

Children and parents with psychosis—Balancing between relational attunement and protection from parental illness

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Abstract

Background: Few studies have explored the experiences of young children and their parents with psychosis. The aim of the present study was to explore parent and child mental health and the parent–child relationship from the perspectives of children and their parents with psychosis.

Methods: The present study had a multiperspectival qualitative design. Seven children (aged 8–15 years) and their six parents with psychosis were interviewed individually. Data were analyzed according to interpretative phenomenological analysis.

Results: Children were found to have a limited understanding of the parent's illness. While both parents and children described the illness as part of ordinary life and focused on improvements, there was incoherence both within and between interviews. Parent–child relationships appeared to be nonhierarchical and to vary in terms of attunement and distance, which in turn seemed to be associated with the child's well-being.

Conclusion: The findings contribute multiperspectival insights into lived experiences of young children and parents with psychosis. Nurses are in a key position to recognize the children's needs for continuous adult support and to promote communication about the illness.

KEYWORDS

children, interpretative phenomenological analysis, parental psychosis, parent–child relationship, parenting, severe mental illness

1 | INTRODUCTION

A substantial minority of patients in adult psychiatric care have children under 18 years (Lauritzen, 2014; Maybery & Reupert, 2018; Ruud et al., 2019). Exposure to both the genetic and contextual risk factors of growing up with a parent with mental illness increases a child's risk of developing mental health problems (Downey & Coyne, 1990; LeFrancois, 2012; Leijdesdorff et al., 2017; Ramchandani &

Psychogiou, 2009). The present study aimed to explore mental health and the parent–child relationship from the perspectives of parents with psychosis and their children.

The complex task of parenting is more challenging for parents with severe mental illness (Campbell et al., 2012; Wan & Green, 2009). Parents with psychosis describe that depression, fatigue, and difficulty focusing negatively impact their ability to provide protection, reciprocity, control, and routines (Strand et al., 2020).

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Mothers with psychosis struggle with maintaining discipline, boundaries, and their parental role while experiencing symptoms or side effects of medication, and worry about the possible effects of their illness on their children (Dolman et al., 2013). One of the few studies (Evenson et al., 2008) to include fathers with psychosis suggests that psychosis may directly and indirectly undermine parenting and the father-child relationship, partly because of hospitalizations and partly because of emotional detachment due to symptoms and medications.

The parenting difficulties found among parents with psychosis are confirmed by a systematic review including 18 quantitative studies (Engur, 2017). It shows that parenting with psychosis can be chaotic and include ambivalent communication, high levels of parental stress, and a neglectful and authoritarian parenting style. In contrast, a large quantitative study including mothers and fathers with psychosis ($n = 234$) reported that most participants were rated by trained clinicians as good-enough or adequate parents in terms of their participation, interest, and competence in childcare over the last 12 months (Campbell et al., 2018).

Most studies including children of parents with psychosis are retrospective (Källquist & Salzman-Erikson, 2019). Adult children have reported a wide range of frightening experiences related to parent's delusional behaviors when recalling their relationships with parents with psychosis (Duncan & Browning, 2009; Kadish, 2015). Participants who described being raised solely by a parent with schizophrenia, either temporarily or full-time, recalled some of the most disturbing experiences, including isolation from family, friends, and community. Adults who grew up with a mentally ill parent described their childhoods as disruptive and sometimes abusive and neglectful (LeClear O'Connell, 2008).

Other childhood experiences recalled by adults were of the ill parent as physically or mentally absent, or as being in the background of family life (Duncan & Browning, 2009). Parents' focus on personal problems or symptoms left them little time or empathy for their children's problems (LeClear O'Connell, 2008). Other adult children mentioned that their relationship with a parent with psychosis resulted in low self-esteem, a constant need for affirmation, and a focus on being a "good girl" with some children taking on a caregiving role (Kadish, 2015). Another study, which included the experiences of both dependent children and their mentally ill parent, found that children were worrying about their parent and had a limited understanding of their parent's illness (Stallard et al., 2004). Their parents were aware that their illness negatively affected their children, particularly by disrupting everyday life.

Parents' fear of losing custody or access to their children (Diaz-Caneja & Johnson, 2004; Pihkala et al., 2012) may serve as an obstacle for parents to speak to psychiatric staff about their concerns (Maybery & Reupert, 2009). Further knowledge about the parents' and children's experiences may provide a basis for improved communication between professionals and parents with psychosis about parenting and about the child's experiences. Despite increasing number of studies into the effects of psychosis from the perspectives of both parents and their adult children, there remains a dearth of studies including young children. Children and their

parents may differ in their views of how parental mental illness affects their interaction (Maybery et al., 2005). Consequently, it seems important to explore these experiences from both perspectives. A multiperspectival interpretative phenomenological framework is a suitable approach which considers each individual's narrative as equally important (Larkin et al., 2019). Consequently, the aim of the present study was to explore descriptions of parent and child mental health and experiences of the parent-child relationship from the perspectives of children and their parents with psychosis.

2 | METHODS

This study was part of a larger research project exploring parenting in persons with psychosis and the effects of Beardslee's family intervention (BFI; Beardslee et al., 2003). The present study had a qualitative design based on interviews with six parents and their seven minor-aged children.

2.1 | Participants

Six parents (4 women and 2 men, 38–47 years) and their seven children (5 girls and 2 boys, 8–15 years) participated in this study (see Table 1 for participants' characteristics). The parents had between one and three children each (total = 11). Children aged under 8 or over 17 were excluded from the study. One parent was a single parent, two had shared custody, two co-habited with the other parent, and one had access to the child who was placed in foster care. The parents had a diagnosis of schizoaffective disorder or schizophrenia and had a long history of psychiatric care (see Table 1). Five parents were on long-term sick-leave, and one parent was on parental leave. All names in the text are pseudonyms.

2.2 | Procedure

Participants were recruited via four outpatient clinics for adults with psychosis. Inclusion criteria for parents were having a child aged 8–17 years and having participated in BFI (Beardslee et al., 2003) as part of regular treatment. The BFI is a brief preventive intervention including parents (five sessions of six) and children (three sessions) aimed to increase knowledge and communication about the parent's illness. Excluded parents were those who staff judged to be too intellectually or psychologically impaired to participate in research.

Case managers provided verbal and written information about the research project to parents who had participated in BFI in the last three years and asked them to share the information with their child and the other parent. All parents were informed that their participation was voluntary, that their choice would not influence their ordinary treatment, and that data would be treated confidentially by the researchers. A researcher contacted those who had provided oral and written consent, and further explained the aim and

TABLE 1 Participant characteristics

Child		Parent						Country of origin	Years in psychiatry
Pseudonym	Age	Living arrangements	Gender	Marital status and custody	Age	Primary Diagnosis	Subsistence		
Ivar	10		F	Single, SC	41	Schizoaffective syndrome	Sick leave	SE	6
Lovisa	15		F	Co-habiting	56	Schizoaffective syndrome	Sick leave	SE	21
Elliot	9		F	Co-habiting	36	Schizophrenia	Parental leave	NSE	8
Ida ^a	8		F	Single, SC	43	Schizoaffective syndrome	Sick leave	SE	4
Johannes ^a	12								
Alva	14		M	Single, SoC	47	Schizophrenia	Sick leave	SE	27
Sara	12		M	Single, FC	43	Schizoaffective syndrome	Sick leave	SE	12

Abbreviations: F, female; FC, foster care; M, male; NSE, not Swedish; SC, shared custody; SE, Swedish; SoC, sole custody.

^aSiblings (Ida & Johannes).

procedure of the study. Of the 13 interviews included in the analysis, 10 were conducted in the participants' homes and three in research facilities according to the parent's preference. All parents and children were interviewed separately by different researchers.

2.3 | Interviews

Interview guides for parents and children were semi-structured and the order of the questions was adapted to follow the participant's narrative. Parents were asked 15 questions about parenting, the parent-child relationship, their perceptions of their child/ren, and their experiences of participating in BFI. The child interviews had a supportive structure with 15 main questions (and 12 optional follow-up questions) about family life and routines, the child's social situation and well-being, the parent-child relationship, their ill parent's well-being and the BFI. For this study, we excluded data related to the BFI. All main questions were open ended (some were more specific and adapted to child's age, such as "Who cooks the meals in your family?" and "Does anyone help you with your homework; if so, who would that be?"). The interviewer adopted an informal interview style, for example, by sharing some of her own family experiences. Interviews with parents lasted from 51 to 76 min ($M = 63$) and with children from 25 to 72 min ($M = 37$). The interviews were recorded and transcribed verbatim.

2.4 | Ethical considerations

The Regional Ethical Review Board, University of Gothenburg, approved the research project's design (599-15). A number of ethical issues needed to be considered during this project and this paper will address the most important of these. Before the interviews, we

informed parents and children of our obligation to report any concerns for the child's safety to social services and the parents' case manager. Such concerns emerged for three children, and as an initial step, the case managers were informed. In all three cases, it turned out that these circumstances were already known to the social services, and that the families were receiving support.

Another ethical dilemma related to our lack of knowledge of how much specific information each child had about their parent's illness before the interview. In line with instructions from the ethical review board and recommendations from psychiatric staff, interview questions about the parent's health were open ended and we aimed to follow the children's own knowledge and perceptions of their parent's mental health. Mental illness and family issues could be sensitive topics for both parents and children. At all times we prioritized the well-being of the participants over the research aims. In practice, this meant that the interviewer was attentive to any signs of participants' hesitation and avoided pushing questions that could cause distress.

2.5 | Analysis

To explore the study aim, we conducted an interpretative phenomenological analysis of the data (Smith et al., 2009). This entails analyzing the data on a descriptive level using a phenomenological approach, but also attempting through hermeneutic interpretation to make sense of each participant's understanding of the phenomenon. An idiographic approach also permeated the analysis as it focused on each participant's particular experiences in relation to individual contextual factors.

Initially we read each transcript and one researcher (PB) coded them from a phenomenological perspective. This part of the analysis entailed the researchers' bracketing any preconceptions (from

theory or previous interaction with data) while attempting to capture each person's lived experiences of parent and child mental health and the parent-child relationship. We (PB and JS) further interpreted the coded meaning units in each transcript to capture latent meaning related to the research aim. During this interpretative part of the analysis, we focused the coding on aspects, such as manner of speech (linguistic and voice), temporal references, and metaphors, as well as relationships between the different parts of the data. Preliminary themes were identified within each transcript. According to guidelines for multi-perspectival interpretative phenomenological analysis (Larkin et al., 2019) we synthesized the perspectives of each dyad noting both similarities and differences between parent and child. Subsequently, the preliminary themes from each dyad were integrated into the final themes by comparing their underlying structure of codes and quotations. To make sense of the parent-child perspectives, we interpreted them in light of a general developmental psychological perspective. For instance, children's need to have an emotionally sensitive and responsive parent, attachment and caregiving, as well as parenting styles were considered during analysis.

When conducting IPA the aim is both to capture participants' life-world perspectives and to provide an interpretation enriched by the researchers' knowledge and experience. Consequently, a challenge was to balance our awareness of the parents' mental illness and narratives about everyday family issues. We believe our broad range of previous research on parenting with and without mental illness facilitated keeping this balance.

3 | RESULTS

The living conditions of the parent-child dyads varied in terms of custody arrangements, time spent together, and whether the parents were cohabiting or separated. Experiences of parent and child mental health and of the parent-child relationship were captured in five themes.

3.1 | An unclear image

Several of the children's descriptions presented an unclear image of their parent and the parent's illness. Despite some awareness, none of the children used words, such as psychosis, hallucinations, or delusions, and few described having been told about psychotic symptoms. Some children's descriptions of the parent's illness were intertwined with their perceptions of the parent as a person. For example, one child described the manic behavior of her mother, who had a schizoaffective disorder, as "funny, she can have funny ideas/.../in periods she goes for a lot of walks."

Some children seemed to have constructed their own understanding to make sense of the parent's illness. Ivar, describing his mother's illness said "I know that she had the illness, that is, it was inside her, but it did not come out. And then when my granny died, it all came out. That's when she got ill." Ivar's mother said she had tried to explain symptoms he might have noticed in ways she thought were comprehensible to him (Table 2, Q1).

Even if some of the children recalled having been informed about the illness by the parent or the mental health services, the child's image still seemed fragmented (Table 2, Q2). Alva's father described that he avoided speaking to her about his frequent voice hearing experiences. Instead, he referred to symptoms he considered more acceptable: "Partly it's that I am ashamed of my illness, but schizophrenia, you could use other words, you could say mental illness."

Some children were vague when asked to describe their parent: "I can't think of anything" or "I don't know." Other children's descriptions lacked authentic examples of situations or parental behaviors. For example, Elliot had trouble finding examples of his mother's kindness (Table 2, Q3).

In contrast to his vague description of his mother, Elliot's descriptions of his father with whom his mother said he had a closer relationship, were quite rich. Other children also gave more distinct and elaborate descriptions of the other parent. Lovisa, for example, who gave a sparse description of her ill mother, spoke about her

TABLE 2 Theme: An unclear image

Q1	Ivar's mother: <i>Before, we didn't have a microwave, because I was so afraid of radiation/.../and that affected the children, but I tried to explain it in an easy way. 'Mummy has this illness that makes her a bit weird sometimes.' I don't really say it in a very serious way.</i>
Q2	Alva: <i>My dad doesn't really talk about his illness. I don't quite understand why he gets like that. I can't really grasp what the illness is/.../I think I would like to ask my dad how it is/.../He might have told me once when I was in second grade. When we were on our way to school, he said 'I have an illness'. I was shocked and thought he must be joking. But it was true.</i>
Q3	Elliot: <i>She is really kind.</i> Interviewer (I): <i>She is really kind. Can you think of a time when you thought she was really kind?</i> E: <i>Yes, like now.</i> I: <i>What do you think she is doing now then?</i> E: <i>Now she just is, and she talks and is probably kind.</i> I: <i>Is there anything else that your mother does that you think is a really kind to do?</i> E: <i>She cooks food sometimes.</i>

father in more detail: "He understands problems really well, because it feels like he has been through stuff/.../I was in an argument with a friend and he understood everything and told me what to do to make it better."

The children's somewhat unclear image of their parent's illness was confirmed by parents' descriptions of restricted communication. The lack of communication about the illness could explain why some children perceived symptoms as being part of the parent's character. Furthermore, the relationship between the ill parent and the child seemed marked by a certain distance as there were aspects of the parent's behavior that remained concealed.

3.2 | An incoherent story

Some children's interviews were characterized by incoherence. The incoherence could be within some answers, between parts of some children's interviews, and between children's interviews and those of their parents. Incoherence in some children's interviews that could be attributable to the child's young age was not included in this theme.

Sara, a 12-year-old girl, had lived with several foster families and at various institutions over the past four years as both her parents were suffering from mental illness. She expressed her own mental health problems both implicitly and explicitly. Her speech was characterized by an unfiltered rush of words and gave a disorganized impression (Table 3, Q4). She also spoke about experiences of depression, anxiety, phobias, and mood problems. In contrast to Sara's troubled accounts, her father claimed her health had improved and that she was managing well despite her previous difficulties. This kind of disagreement between parents' and children's perceptions of the child's mental health was found in other families as well. Ivar's description of his health seemed unproblematic: "I think I'm fine, actually. Yes, just fine" (laughter), while his mother described him as anxious, fearful and insecure, having found a suicide note recently that Ivar had written.

3.3 | Illness as part of ordinary life

Most children seemed to focus on improvements in the parent's health and avoided discussing the more severe problems described by the parents. For instance, children would describe the parent's symptoms as minor problems of daily life: "An ordinary day at home means that I am sitting in my room checking out my mobile and mummy is lying on the couch all day" (Ivar). When Elliot was asked about his mother's well-being, he did not mention her recent hospitalization for a psychotic episode (Table 3, Q5). Elliot's approach to his mother's illness was similar to that of his mother, who seemed to focus on improvements (Table 3, Q6).

Another child, Lovisa, described being disturbed by her mother's shouting while she was reading, but expressed little emotion in relation to her mother's temper tantrums (Table 3, Q7). Lovisa's

TABLE 3 Themes: An incoherent story and illness as part of ordinary life

An incoherent story

Q4. Sara: *I go upstairs to get changed in the bathroom I eat breakfast and get dressed I go downstairs and he has three kids one little girl and she has cancer and you have to have a tube through the nose and it's easier if we bring them because these boys in school help. You look very, very, you have such, you look so much like my ice skating teacher, I could take it as Tuesday today.*

Illness as part of ordinary life

Q5. Interviewer: *Okay, what do you think about your mum's health?*

Elliot: *She's fine, she is.*

I: *Do you think she's always fine or that she is unwell sometimes?*

E: *She can be not well sometimes.*

I: *What happens then?*

E: *Or she doesn't get that happy really but it's always when we are playing or playing cards or something. You're usually not happy when you lose or get bad cards.*

Q6. Elliot's mother: *No, we are doing really well. Sometimes you have problems and then you get over it and get somewhere better/.../Cause I mean, when I was ill before it was a bit hard too, but we got through it and we are grand now/.../I am pleased. Those things happen, and then you're happy again.*

Q7. Lovisa: *I'm not sure if she was always like that, but before, I didn't think about it. But now it has become a problem, because this flat has thin walls and she shouts a lot, and that disturbs me when I'm reading or something. [...] But it doesn't usually go on for very long, which is good.*

mother confirmed that her shouting may be one reason her daughter often stayed out, but she downplayed its impact: "It could be that, a tiny bit."

Both parents and children seemed to use strategies, such as normalizing or minimizing the impact of the parent's illness on everyday life while keeping a focus on improvements.

3.4 | A nonhierarchical parent-child relationship

Both parents and children described the participating parents as permissive, exercising little controlling parenting behavior. For example, Ivar said that his mother usually did not set limits. "So, she usually doesn't say no. And so, if I say, "I want a chocolate sandwich," then she doesn't say "No." Ivar's mother confirmed this description of herself as permissive and repeatedly described herself as "too kind" and "a mother with few rules." In some families, older siblings were reported to take over the ill parent's responsibilities for household chores and for dealing with conflicts with the younger child. "If I argue too much, she can't cope anymore, so she tells my [older] brother, and he comes in and then we fight" (Ivar).

In addition to the low level of control, some parents were described as childlike. Alva described the parent-child relationship as

TABLE 4 Themes: A nonhierarchical parent–child relationship and attunement of the parent–child relationship and child well-being

A nonhierarchical parent–child relationship
Q8. Alva: <i>I say, take a headache tablet then maybe we can go out and play some basketball together? Lie down and rest for a while or something. I comfort him in different ways, ask him if he wants to play a game of cards, and perhaps he will feel better if thinks about something else. I think it's the money matter that doesn't work so well. He thinks mostly about money, also when he has a headache; he gets like anxiety.</i>
Attunement of the parent–child relationship and child well-being
Q9. Johannes: <i>No, it's like she shakes, and that happens to me too when I'm stressed.</i>
Interviewer: <i>What happens then?</i>
J: <i>I shake a bit all the time, but I don't think about it. But when I hold something when I'm stressed, I shake like that.</i>
I: <i>And that used to happen to your mum when you were little?</i>
J: <i>Yes.</i>
I: <i>Was your mum conscious of it?</i>
J: <i>It was as if she was conscious, but I think it's the same that happens to me when I'm stressed.</i>
Q10. Ivar's mother: <i>He is carrying a lot of heavy stuff that he doesn't dare or want to speak to me about./.../I think it makes him anxious and afraid. He always asks 'How long will it take before you get well again?'</i>

mutual and warm, and her father as “really kind, funny/.../like a five-year-old, I'm not kidding!” Her description was confirmed by her father. “When I was growing up with her, I was very introverted/.../. A child teaches the parent to become a good parent,” indicating a nonhierarchical, or perhaps even reversed, parent–child relationship. Alva, among other children, also provided explicit examples of reversed roles (Table 4, Q8). The descriptions of nonhierarchical parent–child relationships indicated that the children and their siblings had to manage responsibilities beyond their level of maturity as the parent could not be fully relied upon periodically.

3.5 | Attunement of the parent–child relationship and child well-being

This theme describes the interplay between the child's well-being and the degree of closeness and emotional dependency in the parent–child relationship. It includes the two subthemes: *An attuned parent–child relationship* and *Child's emotional independence*.

3.5.1 | An attuned parent–child relationship

Johannes' and Sara's descriptions indicated that they were both emotionally involved with and highly focused on their ill parents, despite their different family contexts. Johannes lived with his mother every other week as his parents had separated, and Sara, who

was in foster care, saw her father once a month. Neither Johannes nor Sara described any close relationships other than with their ill parents. Sara did not seem to have formed any close attachments since leaving her birth parents. Although Johannes spent as much time at his father's home as his (ill) mother's, he described his father as somewhat hostile and unable to understand Johannes' emotions. Both he and his mother described their emotional closeness. His mother worried that she might not be able to separate her own problems from her son's: “I think it's hard when he has anxiety. It's hard not to mix it up with my own feelings. I do know what it is like to feel ill. It's easy to be too empathic.”

Johannes and Sara were attuned not only to the ill parent, but also to the illness itself; both displaying symptoms and personality characteristics similar to the parent's. Although Johannes' mother said she had never spoken to her children about her psychosis, Johannes' described his own symptoms similar to his mother's (Table 4, Q9).

When Sara talked about her own difficulties, she used the same words she used to describe her father's problems, such as “mood-swingy.” She also used psychiatric language to describe herself: “You can get ill from moving around a lot, and get mood swings and panic disorder like I have/.../but I also suffer from depression and I don't dare to go out on my own.” Johannes frequently used psychiatric language and spoke of himself as a patient: “I need to get out more and activate myself.” Johannes, who had recently been remitted to child and adolescent psychiatry, also expressed frustration over not being prescribed sleeping pills.

To some extent, Ivar also fit the pattern of emotional dependence and attunement to his mother's state, although his mother was more likely to make this interpretation than Ivar himself. She was concerned about his mental health and she described him as a sensitive, anxious, considerate boy who was highly receptive to her needs (Table 4, Q10).

3.5.2 | Child's emotional independence

Some of the children seemed to manage their own emotional reactions by keeping some distance from the illness and the parent. For example, they would retreat to their rooms when they were angry, or they would avoid disturbing their parent if they woke up at night. When Ida was asked what she would normally do when she was angry, she said “I prefer to be alone.” The image of Ida as independent was confirmed by her mother, who described her as having “a lot of integrity/.../If she is sad or angry, she just wants to leave.”

Some children responded sparsely to questions about family life. Instead, they provided richer descriptions of contexts outside the home, with friends, or at school. Ida, for instance, who offered limited responses about her family (e.g., ‘I don't remember’), became more engaged when talking about school: “I have fun, I enjoy school/.../There are these stumps in the school yard that you can do tricks on. That's good fun. And the bars are fun.”

Alva and Lovisa both described the importance of other adults and friends in their lives. Alva described her relationship with her father, living with psychosis, as mutual and warm. However, her support family, who were also her relatives, seemed vital to her everyday sense of well-being and stability. The importance of Alva's social network was also confirmed by her father, who described her as "extroverted" and "solid" in situations involving her friends. Lovisa described a genuinely close relationship with her healthy father and, talking often about her close friends, gave the impression she had a large social network.

Children who seemed emotionally attuned to their ill parents and their symptoms also presented the most severe mental health problems. In contrast, other children who displayed fewer mental health problems seemed more emotionally independent and paid less attention to their parents' illness. These children had also at least one other close relationship with an adult (e.g., the other parent) and described being part of a social network.

4 | DISCUSSION

The aim of the present study was to explore descriptions of parent and child mental health and experiences of the parent-child relationship from the perspectives of children and their parents with psychosis. The parent-child relationship seemed nonhierarchical and mutually caring, however the relationship varied in terms of attunement and distance and seemed associated with the child's well-being. Some narratives were characterized by incoherence, which could be interpreted as indicating internal turmoil due to chaotic life circumstances. Both parents and children described the illness as part of ordinary life. The children in this did not make a clear distinction between the parent illness and him or her as a person.

The parent-child relationship of the dyads in the present study seemed to be mutually caring. The parents described being considerate by protecting the child from exposure to frightening experiences, and by attempting to maintain an ordinary life with a focus on improvements. Likewise, children described themselves caring for their ill parent, and were described by the parents as kind, considerate, and attentive to their parents' needs. Similar relational characteristics have previously been described by Dunn (1993) and Petrowski and Stein (2016) as role reversal, commonly observed between parents with severe mental illness and their children. Although these findings could be interpreted as role reversal, the extent of the child's caring responsibility seemed to vary and depend upon how the parents were affected by their symptoms.

Parents with severe mental illness have been previously described as overly permissive due to a lack of confidence in their parenting skills, or authoritarian related to their high levels of stress (Oyserman et al., 2005). The present study contributes a view of the parent-child interaction from both perspectives, illuminating a non-hierarchical system with limited parental control combined with mutual caring and warmth. The child's caring behavior could be perceived as undemanding by parents, putting little pressure on

parents, which could shed light on Campbell et al. (2018) findings suggesting that a large majority of parents with psychosis describe themselves as good-enough or adequate parents.

In the present study, some children and their parents seemed to have developed a permeable layer of protection that shielded the child from the negative aspects of the parent's illness but also allowed them to absorb the parent's caring side. However, the children who appeared more attuned to, and part of a more intertwined parent-child relationship did not seem to have sufficient protection against the parent's illness, leaving them more exposed to the vicissitudes of the parent's condition. Similarly, Murphy et al. (2016) described how adult children retrospectively expressed how they lost their sense of self and were unable to distinguish between their own and their parent's reality. The degree of the child's independence and the access to other important adults or a social network are important to the well-being of children growing up with a parent with psychosis (Kadish, 2015). This was supported by the finding in the present study that children's long-lasting relationships to other adults seemed to buffer the parents' disturbing behaviors.

Although the participants had taken part in BFI aiming to help parents communicate about their illness, none of the children used words, such as schizophrenia, psychosis, or hallucinations. The children's unclear images could partly be explained by the parents' apparent hesitation to discuss the details of their illness with their children. This hesitation could be explained by parents' wish to protect their children from the stigma associated with mental illness (Murphy et al., 2017). Despite having made some attempts to speak to their children, the parents may have hesitated due to uncertainty about whether either party would benefit from such openness. The parents' wishes to protect their children seem reasonable, and it is important to consider carefully what information may be helpful since awareness of the extent of a parent's suffering may push a child to be more considerate and responsible than is age-appropriate (Petrowski & Stein, 2016). However, children also need comprehensible information about their parents' illness to be relieved from feelings of guilt and responsibility (e.g., Dunn, 1993; Nilsson et al., 2015; Stallard et al., 2004). Such information could preferably be given by parents with the support of psychiatric staff, helping them to find an age-appropriate way to explain the symptoms. The findings of an unclear image of the illness indicate that children may need more continuous support than provided with the BFI.

In the present study, two children explicitly reported suffering from mental health problems. However, other children more subtly indicated they were affected by their parent's illness. For example, some children's narratives were characterized by incoherence, while other children seemed unwilling to speak about the parent's illness or periods of absences. In contrast to previous retrospective studies (e.g., Dunn, 1993; Engur, 2017), children in this study described few odd parental behaviors and distorted symptom-related expressions. This could reflect both the parents' attempts to protect their children from exposure to symptoms as well as improvements in the quality of psychiatric care, leading to decreased parental symptoms. However, it is also possible that the absence of such accounts is

attributable to children's fear of exposing their parent's problems. This echoes Dunn's findings (1993) indicating conflicts of loyalty in which even children who wish to talk about their parents' illness and to ask for help or support often avoid such discussions to protect their ill parent.

4.1 | Study limitations

The present study offers insights into the narratives of seven parent-child dyads, and may not be representative of the population of parents with psychosis and their children in all contexts. The parents that were initially invited, and volunteered to participate in research, most likely belong to a relatively well functioning group according to professionals (Strand & Rudolfsson, 2017).

Finally, our analysis and interpretations of the interviews are our attempts to make sense of these parents' and children's stories. Our interpretation of data represent just one of many possible ways these narratives could be understood. For the reader to evaluate the validity of the analysis, we aimed to be transparent in distinguishing the participants' accounts from our own interpretations. The participants in the present sample varied in terms of age, gender, and living arrangements. To understand how these factors influence parents' and children's perceptions, future studies could benefit from including more homogenous and larger samples.

4.2 | Relevance for clinical practice

Considering the limited sample size of the present study the implications suggested are tentative. Psychiatric nurses are in a key position to reach these families and detect when there are problems and to provide family-focused care. As parenting difficulties appear to be sensitive topics for both parents and children it seems vital to develop trusting relationships between nurses and families. We suggest that by developing cooperative relationships with parents with a joint focus on the child's well-being, parents could feel more confident in asking psychiatric staff for support and advice regarding parenting issues. Parents may need support to take adult responsibilities, and encouragement to find additional adult support for their child, such as a relative or a support family. To talk to parents about the child's experiences of the parent's behavior and absences during psychotic episodes may improve parents' ability to reflect on the child's perspective. Likewise, parents need professional guidance in how to speak to their child about their illness in non-frightening ways.

5 | CONCLUSION

We found strong resonance between the results of the present study and previous research, which focused mainly on adults' retrospective accounts. However, the stories of young children may not be as explicit regarding the parent's odd behaviors and symptoms as the

stories of adult children. The parent-child relationships in the present study were described as nonhierarchical but varied in terms of the child's independence and attunement to the ill parent. These findings highlight the importance of continuous support from other healthy adults, not only to provide stability for the child, but also to enable the parent to protect the child from exposure to the vicissitudes of the illness. The complexity and importance of supporting parents in talking about their illness in a way that helps their child was another significant conclusion from the present study.

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CONFLICT OF INTERESTS

The authors declare that there are no conflict of interests.

ETHICS STATEMENT

The study was approved by the Regional Ethics Review Board, University of Gothenburg (ref. nr. 599-15).

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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