experience of the intervention from their perspective. The questionnaire contains six items on a five point scale, such as 'I can talk to my parents about mental health issues' with the first scale ranging from 1 (Yes, very interesting) to 5 (Really boring). The remaining items were rated from 1 (yes, totally agree) to 5 (Really disagree).

4.4.2 Semi-structured Interviews

The interview schedule that will be used in these studies is based on the literature and research questions (See Appendix D for Interview Questions). The purpose of the interviews is to extend the questionnaire data and to specifically examine how the children respond to intervention. The interview aimed to explore participants' overall impressions of the intervention, the context in which the intervention was implemented, and what happened for children after taking part (e.g. what kinds of things would you like help with, that haven't been discussed?). Semi-structured interview questions will be employed as this allows participants to provide responses focused on a specific topic, but still provide an opportunity for unique presentations (Lindlof & Taylor, 2002; Merriam, 1998).

All interviews will be conducted via telephone, and with both child and parent permission, interviews will be audio-taped and subsequently transcribed. After the interview, participants will be emailed a copy of the interview transcription so they could add delete or change any responses they believed to be potentially identifiable or incorrect (respondent validation; Doyle, 2007).

4.4.3 Data Analysis

Quantitative Analysis. The questionnaire data will be analysed using the Statistical Package for Social Sciences (SPSS, standard version 17.0.1). Paired-sample t-tests will be employed to identify changes in children's knowledge of mental illness and help seeking after attending the intervention. A mean comparison analysis will be conducted of children's responses on the help seeking behavior questionnaire; while frequency statistics will be used to explore the responses given by children on the post intervention scales.

Qualitative Analysis. Thematic content analysis will be conducted on the interview transcripts, which is a systematic means of describing and organising phenomena, a useful process for the exploratory phase of broader research tasks (Braune & Clarke, 2006; Merriam, 1998). In this process, data will be analysed using a coding system, attaching labels to lines or paragraphs of data and then describing the data at a concrete and more conceptual level, for the final themes to be reported (Anfara, Brown & Mangione, 2002).

Given the analysis was directed by specific constructs around children's experiences, the analysis procedure used in this study can be defined as a guided content analysis method (Hickey & Kipping, 1996). Research questions were outlined and then examined according to specific themes. All transcripts will be examined through this procedure.

5 PROPOSED RESEARCH SCHEDULE

A Gantt timeline chart was designed to establish practicability and management of this project within the time frame allocated to ensure completion by the due date (See Appendix E for Gantt Chart of Proposed Research Schedule). To date, timeframes allocated for various tasks have been met, and this research project is progressing without difficulty. Efforts will now focus on the ethics application for study two: peer support program: CHAMPS.

6 CONTRIBUTION OF PROPOSED RESEARCH

6.1 Benefits of Research

Literature suggests that parental mental illness can be associated with poor child developmental progress (Reupert & Maybery, 2009; 2010b). Consequently, the ability of children of parents with a mental illness to meet the projected developmental trajectory expected during childhood is at significant risk, therefore it is proposed that this research will examine how different types of intervention work and impact on children. While, concurrently, investigating the key ingredients and the mechanisms of change across interventions, to identify what is effective for children of parents with a mental illness; in order to address the associated risk factors and outcomes.

This research promotes an educative role for Educational and Developmental Psychologists, by encouraging and promoting evidence-based practice in the selection of interventions best suited to the child at risk. The present study maintains the requirements and a standard expected by the APS College, and is connected with child development and how they cope with mental illness throughout their lives.

6.2 Communication of Results

Based on the proposed research, plans for four papers for submission to relevant journals are outlined below in Table 2.

Table 2: Outline of Proposed Papers for Publication

Paper	Title/Content	Respective Journal
1	Gaining knowledge about parental mental illness: How does it empower children?	Journal of Child & Family Social Work
2	Peer Support Programs: The experiences of children of parents with a mental illness experience	Journal of Child and Adolescent Mental Health
3	Children's Experiences of Let's Talk about Children	Unknown at this stage
4	Final publication – integration of the above	Unknown at this stage

7 CONCLUSION

There has been evidence to show that children whose parents have mental illness are exposed to a number of associated risks, and are at higher risk of acquiring a mental illness themselves. Therefore, it is important that effective interventions are developed that hinder the transmission of psychiatric disorders in families, and promote positive outcomes for children that are lifelong.

This report has highlighted the potential for further research in this area. To develop an understanding of the outcomes of interventions for children of parents with a mental illness three studies have been defined. The first study involved an evaluation of an educational DVD used within the family setting. The second study will involve examining a peer support program. The third and final study would be exploring the outcomes for children of their parent engaging Let's Talk about Children. Overall, a comparison journal article will be written examining the outcomes and effects across different interventions.

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9 APPENDICES

APPENDIX A. COPY OF JOURNAL ARTICLE SENT FOR PEER REVIEW

Gaining knowledge about parental mental illness: How does it empower children?

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Abstract

Background: This study examined the utility of a DVD intervention, designed to educate children, whose parents have depression and/or anxiety. **Method:** Twenty nine children completed pre and post DVD exposure questionnaires, on mental health knowledge and help seeking, and 18 were interviewed about their experiences and use of the DVD. **Results:** Post DVD, children's knowledge of mental illness improved. The DVD also challenged mental illness misconceptions. Most children preferred watching the DVD with a parent. **Conclusions:** The study explains how children utilize information about mental illness.

Keywords: intervention, parent-child relationship, educational psychology, mental health.

Introduction

It is commonly acknowledged within the literature that ‘knowledge is power’ (Reupert & Maybery, 2009). This means that when people become educated and knowledgeable about something of which they were previously ignorant that they are then able to change and improve their circumstances. Most critically this has been suggested as a significant factor that impedes the transmission of mental illness in families (Beardslee & Podorefsky, 1988). “Knowledge” about a parent’s mental illness is thought to provide “power” to their children and the subsequent reduction in the likelihood of getting the illness themselves (Reupert & Maybery). However, few studies have explored the mechanisms of how knowledge might be utilised or empower children. This study explores the impact on children of a DVD designed to provide knowledge of parental mental illness to 8-12 year old children.

Children whose parents have an affective disorder are at heightened risk of acquiring an anxiety and/or a depressive disorder themselves, when compared to other children in the community (Hosman, van Doesum & van Santvoort, 2009). For example, children whose parent has an anxiety disorder (e.g. generalised anxiety, panic disorder, social anxiety) there is twofold risk of developing an anxiety disorder themselves (Biederman, Petty, Faraone et al., 2006). Similarly, in a 20 year longitudinal study, Weissman and others (2006) found a threefold increase of depression, anxiety and substance dependence in the children of those with a depressed parent, compared to those whose parent had no psychiatric diagnosis. Other adverse outcomes that have been reported for children include the onerous caring responsibilities children might assume of their parent and/or siblings, and lower attainment of communication, academic competencies and social functioning, as compared to other children in the community (Reupert, Kowalenko & Maybery, 2012). In terms of prevalence, one epidemiological study found that 21-23% of children have been

found to have, or have had, a parent with a mental illness (Maybery, Reupert, Goodyear, Patrick & Crase, 2009).

Importantly, Siegenthaler, Munder and Egger (2012) reported that the transmission of mental illness in families can be prevented. In a systematic review of Randomised Controlled Trials studies, conducted with approximately 1500 children, regarding the impact of family interventions where the parent had a diagnosis of depression, anxiety and/or substance, found that family interventions decreased internalising behaviours in children with a subsequent 40% reduced chance that children would develop a similar mental illness as their parent. Thus, given the prevalence of, and associated risks for children whose parents have anxiety and/or depression, it is important that effective interventions are developed to impede the transmission of mental illness in families. Also, it is imperative to identify the mechanism/s that enables positive changes for children in such families to better appreciate how positive changes might be promoted.

Recent research has begun to identify the “active” ingredient/s that make interventions effective or in other words, promotes change. Based on a five year follow up randomised clinical trial of 120 people with bipolar disorder, Colom and colleagues (2009) identified psycho-education as a key component of the approach (note that this was not with children). Findings showed that a group who received psycho-education, compared to a group of controls had long-lasting reductions in the effects and symptoms of bipolar disorder. More specific to children whose parents had an affective disorder, Beardslee and colleagues (2003) conducted a longitudinal study of a psycho-educational family based approach. They found that by increasing children's understanding of parental mood disorder, resilience-related qualities were promoted while a significant reduction in associated risk outcomes was found. In a review of online and family interventions, and peer support groups, Reupert and colleagues (2012) indicated that one of the constant

ingredients across interventions was psycho-education, in which children were provided with age appropriate information about mental illness.

Further extending the focus on psycho-education, Reupert and Maybery (2009) interviewed eighteen program facilitators of peer support programs across Australia, which targeted children whose parents have a mental illness. Program facilitators reported that providing education for children about mental illness is essential, arguing that “knowledge is power”. The rationale for this argument, according to those interviewed was that knowledge provided young people with a language to communicate their perceptions and experiences. The connection between improved knowledge and ability to cope, and a decrease in worry, misperception, and seclusion was also highlighted by these peer support coordinators. While such a study emphasizes the importance of knowledge, how children use this knowledge and the impact of this knowledge has yet to be investigated.

Accordingly, this study investigated the impact on children of a psycho-educational tool, in the form of a DVD. It also examined the process in which the DVD was used within the family setting and how “knowledge might result in power” for children.

Intervention

A “Family Focus” DVD was developed by the Australian Children of Parents with a Mental Illness (COPMI) national initiative, with Australian Government funding. The DVD is based on an intervention developed by Professor William Beardslee and colleagues that has been shown to promote resilience in children of parents with depression (Beardslee, Wright, Gladstone & Forbes, 2009). Beardslee’s Family Talk intervention promotes family communication and an understanding about the impact of parental depression on each family member. Specifically, the ‘Family Focus’ DVD provided children with developmentally suitable information about parental depression and anxiety. The DVD comprised of age-appropriate explanations about parental depression and

anxiety as well as exposing children to accurate knowledge about the misconceptions of mental illness. The DVD included information about how the child can respond to their parent, and also provided coping and help seeking strategies for the child.

This study examined the impact of the DVD on families and particularly in regard to how the intervention empowers children. Specifically, this study examines:

4. Children's mental health knowledge and help seeking behaviour pre and post exposure of the DVD;
5. Children's perspectives regarding the DVD;
6. The ways in which the DVD had been employed by families and particularly children.

Method

Ethics approval was provided to conduct this study by the relevant university committee. The study involved a mixed method research design, involving standardized and self-constructed questionnaires, pre and post viewing the "Family Focus" DVD; and individual semi-structured telephone interviews, conducted approximately two to four weeks following exposure to the DVD.

9.1.1 Participants

The 29 children involved in the questionnaire component of the study were aged between 8 to 12 years and had parent/s with a diagnoses of depression and/or anxiety. Given that the most common intervention provided to children whose parents have a mental illness in Australia are peer support programs (Reupert, Cuff, Drost, Foster, van Doesum & van Santvoort, 2012) all participants were asked whether they had participated in such a program. Notably, only one child had participated in an intervention previously. Table 1 summarises the demographic characteristics of the children who completed the questionnaires. Eighteen of the children also took part in a telephone interview (also see Table 1).

Table 1. Demographics of participants involved with the questionnaires and interviews

Demographic Characteristics	Number Questionnaire Participants (n=29)*	Number of Interview Participants (n=18)*
Age (years)		
Mean	10.4	10.1
Range	8 – 12	8 – 12
Gender		
	Male 18 (62.0%)	Male 10 (56.0%)
	Female 11 (38.0%)	Female 8 (44.0%)
Parental Diagnosis		
Depression	13 (45.0%)	11 (61%)
Depression/ Anxiety	10 (35.0%)	4 (21%)
Depression/Anxiety/	2 (7.0%)	1 (6%)
Schizoid/Depression /PTSD	1 (3.0%)	1 (6%)
Anxiety (Schizoffective)	3 (10.0%)	1 (6%)
*Some participants are siblings		

9.1.2 Procedure

Children were engaged in the study through their parents who were recruited to the study via various consumer online platforms in Australia. To be eligible for inclusion, one or both parents needed to have recently or be currently experiencing depression and/or anxiety, and to be receiving or have recently completed mental health treatment. The DVD was designed specifically for children aged 8-12 years.

Interested parents were invited to contact the research team, who were provided with a verbal explanation of the study, and who established their eligibility for inclusion. A pack containing the explanatory statements and consent forms, the pre and post questionnaires for children, and the “Family Focus” DVD was then sent out to the family. Parents were informed that consent from themselves and from their child/children was necessary. All participants

were informed that they could select to complete the pre and post questionnaires only, or complete these in conjunction with an individual telephone interview.

Participants completed the questionnaires before watching the DVD and were instructed to complete the post questionnaires approximately one week after. The post questionnaires included a separate document inviting participants to the interview. Telephone interviews were conducted approximately two to four weeks after exposure to the DVD. Children received a \$10 gift voucher for completion of the pre and post questionnaires and a further \$10 gift voucher for the interview.

Parents were also instructed to watch the DVD. Their own experiences and reflections are part of a broader project; the purpose of this paper is to report on the data collected from children who participated.

Questionnaires

Three questionnaires were employed:

1. Children's Knowledge Scale of Mental Illness.

The Children's Knowledge Scale of Mental Illness was developed to determine children's understanding of mental health and illness (Goodyear, Maybery & Reupert, unpublished measure). The scale contains seven items asking participants to circle whether a statement is true, false or don't know. Correct scores indicate greater knowledge and positive attitude about mental illness, while incorrect answers are indicative of stereotypes or incorrect beliefs about mental illness (Goodyear et al.). While the measure is reported to have good face and content validity (Goodyear, personal communication) other psychometric data has not been reported. We have not been able to locate a children's knowledge of mental illness scale (with reported psychometric characteristics) in the literature.

2. *Help Seeking Behaviour.*

The General Help Seeking Questionnaire measures prior help seeking experience and future help seeking intentions (Wilson, Deane, Ciarrochi & Rickwood, 2005). Wilson et al., (2005) found the measure to be a reliable and valid measure of help seeking behaviours, reporting a Cronbach alpha of .85. The measure includes items such as “If you were having a personal or emotional problem, how likely is it that you would seek help from the following people?” in regard to a range of various family, friendship, religious and professional supports, with responses ranging from extremely unlikely through to extremely likely (seven point scale). The post questionnaire had a slightly reworded to prompt, “If you were having a personal or emotional problem, how likely is it that you would seek help from the following people in the next month?”

3. *DVD Evaluation Questionnaire.*

A post DVD questionnaire was constructed to gauge children’s impressions of the DVD. Items asked children about their use and experience of the DVD (see Table 2). The questionnaire contained six items on a five point scale, such as ‘The DVD was interesting’ with the scale ranging from 1 (Yes, very interesting) to 5 (Really boring). The remaining items were rated from 1 (yes, totally agree) to 5 (Really disagree).

Table 2. Children’s ratings of aspects of the DVD

Questions about the DVD	Mean
1. The DVD was interesting	2.18
2. The DVD helped me understand about depression and anxiety	1.77
3. The DVD gave me some ideas about how to cope better	2.36
4. I can talk to my parents about mental health issues	1.81
5. I can talk to someone in my family (besides my parents) about mental health issues	2.55

Semi-structured, individual interviews

Eighteen of the 29 participants consented to an interview. The interview schedule was based on the literature and research questions. The purpose of the interview was to extend the questionnaire data and to specifically examine how the children used the materials (i.e. DVD) supplied to them. The interview aimed to explore participants' overall impressions of the DVD, the context in which the DVD was viewed, and what happened for children after watching the DVD (e.g. did the child talk about the DVD after watching it, and if so, with whom?) Semi-structured interview questions were employed as these allow participants to provide responses focused on a specific topic, but still provide an opportunity for unique presentations (Lindlof & Taylor, 2002).

All interviews were conducted via telephone, and with both child and parent permission, interviews were audio-taped and subsequently transcribed. After the interview, participants were emailed a copy of the interview transcription so they could add delete or change any responses they believed to be potentially identifiable or incorrect (respondent validation; Doyle, 2007).

Data Analysis

Quantitative Analysis. The questionnaire data was analysed using the Statistical Package for Social Sciences (SPSS, standard version 17.0.1). Paired-sample t-tests were employed to identify changes in children's knowledge of mental illness and help seeking after watching the DVD. A mean comparison analysis was conducted of children's responses on the help seeking behavior questionnaire; while frequency statistics were used to explore the responses given by children on the post intervention "Family Focus DVD Evaluation" scales.

Qualitative Analysis. Thematic content analysis was conducted on the interview transcripts, which is a systematic means of describing and organising phenomena, a useful

process for the exploratory phase of broader research tasks (Braune & Clarke, 2006; Merriam, 1998). In this process, data were analysed using a coding system, attaching labels to lines or paragraphs of data and then describing the data at a concrete and more conceptual level, for the final themes reported here (Anfara, Brown & Mangione, 2002).

The content analysis procedure used in this study can be defined as a guided content analysis method (Hickey & Kipping, 1996). Research questions were outlined and then examined according to specific themes (for example research question: What are children's experiences of watching the DVD? Identified theme: Understanding mental illness). All transcripts were examined through this procedure.

Findings

Questionnaire Data

A paired-samples t-test showed a significant increase in mental illness knowledge ($t(24) = -3.54, p = 0.002$) after watching the DVD (pre DVD $M=11.2, SD= 2.84$ compared to post DVD $M=13.24, SD=1.58$). There was no significant change in help seeking behaviour (Pre $M=40.21, SD=9.62$ compared to Post $M=40.87, SD 13.08$).

A frequency analysis of the DVD evaluation questionnaire indicated that the DVD provided children with some coping strategies, and ways of talking to someone in their family, besides their parents, about mental health issues. The two strongest (i.e. lower scores) responses were to 'The DVD helped me understand about depression and anxiety' and to 'I can talk to my parents about mental health issues'.

Semi-structured interviews

Several themes were identified as summarized here and outlined in Figure 1.

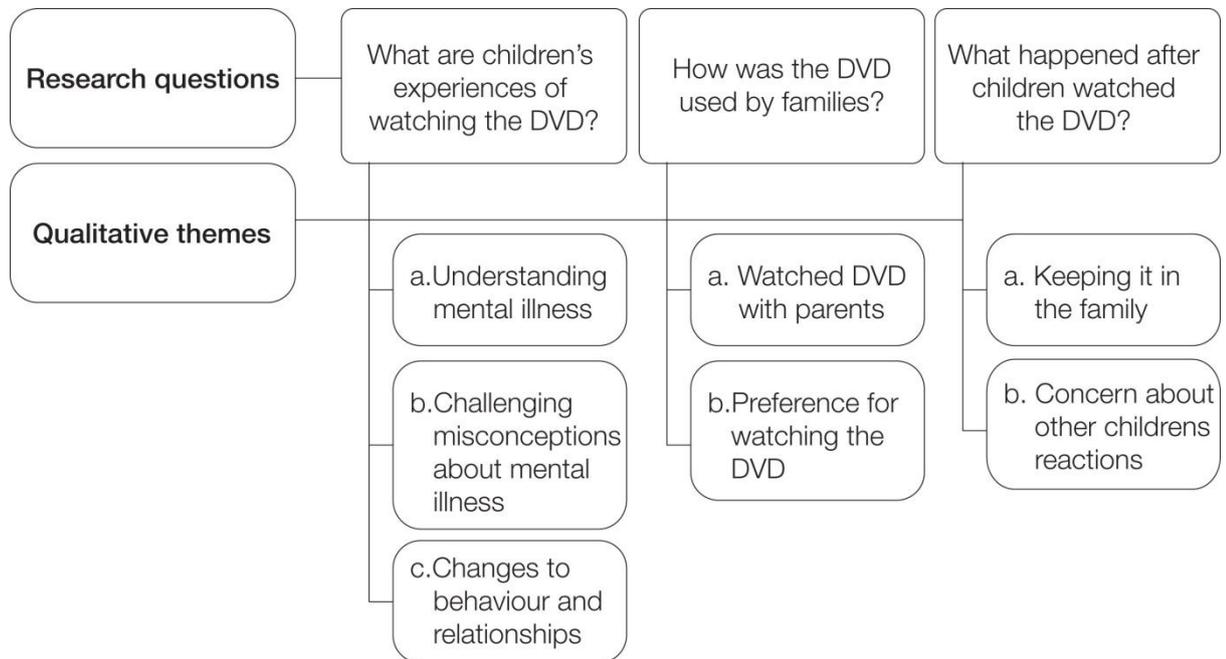


Figure 1. Summary of qualitative themes according to research questions.

1. What are children's experiences of watching the DVD?

Three themes were identified in relation to children's experiences of watching the DVD in terms of how they understood mental illness, how it challenged their conceptions about mental illness and how watching the DVD changed their behaviour and relationships with others as detailed below.

a. Understanding mental illness

A number of participants found that the DVD helped them understand more generally about mental illness. For example, one 11 year old boy indicated that after viewing the DVD he considered that

...people can't do anything about it, they're still the same, they [are] still people...

(Boy, 11 years old).

In particular, they found the DVD useful in understanding what was happening to their parent.

Well people can't do anything about it, they're still the same, they are still people too ... (Boy, 10 years old).

I kind of understand it more that's what depressed meant. It means that I understand a bit more how my mum feels (Girl, 9 years old).

It [the DVD] was very interesting and helped me know why mummy acts funny sometimes and need's to lie down and rest and why she was in hospital when I was in prep[preparatory level] (Girl, 10 years old).

b. Challenging misconceptions about mental illness

Several participants indicated that before they watched the DVD they believed that their parents' mental illness was their fault or that mental illness could be caught like a cold and that they would eventually catch it. However, after watching the DVD these misconceptions had changed.

I was a bit anxious about catching it [mental illness] but now I know that it can't kill you and that it's never my fault. It's not getting a cold really but I learned that it wasn't a cold and it can't get caught like that... (Girl, 11 years old).

And I know that mental health, mental illness it's not caught like a cold, and I think, isn't it one in five people have it?(Girl, 12 years old).

Several participants reported that the DVD helped them realize that their parent's mental illness is not their fault and was no reason to be "scared".

I learnt from the DVD that some things could be done and that it wasn't my fault your life doesn't end if someone close to you has mental illness (Boy, 12 years old).

Sometimes I thought it was my fault maybe I was a bit annoying or I said something wrong. After I watched the movie I realised that it's not my fault and there is something that can be done (Boy, 10 years old).

I used to think it was the person's fault that they've got it, but now I've watched it [the DVD], I guess I've noticed that like they can't always help it. That it's not always their fault and it's not our fault (Girl, 10 years old).

At the start I was scared of mental illness and the way that it worked. But it [the DVD] showed me that there's no need to be scared because it's just like something a part of life (Girl, 11 years old).

c. Changes to behaviour and relationships

In response to watching the DVD a ten year old boy indicated that “*I thought the [DVD] was pretty good. It gave me some better ideas on what I should do when I feel angry and that*”. Others indicated a greater receptiveness to “helping out” and talking to their parents about how they were feeling.

I'd help my mum a bit more when she's like; it's hard to explain, well yeah not really feeling well (Girl, 12 years old).

Having a chat with them and helping them out in things... (Boy, 8 years old).

I'd ask the person if they've got depression or anxiety or that anyone that they know that have mental illness. And ask them whether if I could help them out (Boy, 11 years old).

My thoughts are if you have mental illness, you should help, you should first ask them, how are you feeling and if they say they're feeling not good and they feel like they have a mental illness, you should have a chat to them and help them out (Girl, 10 years old).

2. How was the DVD used by families?

The context in which the DVD was viewed was also identified with preferences for how and with whom they might watch the DVD noted.

a. Watched DVD with parents

Most participants watched the DVD with a parent ($n = 27$), while one participant watched the DVD with a younger sibling and with no parents and another participant watched the DVD on their own, without a family member or friend present.

b. Preferences for watching the DVD

Most participants preferred to watch the DVD with their parents ($n = 21$), though some preferred to watch it alone ($n = 5$), at school ($n = 0$) or with other children whose parents have a mental illness ($n = 3$).

Participants indicated that they would prefer to watch the DVD at home alongside their parents so they could talk to them and ask questions about the material presented.

Because then after they [her parents] watch it, they probably will know that I'm going to ask them questions about it. And once they know that, I'll ask them the questions and then they will answer it (Girl, 10 years old).

Well it would be comforting for my mum to be there and for sharing some of the bits that I don't understand. If I don't understand anything, then I could have asked her, because after we watch it [I] asked her questions (Girl, 11 years old).

I think it will be better to watch it at home, because at school you don't have your mum with you, and then you can't have a conversation with your mum about it (Boy, 9 years old).

One child did not watch the DVD with her parent but clearly required further debriefing:

... it's been a long time and I never – and all those years that have passed, I never knew what it meant and I never knew what was going on. So now when I watch the DVD I knew more but then I got more nervous... (Girl, 12 years old).

She continued by indicating that she would have preferred to watch “*the DVD first and then after the DVD finishes or every time, every 10 or 5 to 10 minutes, we'll [the family] stop the DVD and talk about it*”. Another child concurred by reporting that “*the parents should join in as well a little bit*” namely watch the DVD and participate in a discussion with children afterwards.

The minority of children were not so sure that they wanted their parent to be present whilst watching the DVD. For example, one boy indicated that there were parts of the

video he would like his mother to be present but other parts he would prefer to be by himself (video segments not specified):

Well I would say it would be comforting for my mum to be there and sharing for some of the bits like that I don't understand... but there's also parts of it not to have with your mum –[it's] a bit more personal... personal, like you just want to see it yourself (Boy, 9 years old).

Some participants emphasized that they did not want to watch the DVD with their peers at school. Their main concern was their friends finding out that their parent has a mental illness and the potential for being bullied as a result. Others indicated that they wouldn't want friends or other people to know or find out about their parent's mental illness.

I don't want people...to know that my mum's got depression, like it's not a bad thing but probably like to keep people quiet and it's personal... it's her information (Girl, 10 years old).

No, it's just like still – it's a personal thing (Boy, 9 years old).

There were some however who indicated that they might watch it with other children whose parent had a mental illness, though there was not a consensus on this.

I would probably have two preferences; maybe with one at home, and one would probably be if a friend has a mental illness or mental health, probably at their house because I'd probably feel a bit more comfortable there, because if they've got a question they can ask their parents or me, or if their parents have got a question, they could ask my parents when they come and pick me up (Boy, 12 years old).

3. What happened after children watched the DVD?

The process after the DVD was watched is reported below with reference to keeping mental illness a secret in the family and the child's concern about others' reactions to finding out about their parents mental health difficulties.

a. Keeping it within the family

Children repeatedly indicated that they would prefer not to share information about their parent's mental illness with anyone besides their parents or close family members who already knew:

I wouldn't tell anyone even my friends about mum's mental illness. If it was me [with mental illness] it'd be different because I'm friends with them, but because it's not me it's my mum instead, it's her personal life and information to share (Girl, 11 years old).

It's just more of a family thing than a friend's thing. It's more of a personal thing and I don't want to make it an invasion of mum's privacy by telling people not in our family (Girl, 8 years old).

I haven't told anyone and won't and it's whoever dad tells knows (Boy, 12 years old).

During the interviews some indicated that before they watched DVD their parent's mental illness diagnosis was a secret between their parents. However, children reported that after they viewed the DVD it was still a "secret" but one that was within the family. Consequently, they would not share this new information with others outside their home. The reason for this secrecy was detailed in the second subtheme.

b. Concern about other children's reactions

A main concern for children about their parent's mental illness was the negative reaction of others, and being bullied as a result.

I'm worried about being bullied or called names if everyone knows. Because then they tell others, and then others will tell others, and then, I'll get bullied (Boy, 8 years old).

I mean people might pick on you just because your parents have a mental illness and I don't want that to happen (Girl, 10 years old).

If everyone knows [about my mum's illness] then they will start laughing at me or saying my mum doesn't have a mental illness. They'll start to bully you and then they won't be your friends anymore. And then you won't have any friends (Girl, 12 years old).

The children's reactions were specifically focused around how others outside of the family may react. This focused specifically on the shame for them and other family members and the potential for being bullied.

Discussion

This study sought to establish the views of children in response to the "Family Focus" DVD, to determine how it had been utilised, and to record what changes, if any, watching the DVD might have promoted in children's mental health knowledge and help seeking behaviour. The study also sought to examine how this type of intervention impacted on and empowered children. The data demonstrate that the DVD had a positive impact on children's mental health knowledge after watching the DVD. Additionally, children suggested that the DVD gave them ideas for how to cope with their parent's mental illness by highlighting that they could talk to someone in their family besides their parents about mental illness. There were no significant changes in relation to help seeking

behaviours for any source of support outside of the family home, such as friends, teachers at school or a mental health professional.

In this study, the DVD was used as an educative tool. Reported benefits from the use of this educational tool were an improvement in children's mental illness knowledge and understanding. It needs to be noted however that parents also viewed the DVD and their participation in this process might have had an impact on children's understanding of mental illness as well as family dynamics. At the same time, however, children reported that watching a DVD about mental health conferred benefits, and challenged their misconceptions about mental health, for example that mental illness is contagious, or the "fault" of the child. According to the children in this study, a further benefit after viewing the DVD was that they had an improved understanding of mental illness and what was "going on" for the parent and indicated that they were able to talk to their parents about what was happening and how they might "help out".

Most children reported that they preferred to watch the DVD with their parents, in order to discuss any questions they might have about mental health. There was a minority who reported feeling uncomfortable about having their parents present whilst watching the DVD, preferring instead to watch segments of the DVD on their own, because of the sensitive or "personal" nature of the DVD. A few indicated that they would like to watch the DVD with other children, who also have parents with a mental illness, a finding which suggests that the DVD might be a useful tool which peer support programs might incorporate. For most children interviewed, their clear preference was to watch the DVD with their parents and to have "*parents join in*" to help make sense of the parent's mental illness.

The quantitative findings suggest there were no significant changes in relation to help seeking after children watched the DVD. There are various possibilities for such a result. Given that help seeking behaviour was measured five days after children viewed the DVD,

there may have been insufficient time for children to reflect on who they might approach for help. Whilst not specifically ascertaining help seeking behaviour, during the interviews children describe talking more to their parents about mental illness and using the DVD as a platform for further conversation. Future studies need to ascertain what mediating variables might be in play when children acquire additional knowledge and the secondary outcomes that might be obtained as a result of enhanced understanding of mental illness.

Another reason for a lack of change in help seeking behaviours may be indicated by the qualitative data from this study. The final theme was that children would not share knowledge of their parent's mental illness with others, for fear of bullying or family shame. Perhaps psycho-educational interventions, such as DVD about parental mental illness, which is viewed within the context of the family home, convey the impression that mental illness needs to be a 'secret' with the family. This might explain why the children in this study report being less likely to discuss their concerns about mental illness with others outside of the family environment. The importance of strong connections, both within and outside the family, has repeatedly been found (Biederman et al., 2006; Hosman et al., 2009; Reupert et al., 2012). However, to the best of our knowledge, there are no studies that contrast the benefits received from within the family compared to supports received from outside of the family. Based on the potential notion of 'the more sources of support the better' (Chi, Saucier & Hafner, 2010) this finding perhaps suggests that the DVD may need to be used in conjunction with other interventions that encourage other forms of support, such as peer support groups. This would avail children to additional educational guidance regarding mental health issues, as well as encouragement and support from external sources.

There are several limitations to the quantitative component of this study, in particular the small sample size employed, with no matching control group. Another possible

methodological constraint is the self-reporting nature of the questionnaires used, particularly considering that some children may feel uncomfortable disclosing personal details regarding their parent's mental illness and their family circumstances. Nonetheless, directly tapping into participants' self-reported experiences can provide a good overview of the lived experiences of children and their perceptions of the DVD. Additionally, it is commonly acknowledged that engaging and recruiting children where a parent has a mental illness is difficult and are hard-to-reach as these families are often vulnerable and high risk (FAHCSIA, 2012). Future studies might provide a six week follow-up and/or match an intervention group with alternative interventions or wait list to determine whether changes in mental health knowledge are sustainable in the longer term. Such a follow up study might also determine whether improved knowledge leads to behavioural changes, such as adaptive coping, help seeking or discussing mental illness with others.

In summary, the "Family Focus" DVD aimed to provide age appropriate information to children about their parent's depression and/or anxiety. This study reported the views of children about the DVD, determined children's preferences for using the DVD, and identified that the DVD has utility for children where a parent has depression and/or anxiety. Furthermore, the DVD was shown to have important benefits for children; this includes a change in a child's misconceptions about mental health, an improved understanding and knowledge of mental illness and what is "going on" for the parent with mental illness. However, no change in children's external help seeking behaviours was found. This might be due to the parent's mental illness being a "secret" within the family, which the children did not feel comfortable talking about to those outside of the family. Future studies need to examine interventions regarding how and through what mechanisms positive outcomes can be encouraged in children whose parents have a mental illness.

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**APPENDIX B. EXPLANATORY STATEMENTS AND CONSENT FORMS FOR
PARENT AND CHILD PARTICIPATION**



Explanatory Statement for Parents A DVD evaluation

This information sheet is for you to keep.

Our names are Natasha Marston and Christine Grove and we are conducting an evaluation project with Dr Andrea Reupert (senior lecturer in the Faculty of Education) towards a Master of Psychology at Monash University. This means that we will each be writing a thesis which is the equivalent of a short book.

You are invited to take part in this study. Please read this Explanatory Statement in full before deciding if you wish to participate.

The aim of this study is to evaluate a DVD ” which has been developed by the Children Of Parents with a Mental Illness (COPMI) national initiative (with funding from the Australian Government) for families where a parent has depression and/or anxiety and who has a child or children aged between 8 and 12 years. We believe that the DVD will provide practical information for families experiencing mental health issues in their day to day lives. We have funding from the COPMI national initiative to complete this evaluation study.

To be involved in this study you must:

- Be either a mother or a father
- Have at least one child aged 8-12
- Experience anxiety or depression or both
- Be receiving or have recently completed treatment for your anxiety or depression (for example, from your GP, or a psychologist)
- Have access to a support worker (such as your GP or psychologist)

The DVD has information about mental illness, how mental illness impacts on families, how to discuss mental illness in families and where to access support if required. There are sections for parents and a section for children. The section for children relates to explaining what mental illness is, and how to seek appropriate help.

As the parent it is up to you whether you involve your children or not. You might want to look at the children’s sections first before you show it to them. We would also encourage you to watch the children’s sections along with your children.

Please note that the DVD is still being developed. It will ONLY be available in its draft form to parents who are also prepared to provide us with feedback about it. If you are prepared

to be involved in this project, complete the consent form and email/send to us. We will then send you the draft DVD plus the various evaluation questionnaires.

Please note that the final DVD will be made available to all Australians who wish to see it in mid-2012.

Being in this project involves the following steps:

- First you would complete some questionnaires, relating to parenting confidence and family dynamics;
- Second you would need to watch the DVD (which ever aspects you find most relevant to you and your family)
- Third, you will be asked to complete the same questionnaires again, with some additional questions specifically related to the DVD

You will be able to do this at a time and place of your convenience. Altogether, completing the questionnaires and watching the DVD will take approximately 90 minutes.

If you wish, you can be provided with a copy of your responses to the questionnaire. If you are interested in receiving this, you need to let us know and provide us with your personalised code, so we can locate your specific questionnaire responses.

Once you have completed the questionnaires, you will be given the opportunity to be involved in an interview. The interviews will focus on your impressions of the DVD and with your permission will be audiotaped. These interviews will take approximately 30 minutes to one hour and will be conducted either face to face in a public place such as Monash University, or over the phone. Once the interview has been completed you will be provided with a copy of the interview and given the opportunity to add, delete and/or change any information you believe is potentially identifiable or incorrect. There will be a cut-off date for this to occur.

It is up to you whether you participate in the follow up interview. You can watch the DVD and do the questionnaires without doing an interview.

Also we are asking for feedback from your children. If you provide consent, we would then talk to your child about the study and invite him or her to participate. They would be invited to complete a series of questions relating to mental health knowledge and help seeking, watch the children's section of the DVD and the complete the questions again. At this point we will be asking for their permission to be interviewed to obtain further feedback on the study. If your children will be paid \$20 for completing the questionnaires, and an additional \$20 for the interview.

You will be paid \$60 for completion of the questionnaires and watching the DVD. You will be paid \$40 for your involvement in the interview. Please note that you are eligible for this, regardless of whether your children are involved or not. .

Your involvement, and the involvement of your children, in this study is voluntary and you are under no obligation to participate. Your involvement or non-involvement will not impact on any clinical services you or your children receive.

If you no longer wish to participate, you (and/or your child) may withdraw from the questionnaire aspect of the study only prior to the questionnaire being submitted. You (or your child) can withdraw from the interview part of the study only prior to your approval of the written record of the interview.

All information reported will be de-identified and at no times will names or identifying information be reported. You will be asked to provide a code for the questionnaire but this is so we can match the questionnaires you complete before and after watching the DVD. If you do take part in the interviews we will not report your name at any time. You will also have the opportunity to view a copy of the interview and invited to change/delete any information you believe is incorrect and/or potentially identifies you or your family.

If you find the DVD distressing there is a list of organisations and helplines that you can access. If you find being involved in the evaluation distressing, that is, the questionnaires and/or the interviews, the organisations listed here might help you. We would also encourage you to talk to your usual health care provider. However, we believe that there is minimal or no risk in being involved in this study.

Organisations that might support you if you do experience distress are:

Relationships Australia	1300 364 277 or http://www.relationships.org.au/
Lifeline	13 11 14
Beyond Blue Info line	1300 22 4636
KidsHelpline	1800551800 or http://www.kidshelp.com.au/

Your participation will aid in the development of mental health resources for families, and you may find the information and resources in the DVD helpful to you.

Storage of the data collected will adhere to university regulations and be kept for five years. Only the researchers will have access to the data.

You will not be named or identified in any reports or publications arising from this research. If you would like to be informed of the results of the study, please contact Andrea Reupert by sending an email to andrea.reupert@monash.edu

<p>If you would like to contact the researchers about any aspect of this study, please contact the Chief Investigator:</p>	<p>If you have a complaint concerning the manner in which this research is being conducted, please contact:</p>
<p>Dr. Andrea Reupert, Senior lecturer and psychologist Institute of Human Development & Counselling, Krongold Centre Faculty of Education Clayton Campus Monash University, Vic 3800 Telephone: 03 9902 4587 Fax: 03 9905 5127 andrea.reupert@monash.edu</p>	<p>Executive Officer, Human Research Ethics Standing Committee on Ethics in Research Involving Humans (SCERH) Building 3e Room 111 Research Office Monash University VIC 3800 Tel: +61 3 9905 2052 Fax: +61 3 9905 1420 Email: scerh@adm.monash.edu.au</p>

Thank you.

Natasha Marston

Christine Grove

Andrea Reupert

Explanatory Statement for children aged 8-12

“Family Talk”: a DVD evaluation

Hi!



This sheet is for you to keep.

My name is Christine Grove and I am a student at Monash University, working with Dr. Reupert. We are doing a research project to find out how useful a DVD called “Family Talk” is, for parents and children. I am asking you and your parent if it is okay for you to take part in this research.

We are trying to find out how useful the DVD is for kids. Your experiences and views will help us finalise the DVD. The DVD is for families where a parent has depression or anxiety or both. We hope the DVD gives kids like you some idea of what depression and anxiety is all about.

The DVD was developed by the COPMI national initiative (www.copmi.net.au), who are funding us do this project.

Your parent has already provided permission for you to be involved in this study, but it is up to you whether you are involved or not. You do not have to be a part of this research, it’s up to you.

What will I have to do if I take part?

1. First, you will be asked to complete some questionnaires about your understanding of anxiety and depression and who you might turn to if you want to talk about a problem.
2. Then you watch the kids section of the DVD. We would encourage you to do this with one of your parents. This will go for about 10-20 minutes.
3. You will then need to answer the questionnaires again.
4. Once these steps have been done you will asked if you want to do an interview – again, that is up to you. The interview will cover questions about how you find the website (e.g. Did you like it? What was good about it?).

Watching the DVD and answering all the questionnaires takes between 30 to 60 minutes. The interview will take about 30 to 60 minutes.

You will be paid \$10 for doing the questionnaire and another \$10 for doing the interview. You can decide to only do the questionnaires or only do the interview if you want.

You can change your mind and stop being involved at different times, it is up to you. However, once you send in your questionnaires or submit them online, you won't be able to take them back. In the interviews you might not like some of the questions – again, we can stop the interview. When the interview is finished we will send you the interview notes – you can change any of this, if you think it is wrong or if you think someone might be able to tell from reading your answers that it is you. After you approve these notes, you will not be able to withdraw from the project (there will be a cut-off date for this to occur).

No one will know what information you give us, either in the questionnaires or in the interview. No one will be able to tell that the information comes from you. Your name will not be written in any report.

The information you give us will only be used by the researchers. No one else is allowed to use this information. The information you provide us will help finalise the DVD for families where a parent has anxiety or depression and their kids. Your questionnaires and the interview tapes will be kept in a locked cabinet at Monash University and stored on a computer protected with a password.

It might be upsetting for you to talk about the DVD and your family. We don't think there is much chance of that but if you do feel upset first we would encourage you to talk to your parents or if you have a counsellor you see, you should talk to him or her. There are also other places you can turn to such as:

Kids helpline	1800551800 or http://www.kidshelp.com.au/
Lifeline	13 11 14
Beyond Blue Info line	1300 22 4636

<p align="center">If you would like to contact the researchers about any aspect of this study, please contact the Chief Investigator:</p>	<p align="center">If you have a complaint concerning the manner in which this research is being conducted, please contact:</p>
<p>Dr. Andrea Reupert, Senior lecturer and psychologist Institute of Human Development & Counselling, Krongold Centre Faculty of Education Clayton Campus Monash University, Vic 3800 Telephone: 03 9902 4587 Fax: 03 9905 5127 andrea.reupert@monash.edu</p>	<p>Executive Officer, Human Research Ethics Standing Committee on Ethics in Research Involving Humans (SCERH) Building 3e Room 111 Research Office Monash University VIC 3800 Tel: +61 3 9905 2052 Fax: +61 3 9905 1420 Email: scerh@adm.monash.edu.au</p>

What do I need to do?

If you are interested in being involved, let your Mum or Dad know, sign the consent form and ask your parent to send or email in the form.

If you have any questions, you can ring or email either of the researchers listed below.

Thanks,

Christine Grove and Andrea Reupert

PARENTAL CONSENT FOR CHILD/REN TO BE INVOLVED

“FAMILY TALK”: A DVD EVALUATION

NOTE: This consent form will remain with the Monash University researcher for their records

I agree that _____ (child/ren’s names) may take part in the above Monash University research project. The project has been explained to me, and I have read the Explanatory Statement, which I keep for my records.

I understand that agreeing to take part means that I am willing to allow _____ (child/ren’s names) to:

- Complete a series of questionnaires Yes No
- Watch the children’s section on the Family Talk DVD Yes No
- Be interviewed by the researcher Yes No
- Have the interview audio-taped Yes No

Please note that you can still have your child involved but not in all parts of the project. For example, you might be happy for your children to do the questionnaires and the DVD but not the interview.

Children’s names	Children’s ages (remember to be involved they can only be 8-12 years of age)

Parent’s / Guardian’s Name:

Parent’s / Guardian’s relationship to participant:

Parent’s / Guardian’s Signature:

Date: _____ Preferred contact details:

Email: _____ Phone: _____

CHILDREN'S CONSENT FORMS

"FAMILY TALK": A DVD EVALUATION

NOTE: This consent form will remain with the Monash University researcher for their records

I agree to take part in evaluating the Family Talk DVD. I have had the project explained to me.

I agree to do the following:

I agree to be interviewed by the researcher Yes No

I agree to allow the interview to be audio-taped Yes No

I understand that it is up to me to be involved in this project; no one is making me to do this.

I understand I can stop at any point during the interview if I feel upset. The interview will stop and the information we have collected will be deleted at this point.

After the interview, I know that the researcher will send me notes about my interview. I understand that I can only withdraw the information I give to the researcher before I send back the notes from the interview (or after a certain date).

I know that my name will not be reported.

I know that the information the researchers get from me will be kept in a safe place. No one but the researchers will be able to get it. I know that all the information the researchers have on me will be destroyed after five years.

Participant's name

Signature

Date

Preferred contact details:

Phone:

Email:

APPENDIX C. QUESTIONNAIRES

CHILDREN'S SURVEY

We need a code to match the answers you give us now, and those you will give us later.

You can use a nick name – but you **HAVE TO REMEMBER IT!**

Or you can use a code that we will help you remember.

Take the first two letters of your middle name and the first two numbers of your birthdate.

So, for example, my middle name is Erika and I was born on the 28th so my code is ER28

Please enter your code or nick name here: _____

Survey Questions Start Here

1: Gender: (tick)

Female	<input type="checkbox"/>
Male	<input type="checkbox"/>

2: Date of Birth: _____

Please Turn Page for the Next Part

Children's Knowledge Scale of Mental Illness

What is a mental illness?

Which of these sayings are true and which are false?

Draw a circle around the **T** if you think the saying is true.

Draw a circle around the **F** if you think the saying isn't true.

Draw a circle around **DK** if you do not know if the saying is true or false.

A mental illness can be caught like a cold.

T or F or DK

All people with a mental illness are affected in the same way

T or F or DK

Most people who have a mental illness are dangerous

T or F or DK

Many parents get a mental illness because of the way their children behave

T or F or DK

I am probably the only person in my school who has a parent with a mental illness

T or F or DK

When someone has a mental illness there is nothing that can be done to help them

T or F or DK

It's not the person's fault that they have a mental illness

T or F or DK

Seeking Help Questions

Below is a list of people you might go to for help or advice if you were having a problem.

Tick any of these who you have gone to for advice or help in the *last month*.

1. Friend (not related to you)
2. Mum
3. Dad
4. Sister
5. Brother
6. Other family member
7. Professional like a school counsellor or psychologist
8. Phone help line like kids help line
9. Family doctor or GP
10. Teacher
11. Someone else: Please let us know who this is:.....
12. I did not seek help from anyone for my problem

Post Intervention:

Below is a list of people you might go to for help or advice if you were having a problem.

Tick any of these who you might go to, if you have a problem in the *next month*

1. Friend (not related to you)
2. Mum
3. Dad
4. Sister
5. Brother
6. Other family member
7. Professional like a school counsellor or psychologist
8. Phone help line like kids help line
9. Family doctor or GP
10. Teacher
11. Someone else: Please let us know who this is:.....
12. I would not seek help from anyone for my problem

Please circle which statement that best fits your answer:

1. The DVD was interesting

	1	2	3	4	5
Yes, very interesting		A little interesting	Not interesting or boring	A little boring	Really boring

2. The DVD helped me understand about depression and anxiety

	1	2	3	4	5
Yes, totally agree		Agree a bit	Neither agree or disagree	Disagree a bit	Really disagree

3. The DVD gave me some ideas about how to cope better

	1	2	3	4	5
Yes, totally agree		Agree a bit	Neither agree or disagree	Disagree a bit	Really disagree

4. I can talk to my parents about mental health issues

	1	2	3	4	5
Yes, totally agree		Agree a bit	Neither agree or disagree	Disagree a bit	Really disagree

5. I can talk to someone in my family (besides my parents) about mental health issues

	1	2	3	4	5
Yes, totally agree		Agree a bit	Neither agree or disagree	Disagree a bit	Really disagree

Any other comments you would like to make about the DVD:

Thanks for filling out the questionnaires – for that you receive \$10. Be sure that they go in the envelope along with your parents.

Interviews: We are also interested in talking to you about how you found the DVD. If you are interested have a talk to your mum or dad first and then ask them to let us know. You don't have to do the interview. But with your help we can develop a really cool DVD for kids like you. If you do the interview we will pay you \$10.

If you are upset as a result of doing any of these scales please talk to your mum or dad. You might also want to ring any of these:

Kids helpline 1800551800 or <http://www.kidshelp.com.au/>

Lifeline 13 11 14

Beyond Blue Info line 1300 22 4636

Thanks again.

APPENDIX D. INTERVIEW QUESTIONS

Children's semi-structured interview

Preamble

Thanks for doing this interview. Are you still okay to do it? And have it taped? (If yes, switch on tape recorder now).

Do you have any questions or issues about the study before we begin?

Intervention Evaluation Questions:

1. What did you think of the DVD/CHAMPS?
2. How do you think most kids would find it?
3. Was it easy to understand? Why or why not?
4. How interesting was it? Or was it boring?
5. What do you think the main message of the DVD/CHAMPS was? Or main messages?
6. Would you do anything differently now you have seen the/been to DVD/CHAMPS?
7. Do you think differently about mental illness now that you have seen the/been to DVD/CHAMPS?
8. What are your thoughts about mental illness? Has that changed since being a part of the DVD/CHAMPS?
9. Will you talk to anyone about the DVD/CHAMPS? If yes, who? And why them? If no, why not?
10. Do you think other kids would want to watch this/attend CHAMPS? Why or why not?
11. What are the best bits of the DVD/CHAMPS? The worst?
12. Did you talk about the DVD/CHAMPS/Let's Talk about Children in your family? If yes, what happened? If no, why not? Do you want to talk about the DVD/CHAMPS/Let's Talk about Children in your family? Why or why not?
13. How should kids be told about the DVD/CHAMPS/Let's Talk about Children?

DVD Specific Questions:

1. DVD Specific: Did you watch it with your parent/s? How was that? Would you prefer to watch it with your parents or by yourself?
2. DVD Specific: Would you prefer to watch the DVD with other kids who also have a parent with a mental illness? Would you prefer to watch the DVD at school? What is your preference for where you would like to watch the DVD?

APPENDIX E. GANTT CHART OF PROPOSED RESEARCH SCHEDULE

