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An Exploration of the Social and Emotional Well-Being Narratives of
Children who Live with a Parent with a Mental Health Difficulty

A Thesis Submitted for the Degree of Ph.D. to the
National University of Ireland, Galway

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United Nations
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• Children, Youth and Civic Engagement
• Ireland



• **CHILD AND FAMILY RESEARCH CENTRE**

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Declaration

I, the Candidate, certify that the Thesis is all my own work, and that I have not obtained a degree in this University or elsewhere on the basis of any of this work

Signature: Rebecca O'Shaughnessy

Date: December, 2015

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On Children
Kahlil Gibran

Your children are not your children.
They are the sons and daughters of Life's longing for itself.
They come through you but not from you,
And though they are with you yet they belong not to you.

You may give them your love but not your thoughts,
for they have their own thoughts.

You may house their bodies but not their souls,
For their souls dwell in the house of tomorrow,
which you cannot visit, not even in your dreams.

You may strive to be like them,
but seek not to make them like you.
For life goes not backward nor carries with yesterday.

Abstract

Despite increasing calls for research to contextualise children's experiences with regard to understanding their well-being, children living with a parent with a mental health difficulty remain largely invisible in practice and research. This thesis explores children's subjective experiences of living with a parent with a mental health difficulty. It concentrates on their social and emotional well-being experiences and contextualises these on an individual and environmental level. It focuses on the construction of children's social and emotional well-being experiences with a particular focus on the parent-child relationship. It examines similar and disparate factors that children, parents and gatekeepers perceive as impacting on children's social and emotional well-being. It reflects on their experiences of service provision within this context and considers the implications of the research findings for current policy and service provision in Ireland. The findings of this study are based on the narratives of children, parents and a gatekeeper elicited through a combination of creative and traditional methods. Findings highlight the need for a *Family Model* approach to working with such families as a means to improving outcomes for both child and parent alike.

Chapter 1- Introduction

Section 1.1 Introduction

Children living with a parent with a mental health difficulty are thought to be at increased risk of poorer outcomes on a number of well-being domains (Rutter and Quinton, 1984, Beardslee et al., 1998b, Falkov, 1998, Somers, 2007, Aldridge and Becker, 2003, Reupert et al., 2015c)¹. On the contrary, research also indicates that children may experience few if any adverse outcomes (Parrott et al., 2008, Huntsman, 2008). Research also suggests that children report differing perspectives to parents and professionals as to what might help in this context (Van Roy et al., 2010, Maybery et al., 2005). Much of the research to-date has focused on adult perceptions of children's experiences or has employed adult-centric or uni-dimensional methods to elicit information. Despite the dominance of a risk narrative in the literature, children's subjective experiences of living with a parent with a mental health difficulty are sparse and in this context children's voices remain largely invisible (Barnardos, 2014, Gladstone et al., 2011, Somers, 2007).

Calls for the reconstruction of how childhood is conceptualised have led to significant theoretical advances in understanding children's experiences and in turn a reconceptualization of how their well-being has been constructed (James et al., 1998). Increasingly, efforts to uncover the essence of child well-being are located in the current moment, considered as context dependent and require multiple-informants with primacy given to the voice of the child and their subjective and objective experiences of their social realities (Ben-Arieh et al., 2014a). This has led to calls for research into children's well-being to include children as informants in order to achieve a

¹ Although it is acknowledged that there are families where two parents may have mental health difficulties, this study refers to families where only one parent has a diagnosis.

greater insight into their needs, perceptions and daily realities which are context specific (Fernandez, 2011). With regard to understanding child well-being this requires consideration of factors at an individual, relational and environmental level and how children as social agents interact within these (Bronfenbrenner, 1979).

Research suggests that positive social and emotional well-being in children is dependent on the attainment of social and emotional competencies (National Institute of Clinical Excellence, NICE, 2013). Positive experiences socially and emotionally are thought to nurture competencies in children which can function as protective buffers to adversity through their lives (Hamilton and Redmond, 2010). Children's social and emotional well-being does not develop in isolation but rather is influenced by a myriad of individual and environmental factors including a child's temperament, the nature of the parent-child relationship, and the context of family, school and wider community. For children living with a parent with mental health difficulty their experiences of childhood may be different to those of other children not in that situation and they may face increased challenges across the lifespan (Rutter and Quinton, 1984). Although significant developments have been made in understanding children's well-being, significant gaps remain in relation to specific domains of well-being and the specific context of children living with a parent with a mental health difficulty.

While the exact research question and objectives for this study will be presented in Section 1.4 below, the above information generated a number of broad questions that helped to ground and motivate this study. For example: what are the subjective experiences of Irish children growing up in families where a parent has a mental health difficulty? What are children's understandings of their parent's mental health difficulties? How are these similar or different to their parent and/or a practitioner's understanding of children's experiences? How do children conceptualise their social and emotional well-being in this context and what supports do they identify as important? How does the parent-child relationship contribute to children's social and emotional well-being? What are these families' experiences of receiving support from services in Ireland?

The remainder of this chapter is divided into five sections. Section 1.2 introduces the primary theoretical and conceptual ideas informing this study, pinpointing gaps in the literature on children's social and emotional well-being, and parental mental health which this study seeks to address. The rationale motivating this research study is then provided in Section 1.3, followed by the research aim and objectives in Section 1.4. Section 1.5 presents an overview of the thesis content, providing an outline for each of the chapters in this study. Section 1.6 concludes with a summary of the overall chapter.

Section 1.2 Theoretical Underpinning

The relative neglect of the impact of parental mental health difficulties on children was the primary motivation for this study. Much of what is known about children's experiences in this context has been gleaned from research that has largely employed adult centric and uni-dimensional measures in determining findings. This study brings together three inter-related areas which provide the theoretical basis central to this study: child well-being, parenting, and parenting with a mental health difficulty which will be introduced here and discussed in more detail in chapter 2 and 3.

The first of these areas is *well-being*. The conceptualisation of well-being stems from philosophical discussions that sought to establish what is meant by the good life. Positive well-being is associated with a range of outcomes across the lifespan. It is comprised of two dimensions, subjective or personal well-being and objective well-being based on assumptions about basic human needs and rights. The importance of well-being is largely evidenced in the international policy drive focusing on measuring and improving outcomes for individuals.

Until recently much of what is known about children's well-being stemmed from adult perspectives, highlighting a focus on deficit theories, whereby children were conceived of as merely uncivilised and inferior to adults (Prout, 2005). Moreover, with the influence of the social indicator movement this perception was reinforced with a focus on decontextualized objective data in the hope of creating future productive citizens, thus the focus

was on ‘well-becoming’ (Qvortrup, 1994). However, this focus on well-becoming does not provide insights into how children are doing in the current moment. Thus, research has turned to more child-centred and inclusive approaches to ascertain children’s perspectives on their own lives. From these developments two crucial aspects of child well-being emerged: the centrality of emotional connections and interpersonal relationships with family and friends (Hanafin et al., 2006, Fattore et al., 2007, Land et al., 2006).

Children’s *social and emotional well-being* plays a fundamental role to their well-being, with behaviours considered as by-products of social and emotional experiences on an individual and environmental level. Social and emotional well-being provides the scaffold for healthy behaviours and educational attainment for children and helps mitigate behavioural problems and mental health difficulties. How children experience things socially and emotionally is contingent on the attainment of social and emotional competencies on an individual and environmental level with individual aspects sub-divided in light of inter- and intra-personal influences. The development of children’s emotional competence occurs within their social context, that is, through their interactions with primary contributors to social and emotional experiences i.e. family, peer networks, schools and wider society.

The second of these areas is *parenting*. A key factor in children’s social and emotional well-being is their experience of being parented (Chan and Koo, 2011). However, similar to children’s well-being, parenting does not occur in isolation and is directly and indirectly influenced by the psychological resources of the parent, child temperament and the context within which parenting occurs (Belsky, 1984, Belsky and Stratton, 2002). The psychological resources of parents are crucial and parents who experience mental health difficulties may present with reduced parental capacity and increased negative behaviours and for some children exposure to this may result in poorer outcomes on several well-being domains (Clever et al., 2011, Falkov, 1998, Gopfert et al., 2004b, Smith, 2004). Contextual factors are also significant in a parent’s ability to function in their role as a parent, including the home environment, family structure, parental stress,

socio-economic status and cultural factors (Solem, 2013, Deater-Deckard, 2004, Hoff et al., 2002, WHO and IPSCAN, 2006). Thus, highlighting the bi-directionality of influence within the parent-child relationship on an individual and environmental level.

The third area focuses on *parents with mental health difficulties*. Mental health difficulties refer to a wide range of psychiatric symptoms that persist over time and are ‘functionally disabling in living skills, social interactions, family relationship, jobs and or education’ (Johnson, 1997, p.247). Parents with mental health difficulties face more challenges than their mentally well counterparts as they contend simultaneously with their diagnosis and symptoms and with the natural stresses inherent in caring for and raising children in daily life (Ackerson, 2003, Reupert and Maybery, 2011). Although a diagnosis of a mental health difficulty may increase a range of challenges that negatively impact on families and parental capacity, it does not preclude a parent from parenting well (Oyserman et al., 2000). This highlights that parental mental health difficulties may be one factor in a complex matrix, where psycho-social difficulties are combined with a myriad of factors including environmental and socio-economic factors, the quality of the parent-child relationship and child temperament (Rutter and Quinton, 1984).

By and large children living in this context are presented as being at increased risk of poorer outcomes on a range of well-being domains (Hall, 2004, Mowbray et al., 2006). Efforts to estimate the number of children living in this context are difficult to establish however a recent epidemiological study in Australia found that 21-23% of children are living in this context (Maybery et al., 2009a). In the context of Ireland two recent studies suggest that 11-12% of children may be living in this context (Fives et al., 2010, Dooley and Fitzgerald, 2012). Despite the reported implications for children whose parent has a mental health difficulty, research into children’s experiences of parental mental health difficulties have largely faced criticism for neglecting to include the voice of the child (Huntsman, 2008) with an international review of qualitative literature identifying only ten studies

which focused exclusively on children's personal descriptions of their experiences (Parrott et al., 2008, Gladstone et al., 2011).

However, with recent developments in child-centred methodologies and the inclusion of children in research on and about them, an alternative discourse is emerging to that of traditional *risk* and contrary to popular belief children can have positive experiences and present with high levels of competencies on a range of well-being domains (Parrott et al., 2008, Darlington et al., 2005a, Trondsen, 2012). Thus, the bi-directionality of influence of individual and environmental factors on children's social and emotional well-being and in particular the parent-child relationship in the context of parental mental health warrants further investigation with a particular focus on children's subjective experiences presented through their social and emotional well-being narratives.

Section 1.3 Research Rationale

The rationale for this research was initially personal but has been primarily driven by 10 years' professional experience, observations and engagement with families while working in statutory and voluntary child and family services, where children had experienced significant disruption to their lives as a result of their parent's mental health. Despite these disruptions children had been afforded little or no information or explanation from professionals who deemed this to be outside of their professional remit. Moreover, research suggests that a common experience of children in this context is that of invisibility and being ignored (Fudge and Mason, 2004, Tunnard, 2004, Leverton, 2003). This study seeks to add to both the theoretical knowledge base of children's subjective social and emotional well-being experiences as well as informing the direction of future policy and practice in Ireland.

Section 1.4 Aim and Objectives

Thus, the overarching aim of the research is to *explore the social and emotional well-being narratives of children living with a parent with a mental health difficulty*. The objectives of the study are:

- Objective 1 - To explore the subjective experiences of a small sample of Irish children living with a parent with a diagnosed mental health difficulty.
- Objective 2 - To illustrate factors which these children identify as impacting on their social and emotional well-being while living with a parent with a diagnosed mental health difficulty.
- Objective 3 - To reflect on differences and similarities in children, parent and Gatekeeper perceptions of the social and emotional well-being of the child in this context.
- Objective 4 - To examine the implications of existing policy and practice for children living in families where parental mental health is a factor in Ireland.

Section 1.5 Thesis Overview

Chapter 1 – Introduction

This chapter introduces the thesis, outlining the aim and objectives of the study and the rationale for conducting the research. It provides a brief introduction to the core theoretical concepts underpinning the study, concluding with an outline of the thesis structure.

Chapter 2 – Theoretical Literature Child well-being

This chapter is the first of two introducing the main theoretical grounding for this study. Firstly, it reflects on philosophical assumptions informing answers to the question ‘*What is the good life?*’. It addresses the changing nature of conceptualisations of childhood, introducing some of the key debates in understanding childhood and children’s well-being. It highlights the influence of dominant discourses associated with childhood. Finally, it considers a model of children’s social and emotional well-being which is presented as largely grounded in their experiences on an individual and environmental level.

Chapter 3 – Theoretical Literature Parenting and Parenting with a Mental Health Difficulty (MHD)

This chapter continues with the theoretical grounding of this research and locates children’s social and emotional well-being within the context of the parent-child relationship. It explores the construct of parenting, how it is determined and what this means for children as bi-directional social actors.

The focus then turns to parenting with a mental health difficulty and the possible implications for children's social and emotional well-being.

Chapter 4 – Policy and Context

This chapter situates the research in the policy and legislative context for children, parents and mental health in Ireland. It highlights thematically the dominant policy narratives which inform service provision for children, parents and individuals with mental health difficulties in modern Ireland.

Chapter 5 – Methodology

This chapter introduces the epistemological and ontological basis for this research. Following this, it outlines and describes the methods employed in this study. It explores the theoretical foundation of child-centred mixed-method approaches to research with children and gives a detailed description of the study's design. The next section centres on ethical considerations and how these were supported by the research design concluding with a reflection on research with hard to reach populations and research on sensitive topics. It also presents the analytical strategy employed as a means to understanding and framing the research findings through a combined model of narrative analysis (Fraser, 2004a) multiple text analysis (Keats, 2009) within which attributes of framework analysis (Ritchie and Spencer, 1994) are embedded.

Chapter 6 – Biographical Sketches

In this chapter biographical sketches of children are presented; it is the first of two chapters presenting the research findings. These are co-constructed through perspectives of child, parent and researcher and present an illustration of the uniqueness of children's experiences within their specific context. It presents both subjective and objective data and highlights emerging within case themes.

Chapter 7 – Individual and Environmental Thematic Findings

Chapter 7 provides within and between case thematic findings of children's social and emotional well-being presented on the individual and environmental level. On the individual level it reflects on key themes

identified in the subjective experience of participants. It considers similarities and differences between parents' and gatekeepers' conceptualisations. It highlights key recommendations based on the experiences of participants. Key findings are also considered in light of the research objectives.

Chapter 8 – Discussion

This chapter concentrates on providing an overview of the main arguments contained within this thesis and their relationship with the conceptual frameworks discussed in chapter 2 and 3. Firstly, it summarises the main points of the research, which is followed by a discussion of children's social and emotional well-being in the context of parental mental health on an individual and environmental level. After this broader points are made about the overarching concept of children's social and emotional well-being specifically within the context of parental mental health. Subsequently, it focuses on the relationship between the findings in this thesis and the fields of well-being and parenting and provides recommendations for policy and practice in the context of Ireland.

Chapter 9 – Conclusion

This chapter concentrates on giving an overall summary and conclusion to this thesis. It begins with a recap of the aim and scope of the study and after this gaps in the literature are briefly reviewed. It then looks to provide an answer to the central research question underpinning this thesis. It highlights the key findings of the study and explores the interrelationship between children's social and emotional well-being and parenting with a mental health difficulty. Concluding remarks are made about the findings and the theoretical and conceptual framework it is located in and the nature of children's social and emotional well-being in the context of parental mental health difficulties. It outlines key recommendations for policy and practice for children and families where parental mental health difficulties are a factor. This chapter also sets out the limitations of the study followed by recommendations for future research.

Section 1.6 Chapter Summary

This chapter concentrated on introducing and providing an overview of this study. It introduced the underpinning theoretical and conceptual considerations informing this study. It reflected on gaps in the literature on understanding children's subjective experiences on matters that concern them. In light of this the study's aim, objectives and rationale were defined. The themes contained within Chapter one are elaborated on in greater detail throughout this study as an argument is constructed around the research question. The first step in this involves the development of a theoretical and conceptual framework which is partially laid out in the next chapter.

Chapter 2 - Children's Social and Emotional Well-Being

Section 2.1 Introduction²

Given the discussion in the preceding chapter, the aim of this chapter is to investigate how children's social and emotional well-being has come to be conceptualised. Children's social and emotional well-being is a broad and multi-dimensional concept that is difficult to define; however, it is considered to be inextricably linked to other aspects of children's health, development and well-being (Australian Institute of Health and Welfare, AIHW, 2012). In its early development it is heavily dependent on the parent-child relationship and the 'emotional climate' within which this is communicated (Darling and Steinberg, 1993, p.488). Parenting style and practices are strongly related to children's social and emotional development (Wise, 2003, Denham et al., 2009). However, as children grow and develop the importance of external environments, e.g. school, plays an increasingly important role. Children living with a parent with a mental health difficulty are largely considered to be at increased risk of poorer outcomes socially and emotionally.³ However, much of what is understood about children's experiences in this context is based on the etic or outsider perspective of adults and determined through uni-dimensional or adult centric measures.

Section 2.2 introduces the core concepts of eudemonia and hedonism and how these contribute to continuing debates as to '*What is the good life?*'. It reflects on definitions of well-being in light of theoretical influences including a utilitarian, basic needs and capability approach and the influence of the social indicator movement in understanding adult well-being. Section 2.3 provides an overview of how children and childhood have been

² The search strategy for the literature review focused on seven primary databases: SAGE Journals online, Academic Search Complete (EBSCO), Psychology and Behavioural Sciences Collection (EBSCO), ERIC, Wiley Online, and Psyc Info (Ovid). Search terms included: Mental Health, Well-being, Social and Emotional Well-being, Parenting and Mental Health, Parenting and Psychiatric disorders, Research with Children.

³ Typically the literature refers to the parent as the mother (Smith, 2004)

conceptualised over time including recent efforts to reconstruct childhood and provide alternative discourses. Section 2.4 reflects on the influence of the rights movement and social indicator movement in reconstructing childhood and in turn how children's well-being is conceptualised. Section 2.5 considers how children are contributing to understandings of their own well-being. Section 2.6 reviews social and emotional well-being as a significant building block for children's well-being in the current moment and also crucially important to their well-being across the life-span. It reflects on the individual and environmental aspects that contribute to children's social and emotional well-being and provides a tentative theoretical framework for understanding children's social and emotional well-being in this study. Section 2.7 considers the literature highlighting the need for research to be contextualised and inclusive of children. Section 2.8 concludes with a chapter summary.

Section 2.2 Understanding Human Well-being

How well-being has come to be understood is founded in two important theoretical concepts: hedonism and eudaimonism (Samman, 2007). At its most basic hedonic well-being is based on the premise that maximising one's pleasure experiences and reducing experiences of pain is the route to well-being (Kahneman et al., 1999). It is concerned with positive feelings including happiness and contentment (Ryff et al., 2004, Carroll, 2002). Emphasis is placed on the subjectivity of individuals in defining their experiences, based on three criteria thought to make up happiness: life satisfaction, the presence of positive affect and the absence of negative affect (Diener et al., 1999). However, the focus on subjectivity has been criticised as narrow and reductionist as 'not all desires – not all outcomes a person values would yield well-being when achieved' (Ryan and Deci, 2001, p.145) and as such it is a 'fallible indicator of healthy living' (ibid, p. 146). Although contributing to our understanding of well-being, a hedonic perspective does not account for the 'other', as noted by Tiberius:

Hedonism does not do justice to the deep and important goal of life that well-being is supposed to represent; there are things we care about, for the sake of our well-being and the well-being of others, that are not the same as pleasure (Tiberius, 2004, p.4).

Alternatively, a eudaimonic perspective suggests that well-being is more than happiness and is achieved by ‘nature fulfilment’(Haybron, 2008, p.22). It is largely considered an objective approach where the life of an individual is assessed based on whether it is a life of virtue i.e. whether one’s *daimon* or *true self* is realised (Waterman, 1993, McDowell, 1980, Henderson and Knight, 2012, Ryff, 1989, Ryff and Keyes, 1995, Delle Fave et al., 2011). This perspective has also faced criticism for on over-emphasis on the objective which results in well-being being defined by ‘experts’ and not those experiencing it (Diener et al., 1998). Despite on-going debates it is largely agreed that both perspectives interact bi-directionally and play a significant role in how well-being is understood (Diener and Tov, 2012) and that:

overall, the available data indicate that the causal pathway between hedonic and eudaimonic well-being is bidirectional. Positive feelings can produce positive functionings and positive functionings can produce positive feelings (Huppert et al., 2005, p.321).

Thus, current conceptualisations of well-being are considered to incorporate aspects of both hedonic and eudaimonic frameworks operating in tandem (Ryan and Deci, 2001, Huppert and So, 2013).

Section 2.2.1 Defining Well-being

Well-being as a concept has been described as ‘intangible, difficult to define and even harder to measure’ (Thomas, 2009, p.11). These difficulties are attributed to a plethora of contributions from a broad spectrum of disciplines founded in the philosophical debates put forth by Aristotle and Plato who sought to establish ‘*What is a good life?*’. Both agree that virtue is the basis for happiness or *a good life*, however they differ in their views as to how virtue is acquired. From these philosophical debates four influential perspectives on well-being have emerged: *utilitarian, basic need, capability approaches* (Axford et al., 2014, p.2701) and more recently a multi-dimensional and integrated approach to personal well-being (White, 2009).

Utilitarianism proposes that well-being is *a person’s state of mind* and the fulfilment of desire. Reflecting a combination of hedonistic and eudaimonistic perspectives it focuses on the subjective experiences of maximising pleasure and minimising pain (Eid and Larsen, 2008) and

theories of desire (Gasper, 2004). However, this approach was soon rejected as too individualistic as it validates pleasure derived from the suffering of others and risks negating deficits in individuals with positive dispositions. It is also difficult to quantify as it is malleable to context. This led to more objective attempts to identify the fundamental components of the good life, i.e. the substantive goods that make life better (Scanlon, 1993).

The basic needs approach (Doyal and Gough, 1991) to well-being is concerned with outcomes, or the basic things people need to improve their life circumstances. In their efforts to identify a ‘criterion of welfare external to individual preference’ (Doyal and Gough, 1992, p.179) their approach views human needs as objective and universal. The focus rests on the premise that basic human needs, of which they identify two –physical health and survival, and personal autonomy - must be satisfied for development to occur. However, this approach also faced criticism for failing to account for the social, political, economic and cultural structures which can constrain people’s capacity to make life better and for placing an overemphasis on what Sen refers to as ‘commodity fetishism’ (Sen, 1982, p.366) resulting in an aggrandizement of ownership of basic goods than on what these goods do to people (Sen, 1985).

In an effort to bridge the gap between utilitarian and basic needs approaches Sen proposed *Capability theory* (Sen, 1985, Nussbaum, 2011) which highlights the relationship between structure and the agentic individual in achieving well-being, in that: ‘wellbeing is related to opportunity, to the capacity to utilise distinct opportunities, as well as freedom to do so in correspondence with one’s own preferences’ (Ben-Arieh et al., 2014a, p.5). This perspective purports the view that ‘a person’s capability [capacity] refers to the various alternative combinations of functionings from which he or she can choose’ (Nussbaum and Sen, 1993, p.3). Similar to the approach presented by Doyal and Gough this approach adopts an objective and universal approach to conceptualising well-being.

White (2008) alternatively proposes a multi-dimensional approach to well-being whereby dimensions of well-being are viewed as interrelated and

co-constitutive. White argues that well-being is socially and culturally constructed thus presenting a subjective view of well-being comprised of the integration of three dimensions: subjective, material and relational which are interdependent and intrinsically linked (White, 2009). White imbues her approach with the idea of relatedness and argues that relationships provide the core foundation for well-being arguing that ‘people become who they are in and through their relationships with others’ (White, 2009, p.9). Well-being is viewed not as a state or as belonging to individuals but rather a process that occurs in relationships ‘between the collective and individual, the local and the global, the people and the state’ (White, 2009, p.11).

Thus, well-being is presented as a highly complex and multi-faceted concept that is temporal and fluid situated in contexts and relationships and involves how people feel and function personally and in society and the value they give to their life as a whole (Ben-Arieh et al., 2014b). This emerging interwoven conceptualisation of well-being is increasingly being referred to as ‘flourishing’ (Henderson and Knight, 2012, p.197, Seligman, 2011, Huppert and So, 2013) which is defined as the ability to ‘live within an optimal range of human functioning, one that connotes goodness, generativity, growth and resilience’ (Fredrickson and Losada, 2005, p.675).

Section 2.2.2 The Influence of Social Indicators

Disputes in conceptualising well-being have also led to differing opinions on how well-being should be measured. One such highly influential approach is the social indicator movement (SIM) originating in the 1920s (Niceforo, 1921, Bulmer, 1983) in response to a dearth of social data available and in acknowledgement that the progress of society cannot be adequately expressed in terms of ‘familiar national accounting variables’ (Drewnowski, 1980, p.15). The SIM is based on the premise that the quality of life of groups in society can be determined through the use of well-measured and consistently collected social indicators over time. Bauer (1966) a leading pioneer of the indicator movement defines social indicators as ‘statistics, statistical series, and all other forms of evidence that enable us to assess where we stand and are going with respect to our values and goals’ (Bauer, 1966,

p.1). As such social indicators are considered ‘a vital tool for policy makers working to improve the well-being of the people they serve’ (Ben-Arieh, 2008, p.4).

The selection of social indicators largely rests on how the *good life* is conceptualised (Cobb, 2000, p.6). Despite different approaches to conceptualising well-being there is agreement on certain points. Firstly, a combination of objective and subjective indicators is recommended. Objective social indicators are statistics which represent ‘social facts independent of personal evaluation’ (Pantisano et al., 2014, p.9) and are concerned with the monitoring of social conditions’ and trends in areas of social concern (Noll, 2002). Objective indicators relate to external, tangible measures including: income, employment, housing, health and education, and are commonly considered in terms of ‘outcomes’ and ‘risk and protective factors’ evidenced in a large number of monitoring reports⁴.

However, it became increasingly obvious that such social indicators were reductionist and alone did not constitute ‘quality of life’ leading to calls for an increased focus on subjective measures (Diener et al., 1999) or the ‘moral quality’ of well-being (White, 2009, p.11) focusing on how individuals themselves assess their own circumstances (Newton, 2007). Subjective social indicators are thus measures of individual perceptions and evaluations of social conditions (Noll, 2002) i.e. ‘the subjective interpretation and value that [children] place on discrete aspects of their own life and their life as a whole, irrespective of their objective circumstances’ (Diener, 2009, p. 12). There is also increasing consensus that well-being is not static but a process which involved interaction between individuals and their environments, and as such experiences of well-being change over time (White, 2009). Moreover, well-being is conceived as not only dependant on

⁴ Organisation for Economic Co-operation and Development (OECD) Reports, United Nations (UN) State of the Child reports, United Nations International Children’s Emergency Fund (UNICEF) State of the World’s Children, KIDS COUNT.

an individual's characteristics but also on whether their environment provides enabling conditions (White, 2009, p.11, Hall et al., 2009).

Despite on-going debates about the limitations and benefits of objective and subjective social indicators, their contribution to understanding well-being is evident (Noll, 2013). Thus, considering well-being in its theoretical sense requires combining aspects of eudaimonism (objective measures) and hedonism (subjective measures) which operate concurrently and are limited to an individual's capacity to choose functioning on a temporal and fluctuating basis which assist in the implementation of change, monitoring and development of progress and improve conditions for people and societies as a whole.

To understand how adult conceptualisations of well-being translate to conceptualisations of child well-being firstly warrants an overview of how children and childhood themselves have been constructed overtime.

Section 2.3 Discourses of Childhood

Historical Perception – Human Becomings and Universal Childhood

Influenced largely by the social indicator and rights movements, childhood has become an increasingly complex and interdisciplinary theoretical concept. Both developmental and sociological theories have leant themselves towards how children and childhood are perceived and conceptualised (Woodhead, 1999, Wyness, 2006). Within the field of psychology the dominant view was one of children as human becomings and childhood as universal (Jenks, 1982) while sociologically the dominant perspective was that of childhood as a period of socialization in preparation for their future lives (James et al., 1998). The significant role of psychological and sociological theories in our understanding of children and childhood dominated, relatively unquestioned until the mid-60s.

The work of Aries proved instrumental in developing alternative understandings of childhood in stating that 'in medieval society the idea of childhood did not exist' (Aries, 1962, p.128). Highlighting the constructed nature of childhood overtime, he argued that childhood is a social role

contingent on culture and history. Although these assertions were largely invalidated based on methodological shortcomings (Pollock, 1983) they nonetheless paved the way for new thinking about children and childhood. Stemming from this ten images of childhood have been identified (Sorin and Galloway, 2005, cited in Sorin, 2005) presented in Appendix A. A discussion of all ten constructs of childhood identified in the Sorin and Galloway typology is outside the remit of this study thus the focus will be on two dominant and pervading images of childhood: the innocent child and the child as a miniature adult.

Childhood as a time of innocence and vulnerability is largely associated with the writings of Rousseau (1979). Childhood is depicted as an idyllic and carefree time, whereby children must be protected by adults from *contamination* and their *innocence* preserved (Kehily, 2009b). A clear delineation between children and adults exists whereby children are viewed as passive subjects in need of adult protection, supervision and expert decision-making skills. As noted by Walther (1979, p. 64):

in the course of history children have been glorified, patronized, ignored or held in contempt depending upon the cultural assumptions of adults.

The influence of this discourse of childhood is evidenced in the downgrading of children as economic contributors to families, to a minority position of vulnerability romanticised by adults as a time to be protected continues to have significant influence in contemporary society (Buckingham, 2009).

Prior to late nineteenth century, much of our knowledge of children stemmed from what Kennedy (2006) refers to as ‘deficit theory’. Such theories it is argued have been constructed by adults based on their determinations of what is needed for children to become good adults and good members of the social order. Conceptualising children as lesser beings or miniature adults has resulted in permission for adults to make claims as to how children can be shaped towards achieving optimal societal contributions in adulthood. With the emergence of paidology, researchers sought ‘to

discover laws of normal child development’ as determined by adults (Fass, 2004, cited in Mason and Watson, 2014, p. 2760).

This episode in the study of children is largely reflective of *deficit* theories whereby the focus on ‘ensuring “normal” development and minimising deviations from the norm (the “abnormal”) was fundamental’ (Mason and Watson, 2014, p.2761). Such theories coupled with what Hendrick (1992) refers to a ‘maturing bourgeois domestic ideal’ that reinforced perceptions of childhood as a temporary state, quite distinct to that of adulthood, with its inhabitants (i.e. children) somewhat less *able* or inferior to their adult counterparts (p.2). Thus, children were viewed ‘as a site for investment’ (Mason and Watson, 2014, p.2760) and socio-politically the focus turned to ‘the production and regulation of rational and civilised adult citizens’(Kehily, 2009a, p.9).

Walkerdine (2009, p. 115) describes how childhood became a development process whereby:

Adaptation to the environment was understood as a natural stage-wise progression towards a rational and civilized adulthood, which was to be the basis for liberal government

This is evidenced in the writings of several prominent contributors to child development namely, Piaget, Kohlberg, Maslow and Bowlby which have dominated approaches to the study of children for much of the twentieth century and continue to hold significant influence on children’s current everyday lives. Similarly, sociological and anthropological theories shared the same perspective of children as future becomings. Adults were considered responsible for the socialisation of the child as an optimal contributor to future adult society, and as a means of prolonging cultural traditions and values (Christensen and Prout, 2005). Children are viewed as less knowledgeable and the power lies with adults in their capacity to harness the abilities of children to accommodate adult priorities (Sorin, 2007).

Despite the continued influence of such perspectives they have also faced criticism for presenting childhood as universal, context free and for being founded in adult assumptions of how childhood was and should be

constructed. James et al. (1998) argue that such theories rendered children as defective forms of adults, ‘social only in their future potential and not in their present being’ (p. 6). Moss and Petrie (2005) argue that children were presented as an ‘empty vessel or *tabula rasa*, starting life with nothing, but requiring to be filled with socially sanctioned knowledge and culture and growing into a predetermined identity’ (p.58). These perspectives perpetuate the view of children as *incomplete* and childhood as a stage of life filled with potential which offered a means for controlling social problems in efforts to create ‘pliant members of the social order’ (James et al., 1998, p.10).

However, critics posit that research informing society’s understanding of child development is nothing more than a ‘body of knowledge constructed by adults for other adults to use in order to make sense of, regulate and promote children’s lives and learning’ (Woodhead and Faulkner, 2000, p.11). Leading to increased calls for a ‘focus on the ways that children have been positioned in the construction of knowledge about them, through research on, with and by them’ (Mason and Watson, 2014, p.2757) and to accord equal importance to the cultural and historical dimensions of childhood.

Section 2.3.1 Reconstruction of Childhood

This emerging discourse became known as the *reconstruction of childhood* (Woodhead, 1999) which coupled with the momentum gained by the UN Convention of the Rights of the Child (UNCRC, 1989) brought about a seismic shift in current conceptualisations of childhood leading to the emergence of new discourses namely, that of children as rights holders. Children as a minority group is considered a ‘marker of modern childhood’ (Hutchinson and Charlesworth, 2000, p.577). For the first time the rights of children including their civil, political, economic, social, health and cultural rights were outlined, with an emphasis on the ‘best interests of the child’. The children’s rights movement led to the implicit recognition that rights foster well-being and opportunities for well-being (Ben-Arieh et al., 2014a, p.1). However, despite this progress Wyness (2009) cautions that the notion of adults determining the best interests of the child is one which is difficult to

reconcile with child agency and children having a voice in matters that concern them.

An alternative discourse emerged that recognised children as *social agents*, beginning with the work of Vygotsky (1978) Erikson (1950) and Bronfenbrenner (1986). With a growing scepticism towards mainstream developmental perspectives theorists began to explore the role of the social in ‘contesting the normative nature of child study and its universal assumptions about children’ (Woodhead, 2009, p.50). This culminated in the new paradigm of the sociology of childhood and an acknowledgement that children as social agents play an active role in the ‘construction and determination of their own lives’, and that the lives of children are ‘worthy of study in their own right, independent of the perspective and concerns of adults’ (Prout and James, 2015, p.7).

Childhood as a social construction highlights that experiences of childhood are discursively produced and there exists multiple conceptualisations of childhood. This perspective posits that children, through their actions and interactions, play a crucial role in shaping their experiences of their social worlds and in turn shaping themselves as people. Therefore, children are fundamental to their own socialisation processes through actions and engagement with their worlds and those around them. The sociology of childhood views children not as passive objects but rather as competent, participatory active agents, who are capable of reflecting upon and making decisions about things that concern them (Mayall, 2002).

From these developments James et al. (1998) propose four alternative discourses and suggest that childhood is a distinct and intrinsically interesting and important phase in human experience, and should be valued for its own unique qualities rather than for its resemblance to adulthood, leading to the first discourse, that of the *socially constructed child*.

The socially constructed child represents the varied nature of childhoods which are largely determined by context, time and culture i.e. what it means to be a child has been created and defined by adult society across time and culture. Understanding how children experience their

childhood must be considered in tandem with an understanding of all three. Challenging the view of childhood as universal and determined, what in one context, time and culture are understood to be appropriate childhood experiences may be viewed very differently in alternative ones. Thus, there exists a multitude of childhoods which are framed within differing perspectives on the competencies of children and differing social and cultural understandings of ‘maturity’(Freeman and Mathison, 2009, p.9).

However, criticisms of this approach highlight that the concept of the socially constructed child is based on the construction of children from an adult perspective and fails to account for children’s own contribution to their experiences. Secondly, they promote the view of children as fully formed and complete individuals with perspectives of their own rather than as partially developed, incompletely formed adults – drawing attention to the second alternative discourse, *the tribal child*.

The tribal child depicts childhood as ‘a sort of exotic tribe with its own beliefs and practices’ (ibid, p. 9). Evoking images of *The Lord of the Flies*, the tribal child represents a politicized version of the socially constructed child in that children create their own worlds with divergent values and norms that are distinct from adults’ constructions of that world. By and large children’s worlds have generally been interpreted and understood through an adult centric lens. The tribal child highlights that an adult centric lens may not be very helpful in terms of its validity. The focus thus of this discourse is on centralizing children as people in their own right without the imposition of the adult perspective (Hardman, 1973). However, this perspective has also been criticized for failing to account for the interactions that occur between adults and children which influence how children understand their worlds (Punch, 2002, Alanen and Mayall, 2001). Thus, greater significance was placed on understanding the interconnectedness of the individual and their context resulting in a ‘dialectical perspective’ (Sameroff, 2010, p.6).

The third discourse is that of the *social-structural child*, which considers children as autonomous subjects rather than members (or even

possessions) of their family. The views and interests of parents and family members are no longer assumed to be identical to that of children. Childhood is presented as a structurally distinct social category present in all societies and children as being the same as adults. However, this discourse also faces criticism in that it fails to acknowledge the fundamental differences between children and adults in terms of their development, capabilities and the socio-political and cultural contexts they experience that impede their ability to be autonomous and contributes to what Postman described as the ‘disappearance of childhood’ (Postman, 1982, p.66).

The final discourse offered is that of the *minority group child* which presents children as having rights of their own, including the right to protection from harm and the right to voice opinions and influence decisions in matters relating to their own lives (Brooker, 2001). While the minority group child is the politicized version of the social structural child the emphasis is placed on the oppression of children as a minority group, ‘who lack power to influence the quality of their lives’ (Mayall et al., 1996, p.207). Qvortrup (1994) proposes that the nature of the relationship between children and adults results in the minority group child arguing that this relationship is characterized by marginalization, paternalism, protection and institutionalisation. Mayall reflects this assertion by highlighting that

What is common to the intergenerational relationship of children to adults is that children are inferior to adults. This inferiority is demonstrated in many ways: children are not allowed to make decisions affecting them; must defer to adult knowledge and authority; have little economic power.....in any given society, the relationships between generations are governed by generational contracts, which set out adults’ understandings of the division of labour in that society, and the permitted and required activities of children..... (Mayall, 1994, p.118-119).

Considering how childhood has been conceptualised is important when considering how child well-being is conceptualised today. As noted by Sandin, (2014, p. 31) well-being is:

dependent on the definitions of childhood as shaped by gender, class, age definitions, and ethnicity, as well as on how care for children has been organized in different societies.

Consequently, contemporary theorists advocate that childhood be considered as constrained rather than determined, emergent not universal and thought of as a historically and culturally contingent construction (Lerner et al., 2002, Sameroff, 2010). It is a permanent social phenomenon yet its construction is flexible evidenced in how it is influenced by different generations (temporal) and as a result of socio-political change (contextual). Thus, current conceptualisations of child well-being are viewed as ‘rooted in the interplay of a series of factors on the micro level, framed by the social structures of society’ (Ben-Arieh et al., 2014a, p.3) and ‘directly related to the perspectives and needs of the individual understood within their social milieu’ (ibid, p. 5).

Section 2.4 Conceptualising Child Well-Being – Then and Now

Theoretical advances in understandings of childhood have led to a need to reconsider how children’s well-being has been conceptualised. Significant progress has been made in this regard driven largely by the (UNCRC, 1989) the new sociology of childhood and the child indicators movement. Social indicators play a significant role in approaches to understanding the well-being of children. Fattore et al. (2007) identified four traditional applications of social indicator research in the literature on children’s well-being: the quality of life approach, the domain approach, developmental health and well-being approach and the state of the child reports. Although helpful as means of keeping ‘children’s development on the policy radar’ (ibid, p. 8) they have been criticised as based on the assumptions adults hold about children and their lives. In response to this a fifth approach emerged: the child-focused approach. A discussion on each individual approach is outside the remit of this study thus the discussion to follow will focus on the generic influence of social indicators in the study of children’s well-being and the more contemporary understanding of a child-focused approach which forms the basis of this study.

Until recently our understanding of children’s well-being was largely based on our understanding of adults’ well-being, with a futuristic focus on well-becoming. Brown and Moore (2005) identify the uses of social

indicators specifically in the context of children and young people as a means of ‘monitoring and assessing their needs over time in order to identify personal and communal assets that can be mobilized to meet these needs and improve outcomes for children’ (p.85-86). However, Fattore et al. (2007) cautions that such approaches are influenced heavily by the assumptions held about children and their well-being, which in turn have been constructed predominantly via an adult-centric lens and a positivist model of knowledge, resulting in what (Anderson Moore et al., 2004, p.127) describes as a system that ‘lacks a vision of what might be desired and fostered in the development of the next generation’. While Lancaster (2006, p. 67) highlights how such ‘taken for granted views about children and childhood have the potential to hinder children from actually achieving the outcomes we are working towards’.

This lead to an increased concentration on child-focused approaches towards understanding children’s quality of life. As noted by Casas (2003, p. 2):

to evaluate quality of life of any population we need to go and ask them. It is not appropriate to discuss on children’s quality of life without asking children about their own perspectives on their living conditions

The importance of including children’s perspectives is not to imply that they necessarily represent the *truth* but that their inclusion is crucial to data analysis on their conceptualisations of well-being, as there has been some evidence to suggest that children’s perceptions of their well-being differ to those of adults. Thus, in studying child well-being it is recommended that both the perspectives of children and adult stakeholders need to be taken into account (Ben-Arieh et al., 2009).

Ben-Arieh (2005, 2008, 2010) notes how child-focused approaches have influenced a move away from child social indicators originally based on basic needs for survival to an increased focus on the quality of children’s lives as perceived by children. Secondly, there has been a change in the trajectory of focus on negative social indicators to a more balanced one including positive social indicators. Emphasising this focus Moore asserts that ‘we have a clearer sense of what we do not want for our children than what we do want’

(Moore, 2002, N.P.). Thirdly, there has been an increased focus on identifying objective and subjective measures which account for and include children's perspectives rather than a sole focus on traditional adult-centric ones. This has resulted in a broader conceptualisation of childhood and well-being and the emergence of new domains. Finally, in order to facilitate access to 'a different interpersonal and social world' (Ben-Arieh et al., 2014a, p.20) there must be a continued focus on understanding children's well-being in the present moment to enhance understandings of 'how children and young people assess their lives, in particular how satisfied or happy they are with aspects of their lives or their lives overall' (Axford et al., 2014, p.2700).

Thus, in attempting to understand children's well-being, Ben-Arieh (2005) advocates that efforts must include children, focus on their daily lives, and seek to understand what are children doing? What do they need? What do they have? What do children think and feel and to whom or what are they connected and related? What do children contribute? Section 2.7 provides an overview of children's perspectives on their well-being.

Section 2.5 What are the Children Saying?

Increasingly research on child well-being is being informed by the voice of the child. The inclusion of children as informants has resulted in differences in adult and child perspectives and to the introduction of previously unidentified domains. An innovative study carried out by Nic Gabhainn and Sixsmith (2005) into children's understanding of well-being in Ireland began the process. The primary aim of this research was to focus on the 'whole child' and in line with policy thinking develop a national set of child well-being indicators that encompassed the many facets of children's lives (Lamb and Land, 2014, p.2751). For the first time children were invited to share their views, perspectives and understandings of well-being in a variety of ways, which were then amalgamated with adult perspectives resulting in twenty-two categories considered representative of child well-being in the context of Ireland illustrated in Figure 2.1 below:

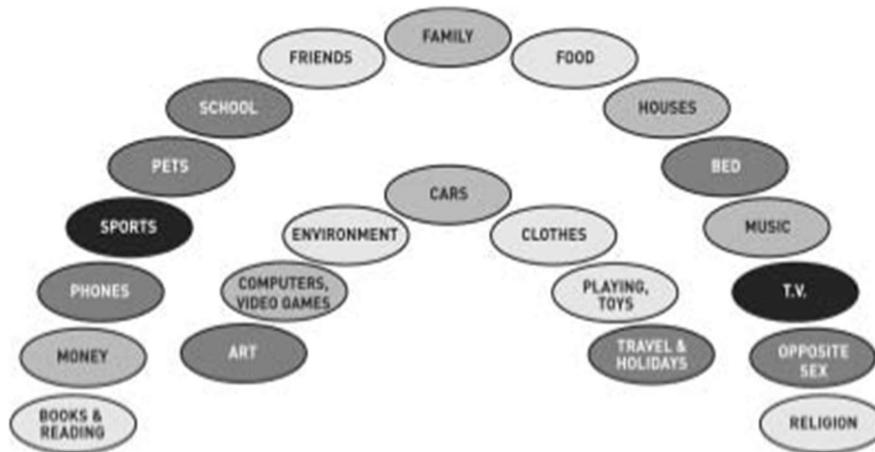


Figure 2.1: A Set of National Child Well-Being Indicators in Ireland.
(Hanafin and Brooks, 2005)

The outer rainbow places ‘family’ at the top centre as this was what children identified as most important, ‘friends’ and ‘food’ were deemed joint second in importance and ‘school’ and ‘houses’ as third, this format continues to the final two categories of ‘books/reading’ and ‘religion’. The inner rainbow follows the same format however, the entire inner rainbow was deemed by children as more important than the categories of ‘books/reading’ and ‘religion’. Children then reflected on the categories and agreed there was a gap as ‘happiness’ was not included. It was also noted that of the categories identified children consistently emphasised emotional aspects and their relationships.

This study highlights the wide spanning conceptualisation children have of their well-being. It shows the value they place on engaging in activities and the centrality of emotional connections and interpersonal relationships with family and friends. This reflects the perspective of White (2008, 2009) who argues that well-being is intrinsically linked to our relationships with others and our environments. These indicators are firmly embedded in a ‘*whole child perspective*’ and encompass an understanding of children that recognises ‘the multi-dimensional nature of children’s lives, the importance of formal and informal supports in their lives and the centrality of children’s relationships to their well-being’ (Hanafin and Brooks, 2005, p.10). Further evidence supporting the importance of relationships with others

to children's well-being have emerged in both Australia and the UK (Fattore et al., 2007, Lamb and Land, 2014) where dominant themes of well-being were defined through feelings and were related to children's relationships with family, and peers, their sense of self, and the importance of safety and security (Lamb and Land, 2014, p.2752).

Section 2.6 Conceptualising Social and Emotional Well-Being

Debates in the literature abound regarding appropriate terminology in reference to well-being and competencies, their definitions and means of assessment (Barblett and Maloney, 2010). Differences in terminology appear in relation to differing disciplines and add to difficulties defining these constructs. With regard to social and emotional well-being, terms such as intelligence, literacy, competencies and learning are used interchangeably (Humphrey et al., 2010, Weare and Gray, 2003). For example, Elias et al. (1997) use the term 'social and emotional learning' to refer to the process of acquiring core competencies, to recognise and manage emotions, set and achieve positive goals, appreciate the perspective of others, establish and maintain positive relationships, make responsible decisions and handle interpersonal situations constructively. While Lau (2006) provides distinctions between the terms emotional intelligence and competence, arguing that emotional intelligence is an innate ability whereas emotional competence is acquired through skills development attained through cultural and contextual influences as children develop. Despite these variations in terminology it is largely agreed that social and emotional well-being in childhood largely rests on children's opportunities to attain a range of social and emotional competencies, skills or assets which have significant implications for children's well-being and future well-becoming.

Social and emotional well-being refers to the way a person 'thinks and feels about themselves and others. It includes being able to adapt and deal with daily challenges (resilience and coping skills) while leading a fulfilling life' (AIHW, 2012, p.8). NICE (2013) considers social and emotional well-being as providing personal competencies which form the basis for children's personal development and protect against adversities throughout the lifespan.

Positive development of social and emotional competencies in childhood are thus thought to pave the way for positive mental health in the future. They form the basis from which positive and inclusive relationships are formed and are a more significant predictor of academic attainment than IQ and are linked to other developmental domains including language and communication skills as well as literacy and numeracy. Children lacking in social and emotional competencies can experience significant difficulties, in their social, emotional and long-term well-being (Durlak et al., 2011).

Emotional competence is defined as ‘the extent to which one is aware of, and able to act on, one’s own and others emotions, as well as the ability to regulate emotional experience within oneself and to be effective in interactions with others’ (Humphrey et al., 2010, p.514). It is thought to comprise of eight core components (Saarni, 1999). These include being aware of one’s own emotions, discerning and understanding others emotions, using the vocabulary of emotion and expressions, having the capacity for empathic involvement, differentiating internal subjective emotional experience from external emotional expression, coping adaptively with aversive emotions and distressing circumstances, being aware of emotional communication within relationships and possessing the capacity for emotional self-efficacy. The ability of a child to manage social relationships is dependent on their personal attributes, emotional competencies and the social supports they have in place.

Social competence relates to developmentally appropriate interaction, defined by individual characteristics including but not limited to pro-social behaviour, the initiation and maintenance of positive relationships and conflict resolution (Humphrey et al., 2010). It refers to the capacity to integrate thinking, feelings and behaving to attain interpersonal objectives and social outcomes (McCay and Keyes, 2001). It is the basis through which expectations for future relationships and interactions with others are formed, and through which children develop self-perceptions of their behaviours. Three factors have been identified in the achievement of social competence: adaptive behaviours, social skills and peer acceptance (Gresham and Elliott, 1987). They further identified four ‘deficits’: skills deficits, performance

deficits, self-control skill deficits and self-control performance deficits (Gresham and Elliott, 1989).

Much of the literature in the area adopts a deficit approach and focuses on the difficulties children experience referring to Behavioural, Emotional and Social Difficulties (BESD), markedly in the context of education. BESD is thought of as an umbrella term for describing learning difficulties where children and young people express/experience difficulties emotionally and behaviourally including being withdrawn/isolated; displaying a disruptive/disturbing nature; being hyperactive and lacking concentration; presenting with immature social skills and challenging behaviours arising from other complex special needs. It also refers to children who experience emotional disorders and conduct/hyperkinetic disorders including Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder, ADD/ADHD (Department of Education and Skills, 2001). Put more simply, Broomhead (2013) defines BESD, as ‘children who experience difficulties with their behaviour, emotions, and/or social relationship which consequently interfere with their learning and development’ (p. 310).

One definition of BESD in the Irish context is:

difficulties which a pupil or young person is experiencing which act as a barrier to their personal, social, cognitive and emotional development. These difficulties may be communicated through internalising and/or externalising behaviours. Relationship with self, others and community may be affected and the difficulties may interfere with the pupils own personal and educational development or that of others. The contexts within which difficulties occur must always be considered and may include the classroom, school family, community and cultural settings (National Educational Psychological Service, 2013, p.4).

However, Cole and Visser (2005) caution that it is not solely the presence of the difficulty that defines BESD but rather the frequency, intensity and duration of the behaviour. More recently research suggests that intervention programmes that focus on building children’s competencies socially and emotionally have a more enduring impact than those targeting solely the reduction of negative behaviours (Weare and Nind, 2011, O’Connell et al.,

2009). Thus, the emphasis has been transferred toward identifying positive factors that contribute to children's social and emotional well-being and it is increasingly more common to see positive terms such as competencies and assets (Benson et al., 1999, Scales and Leffert, 2004).

The terms social and emotional well-being are inter-related constructs which refer broadly to how children 'act, behave, feel, communicate their feelings and get along with others' (Fauth and Thompson, 2009, p.5). Hamilton and Redmond (2010) highlight that there is no single indicator or set of indicators relating to social and emotional aspects of human well-being or indeed that of children. In general, it is thought that children's behaviours are a bi-product of their social and emotional well-being, in that they are the means through which positive or negative social or emotional experiences are made tangible. Positive experiences socially and emotionally are thought to help create competencies in children which can function as protective buffers to adversity and enhance the personal development of young people.

Looking closer at how social and emotional well-being is thought to contribute to behavioural responses, Hamilton and Redmond (2010) draw on philosophical and social theories creating a link between those and applied social research to identify key principles to inform indicators of children's social and emotional well-being. Firmly embedded in an ecological model (Bronfenbrenner, 1979) presented as a *foundation stone* of the child indicators movement they propose a dual conceptualisation of children's social and emotional well-being comprised of individual and environmental dimension which are engaged in a dynamic relationship. This model is presented below in Figure 2.2:

Conceptualising Children's Social and Emotional Well-being

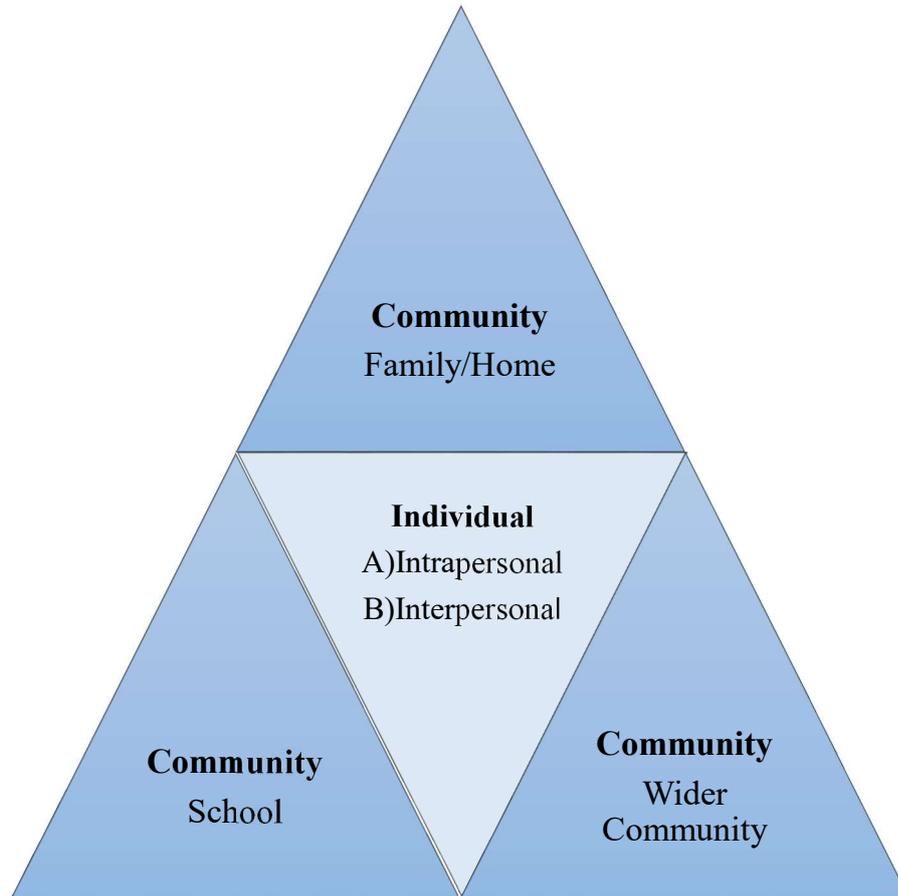


Figure 2.2: Conceptualisation of Children's Social and Emotional Well-being: An Ecological Approach (Bronfenbrenner and Ceci, 1994, Bronfenbrenner, 1979, Hamilton and Redmond, 2010)

The individual dimension is sub-divided into intra and inter-personal characteristics. The intra-personal level is related to children's internal characteristics including temperament, attitudes and values (AIHW, 2012, p.12). These characteristics are thought to include children's emotional regulation that is their ability to experience, manage and appropriately express emotions (Pitel et al., 2006). It also refers to their ability to regulate behaviour (AIHW, 2012) resilience and coping skills, alongside confidence and persistence in learning (Bernard et al., 2007). At the inter-personal level

it relates to children's ability to identify and understanding the emotions of others (AIHW, 2009) the development of social skills including empathy, trust, co-operation and conflict resolution (Bernard et al., 2007) and the capacity to form and maintain relationships with others (NICE, 2009). At the individual level (both inter and intra) consideration must be given to the developmental stage of the child, as well as understanding genetic/biological influences and the presence or absence of disability or health conditions (AIHW, 2012).

The environmental dimension comprises of three components: the family/home, the school environment and community (NICE, 2009). Family factors include children's relationships with their parents, parental expectations, and family communication. School or the educational environment is the second characteristic within the environmental dimension and refers to children's engagement with schools, including positive relationships with teachers, a quality curriculum and activities of interest to children. It also includes the level of parental engagement with schools. These characteristics are thought to influence children's social and emotional well-being at the individual internal level and influence children's self-esteem, sense of belonging and educational attainment. The third sphere relates to children's experiences within the wider community and include growing up in caring neighbourhoods where children are valued and considered resources, as well as social capital and networks (AIHW, 2010). At a broader societal level consideration must also be given to factors such as culture, social values, human rights and governmental policies.

The extent to which the environmental spheres of family, school and wider community impact on children's social and emotional well-being must be considered in light of the increasingly complex and changing interactions children have with their environments as they grow and develop. Children's dependencies change according to their development and as they get older the social context and interaction with others external to the family increase. Despite this Saha et al. (2010) identify that parental support is still a significant factor in adolescent social and emotional well-being. Adopting an ecological approach in understanding the social and emotional well-being of

children accounts for both the individual and the environmental, the internal and external and views children's behavioural responses as outcomes of person-environment interactions.

Denham et al. (2009) propose four dimensions linked to individual inter and intra personal characteristics: social and emotional competence, attachment, self-perceived competence, and temperament, which are thought to predict positive well-being outcomes across the lifespan. Social and emotional competence although considered distinct attributes are strongly related (Squires et al., 2003). Social competence refers to 'effectiveness in developmentally appropriate social interactions' (Denham et al., 2009, p.38). Children considered socially competent present with personal attributes such as, cooperativeness, pro-social behaviours, helpfulness, conflict resolution skills and the ability to develop and maintain positive relationships (Denham et al., 2009, Humphrey et al., 2010). Emotional competence is defined as 'the multifaceted ability strategically to be aware of one's own and others emotions and to act on this awareness, to negotiate inter-personal exchanges and regulate emotional experience' (Denham et al., 2009, p.42). Emotional regulation refers to a child's ability to monitor, evaluate and modify positive and negative emotional reactions in a socially appropriate manner (Gullone et al., 2010). Early emotional expressiveness and regulation is linked to social skills, prosocial behaviours and popularity in adolescence (Denham et al., 2009).

Attachment, the second dimension, refers to the emotional relationship that develops between humans, it begins with the parent-child relationship, and is the foundation on which all future relationships are formed (Denham et al., 2009). The security of the attachment is considered the most important aspect of attachment for overall functioning and is often related to competencies in a range of developmental domains. Parenting style and parenting practices have a significant influence on the nature of attachment and secure attachments in the early stages of childhood are linked to positive social and emotional competence, cognitive development and physical and mental health (Bowlby, 1977). Self-perceived competence involves how children evaluate their own cognitive, physical, social and

emotional abilities. These self-evaluations are influenced by our experiences and internalisation of external evaluations from others. Positive evaluations of self-perceived competence are linked to high feelings of self-efficacy and academic performance, while negative evaluations are strongly related to cognitive models of depression and low self-esteem (Denham et al., 2009). Finally, temperament, an innate characteristic, refers to the ‘tendency to express particular emotions with a certain intensity that is unique to each individual child’ (Fox, 1998, p.1230). People are thought to have positive or negative temperamental predispositions, largely influenced by their emotional reactivity and emotional regulation. Despite its biological nature, temperament is also susceptible to change through a child’s interaction with their environment, and of particular importance are parenting practices and environmental exposure.

As noted above children’s social and emotional well-being does not develop in isolation, rather it is influenced by a myriad of factors and the ongoing interaction between individual and environmental dimensions. Hamilton and Redmond (2010) refer to three specific environmental dimensions important to children’s social and emotional well-being: family/home, school and community. Lee (2005) argues that as a child is embedded in a network of relationships and social interactions they can be considered only as separable but not separate from their parents. Research by Cooper and Cefai (2009) found that children’s emotional stress and behavioural difficulties increased alongside increasing problems in the family, peer or school settings. While Deater-Deckard and Dunn (1999) identify a number of consistent factors of families related to children’s social and emotional well-being. These include: family cohesion and support, conflict, sibling relationships, parenting style and discipline methods and parental mental health. Research suggests that children who live in families that get along well together report higher levels of overall well-being than those living in families that do not (Rees et al., 2009). While children who experience conflict in the family home, a re-structuring of the family and their subsequent adaptation to same, and poor sibling relationships are thought to contribute to increased social and emotional difficulties for children.

Research in the context of Irish families indicates that experiences within the family have a major influence on the well-being of children and adults (McKeown and Sweeney, 2001). A study by McAuley and Layte (2012, p. 523) sought to establish the influence of family stressors and socio-economic circumstances on the well-being of children. Included under the title family stressors were: conflict in parent-child relationship, children with emotional and social problems, parental depression, low parental self-efficacy and child isolation. Findings from this study reflect that irrespective of socio-economic and socio-demographic variables children's self-assessed happiness was significantly lower in families experiencing a high level of stress. Family stressors were identified as explicative of twice the variance in children's happiness than those explained by socio-economic factors. The most significant factor contributing to children's social and emotional well-being within the family are parenting practices that promote the discussion of feelings and how to cope with them (Bernard et al., 2007). Thus, in considering the social and emotional well-being of children the immediate family environment and in particular a child's relationship with their parent(s) is of crucial importance.

Aside from the family context Weare and Gray (2003) argue that the school environment is one of the most important determinants of children's social and emotional well-being. A range of protective factors from within school settings have been identified in promoting resilience in young people and schools are thought to play a pivotal role in empowering young people to overcome adversity, enhance social, emotional and cognitive well-being and in the acquisition of lifelong skills (Cooper and Jacobs, 2011, Terrion, 2006). Positive relationships with teachers have been identified as positive for young people notable in learning how to manage feelings when coping with stress (Bernard et al., 2007). A supportive school environment has been characterised by a 'sense of connectedness and belonging among students, positive classroom climates, good relationships with teachers and peers and parental involvement with the school' (AIHW, 2012, p.20). Research highlights that effective schools and educational interventions can improve learning outcomes substantially for children, especially those from

disadvantaged backgrounds. Furthermore, research consistently suggests that improvements in the social and emotional well-being of children will in turn improve educational outcomes (Durlak et al., 2011, Banerjee et al., 2014).

The importance of children's environments goes beyond that of the immediate family and school systems. Children need to have access to appropriate environments and resources within communities to allow for creative and exploratory play and to facilitate their development socially, emotionally and behaviourally (Bird, 2007, Forkan et al., 2013). Children need communities within which they have access to support services, feel safe, secure and have spaces to go where they feel a sense of belonging and value (Matthews, 2001). Children must also have opportunities to actively engage with their communities as valued members, fostering a sense of social responsibility and citizenship. Restricting children's freedom in their local communities can impede their opportunities to create social networks and build strong trusting relationships (Munoz, 2009). Whereas neighbourhood factors associated with reduced well-being include high crime rates, neglect, vandalism and conflicting or ambivalent relationships between residents. Hence, through their active engagement with their communities, children can learn the rules of social life.

Ergo, social and emotional well-being is a multi-faceted construct dependant on the acquisition of a range of competencies and influenced by factors on an individual and environmental level. Defining competencies no less than well-being is difficult as they change along with the continuous and rapid changes in children's development thus assertions about such competencies need to be socially, contextually and temporally framed.

Section 2.6.1 Socialising Emotions

Emotions are the primary and integral elements of social interactions as they create and are created by interactions with others (Halberstadt et al., 2001). Lau and Wu (2012) suggest that emotional competence can be considered a group of generic skills that can be applied to many types of emotion-related skills, emphasising those acquired through cultural and contextual circumstance throughout development. Ciarrochi and Scott (2006)

argue that emotional competence includes the ability to identify emotions and individual differences in how effectively people deal with emotions and emotionally charged problems. Acquiring emotional competence is thought to occur through a process of socialisation of emotions linked to intra- and inter-personal factors and includes emotional expression and experience, understanding emotions of self and others and emotional regulation which evolve over time (Denham et al., 2009) and contribute concurrently to children's social competence and over-all well-being into adulthood (Denham et al., 2009). Children's emotional competence is linked predominantly but not exclusively to three capabilities: the expression of emotions, understanding of emotions and how children regulate their emotions. Thus, emotional competence is considered transactional within self and between self and others (Lau and Wu, 2012) and is interlinked with social experiences which nurture or impede its development (Denham et al., 2009).

The link between emotional and social competence is well established. Happier children who express less angry behaviours gain increased acceptance from peers and are judged higher on prosocial behaviours such as friendliness and co-operation by teachers. While research also suggests that more negative social outcomes are associated with higher rates of negative emotional expressiveness in children (Cumberland-Li et al., 2003). Of relevance also is the influence of intra- and inter-personal contributors to emotional competence. The temperament of individual children is important in promoting or impeding emotional competence. Children with temperamental characteristics involving the expression or suppression of emotion can significantly impact on children's social behaviours.

On an intra-personal level children's family, school and peer groups play important roles in children's acquisition of emotional competence. Denham draws our attention to both intentional and unintentional parental socialisation process, whereby 'socialisation is a task or content area that is part of learning a cultural pattern'; 'affect is....an integral part of... the ideas we hold, the practices that we follow and our experiences with others' (Bugental and Goodnow, 1998, p.441). As such, the socialisation of emotions

is considered to occur within the context of a higher order parenting style which in turn is informed by parental goals and values (Denham et al., 2007). Research supports this assertion and findings indicate that parental philosophies and beliefs about emotions and how they are socialised predict emotion socialisation behaviours in children (Baker et al., 2011, Perez Rivera and Dunsmore, 2011, Wong et al., 2008, Wong et al., 2009). Thus, the parent-child relationship and the style of parenting children experience is integral to how they learn to socialise their emotions.

Three processes are thought to be involved in the socialisation of emotions: emotion modelling, contingent reactions and emotion coaching with each of these processes influencing children's emotional expression, understanding and regulation alongside their social functioning (Newland and Crnic, 2011, Bariola et al., 2012). Children's exposure to specific emotion profiles can promote their expression of similar emotions through a process of modelling. Research has found that positive emotional expression in parents is co-related with positive emotional expression in children, increased popularity with peer groups and expression of prosocial behaviour towards siblings (Isley et al., 1999, Garner et al., 1997). Inversely, children's exposure to negative emotion profiles experience more negative emotions and increased difficulties socially (Garner and Estep, 2001, Denham, 1989, Denham, 1998). Denham (1989) found evidence to support that maternal negative emotions co-related with children's negative emotions and in turn a lack of social competence (Newland and Crnic, 2011, Snyder et al., 2003). Thus, highlighting that emotional competence is 'contextually anchored in social meaning' (Saarni, 1999, p.2) and suggests that mothers may be the 'emotional gatekeepers' of families (Anzar, 2013, p.2).

How children learn to express emotions is another important factor for the socialisation of emotional competence and this learning occurs in both the family and school environments and is contingent on experienced reactions from contributors to their socialisation i.e. parents, teachers and peers (Denham, 1998, Nixon and Wartson, 2001). Children who live in an environment characterised by 'truncated family emotional expression' may experience difficulties (Suveg et al., 2005, p.145) supported by their research

which indicates that both mothers and children with diagnoses of anxiety report reduced emotional expressiveness than their non-diagnosed counterparts. In contrast, research by Bronstein et al. (1993) found that the non-hostile expression of emotion within families buffers adolescents against the emergence of psychological problems and increases long-term social competence. Whilst research in schools suggests that children will express corresponding positive emotions to those expressed by teachers, which are considered to encourage exemplary behaviours.

A developmental perspective proposes that social competence is acquired and developed over time through the mastery of social skills and interpersonal interactions with those in our environment. It involves a continuous process of evolving understanding and building on previously learned skills and knowledge acquired through interaction with others and our environment. Three factors are important in considering children's social competence or ability to acquire skills of social interactions. These include temperament, attachment and parenting style similar to conceptualisation of social and emotional well-being they account for inter- and intra-personal aspects of children's realities.

In summary, the social and emotional well-being of children is considered to comprise of a spectrum of social and emotional competencies which are influenced by core inter- and intra-personal characteristics including children's temperament, attachment experiences, parent-child relationship, parenting style and experiences within their peer group, family and the school setting influenced by broader social structures all of which contribute directly and indirectly to children's social and emotional well-being and the behavioural manifestations of same.

Section 2.7 Chapter Summary

In conclusion, concepts of well-being have morphed throughout time and across cultures. It is considered a multi-dimensional concept informed by many differing perspectives, incorporating aspects of both hedonism and edumaimonism and the measurement of which requires consideration of both objective/subjective and positive and negative indicators on the individual

and environmental level, it is ‘a multidimensional entity framed by a multilevel context’ (Minkkinen, 2013, p.557). In terms of understanding children’s well-being, this is largely influenced by how children and childhood have been and continue to be conceptualised. Traditionally childhood was viewed as a distinctive, predictable phase within the lifespan, without context and children as having no relevant contribution to make (Hogan, 2005). Interdisciplinary contributions have led to a reformation of more traditional perspectives, which in turn has influenced how research engages with children (Freeman and Mathison, 2009).

Including children in understandings of and research on their well-being is in line with the perspective that they are rights holders (UNCRC, 1989) and social agents. Without their inclusion the question of subjectivity is raised as understandings of children’s well-being ‘should accept that other human beings cannot simply by virtue of age decide what children’s well-being consists of, how it should be measured and analysed’ (Ben-Arieh, 2005, p.575). Ben-Arieh et al. (2014b) argue that any attempt to conceptualise child well-being would be redundant without the experiences of children while they are children. They further argue that children’s well-being should take into account children’s conditions of living and ‘objective’ measures of their well-being; their perceptions, evaluations and aspirations regarding their own lives (Campbell et al., 1976, cited in Ben-Arieh et al., 2014, p. 7) including their subjective well-being; and, the perceptions, evaluations and aspirations of other relevant social agents in their lives (Ben-Arieh et al., 2014a).

Although difficult to define, the social and emotional well-being of children plays a fundamental role in their overall sense of well-being and quality of life. It is considered to be influenced largely by children’s intra-personal characteristics and interaction with others and their environment and dependant on the attainment of a range of social and emotional competencies. Research consistently highlights the role of intra- and inter-personal factors at the individual and environmental level in conceptualising children’s social and emotional well-being, highlighting the multi-faceted nature of the concept (Hamilton and Redmond, 2010).

Despite significant progress in recent years towards including children in our understanding of their lives, Flavell (1992) notes that there remains evident multi-disciplinary gaps in how we conceive of and perceive children and childhood. In turn, Bradshaw and Richardson (2009) argue that despite progress in developing indicators of child well-being ‘we are still lacking indicators covering some important domains’ (p. 349). Further criticisms refer to the failure to include what children think about their wider social environments, e.g. neighbourhoods and communities (Bradshaw and Richardson, 2009). Hanafin and Brooks (2005) highlight the importance of indicators in the identification of cohorts of children who are potentially at risk ‘relative to others’ (p.13). While Fattore et al., (2007) argue that ‘the potential of subjective well-being measures to take into account children’s own experiences and the complexities of their lives has not yet been realised’ (p.12). Findings from these studies indicate that measures that are contextually specific should be prioritised by the research and policy agenda and the implications of specific situations considered (Fernandez, 2011, Carboni and Morrow, 2011).

Chapter 3 - Parenting and Parenting with a Mental Health Difficulty

Section 3.1 Introduction

The importance of parenting to children's social and emotional well-being has been presented in Chapter 2 as highly significant on an individual and environmental basis. This chapter is divided into nine sections. Section 3.2 reflects on theoretical perspectives that have assisted in constructing how parenting is understood. It will review the contribution of socio-ecological determinants to this understanding, highlighting a nexus of factors interacting at an individual, relational and environmental level which contribute to how parents parent. Following this, the discussion moves to an overview of key research on parenting style and of concepts of the 'good enough mother' and 'parental capacity'. Section 3.3 considers the role of parenting in terms of well-being outcomes for children. Section 3.4 provides an insight into children's perspectives on parenting.

Section 3.5 then considers parenting within the context of having a mental health difficulty, highlighting the complex interaction of factors on an individual and environmental level. Section 3.6 reviews the literature on outcomes for children living in this context. Concluding with a reflection of what children themselves say. Section 3.7 considers the evidence-base on the parenting supports that are available. Section 3.8 highlights what could help parents and children in the context of living with a parent with a mental health difficulty. Section 3.9 provides a summary of the content of the chapter.

Section 3.2 Defining Parenting

Derived from the Latin verb *parere*, parenting means to bring forth, develop or educate, and plays a fundamental role in the social and emotional development of children. Parenting was originally conceived of as a uni-directional practice that adults carried out on children, this perception of parenting has been criticized as a 'overdrawn, a fiction of convenience rather than beliefs' (Bell, 1968, p.82). Current thinking suggests bi-directionality in parenting is not merely the action of a parent on a child (Bell, 1968). The emerging evidence base illustrates the importance of considering the

interrelations between the individual and the social world they inhabit.

Parenting can be considered as:

bidirectional relationships between members of two (or more) generations, can extend through the respective lifespans of these groups, may engage all institutions within a culture (including educational, economic, political and social ones) and is embedded in the history of a people (Lerner et al., 2002, p.316).

Alongside acknowledging the transactional and dyadic nature of the socialisation process, Gopfert, Webster & Nelki (2004) argue that parenting is a socially constructed concept relating to an individual's role within society which is culturally determined. Based on theories of personality development whereby individual's early experiences are thought to be internalized. They propose a role-relationship framework for understanding the personal and social role of both parent and child and the context within which the relationship occurs. Proposing that this framework is helpful as a means to understanding the 'interface between a social role, such as parenting and the personality of the person enacting the role' (p. 62). They argue that this framework allows for an alternative perspective of parenting in which parents are one of many actors who engage in *role enactment* in terms of children's development. They state that:

the script is clear: children need to grow up and, in the interim, need to be looked after by a carer. This creates a reciprocal role relationship. Each actor in such a role relationship will attempt his or her individual and unique interpretation of the script. The entire script can only be enacted with a wider cast, which includes not only the child and a parental character but also a network of other actors whose presence is necessary in order for children to grow up in reasonable mental health. (Gopfert et al., 2004a, p.65).

They further emphasise the importance of considering factors including, marital conflict, poverty and parental health and how these factors alongside the role of siblings and extended family contribute to or detract from the ability of parents to fulfil their role. This is supported by Chambers (2012) who suggests that although parenthood may appear to be a natural phenomenon, it is socially constructed, and a process that is 'embedded in and shaped by wider social values, structures and institutions' (p.55).

Section 3.2.1 Determinants of Parenting: An Ecological Perspective

Bronfenbrenner (1958, 1979) proposed the bio-ecological model of human development whereby individuals are viewed as embedded in their environment. The model focuses on biological and environmental contexts of individuals identifying five systems (micro, meso, exo, macro, and chrono) which influence development. The model proposes that development takes place through a process of progressively more:

complex reciprocal interactions between an active, evolving biopsychological human organism and the persons, objects and symbols in its immediate external environment' (Bronfenbrenner and Morris, 2006, p.797).

Of fundamental importance to this theory is the interaction that occurs between a child and their immediate environment especially that of the parent-child relationship, conceptualised as *proximal processes*.

Bronfenbrenner and Morris (2006, p. 994) argue that:

the power of such processes to influence development is presumed, and shown, to vary substantially as a function of the characteristics of the developing person, of the immediate and more remote environmental contexts, and the time periods in which the proximal processes take place

Bronfenbrenner purported that parenting interacts with a myriad of social factors which in turn can affect children's outcomes. This highlights that parenting occurs within the unique context of each specific parent-child dyad and within the broader more generic context of family, community, society and culture.

Belsky sought to identify factors that determine 'competent parental functioning' (Belsky, 1984, p.83). This model proposes that child development can be predicted by parenting that is directly and indirectly determined by three core factors: 'personal psychological resources of parent, characteristics of the child, and contextual sources of stress' (Belsky, 1984, p.83). The process model emphasises the restrictions or enhancements that structural and environmental factors or '*contextual stress*' can have and how these can directly influence parental functioning. Indirectly these stressors can impact on a parent's individual psychological well-being, i.e. experiences

in childhood, one's developmental history influences functioning in adulthood. At the same time personality influences contextual support and stress which also indirectly shapes parental functioning. Belsky asserts that the psychological resources of a parent are the most important determinants of parenting as they directly influence parenting as well as influencing contextual factors and the parent-child relationship (Belsky et al., 1986, Belsky and Vondra, 1989).

Reflecting the bi-directional influence of parent-child relationships, Belsky highlights the role of child temperament on parental functioning. Temperament is largely considered as either a risk or protective factor, with the ability to alter the effect of parenting on development (Lengua, 2006). According to Bradley (2002) it reflects how 'both parent and child are active constructors of their environments as well as responders to what the environment affords' (p.282). This suggests that both temperament and parenting contribute uniquely and simultaneously to children's social and emotional adjustment. However, Rothbart and Bates (2006) highlight the role of experience and context in shaping how temperament manifests. Thus, Kiff et al. (2011, p. 255) suggest temperament be considered as:

characteristics present early in life that shape and are shaped within the context of social and environmental interactions and that result in differential responsiveness to socialization experiences.

Therefore, parenting can be considered a multi-dimensional bi-directional process, formed directly and indirectly through the interaction of a variety of intra-, inter-personal and contextual factors which contribute to or impede parents in fulfilling their role which can in turn impact on children's socialisation (Swords et al., 2013).

Section 3.2.2 Parenting Styles & Practices

Parenting style has been defined as:

a constellation of attitudes toward the child that are communicated to the child and that, taken together, create an emotional climate in which the parent's behaviors are expressed (Darling and Steinberg, 1993, p.488)

Parenting style plays a significant role in terms of children's outcomes. The parenting-trait framework conceptualized by Baumrind (1979, 2005) has proven instrumental in highlighting positive outcomes for children including emotional security, social competence and intellectual achievement which are promoted by parenting that is responsive to children's capabilities and parental awareness of children's' appropriate developmental tasks (Belsky et al., 1984).

Two significant components of parenting style are 'parental responsiveness' and 'parental demandingness' (Baumrind, 1978, Maccoby and Martin, 1983). Parental responsiveness or warmth refers to the level to which parents respond, support and are sensitive to their children's socio-emotional needs, fostering 'individuality, self-regulation and self-assertion' (Baumrind, 1991, p.62). While parental demandingness refers to the demands parents place on children including parental expectations, levels of responsibility and maturity alongside the setting and enforcing of boundaries for them in a consistent and developmentally appropriate manner. From these two components, three styles of parenting have emerged: authoritative, authoritarian and permissive (Baumrind, 1978, Chan and Koo, 2011). These three typologies, are often considered as contributing significantly to positive and/or negative outcomes for children on a range of well-being domains with research consistently reporting authoritative parenting style as the preferred style in terms of positive well-being outcomes for children, including increased self-esteem, self-confidence, and improved interpersonal relationships and emotional well-being (Parke and Buriel, 1998).

Authoritative Parenting

Authoritative parenting is characterised by a balance of both parental demandingness and responsiveness. Baumrind defines this approach to parenting as 'assertive, but not intrusive and restrictive' (Baumrind, 1991, p.62). Parenting of this nature is expressed in a supportive rather than punitive manner with parents directing their child in a 'rational issue-oriented manner'(Baumrind, 1978, p.245). Darling and Steinberg (1993) conceptualise this style of parenting as including a 'constellation of parent

attributes' (p.487) such as emotional warmth, support and autonomy granting. It involves the provision of clear and appropriate expectations and encouragement and facilitation of reciprocal communication between parent and child. This type of parenting is attributed to positive indicators or 'instrumental competence' (Baumrind, 1970) in children characterised by responsibility, independence, positive interaction with adults and peers, emotional competence, academic success and an ability to balance individual and social needs and responsibilities.

Authoritarian Parenting

In contrast, authoritarian parents 'expect their orders to be obeyed without explanation' (Baumrind, 1991, p.62) making high demands on their children, with minimal responsiveness in return. Parenting occurs in a structured, directive manner with clearly stated rules and expectations, leaving little room for negotiation and reluctance towards granting children autonomy. In response to parent-child conflict authoritarian parenting favours 'punitive, forceful measures', characterised by a rigidity dominated by the parent's perspective with the child's viewpoint ignored (Baumrind, 1978, p.244). Authoritarian parenting can be divided into two subtypes: non-authoritarian-directive and authoritarian-directive. The difference being the former is non-intrusive and the latter considered highly intrusive. Parenting of this nature can manifest as either protective or neglectful (Baumrind, 1978, p.244). Research indicates that an authoritarian parenting style may lead to poorer outcomes for children across a range of well-being domains (Steinberg and Silk, 2002).

Permissive Parenting

Permissive parenting is characterised by a leniency and failure to establish boundaries for children. Baumrind defines this typology as parents who are 'more responsive than they are demanding. They are non traditional and lenient, do not require mature behaviour, allow considerable self-regulation and avoid confrontation' (Baumrind, 1991, p.62). Although a loving style of parenting, it is also liberal in that children of a young age are granted autonomy with few or no limits or expectations in place. Parents do

not view themselves as ‘active agents’, with a responsibility towards their child’s behaviour in the present and future (Baumrind, 1978, p.248). Permissive parenting can also be subdivided as either democratic/involved or non-directive/laissez-faire. The involved permissive parent is emotionally responsive to the needs of their child however fail to assign expectations or responsibilities instead allowing children as much as possible regulate themselves, usually considering themselves as more of a friend to their child. Whereas the laissez-faire permissive parent fails to assign expectations or responsibilities to children but do so in an emotionally disengaged way (Maccoby and Martin, 1983). While such parents may fulfill a child’s basic needs, they are generally emotionally detached. In extreme cases this style of parenting may result in the neglect of children’s needs.

Baumrind (1991) states that ‘the construct of parenting style is used to capture normal variations in parents attempts to control and socialize their children’ and is not the same as parenting practice (cited in Darling, 1999, p. 2) . Parenting practices are thus considered the situation-specific behaviours that parents engage in when rearing a child (Skinner et al., 2005, Stewart and Bond, 2002). Hoff et al. (2002) expand on this and provide a broader view of parenting practice as the:

behaviours parents produce in interactions with their children, the kinds of home environments parents create for children and the connections to the world outside the home that parents both enable and permit (Hoff et al., 2002, p.235)

Highlighting that the influence of one singular parenting practice cannot be easily separated from the complexity of other parent/child characteristics and contexts (Darling and Steinberg, 1993).

Section 3.3 The Good Enough Parent – Competence and Capacity

The concept of the *good enough* parent largely conceived of in relation to mothers, emerged in the early 1950s with the writings of Donald Winnicott (1953, p. 93) describing her as a mother who:

is neither good nor bad nor the product of illusion, but is a separate and independent entity: the good-enough mother..... starts off with an almost complete adaptation to her infant's needs and as time proceeds she adapts less and less completely, gradually, according to the infants growing ability to deal with her failure. Her failure to adapt to every need of the child helps them adapt to external realities

However, Taylor et al. (2009) argue that attempting to provide a precise definition of *good enough parenting* is a complex and ambiguous task. By conceptualising the *good enough mother*, Winnicott sought to highlight that striving for perfection in parenthood is an unrealistic goal. Smith (2003, p. 1430) cautions that 'being a good enough mother is to be a good mother, whereas the attempt to be the best will guarantee that you won't be (indeed, you may be a highly damaging mother)'. The insurmountable task of achieving perfection in parenting has led to a more pragmatic approach as noted by O'Shaughnessy et al. (2015, p. 64) 'none of us are always optimal parents!' thus the current focus is on *competent parenting*.

In contrast to striving for perfection, *competent parenting* involves a parent's ability to adapt to a child's changing needs, requirements and circumstances across the lifespan (Azar and Cote, 2002, White, 2005) based on their perceptiveness, responsiveness and flexibility (Commonwealth of Australia, 2004, p.5-9, White, 2005, p.14). However, a parent's capacity to be adaptable can be influenced by a wide array of factors including family structure, marital conflict, stress, socio-economic status, mental health and substance misuse. Cumulatively these factors may increase parental vulnerability and in turn reduce parental capacity.

Conley (2003) defines parenting capacity as 'the ability to parent in a 'good enough' manner long term' (p.16). Parental capacity is generally assessed through parental capacity assessments (PCA) defined as:

a planned process of identifying concerns about a child's welfare, eliciting information about the functioning of the parent's and the child, and forming an opinion as to whether the child's needs are being satisfied (Reder and Lucey, 2003, p.3).

Research carried out by Kellet and Apps (2009) report multi-disciplinary perspectives from practitioners as to what constitutes good enough parenting in terms of PCAs. Four components were identified including whether children's health and developmental needs are being met and whether priority is awarded to the child's needs, is there consistency and routine in the provision of care to the child and, is the parent able to acknowledge problems and engage with support services. Research suggests that parents who are most likely to meet the needs of their children are frequently those who are continually questioning their skills and ability as parents (Cann, 2004). From the perspective of practitioners, poor parenting capacity includes neglecting the basic needs of children, placing them below parental needs, a lack of parental control or routine and an unwillingness to engage with support services. Thus, from a practitioner perspective the focus of PCAs are centred on the needs of the child which supersede those of parents.

However, this does not account for the fact that not only does the child grow and develop in the context of the family, but so do parents (White, 2005, p.14) and in order for them to have the capacity to parent consideration of their needs is warranted. Gopfert et al. (2004a) dispute the emphasis placed on the child's needs above those of the parent arguing that any commitment to the parent-child relationship must include a commitment to the welfare of *both* child and parent (p. 94). They argue that parental capacity must be established within 'each [individual] instance' (p. 96), and posit that the needs of the parent are of great significance in terms of the care provided to children so should not be minimalised, but rather considered as equal.

Section 3.4 Parenting and Child Outcomes

Research indicates that prominent influences on child development include parenting style, the parent-child relationship and the home environment (Bornstein et al., 2006, Kochanska et al., 2008). Parents are largely considered key agents in the trajectory of their children's social and emotional well-being. The following section will consider outcomes for children reflecting on the literature on the three aforementioned factors.

Section 3.4.1 Parenting Style

Research consistently identifies that the most conducive parenting style for positive child well-being outcomes is that which is characterised by responsiveness, warmth, and support (Belsky, 2005). As seen previously, authoritative parenting is thought to lead to more positive outcomes, including secure emotional attachments, good peer relations, increased self-esteem, subjective well-being and higher academic performance (Chan and Koo, 2011, Ladd and Petit, 2002). Whereas authoritarian and permissive parenting styles are thought to be associated with a range of negative outcomes, including reduced social competence, increased aggression, higher rates of depression and anti-social behaviours (Steinberg and Silk, 2002).

However, a meta-analysis on parenting and anti-social behaviour carried out by Hoeve et al. (2009) highlights a dearth of research looking specifically at parenting style or the combination of support and control in relation to anti-social behaviour. Instead research has focused primarily on individual parenting behaviours or parenting dimensions. More recently, Yap et al. (2014) carried out a systematic review looking at the association between parental factors, depression and anxiety in young people (12-18 years), concluding that authoritarian parenting styles predicted higher levels of depression in young people, with no effect size calculated for anxiety. Interestingly, with regards to authoritative parenting the findings were inconclusive due to a lack of research, thus again no effect size was calculable. Thus, evidentiary gaps in the literature remain and Chan and Koo (2011) caution that with regards drawing conclusion or making causal interpretations about child outcomes and parenting style much remains to be answered.

Section 3.4.2 Parent-Child Relationship

The quality of the parent-child relationship and how this is communicated is crucially important to children's well-being, including their: self-regulation and behaviour, engagement, participation, mental health, social competence, academic achievement and the ability to develop and sustain relationships over the lifespan (Grimes et al., 2004, Chan and Koo,

2011). However, most of this research focuses on parental self-reports of the relationship (Smith, 2011). Russell (2011, p. 344) asserts that research seeking to claim effects of parent-child relationships on outcomes for children must take account of 'bidirectional influence processes as well as contemporaneous and overtime influences in both direction in a transactional and circular causal process' (Laible and Thompson, 2007, Bornstein et al., 2006, Pettit and Arsiwalla, 2008). Thus, the perspective of children is required to understand parenting within the context that it occurs. As noted by Madge and Willmott (2007, p. 3) 'How children see parents and the parental role is an essential starting point for understanding parenting from young people's point of view'.

Section 3.4.3 Parenting and the Home Environment

A range of factors can facilitate or detract from an individual's capability and competence to parent. Darling and Steinberg (1993, p. 487) contend that parenting depends on the 'social milieu in which the family is embedded'. Parke and Buriel (1998, p. 109) describe families as:

units [that] change across development in response to changes in the individual members, life circumstances, and scheduled and unscheduled transitions

Thus, parenting must change along with changes in the development of the parent and child, their relationships and environments. Solem (2013, p. 62) asserts that:

a contextual understanding of parenting requires a focus on the parental environment and day to day life and recognition of the different ways parents' social and material conditions influences their parenting.

Solem emphasises the need to move from a conceptualisation of parenting defined by 'a difficult child', to that of parenting defined by 'a difficult child-rearing situation' (ibid, p. 62). She argues this creates an understanding of parenting which is situated and situation-specific, and considerate of factors such as family structure, socio-economic status and culture.

Section 3.4.4 Parenting and Family Structure

The family and thus parenting for the development of children requires consideration of how the structuring and/or restructuring of a family can have a bearing on parenting and children's development (Demo and Acock, 1996). A UK study suggests that family structure has a greater influence on parenting style than education and social class and was also most significant in terms of children's developmental outcomes (Chan and Koo, 2011). Research suggests that parents in single parent households are at increased risk of experiencing stress. Lehmann and Wirtz (2004) found that 80-90% of lone-parents in the European Union (EU) were mothers, majority of whom had experienced marital breakdown, frequent experiences of prejudice, stigma and personal doubt over their parental ability. Kavanaugh et al. (2006) report that single mothers are more likely to experience depressive symptoms, which in turn impacts on parenting behaviours and in turn increase the likelihood of mental and behavioural difficulties in children (Strohschein, 2005).

Section 3.4.5 Parenting and Stress

A study by Deater-Deckard (2004) found evidence suggesting that stress affects a parent's mental health and in turn the quality of their parenting. They define parenting stress as 'a set of processes that lead to aversive psychological and physiological reactions arising from attempts to adapt to the demands of parenthood' (p. 6). Several longitudinal studies suggest that a negative increase in parental mental health is associated with reduced parenting capacity and increased negative behaviours in parents (Wilson and Durbin, 2010, Waylen and Stewart-Brown, 2010). A recent study by Ajilchi et al. (2013) found a significant relationship between the parenting styles of overstressed mothers and their children's self-esteem ratings. Research suggests that children who are exposed to increased stress show poorer outcomes on a number of well-being domains.

Section 3.4.6 Parenting, Class and Socio-Economic Status (SES)

The role of socio-economic status and parenting has long been

debated in the literature. Furstenberg et al. (1999) found that an authoritarian approach to parenting was more likely to be the dominant parenting style in lower socio-economic status families. They suggest that this is as a result of an adaptation to their environmental conditions, in response to increased danger in their environment. In support of this Hoff et al. (2002) found that parents in families of low socio-economic status displayed an authoritarian parenting styles characterized by more punitive interaction than families with higher socio-economic status, who are thought to parent more democratically. Arguing that education, occupation and financial factors all contributed to socio-economic status differences in the circumstances and characteristics of parents, with educational factors appearing to account for most of the variance.

Section 3.4.7 Parenting and Culture

Parenting occurs within a cultural context and is comprised of differing beliefs and value systems within individual family contexts (Roschelle, 1997, Le et al., 2008, Bornstein, 2012). Research highlights that parenting practices vary cross-culturally with different interpretations of what is considered as good or appropriate and inappropriate parenting across diverse ethnic groups (World Health Organisation, WHO and the International Society for the Prevention of Child Abuse and Neglect, ISPCAN, 2006, Azar and Cote, 2002). Phoenix and Husain (2007, p. 8) found that differences in the parenting of minority ethnic groups and the outcomes of children are often interpreted as ‘deficiencies or deviations from the norm’. Bornstein and Lansford (2010) found evidence supporting cross-cultural distinctions in parenting practices, suggesting that Eastern cultures adopt practices that promote interdependence and family orientation in contrast to Western cultures, whereby parents seek to promote independence in their children.

Section 3.4.8 Parenting and Gender

The role of gender is an important factor when considering parenting roles and is thought to be linked to traditional gender norms and expectations

present in society. Gender roles are beliefs about the ways individual, familial, community and societal roles are defined by gender (Slavkin and Stright, 2000). The role of fathers within families is historically and socially linked to their role as bread-winners and providing economic support they are also largely considered to be play-mates to children. Alternatively, the role of women has been largely based on the provision of emotional support and nurturance (Bernard, 1981, Thompson and Walker, 1989). These different parental roles lead to different patterns of interaction between parents and their children (Lamb, 1977). On average, mothers spend more time taking care of children than fathers, however, in recent decades Western societies have seen an increased role of father involvement with children, although research still suggests that mother's remain primarily responsible for childcare (Lamb, 2004, Craig, 2006).

Research suggests that maternal parenting styles are a more significant factor in relation to child outcomes than paternal styles (Simons and Conger, 2007). Research also suggests that mothers and fathers may interact differently with their children depending on the child's gender (Larson and Richards, 1994). Research in Ireland found that child's gender did not appear to affect a mother's use of authoritative parenting style, but that fathers were more likely to use this parenting style with boys than girls. Fathers were also more likely to adopt an authoritarian style with boys than girls (Williams, 2011). Mothers are thought to have a greater impact on the outcomes of daughter's than son's (Milevsky, Schlecter, Klem and Kehl, 2008). However, research also suggests that fathers are more likely to treat their sons and daughters differently to mothers, and are more likely to encourage boys autonomy and individuality, be more disciplinarian and directive, and more reactive to signs of atypical gender behaviours (Music, 2011).

Research suggests that the quality of the father-child relationship is more likely to be associated with the quality of the marital-relationship and level of marital support (Parke, 2002). This has come to be known as the 'fathering vulnerability hypothesis' (Cummings et al., 2010, cited in Lamb, 2010, p. 157), whereby marital conflict is more likely to impact on both the

quality and quantity of father-child interaction (Lindsey, Caldera and Tankersley, 2009; Christensen and Heavey, 1990). Mothers are considered as the 'gatekeeper's' to father's involvement (Schoppe-Sullivan, Brown, Cannon, Mangelsdorf and Sokolowski, 2008), and when encouraged and the parental relationship is positive, father's involvement is can play a significant role in child outcomes (Flouri, 2005). Children whose fathers are less involved may experience poorer outcomes in terms of educational achievement, increased anti-social behaviour in boys and increased likelihood of early pregnancy in girls (*ibid*, 2005). Whereas, children whose fathers are highly involved are less likely to experience depression or anxiety, get involved in anti-social behaviour and show an increased likelihood of higher self-esteem (Dubowitz, et al., 2001). Further research is required as the role of fathers remain largely under-represented in studies of child developmental outcomes (Phares, Field, Kamboukosand Lopez, 2005).

Section 3.5 What Children Say About Parenting?

As stated previously children's experiences and perspectives on parenting are essential to our understanding of parenting, yet have received little attention. Nixon (2012) posits that children consider parenting as a multidimensional role with fluctuating levels of dependency. From children's perspectives these roles include, providing sustenance, protection, emotional and financial support, monitoring and regulating children's behaviour, sharing activities, guiding, teaching and facilitating children's independence and autonomy. Children viewed these roles as fluctuating, with older children attributing greater relevance to the role of parents in guiding them, providing emotional support and boundary setting. While younger children identified the parental role as primarily concerned with practical matters such as protection and provision of basic care.

Research suggests that children do not have a fixed idea of a family (Anyan and Pryor, 2002, Rigg and Pryor, 2006). Nixon et al. (2006) found that the manner in which members of a family loved and cared for each other

were defining features of children's conceptualisations. Brannen et al. (2000) found that children reported parental love, emotional security and affective support as the most important things about being part of a family. Similar findings are reported by Choudhury and Fahmida Jabeen (2008) again emphasising children's self-identified need for love and emotional support through the parent-child relationship alongside open communication. However, research further found that, in general, boys perceived parents as lacking the patience to listen to them, lacking an understanding of the issue at hand or resorting to lecturing or criticising what they said (Choudhury and Fahmida Jabeen, 2008). Findings also suggest that as adolescents, children perceived parents as not generally expressing love through physical affection. This research further explored children's perspectives on 'bad' parenting behaviours, which included: parental/domestic violence, alcohol abuse, physical or humiliating punishment and parental infidelity (Choudhury and Fahmida Jabeen, 2008, p.17-18).

Despite a lack of consensus on how children conceptualise their family, research shows that children clearly distinguish between the roles of mother and father (Alanen and Mayall, 2001); however, they do view them as interchangeable and equally important (Brannen et al., 2000, Nixon, 2012). Supported by Langford et al. (2001) who found differences in how children perceived their relationships with their mother and father. By and large fathers were presented as the disciplinarians and breadwinners of the families, while mothers were often characterised by childcare and home maintenance with children reporting higher emotional closeness to mothers (Choudhury and Fahmida Jabeen, 2008) supporting the view of mothers as emotional gatekeepers of families (Denham et al., 2007). Children also clearly distinguish between childhood and parenthood, with regard to dependency, responsibility, rights and fun. Children conceded the difficulties that parents faced in terms of responsibility and enduring obligation to care and protect children, and by and large acknowledged their parents' rights to monitor, control and discipline.

Section 3.6 Parenting with a Mental Health Difficulty

The previous sections above reflected on parenting in its generic sense however, it is largely acknowledged that parent's with a mental health difficulty face a wider spectrum of challenges than their mentally well counterparts as they contend simultaneously with their diagnosis, symptoms and with the natural stresses inherent in caring for and raising children (Ackerson, 2003, Reupert and Maybery, 2011). Falkov and Lindsey (2002, p. 8) state that:

the presence of a mental illness in a parent can adversely affect the way in which that parent accomplishes the tasks and responsibilities of parenthood and similarly the stresses of parenthood can precipitate or exacerbate mental ill health.

The extent to which parents struggle with their symptomology can depend greatly on the nature and severity of the mental health difficulty. However, when these factors are compounded by the social and environmental context, the cumulative effect for parents if unsupported can be detrimental for both parent and child.

Section 3.6.1 Causes and Challenges for Parents with a Mental Health Difficulty

All parents face challenges in carrying out their role, however for parents with mental health difficulties these challenges can be amplified (Solantus et al., 2015, Nicholson and Deveney, 2009). Commonly reported challenges facing parents with a mental health difficulty include their own experience of child maltreatment, poor partner/marital relationships, poverty and stigma (Oyserman et al., 2000, Huntsman, 2008, The Royal College of Psychiatrists, 2011).

Conservative estimates suggest that prior to age 18 at least one third of women and one-quarter of men will experience some form of sexual, physical or emotional maltreatment (Breslau, 2002) the consequences of which can be serious, persistent and enduring (Weichelt et al., 2005). Research suggests that individuals who have experienced such trauma are at increased risk of mental health difficulties (Bonoldi et al., 2013, Nock, 2009,

Bruffaerts et al., 2010). Relationship breakdown has been identified as an adverse social outcome of mental health difficulties (Butterworth and Rodgers, 2008) and is thought to have significant adverse effects on mental well-being (Amato, 1991). A common reported factor contributing to relationship breakdown is domestic violence which is considered a 'hidden epidemic' associated with a variety of mental health difficulties (Hegarty, 2011, p.169, Beydoun et al., 2012). A recent meta-analysis indicates that women who experience depressive disorders, anxiety disorders and PTSD are at an increased risk of experiencing adult lifetime partner violence compared to their mentally well counterparts (Trevillion et al., 2012).

Hudson (2005, p. 3) notes:

one of the most consistently replicated findings in the social sciences has been the negative relationship of socioeconomic status (SES) with mental illness. The lower the SES of an individual is, the higher is his or her risk of mental illness.

Rank (2011) identifies three facets of poverty that are considered to be contributory factors leading to reduced mental well-being: a lack of resources, the amplification of stress and the environmental context. Furthermore, several studies indicate a causal relationship between poverty and mental health difficulties, suggesting that families who were taken out of impoverished circumstances showed a reduction in mental health difficulties (Hudson, 2005, Leventhal and Brooks-Gunn, 2003, Costello et al., 2003).

Mental health difficulties rank as among the worst of all stigmatised conditions (Hinshaw, 2007). Goffman defines stigma as 'an attribute that is deeply discrediting and leaves a whole and usual person to a tainted discounted one' (Goffman, 1963, p.3). Watson and Eack (2011) identify mental health difficulties as 'one of the most discrediting labels' (p. 22) due to its link with several negative stereotypes including that they are less competent or more dangerous than their mentally well counterparts - one of society's most 'notorious myths' (Watson and Eack, 2011, p.24, Phelan, 2005, Steadman et al., 1998). These negative stereotypes are reflected historically and socially in how people with mental health difficulties have

been viewed by society (Corrigan et al., 2011).

More recent research suggests this may still be the prevailing sentiment towards mothers with mental health difficulties as they may be overrepresented in terms of child protection interventions and face an increased risk of entry into out of home care (Park et al., 2006, Hollingsworth, 2004, Mason and Miller, 2009, Kohl et al., 2011, Franzen et al., 2008). Thus, suggesting a heavy reliance on statutory intervention in response to such families. Aldridge (2008) suggests that such an approach is often unwarranted and posits that professionals' often assume an inevitability of risk and that this association is often made without speaking with children or their families.

Much of the literature in relation to parental mental health refers predominantly to mothers, with fathers in this context frequently overlooked (Stanley and Cox, 2009, p. 16). Research suggests that no consistent gender differences are evident in low-prevalence and severe mental health difficulties such as schizophrenia and bi-polar disorder. However, significant differences are consistently reported in high-prevalence mental health difficulties including depression and anxiety. Internalising mental health difficulties such as depression and anxiety are the most frequently encountered in women (Rosenfield, 2000; Piccinelli and Homen, 1997; Murray and Lopez, 1996). Evidence supporting gender bias and stereotyping for women who experience mental health difficulties have been reported since the 1970's (Broverman, Vogel and Broverman et al., 1972). Research also suggests that 48% of women are more likely to be prescribed and use medication for their mental health difficulties (Simoni-Wastila, 2000), however this may also be linked to men being less likely to seek support for difficulties experienced with their mental health (Oakley-Browne, Wells and Scott, 2006). More recently research exploring gender differences in the mental health of single parents (Collings, Jenkin, Carter and Signal, 2013) found that single mother's experience worse mental health than single father's and that socio-economic deprivation is a key contributor to this.

In summary, parents with a mental health difficulty often experience a range of challenges which can exacerbate their condition (Bifulco et al.,

2002, Dixon et al., 2005, Sidebotham et al., 2006). Mothers with a mental health difficulty are more likely to have experienced childhood sexual abuse, poverty, and domestic violence (McPherson et al., 2007, Royal College of Psychiatrists, 2002) and are more likely to experience social isolation, unemployment, and substance misuse difficulties (Mowbray et al., 2002, Caron et al., 1998). This reaffirms that the frequent co-existence of other family/environmental stressors combined with possible underlying trauma makes it difficult to measure the specific contribution of parental mental health difficulties to specific outcomes.

Section 3.7 Parenting with a Mental Health Difficulty and Child Outcomes

International research indicates that children who have a parent with a mental health difficulty are at increased risk of developing emotional, behavioural and mental health difficulties in later life (Hall, 2004, Mowbray et al., 2006). Children in this context are thought to represent one of the most important and prevalent populations at high psychiatric risk in society (Van Doesum et al., 2015, p.223). Falkov (2004, p. 55) states:

children whose parents are mentally ill live with the symptoms, behaviours and expressions of mental illness. They see it and feel it.

Although children in this context are not a homogenous group as risk exposure is not uniform and there are multiple influences on children's well-being outcomes, they do share some common needs (van Santvoort et al., 2015). A number of factors are thought to increase children's vulnerability when a parent has a mental health difficulty. These include the age of the child at the onset of the illness (Benjet et al., 2003); a higher temperamental risk (Rutter and Quinton, 1984) lack of supportive relationships (Beardslee et al., 1998b, Brennan et al., 2003) and poor coping skills (Langrock et al., 2002, Webb et al., 2005, Tebes et al., 2001, Beardslee et al., 2003). Duncan and Reder (2000) suggest that children can be affected by parental mental health difficulties in two ways: the primary manifestation of the illness; and the secondary social consequences, but that the mental health difficulty as such seems to be of less importance in its effect on children than in the quality of parenting (Bibou-Nikou, 2004).

Rutter and Quinton (1984) identified several risk factors significant to poorer outcomes common among children whose parents have a mental health difficulty, these include: single-parent households, separation, divorce, marital disharmony, admission to care, parental involvement in crime, large family size, overcrowding and low employment status and low educational attainment. As such it is largely considered that the greater the psycho-social disadvantage faced by a parent with a mental health difficulty, the greater risk of poorer outcomes for children. In terms of making any claims about outcomes for children, Kinard (1996) cautions that parental mental health difficulties may be but 'one factor in a complex matrix', where psycho-social difficulties are combined with increased life stress, poor social support and low self-esteem.

Parents with a mental health difficulty may have a number of factors impacting on their role as parent and patient. Duncan and Reder (2000) report several factors of parenting behaviour which may be impaired when a parent has a mental health difficulty: self-preoccupation, emotional unavailability, practical unavailability, frequent separations, threats of abandonment, unpredictable behaviour, parental irritability, distorted expectations of reality, strange behaviour/beliefs, dependency, self-blame, blaming the child, unsuccessful boundary setting, marital discord and social deterioration.

Parental mental health difficulties can interfere with a parent's ability to parent and can result in periods of parenting characterized by suboptimal supervision and structure, and a lack of consistency warmth and nurturance towards children. Cleaver et al. (2011) suggest parenting with a mental health difficulty can include insensitivity to children's needs, increased criticism and higher levels of expressed anger (Berg-Nielsen et al., 2002). Parents can struggle to express love and affection, while their ability to provide emotional support and a secure base for children to explore their environment can be impaired. In some situations a period of separation from the child due to hospitalisation may be required, which may significantly impact children's emotional development (Bowlby, 1977).

These factors contribute to what Anthony and McGinnis (1978) refer

to as *intermittent parenting*. Intermittent parenting manifests as a result of the intermittent and episodic nature of mental health difficulties, which can result in the sporadic availability of a parent in carrying out their role. Intermittent parenting can occur as a result of a symptomology, side effects of anti-psychotic interventions (Falkov, 1998) and periods of hospitalization. Studies suggest a significant correlation between parental mental health difficulties and poor attachment, with infants expressing anxious or avoidant attachment by age 2 (Hall, 2004). Research also suggests that fathers as well as mothers have a propensity for postnatal depression (Rachmandi et al., 2005), with children of depressed fathers' showing emotional and behavioural difficulties which are increased depending on children's gender with boys more likely to be affected than girls (Music, 2011). Depressed mothers are less likely to be emotionally available and affectionate (Hammen, 1991) and parents with schizophrenia may have unusual or inappropriate affective responses to their children (Nicholson and Miller, 2011). Research suggests that such emotional deprivation may contribute to long-term negative consequences for children (Smith, 2004).

Research reports significant challenges facing children including: understanding their parent's mental health difficulty, additional care giving responsibilities, emotional difficulties, poverty and poor social support networks (Fudge and Mason 2004, Gladstone et al., 2011, Mordoch and Hall, 2008). Moreover, these factors are complicated by the burden of negative attitudes, blame and stigma (Corrigan and Miller, 2004, Haug Fjone et al., 2009). Research indicates that children who live with a parent with a mental health difficulty are at an increased risk of challenges socially, emotionally and behaviourally, including higher rates of internalizing and externalizing behaviours (Ramchandani et al., 2005) increased rates of psychopathology as adolescents (Beardslee et al., 1998b) and continued and increased risk of psychopathology as an adult. While, Beardslee et al. (1998b) found that among adolescent children whose parents had a diagnosis of depression, 61% had developed a psychiatric disorder and 40-70% of those children had a dual-diagnosis of substance misuse, anxiety and dysthymia. Further studies report correlations between parental psychiatric disorder and increased anti-social

behaviour (Preski and Shelton, 2001) and between first time suicide attempts in adolescents aged 14-27 (Christofferson et al., 2003).

Research indicates that children who live with parent with a mental health difficulty frequently adopt a caring role, with numbers thought to be on the increase (Aldridge and Becker, 2003). A study in the UK suggests that 29% of young carers provide care for a family member with a mental health difficulty (Dearden and Becker, 2004, p.7). Of those receiving care from their children 50% were mothers and 43% were fathers. The extent of caring responsibilities was found to fluctuate rapidly pending on changes in their parent's symptomology. The primary form of self-reported care given by young carers in the UK was emotional support. A further study focusing specifically on the experiences of young carers of parents with mental health difficulties the *Young Carers Research Group* (Aldridge, 2006, p. 81) highlight the emotional care responsibilities children provide referred to as 'critical crisis support'. This support includes children reporting being there during difficult episodes experienced by parents including: self-harming, psychotic episodes, monitoring and assessing the emotional well-being of their parent and in some situations having responsibility for administering medication. Thus, highlighting the critical preventative role children undertake during these incidents (ibid, p. 82).

In light of the caring responsibilities children take on, some may have restricted opportunities for social networking and developing friendships (Bilsborrow, 1992). They may experience educational interference, and have limited opportunities for partaking in leisure activities (Aldridge, 2006). Research by Siskowski (2006) found that children in a caring role were less happy than their school counterparts, more depressed, had lower self-esteem and were more likely to leave home earlier. Experiences of childhood in this context may be quite different than those of other children.

Little is known of the numbers of children in Ireland who may be caring for a parent with a mental health difficulty. However a recent study of young carers in the Irish population indicate that 12% of participants were caring for a parent with a mental health difficulty (Fives et al., 2010). Thus, the research

would indicate that socially, emotionally and behaviourally children in this context are at a higher risk of poorer outcomes with significant immediate and long-term consequences.

A recent Norwegian study explored adolescents' experiences of everyday life while living with a parent with mental health difficulty via an on-line self-help group. This innovative study found that adolescents described their everyday life as profoundly influenced by their parent's illness, with many reporting difficult practical and emotional challenges. These challenges were categorised into five dominant subtopics including: a lack of information and openness; unpredictability and instability; fear; loneliness and loss and sorrow. Children in this study emphasised the need and importance of having access to information on their parent's mental health diagnosis to help them understand changes in their parent's mood and behaviour. They described feeling a sense of *invisibility* as a result of the lack of information provided within their family and by professionals (Trondsen, 2012, p.179) and viewed this as directly linked to their experiences of increased confusion and worry, which intensified difficult feelings alongside increasing their struggle to manage the practical and emotional consequences (Trondsen, 2012, p.183).

Young people also reported that the unpredictability of their parent's mood and behaviour impacted on the atmosphere of the family as a whole, and on their subjective well-being. Unpredictability and instability were reported as factors impinging on their ability to plan their daily lives and led to increased feelings of fear especially when parents had attempted to take their own life. In this context adolescents reported fear of finding suicide notes, searching for a suicidal parent, or visiting a parent in a mental health facility after the fact. Adolescents also expressed fear of heritability of the mental health difficulty highlighting their understanding of the genetic correlation of mental health difficulties. They also reported that overall they experienced a strained relationship and expressed feelings of ambivalence towards their parent.

Children's concern for the well-being of their parent when experiencing

a mental health difficulty is well reported (Knutsson-Medin et al., 2007). Children whose parents experience depression are sensitive to behavioural signs and cues in conversations with parents that inform them about their parent's well-being or distress (Pölkki et al., 2005). A study by Mordoch and Hall (2008, p. 1139) highlights the range and intensity of emotions experienced by children in this context. These include: joy, love, pride, sadness, worry, frustration, anger, guilt, fear, despair, anxiety, grief, hurt, discouragement, embarrassment, relief, hope and loathing. However, it must be remembered that the implications for children in this context are contingent on the interplay between the age of onset of the mental health difficulty, the temporal and episodic nature of the mental health difficulty, the developmental stage of the child, the child's temperament and the context within which parenting itself occurs (Leverton, 2003, Fudge, 2004).

Along with the widely reported negative implications that abound in the literature an alternative discourse has emerged. Darlington et al. (2005a) advocates that a mental health difficulty in a parent does not necessarily constitute a protective concern. Research indicates that children also report positive experiences, and can present with a high degree of overall competence on a number of well-being domains (Mowbray et al., 2006, Trondsen, 2012). Suggesting that contrary to popular belief many parents with mental health difficulties parent their children effectively and few adverse outcomes are experienced (Smith, 2004, Parrott et al., 2008). This may be linked to a parent's level of self-awareness as research also suggests that parents with mental health difficulties are aware of the difficulties their illness causes, acknowledging the impact to disruption of care and everyday life and how this might impact on their children, and many perceived their relationships with their child positively (Stallard et al., 2004). Children also report positive experiences and research reports that children may experience increased feelings of loyalty, caring, empathy, connectedness and increased maturity (Slade, 2006, Fonagy and Target, 2006).

Furthermore, despite the potential for difficulties in attachment with a parent with a mental health difficulty (McKinsey Crittenden et al., 2015) the presence of one mentally *well* parent can buffer a child from the consequences

of poor outcomes socially and emotionally. A stable home environment and a sense of being loved along with a positive parent-child relationship can be emotionally protective for children (Downey and Coyne, 1990). Positive social and emotional connections from within and outside the family can be effectively established and have a buffering effect for both parent and child (Lee, 2001, Gopfert et al., 2004b). Summarizing, Roy (1990) cautions that 'overall, the answer to the question of risk factors has to be viewed as very incomplete' (p. 120).

Despite children's exposure to a parent's mental health difficulty, more often than not they are excluded and ignored with regards their parent's care by professionals. This can be attributed to adults' perception that children are not capable of understanding the complex and multi-dimensional nature of mental health, or in light of their vulnerability that they should be protected from such concerns (Ueno and Kamibeppu, 2012). However, current research indicates that children indeed do show a clear conceptualisation of mental health difficulties and that with age this understanding becomes more sophisticated (Wahl, 2002). It is argued that children from a young age even as toddlers have the capacity to make sense of their parent's behaviours and as such any communication which alleviates their concerns or confusion and provides reassurance to children about their own and their parent's safety is critical (Reupert et al., 2015a).

A study by Roose and John (2003) found that children aged ten years old are able to differentiate between physical and mental illness and understand the complexities of mental health difficulties, identifying emotions, thoughts and behaviours as aspects of mental health. While Fox et al. (2008) found further support that as children get older they demonstrate more accurate and sophisticated thinking about mental health difficulties in all the areas moving from a 'medical conceptualisation to a comprehensive and detailed knowledge system' (Fox et al., 2008, p.16). This research found that children as young as six years of age held coherent explanatory ideas about the causes, consequences, curability and timeline of both mental and physical illness. The authors argue that children of all ages hold coherent conceptions of mental health difficulties, but that understanding them as an

ontologically distinct concept emerges at the end of middle childhood. Ultimately, this research supports that there is a clear progression of children's understanding of mental health difficulties with age (Fox et al., 2008).

Meadus and Johnson (2000) argue that children need appropriate information to facilitate their understanding of their parent's behaviour, and to make sense of their own experiences and how they cope with a parent's diagnosis. Research has found that children's misconceptions of parental mental health difficulties may indeed result in increased levels of distress (Marsh and Dickens, 1997, Garley et al., 1997). While Beardslee et al. (1998a) found that if children's anxieties about their parent's mental health are addressed and if facilitated in their understanding they will show improved mental health outcomes. In support, Mordoch and Hall (2008) found that children who are informed about their parent's mental health difficulties are better able to interpret their parent's behaviour as being indicators of their illness, which in turn contributed to less uncertainty and made painful memories less intense. While (Cooklin, 2013) argues that assisting children through explanatory discussions can help children obtain some distance from their parent's emotional expressions and help them develop their own thinking. Furthermore, in supporting parents to discuss their mental health difficulties with parents is thought to have an empowering function for parents by acknowledging the critical role they hold within the family setting (Marston et al., 2014). Despite these findings, research highlights that children of parents with a mental health difficulties receive few factual explanations which results in unnecessary hardship for them (Mordoch, 2010, Maybery and Reupert, 2009, Grove et al., 2015).

Section 3.8 Supporting Generic Parenting

Supporting parents in their role as parents is now considered an important factor and a core feature of policies relating to child well-being outcomes. Children benefit from effective parenting from birth across the lifespan (Gillen et al., 2013, p.4). Parenting support is a broad term usually considered under the umbrella of 'family support' and is defined as 'a range

of information, support, education, training and counselling and other measures of services that focus on influencing how parents understand and carry out their parenting role' (Daly, 2012, p.1). Humphreys (2004) argues that parenting is not something that is intrinsic to individuals, but requires acquiring a highly refined and intricate range of skills. Despite this position, Sanders et al. (2003, p. 2) note that:

parents generally receive little preparation beyond the experience of having been parented themselves, with most learning on the job, through trial and error.

Parenting support in Ireland is viewed under the wider concept of family support and its function has been laid out in the Parenting Strategy which supports parents through the provision of information, advice and assistance. In doing so the strategy seeks to support parents with the 'upbringing of their children in order to maximise their child's potential' (Gillen et al., 2013, p.1). A further discussion of the policy and legislative context for parenting in Ireland is presented in Chapter 4.

Section 3.8.1 Generic Parenting Support Programmes

A common means of supporting parents in a formal capacity is through the provision of parenting programmes, underpinned by the basic assumption of a 'parenting skill deficit' (Barlow and Stewart-Brown, 2000, p.358). Parenting programmes have been defined as:

focused short-term interventions, which are typically aimed at helping parents to deal with their children's emotional and behavioural development (Barlow et al., 2004, p.34)

A range of universal parenting programmes now exists to enable parents acquire competencies in order to effectively manage children's behaviour, and learn to respond in a new way.

Barlow and Stewart-Brown (2000) propose differing types of parenting programmes namely: relationship or behavioural or a combination of both (p. 357). The theoretical perspectives underpinning such programmes include: Adlerian, behavioural and family systems theories, to name but a few. Programmes based on Adlerian theories emphasise the need for parents

to understand children, how they think and the motivations behind their actions. While behavioural parenting programmes, stem from social learning theories and focus on the problem behaviours of children, which parents are enabled to manage by implementing a range of reinforcement and modelling techniques (Furlong et al., 2012). These programmes are commonly used as a means of intervening in child behavioural difficulties (Hutchings et al., 2007, Asa Kling et al., 2010). Programmes founded in family systems theory seek to enable parents in understanding their own behaviour and the behaviour of others in the family and how this contributes to children's problem behaviour. A systemic perspective places an understanding of the child's behaviour in the context of their relationships in the home, school and wider community (Smith, 1996).

Evidence suggests that group based parenting programmes are a cost effective way to improve parenting, parental mental health and the mental and behavioural well-being of children (Barlow et al., 2004, Richardson and Joughin, 2002, Patterson et al., 2002, Dretzke et al., 2005, Lindsay and Strand, 2013). These programmes suggest improvements in children's adjustment but also short-term improvements in the psycho-social health of mothers, including reductions in anxiety and depression and improved self-esteem (Barlow et al., 2002).

Furlong et al. (2012) reviewed behavioural and cognitive-behavioural group based parenting programmes for early onset conduct problems in children aged 3-12 years. The aim was to assess the effectiveness and cost-effectiveness of such programmes in improving child behavioural difficulties, parental mental health and parenting skills. Overall, this review found that in both independent and parental, post-parenting programme reports, although moderate, statistically significant results were found in relation to reduced child conduct difficulties, decreased parental mental health difficulty including anxiety, stress and depression, improved positive parenting skills (play, reward and praise), and a reduction in negative or harsher parenting practices. Moreover, the cost-effectiveness of these programmes was also demonstrated.

Lindsay and Strand (2013) evaluated four parenting programmes for parents of children aged 8-13 years, being implemented in the UK between 2008 and 2011. Programmes were specifically targeted at families where concerns already exist that children were at risk of developing social, emotional and behavioural difficulties. Three parenting programmes including; *The Triple P1*, *Strengthening Families*, *Strengthening Communities* and *Incredible Years Parenting Programmes* were evaluated with regards to parenting style, parental mental well-being and child behaviour across three different time points. All programmes reported similar levels of effectiveness across the three variables of interest, although the *Strengthening Families, Strengthening Communities Programme* showed lesser effects than the other two. A fourth programme was included in this evaluation: *Strengthening Families Programme 10-14*. Post-programme evaluations found similar effectiveness to the other three programmes across all three variables. Moreover, parents' ratings one year post follow up indicated that improvements were maintained, although small reductions were noted at follow-up in comparison to scores immediately following course completion. Child improvements were maintained completely, with the *Triple P Programme* showing significantly greater effects in improving problematic conduct behaviour in children than all other programmes. Support for the *Triple P Parenting Programme* has been evidenced in the context of Ireland, whereby statistically significant improvements were found in both child and parent outcomes (Fives et al., 2014).

A recent systematic review of group based parenting programmes was carried out by Bennett et al. (2013). This review following that of Barlow et al. (2002) sought to establish the effectiveness of group based parenting programs on improving parent psychosocial health including: symptoms of anxiety and depression, parental self-esteem and parental relationship. Programs included were distinguished as either behavioural (e.g. *Triple P Parenting Program*), cognitive behavioural (e.g. *The Incredible Years*) or multi-modal (e.g. *The Systematic Training for Effective Parenting (STEP) Program*). Outcomes were measured using a range of standardised instruments across three follow-up time points: one month, two to six months,

and six plus months. Findings from this study support those of Furlong et al. (2012) in that parenting programs were immediately effective in producing statistically significant improvements in parental depression, anxiety, stress, anger, guilt, confidence and satisfaction with relationship with partner. However, reported effects appear to be short-term. The authors suggest this decline may be resultant from parents requiring additional supports to maintain effects. It may also suggest that parents rapidly require new skills, information and support to correspond with the speed at which their child and environment can change and develop, which supports the need for parental adaptability.

Research suggests that the effect of parenting programmes are mediated by specific parental processes including parental warmth, authoritative parenting (Cowan et al., 2005) effective and consistent discipline (Bernat et al., 2007) and good family communication and problem solving (DeGarmo et al., 2009, Brody et al., 2008). Research also suggests that socio-economic disadvantage can have a moderating impact on programme outcomes (Lundahl et al., 2006, Reyno and McGrath, 2006). However, Gardner et al. (2006) found evidence of positive outcomes for all parents, regardless of socio-economic status if specific parenting programmes are implemented. Furlong et al. (2012) also found evidence supporting this, along with evidence of programme effectiveness regardless of trial setting or severity of conduct difficulties at baseline, while implementation fidelity was of importance to a programme's clinical effectiveness (Furlong et al., 2012, p.37). Sandler et al. (2011) highlight that through targeting specific parenting processes, long-term improvements in children's outcomes, including internalising behaviour can be seen.

However, the long-term effectiveness of such programmes remains unclear. Thus, Bennett et al. (2013) point to the need for caution in interpreting findings from such meta-analysis, as all outcome measures were based on parental self-reports whilst there was also evidence of statistically significant heterogeneity these factors raise questions about finding reliability, as much of the evidence base supporting the effectiveness of parenting programmes stem from randomized control trials (RCT's).

Although, RCT's are considered the *gold standard* in research it does not facilitate subjective experiences.

Dixon-Woods and Fitzpatrick (2001) highlight the importance that evidence based practice should not be confined to randomised trials but rather should also incorporate qualitative perspectives. In response, Kane et al. (2007, p. 784) adopted a meta-ethnographic approach to understand the more subjective side of the effectiveness of parenting programmes in attempting to understand what parents found meaningful and helpful. In doing so they hoped to highlight the subjective values of such programmes in order to 'sensitize policymakers and practitioners'. Only research examining parenting programmes for children with behavioural difficulties were included in this study. Figure 3.1 illustrates the core components of parenting programmes that parents viewed as important.

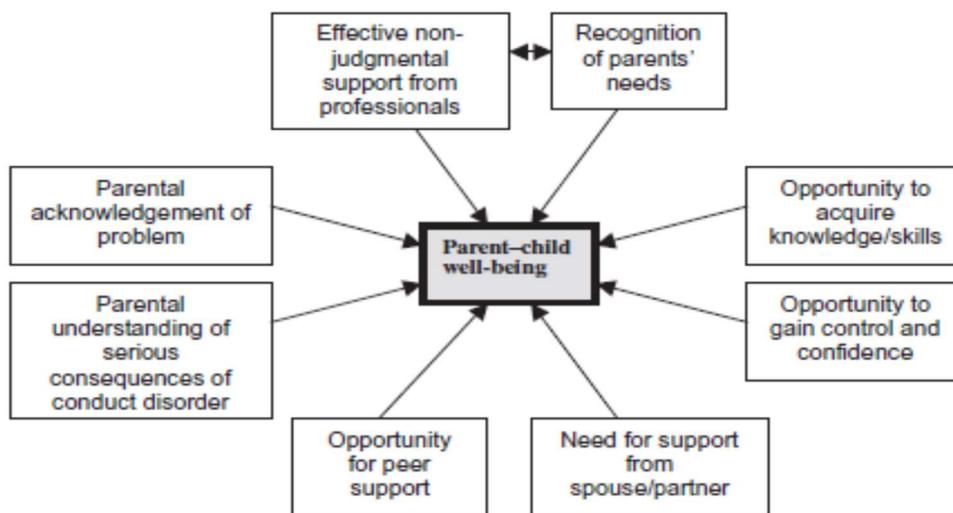


Figure 3.1: Parental Perceptions of Core Aspects Required for Effective Parenting Programmes (Kane et al., 2007)

The above offers a framework of key components valued by parents in parenting programmes. It highlights key factors for consideration in efforts to engage parents in parenting programmes. It highlights the need for parents to be recognized in their role as parents in a non-judgmental and supportive manner. It identifies the supportive influences parents value from partners, peers and professionals. Parents identify the need to acquire knowledge and

skills in order to manage children's behaviour and to increase their sense of confidence and control in their roles as parents. All of this must be considered in light of a parents acknowledgement of the problem and have an understanding of the consequences of children's conduct and behavioural difficulties.

As evidenced previously a parents ability to acknowledge that there was a problem was a significant factor reported along with a parents understanding of a child's behavioural expression (Moran, 2004). Thus, Kane et al. (2007) recommend programmes that seek to facilitate the development of knowledge and skills regarding behaviour management alongside promoting a parent's sense of confidence and control. While parents reported the importance of having their own needs recognised along with feeling supported by professionals in a non-judgmental way. The role of peer support was also significant (for mothers) alongside support from their partners. Overall the authors concluded that parents perceived the programmes as important towards aiding:

the acquisition of knowledge, skills and understanding, and together with feelings of acceptance and support from other parents in the parenting group, enabled them to regain control and feel more able to cope. This led to a reduction in feelings of guilt social isolation, increased empathy with their children and confidence in dealing with their behaviours. (Kane et al., 2007, p.791).

Despite a plethora of generic parenting programmes available for parents and children that focus on children's behavioural difficulties or are focused on generic health promotion initiatives, such programmes fail to address the specific needs of parents with mental health difficulties (Craig, 2004, Reupert and Maybery, 2011).

Section 3.9 What Supports Do Parents with a Mental Health Difficulty and their Children Need?

In terms of supporting parents with a mental health difficulty, parenting programmes in existence have tended to focus on supporting parents with children from birth to age 5 (Steele et al., 2010) with few programmes available for parents with older children (Reupert and Maybery, 2011, p.257). This seems to contradict research and policy initiatives which

seek to promote child well-being in the context of parental mental health difficulties. Findings suggest that mothers with a serious mental health difficulty have significantly less adequate parenting skills than others in the community (Oyserman et al., 2000). In spite of this a significant gap in the research has been identified in the lack of support programmes for the families deemed to be high risk i.e. where a parent has a mental health difficulty leading to urgent calls for the development and evaluation of effective programmes for this group (Stewart-Brown and Schrader-McMillan, 2011).

Studies indicate that parents with mental health difficulty are aware of the potentially negative impact of their health status on their children. A descriptive study by Stallard et al. (2004, p. 42) found that 21 out of 24 participating parents felt that their illness had an effect on their children, with more than 50% reporting that their child worried 'a lot' about then becoming ill. Over half of the parents in this study felt it would be helpful if their child knew more about their illness and were explicitly concerned that children felt no responsibility for their illness and that they as parents could not help their behaviour or prescribed treatment (i.e. medication or hospitalization). However, this study also highlights that there must be a balance of information provision so as not to unnecessarily burden children with unwanted information. Overall, parents in this study reported positive relationships with their children; however, the perspectives of children were not included so it is unclear whether this would be corroborated.

A study by Cowling (2004, p. 87) found that parents who had a mental health difficulty wanted to be acknowledged as parents over patients and for service providers to acknowledge their family relationships and responsibilities. Parents further reported feeling increased support when they felt the needs of their children were addressed by professionals. Research further indicates that parents with mental health difficulty want increased understanding and support in caring for and raising their children, alongside good quality services to meet their children's needs and access to parent support groups with on-going support from services following a crisis (Diggins, 2011, p.9).

While research reports that children when asked have consistently identified the following as helpful to their situation: firstly, they need more information about their parent's illness (Bilsborrow, 2015, Maybery et al., 2005, Fudge and Mason, 2004). Secondly, they need to be informed and consulted by professionals and need to be informed about what is going to happen (Bilsborrow, 2015, Cooklin, 2006, Aldridge, 2006). They also need someone to talk to (Bilsborrow, 2015, Maybery et al., 2005, Fudge and Mason 2004) and help with practical issues (Maybery et al., 2005). The most significant and recurring theme reported by children with regard to professional involvement with their parent was that they did not want to be ignored (Bilsborrow, 2015). In terms of supports for children, similarities are evident in the requests/perceptions of both children and their parents. Both agree it would be helpful for children to have someone they can trust to talk to about their concerns and to answer their questions. They want to be provided with information and a safe space for discussing their parent's mental health difficulty. Thirdly they report wanting to have opportunities to meet and engage with other children who may also share this experience (Diggins, 2011, p.9).

Section 3.9.1 What Works For Parents with a Mental Health Difficulty in Terms of Parenting?

Challenges emerge not just for the individual but also for professionals involved in trying to balance the role and well-being of parent, patient and child. So what works in supporting parents in their role as parent and patient in order to increase the likelihood of a positive trajectory for children's outcomes? Falkov (2012) proposes a *Family Model* as a conceptual framework for understanding the interrelated and bi-directional nature of the mental health and well-being of parent and child. Figure 3.2 illustrates this family model.

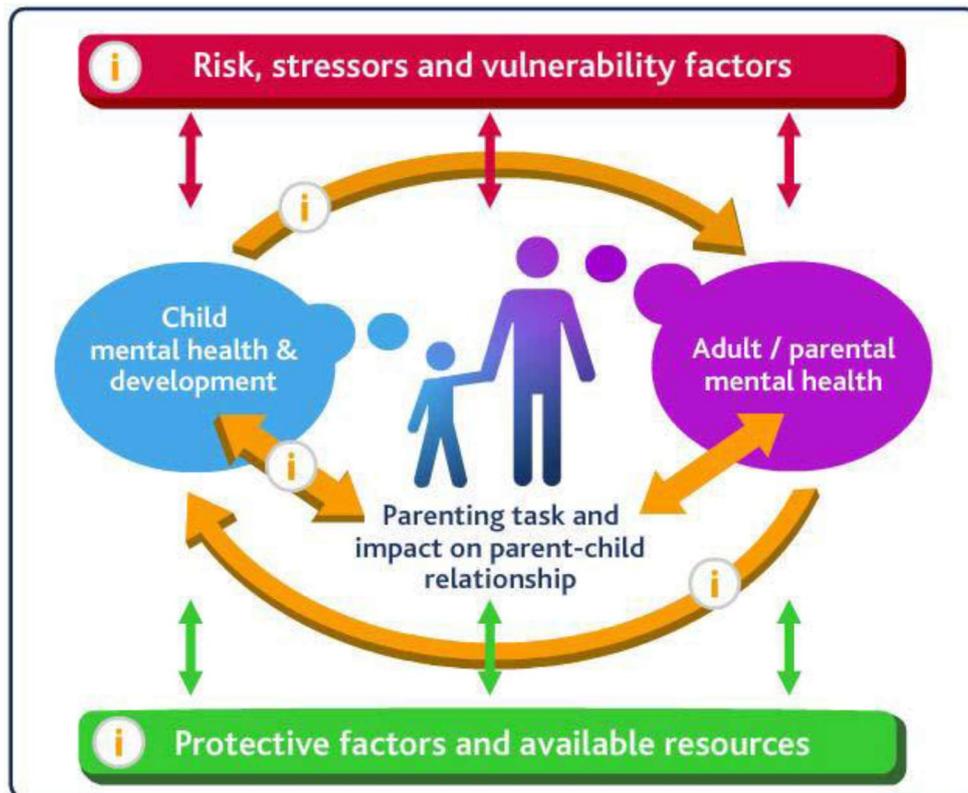


Figure 3.2: *Crossing Bridges The Family Model* (Falkov, 1998, 2012)

The *Family Model* is a developmental model that provides an integrated approach to supporting families where a parent has a mental illness. It provides a framework for mental health services to consider when responding to the needs of such families. The model provides a broad life-span approach and focuses primarily on the interactional relationships between parent and child inclusive of other interrelationships between multiple individuals and factors thought to influence parent, child and mental health (Reupert et al., 2015b, p.8). It focuses on six interrelated domains including: parent to child influence, child to parent influence, childhood to adulthood family life-span influence, closer environment to family influence, service to family influence and a broader environment to family influence. The aim of the model is to allow services an insight and understanding into how parental mental health difficulties can affect children, alongside the fact that mental health difficulties can affect parents, parenting and the parent-child relationship. Moreover, it highlights that the difficulties of being a parent can precipitate, exacerbate or influence the mental health difficulty and

that the developmental needs and mental health of children can in turn impact on a parents mental health (Falkov, 2012, p.12).

In a similar vein, Gopfert et al. (2011) propose the notion of the *Family Interest Principle*. They suggest, when it is a case of a parent with a mental health difficulty, the divisive notion of ‘best interest of the child’ or ‘best interest of the patient’ be discarded and for the focus instead to be placed on the ‘best interests of the family unit’. Through the *Family Interest Principle* it is argued that:

as long as the family unit including any parent-child relationship is viable, any individual’s needs and best interests are to a significant degree constituted by the interests of the family as a whole, and so individual welfare needs will mainly be met by supporting the viability of the family as a whole (Gopfert et al., 2011, p.63).

The principle recognizes the fact that the whole of the family is more than the sum of its constituent parts, and is also inclusive of and values the perspectives of children, with the crucial proviso that the relational unit is *viable*. Smith (2004) supports the concept proposed by Gopfert in that she advocates for ‘supporting parents in the context of supporting the family as a whole’ (Somers, 2007, p.1329). In spite of this research suggests that the most common parenting support service in mental health services is referral to another agency (Hilton and Turan, 2014).

Little is known of the effectiveness of structured interventions or support programs for children living in this context. Until recently what little evaluation did exist faced criticism for weak methodological grounding (Fraser et al., 2006). More recently, Reupert et al. (2012) provided a comprehensive review of intervention programmes for children between the ages of 5-18, whose parents have a mental health difficulty (excluding parents with a substance misuse difficulty). Data was collected from Australia, Europe and North America and were grouped under the following four headings: family interventions, peer-support, on-line interventions and bibliotherapy.

The two most common types were Family Interventions and Peer support programs. In general, family interventions were targeted at reducing

family dysfunction and maximizing the support networks of children and their individual competencies. Family interventions were targeted at families whereby parents had an affective disorder and were founded primarily in psychoeducational and cognitive behavioural approaches. Duration of programs ranged from 2 to 20 sessions; however, it is not clear whether the intensity of delivery contributes to program effectiveness. The most prominent of these programs is the Family Talk programme (2003; 2007) developed in the USA targeting families with parental affective disorders. The programme adopts a cognitive psychoeducational approach designed to increase parental focus on children, increase children's understanding of parental depression with the aim of reducing depressive symptoms in children. Through a strength-based approach family members are invited to discuss the effects of parental depression on family members. It incorporates both individual and family meeting sessions with parents and children. Longitudinal studies have found long-term benefits for both parents and children (Beardslee et al., 2003, Beardslee et al., 2007) and it has been adapted across many populations (D'Angelo et al., 2009, Beardslee et al., 2010). Many of these family based programmes have been evaluated through an RCT design and initial findings for family interventions suggest promising results in terms of children's outcomes (Ginsburg, 2009, Beardslee et al., 2003, Compas et al., 2011, Buhler et al., 2011, Valdez et al., 2013, Solantaus et al., 2010).

A total of twelve Peer support programs were identified which sought to increase children's understanding about mental health difficulties, enhance their coping strategies and facilitate the development of peer relationships (Reupert et al., 2012). Most programmes adopt a group, strengths-based preventative approach and are delivered as after-school programmes, school holiday programmes or camps. Although many of these programmes have been evaluated, methods of evaluation have been criticized for not using valid outcome measures or the use of control groups (Reupert et al., 2012, p.21). Moreover, some concern has been raised identifying potential risks to children engaging in peer support programmes for exposure to difficult

information about mental illness and limiting the peer support network to those attending the programme (Hargreaves et al., 2008).

Reupert et al. (2012) suggest that increased evaluations are required, based on rigorous methodological designs and incorporating validated measures of child outcomes. Moreover, they argue that evaluations must be cognizant of the context and the community setting within which programs are delivered and sensitive to a diversity of mental health difficulties and the individual experience of each child. Although the preliminary findings are useful they must be interpreted with caution as no longitudinal data is available for either family or peer support interventions. Despite limited evaluations using valid outcomes measures initial support for the use of peer programmes is promising with many reporting improvements in children's self-esteem (Goodyear et al., 2009) confidence (Hayman, 2009) prosocial behaviour and mental health literacy (Fraser et al., 2008, Morson et al., 2009) and improved coping strategies (Goodyear et al., 2009).

Section 3.10 Chapter Summary

Despite there being no clearly defined concept of *parent* or *parenting*, contributions from a range of disciplines and theoretical approaches show by and large the constructed nature of parenting as fluid and changeable, and as inseparable from the temporal, socio-political, socio-economic, environmental and relational contexts within which it occurs. It occurs within the bi-directional relationship between parent and child and the wider environment, and plays a crucial role in child well-being and well-becoming. Factors impacting on parenting include: parenting style, family structure, stress, socio-economic status and culture. Despite the significant contributions made by Baumrind's *parenting trait framework*, several limitations have been noted, including an inability to clearly categorise a parent, within a singular type of parenting style. Moreover, it fails to consider the role of fathers in terms of parenting and child outcomes. Thirdly it fails to account for child effects when considering the determinants of parental behaviour (Kerr et al., 2003). Finally, this framework does not consider the malleability of parenting across differing contexts and time.

However, despite its limitations this theory of parenting has made a significant contribution to our understanding of well-being outcomes for children. Significant evidence has accumulated highlighting that the parent-child relationship is crucial to both the well-being of parent and child (Booth et al., 2003). Research by and large suggests that a warm, supportive and emphatic relationships and an authoritative style of parenting as presenting the greatest likelihood for positive child outcomes (Chan and Koo, 2011). While, poor quality parenting is considered a precursor to a range of poorer outcomes for children (Farrington and Welsh, 2007, Odgers et al., 2008). However, the literature notes disparities in parental and child reports on a range of factors particularly in relation to parenting style. Cohen and Rice (1997) report little congruence between child and parental reports regarding parenting style, highlighting difficulties in determining which perspective is most accurate. More research is required exploring children's perspectives as this will greatly increase understanding of parenting process and children's experiences of them.

Parenting is a role filled with challenges as parents try to adapt to their children's needs. This task is thought to be made more complex if a parent has a mental health difficulty. Mental health difficulties can significantly compound a parent's ability to carry out their role. Children in this context are by and large thought to be at increased risk of social, emotional and behavioural difficulties which can persist across the lifespan. Despite a significant amount of research reporting outcomes for children in this context, much of this is from an adult perspective with little known of the subjective experiences of children themselves (Leverson, 2003). There have been calls for qualitative studies to include children as valid informants about their everyday social processes, various contexts, interactions and incidental events experienced (Backett-Milburn et al., 2003, Mordoch and Hall, 2002, Trondsen, 2012). Their inclusion will allow for deeper insights into their needs and perceptions with the aim of developing policy and improving health care in support of a family model approach (Aldridge, 2006).

In terms of what helps for children and parents in this context, parenting programmes are showing early yet promising results in improving

situations for both parent and child however, the long term effectiveness of such programmes remains unclear. Also much of the research showing improvements neglect to include the subjective experiences of parent and/or child. Of those that do include perspectives of parents findings suggest support for programme effectiveness (Kane et al., 2007). In terms of programmes for parents and children in the context of parental mental health difficulties increased evaluation is warranted before effectiveness can be determined. However, parents and children agree that aside from parenting programmes what would be helpful is having someone to talk to, to have information provided and to meet peers in similar situations. The *Family Model* approach was introduced as a tentative framework for supporting children and parents in families where a parent experiences mental health difficulties.

Chapter 4 - The Policy and Legislation Context - Mental Health, Parenting Support and Child Well-being In Ireland

Section 4.1 Introduction

This chapter outlines the policy and legislative context of mental health, parenting support and children's well-being in Ireland. It provides a context within which the narratives of parents and children who participated in this research can be situated. The chapter is divided into two primary sections. Section 4.2 provides an overview of Irish policy and legislation supporting mental health in Ireland. In light of the overlap in policy and legislation regarding parenting support and children's well-being in Ireland Section 4.3 will consider these together. A detailed overview of relevant policy and legislation is also provided in Appendix B.

Section 4.2 Policy and Legislation - Mental Health in Ireland

Historically in Ireland, mental health legislation was drafted in an effort to protect the wider public from *dangerous* individuals suffering from the 'spreading evil of mental disease' (Boyd Barrett, 1924, p.29). Mental health as a social issue came to the fore with the introduction of the Mental Treatment Act (Department of Health, 1945) which outlined grounds for the voluntary and involuntary admission of individuals with mental health difficulties to public hospitals, directing policy initiatives in their management towards one of confinement through the introduction of an extensive system of public asylums. For an in-depth review of the history of institutional care for the mentally ill in Ireland see Walsh and Daly (2004). By 1961 Ireland was reported as having one of the highest rates of psychiatric hospitalisation at a rate of 7.3 per 1,000 in the population (Walsh and Daly, 2004a, p.68). The Mental Treatment Act remained the leading legislative document in Ireland for a further 60 years.

The introduction of the Mental Health Act (Government of Ireland, 2001c) strove for significant reform and progress in bringing Irish mental

health legislation in line with international standards ⁵ (Latif and Malik, 2012). The Act introduced a set of rights and a range of reforms with regard to involuntary admissions, independent reviews of involuntary detentions, consent to treatment and the treatment of children and adolescents. It further saw the creation of the Mental Health Commission and the Inspector of Mental Health Services tasked with monitoring the quality of service provision and to protect the interests of those who are involuntarily detained in Ireland.

Currently the key policy document governing mental health service provision in Ireland is *A Vision for Change* (Government of Ireland, 2006). *AVFC* provides a framework for the provision of mental health services in Ireland, founded on fostering positive mental health and the provision of accessible services within communities, along with specialist services. It further established the first independent monitoring group to oversee progress on policy implementation. *AVFC* puts forth a holistic model of service provision, emphasising a person-centred, integrated multi-disciplinary approach towards supporting individuals with the bio-psychosocial factors that contribute to mental health difficulties. Based on the recovery model it seeks to include families of service users' and focus on the resources available to individuals within their communities. However, recent research suggests that many Irish professionals working with children and their families are not family focused (Cusack and Killoury, 2012, Independent Monitoring Group, 2010, 2012).

Primary responsibility for implementing *AVFC* lies with the Health Service Executive (HSE), established under the Health Act (Government of Ireland, 2004a) with responsibility for the provision of health and personal social services in Ireland, underpinned by two national policies namely *Quality and Fairness: A Health System for You* (Government of Ireland, 2001e) and its sister document *Primary Care, A New Direction* (Government

⁵ European Convention on Human Rights, United Nations Principles for the Protection of Persons with Mental Illness.

of Ireland, 2001d). These documents place an emphasis on empowering people by enabling their active participation in decisions regarding their health and are founded in an ethos of equality, fairness and accessibility to quality services which place the individual at the centre.

Mental health also falls under the remit of the Disability Act (Government of Ireland, 2005) which provides a framework of legal measures supporting social inclusion. The Disability Act (Government of Ireland, 2005) aims to increase participation of people with disabilities through the provision of accessible, disability specific services. The Disability Act (Government of Ireland, 2005) also provides a basis for the independent assessment of individual needs and a multi-sectoral approach to supporting those with disabilities. In 2004 the Government introduced a National Disability Strategy (Government of Ireland, 2004b)⁶, the overall aim of which was to support equal participation in society of people with disabilities. This is being viewed as a key policy document in terms of progressing a ‘whole of government’ approach to effectively support individuals with mental health difficulties.

Supported further by the signing of the International Convention on the Rights of Persons with Disabilities (United Nations, 2007). Although not yet ratified in Ireland, this reflects a significant milestone in promoting, protecting and ensuring the full and equal enjoyment of human rights and fundamental freedoms of persons with disabilities, including the right to be supported as parents. This places responsibility on the government to provide services compatible with human rights norms in stating that ‘state parties shall render appropriate assistance to persons with disabilities in the performance of their child rearing responsibilities’ (Article 23.2). However, anecdotal evidence suggests this may not be the case (*Irish Times*, 1 June 2011).

⁶ Comprised of components of the Disability Act (2005), the Education for Persons with Special Educational Needs Acts (2004) and the Citizens Information Act (2007).

Section 4.2.1 Current Provision of Services

AVFC (Government of Ireland, 2006) recognises the fundamental role of primary care services in the delivery of mental health service provision. The proportion of mental health difficulties dealt with in primary care services without referral to specialist services is 90%. GPs play a significant role as ‘gatekeepers’ to mental health services and are usually the first point of contact for those in the community (Government of Ireland, 2006, p.60). *AVFC* outlines several recommendations regarding service delivery in primary care settings. These recommendations reflect the need for a comprehensive range of interventions and mental health professionals, a registration system for mental health service users within GP settings, appropriate training for GPs and the adoption of a ‘shared care’ approach through the implementation of a framework of consultation and liaison between primary care and specialist mental health services (Government of Ireland, 2006, p.64).

The *Primary Care and Mental Health Group* was established as a sub-unit of the *Vision for Change National Working Group* (HSE Working Sub Group on Mental Health in Primary Care, 2010). The objective of the group was to establish a ‘road map’ for practitioners to support collaborative working between primary care and specialist mental health services in the delivery of a comprehensive, integrated and inclusive programme of care (HSE Working Sub Group on Mental Health in Primary Care, 2010, p.4). Further developments in primary care services saw the establishment of the *Counselling in Primary Care Service* by the HSE in 2013, with the aim of improving access to psychological therapies. However, this service is provided only to adults in receipt of the General Medical Services card⁷ who present with mild to moderate psychological difficulties.

⁷ As part of the General Medical Services Scheme, persons who are unable without undue hardship to arrange general practitioner services for themselves and their dependants receive a free general medical service.

Community Mental Health Teams (CMHTs) were another feature of the reforms under *AVFC* which recommended that integrated care is provided within the service user's local community and are considered as the 'basic unit of service delivery' (HSE National Vision for Change Working Group, 2012, p.10) tasked with the provision of multi-disciplinary, home-based and assertive outreach care, 24/7 crisis intervention arrangements and a comprehensive range of medical, psychological and social therapies relevant to the needs of service users and their families underpinned by the principle of recovery (Government of Ireland, 2006). Access to CMHTs is via referral from primary care or A & E services. Team co-ordinators are responsible for facilitating intra-team discussion on the management of referrals. An initial assessment is then carried out and a collaborative care plan developed in conjunction with the service user's key worker. Interventions may include out-patient clinics, day centres, home-based alongside more specialised services such as assertive outreach teams. The development of the care plan is dependent on locally available resources. Following a review, if clinical improvement is evidenced, service users may be discharged back to primary care (Byrne and Onyett, 2010).

Section 4.2.2 Access and Outcomes for Patients

Despite progress in terms of policy, significant issues have arisen in relation to the full implementation of recommendations outlined in *AVFC*. In its most recent report the Independent Monitoring Group (Independent Monitoring Group, 2007, 2008, 2009, 2010, 2011, 2012) described its implementation as slow and inconsistent. It is explicitly critical of the lack of a consistent framework for the development of mental health specialities and a lack of coherency in the planning and development of community based services. They highlight reactive rather than proactive approaches to service users and an 'absence of the ethos of recovery' (Independent Monitoring Group, 2012, p. 3). They do acknowledge 'bottom-up' (*ibid*, p.3) developments in line with *AVFC*, citing the on-going closure of unfit for purpose facilities towards community-based services.

Although there are 119 adult mental health CMHTs in place, none had the full complement of staffing recommended with an estimated 1,500 vacant posts (Independent Monitoring Group, 2007, 2008, 2009, 2010, 2011, 2012). While no information is available on the types and extent of availability of treatments although anecdotal evidence suggests lengthy waits and a uni-dimensional approach to treatment through medication. Furthermore, there is limited access to crisis services outside of routine working hours. The report highlights the urgent need for the development of recovery competencies for all staff and the need for all relevant government departments to focus on their responsibilities in implementing fully *AVFC*. Underpinning all of these recommendations is the identified need for a cultural shift in terms of service provision from one of professional dominance promoting a largely medicalised maintenance model to a person-centred, partnership approach, based on recovery competencies within a biopsychosocial model promoted by *AVFC*.

Section 4.2.3 Key Strengths and Weaknesses

The last century has seen significant and much welcomed steps towards rehabilitation of individuals with mentally health difficulties within the community (Cummins et al., 2007). In the context of Ireland the 'somersault' from institutionalisation to community based rehabilitation is evidenced by a drop in numbers of 83% from 1963-2006 (Walsh and Daly, 2004b). In the last century policy trajectory has moved from the decline of the 'great confinement' of those with mental health difficulties (Foucault, 1965) towards a more community oriented support service thus we can conclude that more children are in contact with their parents who experience mental health difficulties. Although improvements have been noted in how mental health services are provided in Ireland several reports from both the Independent Monitoring Group for *AVFC* and the Mental Health Commission have been highly critical of the policy's slow implementation (Independent Monitoring Group, 2007, 2008, 2009, 2010, 2011, 2012, Mental Health Commission, 2009).

The commitment of the Irish government to fully implement *AVFC* has been heavily criticized, implementation has been slow and significant gaps remain (Mental Health Commission, 2009). Service provision remains underfunded and well below the recommended figure in *AVFC* of 8.4% of the overall health budget (Health Service Executive, 2014). Recurring gaps in terms of service provision include that practice has been slow to fully adopt the recovery model and service provision remains dominated by a medical model. There is a significant gap in terms of access to alternative interventions such as psychological, social and occupational therapies. There has been some reform in the area of alternative therapies with the roll out of the Counselling in Primary Care service, although restrictive in its service provision. Multi-disciplinary services and specialist services remain under resourced and are not equally distributed or accessible across geographical locations. Service users are not receiving active rehabilitative interventions to facilitate more independent living, resulting in prolonged stays for individuals in supported community residential programmes. It has been further criticised for failing to adopt a national approach to co-ordination between mental health and primary care services, despite the publication of the HSE guidance paper on advancing a shared care approach (HSE Working Sub Group on Mental Health in Primary Care, 2010).

So therefore, on paper it appears that significant reforms were anticipated with the introduction of *AVFC*, yet the reality appears to see these reforms as simply superficial and tokenistic. Culturally service provision continues to be provided solely through a medical power based model in light of a lack of alternatives. Moreover, service users continue to remain invisible within the frameworks of their own care plans contrary to a person-centred recovery model proposed. Ireland continues to fail to see the link and importance of mental health to a range of domains for the well-being of individuals and continues to support a division of care for mental and physical health. Ireland is failing in its duty of care for vulnerable individuals in need of support and their families.

Section 4.3 Policy and Legislation –Parenting Support and Child Well-being in Ireland

This section considers policy and legislation relevant to parenting support and children’s well-being outcomes in Ireland. The UNCRC (1989) ratified in Ireland in 1992 provides for the recognition of children’s rights and outlines the role of the state in facilitating this via the family. The convention is underpinned by four general principles: non-discrimination; consideration of the best interests of the child; assertion of a child’s right to survival and development; and, a determination that children have a right to be heard in matters that concern them. The influence of the UNCRC is evident in many policies relating to children and their well-being, as rights and well-being are considered intrinsically linked (Ben-Arieh, 2008). The participation and inclusion of children in matters that concern them is the central tenet to ensuring their rights and forms a key focus of current policy thinking in the lives of Irish children.

The *Child Care Act* (Government of Ireland, 2001a) provides a legal framework specifically addressing the protection and welfare of children. However, its introduction has also been attributed to the prominent discourse underpinning Irish children's policy as being directed solely towards *at risk* children as opposed to policies which promote and support the well-being of all children (Hanafin et al., 2012). The *National Children's Strategy* (NCS, Government of Ireland, 2000) was the first policy document that reflected a clear shift in the positioning of children in Ireland, giving status and clear commitment to improving their lives. It further acknowledged the multidimensional nature of children’s lives in asserting that improvements can only be achieved through the integrated delivery of services in partnership with children, their families and wider communities.

Section 4.3.1 Focusing on Well-being and Child Outcomes

Stemming from key recommendations outlined in the NCS (Government of Ireland, 2000) Irish policy now places an emphasis on the measurement of child well-being (Fitzgerald, 2004). The Strategy emphasises the development of an indicator base as indispensable to ensuring the primary aim of the document and enhancing our understanding of children’s lives by

giving them a voice in matters that concern them (Government of Ireland, 2000). This would provide an improved understanding of children's lives and in turn allow for the provision of improved quality supports and services. Ireland's historical tendency to silence the voice of children⁸ has receded in light of efforts to ensure their participation and inclusion began with the establishment of the Ombudsman for Children through the Ombudsman for Children Act (Government of Ireland, 2002). This provided an independent body to promote and safeguard the rights and welfare of children and young people and advocate on their behalf.

While the Agenda for Children's Services (Office of the Minister for Children, 2007) was developed as a broad policy framework document aimed at advancing policy at a national level, evidenced by improved outcomes for children and young people. This document identified seven National Service Outcomes for children and stresses the importance of a whole child perspective as a 'shared responsibility reflecting the complex, overlapping task of achieving good outcomes for children' (Office of the Minister for Children, 2007, p.12). The Department of Children and Youth Affairs have since made outcomes for children the central tenet of the recently proposed changes to service delivery. It states that one of its primary objectives is to 'develop, strengthen and align policies, legislation and resources in order to achieve better outcomes for children and young people and provide support for parents and families'(DCYA, 2012c, p.vi).

More recently *The National Strategy for Research and Data on Children's Lives (2011-2016)* (DCYA, 2011b) reaffirms the government's commitment to understanding children's lives better through their inclusion and the inclusion of relevant stakeholders i.e. parents in generating data. However, a fundamental and recurring critique of services provided to children in Ireland, is that they are fragmented and founded on a silo-based approach. Further to addressing this issue the government established The

⁸ (Department of Justice and Law Reform, 2009, Government of Ireland, 2009), (Government of Ireland, 1936, Government of Ireland 1970, McGuinness, 1993, Department of Health, 1996)

Child and Family Support Agency (Government of Ireland, 2013a) largely considered a welcome step to reform and improve services for children and their families. A task force established to inform the development of CFSA, proposed a vision based on inter-agency collaboration, provision of a spectrum of universal and specialist services with a focus on early intervention with the aim of achieving a ‘quality Irish childhood’ for all children (DCYA, 2012b, p.vii).

Section 4.3.2 Improving Child Outcomes Through Parenting Support

The Commission on the Family was established in 1995 by the Minister for Social Welfare to examine the impact of legislation and policy on families and advise the government accordingly. Key recommendations stemming from the Commission were outlined in the report *Strengthening Families for Life* (Government of Ireland, 1998). The Report highlighted the need for the Government and state agencies to enhance support for parents in their efforts to carry out their role. This was to be achieved by providing choices in relation to caring for their children alongside more practical support such as knowledge and skills development. This was reflected legislatively with the implementation of the Family Support Act (Government of Ireland, 2001b) reaffirming the idea of supporting parents and children with the introduction of community based family resource centres increasing accessibility to parental supports allowing for the identification of vulnerable families earlier.

In 2002 the strategy document *Investing in Parenthood* was published providing a framework for supporting parents in order to achieve best health for children (Best Health for Children, 2002). The strategy’s vision is one of a society in which children have the right to be cared for by people who are supported in the role of parenthood. Broadly speaking, the strategy prioritises the rights and well-being of children and, concomitantly, views parents as experts and key to their child’s health and well-being. Furthermore, parents must be supported as individuals and access to supports and services facilitated. All of which is to be achieved by building on what resources are already in place, developing a partnership approach and interagency planning

and collaboration. The strategy calls for universal and targeted supports for parents, multi-agency and cross-departmental working, people-centred and community development approaches and the promotion of children's rights.

Whose Rights?

With the introduction of the UNCRC (1989) a reconstruction of the relationship between children and their parents occurred. The convention raised challenges to the normative thinking of the *absolute* rights of parents, to balancing these with respect to the rights of children simultaneously reflecting the paramountcy principle. Thus the emphasis is no longer placed on parental authority but rather that of parental responsibility (UNCRC, 1989, article 5, 18 and 27). The provision of rights to children has proved controversial amongst some who view this as undermining the rights of parents. However, Doek (2004) points out that not only does the UNCRC serve the rights of children but also those of parents in that it states its conviction that:

the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community (UNCRC, 1989, Preamble)

As highlighted by Juul (2005, cited in Daly and Abela, 2007) 'adults are compelled not just to reinvent the meaning of partnership but to forge a new path of leadership in relation to children and young people' (p. 7). This led to the introduction of the concept of 'positive parenting' or 'parenting in the best interests of the child' where the focus is on promoting positive parent-child relationships while optimising children's developmental potential (Daly and Abela, 2007, p.11). Thus, parents have the right to be supported in their responsibilities towards their children in their role as parents. Evidence of governmental support for parenting in the best interests of the child is apparently evidenced by the current policy focus on parental support.⁹

⁹ This includes the *National Children's Strategy* (2000); *Investing in Parenthood* (2002); *The Agenda for Children's Services: A policy handbook* (2007); *The Child and Family*

Supporting Parents

The inclusion and participation of parents is key to policies regarding children and parenting in Ireland. Although the best interests of the child dominates, it is thought this is best assessed/achieved through collaboration, participation and inclusion of parents as ‘experts’ (Best Health for Children, 2002) with separation from parents as a last resort (DCYA, 2011a, United Nations, 2007). The notion that the family is the primary environment within which children grow and develop requires their participation and inclusion, as children are not isolated entities, nor are parents. Parental participation and inclusion is promoted in several policy documents relating to children and parenting and is linked to policy developments regarding parental support and early intervention and prevention initiatives.

In order to address further how parents can be supported in their role a special interest group on parenting *Supporting Parents* was established by the *Centre for Effective Services* in 2010. The purpose of the group was threefold. Firstly, they were mandated to generate thinking about issues relevant to parents in their parenting role with an emphasis on well-being outcomes of children. Secondly, they aimed to build bridges to value existing supports and networks, between people, groups and agencies. Thirdly, the group sought to develop a strategy that promoted parenting in Ireland as a highly valued and supported activity. The Special Interest Group on Parenting in Ireland identified its vision as one whereby,

The island of Ireland will actively value and support parents in their parenting role to achieve better outcomes for children, parents and families (Special Interest Group on Parenting, 2015, p.1).

New Directions

The Task Force on the Child and Family Support Agency was established in September 2011. Its aim was to assist in the preparation for the establishment of the Child and Family Support Agency, since renamed *TUSLA* on a statutory basis in 2013. While the Child and Family Agency Act

Agency Act (2013); *Better Outcomes; Brighter Futures* (2014-2020); and *The Parenting Strategy* (2013).

(Government of Ireland, 2013a) heralds a new departure for the provision of services to children and their families in Ireland by bringing together a range of existing services into one single agency. The function of *TUSLA* is to maintain and develop community based support services for children and their families. The new agency promotes the realignment of services across a number of departments and recognises the need for a comprehensive, integrated and accountable agency that operates in a ‘singular unified fashion’ for children and their families (DCYA, 2012b, p.ix).

The model of service provision employed by *TUSLA* is based on recommendations of the task force (DCYA, 2012b) and proposes a continuum of need framework across four levels¹⁰. Level one refers to all mainstream services available to all children universally e.g. health and education. Level two refers to children who may have additional needs. Services provided at level two, such as parenting support programmes, require full parental consent and negotiation. Level three services are targeted at families experiencing chronic or serious problems whereby children are considered to be at risk. Support from a nexus of services is usually the characteristic feature of this level; examples of services at level three include the allocation of a social worker. The fourth level represents families who have experienced temporary or more permanent breakdown. This level is often used in instances of out of home care or detention in a state facility.

The aim of *TUSLA* is not solely to function as an agency catering solely to the needs of families where there are concerns of child welfare or protection, but rather a service for all families based on levels of need and focused on early intervention, primary prevention and universal family support with access to more intensive support including accessible mental health services. However, neither child nor adult mental health services along with many other services are currently included in this comprehensive and

¹⁰ Based on the Hardiker Model (Hardiker et al., 1991)

integrated agency again raising questions of tokenistic rhetoric in Irish policies and service provision.

In acknowledgement that parents need to be supported in their roles, *TUSLA* have published Ireland's first National Strategy on *parenting support* for child and family services, which highlights significant changes in modern parenting (Gillen et al., 2013). The strategy acknowledges the complexities of parenting and commits to working with and enhancing the provision of supports to parents, in order to improve outcomes for children. Parenting support is viewed as the 'core business' of the agency based on a continuum of need illustrated in Appendix C. Placing the emphasis on universal parenting support stigma is thought to be removed from families in need allowing for the identification of families facing increased adversity, which in turn allows for a tailored approach to parenting support based on the unique needs of individual families. It categorises services rather than families, and allows for the fluidity of movement of families along four levels of parental support based on their ever-changing needs and contexts.

TUSLA acknowledges that any effort to improve outcomes for children must be cognisant and inclusive of the need to support parents in their parenting role. *Children First* (DCYA, 2011a) is the primary policy document that promotes the safety and well-being of children and further supports that parents, will at times require the support of the state in fulfilling their roles as parents. It specifically refers to parents with mental health issues and disabilities as requiring specific support. It outlines the roles and responsibilities of mental health and addiction services in section 4.11.1

Professionals who are treating a person with a mental health or addiction problem must consider the welfare and safety of any children in that person's family and/or children in regular contact with the person.

Building on the *National Children's Strategy: Our Children – Their Lives* 2000-2010, (Government of Ireland, 2000), 2014 saw the publication of the most recent policy document, entitled: *Better Outcomes, Brighter Futures* (DCYA, 2014). This again reflects the multi-dimensionality of children's lives and is linked with several national and European policy

strategies.¹¹ Five national outcomes for children have been identified by the DCYA (2011b) which form the basis for TUSLA's approach to parenting support. These outcomes are that children are both physically and mentally happy and supported in active learning. That children are safe from accidental and intentional harm and secure in their immediate and wider physical environment, including economically. That they are part of positive networks of family, friends, neighbours and the community and are included and participating in society.

The passing of the recent Children's Referendum in Ireland (2012) awarded children the protection of their rights within the Irish constitution (Government of Ireland, 2012). Article 42A asserts that all children will get the same protection from the state by acknowledging children have rights to be protected, the right to have a chance to grow up in a loving and stable family and where this is not possible the state will take proportionate steps towards supplying the place of the parents. It serves to reinforce that decisions will be made in the best interests of individual children who will equally have a right to be heard in matters that concern them.

Section 4.4 Chapter Summary – Rhetoric or Reality?

As discussed above several significant policy documents highlight that parenting, child well-being and mental health issues are complex, multi-dimensional concepts requiring an integrated multi-disciplinary cross-departmental response (Government of Ireland, 2006, DCYA, 2012b, DCYA, 2012c). Current national policy on children emphasises the role of the family in the lives of children and holds that family, extended family and communities must be included in services for children to ensure their effectiveness (Office of the Minister for Children and Department of Health and Children, 2007, p.v). However, Irish policy has been criticised for its lack of emphasis on the needs of families where parents have a mental health difficulty, with only two policy documents briefly referring to this context -

¹¹ European Commission (2013), (Government of Ireland, 2013c, Government of Ireland, 2013b).

AVFC and *Children First* (Nicholson et al., 2015). Further criticisms include the limited scope of *AVFC*, the lack of national investment in services including the provision of training and clinical guidelines for professionals, ongoing recruitment embargos in the health services and public service moratoriums (Independent Monitoring Group, 2007, 2008, 2009, 2010, 2011, 2012).

The case is obvious in that supporting parents in their role as a parent, especially when parenting with a mental health difficulty is the optimal strategy in terms of improving outcomes for children and parents alike. As research indicates that in families where parents have a mental health difficulty, risks to children will be compounded by a lack of suitable and timely responses from support services. Following on from international¹² policy developments calls have been made in Ireland for adult mental health services to see parents' and children in the context of their families, through a family model approach. Despite the awareness of the importance of parenting in a child's life, and the fact that having a mental health difficulty makes the task of parenting more complex and can lead to poorer outcomes for children, in Ireland there has been little acknowledgement of these facts in terms of tangible service provision, professional guidance and/or policy initiatives (Special Interest Group on Parenting, 2015).

AVFC outlines the responsibilities of professionals within mental health services working with parents in stating that the 'experiences and needs of children of (mental health) service users must be addressed' (Government of Ireland, 2006, p.29). However, there appears to be a reluctance on behalf of adult mental health services and child and family services to engage collaboratively in a *shared care* or *family-focused* approach, thus providing a poorly co-ordinated response to the needs of parent, child and the family as a whole (Grant, 2014, Cusack and Killoury, 2012, Mental Health Reform, 2012, Independent Monitoring Group, 2009, 2011). In light of the evidence base calls for a *Think Child, Think Parent*,

¹² UK and Australia

Think Family approach to service planning and delivery across child, family and mental health services towards the provision of more holistic family-centred services are warranted in order to achieve better outcomes and brighter futures for parent, patient and child (Diggins, 2011).

To conclude, *TUSLA* proposes to facilitate service provision to children and families that is inclusive, strengths-based and empowering. Through inter-agency co-operation, the Agency aims to ensure a timely and co-ordinated response to children and their families. Although the Child and Family Agency Act (Government of Ireland, 2013a) tentatively indicates a long overdue increase in government interest in promoting parenting initiatives to improve the well-being of children and their families, the inclusion of a comprehensive range of services to facilitate and fulfil the vision of the agency is slow to materialise. In terms of child outcomes and parental support, Irish policy has moved in theory towards integrated thinking, however it remains to be seen how such policies are being implemented and their effectiveness in the lives of children and parents.

Chapter 5 - Methodology

Section 5.1 Introduction

Methodology is considered the crux of any research study and can be conceptualised as a series of choices made by a researcher in order to address the research question (Miles and Huberman, 1994). This research seeks to explore the social and emotional well-being narratives of children living with a parent with a mental health difficulty. Therefore engaging children in such research warrants careful consideration, especially with regard to the methodological approaches employed. This chapter outlines the development of the research methodology recapping firstly on the rationale, aim and objectives of the study. Section 5.2 reviews the key theoretical and methodological considerations in designing this study. Section 5.3 continues on to reflect on this in light of approaches to measuring children's social and emotional well-being, highlighting the move from uni-dimensional adult measures to more inclusive multi-dimensional approaches.

Section 5.4 outlines the research position adopted for this study. Section 5.5 locates the study sample. Section 5.6 details the selected data collection tools deemed appropriate to meet the study's objectives. Section 5.7 details the implementation process, and Section 5.8 includes a discussion on ethical considerations in light of *hard to reach* populations. Theoretical underpinnings of analytical approaches to quantitative and qualitative analysis are reviewed in Section 5.9. Section 5.10 outlines the chosen analytical strategy and its application in this research. Section 5.11 discusses the application of the analytical strategy with regard to within and between case analysis and the tentative conceptualisation of children's social and emotional well-being presented in Chapter 2. The chapter concludes with Section 5.12 providing a summary of the chapter contents.

Section 5.1.1 Rationale, Aim and Objectives

As stated in the introduction the rationale behind this research was initially personal but increasingly driven by ten years' professional experience, observations and engagement with families while working in

statutory and voluntary child and family services, where children had experienced significant disruption to their lives as a result of their parent's mental health. Despite these disruptions children had been afforded little or no information or explanation from professionals who deemed this to be outside of their professional remit. Moreover, research suggests that a common experience of children in this context is that of invisibility and being ignored (Gladstone et al., 2011, Trondsen, 2012).

The aim of this research is to explore the social and emotional well-being narratives of children living with a parent with a mental health difficulty. The objectives of the study are:

- Objective 1 - To explore the subjective experiences of a small sample of Irish children living with a parent with a diagnosed mental health difficulty.
- Objective 2 - To illustrate factors which these children identify as impacting on their social and emotional well-being while living with a parent with a diagnosed mental health difficulty.
- Objective 3 - To reflect on differences and similarities in children, parent(s) and gatekeeper perceptions of the social and emotional well-being of the child in this context.
- Objective 4 - To examine the implications of existing policy and practice for these children living in families where parental mental health is a factor in Ireland.

Section 5.2 Key Theoretical and Methodological Considerations in Designing This Study

The term paradigm was coined by Thomas Kuhn (Kuhn, 1962) and refers to 'an intrinsically integrated cluster of substantive concepts, variables, and problems which can be attacked with corresponding methodological approaches and tools' (Gage, 1985, as cited in Tomic, 1992, p. 21)(Tomic, 1992). Terre Blanche and Durrheim (1999) posit that a research paradigm is an all-encompassing system of interrelated practice and thinking that defines the nature of enquiry along three dimensions: ontology, epistemology and methodology. A paradigm is essentially a conceptual framework based on values and assumptions which provides a basis for how the world is understood and which directs the course of action required when engaging in

research. This section will explore these dominant worldviews, and their inextricable link to the research process.

Section 5.2.1 Theoretical Approaches

The way in which research is carried out is informed by both the ontological and epistemological stance adopted. Ontology refers to the nature of existence (Gray, 2014). Epistemology, on the other hand, refers to the relationship between the researcher and reality (Carson et al., 2001) and provides a philosophical basis for deciding what kinds of knowledge are legitimate and adequate (Gray, 2014). Research in the social sciences has been dominated by three major philosophical traditions: positivism, interpretivism and critical theory. These approaches contrast primarily through their differing theoretical perspectives held about what defines social reality. A comprehensive account of all three approaches is outside the remit of this study, however both positivism and interpretivism are central to this study and a brief overview is provided.

Positivism

Research informed by positivism is identifiable by the emphasis on objectivity, measurement, hypotheses generation, theory building and testing. The emphasis is on the construction of universal laws and rules of normative human behaviour. Research informed by this ontological approach seeks to discover patterns and regularities of the social world through the use of ‘scientific’ methods. It is considered:

an organised method for combining deductive logic with precise empirical observations of individual behaviour in order to discover and confirm a set of probabilistic causal laws that can be used to predict general patterns of human activity (Neuman, 2000, p.66).

Positivist approaches generally employ quantitative methodologies and rely on large sample sizes and employ experimental methods. Cohen et al. (2000) identify the assumptions of positivism as: determinism (events are caused by other circumstances), empiricism (theory and hypothesis generation and testing), parsimony (economic explanations) and generalisability (extending meaning to the wider public). However, the objective and value free stance proposed by positivism has faced criticism in that it offers only an

abstract explanation of social reality and a devaluation of the human experience and voice.

Interpretivism

An interpretivist stance posits that human understanding, interaction and interpretation define reality (Silverman, 1998) of which there are multiple versions. Interpretivism refers to the unique capacity of humans to make sense of their world, understood through the interpretive or participatory examination of social phenomenon and action. Individuals are seen to create their world by organising their understanding of it and attributing meaning to it through these interactions. It permits the examination of multiple realities of any given issue within the context in which it is embedded (Ambert, 1995).

In seeking to interpret the meanings individuals ascribe to aspects of their lives and circumstances, qualitative research designs focus on small numbers of participants and value observation and semi-structured interviews methodologically. Interpretive approaches are concerned with depth of data as opposed to its generalizability. The primary criticism of interpretive approaches are in direct contrast to positivism in that they lack objectivity and are ‘fiction not science’ (Denzin and Lincoln, 2000, p.8). Moreover, the process of data collection can be messy, time-consuming and does not allow for inferences to be drawn suggesting that qualitative approaches are likely ‘to be tarred with the brush of sloppy research’ (Guba, 1981, p.90). However, Warick & Liniger note that ‘every method of data collection provides a different glimpse of reality and all have limitations when used alone’ (Warick and Liningerm, 1975, p.5-6).

Interpretivism is in turn influenced by the epistemological position of social constructionism, which provides the epistemological basis for this thesis (Burr, 2003, Bryman, 2008, Gergen, 2009, Gray, 2014). Social constructionism contends that knowledge or *truth* is created perspective, hence all truths are relative to some meaning, context or perspective (Schwandt, 1994, p.125). A constructionist paradigm concerns itself with how people construct their worlds (Williamson, 2006, p.85) and that reality is developed through the meanings that people create through their interaction

with others and the social structures with which they engage (Berger and Luckmann, 1966). This is in opposition to positivistic frameworks where reality exists and can be measured and observed consistently over time (Bryman, 2008, Silverman and Marvasti, 2008, Gray, 2014).

The purpose of research adopting this stance is ‘to achieve a sense of the meaning that others give to their situation’ (Smith, 1983, p.12). From this perspective, the data generated in communication with research participants is regarded as a tandem creation of the bi-directional interaction between researcher and participant, and is not a provision of ‘pure’ information or viewpoints from the respondent (Huberman and Miles, 2002). Or, to put it another way, ‘we know the world not by objectively observing an external reality, but by constructing how we understand it with others’ (Kikooma, 2010, p.41).

Adopting an epistemological paradigm which considers knowledge to be created through the interactions between people and their contexts complements the perspective that both well-being and childhood are socially constructed as discussed previously (Fattore et al., 2007, p.13). In doing so it supports the idea that as ‘individuals all of our understandings are contextually embedded, interpersonally forged and necessarily limited’ (Neimeyer, 1993, p.1-2). This perspective allows for the personal predispositions of individuals to be considered alongside the impact of the socially constructed reality within which they are positioned (Lock and Strong, 2010) and values interpretive qualitative approaches to the understanding of human experiences (Miles and Huberman, 1994).

When examining the various forms of interpretive research, narrative inquiry emerged as most relevant for this study. Narrative inquiry is an umbrella term that captures personal and human dimensions of experience over time, and takes account of the relationship between individual experience and cultural context (Clandinin and Connelly, 2000). Kohler Riessman and Quinney (2005) support this in their assertion that central to narrative inquiry is ‘human interaction in relationships’ (p. 392). It is concerned with how individuals attribute meaning to their experiences and

realities, and is the means through which ‘human existence is rendered meaningful’ (Polkinghorne, 1988, p.1). Through stories people have a means to represent and understand their experiences, make sense of the world and constitute social identities (Somers, 1994, Rustin, 2000). Rainbow and Sullivan (1979, p. 12) characterise the focus of narrative approaches as those that focus on:

human agency as opposed to determinism, human complexity rather than reductionism, and place an emphasis on context and human interactions rather than humans and reality as isolated and static.

It is a means for accounting for human subjectivity and the agency of individuals within specific contexts.

Narratives provide a way to organise and articulate experiences and interactions which are influenced by past, present and future. Narrative approaches allow consideration of an individual’s value system, where, when and by/to whom the story is being told and are influenced by social, cultural and political experiences (Moen, 2006). In light of these many factors, narratives are often considered as co-constructed or a representation of many *truths*. They do not represent ‘life lived’ but rather researchers’ representations of those lives as told. Sutton-Smith (1986, p. 68) suggest a social-interactional approach to narratives and posits that ‘if we are to understand the meaning of stories to those who use them, rather than some truth they tell us.... We must study them in their contexts of use’ (p. 68). Thus, the aim of narrative research is not to find one generalizable truth, but to ‘sign-up to many truths/narratives’ (Byrne-Armstrong, 2001, p.112). Narratives are context dependent, and co-constructed between participant and researcher, and shaped by specific social, cultural and historical contexts, thus ‘there is never a single authorised meaning’, they ‘don’t speak for themselves’, but offer ‘a window into an essential self’ (Riessman, 2008, p.3).

Narrative inquiry can be understood as a means to exploring the content, structure, dialogue or visual aspects of people’s stories and experiences (Riessman, 2008). Lieblich et al. (1998) identified four types of interpretive models which are employed to understand a particular aspect of

meaning: holistic content, holistic form, categorical content and categorical form¹³.

Four levels of understanding narratives have been suggested: the personal, interpersonal, positional and ideological (Atkinson, 1992). The personal level emphasises explaining the experience and the connection between self and the social, or as ‘expressions of the lived experience of the narrator’ (Atkinson, 1992, p.337). Somers (1994) describes the personal level as ‘ontological narratives’ (p. 618) in that they are used to make sense of our lives and how we define our identities. At an interpersonal level narrative is considered a co-construction of dialogue between researcher and researched (Mischler, 1986). This level highlights the social context within which the production of narrative is facilitated and the role of the researcher in facilitating its production (Riessman, 2008). The positional level allows consideration of the broader social context, and the social and moral functions of narratives, and reflection on power relations and on how people see themselves positioned in their worlds. It accounts for the ‘differences in social position between the narrator and the listener’ (Atkinson, 1992, p.337). The ideological level focuses on the wider social systems of shared beliefs and representations in which narratives are embedded. It is concerned with the socially shared stories that characterise certain groups, communities and societies, in recognition that stories do not occur in isolation (Gergen, 2001). All four levels of analysis can be combined into what Murray refers to an ‘emancipatory narratives’ (Atkinson, 1992, p.337) which challenge *master* or dominant narratives and offer a process for creating new meanings (McEwan, 1997).

¹³ Holistic content involves the holistic exploration of implicit and explicit content of narratives. Holistic form considers content in terms of formal aspects of the story structure e.g. plot development. Categorical content focuses more specifically on segments of the story content which are counted and categorized into researcher defined categories. While categorical form involves counting and categorising the characteristics or style of language used in narratives into defined categories (Lieblich et al., 1998).

Mixed Methods

By and large, it is agreed that there are positives and negatives to adopting either positivistic or interpretivist stances in research designs. This section considers mixing methods as a means to overcoming the shortcomings of both approaches (Warick and Linningerm, 1975, cited in Neuman, 2000). Mixed methods research (MMR) is an umbrella term which covers a spectrum of ways in which approaches to research, methodology and interpretation can be combined, integrated and linked. It offers a deeper understanding of human experience through a synthesis of qualitative and quantitative methods (Punch, 2014) and has been referred to as ‘a new star in the social science sky’ (Mayring et al., 2007, p.1). The fundamental principle of MMR is the acknowledgment that by combining the strengths of qualitative and quantitative research, while also compensating for the weakness of both methods we gain greater understanding into a phenomenon (Johnson and Onwuegbuzie, 2004, p.18).

Johnson et al. (2007) define MMR as ‘an approach to knowledge ...that attempts to consider multiple viewpoints, perspectives, positions and standpoints’ (p. 113). Three philosophical worldviews underpinning attitudes towards MMR have been identified: purist, pragmatic and dialectical (Greene and Caracelli, 1997). A purist stance contends that the merging of interpretivism and positivism is not possible due to their contrasting epistemological and ontological positions. Pragmatists, on the other hand, argue that, despite these differences, combining methods is acceptable, and methods should be determined based on their appropriateness and suitability in answering specific research questions. A dialectical worldview posits that a deeper and more integrated understanding of complex phenomena is achieved through the analysis and comparison of data emerging from each worldview. MMR allows for ‘multiple ways of knowing’ (Greene, 2005, p.208) as the process of combining methods can expand understanding elicited from one method to another and helps to converge, confirm or refute findings from different data sources and requires active engagement with difference and diversity (Greene, 2007)

The ways and sequence in which research methods are combined can differ and Creswell and Plano Clark (2011) offer a helpful explanation identifying six primary strategies considered prototypical in mixed methods designs: the convergent parallel design, the explanatory sequential design, the exploratory sequential design, the embedded design, the transformative design and the multiphase design which are presented in Appendix D. Crucial to deciding the appropriate research design requires reflecting on several factors including the level of *interaction* between methods, the *priority* of the quantitative and qualitative strands, the *timing* or implementation of the different strands and considering *where and how* to mix the different strands.

Determining the level of interaction between qualitative and quantitative strands is considered the ‘most salient and critical’ decision in mixed methods research and can be either *independent* or *interactive* (Greene, 2007, p.120). Independent designs maintain a separation between qualitative and quantitative strands with interaction only occurring when conclusions are being drawn during the overall interpretation. An interactive level of relations is created by directly qualitative and quantitative strands at different points in the research process which are mixed before drawing overall interpretations.

Determining the priority or importance of differing strands must be considered in light of the research question and strands may be considered as *equal priority*, *quantitative priority* and *qualitative priority*. Timing of the implementation of strands can be considered *concurrent* (a single phase study implementing both strands concurrently), *sequential* (strands are implemented in two distinct phases) or *multiphase combination timing* (Multiple phases including concurrent and sequential timing). The where and the how must also be considered. The *point of interface*, or the stage of integration, refers to a point within the process of research where qualitative and quantitative strands are mixed (Morse and Niehaus, 2009). Mixing can occur at four stages during the process of research: interpretation, data analysis, data collection and design.

Four mixing strategies have been identified: merging both sets of data, connecting the analysis of one set of data to the collection of a second set of

data, embedding one data form within a larger design or procedure and using a framework to bind data sets together. Considering these factors in choosing an appropriate mixed method research design provides a logical framework which guides the implementation of research methods and is thought to contribute greatly to the rigor, persuasiveness and quality of research (Creswell and Plano Clark, 2011, p.68).

Section 5.2.2 Being Reflexive

In adopting a narrative approach there was an awareness that ‘a story is never just a story - it is a statement of belief, of morality, it speaks of values’, of both the researcher and researched (Goodson, 1998, p.12). Thus, writing ‘no longer merely “captures reality”, but rather helps to construct it’ (Plummer, 2001, p.171 cited in Bolton, 2005, p. 46). Finlay and Gough suggest reflection is defined as ‘thinking about something after the event’, while reflexivity as a developmental process involves ‘a more immediate, dynamic and continuing self-awareness’ (2003, p.ix). As such, this required becoming as close as possible to an awareness of the way I am experienced and perceived by others. I was conscious of the need to be aware of self as person and professional, as Nin suggests ‘we see things as we are’ (cited in Epstein, 1999, p. 834). Freire (1972) argues that

authentic reflection considers neither abstract man
[sic] not the world without men, but men in their
relations with the world (p. 35).

Thus, reflexivity requires the thoughtful, self-aware analysis of the intersubjective dynamics between researcher and researched (Finlay and Gough, 2003, p. ix)

Coffey (1999, p.59) suggests that research practices are concerned with ‘the positioning, visibility and performance of our own embodied self’, which can shape how we make sense of the lives and experiences of others and as such out research findings (Procter, 2013). Reflexivity refers to the ‘continuous process of self-reflection that researchers engage in to generate

awareness about their activities, feelings and perceptions' (Darawsheh, 2014, p. 561). Reflexivity is thought to add to the rigour of research and is used as a means to guide the research process and to limit the bias of researchers and their subjectivity (Jootun, 2009; Lambert et al., 2010). In light of my personal, professional and educational experience the importance of being reflexively conscious of my actions, thoughts, feelings, motives, assumptions and led me to acknowledge the need to be critical and questioning of my own personal, professional and social situations and how these might influence the research process and findings (Bolton 2005, p. 85).

Procter (2013) argues that researchers must take account of the role of emotion during fieldwork. In light of this research exploring the social and emotional narratives of children in the context of parental mental health difficulties allowing a space for emotional reflexivity was important. In acknowledgement that the stories that may be shared would be emotional in their content this was a significant factor to consider. Bondi (2005) supports the use of psychotherapeutic supervision as she argues what one experiences in their emotional life, can provide an insight into the 'flow of emotion between the body, the mind, spaces and places' (p. 422). In order to engage with this research in a reflexive manner, I employed three methods: the use of a reflective journal and the use of academic supervision to minimise the potential for subjective bias and add to the rigour of the research (Jootun, 2009; Lambert et al., 2010). Furthermore, based on the suggestions of Procter (2013) I engaged in external psychotherapeutic supervision as a means to facilitate emotional reflexivity.

Section 5.3 Measuring Children's Social and Emotional Well-Being

Having reviewed the various theoretical approaches and mixed method approaches to understanding children's well-being and considering the need for reflexive research, this section will focus more specifically on how best to measure and understand their social and emotional well-being. This will be achieved by looking at:

- quantitative approach to measuring social and emotional well-being

- participatory/mosaic approaches to understanding social and emotional well-being.

Quantitative Approaches to Measuring Social and Emotional Well-Being

As discussed in Chapter 2, the assessment and measurement of children's social and emotional well-being and coinciding competencies is a complex task (Barblett and Maloney, 2010). Largely driven by positivistic approaches resulted in significant shortcomings with objective measures of well-being. Traditional measurement emphasised the use of standardised measurement scales, focusing on anti-social or problem behaviours as determined by adult perspectives of appropriate socially normative behaviour and included developmental inventories, tests of school readiness, diagnostic tools, aptitude and achievement tests and tests in almost any domain of learning (MacAfee and Leong, 2002). However, traditional approaches have come under increasing criticism as overused, misused, unsuitable, inadequate, reductionist and based on the norms of white westernised middle class groups (Weare and Gray, 2003, Stipek, 2006, Weare, 2002). Furthermore, they fail to acknowledge the emotional factors underpinning behaviour and to include children's voices on their subjective social and emotional experiences. Measurement instruments have also been criticised for lacking social validity as they are not representative of children's real world experiences (Bierman and Welsh, 2000).

Including the subjective views of children is now considered crucial as research suggests children may hold differing perspectives to adults (Sweeting, 2001). Moreover, although objective measures can be superior as sources of data for certain factors e.g. monitoring academic grades, there are certain indicators that warrant children's subjective reports such as mental well-being and social relationships (Ohannessian, 2012, Ohannessian, 1995, De Los Reyes and Kazdin, 2005). While, failing to consider children as the unit of analysis can result in inaccurate reflections of children's lives (Sauli, 1997). However, despite shortcomings the appearance of administrative data and variance of data sources have proved to be important sources of information on the conditions of children maintained by organisations that

serve children and families, and subsequently several dominant indices of well-being have been developed.¹⁴

In acknowledgment of a deficit focus and the progression of the positive psychology movement, later instruments sought to include more positive aspects of social and emotional competence (Seligman and Csikszentmihalyi, 2000). These instruments also moved away from a solely 'expert professional' perspective to include perspectives from parents' and children. However, these too faced criticism for lacking social validity and as unrepresentative of the real worlds of children (Bierman and Welsh, 2000) and the social context within which research occurs or the researcher's social and cultural influence on the construction of such instruments.

Such criticisms led to an increase of interest in developing measures inclusive of the voice of children. Edmunds and Stewart-Brown (2003) identify three different approaches to the use of measurement scales to assess social and emotional competencies in children: screening (early identification), profiling (perspectives from different sources), and monitoring (assess change over time). All three approaches have a shared purpose in their efforts to improve outcomes for children and must be valid and reliable.

The review by Edmunds and Stewart-Brown, supports that measures used in the assessment of children's social and emotional well-being require multiple informants, must be inclusive of multiple contexts and assessed with multiple methods. They must be cognisant of both the individual and environmental aspects of children's lives, the objective and subjective, and include positive and negative indicators. They also highlight the need to consider environment as key in supporting the development of social and

¹⁴ Such measures include the Index of child and youth well-being (Land et al 2001, 2007) the child well-being index (Bradshaw et al., 2007; Bradshaw and Richardson, 2009; EU) the microdata child well-being index (Moore et al. 2007, 2008) and the deprivation index (Bastos et al, 2004, 2008); DIPOV index (Kogan & Jenkins, 1974) the index of social health (Miringoff, 1990) and the Child development child and Youth wellbeing index (CWI 10, Land et al. 2001).

emotional competencies. Measures must include the perspectives of children themselves (Hamilton and Redmond, 2010) and emphasise the ‘underlying mediums through which children understood experiences of wellbeing [their] significant relationships and emotional life’ (Fattore et al., 2009, p.61). Thus, research exploring the social and emotional well-being of children must consider multiple perspectives and reflect on both the intrinsic and extrinsic factors at play within the context which children understand and experience their daily realities over time and across cultures (Sameroff, 2010).

Participatory/Mosaic Approaches to Understand Social and Emotional Well-Being

‘Grown-ups cannot on their own understand the world from the child’s point of view, they need children to explain it to them’

(Antoine de Saint-Exupery 1945; cited in (Christensen and James, 2000, p.7)

As researchers move towards the increased inclusivity of children in research on them, Lambert and Glacken (2011) emphasise it must be carried out ‘using methodologies/methods meaningful to them and which support their intellectual and social abilities’ (p. 782). The basic premise of participatory research methods is to engage with individuals in planning and/or conducting the research whose understanding, experience, interaction and responses to social reality are of interest. It involves a transfer of power from the researcher to the researched. Participatory methods have a strong following in research with children as in order to understand how children experience their worlds requires their inclusion in research. However, there are varying degrees to which the participation of children can be achieved resulting from tensions between participation and protection rights, child and adult rights and based on concerns of competence and consent. A further discussion reflecting on the tensions of children’s participation is provided in Appendix E.

Research with children involves a process of partnership between the researcher and child. It is through this partnership that data is co-created. Children communicate in different ways to adults and much participatory research uses creative and arts based techniques such as visual methods,

drama, dance, photography, video-making or a combination. Grover (2004) notes the shift towards recognizing children as collaborators in the research process has required researchers to think outside the box and uncover creative and innovative ways of engaging with children. The mosaic approach is one such participatory mixed-method approach and is discussed in more detail later in this section.

Children experience through a range of social interactions within a range of contexts, they also learn to tell stories about them (Gudmundsdottir, 2001). Bennett (2008, p. 16) suggests that narrative approaches are an effective means of working with children as the ‘methods fit with children’s needs for a playful attitude towards serious problems....it facilitates and respects the inclusion of children’s voices’. Narrative approaches and arts based approaches are complementary (Leavy, 2009) and Mason (2006) recommends that creatively mixing methods can promote thinking ‘outside the box’, facilitating new understandings of experience (p. 9). This is supported by Bennett (2008, p. 22) who suggests that narrative methods be integrated with the expressive arts as a means to ‘engaging the child and generating a rich description of experience as well as the imaginative co-creation of new meanings’ .

The mosaic approach is a flexible, multi-method framework for listening to children and young people (Clark and Moss, 2001). The primary characteristics of the approach are that it is multi-method, participatory and focuses on children’s lived experiences (Clark, 2005). It emerged from efforts to include the *voice of the child* in an evaluation of early childhood services, and as such is embedded in practice. It facilitates the bringing together of different perspectives or mosaics in order to illustrate the individual and collective worlds’ of children. Theoretically underpinned by the new sociology of childhood (James and Prout, 1990) the UNCRC (1989) and the Reggio Emilia approach (Malaguzzi, 1993a) it views children as social actors and incorporates Participatory Appraisal techniques which seek to ‘make visible the voices of the least powerful [adult] members of communities, as a catalyst for change’ (Clark, 2005, p.12). The underpinning values and principles of this approach are based on an image of the child as, ‘rich in

potential, strong, powerful, competent and most of all, connected to adults and other children' (Malaguzzi, 1993a, p.10). Children are not seen as passive objects, but rather social agents who are 'being not becoming' (Qvortrup, 1994, p.2).

The *Reggio Approach* is referred to as the pedagogy of listening and is the primary value underpinning the mosaic approach. Rinaldi (2005) describes the pedagogy of listening as comprising of three elements: internal listening (listening to ourselves); multiple listening (being open to hearing the voices of others); and visible listening (making children's thinking visible through documentation). The final principle of the approach emphasises the importance of respectful pedagogical relationships. The development of the mosaic approach was influenced by the above as it offers a creative framework for listening to young children's perspectives through viewing children as 'experts in their own lives' (Yardley, 2011). It offers the possibility to understand the critical thinking and creativity of young children through their 'Hundred languages' (Malaguzzi, 1993b).

As an approach to research with children, the Mosaic approach highlights the possibilities of learning new ways of listening to children. Reflecting on the multidimensional nature of children's lives it incorporates the perspectives of children, parents and practitioners, and acknowledges the co-construction of meaning, providing a composite view of children's perspectives and how they experience their social worlds through the piecing together or integration of data. It provides a range of modes of communication catering to all children and their differing abilities and interests (Clark, 2010). The basic elements of the mosaic approach are that it is multi-method, participatory, reflexive, and adaptable, focuses on children's lived experiences and is embedded in practice. It combines traditional methodologies such as observation and interviewing with participatory tools including for example the use of cameras and artwork.

Research indicates *task centred* methods of data collection are appropriate for use with children (Harden et al., 2000). Using varying visual methods in research with children such as mapping, cameras and drawings

allows them to become actively involved in the process while retaining control over what they share. It can also provide a deeper insight into children’s perceptions of their relationships and environments and allows children to visually situate themselves within their families and social contexts (McCormick et al., 2008, Thomson, 2008). Dialogue with children is necessary to minimise misinterpretation and to gain more detailed accounts of the content and meaning of data. Informal case conferencing or talking with children while completing task-based activities allows children control over the information shared and how the conversation proceeds.

Moreover, offering children choice on how to express themselves is thought to help in communicating complicated and sensitive issues (Thomas, 1998). In having greater control over data production children may enjoy the research process more and findings will more accurately reflect their subjective views and experiences (Alderson, 2000). Combining talk- and task-centred activities allows children time to think about what they would like to communicate reducing power imbalances (Punch, 2002) and empowering children to engage with the research process in a critical manner (Christensen, 2004).

Section 5.4 Establishing my Research Position and Design

After reviewing the theoretical and methodological literature the chosen approach for this study was an embedded mixed methods narrative research design, presented in Figure 5.1 below.

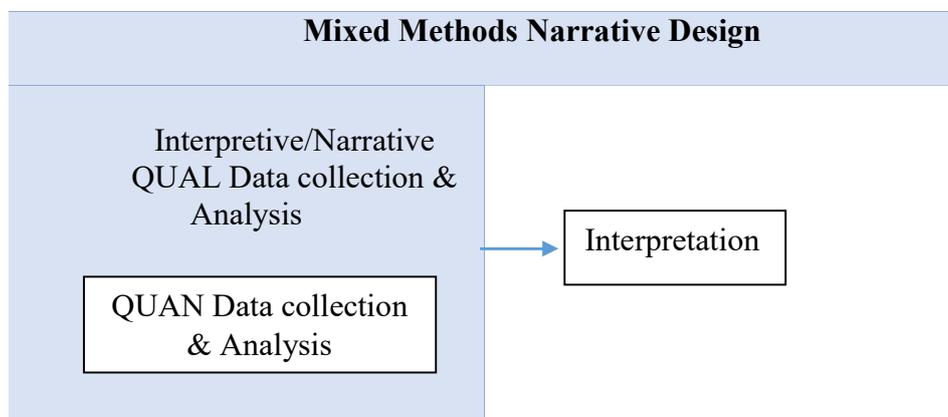


Figure 5.1: The Embedded Mixed Methods Narrative Research Design

The purpose of this research was to explore the social and emotional well-being narratives of children living with a parent with a mental health difficulty. That is to reflect on how children construct understandings of their experiences narratively. In terms of this study an embedded mixed method narrative approach was appropriate to capture the experiences of children from multiple perspectives.

Narrative inquiry is underpinned by social constructionism and sits well with the previously presented argument that children's social and emotional well-being is socially constructed as are their experiences of childhood. Considered collectively, a common undercurrent is identified that there are many truths, experiences and realities. A narrative approach supports the co-constructed nature of children's experiences which are deemed contextually positioned (Lock and Strong, 2010). Moreover, it facilitates consideration of individual experience which can be reflected on in light of socio-political structures. Thus, it allows for the retention of the individual within the contextual.

In an effort to 'think outside the box' (Mason, 2006) creative methods were also incorporated in order to increase children's participation, promote narratives and generate 'a rich description of experience' (Bennett, 2008, p.22). The research sought to provide children with the opportunity to express their views visually, symbolically and verbally catering to a range of abilities and modes of communication, thereby enhancing their participation, warranting a mixture of methods to enhance validity. The mosaic approach is one such approach that allows for the combination of ways to engage with children by mixing traditional qualitative and quantitative measures alongside more creative methods such as the use of cameras and artwork. Qualitative tools were adapted from a variety of methods used in social work practice which allowed for the subjectivities of children's experiences to be explored. They provided an insight into the meanings children create through their interaction with others and the social structures with which they engage (Merton, 1968). Moreover, different tools were required to capture perspectives from child, parent and professional while the triangulation of

perspectives added further validity and further supported ‘multiple ways of seeing’ (Greene, 2007, p.20).

This research was informed by a dialectical worldview and as such an embedded mixed methods approach was deemed appropriate as a single data set was considered insufficient in capturing the complex and multi-dimensional nature of children’s social and emotional well-being (Creswell and Plano Clark, 2011). By adopting a dialectical perspective this research posits that a deeper and more integrated understanding of children’s social and emotional well-being would be achieved through the analysis of data emerging firstly from each worldview (positivist/interpretivist) and through the inclusion of multiple perspectives in line with theories of child well-being.

An embedded mixed methods approach also allows for the prioritisation of children’s voices through the dominance of qualitative data over quantitative. Quantitative measures functioned as supplemental data and were selected based on their reliability, validity and wide use in research with children and a variety of clinical settings internationally (Nixon, 2012). The purpose of their inclusion was not for generalization but rather to reflect how a particular child would be constructed within the clinically based world of practice.

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perspectives added further validity and further supported ‘multiple ways of seeing’ (Greene, 2007, p.20).

Section 5.5 Locating the Sample

Probability sampling refers broadly to a process of random selection, based on a systematic procedure, and results of the sample are considered inferable to the overall population from which the sample was chosen (Creswell and Plano Clark, 2011). On the other hand, non-probability sampling selection is not random but determined by assumptions regarding the population of the interest is in the presence of specific factors leading to the inclusion or exclusion of a population, thus limiting the extent to which information can be extrapolated from the sample to the wider population (Collins et al., 2007). Depending on the nature of the research project, basic assumptions made about the population of interest and the research objectives will determine the most appropriate sampling framework.

In determining the research sample, consideration was required in light of the *hard to reach* nature of the population of interest (children and parents with a mental health difficulty) and the research interest in a *sensitive subject* – experiences of parental mental health difficulties. (Sydor, 2013) distinguishes between these two concepts and defines *hard to reach* as ‘a population that is difficult for researchers to access’ (p. 35) while a *sensitive subject* is defined as ‘a subject that some people prefer not to discuss publicly, usually because they perceive a risk associated with self-disclosure’ (p. 35).

The inclusion of *hard to reach* populations, especially children, raises significant ethical and methodological issues in efforts to balance the protection of children with the need to respect their competencies (Kennan et al., 2012). Children are deemed *hard to reach* in general due to adult perceptions of competence and non-competence and generally consent from gatekeepers is considered a pre-requisite of ethically sound research practice. Also individuals with mental health difficulties are frequently perceived in the literature as *vulnerable* and *hard to reach*, and also frequently require the consent of gatekeepers in the form of professionals who determine

competence/non-competence or level of risk, based on expert perceptions of distress in light of the research topic.

Research with hard to reach populations tends towards the combination of purposeful, snowball or respondent-driven techniques (Benoit et al., 2005). Purposeful sampling refers to the intentional selection of participants who have experienced the central phenomenon being explored in the study (Creswell and Plano Clark, 2011). The emphasis is on providing an in-depth understanding of the phenomenon of interest which informs the sample selection by selecting information rich cases, increasing the reliability and efficacy of the information elicited (Cournoyer and Klein, 2000). Onwuegbuzie and Leech (2007) identified twenty-four sampling schemes for mixed method research presented in Appendix F.

The specific purposeful sampling strategy used in this research was maximal variation sampling, whereby the researcher intentionally sampled cases or individuals that differ in some characteristic or trait (e.g. age, parental mental health difficulty, family structure). The researcher used maximum variation sampling in order to accommodate a diverse sample differentiated by various demographics in order to exemplify the complexity of the world (Collins et al., 2007, Onwuegbuzie and Leech, 2007).

Sample size for this research was determined in light of the target populations, both parent and child being deemed *hard to reach* and *vulnerable*, and that the nature of the research is exploratory and values a depth of children's subjective experience over generalizability (Denscombe, 2007). Children and parent(s) were purposively selected if considered 'information rich' (Patton, 1990, p.169) and met 'eligibility criteria' (Burns and Grove, 2003, p.213). Inclusion and exclusion criteria for this study are outlined in Appendix G. One family was recruited via snowball sampling, whereby a parent involved in the research recommended participation to other parents they knew who met inclusion criteria. In addition, a mother speaking at a conference on parental mental health was approached in person.

The researcher endeavoured to include both parents in the research project. Where parents were married/cohabiting, consent from both to

participate in the research and to discussing the research with the child was required. In terms of seeking consent of both parents where the child is resident with only one parent a flexible approach is recommended (Smart et al., 2001). Ethically it is recommended to base the inclusion of the second parent on the wishes of the individual child and the resident parent on how the non-resident parent would be involved or not. This is deemed appropriate as it is tailored specifically to children’s real lives and relationships (Smart et al., 2001). Table 5.1 - provides details of the final sample of this research.

Child (n)		Parent(s) (n)		Gatekeeper (n)	Total (N)
8	6 =	6	5 =	1 = Female	15
Total Children	Female	Total parents	Female	Total gatekeeper	Total Sample
	2 = Male		1 = Male		

Table 5.1: Number of Participants Per Category and Gender Along with Total Sample Size

Section 5.6 Deciding On and Designing the Data Collection Tools

The selection of appropriate tools is fundamental to meeting research objectives and must be informed by theory. In light of the theoretical discussion provided in Chapter 2 regarding theories of childhood and measures of children’s social and emotional well-being the following section reflects on how the selected data collection tools complemented the achievement of the objectives of the study. These will be presented in two sections 5.6.1 and 5.6.2.

- 5.6.1) Quantitative approaches to measuring social and emotional well-being
- 5.6.2) Participatory/Mosaic approaches to understanding social and emotional well-being

Section 5.6.1 Quantitative Approaches to Measuring Social and Emotional Well-being

Scales selected for this research were based on their wide use in research and clinical settings. The following section provides a description of

selected scales and scales completed by children, parents and gatekeeper can be found in Appendix H:

- The Child and Youth Resilience Measure – 28 (CYRM-28, Resilience Research Centre, 2009)
- The Strengths and Difficulties Questionnaire (SDQ, Goodman, 1997)
- The Emotional, Activity, Sociability and Temperament Survey (EAS-T, Buss and Plomin, 1984)
- The Parenting Style Inventory II (PSI-II, Darling and Toyokawa, 1997b)

Each instrument measures variables thought to be associated with social and emotional aspects of children’s well-being such as temperament, resilience, child mental health and prosocial behaviours and parenting style. Table 5.2 presents selected measurement scales and their association to either emotional, social or overall well-being.

Scale	Aspects of Emotional Well-being	Aspects of Social Well-being	Overall well-being
CYRM-28	✓	✓	✓
SDQ	✓	✓	
EAS-T	✓		
PSI-II	✓	✓	✓

Table 5.2: Relationship of Selected Measurement Scales to Children’s Social and Emotional Well-Being

Child and Youth Resilience Measure, CYRM- 28 (Ungar & Liebenberg, 2009)

The CYRM-28 was designed as part of the International Resilience Project (Ungar and Liebenberg, 2005) and is a culturally sensitive screening measure used in exploring the psychosocial resources available to children and young people (Simmons and Lehmann, 2013). It measures three components of resilience processes in the lives of young people namely: individual, relational and contextual components which are thought to increase the likelihood of positive development (Ungar and Liebenberg, 2005). It is a 28 item self-report screening tool suitable for completion by children and young people aged (9 – 23 years) (Resilience Research Centre, 2009). Developed in collaboration with children through a mixed methods

approach it adopts a holistic view and allows for the identification of unique and common aspects of resilience cross-culturally. It acknowledges the multidimensional nature of resilience and explores the individual and the interpersonal alongside contextually distinct factors such as community supports, values and the cultural resources available to children and young people (Windle et al., 2011).

Reliability and Validity of the CYRM-28

In a review of the psychometric rigour of scales for measuring resiliency, Windle et al. (2011) found the CYRM-28 achieved the maximum score for content validity, while the overall scale showed acceptable Cronbach's alpha. Further studies have found evidence supporting high internal consistency of the CYRM-28 (Zahradnik et al., 2009). Daigneault et al. (2013) found evidence supporting the content validity, internal consistency, construct validity and test-retest reliability specific to a sample of French Canadian youth. Further investigation of validity using exploratory and confirmatory factor analysis of the scale, confirmed a three-factor structure (Liebenberg et al., 2011). Further evaluation of the measures psychometric properties continues internationally.

Scoring the CYRM-28

Items are scored on a 5-point scale from 1 ("not at all") to 5 ("a lot"). Total scores are the sum of all items and range from 28 to 140. Subscales are the sum of the included items: *individual* (items 2, 4, 8, 11, 13, 14, 15, 18, 20, 21 and 25), *caregiver* (Items 5, 6, 7, 12, 17, 24 and 26), and *contextual* (items 1, 3, 9, 10, 16, 19, 22, 23, 27, and 28). Higher scores indicate stronger endorsement of the given construct.

Strengths and Difficulties Questionnaire - SDQ (Goodman, 1997)

The SDQ is a 25 item screening questionnaire employed to assess emotional and behavioural difficulties experienced by children and young people aged 4-17 years (www.sdqinfo.com, 2014). It is considered a brief, simple, reliable and valid dimensional measure of child mental health and pro-social behaviour (Goodman, 2001a, Goodman and Goodman, 2009). The SDQ is thought to provide an outcome measure of psychological adjustment

across behavioural and psycho-social domains. The scale consists of both positive and negative items which are categorised into 5 subscales examining emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and pro-social behaviour (Simmons and Lehmann, 2013).

Extended versions of the SDQ include an impact supplement which asks whether participants think the child in question has a difficulty. The impact supplement is considered useful for researchers and clinicians as it provides further information on chronicity, distress, social impairment and burden to others (Goodman, 1999). A further two questions can be included in the event of the use of an intervention (Haggerty et al., 2011). The scale can be administered to parents, teachers and to children aged 11 years to 16 (Goodman et al., 1998). More recently however, research has indicated the SDQ can provide useful information when used as a self-report measure in children as young as 8 years old (Muris et al., 2004).

Validity and Reliability of the SDQ

The SDQ has been translated into 69 languages and cited in over 1,100 studies, providing considerable evidence as to its validity and reliability (Simmons and Lehmann, 2013) and is strongly supported as the most appropriate tool for measuring the social and emotional well-being of children (AIHW, 2012, p.vii). It is considered a valid measure of child mental health (Goodman and Goodman, 2009). The SDQ has been used in large-scale longitudinal research including the Millennium Cohort Study (Johnson, 2012) and The Growing up in Ireland study (Nixon, 2012) and internal consistency, high construct validity and test retest reliability have been confirmed (Goodman, 2001a, Muris et al., 2003, Smedje et al., 1999, Hawes and Dadds, 2004, Becker et al., 2004a, Becker et al., 2004b). The self-report SDQ has been shown to adequately discriminate between clinical and community populations (Goodman et al., 1998) and shown to identify children with psychiatric diagnoses with a high degree of specificity (Goodman et al., 2000). Correlations between parent, teacher and child report are moderate and

compare favourable to the correlations of other multi-informant measures (Goodman, 1997, Goodman, 2001b).

Scoring the SDQ

The SDQ comprises 5 scales of 5 items each. Items are scored on a 3-point scale from 0 (“not true”) to 2 (“certainly true”). Items 7, 11, 14, 21 and 25 are reverse scored. For each of the 5 subscales items scores can range from 0-10 if all items were completed. If at least three items were completed, these scores can be scaled up pro-rata. The total difficulties scores is generated by summing scores from all the scales except the prosocial scale resulting in a possible score range of 0-40.

Scores can be subdivided to reflect internalising and externalising scores. Externalising scores are calculated by the sum of the scores of the conduct and hyperactivity scales and can range from 0-20. Internalising scores are calculated by the sum of the scores of the emotional and peer problem scales and also ranges from 0-20. When using the impact supplement the items on overall distress and impairment are summed to generate an impact score that ranges from 0-10 for parent and child versions and 0-6 for teacher reports. Higher scores on scales indicate stronger endorsement of the given construct.

Emotionality, Activity and Sociability Temperament Survey for Children - EAS-T (Buss and Plomin, 1984)

The EAS-T is a brief, simple 20 item standardized measure of the behavioural aspects of temperament. It covers a broad age range, can be completed by multiple informants, is not affected by gender or age and refers to behaviours that are observable in children from 1 year of age (Boer and Westenberg, 1994). It can be scored by adults as a self-report measure (5 subscales comprised of 4 items each) or as parental rating of a child (four subscales comprised of 5 items each). In the parental report of child version items are categorised into four subscales corresponding to the following temperamental traits: emotionality, activity, sociability and shyness which are designed to measure heritable aspects of temperament related to developmental differences in personality and behaviour. Each subscale is

comprised of 5 items each and children are scored on a scale of 1 (“not characteristic or typical of your child”) to 5 (“very characteristic or typical of your child”). In the self-report version the three subscales of emotionality, activity and sociability are also included, however emotionality is subdivided into constructs of fear, anger and distress. Subscales in the self-report version are comprised of four items each and the same scoring format is followed.

Validity and Reliability of the EAS-T

The EAS-T has been widely used in both clinical and non-clinical populations (Masi et al., 2003). A longitudinal study by Bould et al. (2013) found evidence supporting a four factor model as the best fit for the data supporting the scales use as a stable measure of temperament over time. Internal consistency replicated that of previous studies (Gasman et al., 2002, Mathiesen and Tambs, 1999). Moreover, the validity of the scale has been evidenced along with showing good test-retest reliability (Plomin and DeFries, 1985, Goodyer et al., 1993). The EAS-T was also used in the Irish longitudinal study on child well-being Growing up in Ireland (Nixon, 2012).

Scoring the EAS-T

To calculate scores of parental rating of child, items 7, 8, 12, 16, 17 and 20 are reverse scored (5=1, 4=2, 3=3, 2=4, 1=5). Scores for each of the 5 subscales are then calculated by adding the four items comprising the scale. Scores can be divided by 5 (number of items per scale) in order to interpret scores in terms of a 1-5 scale.

To calculate scores of parental self-reports, items 6, 18, and 19 are reverse scored as above. Scores for each of the 5 subscales are then calculated by adding the four items comprising the scale. Scores can be divided by 4 (number of items per scale) in order to interpret scores in terms of a 1-5 scale.

Parenting Style Inventory II - PSI-II (Darling and Toyokawa, 1997a)

The PSI-II measures the construct of parenting style independent of parenting practice (Lefebvre, 2004). It provides a measure of children’s

perceptions of the parenting styles they experience (Axford and Hobbs, 2011). It is designed for use with children 11 + years. The PSI-II contains three sub-scales comprised of 15 items assessing: parental responsiveness, demandingness and psychological autonomy granting. The method of scoring on a 5 point Likert scale allows children to provide positive, neutral or negative scores.

Validity and Reliability of the PSI-II

Studies have shown the PSI-II has adequate internal consistency, variability and predictive validity (Darling and Toyokawa, 1997a).

Scoring the PSI-II

Each subscale is comprised of 5 items each and children score the parenting style they experience on a scale of 1 (“strongly disagree”) and 5 (“strongly agree”). Items B, G, D, L, I, and BB are reverse scored (2=1, 4=2, 3=3, 2=4, 1=5). Subscales are scored by calculating the sum of the included items in each construct: *responsiveness* (items B, G, R, AA, CC), *autonomy-granting* (Items D, F, H, L and P), and *demandingness* (items A, I, J, T, BB). Scores on each sub-scale ranged from five to fifteen and were classified as low (5-10) or high (11-15). Scores from the PSI-II are based on children’s responses to the responsiveness and demandingness dimensions, this is in line with several international studies (Carlo et al., 2007, Eisenberg et al., 2006, Nijhof and Engels, 2007, Nixon, 2012, Nixon, 2010).

Section 5.6.2 Participatory/Mosaic Approaches to Understanding Social and Emotional Well-being

In addition to using the quantitative tools described in this study and in line with recommendations from research into social and emotional well-being (Edmunds and Stewart-Brown, 2003, Hamilton and Redmond, 2010, Fattore et al., 2009) as well as recommendations from children (Hill, 2006) several qualitative data collection approaches were also adopted. These tools were selected based on their potential to facilitate communication between researcher and child (White et al., 2010) and provide insights into the individual and relational aspects of children’s social and emotional well-

being (Hamilton and Redmond, 2010). They fall under the umbrella term referred to above as the Mosaic Approach.

A more detailed discussion of selected tools is provided below:

Photo scrapbook

The use of photos as a means of exploring subjective experiences is widely recognised in the literature. The use of photos provided a means to engage children through a combination of visual and verbal communication. Children were provided with an individual photo scrapbook and a digital camera and were required to take 10 photos of the *people, places and things that keep them happy, safe and well*. Based on photo elicitation techniques to encourage narrative, discussions of the photos followed and children were asked to describe the person/place or thing and what they/it meant to the child. The use of visual images is considered an ethical approach as it combines respect, inclusion and protection during the research process (Emmison and Smith, 2000). Research suggests that the use of photography can allow children to actively participate and provide researchers with a ‘view of a child’s world through the child’s eyes’ (Driessnack and Furukawa, 2012, p.6)

Activity workbook

As discussed above the activity workbook was developed based on adapted versions of activity work sheets created by Moore and Layton (2007).

¹⁵ Two versions of activity workbooks were developed in an effort to

¹⁵ Kids Central Toolkit (Moore & Layton, 2007) was developed in response to research carried out by the Institute of Child Protection Studies and in partnership with the Department of Disability, Housing and the Community Service Directorate on children’s experiences of homelessness (Australia). The workbook was developed in response to workers identifying a need for practical ideas and tools to assist practitioners to support children through child-centred approaches. The workbook is based on 6 principles: 1) Children and young people’s safety and well-being are of primary importance; 2) Children are individuals with unique needs and wishes; 3) Children are best supported in their families therefore every effort should be made to assist families to support their children; 4) Environments surrounding children need to be child friendly and provide them with opportunities to grow and develop; 5) Children need to be provided with information and given opportunities to participate in decision making processes that affect their lives and 6) The best outcomes are often achieved in partnership with others who can assist children and families in an on-going way.

acknowledge the differing developmental capabilities of children. The content of which was broadly similar but were piloted on two groups of children (7-11 years and 12-17 years) to reflect age and cultural appropriateness in a cohort of Irish children. Final selected activity worksheets included: 'All about me' (7-11 years)/ 'This is me!' (12-17 years), 'my week of feelings', and 'here and there' work sheets. A fourth activity worksheet was developed entitled 'my supports' based on the social work technique of eco-mapping as a means for children to identify supports in their environments. This activity workbook provided an opportunity for building rapport, providing unique insights into children as self, their family relationship, support networks, and also into their social and emotional experiences.

Some tools were adapted from the Kids Central Toolkit (Moore and Layton, 2007). This toolkit was developed following research with children, parents and practitioners which found that family services benefited greatly from adopting child-centred approaches. The toolkit is based on six key principles, which highlight the importance of children's safety and well-being, that as individuals children have unique needs and wishes and that they need to be provided with information and afforded opportunities to participate in decision-making processes that affect their lives and that children are best supported within their families and families should be assisted to support their children grow and develop (Moore and Layton, 2007). Selected adapted activity worksheets were combined with visual methods of photography and an additional worksheet was developed based on the method of eco-mapping in order to identify children's supports. Examples of activity workbooks are illustrated in Appendix I.

Informal case conferencing

Child conferencing refers to the process of talking with children in a formal setting guided by specific questions. Questions were emergent and based on narratives children shared in relation to the activity worksheets and photographs, but were broadly concerned with aspects of children social and emotional well-being experiences. Following recommendations by (Sheerin

O Toole and Carroll, 2010) data collected was co-constructed with the researcher through a process of informal case conferencing – talking while completing tasks.

Semi-structured interviews

Research recommends the inclusion of multiple perspectives when carrying out research with children. In light of this semi-structured interviews were carried out with parents and gatekeeper focusing on how they perceived a child to be doing socially and emotionally well-being. The inclusion of differing perspectives is facilitated by the mosaic approach.

Observation

Communication can also occur non-verbally and so watching is an important part of the listening process. Observations provide snapshots of situations, behaviours and interactions that can be reflected on with participants at a later stage. Observation was an on-going process throughout this research. Data was collected based on the researcher's observations during the process and recorded digitally or in writing alongside the researcher's personal reflections on data collection.

Table 5.3 presents the chosen mixed-methods data collection tools providing a rationale for their selection in light of the sample and the objectives of the study.

Research Objective	Source of Data	Method of Data Collection	Rationale	Comments
Objective 1 - To explore the subjective experiences of a small sample of Irish children living with a parent with a diagnosed mental health difficulty.	Children	Child case conferencing	Informal relaxed manner for exploring children's perspectives while engaging in child-centred activities. Considered to alleviate pressure on children/young people in discussing sensitive topics.	Task and talk centred work, children completed a series of activities while engaging informally in a semi-structured interview conducted one on one or in groups of siblings
		Photo scrapbook	Facilitates children's participation. Provides an insight in to their realities	Children's photos of the people places and things that keep them happy safe and well
		All about me!/This is me!	Helps build rapport, provides an overview of the child as an individual, their likes/dislikes, interests and relationships	An activity page including a series of stars with specific questions exploring interests, likes/dislikes, self-perception, strengths and fears.
		My Supports	Based on the social work method of eco-mapping children mapped the supports they perceived in their lives	Children drew/mapped/wrote perceived sources of support in their lives.
		My week of feelings	Similar to eco-mapping but a map of children's feelings as opposed to supports. Allowed an exploration of	Children were provided with a broad range of emoticons and were asked to map their

Research Objective	Source of Data	Method of Data Collection	Rationale	Comments
			the feelings children experience and what led to it and techniques they may implement to manage.	feelings over the course of a week. Blank emoticons were also provided
		Here and there	Provides an insight into children's evaluation of how their life is right now and also into their hopes for the future and any changes they might like to see.	Children were asked to reflect on their current situations and future hopes and dreams and how they would like things to be in 5 years' time. If there was anything they could change what would it be?
		Observation	Verbal and written observations of the researcher were made post interview.	Researchers observations of behaviours, interactions and non-verbal information
	Parent (s)	Semi-structured interviews	Multi-perspective approach to children's well-being	Semi-structured interviews were carried out with parents (Appendix J)
		Socio-demographic Questionnaire	Provides contextual information for children's environments	Socio-demographic questionnaire was completed by parents (Appendix K)
	Gate-keeper (s)	Semi-structured interviews	Multi-perspective approach to children's well-being	Semi-structured interviews were carried out with Gatekeeper's (Appendix L)

Research Objective	Source of Data	Method of Data Collection	Rationale	Comments
Objective 2 - To illustrate factors which these children identify as impacting on their social and emotional well-being while living with a parent with a diagnosed MHD	Child & Young Person	As per objective 1	As per objective 1	As per objective 1
Objective 3 - To reflect on differences and similarities in children, parent(s) and gatekeeper perceptions of the social and emotional well-	Child & Young Person	As per objective 1	As per objective 1	As per objective 1
		Standardised measurement scales	Provides a baseline measure of children's functioning/competencies on a range scales measuring aspects of children's SE well-being	A series of measurement scales widely used in research and clinical settings were completed by parents and children appropriately.
	Parent	Semi-structured interview	Multi-perspective approach to children's well-being	Semi-structured interviews were carried out with parents

Research Objective	Source of Data	Method of Data Collection	Rationale	Comments
being of the child in this context.		Standardised measurement scales	Provides a baseline measure of children's functioning/competencies on a range scales measuring aspects of children's SE well-being	A series of measurement scales widely used in research and clinical settings were completed by parents and children appropriately.
	Gate-keeper	Semi-structured interview	Multi-perspective approach to children's well-being	Semi-structured interviews were carried out with parents
		Standardised scales	Provides a baseline measure of children's functioning/competencies on a range scales measuring aspects of children's SE well-being	A series of measurement scales widely used in research and clinical settings were completed by parents and children appropriately.
Objective 4 - To examine the implications of existing policy and practice for children and young people	Child & Young Person	As per objective 1	To explore and critically reflect on narratives of child/young person, parent and gatekeeper in light of current policy documents supporting children and parents and individuals with a MHD in practice in Ireland.	Provide an insight into how Irish policies are in practice impacting on the lives of children in this context.
		Policy documents relating to child well-being in Ireland		

Research Objective	Source of Data	Method of Data Collection	Rationale	Comments
living in families where parental mental health is a factor in Ireland.	Parent	Semi-structured interviews		
		Policy documents relating to child well-being in Ireland		
	Gate-keeper	Semi-structured interviews		
		Policy documents relating to mental health service provision for children and families in Ireland		

Table 5.3: An Overview of Chosen Sources and Methods of Data Collection and a Rationale for Same (Clark, 2005, p.32)

Section 5.7 Implementing the Study

The following section outlines how the study was implemented. It provides an overview of the process of data collection with children, parents and gatekeepers. It outlines firstly the recruitment process and then how consent was obtained before detailing the data collection process.

In order to access children meeting inclusion criteria practitioners working in the areas of children, families and mental health were contacted by phone and e-mail and invited to consider participating in the research. Many presentations were carried out by the researcher in order to promote the research nationally. Although a gatekeeper approach is recommended in research with children and vulnerable populations, it proved exceptionally difficult to gain access to families suitable for inclusion in this way. Primary reasons provided by gatekeepers for refusing access to families, was that the issue was *'too sensitive'* or that they didn't have the time to *'do child-centred work'* or that they did not *'know the child well enough'*.

Following a poor response to a 12 month recruitment drive alternative options were considered and the research was advertised in national and local newspapers, on local radio and through a national website dedicated to the promotion of reforming service provision in mental health service. The researcher also availed of professional contacts in child and family services from previous employment. Despite these efforts only three gatekeepers were identified who agreed to participate. This required their agreement to function in the role of gatekeeper and to identify parents and children suitable for inclusion (See Appendix M). Unfortunately, only one practitioner (family support worker) completed the full research process, the second (family support worker) functioned solely as a 'gatekeeper' in identifying a family for inclusion. They opted not to complete interview or measurement scales as they felt they did not know the child well enough to comment. The third practitioner (Child and adolescent psychiatry) functioned in a similar capacity to the second gatekeeper. However, despite numerous efforts to contact this gatekeeper by phone and email following obtaining consent from the family

in question the researcher was unable to contact them and all efforts to do so went unaddressed

Once consent was obtained from gatekeepers, they were provided with an information pack containing information sheets and consent forms for parents and children outlining the nature of the research. Gatekeepers were asked to discuss the nature of the research with the parent, who in turn was required to discuss it with their children. On receipt of initial verbal consent from parent and children an initial meeting with the researcher was scheduled to finalise written consent (Appendix N). This was done in person by the researcher following a review of the information sheets provided. This was important as an initial step in building rapport with participants but also as it allowed for any questions/concerns arising for either children or parents to be answered by the researcher. This was deemed important in recognition that trust is an essential aspect of communication during the consent process which can influence decisions regarding participation (Corigan, 2003, Molyneux et al., 2005, Molyneux et al., 2004). Families were also advised that they would receive a one4all voucher to the value of €25 as thanks for their contribution and children were awarded a certificate of participation (Appendix O) a small personalised gift valuing no more than €5, along with retaining the data collected during the course of the research.

On receipt of consent the first of three meetings was arranged.¹⁶ Participants were given the choice of three research locations: the family home, the workplace of the gatekeeper and the Child and Family Research Centre, NUI Galway. Children were given the choice as to whether they wanted to proceed with their parent present or alone with the researcher. This was revisited throughout the research process and children's choices fluctuated. Children were then invited to choose a pseudonym as their unique

¹⁶ On average three meetings with children and young people were required. However there was exceptions where extra meetings were required depending on the child's level of engagement and ability to communicate.

identifying name and for anonymity purposes. This name was also used to identify the parent(s), gatekeeper or family as a whole.

An introduction to the data collection tools followed, including the scales workbook, the camera, the photo scrapbook, activity workbook, and the audio digital recorder. Children were specifically advised of issues of confidentiality and anonymity in the use of visual data, and in particular with photographs. They were given three weeks and invited to take photographs of the *people, places and things that kept them happy, safe and well*. Children were informed that they would only be able to select ten final photos for the purposes of the research and would be asked to name and describe the photo and say what the person, thing or place means to them. The two subsequent meetings with children were informal in nature and focused around the completion of the scales workbooks and the activity workbook. Children led the process and were given the choice of which activities to carry out in which order. Appendix P contains some examples of children's completed worksheets.

During the initial meeting with parents were also introduced to the data collection tools. They were provided with a brief socio-demographic questionnaire and copies of the selected scales for completion. Parents were advised scales could be completed alone or with the assistance of the researcher. Parent(s) were invited to take part in a semi-structured interview to be scheduled at their convenience. Duration of interviews ranged broadly between 1 hour to 2.5 hours depending on whether a parent was discussing one or two children and also dependent on the parent narrative style. The partaking gatekeeper also took part in a semi-structured interview which lasted approximately 1.5 hours and returned completed copies of measurement scales to the researcher.

Table 5.4 provides an overview of participant profiles including child, parent and gatekeeper. It provides contextual information including age, diagnosis of parent, pre-existing known difficulties' that children experience, family structure and services through which they were recruited. It highlights the multiple individual and environmental contexts that children experience.

Child	Blue Rose	Petey Pie	Katie	Boldielocks	Ishthara	Kathy	Josh
Age	10	8	13	9.5	12	9	14
Parent with MHD	Father	Mother	Mother	Mother	Mother	Mother	Mother
Participating Parent(s)	Father and Mother	Mother	Mother	Mother	Mother	Mother	Mother
Marital Status	Married	Married	Married	Married	Divorced	Divorced	Married
Family Structure	Only child	Youngest of 3 boys	Eldest of 4 (step-siblings)	2 nd eldest to Katie of 4(step-siblings)	Eldest of 2 (Kathy)	Youngest of 2 (Ishthara)	Eldest of two (step-sibling)
Diagnosis of Parent	Depression & Anxiety	Eating Disorder	Post-natal depression	Post-natal depression	Depression, Anxiety & a side order of BPD	Depression, Anxiety & a side order of BPD	Depression, Anxiety.
Child Diagnosis (Formal)	n/a	Conduct Disorder & ADHD	n/a	ADHD & ?	Dyscalculia	'gifted child'	Awaiting assessment
Gatekeeper	n/a	n/a	n/a	n/a	n/a	n/a	Family Support Worker
Recruited Via Gatekeeper service	Family Resource Centre	Child and Adolescent Mental Health Services	Snow-ball from participating family	Snow-ball from participating family	Researcher present at conference on PMHD	Researcher present at conference on PMHD	Family Support Service

Table 5.4: Participant Profile

Section 5.8 Research Ethics

This research was designed in line with good practice ethical guidelines in research with children (DCYA, 2012a) and approval was obtained from NUI Galway Research Ethics Committee (2011). The DCYA (2012a) outline six key principles to research with children which guide the design of this research: minimising risk of harm, informed consent and assent, confidentiality and anonymity, child protection principles, legal obligations and policy commitments in relation to children and a child-centred inclusive approach to research (p. 1). The following section provides a discussion of these principles in light of this research which are also presented in table format in Appendix Q.

Minimising Risk

The principle of non-maleficence underpins all research practices more so when children are involved, the paramouncy principle applies. Some children living with a parent with a mental health difficulty may have experienced distressing events and talking about these or their parent may cause some distress to children. Concern of risks to participants' well-being and safety were on-going throughout the research. The sensitive nature of the research topic required a non-intrusive, empowering approach which was achieved through the decision to adopt a creative, participatory mosaic design as a means to co-constructing meaning with children in a manner which reduces the likelihood of distress. The multi-method design of this research offered modes of communication appropriate to children's age, needs and comfort. Moreover, children retained control over the information they choose to share in an effort to address issues of hierarchical power traditionally associated with the research process.

Consideration was also be given to the potential harm that may have arisen from participation in the research and measures put in place to mitigate potential harm. A child safe-guarding protocol was developed and discussed with parents and gatekeepers, in order to ensure a clear understanding of confidentiality prior to obtaining consent (Bostok et al., 2005) (Appendix R). Child participants were informed through age appropriate materials the

grounds for information sharing prior to obtaining consent. Moreover, a gatekeeper recruitment approach was adopted as means not only to recruit participants but to provide support in the event of any distress arising during the course of the research.

Informed Consent and Assent

The DCYA (2012a) recommends the fully informed consent of parents/guardian is required, while children's independent assent should be determined based on their age and maturity. In line with the thinking of the Reggio school, children in this research are viewed as social actors and as such competent in determining participation independent of their parents. In light of this full consent from both parent and child was warranted for participation in this research. Fully informed process consent was used throughout and consent was checked verbally on an on-going basis prompted by the researchers observations and awareness of non-verbal cues (Gorin et al., 2008). Children were also given control of the digital recording device affording them ownership of when to choose to stop or continue with the process at any point (Kirk, 2007). Ensuring informed consent was accomplished through the extensive development of information and consent sheets that were child friendly and piloted with age appropriate samples of children. Children were provided the opportunity to read these with their parent or alone initially. While the researcher went through information and consent sheets with children again immediately prior to written consent was obtained allowing for questions to be posed and to ensure accurate understanding. Children were also offered a four-week time frame to decide on participation.

Confidentiality and Anonymity

Although absolute confidentiality cannot be guaranteed in research especially when it involves children discussing sensitive issues, it is imperative to strive for it. With the caveat of possible child safeguarding concerns arising during the research process child participants were offered the choice of using their real names or a pseudonym in relation to their data. Names chosen by children were also used to reflect their parent e.g. Blue Rose

(child), Blue Rose Mum, Blue Rose Dad. All data was stored in line with data protection legislation and encrypted password access was required. In light of the use of photographs consideration was also given to the need for consent from individuals featuring in photos. In order to address this the researcher devised a separate consent form which both children and parents were required to sign permitting the use of the photograph. In the event that consent was not obtained any identifying information contained in photos was blurred out. The data collected by children in the photo scrapbooks and activity workbooks were returned to children after being digitally scanned, again increasing their ownership of the data.

Child Protection Principles

In line with child protection legislation and policy research must be founded in *child protection principles*. Based on legal obligations and recommendations of the DCYA this research adhered to Children's First Guidelines (DCYA, 2011a). This is reflected primarily in the development of the child safeguarding protocol. However, it is also of note that the researcher has a theoretical and practical knowledge of statutory child protection social work in Ireland. Moreover, for the purposes of the research the researcher underwent a Garda vetting process. The child safeguarding protocol proved crucial during the course of the research as a disclosure of risk was made during the data collection process. Appropriate steps were taken by the researcher at this point as outlined in the safeguarding protocol and in line with the Child and Family Research Centre child protection policy, NUI Galway (www.nuigalway.ie).

Legal Obligations and Policy Commitments

The penultimate principle informing this research considers *legal obligations and policy commitments*. With regard to children this refers to their right to participation (UNCRC, 1989, Government of Ireland, 1937). Children's right to participate in this research was constrained to some extent by the recruitment process adopted with significant difficulties encountered in obtaining gatekeepers' permissions to access children and their parents. This has been reflected on in Appendix E. However, the researcher as much

as was possible strove to have the children's right to participate respected through the chosen methodological tools which sought to enhance their participation.

Child-Centred Inclusive Approach

The final principle presented by the DCYA (2012a) calls for *child-centred inclusive approaches*. This is largely supported by the broader literature base relating to research with children (Clark and Moss, 2001). Again this was reflected in the choice of the mosaic approach as a means to accessing children's voices, enhancing participation and in acknowledgement of the sensitive nature of the research. It is further evidenced in the piloting of qualitative tools for age and developmental appropriateness.

Section 5.9 Data Analysis

This section will discuss approaches to the analysis of both qualitative and quantitative data. It considers the positives and negatives of both and reflects on these in light of informing the analytical framework employed for this study.

Section 5.9.1 Quantitative Data Analysis

Scales selected for this research were based on their wide use in research and clinical settings as instruments designed to measure social and emotional aspects of children's well-being such as temperament, resilience, child mental health and prosocial behaviours and parenting style. Moreover, selected scales allowed for the inclusion of multiple informants in line with a whole child approach. The Statistical Package for the Social Sciences (SPSS) was used for quantitative analysis. Descriptive statistics were generated throughout the analysis and integrated with qualitative findings which are presented in Chapter 6. Due to the limited sample size across case comparative analysis was not carried out with the quantitative data.

Section 5.9.2 Qualitative Data Analysis

In contrast to the tight pre-specification of design required for quantitative data collection (Robson, 2002, p.164) qualitative data analysis has faced criticism for not having a 'clearly defined set of quality criteria available for judging it' (Hammersley, 2007, p.287). However, others

challenge this notion of set criteria arguing that it would be incompatible with the basic philosophical assumptions underpinning qualitative approaches (Smith, 1984, p.384). More recently though it has come to be accepted that a list of considerations should be taken into account when judging qualitative work (Smith and Deemer, 2000, p.894).

Robson (2002) contends that ‘good’ qualitative research designs do have a number of identifiable characteristics. Rigorous data collection, analysis and reporting procedures are required which typically involve multiple data collection techniques. The research needs to be framed within the assumption of qualitative approaches including ‘an evolving design, the presentation of multiple realities, the researcher as an instrument of data collection and a focus on participants views’ (Robson, 2002, p.166). This is supported by Mason (2002) who postulates that qualitative research should be systematically, rigorously and strategically conducted, yet remain flexible and contextualised and involve researchers’ active reflexivity. It should be generalizable in some way and produce social explanations to ‘intellectual puzzles’ (Mason, 2002, p.173) and crucially it must be ethical. The following section will outline the process adopted in this research study and introduce the list of considerations relevant to this research.

Creswell (2012) identified five distinct approaches to qualitative inquiry: narrative, phenomenology, grounded theory, ethnography and case study. Each of these approaches differs in what they are trying to accomplish, their focus and the primary objective of the study, however a detailed discussion of each is outside the remit of this research. This research did not seek to describe the ‘*essence*’ of participants experience (phenomenology), nor to generate theory (grounded theory), or describe how a culture-sharing group functions (ethnography), nor did it seek to focus on the issue with individual cases (case study) rather it sought to understand the subjective experiences or lived stories of children living with a parent with a mental health difficulty and to explore their social and emotional well-being narratives, thus narrative inquiry was adopted as the mode of analysis primarily for this focus on contextualised stories of lived experiences (Clandinin and Connelly, 2000, Creswell et al., 2007). As the stories that

people recount are located and acted out within social and cultural contexts and serve as a mechanism through which researchers can enter participants worlds and through this, their experience of it can be interpreted in relation to these influences (Connelly and Clandinin, 2006). Stories then become a scaffold through which participants interpret their past in the present moment of the interview (Clandinin and Rosiek, 2007). Therefore, narrative inquiry is a means to framing and recognising how individual actors speak of their life and imbue the context they are immersed in with meaning (Moen, 2006).

In terms of this study as identified in Table 5.3 in Section 5.6.2.5, a range of methods were used as a means to elicit narratives from participants in order to collate a 'mosaic' of experience and perspectives inclusive of child, parent and gatekeeper. Data was constructed through a range of task and talk centred activities and included visual data alongside objective measures of aspects of children's social and emotional well-being. The use of the visual data i.e. photos was primarily as a means to eliciting talk and expanding understanding of the meaning and significance of photo content in children's constructions of their social and emotional well-being. It is important to note that the majority of data came from interviews that is what participants verbally chose to share with visual data used as a means to eliciting narratives, or functioning as a reinforcer or contradiction of narratives. In light of the nature of the data collected and having reviewed various qualitative analytical strategies it was deemed appropriate to employ a combination of analytical approaches.

The following section is presented in two-parts, firstly, the analytical approaches employed in the analysis of qualitative data will be discussed, namely narrative analysis (Fraser, 2004a) within which aspects of Framework Analysis (Ritchie and Spencer, 1994) and multiple text analysis are embedded (Keats, 2009). Secondly, how the stages of analysis were combined and applied to within and across-case analysis will be considered, underpinned by a tentative conceptualisation of children's social and emotional well-being, derived from that proposed by Hamilton and Redmond (2010). Combining these analytical strategies allowed for a comprehensive within and across-case analysis to be carried out focusing on children's social and emotional

well-being narratives within the context of their lived experiences. However, firstly a discussion of each of the analytical approaches is presented.

Narrative Inquiry

Narrative inquiry seeks to understand how people make sense of their worlds and can provide ways to understand the interactions that occur between individuals, groups and societies (Kohler Riessman, 2002). In seeking to 'get up close' to data Fraser (2004a) proposes a seven stage model to guide the narrative analytical process presented in Appendix S, and considered briefly below.

Phase I requires an emotional attunement of researcher with shared narratives. This involves paying attention to the emotive content of participant narratives as expressed verbally but also non-verbally. Following which phase II, transcription serves to heighten a researcher's emotional connection to stories and achieve a '*closeness*' to personal stories. Phase III focuses on the '*specificities*' of stories and experiences shared, the interest is on the specific aspects of participants stories which form the basis for interpretation and offers a rough structure to participant experiences. This rough structure is crucial to the fourth phase which requires scanning across domains of experience on four levels: intrapersonal, interpersonal, cultural and structural. The fifth phase seeks to identify personal narratives that have the political embedded within, that is attention is paid to the master narratives of popular discourse, which in the context of this research included references to policies and service provision relating to children, parenting and mental health. The penultimate phase seeks to identify commonalities and differences across narratives. The final phase combines all six phases to present a comprehensive and coherent account of restoried personal experience which correspond to participants stories and to the research objectives.

Multiple Text Analysis

Including a variety of participant constructed narratives is considered to reflect more accurately the complexity of life experiences, as such it was decided to embed aspects of Keats (2009) approaches to multiple text analysis

within this heuristic guide. This decision was further supported so as to account for the visual data included. Keats (2009) proposes 5 factors for consideration when carrying out multiple text analysis: text record; general reading of all texts; specific reading of written and spoken texts; visual readings of photographs and visual representations, and relational readings.

Text records refers to identifying and recording the number and types of texts offered by each participant. This is followed by a general reading of all texts to allow the meaning of texts to arise, leading to a more specific reading focusing on distinct aspects of narratives relevant to the research question (Bal, 1997). Keats (2009) proposes two approaches to visual readings. Firstly, a general reading for the content of the photograph and secondly, engaging in a process of co-exploration with participants during interviews (Bal, 1997, Banks, 2001). A relational reading of data, focusing on the connections, parallels and differences in multiple texts follows. This allows an exploration of the intertextual relations, offering an insight into how texts are related and influence each other (Bazerman, 2004). This process will assist in understanding the intertextual connections in the restorying process (Keats, 2009).

Framework Analysis

Framework analysis is a method of data analysis that summarizes and classifies qualitative data through a thematic framework. Developed by the National Centre for Social Research in the UK (Ritchie and Spencer, 1994) it allows for the reduction and classification of data through a thematic framework. It is a useful approach when different types of textual data are collected from a range of participants as it facilitates the application of structure and coherence to data while retaining the wholeness of the data set. It is dependent on the creative and conceptual ability of the researcher to determine the meaning of and connections within and between the data, and is not a 'purely mechanical process' (Ritchie and Spencer, 1994, p.177). It does however provide a well-defined and systematic process for researchers which facilitates the sifting, charting and sorting of data according to key themes and issues (p. 177). Key features of the approach include that it is

grounded in that it is heavily based in and driven by the original accounts and observations of participants. It is *dynamic* and open to change throughout the analytical process. It is *systematic* and *comprehensive* and allows a full methodical review and audit trail of data collected. It permits *easy retrieval* of original texts while allowing for *between and within case* analysis. It is also a means to making the analytical process *accessible to others* (Ritchie and Spencer, 1994, p.176). A detailed look at the stages of the framework is presented in Appendix T.

However, as with all approaches to analysis it also has limitations. Barbour (2003) argues that approaches to qualitative analysis have been hindered by a ‘mechanistic overemphasis on fulfilling itemized checklists’ which has resulted in ‘technical essentialism’ resulting in a focus on outcomes rather than the analytical process (p.1020). She draws particular attention to framework analysis which, although an appealing approach in terms of its systematic application, she argues can also impede inductive and interpretive thinking. According to Barbour, this is conceded by the authors who note that some stages of the analysis are more difficult to capture ‘particularly those which involve inductive and interpretive thinking’ (Ritchie and Spencer, 1994, p.193).

Barbour argues that it is this aspects of Framework analysis that characterizes ‘technical essentialism’ (p. 1020) however, notes this is only if it is used in isolation. This assertion resulted in the decision to combine aspects of narrative approaches to analyzing personal stories proposed by Fraser (2004a). As both narrative approaches and framework analysis are complementary and are commonly used in applied research settings albeit separately. However, unlike framework analysis, narrative approaches emphasise the dynamic ‘in process’ nature of interpretation (Ezzy, 2002, p.95). In other words, in this research study, for example, children’s social and emotional well-being might change with time, new experiences and new social interactions. Simms (2003) suggests that it is this integration of time and context in how meaning is constructed that is a distinct characteristic of narrative inquiry.

NVivo 10

In light of the large amounts of data anticipated through the multi-method approach adopted it was considered important to include NVivo 10 software. NVivo 10 is a software programme that supports qualitative and mixed-method research. It is designed to assist in the organization, analysis and exploration of unstructured or qualitative data. There are many advantages to using this software programme as it aids in the organisation of a very large amount of data, allowing for data to be worked through systematically and coded (Gray, 2009). The use of NVivo can provide a good level of dependability by a careful audit process and complete record keeping of all phases of the research. This is crucial as noted by Denzin and Lincoln (2000) credibility and dependability are a key quality control measure of qualitative research.

However, the use of software programme such as NVivo also have limitations as data can be analysed in terms of breadth but not so much depth. In order to relate themes to each other and to understand the context and meaning of what was said requires the human touch. Holloway and Jefferson (2013) caution that computerised methods cannot replace human intuition and judgement in relation to coding of research data. Although consistent and accurate in establishing groupings of data, computer programmes cannot provide the codes these must be created by the researcher (Welsh 2002). In light of the anticipated large amount of data collected, and accounting for software limitations in the intuitive process coupled with Framework analysis incompatibility with visual and numeric data supported further the decision to combine analytical approaches as Gray (2009) suggests combining coding as a manual process alongside the use of qualitative software packages is arguably the best way to analyse large quantities of data.

Section 5.10 Application of an Analytical Framework

The next section provides an overview of how the chosen analytical approaches were applied in this study. A two-phase approach to analysis was employed. Phase I involved a within case analysis whereby children were the unit of analysis was carried out in order to bring their voices to the fore and

offer a contextualised insight into each child's unique reality. This in turn served to highlight their subjective experiences in line with objectives 1 and 2 of this study. The within case analysis also required an across participant analysis within each child case i.e. the perspective of parent and gatekeeper.

Phase II involved a between case analysis in order to highlight differences and similarities in experiences and meanings that children attribute to their context in line with objective 3. The between case analysis also allowed for the identification of recommendations for policy and practice in order to address objective 4.

Section 5.10.1 Within Case Analysis

To begin the process and in line with recommendations by Keats (2009) a text record or summary of the types of data collected is illustrated in Appendix U. Then to begin the within case analysis Frasers model was adapted as follows.

Phase I – Hearing the stories, experiencing each other's emotions

This required several listens to the audio tapes in order to establish what *sense* or to get a feel for what was present in each interview to gain a *holistic content* understanding (Lieblich et al., 1998). This required actively listening and hearing the stories being narrated and experiencing the emotions of participants and interviewer and identifying the main points presented in participants' narratives. It further involved attending to the emotional experiences of interviews including before, during and after. At times this was a difficult emotive process as some parent and child narratives were distressing and a constant reflection on the researcher's role as researcher and not practitioner was essential as a means to managing this. The researcher sought to establish how each individual story began, unfolded and ended. This also involved reflecting on body language used, tone of voice, silent narratives, feelings depicted or described by participants and initial thoughts and feelings of the researcher. These were recorded digitally and transcribed as analytical memos in phase II of the analysis.

Phase II – Transcribing material

This phase was informed by the perspective of Mischler (1991) whereby transcribing 'is as much a form of interpretation and analysis as it is a technical activity' (Fraser, 2004a, p.188). Once collected, audio data was transcribed verbatim by the researcher, to maximize familiarity with the data. As both framework analysis and thematic narrative analysis emphasise an interest in the content rather than the structure of participant's response for analysis purposes long pauses, interruptions and nonverbal communication (e.g. giggles awkwardly) were noted within the text. All transcripts were reviewed for errors by listening to the audio recording while simultaneously reviewing the transcripts. Transcribed data were then imported to NVivo 10 and supplemented with the analytical memos referred to above made during and immediately after interviews. In line with Keats (2009) all visual data was imported to NVivo and a '*general reading of all texts*' took place by looking at the references that participants made to their other texts (e.g. images, descriptions, and paraphrases) and by linking the visual with textual. The researcher immersed herself in the data completing several readings of transcripts in order to gain a general overview of data collected. Initial impressions were also recorded in the transcript margins for example where parent and child within cases expressed similar or disparate views.

Phase III – Interpreting individual transcripts

Following transcription, a two-stage 'bracketing' process was applied. 'Analytical bracketing' Gubrium and Holstein (1998) involves focusing on one aspect of narrative in participants' stories while suspending interest in others. However, prior to analytical bracketing the same principle was applied in the form of 'participant bracketing' as a means of separating participant narratives. This was a challenging exercise as the majority of interviews took place in participants' homes, where normal family life continued which meant interviews were often interrupted by other children or parents engaging in everyday activities i.e. cooking dinner. It was also complicated by many interviews having multiple voices i.e. when two or more children completed the interview together, or when younger children not partaking in the research engaged in activities which were not included in the research due to age restrictions but used as a means to them not feeling excluded. However,

‘participant bracketing’ was important as it allowed for each participant’s personal narrative to be presented in their uniqueness and allowed children’s perspectives come to the fore as well as similarities and differences in participants’ experiences. Once transcripts had been comprehensively reviewed and individual narratives constructed a detailed exploration of the ‘specificities’ of participants’ narratives was required to capture children’s social and emotional well-being narratives from multiple perspectives (Fraser, 2004a, p. 189). By ‘specificities’, Fraser refers to the types, directions and contradictions or similarities present in stories.

At this point it was considered helpful in light of the large amount of textual data to incorporate stage II of Ritchie’s and Spencer’s (1994) framework analysis, resulting in the development of a thematic framework. This was considered important to account for some of the criticisms of thematic narrative approaches which it is argued results in findings that are ‘subjective and lacking transparency in how themes are developed’ (Smith and Firth, 2011, p.54). This process enabled the researcher to explore the data in-depth while simultaneously maintaining an effective and transparent audit trail thus offering a systematic and structured approach to coding resulting in an analytical framework. Based on the topic guide used in interviews with parent and children a cyclical inductive approach to coding was adopted, whereby the separated narratives of children, parents and gatekeeper provided the foundation for the thematic framework founded in a priori themes. Interesting segments of text were underlined and the left hand margin provided a space to describe the content of each passage with a code. This could range from only a few words to parts of sentences or whole paragraphs. However, in line with narrative thinking an inductive approach was also employed in order to allow space for the inclusion of emergent themes.

Children’s narratives were sparser than adults thus, longer narrative segments were by and large attributed to adult narratives. The right hand margin of the transcript was used to record more detailed notes and ideas, for example, questions to consider as the analysis proceeded, and ideas for explanations or patterns in the data. Below an example of this open coding process is provided in Table 5.5.

It also provides an example of task and talk centred work in action as Katie shared her narrative while completing her 'my week of feelings' which she linked directly to her experiences of separation from her mother during her hospitalisation. This process offered an insight into some of the difficult emotive experiences she reported including feelings of anger, confusion, rejection and abandonment.

Coding Labels	Katie's Experience of her Mother's Mental Health Difficulties	Notes
Experience of PMHD Lack of Information	Katie: My mum was,... well <u>puzzled, I hadn't a clue what was going on</u> R: you were puzzled? Katie: yeah <u>I didn't know what was going on</u> R: when your mum was sick? Katie: (nods)	Feelings of confusion Lack of information
Rejection	R: so puzzled, did nobody talk to you about what was going on? K: no R: no Katie: <u>as far as I was concerned Mammy didn't want me there,</u> R: that's what you thought? Katie: (nods)	Lack of understanding of separation from mum resulted in feelings of rejection
Talking to children about PMHD	R: yeah and did you ask gran what was happening, cause that's who you stayed with wasn't it? Katie: (nods) R: yeah, she didn't Katie: <u>she didn't know how to explain it to me....,</u> R: do you remember ever trying to ask her, or her trying to explain it? K: (nods)	Difficulty adults experience explaining sensitive issues to children
Talking to children about PMHD Lack of control/info	R: what was that like what do you remember or.... Katie: <u>weird, like weird, because she was there like, well mammy's sick, but she's not dying she's just sick,</u> and she's in this <u>special place to get better,</u> and <u>you're not allowed see her, that was it</u> R: ok Katie: it was kinda <u>like awkward</u> R: and did it feel like a long time that you weren't allowed see her? Katie: nods	Feeling uncomfortable. Adult efforts to reassure child. Lack of control/voice over separation.
Time separated	R: yeah do you remember how long it was? Katie: <u>two months nearly,</u> R how long? Katie: <u>nearly two months I think</u> R: two months ok that is a long time K: <u>I seen her once</u> and that R: you saw her once, and do you remember where you saw her? Katie: <u>she was down town getting something</u>	Time separated from parent Visiting parent
Visiting parent	R: ok so it wasn't in the hospital or anything like that, that you Katie: no	Avoidance of parent – similar to Petey's response to mum when in hospital - Due to feelings of Anger, rejection and lack of control. There is a sense of self-blame in her narrative
Anger	R: no what do you think that would have been like going to Katie: <u>I waved at her that was it,</u> R: you waved at her Katie: <u>I just waved at her</u>	

Coding Labels	Katie's Experience of her Mother's Mental Health Difficulties	Notes
Anger Rejection	<p>R: did she wave back? Katie: nods R: yeah? And you didn't want to talk to her Katie: no R: no Katie: <u>I was angry, because I wasn't able, I thought she just didn't want me anymore,</u> R: so you were feeling angry with her, and did you ever talk to her about feeling angry Katie: no R:no</p>	<p>– this is echoed throughout – is it linked to her negative self-concept?</p> <p>Inability to communicate feelings.</p>
Talking to parent	<p>Katie: <u>I was only 4! I didn't know how to say it!</u> R: and what about now, do you think back about that time now? K: not really, to be honest <u>I don't really think about it, that's the past</u></p>	<p>Emotional capabilities of young children.</p>
Denial	<p>R: you don't worry about those kind of things anymore Katie: <u>time to move on</u></p>	<p>Avoidance/Denial</p>
Anger	<p>R: time to move on very good, hmm, ok , so you were puzzled, what else Katie: <u>angry</u> R: you were angry, let me see, we must have an angry here Katie: (giggles) how many kids are that angry ha?</p>	<p>A frequent mantra of her narrative. Although her feelings of anger are still current and she frequently refers to feeling angry – is this linked to mum's broader narrative about not encouraging them to dwell on things, just get on with it narrative?</p>
Change	<p>R: do you think there might be a few? There we go! There's an angry. So, what was happening that you felt angry Katie: <u>Eh, I was living with my Grandparents and I hadn't a clue what was going on</u></p>	<p>Change in environment and confusion resulting from separation. Support from extended family Lack of father relationship – a significant recurring issue for Katie which may be linked to her feelings of abandonment and rejection resulting from her separation from mum? Lack of control over situation. Uncertainty about coping. Idealised perception of Father-daughter relationships?</p>
Confusion Lack of Info Grandparents Father relationship Change Lack of control Coping Father relationship	<p>R: mhm Katie: <u>I didn't have a Daddy at the time,</u> and I knew that, R: you knew you didn't have a dad Katie: yeah and I was angry cause there was <u>all these different people coming in and out of my life,</u> and I wasn't sure how to deal with that R: ok and do you think having a dad would have helped? Katie: nods R: yeah Katie: it's kinda hard to explain, but like (giggles, feeling awkward) what's going on here! Ehm, you have kinda more support R: ok Katie: like someone who's, I know my <u>Granny's really good to me,</u> and <u>she's always been there,.....</u></p>	<p>Extended family support – Security. Insecurity is reflected throughout Katie narratives which she directly links to her experiences of her mum's MHD</p>
Grandparent Support Father relationship	<p>R: mhm Katie: she was a <u>big help,</u> but it would have been <u>more of a help to deal with it,</u> and <u>he might have been able to explain it a bit better</u> R: ok</p>	

Coding Labels	Katie's Experience of her Mother's Mental Health Difficulties	Notes
Separation	Katie: and <u>I wouldn't have to be that far away from both of them</u>	Father relationship Separation from parents'.

Table 5.5: Example of Open Coding Process

This coding process was carried out for each participant, child, parent and gatekeeper, resulting in the identification of within case themes for each child and parent participant an example of which is presented in Table 5.6.

Family 1 Blue Rose

Blue Rose Themes	Mum Themes	Dad Themes
<ul style="list-style-type: none"> • Who am I? • My Supports • My Pets • My Relationships <ul style="list-style-type: none"> ○ Parents ○ Friends ○ Second Family/Others • Understanding parent’s mental Health difficulty • My Worries • My Future 	<ul style="list-style-type: none"> • Overall description (who is she?) <ul style="list-style-type: none"> ○ Painfully Shy ○ Talking about her feelings ○ Empathy • Our Supports <ul style="list-style-type: none"> ○ School ○ Someone to talk too ○ To be heard a bit more • Understanding parent’s mental health difficulty • Relationship with parents • Parents Worries <ul style="list-style-type: none"> ○ Parenting ○ Parents experiences of supports ○ What might help? ○ Advice to others partners ○ Hopes for Blue Rose 	<ul style="list-style-type: none"> • Overall description (Who is she?) • Our Relationship • Understanding of parent’s mental Health difficulty • Year’s Lost • Advice to others • Hopes for Blue Rose

Thematic Summary Points

1. **Understanding of parent’s mental health difficulty**
2. **Parenting and the Parent-child relationship**
3. **Supports/Friends**
4. **Pets**
5. **Someone to talk too – experience of service provision**
6. **Advice to others**

Table 5.6: Example of Within Case Themes from Child and Parent Narratives

This process allowed for the identification of thematic similarities and differences across parent and child participants within specific child cases.

Having originally separated participants' narratives to attend to their subjective experiences, narratives were then restoried through a process of weaving between child, parent and gatekeeper narratives combining quantitative, qualitative and visual data which resulted in the construction of portraits of each child in context. This allowed for stories to be captured and as such narrative strands and sequences were amalgamated.

In terms of then presenting this data as results participants' voices were combined and short biographical sketches were created for each child summarising the key details of their background, context, key supports and combined with quantitative measures an objective overview of children's social and emotional well-being. This forms the basis for Chapter 6 of this study. The centrality of the children's voice to the analysis was highlighted by presenting it in the third person e.g. wording it as e.g. Blue Rose *feels*, *believes* or *experiences*.

Section 5.10.2 Between Case Analysis

Phase IV – Scanning across different domains of experience

Having identified themes within each child case the analysis of themes across child cases began. As discussed previously Fraser (2004a) proposes four levels of analysis: personal, interpersonal, cultural and structural. As this research was interested primarily in children's subjective experiences within the interpersonal context of their families and within the broader socio-political context three levels of analysis were included: the personal, interpersonal and structural. This was complemented by Keats's assertion of focusing on the specificities of written and spoken data. Attention was paid on the intrapersonal level to participants shared thoughts and feelings by paying attention to narrator 'self-talk' or sharing thoughts and feelings that are concealed, attention was thus paid to terms perceived as self-talk identified by statements beginning with 'I thought/ I felt/ I believed etc. Interpersonal aspects of stories were then attended to and essentially reflected aspects of stories that involved other people. This involved being attentive to

what Fraser (2004, p. 192) refers to as ‘reported speech’ i.e. I/He/she said. Finally, the researcher reflected on the structural aspects of participants’ stories that is stories reflecting the influence of public policies and service provision.

Phase V – Linking the ‘Personal with the Political’

During this phase attention was paid to evidence of dominant popular discourse i.e. child at risk; Good-enough mother. This was considered important to identify the relationship between narratives and particular discourses or ‘master narratives’ in society. Attention was also paid to the use of metaphors, humour, irony, sarcasm and the unspoken. This was also important along with consideration for structural aspects of stories discussed above to highlight how policies and services are experienced in practice by families in need.

Phase VI – Looking for commonalities and differences among participants.

Following the identification of within case themes, themes or patterns across child cases were identified. It was evident at this point that some codes were conceptually linked and therefore were grouped together. For example codes such as: hospital, medication, information, were grouped together to make an overarching category of ‘Understanding/Experience of parent’s mental health difficulty’. This process of applying and refining the analytical framework was repeated until no new codes were generated. The example below in Table 5.7 shows the category ‘Understanding and experience of parent mental health difficulty’ from the perspective of child and parent included in the final analytical framework with constituent codes and descriptions.

Code	Description	Code	Description
Understanding and Experience of PMHD– Child perspective		Understanding and Experience of PMHD – Parent perspective	
Hospital	Child’s experience of parent’s hospitalisation	Stopping the cycle	Parent reference to stopping intergenerational cycle of mental health
Professional support	Children’s perceptions of experiences of professional support for themselves	Think Parent	References for the need for parental support
Medication	Children’s experiences of parent when medicated	Impact on child	Parent’s perspective of impact of MHD on child
Information	Children’s experiences of information provided about parents MHD	Hospital	References to experience of hospital
‘Not mental enough’	Children’s perspectives on professional support provided to their parent	Medication	Reference to medication
Concern for parent	Child reference to being concerned for parent	Not a quick fix	Parental reference to recovery
‘I try to make him smile’	Child reference to strategies they use to support parent	Lack of awareness of child	Parental reference to not being aware of child as a result of MHD/Medication
		Information	Parent reference to information provided to children about PMHD
		Contagious	Reference to transmission of MHD
		Intermittent parenting	Reference to intermittent parenting (unavailability of parent as a result of PMHD or subsequent treatment i.e. medication).
		Copycat	Parental reference to child imitating behaviours manifesting from MHD

Table 5.7: Example of Between Case Coding

Themes which were considered to reflect aspects of children's social and emotional well-being experiences based on the thematic framework were selected. Each theme contained several sub-themes which were constructed through a process of refining and combining each participant's narrative, resulting in the identification of a range of similar and different themes based on across narrative analysis. These themes were then categorised within the theoretical framework of children's social and emotional well-being proposed by Hamilton and Redmond (2010).

Themes were mapped around the individual level which was subdivided into the inter and intra personal and included factors, such as children's self-concept, their understanding and experience of their parents mental health difficulties, the parent child-relationship, peer and sibling relationships, and experience of services. Data triangulation and investigator triangulation were used to add rigor, breadth, depth and complexity to the inquiry process in order to enhance the credibility and persuasiveness of the analysis (Flick, 2006). Final themes are presented in a tentative conceptual framework based on conceptualisation of social and emotional well-being within which quantitative measures are incorporated (Hamilton and Redmond, 2010) presented in Table 5.8 below:

Hamilton & Redmond (2010)	Child Themes	Parent on Child Themes	Parent on Self Themes	Gatekeeper Themes
Individual: Intra-personal	• Self-concept	• Perception of Child	• Experience of Parenting	• Perception of Child
	• My Feelings	• Child's Expression of Feelings/Emotions	• Parenting with a Mental Health Difficulty	• Parenting Style
	• Understanding and Experience of PMHD	• Perception of Child's Understanding/Experience of PMHD	• Parenting Style • Parental Insight into impact of MHD on child • Recovery	• Perception of Child's Understanding and Experience of PMHD
Individual: Interpersonal	• My Supports	• Informal Supports for Child	• Parental Support (Informal)	• Parental Support (Informal)
	• Role Model	• Surviving Socially	• Marital Relationship	
	• Experience of Social Exclusion	• Making Friends Wherever I Go	• Parents Experience of Being Parented	• Marital Relationship
	• Belonging	• Parent's Understanding of Child's Worries	• Struggling to Talk about MHD	
	• Importance of Pets	• Parental Hopes for Child		• Hopes for Child

Hamilton & Redmond (2010)	Child Themes	Parent on Child Themes	Parent on Self Themes	Gatekeeper Themes
	<ul style="list-style-type: none"> • My Worries – Concern for Parent 	<ul style="list-style-type: none"> • Manifestation of Behaviours 		<ul style="list-style-type: none"> • Manifestation of Child Behaviour
Environmental: Family/Home	<ul style="list-style-type: none"> • Parent-child relationship 	<ul style="list-style-type: none"> • Parent-child Relationship 		<ul style="list-style-type: none"> • Parent-Child Relationship
	<ul style="list-style-type: none"> • Sibling Relationship 	<ul style="list-style-type: none"> • Sibling Relationship 		<ul style="list-style-type: none"> • Sibling Relationship
	<ul style="list-style-type: none"> • Change 	<ul style="list-style-type: none"> • Change 		
	<ul style="list-style-type: none"> • Discipline 	<ul style="list-style-type: none"> • Parental Expectations 		
	<ul style="list-style-type: none"> • Extended Family • Blended Families 	<ul style="list-style-type: none"> • Extended Family 		<ul style="list-style-type: none"> • Change
Environmental: School	<ul style="list-style-type: none"> • Teachers 	<ul style="list-style-type: none"> • Experience of School 	<ul style="list-style-type: none"> • Experience of Interaction with Schools 	<ul style="list-style-type: none"> • Support for Child (Formal)
	<ul style="list-style-type: none"> • Experience of School 			
	<ul style="list-style-type: none"> • Teachers 			
Environmental: Community Supports and Services	<ul style="list-style-type: none"> • Support Received (Formal) 	<ul style="list-style-type: none"> • Support for Child (Formal) 	<ul style="list-style-type: none"> • Support for Parent (Formal) 	<ul style="list-style-type: none"> • Support for Child (Formal)
	<ul style="list-style-type: none"> • Advice to Others 	<ul style="list-style-type: none"> • Advice to Others 	<ul style="list-style-type: none"> • Advice to Others 	<ul style="list-style-type: none"> • Policies – Think Family
	<ul style="list-style-type: none"> • Talking to Professionals 	<ul style="list-style-type: none"> • Policies – Think Parent and Child 		

Table 5.8: Final Themes That Construct the Tentative Conceptual Framework (Hamilton and Redmond, 2010)

An illustrative diagram of the analytical strategy is provided in Appendix V.

Section 5.11 Chapter Summary

This chapter has attempted to comprehensively describe, rationalise and justify the methods employed in this research. It reflects on the theoretical approaches to understanding or knowledge creation and how this is conceived in terms of research with children. It maps the progression of the research theoretically and methodologically and how the selected approaches matched the overall study aims and objectives. It provides an insight into the intricacies of research with children in practical terms while highlighting some significant constraints in carrying out child-centred research, including access and participation. This research sought to provide an in-depth exploration of the social and emotional well-being narratives of children living with a parent with a mental health difficulty. By focusing on a small number of children, the inclusion of multiple-perspectives and in adopting a mixed-method approach that facilitated collaboration with children created rich and descriptive understandings of their experiences.

Chapter 6 - Portrait of a Child

Section 6.1 Introduction

This research sought to present children's objective and subjective experiences of living with a parent with a mental health difficulty in order to highlight the uniqueness of their contextualised realities. Before moving onto the presentation of results in Chapter 7 based on a thematic narrative analysis of data, this chapter presents a set of bio-graphical sketches on the children who participated. The sketches introduce the readers to the unique contexts of these children. This allows each child's voice to be heard, while providing access for readers to the broad range of differences and similarities children experience. The vast array of experiences portrayed here for these children are very much attributable to the sampling strategy employed, as discussed in Chapter 5. The sketches highlight the personal context of each child's situation providing an insight into who they are, their family context, what the mental health difficulty of the parent is and children's experience of it. It further reflects children's key supports and provides an objective view of children as measured by administered scales. All scores for scales completed by participants are provided in Appendix W. As referred to in Table 5.1 in Chapter 5, a total of 7 children took part across 5 families. For ease of reference Table 6.1 recaps on the subscales and scores for each scale discussed in the objective view of the child.

Scale	Subscales	# of Items	Score Range	Maximum Score
CYRM-28	➤ Individual	11	1-5 for each subscale	140 (Higher Scores Increased Resilience)
	➤ Caregiver	7		
	➤ Contextual	10		
SDQ	➤ Emotional symptoms	5	1-3 for each subscale	40 (Higher Scores Increased Difficulties)
	➤ Conduct problems	5		
	➤ Hyperactivity	5		
	➤ Peer relationship problems	5		
	➤ Pro-social behaviour	5		
EAS-T	➤ Emotionality	5	1-5 for each subscale	20
	➤ Activity	5		
	➤ Sociability	5		
	➤ Shyness	5		
PSI-II	➤ Responsiveness	5	1-5 for each subscale	5-15 Low (5-10) High (11-15)
	➤ Demandingness	5		
	➤ Autonomy granting	5		

Table 6.1: Scales, subscales and score range

Section 6.2 Blue Rose

Family Context:

Blue Rose is the daughter of a married couple living in a town in the north-west of Ireland. Her mother describes herself as a homemaker and her father works with animals, both have FETAC Level 6 qualifications and the net household income is €340 per week. Blue Rose is an only child and describes herself as a funny person who loves to make people laugh. Her mother describes her as a ‘normal’, happy, bubbly and interested child who never really had tantrums. She also describes her as being a painfully shy child and feels although she can be shyer more so with other children than adults, this has improved greatly. Her Father describes her as unique and both parents view her as a ‘joy to parent’. Both parents comment on her ability to empathise with others.

Description of Parental Mental Health Difficulty:

Blue Rose's father has a history of mental health difficulties including a breakdown, self-harm, anxiety and depression. His difficulties have been ongoing since young adulthood and he received a formal diagnosis in 2000 which became more acute in 2005 resulting in several hospitalisations. Blue Rose began to notice changes in her Father when she was 7 years old, but believes that her Father has been sick since she was born and states she used to call him *Black Dog*.¹⁷ The last hospitalisation she recalls was a little over two years ago when her father spent 6 months in a mental health facility she describes as similar to a care home, but not for the elderly. She only saw him on Sundays and enjoyed the day trips to see him but also notes that these are not happy memories for her and she was happy when he came home.

Child's Understanding and Experience of Parental Mental Health Difficulties:

She describes her father's mental health difficulties as him being afraid to go outside and that 'he sees the darker side of everything', this understanding stemmed from her mother's explanations. Blue Rose experiences her father's mental health difficulties in terms of 'not laughing or smiling that much' which causes her sadness and this is one of the things she identifies as not fine in her life right now. Despite feeling that 'he didn't have that bad mental illness' she held significant concerns regarding his mental health and recalls a time three years previously when she thought he was going to die from his mental health difficulties which also made her sad. This was something that emerged when visiting her G.P. and shocked her parents. She identifies the hardest thing about her father's mental health difficulties as the limited time he spends with her. She has a close relationship with her mother and acknowledges that she can talk to her about her father's mental health. Despite significant improvements reported by both her parents

¹⁷ In reference to a book; '*Living with a Black Dog*' which her mum used as a means to explain the Father's mental health difficulties to Blue Rose.

regarding her father's current mental health, Blue Rose feels she has noticed some changes, 'not a big one, but a little change'.

Child's Key Supports:

Blue Rose experiences a close bond with both her parents, in particular her mother. She identifies her both as providing her with a sense of strength, safety and support. She acknowledges the extra role her mother took on in light of her father's illness stating 'she kinda fills in for Dad a lot'. Her mother also acknowledges that she carried extra responsibilities as a parent and emphasises the need for her to be well in herself and proactive in maintaining her own well-being in order to function effectively in her role. This is further supported by her husband who acknowledges her role in supporting him and Blue Rose. Her father also expresses feelings of guilt in light of 'mistakes, years lost' and 'not having done enough recently' as a parent. Blue Rose identifies with this stating she knows he tries to make it better by saying he'll try to laugh or smile more.

Blue Rose identifies a significant number of supports in her life external to her parents, namely other adults, her second family, pets and a wide range of activities and interests. She identifies her mother's friend as her role model as she makes her feel like her daughter. She further views her second family in similar terms and sees herself as part of the furniture which brings her feelings of joy. Looking after the pets is something she does with her father. This is something Blue Rose is very proud of. Blue Rose believes that she adopts a more caring role with the animals while her father is their master. She enjoys this shared activity but did not like all the responsibility of the animals when her father was in hospital.

Objective View of Child's Social and Emotional Well-being:

Despite the family's difficulties Blue Rose presents as a happy, contented, socially engaged and articulate child with a largely positive outlook on life. Her parents score her almost exactly the same on the EAS-T survey with only one difference in the emotionality score. While Blue Rose reports experiencing different parenting styles reflected in her PSI-II which

reflect her mother's authoritative style and her father's more permissive style. Her primary concerns are linked to worry for her father's mental health yet she presents with significant supports in her environment who she can talk to for support. Self-report scores from the CYRM-28 support this reflecting a high level of resilience on the individual and relationship with care-giver subscale and slightly lower reported resilience in the context subscale. Moreover, findings from the SDQ place her in the 'close to average bracket' indicating she is well within the normal functioning range. Overall, objective measures suggest that Blue Rose is functioning well within a normal range.

Section 6.3 Petey Pie

Family Context:

Petey Pie is the youngest son of a married couple living in the suburbs of an urban city in the west of Ireland. He has two older brothers, and his relationship with them in particular the brother closest in age to him is strained. His mother describes her occupation as the homemaker. No household income is provided. Her husband has recently established his own business.

Petey describes himself as a nice and kind person. His mother describes him as a live wire who manages in a very specific bubble and cannot seem to survive socially without real professional handling. His father did not take part in the research. Petey Pie attends the child and adolescent mental health services for Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD) for which he is currently taking medication. His mother feels she was never designed to have children and her life experiences didn't make her a good mother. She describes not having a good relationship with her own extended family and acknowledges that she was raised by a parent with an eating disorder. His mother views herself as a failure as she feels she was unable to 'fix' herself or her sons. She describes parenting as an isolating and extremely challenging experience.

Description of Parental Mental Health Difficulty:

Petey's mother has a diagnosed eating disorder, which began following the birth of her first son. She associates her mental health difficulties to experiences of childhood trauma and being raised by a parent with an eating disorder. Petey's understanding of his mother's mental health is limited as this has not been discussed with him due to his age. However, he holds some awareness in light of hospitalisations and attendance at mental health appointments. His mother is currently awaiting a placement in an in-patient facility in the east of the country, three days a week.

Child's Understanding and Experience of Parental Mental Health Difficulties:

Petey struggled to discuss his mother and her mental health difficulties. The little he did speak was presented ambivalently. He stated he didn't want to know what was happening, as then he would know that something was wrong. Although he acknowledged that when she was sick he 'worried about everything'. His mother acknowledged that she had not spoken to him about her difficulties as he was too young and she felt that he was struggling enough with his own difficulties and didn't need to be burdened with more.

Child's Key Supports:

Petey's presented his primary supports as his teddy bears, his dog, school and his mother and father. His role model is his teddy bear given to him by his parents when he was born and he associates her with feelings of safety. The family acquired a dog during the course of the research, which quickly became a significant support for Petey as someone he could talk to and that he associated specifically with helping him when his mother was sick in his advice to other children. Petey has experienced difficulties in school resulting in his expulsion from his initial primary school. He has just completed the first year in a DEIS school in the city which has been a hugely positive experience for him and which he describes as the only place he feels safe.

Petey's mother expresses significant concern about Petey's social survival and finding a place for him. Petey makes reference to two friends during the course of the research and makes no reference to his mother's perceived lack of friendships. He has a best friend with whom he plays soccer, but lives in the same location as the school, so school is the only place they see each other. Although Petey has been to visit his home once, his friend is not allowed to visit Petey. His mother acknowledges that he has some friends but specifically locates these relationship within his new school environment, which she describes positively as controlled.

Objective View of Child's Social and Emotional Well-being:

Petey had laconic interaction with structured interview questions and sensitivity and flexibility of approach was required. Petey did not want to complete the measurement scales included. He became quite agitated when he attempted them, effectively shutting down, and it was decided that they would be omitted. His mother completed all scales from her perspective. His mother's total score on the SDQ is 24 which places Petey in the very high/very low categorisation, suggesting he is experiencing significant difficulties in terms of conduct problems, hyperactivity and peer problems. She does not perceive him to be experiencing difficulties in emotionality and scored him in the close to average category. His mother also provides EAS-T scores for herself and Petey. She presents herself as experiencing high on activity, fear, distress and anger and average on sociability. While Petey is scored as high on shyness and activity average on emotionality and low on sociability. Objective measures based on his mother's perception suggest that Petey Pie is experiencing significant difficulty and is functioning well below the normal range.

Section 6.4 Kathy

Family Context:

Kathy lives with her mother and older sister in an urban town in the east of Ireland. She has no contact with her father and her parents are divorced. Her mother is currently unemployed and has a Master's level qualification. The household income is €1,248 per month. Kathy considers

her mother, her sister and all four-legged animals and her best friend to be her family. Kathy's mother describes her as an introvert and a 'gifted child' who's incredibly academic and she feels needs to be handled differently. She does not view Kathy as someone who needs to be fixed and expresses a dislike for the view that her introversion is something to be concerned about pathologically. Kathy describes herself as someone who finds it hard to meet people and does not like change. Her mother describes her as more of a worrier than her sister. Kathy has a very close relationship to her mother and her sister and considers them as significant supports in her life. Her mother is estranged from her family of origin except for contact with her maternal aunt.

Description of Parental Mental Health Difficulty:

Her mother has a diagnosis of post-traumatic stress disorder (PTSD) with a 'side-order' of border-line personality disorder. She was hospitalised four and a half years ago for one week as a result of suicidal ideation. During this time Kathy and her sister were placed in the care of their maternal grandmother which their mother described as a big mistake.

Child's Understanding and Experience of Parental Mental Health Difficulties:

Kathy understands her mother's mental health difficulties to be linked to the stress her mother experiences in being an adult and as a result expresses a desire not to become an adult. She does not like when her mother takes medication as she does not feel like she is herself. She didn't like being separated from her mother during her hospitalisation and felt the hospital staff didn't like their jobs and didn't care enough about her mother. She describes how she tries to alleviate some of her mother's financial stress by monitoring the amount of electricity she uses in the home and by helping out with the cooking, or going to the shop. She talks to her sister Isithara when she gets a bit scared about her mother. She would not ever talk to anyone about her mother's difficulties and wouldn't like a stranger to tell her there's something wrong with their mother.

Child's Key Supports:

Kathy identifies her mother, her sister, her friend, pets and her teacher as her primary supports. She feels supported at home and in school. She describes her mother as someone who keeps her happy, safe and well ‘in every way possible’ and Ishthara as the best sister ever. Her best friend also provides her with support through her unconditional love and she would talk to her when she is sad. Her pets are a source of happiness, and she feels they listen to her, especially when she’s sad, angry or upset. Despite having had a difficult introduction to the education system, resulting in her mother home schooling her for a year, she has since returned to a different school and her mother highlights the positive impact her engagement with an external institution for academically gifted children has had. Kathy however, makes no reference to this, highlighting instead the difficulties she felt in returning to school in terms of being behind in her work and not belonging. She describes the support she received from her teacher who made her feel special and expresses a longing to contact this teacher during the holidays.

Objective View of Child’s Social and Emotional Well-being:

Kathy’s mother scores Kathy on the EAS-T survey as high on emotion, and shyness, average on activity and low on sociability. Kathy also self-reports high levels of resilience on the CYRM-28, more so on the individual and relationship with caregiver subscale. On the SDQ Kathy scores a total difficulties score of 14 placing herself in the close to average category. In terms of internalising and externalising difficulties she scores a 5 and 9 respectively, suggesting more difficulties with internalisation. Her mother’s scores on the SDQ suggest she perceives Kathy to be experiencing difficulties emotionally and within her peer group and placed her in the high/low category. Objective measures completed by Kathy suggest she is functioning within the average to normal range; however, her mother perceives her to be functioning lower in emotional terms.

Section 6.5 Ishthara

Family Context:

Ishthara lives with her mother and younger sister Kathy (above) in an urban town in the east of Ireland. She has no contact with her father and her

parents are divorced. Her mother is currently unemployed and has a Master's level qualification. The household income is €1,248 per month. She considers her family to include her mother, her sister, her maternal great aunt and her pets. She has just completed 6th class and found saying goodbye to her friends very difficult. She describes herself as being good at talking and finds it hard to keep silent. Her mother describes her as being really easy to parent since she was a baby. Her mother describes her as an extrovert with an attitude towards life that 'everything's gonna be grand!', and as someone who is bothered by very little. She also describes her as someone who is very careful about whom she lets into her life. Ishtara is very close to her mother but at times finds her over-protective.

Description of Parental Mental Health Difficulty:

Her mother has a diagnosis of post-traumatic stress disorder (PTSD) with a 'side-order' of border-line personality disorder. She was hospitalised four and a half years ago for one week for suicidal ideation. During this time Ishtara and her sister were placed in the care of their maternal grandmother.

Child's Understanding and Experience of Parental Mental Health Difficulties:

Ishtara does not tell people her mother is sick; the only people she would tell are her sister and her mother's friend, who is also their neighbour and a nurse. Ishtara describes her mother's mental health difficulties in terms of her mother sometimes getting 'quite stressed' and 'kind of sad'. She says she does not mind it that much as she knows her mother will get over it in a while. However, she acknowledges that it can be overwhelming at times. Her mother also acknowledges this as a concern. Ishtara manages her mother's mental health difficulties by consulting with her sister about the best course of action to take. She does not feel the doctors did much to help her mother and she did not like the hospital. She acknowledges that her mother does not like taking medication, but in her opinion medication is quite good for you. She feels her mother handles her mental health quite well, and seeing her mother happy makes her feel happy.

Child's Key Supports:

Issthara identifies her mother, her friends, and her sister as her primary supports. She identifies her mother as her role model and she knows her mother loves her as she hugs her and tells her she loves her every day. Although she talks to her mother about somethings she does not go to her for advice about everything and avoids talking about school with her. Her mother also acknowledges that Issthara is not as interested in academia as her sister, and that she is trying to accept this. Issthara describes her sister as very clever, nice, kind and caring and feels comfortable in that sometimes they fight but they always make up with each other. However, she does not like being hugged by her sister. Issthara finds it easier to talk to her friends than her family when she is sad. She feels they understand more although also states she does not get sad that often. However, she wouldn't talk to them about her mother. Her mother acknowledges Issthara's increasing dependence on her peer group and states that it is ok 'that her mum is not her best friend anymore'. Issthara also feels supported by her pets, describing them as caring, generous and nice to be around if she's feeling sad or lonely.

Objective View of Child's Social and Emotional Well-being:

Issthara's self-report scores on the SDQ suggest she is in the close to average category. Issthara rates herself as higher in terms of externalising scores than internalising scoring an 8 and 6 respectively and places herself in the close to average category for the emotional, conduct and prosocial scales. In terms of hyperactivity Issthara scores herself in the high/low category while in terms of peer problems she placed herself in the slightly raised/slightly lowered category. Her mother's scores on the SDQ placed her in the close to average category on the total scale and all subscales. While her scores on the EAS-T present her as high on activity and sociability average on shyness and low on emotionality. Issthara views herself as having high resilience on the individual CYRM-28 subscale, she perceives herself as having a resilient relationship with her mother which is higher in terms of psychological rather than physical care. She also presents with high resilience on the contextual subscale. In terms of the parenting she experiences, she

perceives her mother's parenting style to be high on responsiveness and autonomy granting and average on demandingness. Objective measures based on scores from Ishthara and her mother suggest that she is functioning well within a normal range in terms of her social and emotional well-being.

Section 6.6 Josh

Family Context:

Josh lives with his mother his step-father and his step-sister. They live in a rural location in the West of Ireland. His mother's occupation is a housewife. He considers his mother and his birth father to be his family. Josh has contact with his birth father and frequently stays with him for weekends, during the holidays and when his mother is in hospital. He does not feel he has a positive relationship with his step-father or his step-sister and articulated this throughout our meetings. His step-father has three daughters from his previous marriage and they spend a lot of time in Josh's home also.

His mother describes Josh as innocent and feels that there is 'something not quite right' which has been an on-going concern of hers since he was two years old. The gatekeeper has been involved six times in three and a half years and describes the family as a whole as 'very, very mixed up'. The gatekeeper expresses significant concerns for Josh describing him in similar terms to those used by his mother that there is something 'not quite right' and expressing fears that his difficulties will get him into trouble in the future. The gatekeeper also shares she feels that both Josh and his mother have been let down by services involved.

Description of Parental Mental Health Difficulty:

Josh's mother experiences a range of physical and mental health problems including chronic pain, (former) alcohol misuse, depression, and anxiety and recently received a diagnosis of an incurable immune system illness. She is frequently admitted to hospital. His mother specifically links her anxiety and depression to the sudden death of her father when he was only 48 years old. Social work services have been involved with Josh and his

mother since he was born. It is unsure how much exposure Josh experienced to his mother's substance misuse, and the gatekeeper questions whether it may have been pre-natal. She feels that social work should have arranged a full psychological assessment for Josh long ago, and feels he is nearly getting to old now. When Josh's mother is in hospital Josh is sent to stay with his father as his step-father refuses to care for him.

Child's Understanding and Experience of Parental Mental Health Difficulties:

Josh refused to speak about his mother's mental health or her hospitalisations. His mother has never spoken to Josh about her mental health as she feels she wouldn't know how to discuss it and because she feels Josh would make a joke out of it. She also believes it would not be appropriate. She does not believe that her mental health difficulties had an impact on Josh although acknowledges that it is hard to know. The gatekeeper feels that Josh does not understand anything about his mother's mental health difficulties as this has always been the norm for him and he is used to her being like that. She believes that Josh has grown up with it and learnt to co-exist in it.

Child's Key Supports:

Josh identifies his key supports as his dog, his birth father, his Nan, his friends, his cousins (paternal) and mother. He describes the support he receives from his parents in practical terms i.e. she feeds me. While he refers more to emotional support from his Nan, friends and, in particular, his dog, Josh presents as uncertain as to whether he is loved by these people. His dog is his best friend and he talks to her about everything and feels that she listens. Josh does not have a role model and when he's feeling sad he talks to no-one but then interjects he talks to his dog. Josh experienced bullying in primary school and feels that education is not important and school is boring. However, he feels happy with his grades and how he is doing at school. Since starting secondary school he appears to have made two friends although sometimes continues to experience bullying. Josh enjoys spending his time being active with his hands and likes to do art, woodwork and play computer games.

Objective View of Child's Social and Emotional Well-being:

Josh's mother provides scores for the EAS-T whereby she views Josh as having low emotionality and average activity, shyness and sociability. Differences emerge in Josh's, his mother's and the gatekeeper's scores of perceived difficulties Josh is experiencing. Josh scores himself on the SDQ as having no significant difficulties, while his mother's scores place him in the High/Low category and the gatekeeper scores him in the Very high/low category. Thus, his mother and gatekeeper perceive him to be experiencing significant difficulties with his externalising behaviours appearing more problematic. In terms of the parenting he experiences, Josh scored his mother as low on responsiveness and autonomy granting and high on demandingness while he viewed his father as low on demandingness, high on autonomy granting and average in terms of responsiveness. In terms of his own resiliency, Josh scores himself high on the individual subscale. In his relationship with his caregiver he views his physical care as high and scores psychological care as low. He also perceives himself to have low resilience in the educational and spiritual context subscale. Josh's self-report scores on objective measures suggest he is functioning within the normal range of social and emotional well-being. However, Josh's self-report scores are not corroborated by either his mother or the gatekeeper whose scores would suggest he is experiencing significant difficulties.

Section 6.7 Boldielocks

Family Context:

Boldielocks is the second eldest daughter of her Mother. She lives with her Mother, her step-father (biological father to her younger two siblings) and her two maternal step-sisters and step-brother. She has sporadic contact with her birth father and her paternal step-sister. Her Mother's occupation is in the catering industry and she holds a degree qualification. Her step-father works away from the family home, which usually means he is absent for a fortnight at a time. The net monthly household income is €2,500. Boldielocks sees herself as unique and as someone who is herself. Her mother describes her as an energetic, strong-minded little woman who is

also 'very clingy'. She describes her as never being an easy child to parent and noticed a change in her when she was 13/14 months old.

Boldielocks has been attending the Child and Adolescent Mental Health Services (CAMHS) for three and a half years as a result of emotional and behavioural difficulties which are having an impact on her socially and on family life in general. She has had a formal assessment and diagnosed with Attention Deficit Disorder (ADD) and a possible yet undetermined further behavioural disorder. Her mother describes her behavioural difficulties as a source of ongoing concern since she was a toddler. Her mother describes her behaviour in terms of tantrums, behavioural and verbal outbursts and also self-harming behaviour. Boldielocks is in primary school and receives support from a Special Needs Assistant (SNA).

Description of Parental Mental Health Difficulty:

Her mother suffered post-natal depression following her birth and was hospitalised for a period of three months. Her mother experienced further episodes of post-natal depression with the births of her youngest two children, no hospitalisation was required during these episodes, solely medication. Her mother describes her mental health difficulties as on-going but has currently chosen not to take medication despite professionals recommending anti-anxiety medication. She feels the pressures she experiences are no different to those any parent of four children would experience. She feels she has learnt to manage it.

Child's Understanding and Experience of Parental Mental Health Difficulties:

Boldielocks has no recollection of the time when her mother was hospitalised and appears not to recall any further periods of noticing changes in her mother's mental health. Her mother also expresses uncertainty as to whether her mental health difficulties impacted on Boldielocks as she feels Boldielocks was too young at the time. However, she further shares that she feels that Boldielocks insecurity and need to be hugged may possibly be linked to a lack of affection as a child when she was unwell. She also

expresses concern that Boldielocks may be mirroring some of her symptomology through her behaviours.

Child's Key Supports:

Boldielocks identifies her mother and her step-father as her primary supports. She feels she can talk to her mother when she's feelings sad and that her step-father provides her with encouragement. She does not feel she has very positive relationship with her siblings and notes that it is more important to be her friend than her sister. Boldielocks, presents her elderly neighbour as providing her with support also as she is nice and kind and especially good to her. Boldielocks feels she has lots of friends who she gets supports from. This is usually in the context of being listened to or defended by them if she is being bullied. She describes being bullied in school, in particular about her teeth. This makes her very sad. Her mother is uncertain as to the veracity of her bullying experiences and believes that she is struggling socially and has no real friends as a result of her behavioural difficulties. She believes that Boldielocks must learn that there are consequences to her behaviour. Boldielocks usually experiences these consequence through exclusion.

Objective View of Child's Social and Emotional Well-being:

Self-report scores for the CYRM-28 present Boldielocks as having high resiliency with a total CYRM score of 120. Scores provided by her mother for the EAS-T indicate that her mother perceives her to be high on emotionality, activity and sociability and low on shyness. Both Boldielocks and her mother score her in the Very high/Very low category on the SDQ total difficulties scores, with Boldielocks awarding herself full score in terms of difficulties. Boldielocks views herself as having definite difficulties which have been present for 6-12 months, however, she reports they only upset her a little bit in terms of her home life and leisure activities. She does not feel they upset her in terms of her friendships or classroom learning. Both also perceive her difficulties to be greater in terms of externalising not internalising although this too is problematic. Objective scale scores from both Boldielocks and her mother would suggest that Boldielocks is

experiencing difficulties in terms of her social and emotional well-being which are presented as more problematic in terms of externalising behaviours.

Section 6.8 Katie

Family Context:

Katie lives with her Mother, her step-father (biological father to the younger two siblings) and her two maternal step-sisters and step-brother. Her mother's occupation is in the catering industry and she holds a degree qualification. Her step-father works away from the family home, which usually means he is absent for a fortnight at a time. The net monthly household income is €2,500. She does not know who her birth father is and describes this as a significant loss in her life. Katie is experiencing a strained relationship with her step-father at the moment and did not want to count him as part of her family. Her step-father has been a presence in her life since she was 2 years old and moved in with the family when she was about 5 or 6 years old. In light of difficulties resulting from her behaviour Katie was grounded for a month during the course of the research. Katie describes herself as a 'crazy, wild and fun girl' she also views herself as fat, ugly and aggressive but kind, caring and happy. She feels she does not mean a lot to herself describing herself as 'a total shit' as this is what she has been called a lot by her mother.

Her mother describes her as a ball of energy, someone who is self-confident and strong minded and easily led. She feels Katie is a carbon copy of her personality wise as a teenager. This is something of a concern for her mother as she feels she got herself into 'some serious messes' as a teenager.

Description of Parental Mental Health Difficulty:

Katie's mother experienced post-natal depression following the birth of her second child. Katie was four years old at the time and was separated from her for a period of 3 months. During this time she was cared for by her maternal Nanna. Her mother experienced further episodes of post-natal depression with the births of her youngest two children, no hospitalisation was required during these episodes, solely medication. Her mother describes

her mental health difficulties as on-going but has currently chosen not to take medication despite professionals recommending anti-anxiety medication and she feels the pressures she experiences are no different to those any parent of four children would experience. She feels she has learnt to manage her mental health difficulties.

Child's Understanding and Experience of Parental Mental Health Difficulties:

Although 4 at the time Katie recalls vividly her experience of her mother's mental health difficulties. She noticed that her mother was sad a lot and taking lots of medication. She describes feeling 'puzzled' and that she didn't understand what was going on and felt that her mother didn't really want her. She did not visit her mother for the 3 month duration of her hospitalisation. Her mother describes being blissfully unaware of the effect her mental health difficulties and subsequent hospitalisation had on Katie at the time as a result of the medication she was on. She feels that Katie blames herself for what happened. Her mother feels that everything changed for Katie overnight. She believes that Katie experienced feelings of anger, hurt, fear and upset and felt abandoned by her. She believes Katie resents her younger sister as a result of the post-natal depression she experienced following her birth.

Child's Key Supports:

Katie identifies her key supports as her Mother, her Nanna and her two friends. She describes her mother as 'loving, caring, aggressive, and bonkers and someone who will always love her no matter what'. Despite identifying her mother as a key support she also acknowledges that their relationship has deteriorated since the birth of the third child. She also feels very angry with her mother and states she would rather live with her Nanna. Katie's Nanna has taken on a maternal role in Katie's life, which is acknowledged by Katie's mother. Katie describes feeling like she is her Nanna's daughter.

Katie places huge value on her friendships and views her friends as her support system who she can share her problems with and fix together. She trusts her friends and they help her feel safe. She feels that they understand some of the difficult emotional experiences she has had.

Objective View of Child's Social and Emotional Well-being:

Katie and her mother differ on their perceptions of difficulties Katie experiences. On the SDQ self-report, Katie scores herself in the slightly raised/slightly lowered category while her mother places her in the perceived to be normal category. Both, nonetheless, score her higher on externalising rather than internalising difficulties. On the EAS-T her mother scores her as having high activity and sociability and low on emotionality and shyness. Katie's scores on the parenting style she experiences indicate that her mother is high on demandingness and average on responsiveness and autonomy-granting. Katie's self-report scores on objective measures suggest she is experiencing some difficulties in terms of her social and emotional well-being. From the perspective of her mother these difficulties appear to be minimised and not viewed as causing significant problems.

Section 6.9 Chapter Summary

This chapter provided biographical sketches of participating children in this research that is a portrait of each child in context. The sketches highlighted the personal and unique contexts of each child's situation providing an insight into who they are, their family context, what the mental health difficulty of the parent is and children's experience of it. It further reflected children's key supports and provided an objective view of children as measured by administered scales. The sketches serve to highlight the continuum of experiences children in this study have through an ecological lens which is central to the aim of this study as it allows for the individual voices of children to be heard.

Chapter 7 – Results: The Individual and Environmental

Section 7.1 Introduction

The overarching aim of this research was to explore the social and emotional well-being narratives of children living with a parent with a mental health difficulty in Ireland. Following on from the preceding chapter whereby biographical sketches highlighted a unique and contextualised account of children's realities, the overall aim of this chapter is to present the findings of children, parents and gatekeeper through the framework proposed by Hamilton and Redmond (2010). Their model conceptualises social and emotional well-being on an individual and environmental level and is founded in an ecological approach. Through this dual conceptualisation, findings are presented on the individual level consisting of the subdomains of inter and intra personal factors and on an environmental level comprised of three subdomains: the family/home, school environment and wider community. Findings presented were constructed by moving reflexively from within-case to across case analysis through the strategy outlined in Chapter 5 in an effort to identify differences and similarities in participants' experience. This framework will then be linked to the objectives of the study as outlined in Chapter 1.

The chapter is divided into nine sections. Section 7.2 looks at the individual level of analysis focusing on firstly the intra-personal experiences of children and their parents. These factors are central to how children construct their social and emotional well-being and on the intra-personal level include themes such as; self-concept; parenting and parenting with a mental health difficulty. Section 7.3 considers the Individual inter-personal level, and includes themes such as children's understanding and experiences of parental mental health, disruptions to children's lives, children's feelings, parents struggling to talk to their children, and supports for parents.

Section 7.4 considers environmental factors related to children's social and emotional well-being, respectively the family/home, school and wider community. Themes included in the family/home domain include the parent-child relationship, sibling relationships and pets. This is followed by Section 7.5 reflecting the environmental level of school. Section 7.6 considers findings in light of the wider community including themes relating to children, parent and gatekeeper experiences of support services. Section 7.7 presents their advice to how children and parents can be supported in this context. The penultimate section, Section 7.8 considers the findings in light of the four objectives of the research outlined in Chapter 1. Section 7.9 provides a chapter summary. Overall, the thematic findings highlight that there is significant overlap among the spheres proposed by Hamilton and Redmond (2010) supporting the complex and multi-dimensional nature of children social and emotional well-being experiences in this context.

Section 7.2 Individual Intra-Personal Level

This section considers thematic findings reflecting the individual intra-personal level. It provides an insight into children's self-concepts and considers possible factors relating to its development. It also considers parent's perspectives of their experiences of parenting, narrowing the focus to look at their experiences of parenting with a mental health difficulty. It concludes with parental perspectives on *being good enough*.

Section 7.2.1 Self-Concept

Children were uncomfortable, uncertain and hesitant in reflecting on themselves directly struggling to respond to questions about whether they loved themselves, what they meant to themselves, and were they important to themselves. From the data it emerged that children's perceptions of self could be linked to the perceptions of those in their immediate environments, notably that of their parents. Some children appeared to internalise external perceptions either positive or negative which formed the primary basis for their self-concept. Some children however, presented as conflicted and appeared to challenge the constructions of others, namely their parents. Three

themes emerged around children's concept of self: positive, negative and conflicted.

All parents linked their perception of their child to their experience of parenting. By and large if the parenting experience was positive, parents held a largely positive view of the child which in turn transferred to the child's view of self. Where parents experienced difficulties in parenting their child or in the parent-child relationship their perceptions were dominated by negative narratives. Where children were experiencing difficulties in their relationship with their parents children's negative conceptualisations increased. Moreover, parents who held a negative concept of themselves during childhood tended to transfer negative similarities to their child which heightened parental concern for their child's future.

Children's Positive Self-Concept

Children whose parents expressed a positive narrative in terms of their experiences of parenting their child had a more positive self-concept. Blue Rose's mother (as a mentally well parent) describes her as a pretty '*normal*' child, and a child who has always had an easy temperament: '*she never really had tantrums even as a two year old*'. She links this to Blue Rose having a wide support network, and interest and participation in a range of activities which are actively encouraged by both parents. Similarly Blue Rose acknowledges that '*as you can see I have lots of people and things I like to do in my life...there are lots of people, things and places that keep me happy, safe and well*'. Her father describes her as '*unique*' and a '*parent's joy really*'. Both parents acknowledge her impact on the family as positive despite the difficulties that they have experienced:

Blue Rose Mum: mmm, she's a joy but also parenting her because of what's going on, it can be, as we said earlier that you actually have to watch that you don't feel that, that you might feel guilty about something but you don't let it take over, and eh.....but having her as a child, is a real pleasure, it actually probably even helped us through a lot of stuff too.

Blue Rose Dad: I mean, what you see going on in other you know, different families and stuff like, I mean we don't we really don't have, there's no tantrums or anything like that, she's unique I think, there's

some conflict in the house, and I'm not saying conflict is always a bad thing but it's unique I think

Blue Rose Mum: mmm, Yeah I think it has been. She has made parenting pretty easy for us so far,..

Blue Rose held a very positive self-concept which could be through internalising the positive narrative of her parents, but it also could be linked to placing herself as a polar opposite to her father. This is reflected in her perception of self as someone funny and to whom laughing is intrinsic. This is evidenced in the following statement of herself as someone who *'loves to make people laugh – laughing that's my nature'*, while she views her father's mental health difficulties very much in terms of not *'laughing or smiling'*. It may also be reflective of her scores on the resiliency measure in which she self-reported maximum scores for the 3 individual subgroups of resilience. It may also be linked to her mother being mentally well and very proactive in maintaining this, and also actively encouraging Blue Rose in her friendships, activities and interests outside of the family. Such external supports, activities and interests may mediate the potential negative impact on her. Her mother's emphasis on being well in herself may further mediate the impact of her father's mental health difficulty. Similarly, for Isithara and Kathy who both expressed positive self-concepts their mother expressed very positive experiences of being their parent and parenting as she notes: *'I was in the lucky position where all I had to be was their mother'*.

Children's Negative Self-Concept

Some parents who saw their children as *'carbon copies'* of themselves expressed significant concern for their children's future well-being. Those who did spoke with an air of anticipation that their child would experience difficulties similar to those the parent experienced throughout their life. Parents who perceived their children as similar to them associated these similarities to either themselves as young adolescents, or to their perceptions of their children's behaviours as similar to the behavioural manifestation of their mental health difficulty. Parents who viewed their children as similar expressed significant concern for their children as a result:

Petey Mum: in other ways, cause I'm, I would see myself as so damaged by life... I don't want that for him and he has you know he has those

tendencies,.....will he be ok?....d'you know, ehm.....that perfectionism like can drive you mad, that need to have things in an orderly way ehm.... it does make your life..... hard.....

Boldielocks Mum: I think she portrays me a lot. I think she'll do anything to be noticed 'oh, ok Mammy behaves like that maybe this is the way to do it?.....

Moreover, although only one gatekeeper was involved in this study the findings suggest that gatekeepers too may internalise parental narratives in how they conceptualise the child. Parent and gatekeeper perceptions of children mirrored each other. In this research there was a dominant narrative from both parent and gatekeeper that *'there's something not quite right'*:

Josh Mum: Since he was two I've know he was not quite right..

Josh Gatekeeper: it's not just everything that's happened, there's someth, there's something there. It's like even sometimes, he'd look at you, you'd just little things you're kind of going, for want of a better word, I know this sounds a bit much, but kind of like, Evil.....there's I don't know have you seen it, but there's a funny streak there.....

The similarities in narratives are evident despite the gatekeeper acknowledging difficulties in relating to and engaging Josh which resulted in her work being more centred on engaging the mother. Parental conceptualisations of children were supported or negated by children's wider environments. For example, two children who were perceived by parents to be struggling socially, emotionally and behaviourally appeared to struggle less in the school environment which was acknowledged by the parents.

Boldielocks Mum: She's fine in school. She doesn't seem to present as much unless she's very stressed but she will on the playground between other kids....

Petey Mum: Well he has friends in school, but it's a controlled environment and he has the ability to have friends in school cause it's controlled.....

Although perspectives of teachers were not included in this research, differences parents note in children's behaviour raises questions as to whether this is resulting from a differing and possibly more positive narrative towards the child outside of the home environment. For example in talking to Petey's school principal he describes Petey as having changed *'phenomenally'* in the context of school however questions how this has *'translated to the home'*. The school principal largely presents with a positive concept of Petey which

seems reinforced by the wider school environment such that Petey is given the responsibility to do a reading in his Communion mass something his mother '*never thought was possible*'. The more positive approach of the school is also reflected on by his mother who comments '*they deserve every resource they get for their attitude alone*'.

Children's Conflicted Self-Concept

Some children seemed conflicted in their self-concept. Many children whose parents held more negative conceptualisations struggled in separating the negative views with the more positive ones they held. For example, Boldielocks's choice of name for the research is linked it to how she sees herself as being perceived by the family in general as a '*bold*' child. Boldielocks seems to fluctuate in her self-concept, she views herself as bold, someone who gets angry and unaware of her strength in hurting her siblings. She also presents as very strong minded and on several occasions presents a defensively strong positive self-concept. She challenges the dominant external perception of herself as '*bold*', and although surrounded by largely negative behavioural narratives, views herself positively. Her narrative suggests she may be feeling external pressure to change and although she challenges this view she also appears conflicted in the following excerpt:

R: and now what are you like, describe yourself to me? [Boldielocks begins to write] You're fun, you're happy

B: happy, that's it!

R: and what do you mean to you?

Boldielocks: It's just me

R: are you important?

Boldielocks: (no answer)

R: are you important to yourself?

Boldielocks: mm...no

R: no, you're not important to yourself?

Boldielocks: It's just me....

R: just you?

Boldielocks: and me is me...

R: and do you love yourself?

Boldielocks: You can't change me..... Not really

R: you don't love yourself?

Boldielocks: Not at times.....

R: at times

Boldielocks: Not at times

R: what kind of times?

Boldielocks: ehm,..... these are my left over pictures,

All children's self-concept presents as largely influenced by the perceptions of those around them in particular their parents. Some children whose parents held a positive narrative of the parenting experience and their child in general had a positive view of self. While some children whose parental narratives were dominated by more negative parenting experiences and conceptualisations of the child tended to view themselves more negatively. This may be exacerbated when professionals adopt the negative parental narrative. Children's narratives suggest that they may internalise the dominant narratives of those around them either positive or negative. However, some children who were surrounded by largely negative narratives in terms of their behaviour challenged these narratives and seemed conflicted in their view of self.

Section 7.2.2 Parenting

Children reported mixed experiences of parenting styles. One child reported uninvolved parenting, while three reported authoritarian style and the remaining three reported authoritative styles. Children who reported authoritarian and uninvolved parenting were largely perceived to have difficulties socially and emotionally while those who experienced an authoritative parenting style were perceived to have fewer difficulties. Children reporting on both parents highlighted differences in the parenting styles of both parents with particular reference to disciplining. They also suggested a preference towards who did the disciplining in the family home. Parents also identified differences in parenting that children experienced. Many children reported feeling that their parents were too overprotective

which they viewed as unnecessary. While some children didn't like that their parents '*bossed them around*' and linked this to having to do household chores. Many children also reported that they wanted to spend more time with their parents. Factors children reported as impacting on the time spent with their parent were '*other siblings*', '*mental health difficulties*' and '*work*'.

Blue Rose distinguishes between her parents identifying her mother as the disciplinarian. When asked what her father does in this situation she replies:

Blue Rose: he just stands there....

She also acknowledges a preference for her mother as disciplinarian:

Blue Rose: he's more scary when he's angry

Differences in parenting were further noted by the gatekeeper. These differences were perceived to be causing difficulties in implementing changes to parental practices resulting in significant confusion for Josh. The gatekeeper viewed the ensuing confusion for Josh as a significant factor in the difficulties he experienced:

Gatekeeper: I think it's a combination for him, of the parenting he's getting they all love him but they're parenting him in different ways and I think he's very, very confused.....

Some children reported highly emotionally responsive parents who told them every day that they were loved. However, some parents struggled in their emotional responsiveness which was reflected on in terms of their child's current emotional and behavioural difficulties and the parent's mental health difficulties suggesting intermittent parenting in terms of the attachment relationship in their child's early formative years.

Gatekeeper Josh: he can't show emotion, and now that I think about it, I've never seen her hug them....it's only as you ask me....it's the one thing I've never seen

Katie and Boldielocks Mum: I don't know if this need to be hugged is it because of a lack of as a kid? As a baby?

Parents reported a wide spectrum of experiences of parenting their children positive and negative. Some parents found the experience of parenting hugely positive and rewarding identifying it as the best and most

important thing they would do. One parent challenged what she perceives to be the dominant narrative of parenting which she presents as socially constructed, whereby it is viewed as challenging and requiring sacrifice. She also views parenting as a life-long collaborative exercise she shares with her children:

Kathy and Issthara Mum: it certainly it's not hard work (laughs) you know you're supposed to say these things like it's so challenging' and it's so difficult and it isn't I mean the most difficult thing about it is that we're so financially constrained and kind of have been since we came back to this country and it's just, boring at this stageehm, but it's no, parenting is wonderful, I'd highly recommend it (laughs) it's the best thing I've ever done, it's the most interesting thing I've ever done, you know and I suppose the beauty of it that is that I'll never stop d'you know, you don't stop being a parent, it's a wonderful collaborative exercise. I think I collaborate with them in their own parenting

She distinguishes between the difficulties of being a parent and the difficulties of societal structures that impact on parenting which for her are primarily financial. She presents parenting as a role which is constrained by environmental factors and sees her role as a parent as providing her children with the tools to 'cope with life' and distinguishes between 'sacrifices' and 'choices':

Kathy and Issthara Mum:I think it's difficult to parent when you've no bloody money and I think it is ehm, oh I don't know, people talk about making sacrifices, but I don't make sacrifices for my kids, I make choices and sometimes, the choices that I make for my children are to fulfil their immediate needs, by putting my own needs, on a mm, to be filled later sort of scale, but it's not a sacrifice. I mean what's a sacrifice, d'you know, it's a stupid word to use, don't have children then (Laughs) Sorry!..... 'I sacrifice so much for my children', I've sacrificed nothing for my children, my life would be different without them, but it certainly wouldn't be any better, because this is all I ever wanted so this is as good as it gets

However, many parents' narratives reflected the difficulties they experienced in their role as parents. Some parents reflected that they had made sacrifices for their children. There is a sense of loss of identity or sense of self through taking on the parental role and also through their role as a patient. Parental sacrifices were largely attributed to the changes to parent's lives as a result of having children which occur on an individual and relational level and are presented as sudden and dramatic:

Katie and Boldielocks Mum: Sacrifices, lack of sleep, financial stress, financial insecurity, trying to get everything done, lack of your own life, you do give up a lot to have a family and anyone who says otherwise is lying through their teeth. Being a parent you make a hell of a lot of sacrifices for yourself, but in a relationship you have children your relationship changes with your husband, you have children together, it does change, your priorities change overnight,sacrifice a lot of it, but it's worth it, for me it's worth it, for other people it might not be

Petey's Mum: I don't know, I suppose I felt a little bit resentful of them, cause they stripped me of me...

Parents who were struggling and expressed a negative experiential narrative of parenting, reported increased difficulties in their relationships with their children and within the family as a whole. Many parents experiencing difficulties attributed this to their children's adverse behavioural responses:

Katie and Boldielocks Mum: Difficult, difficult, because nine times out of ten you're biting your tongue because you want to kill her [Boldielocks]. You might get 2/3 hours in the day that she's ok but you're still gonna have a tantrum or two in there...

Thus, parents experiencing greater difficulties in their role as parent, appeared to have a more negative perception of their child, and appeared more likely to attribute these difficulties to their child's behaviour. In turn, these children presented with a more negative self-concept than their counterparts whose parents viewed their child positively and whose experience of parenting was largely positive.

Section 7.2.3 Parenting with a Mental Health Difficulty

All but one parent made reference to the increased difficulties they experienced in parenting their children as a result of their mental health difficulties. Some narratives suggest struggling to balance attending to their own personal issues and those of their children. Many parents refer to having a lack of insight into the needs of their children when their mental health difficulties were 'active'. They describe intermittent parenting through a lack of awareness and understanding of their children's needs as a direct result of their mental health difficulties and indirectly through other issues emerging from it such as marital difficulties. These narratives point towards parent's feeling 'consumed' or 'overwhelmed' by their mental health difficulties.

Katie and Boldielocks Mum:as a parent and when you're not well in yourself, you don't notice everything, you don't take in everything, you don't you're not aware of your children as much. Genuinely, you're not aware, your too caught up in your own stuff that you don't realise you're kids you don't and there's no point saying you do, cause you don't, you're lying through your teeth if you say you do, you wouldn't be in the position you are and in the state you are, you can't do both. I'm telling you that straight out.....you can't your problem is your problem nobody else in the world has your problem and you're not able to deal with your child's feelings you wouldn't even consider, it wouldn't even come into your head, it wouldn't and if you were depressed to the extent I was it certainly didn't

Some parents and the gatekeeper viewed their children as exacerbating their difficulties. Highlighting the bi-directional influence of the child on parent, they presented children as having the ability to *pick up* on their affective states which were perceived to be use advantageously. This was also supported by the gatekeeper perspective:

Petey Mum: I can feel a little bit hard done by, then d'you know, and they upset me and they see my buttons, and sometimes I wonder, why it's news to me cause, they probably know me like the back of their hand, they can make me cry, they shouldn't be able to do that,.....

Gatekeeper Josh: He's also cute enough to know how to push the buttons. That's what I'm saying about the devious side, I've watched, he knows the moments that she is vulnerable so that's what he's learnt from her mental health, he knows the moments she's vulnerable and he could say or push that button until he gets what he wants, and he knows the days she's stronger, you can see, that they're actually quite good those days, but is that how he's dealt with her mental health that he's learned to co-exist in it? Or is there something deeper? Not sure....

Despite Petey's mother's perception of children '*not being able to make adults cry*' she describes her thinking as '*deluded*' and her disappointment on realising this, highlighting the bi-directional influence of parent on child and child on parent. There is a sense of rejection in her narrative that she has been '*hurt*' by her children. Her narrative also suggests the perception of children as a redemptive vehicle and that the child as innocent and vulnerable can repair all that is wrong:

Petey Mum: And it was probably the biggest mistake I ever made because I don't think I was ever designed to have children, I don't think my life makes me a very good mother, and I really believed that children wouldn't be ok with me.... and then I made my life and I dragged myself through and I compromised and then when [eldest son] was born I said d'you know what, I mean how delusional was I like it just shows you how ill, even though it wasn't the eating disorder present at that time but how

ill my thought process was, that I have something now that I can pour absolutely every piece that might be good in me into and I can love him intensely and he'll never hurt me cause he's mine....Oh my god what do kids do every single day of the week they push all your buttons they make you into a lunatic even if you weren't one already d'you know, there's no logic to them and I don't know why I thought this, d'you know....He'll fix me, I actually thought he would fix everything that has ever been wrong, he'll give me something that's good....

The context within which parenting occurs is highlighted in this research as significant for both parent and child. These findings highlight the bi-directional emotional impact that children have on parents and parents on their children which can be exacerbated or exacerbate parents mental health difficulties.

Section 7.2.4 Being Good Enough

Some parents commented on being ‘*good enough*’ parents. This was usually presented in terms of parents feeling they were ‘*not good enough*’ and as having failed their children by not getting ‘*it right all the time*’ and not being ‘*Mary Poppins*’. Some parents linked this to their mental health difficulties and subsequent difficulties in parenting while others viewed this in light of environmental constraints. While others viewed themselves as fundamentally flawed, and that their experiences of parenting has resulted in significant emotional confusion again linked to exacerbating their mental health difficulties. Petey’s mother feels enormous guilt for not being ‘*enough, that I’m not good enough*’. When asked what she understood by good enough she states ‘*somebody normal*’ which she continues to describe as:

Petey Mum: somebody more capable of loving them than I am, you know I don't think I love them enough, like I try to d'you know, and I've always been too much to love them, cause I want to fix them. I do love them but, I don't know if they know how hard I work for them, and fight for them, and so that's where it gets so hard, to not take it personally, because even as a normal person, it's hard to keep fighting for somebody all the time, when you can't, when they turn around, and then they tell you that they hate you and they wish you were dead (laughs) cause, as a not normal person you believe itd'you know, I think it might be hard for any person to take, but it's extra hard for me to take, that's it, I don't think I have anything else.....

She describes parenting in terms of a constant battle of adaptation and struggling to alternate between the different types of parenting needed for different children in the family home. Difficulties parents experienced were

also exacerbated by different approaches to parenting within the marital relationship and also the absence of 'active' fathers in children lives. Parenting presents as a very isolating experience for some parents, even within the context of a marital relationship. One parents reflects on their loneliness in the context of gender:

Petey Mum: I feel a loss that I didn't have girls, I kind of feel very lonely in this house that I will never have anybody....

She further reflects on this in the context of impossibility due to the different requirements of her children in terms of parenting. Her narrative again suggests that she views herself alone in her role as parent:

Petey Mum: Me, with him, I get it more and it's like just reiterating like, sometimes I struggle because [brother] needs routine and structure I suppose, and Petey, you couldn't even begin to try and put structure on him, so that always challenged me, why couldn't He have given me two the same. That we had one modus operandi and that they didn't upset each other or unhinge each other, it's like trying to work on different flight plans all the time....you can't...with one person you can't give both of them what they needed when they're so different

She links her failure as a parent to the role she adopted in her own family as that of the 'fixer'. The difficulties she experiences as a parent may be linked to her perception of herself as inherently flawed since birth and her perceived failure in being able to fix herself and her children reflected in the following:

Petey Mum: I still struggle with being born wrong and that's why all of these things happen and why I suppose I'm so involved with the kids as well I find it hard to pull back sometimes that I take things so personally..... I spent years trying to fix them, cause I think that's what I've done my whole life cause I've never really known how to fix me. So I've always been the go to person, like when mum and dad were arguing, or when everything was falling apart, if there was trouble at home they would ring me to come and referee. I was a fixer, and I couldn't fix the lads, and I failed to fix me so.....but you see it's to fix, I want to fix them and I can't. I just wanted them to be normal, you know, and it's taken me a long time to accept that they're not....

She describes a mixture of anger, guilt and shame and her narrative suggests significant self-blame for her children's difficulties in light of her mental health difficulties:

Petey Mum: ... my anger at him is me being ashamed of myself that I'm not stronger for him. I think that's where it comes from, and it's a crappy

place to be. I feel I've let them down. I feel the longer I can't kick the eating disorder the more I let everybody down. It's not all I am and I think I can make some really good decisions and I genuinely at the back of it have their best interests at heart, but my method isn't always the best, but I just have no..., I guess I'm looking for guidance,

She feels judged for how her children are perceived, and expresses guilt and shame as a result and seeks external reassurance from her husband. However, she reflects that the reassurance is not forthcoming as in her eyes, her husband views her solely as her illness:

Petey Mum: I do and I'm always looking somebody, as well as that I look to [husband] to justify my existence, that I am doing a good job, and he doesn't think so because he just thinks I am just an ill person

She expresses uncertainty for the future and constructs parenting as a relentless battle with little light at the end of the tunnel. This she attributes to the constant changes required to meet her child's needs:

Petey Mum: fundamentally I don't know if I'll change enormously in my parenting d'you know I don't know I mean I'm constantly trying to change my parenting to adapt but it just feels like this unending battle, that it's never going to be good enough, cause there's never one way of getting it right. And you say 'oh he responds to this all the time'. Petey is a work in progress all the time what he'll respond to today he may adapt and not respond to tomorrow, you know you have to constantly be adapting scenarios and styles and you know try and figure out what's going on in the moment, and its bloody exhausting

Some parents felt significant guilt at the impact of their mental health on their relationship with their child and their ability to function as a parent. Blue Rose's father's narrative suggests a tone of regret as he refers to 'mistakes', 'years lost' and 'not having done enough recently' as a parent. Blue Rose also identified with her father's sense of guilt and refers to the efforts that her father makes in trying to make her feel better:

Blue Rose: Yeah sometimes, when he tries, and I know he tries to make it better like, maybe when I tell I don't really like that he doesn't really smile that often, he says I'll try to make do it, and then he improved a bit since the last week....

In terms of the extra parenting role her mother undertook she emphasises the need for herself to be proactive in keeping herself well in order to be able to function as a parent. Her mother acknowledges:

Blue Rose Mum: Yeah I, I think I'm definitely the one who gets a wider range of the feelings too, I also get more of the ones where she's mad and when she's you know not so happy with something, she does that with you [Dad] recently a bit more now. I think, she must have known that you're not able or something to take that

She also reflects on the difficulties this distinction in roles causes her in having to deal with the less 'fun stuff', however she reflects on this with an openness to communicating about difficult issues present throughout her narrative, whereby she actively encourages talking about difficult as well as positive experiences:

Blue Rose Mum: I think with [Dad] it's more the (laughs) fun, I think with me she wouldn't be as careful, as she is with [Dad], I think she's a little bit more careful with you than she is with me as in we would have arguments Blue Rose, generally not always but you know generally we would talk through our stuff and it wouldn't always be nice and stuff and em, which is sometimes hard, but I think it's good too really, I wouldn't like to think that she would not say stuff to me that she would like to say..

Section 7.3 Individual Inter-personal Level

The second level of Hamilton's and Redmond's (2010) conceptualisation of children's social and emotional well-being is the individual inter-personal level which is considered in this section. Themes included in this level are children's understandings and experiences of their parent's mental health difficulty, the change and disruption children experienced in light of their parent's mental health difficulty, the difficulties parents experience in trying to talk to their children about their mental health, parental informal support, and how children provide support to their parents.

Section 7.3.1 Understanding and Experience of Parent's Mental Health Difficulty

Many children struggled in talking about their parent's mental health and their experiences of it. One child refused to talk about their understanding or experience. However, all children in this research had an understanding of their parent's mental health difficulties whether this had been explicitly discussed with them or not. Children became aware of their parent's mental health difficulties either as a result of the separation that occurred through hospitalisation, through their other parent informing them or simply by what they observed when their parent was present. Their level of understanding and awareness was varied and coincided with the level of openness that

parents shared and the information provided about the mental health difficulty and what was happening. Despite the level of understanding all children expressed concern for their parent.

Parents held differing perspectives as to whether children needed to be burdened by excessive and emotionally difficult adult information, while others felt that a certain level of appropriate understanding was needed. All parents acknowledged the difficulties of trying to explain to children what was happening. Some parents were unsure whether their mental health difficulties had impacted on their child. Most parents acknowledge either an emotional or social impact on their child. Parents who had spent time talking with their children about their mental health had a better understanding of how their children experienced it, what their concerns were, and what might help. Their openness to discussion and in allowing children to express their feelings and concerns appeared to reduce children's concerns when information was shared. The majority of children stated that there were few people who they would talk to about their parent's mental health difficulties.

Some children understood their parent's mental health difficulties as a result of changes in their parent's affective responses, not laughing, not smiling, being sad and stressed were reported by some children. From the perspective of Blue Rose, whose mother used excerpts from the book *Living with a Black Dog*, to assist the explanation of what was happening, her father's poor mental health was presented in emotional terms including '*he doesn't laugh*'. She appears to use the frequency of laughter as a measure for her father's mental health. She also presented it as arising from her father's concern for external and internal judgements i.e. being afraid of what people may say and also '*seeing the darker side of things*'. Throughout her interviews the importance of laughter and smiling for Blue Rose is evident, she makes several references to it and values it highly as a characteristic in herself and those she interacts with, the importance of laughter and smiling seems to stem from father's lack of these expressions:

Blue Rose: Ehm, he doesn't really laugh or smile that much

Katie: The change I noticed was she was sad a lot and lots of medication.

Her mother and father also reflect that she experiences her father's mental health difficulty through his lack of laughter and smiling, her mother comments:

Blue Rose Mum: and I think the way she experiences it, she says, it's okay to tell it, that she misses [Dad] laughing more in the house that is what she misses really...

Some children understood their parent's mental health difficulties as socially constructed and linked them to the stresses their parents experienced in their own childhoods or in their current life. Some children perceived life stress as inherent to the etiology of their parent's mental health difficulties. This was reflected on through children's perceptions of their parents' difficult adverse childhood experiences, young parenthood, relationship difficulties and financial stress.

Katie: everybody just thought she was mad, that's really how she managed to get depressed, and Uncle [Boldielocks dad] just dumped her thinking she was crazy

Isthara: ehm, well she's quite stressed

Kathy: not all the time

Isthara: no not all the time it's sometimes, though and, sometimes she gets kind of sad cause she feels she's not giving us all that we can have

Some children did not wish to talk about their understanding or experience of their parent's mental health difficulties. Children's lack of understanding and uncertainty as to what was happening with their parent raised conflicting feelings in children towards the parent. Some children responded ambivalently to their parent's absence at home due to their hospitalisation.

R: What's it like when mum is sick?

Petey: Good

R: It's good.

Petey: Nods

However, on a return visit:

R: was it good this time?

Petey: no

R: no it wasn't good was it?

Petey: no

R: why was it different this time?

Petey: she's been in hospital a few times..

R: ok and do you find it hard when mum's in hospital?

P: kind of

Some children took comfort in their lack of certainty. There is a sense of denial in accepting the reality of their parent's health difficulties which may be used in a protective manner as illustrated below:

R: no, and does mum explain to you

Petey: (hesitantly) Not really, no

R: not really, would you like if she did...

P: ye... no....

R: no

Petey: cause then I would know somethings wrong....

Petey's hesitation in whether he would like to understand more, highlights his emotional uncertainty. In deciding, ultimately, that he is better not knowing, he indicates this is an emotionally protective decision for him. However, for other children the uncertainty of what was happening with their parent led to significant emotional concerns including feelings of abandonment and rejection:

Katie: but I didn't really understand the whole, what was going on and I was like does mammy, at times does Mammy really want me or did she just leave me with Nanna because she's had enough.....

By and large children with a greater understanding of their experience and who had someone, usually another adult, to talk to about their difficulties presented as more secure in their understanding of the situation. Although this

factor did not exclude them from experiencing some difficulties in light of worries or anxieties about their parent.

Ishthara: ehm, I don't know it's kind of, overwhelming sometimes, like when she's really upset or something

Kathy: cause sometimes I almost get a bit stressed because she's stressed

Section 7.3.2 Disruption to Children's Lives - Change

Some children experienced significant disruptions to their daily lives and coupled with their uncertainty or lack of understanding this stirred painful emotions in them with feelings of rejection, abandonment and self-blame emerging which continued throughout childhood.

Katie: well I didn't really understand it cause I was only like just turned 4. I didn't really understand the whole, what was going on and I was like does mammy, at times does Mammy really want me or did she just leave me with Nanna because she's had enough.

She continues:

Katie: even like when I got older and she was going on a night out with her friends, and yeah I would have had my step-dad or whatever, I always worried that she was never gonna come back, cause she was gone for so long, I used to try to stay up until she'd come back so I knew she'd come back....

Katie's feelings at this time were linked to the significant disruption to her life when her mother was hospitalised, including the unexplained absence of her mother, the departure of the man she had come to know as her father (Boldielocks, Dad) the change in her home environment, the birth of her siblings and her mother's new relationship. She describes feeling 'messed up' and having to relearn to trust in her mother and links this to a fear of abandonment at this time. What helped decrease the anxiety she experienced was the security she perceived in her mother's new marital relationship.

Katie: and I kinda trusted her more now, cause when that happened I like I thought that my trust had broken for her, cause I was worried that she was never gonna come back see and I wasn't able to trust her, knowing that she wouldn't be able to come back. To me she was gone, because I didn't care for her,

Parents and gatekeepers also acknowledge the significant disruption children experience, linking this to their children's experiences of separation,

change and instability. These were largely perceived as having a negative emotional impact on children:

Katie and Boldielocks Mum: I wasn't there for three months of her life, we moved house, we moved from [place A] to [place B], I moved into this house straight after, I didn't move back to the house in [place A] in [place B] she changed schools, her whole friends everything changed, overnight like literally so yeah that did have an effect on her of course it did,

Josh Gatekeeper: if anything goes wrong, Josh is sent away, continuously when Mum was sick, Josh would be sent away. [step-father] wouldn't be able to handle him. He feels he's being thrown away all the time that he's not wanted....

Kathy and Isithara Mum: because they have had a lot of change in their lives, in terms of moving country, and moving continent, moving schools, moving home, moving, there's a lot of moving and I think I have been the only constant in their lives

This suggests that the changes that occur in the lives of children as a result of the outcomes of their parent's mental health may have significant social and emotional outcomes for children which are presented as negative for their well-being as Kathy notes 'cause I don't really like change'.

Section 7.3.3 My Feelings

Children's daily lives presented a range of feelings both positive and negative. Some children linked their feelings to the time of their parent's mental health difficulties. Other children considered their feelings in the current moment. Feelings associated with children's experience of their parent's mental health were usually considered in terms of sadness, anger, confusion, and relief associated with their parent's symptoms or the period of separation that occurred. Gender differences emerged in that boys struggled more in discussing their feelings than the girls in this research presenting with a more silent narrative, with Josh saying he had no feelings, seeing this as just who he was and describing it as fun and Petey identifying two dominant feelings presented in his feelings map as anger, which he repeated 16 times and sadness. These feelings were linked to his parents, his brothers and home life in general.

The gatekeeper and Josh's mother also identified with Josh's inability to express emotion:

Gatekeeper: There's no emotion there, he doesn't show it. Emotionally he's very immature emotionally for his age I think in one way he acts a lot older, but emotionally he's like a little child, but his emotions doesn't show, it's either anger or just doesn't talk to you, there's no in between....

Josh Mum: He finds it very hard to express himself, I've always said that. He tends to bottle up a lot. He's not a child that would come to you if he had a problem

Section 7.3.4 Struggling to Talk About Parental Mental Health Difficulties

Many parents expressed uncertainty as to what their children understood about their mental health difficulties or how they experienced it. Some parents reported their child understood nothing about their mental health difficulties. Many parents reported struggling in discussing their difficulties with their child thus avoiding the conversation. Parents who reported struggling with how to broach the subject also commented on their own emotional discomfort in addressing it. Finally, these parents were more likely to attribute reasons such as the child's age, or that it was inappropriate to discuss it with the child.

Petey Mum: I have no idea, no never, just he's a bit small and I think he's enough going on, I just don't think he needs it. I don't know, I haven't talked to him about it, it's just something that we've never... I think he struggles with figuring things out enough besides burdening him even more with something that he may not be able to grasp.....

Some parents felt strongly about being open with their child about their difficulties, not wanting them to see it *'as something she'll get, not as something that she has to be ashamed of, not as something she can't talk to anybody about'*. Some parents and the gatekeeper reflected on the normalisation of the context for children *'cause that's what they've seen, that's what they've learnt and that's part of the norm now'*.

Kathy and Ishthara Mum: (deep inhale) I suppose they understand as much as I do, you know, that it's there and it's probably never going to go away and we just live with it.

Kathy: she had a panic attack

Ishthara: (giggles)

Kathy: no she didn't, she didn't really have a panic attack it's just, sometimes she gets an awful headache if she doesn't have coffee

R: ok

Ishthara: (laughing)

Kathy: (defensively) No she does!

Ishthara: it's kind of funny though, she loves coffee, sorry that sounds kind of mean but

Petey's Mum: I don't know, I guess the boys have grown up with it,....

Many parents expressed difficulties in how to talk to their children about their mental health. Finding the words to communicate to children about their mental health was challenging. Parents reported little suitable information or advice on this as problematic. Some parents opted to adapt adult information in assisting their discussion e.g. Blue Rose's mother. While others simplified it to what they perceived to be their child's level of understanding, using terms such as 'Mommy's not well, Mommy's tired'. Some parents highlighted the importance of having open communication within the family about their mental health difficulties. Blue Rose's father acknowledges that despite the difficulties in talking about his mental health difficulties due to the emotionally challenging nature of the topic, found it to be somewhat therapeutic for him:

Blue Rose Dad: and it's eh, it's vital I think to actually discuss it because, em Blue Roses Mum was quite open about it, and I probably wasn't, but you could see that between the really bad times and the really, the times when things are good, if that wasn't discussed at that time, or even brought up or explained to Blue Rose properly, I don't think it would be the way it is... so it's vital that they're involved on some level, ok when you talk about Mental illness, it can be very heav, maybe difficult for a younger child to understand but I think what Blue Roses Mum wanted to do and she's and we did as a family, was to discuss Daddy at an early point, it was awkward for me cause I don't really usually open up my feelings, but it really helped me a lot emotionally I think. Em, it's just nothing to be swept under the carpet....

Despite difficulties in talking with their children, all but one parent felt that children should be informed about what was happening.

Section 7.3.5 Parental Informal Support

Few parents in this study had access to support from extended family be it as a result of geographical distance, death or estrangement. Some parents reported significant difficulties in their relationship with their birth families,

especially with their parents. Some parents without extended family support highlighted the importance of having good friendship networks in their lives. This was discussed in the context of friends as supports to parents and also as supports by providing children with a place to go if needed. This was increasingly so when there was a crisis situation with the parent or when the parent needed a break:

Blue Rose Mum: and I know there was once or twice well, there was a few times, where thank god we had good friends where I could call and say look things aren't so good, would you mind, could she be in your house for a bit and that's fine,

Kathy: and she's (mum's friend) always offering that she can take us, if my mum needs a break or something

Children also identified their parents' friends as positive supports, with some children including them as their role models:

*Blue Rose: I consider my mum's friend T*** my role model, she makes me feel like her daughter....*

*Issthara: Ehm, she doesn't need that much, I don't know I think she likes to be on her own, some of the time or actually call her friend S**** and she's really nice to my mum and she's only a few doors down and she's a nurse so she knows what to do as well....*

Section 7.3.6 Children Supporting Parent's

In terms of helping when their parent was unwell, children generally spoke of this in terms of providing practical and/or emotional support to their parent. Blue Rose, Issthara and Kathy all spoke of taking on some extra responsibilities in the house namely helping with the cooking, cleaning and taking care of pets but by and large this was not problematic:

Blue Rose: I did most of the jobs that dad usually does, I walked the dog, it's was a bit, I didn't really like doing it for 6 months in a row and I even had to clear (the dog's) poop!

Children viewed themselves as sources of emotional support for their parent. Many children valued themselves for providing both emotional and practical support to their parent.

Issthara: Ehm, I usually comfort her. I'll go and I'll talk to her and ask her what's wrong and then I make coffee for her cause that's the thing she likes most

Some children viewed their increased responsibilities as positive as it provided the opportunity for them to '*practise being older*'. Kathy reflected on this in terms of what she wanted adults to know that she didn't like which she stated was not being trusted or '*treated like a real person*'.

Kathy: well it's almost like they don't want to give me any responsibilities because I might do something wrong, it's almost like they're saying that everyone makes mistakes and then they won't give any children any responsibility to practise, being older, but our mum gives us, I think, sometimes, if she's sick we'll walk down to the Tesco ...

Children presented with different ways of managing their parent's mental health. For some children where there was no second parent the responsibility appeared to be greater. However, due to the participation of only one family where both parents participated this is difficult to ascertain, as are the implications of the gender of the parent who is unwell. Having a close sibling relationship proved helpful for some children when their parent was unwell. In the context of Ishthara and Kathy they took a unified approach in supporting each other to support their mother:

Ishthara: I would probably talk to Kathy, cause I don't really tell people that my mum was sick, well my friends, like, I might tell my neighbour, my mum's really good friend, but I don't really tell anybody at school

Kathy: Sometimes, I get a bit scared so I just cover my ears (giggling).. and I go to Ishthara

In terms of managing when their mother is experiencing a panic attack, Ishthara describes a process of consultation with her sister in terms of how best to manage the situation in the best interest of their mother, selecting carefully who she would discuss the situation with and seek advice from.

Section 7.4 Environmental Level – Family/Home

Hamilton and Redmond (2010) propose three components that comprise the environmental level: the family/home, school, and the wider community. This section will reflect on the first sphere in the environmental level of children's social and emotional well-being and include factors relating to children's family and home. The primary factors of relevance reported by all children included their relationship with their parents and siblings. Children also included pets as important. Some children included

friends in their family also but the majority of children referred to friends in the second sphere of school and so it will be considered in the following section. Narrative findings were also supported by the majority of children through their visual data with all but one child including photos of their parent(s) and friends. The sibling relationship was presented by two children as a source of support however, most children did not include their siblings in their supports, reporting significant difficulties in their relationships. Two children included their grandmothers and one child included their cousins as sources of support. One child reported his primary source of support as combined between his teddy bears and his mother. In terms of where children reported feeling supported this was primarily reported as at home and school with one child reporting at a friend's house.

Section 7.4.1 Parent-Child Relationship

Many children reported having a positive relationship with their parents. Many children reported that their parent was their role model and linked this largely to their parent having overcome difficulties linked to their mental health difficulties. In this regard children viewed their parent as being brave and strong. Children reported that their parent was someone they could talk to about most things, and as someone they would go to if they were upset. Although some older children acknowledged that there was some things they would not talk to their parents about, preferring instead to seek counsel from friends.

Only two children reported on their fathers in this research, some children had no contact with their fathers. Some children perceived the lack of contact with their fathers as a loss; others did not. Some children reported difficulties in their relationship with their parent's new marital partners. Some children felt uncomfortable talking to their parent about their mental health difficulties, fearing that it may make the situation worse.

Blue Rose experiences a close bond with both her parents, in particular her mother. She identifies both parents as providing her with a sense of strength, safety and support. She identifies her mother as someone she can talk to if she's worried about her father or if she cannot talk to her

father about something, or when he's angry with her and she does not know what to do. She differentiates between her parents describing her mother as: *'funnythe complete opposite to my dad'*. She also acknowledges the extra role her mother had to take on in light of her father's illness stating: *'she kind of fills in for dad a lot I think'*.

Many children reported wanting to spend more time with their parents. Reasons children gave for their parent not being able to spend time with them were that they were too busy with their friends, work, money and other siblings.

Katie: you can't have her alone, there's always someone stuck to her or she's always doing something else. She doesn't have time, and we don't have money for it either,

Blue Rose: I always think that he's too busy going to his friend's house... I think he spends more time with him than me...

Josh: no I want to do things as a family, cause the only thing that he (step-father) wants to do with me is go out on the farm, that's it.

Most parents were aware of the impact their mental health difficulties had on them in their role as a parent and in turn on the parent-child relationship. Many spoke with a sense of guilt in terms of not having done enough or spent enough time with their child:

Blue Rose Dad: Yeah I mean we take turns in bringing her to bed and stuff and she insists that Daddy brings her to bed every second or third night so I'll sit down with her and we'll talk about things, we'll listen to an audio thing together, we'll start, I'm not a big reader, we'll just chat, em, there's a lot more that we do together now than we did, but I know there's room for that eh, maybe should be a bit more.

All but two parents acknowledged the difficulties of managing all their children and trying to spend time with them with some acknowledging it as a rarity. Some parents described outsourcing to other adults so their child would have someone to support them in their absence. This was usually someone from the extended family or close friendship network of the parent:

Katie and Boldielocks Mum: not as much as we used to, ehm, we used to do a hell of a lot more together, but she's in secondary school now, and by the time she gets in, and homework and everything the time isn't here, and at the weekends then I have so many younger kids, ehm, its fine if my husbands around, we can bugger off and do shopping or we do something. My Mum has stepped in in that department, I couldn't do it for

her, I know it's not the nicest thing to do, but I asked my mum to help out, to give her some attention, give her someone to, because I can't, I genuinely I do try,

This was increasingly so if there was another child in the family with a behavioural diagnosis. Some parents however viewed themselves as spending a lot of time with their children and questions whether this is a positive:

Kathy and Issthara Mum: Pretty much everything (laughs) which sometimes, I wonder how good that can be for them, that they're never away from me and then sometimes I think well they'll be away from me for long enough, they're children now, they should be with their mother, you know, that's pretty much it, ehm if we were back in the cave where else would they be!.....

She perceived herself to be the 'only constant in their lives' and comments on what she perceives their experience is when she is unwell and the loss they would experience but the strength they would draw from each other as a 'tight unit' and in turn the strength, comfort and reassurance this provides to her as a parent:

Kathy and Issthara Mum: Ehm, which if the wheels start to come off my wagon, I could only begin to understand, begin to imagine that makes things very difficult for them.

Some parents noted changes in their relationship with their children as they got older. Parents referred to 'teenage behaviour kicking in', and that their child was 'pulling away' and that they realised that their mother 'wasn't their best friend anymore'. These changes were linked to increased dependency on their social group and the testing of boundaries by their child within the parent-child relationship. However, most parents viewed these changes as 'entirely age appropriate' in light of their child's developmental stage. One parent made reference to how she changed as a parent which in turn impacted on the parent-child relationship.

Katie and Boldielocks Mum: She hates I've changed, She'll tell you I've changed as a parent, I had to because she's hitting the teenage years, I said 'I can't be your friend and your parent'. She'll tell you she doesn't like what I've become and we're not as good and we're not as close anymore but it's because I've had to become more of a parent

Where children and parents were experiencing difficulties in their relationship and parents held negative conceptualisations of the child, some children's narratives suggested they were experiencing significant self-blame. As reflected in the following dialogue where Katie reflects on her current difficulties with her parents and what she perceives to be the cause of the difficulties:

Katie: Me and the way I've become, and that's what happened.....

R: How have you become?

Katie: The devil child.....

R: who calls you that?

Katie: my mother, but Nanna says I'm just the way that she was and that there's ways around it, cause she doesn't want me to end up the way she was, and like having a kid at the age of [age], when you haven't got to do what you want to or second level education, well third level education.....

Katie identifies an internal struggle about her needs and happiness and her Mother's happiness, being quite hard on herself in having taking a child-centred approach to her well-being:

Katie: it's important to see her happy that's what happened, I put my happiness before hers' and that's what the big argument was about, that's really what it was really all about

Katie self-blame is evident, and her narrative suggests an internalisation of her mother's narrative as she feels that she 'wrecked everyone's lives' and links this directly to her being born when her mother was young. She also links this to her mother's narrative in that her birth 'messed her [mum] up'. Katie's self-concept is surrounded in a blame narrative that she is somehow responsible for the events of the family.

Section 7.4.2 Sibling Relationship

The sibling relationship emerged as meaning many different things to different children. It was presented as a source of support, as a source of feeling unsafe, a cause of great upset and an obligation for children in this research. It was both a positive and a negative and was hugely influential in terms of both children and parents' social and emotional well-being. Some children expressed a strong positive bond and acknowledged the mutual

support each other gave in terms of their social and emotional well-being. For many children their sibling was whom they would talk to when their parent was unwell. For children whose relationships were positive they drew further on each other for support when their parent was unwell. One child was an only child and viewed this as a positive as having observed her friends who are three siblings she reflects that she would rather not have to fight for her parents' attention. Interestingly, children who did have siblings supported this in reflecting on the time they spent with their parent, which was usually constrained by the needs of other siblings, especially younger siblings and siblings engaged with the CAMHS services

For parents whose children reported positive sibling relationships parents acknowledged themselves as fortunate and emphasised the positive impact this had on the home environment and their ability to parent.

Kathy and Isithara Mum: I'm very fortunate that they get on very well together. I know there's so many siblings, who can't stand each other, or can only stand each other for small periods of time, whereas mine are very attached to each other, even though in a lot of ways they're very different, in some ways they're very similar, and I think the similarities are what binds them they rather than see the difference and, hone in on them, they're more inclined to see what they have in common, which is very helpful, and I think it leads to a very peaceful home life. The atmosphere here is never strained, there's never, ehm (laughs) the killings that goes on in other houses, you know, ehm, so I don't worry, if I have to pop out to the shop for 10 or 5 minutes, God, or even half an hour, I don't worry, that I'll come home to a blood bath. They are very close, which is very reassuring to me as a parent,

However, many children in this research were experiencing difficulties in their sibling relationships and many spoke of them negatively. Some children reported feeling unsafe with their sibling:

Petey: I'm never safe when they're around

This is further supported by his mother's narrative who reflects on having to protect one from the other. Some children identified difficulties with their siblings as impacting on them socially and cited their siblings as reasons they couldn't have their friends visit them at home. The impact of the sibling relationship and issues of space and privacy also emerged in as problematic for some children. For example, Josh in response to what it was

he most liked doing after playing with his dog, responded having his friends over to his house however he highlights that this is not an easy task as a result of his sister:

Josh: but I know that's not very possible. [Names step-sister] Again!

Despite Boldielocks being presented as time consuming by both her mother and her sister, she also views the issue of time as something that affects her too as a result of her siblings:

R: ok, so a 5, I know how to behave in different social situations, so you said 5 there yeah, ok, my parents watch me closely,

Boldielocks: not (?) cause they've other children to watch as well

Children who were involved with the CAMHS services expressed significant difficulties in their sibling relationship. Sibling relationships were also presented less frequently as positives in families which were 'blended'. The arrival of new siblings for some children was hugely difficult, and children also attributed anger and blame to their parents:

Katie: angry at him, yeah of course I would, he took my mum away from me and made more siblings, like I tried to kill her when she was younger, how bad is that,.....

Some children did not acknowledge their step-sibling as being part of their family. Some children who visited their other parents not living in the family home and, where there was no other child, expressed a desire to live with this parent so they wouldn't be annoyed by their sibling. However, for children who had a step-sibling living with their other parent where there was a step-sibling cited them as the reason they wouldn't like to live with that parent.

Parents also reflected on difficulties in sibling relationships, and in managing this. Some parents viewed the relationship difficulties as stemming from children's feelings of anger, founded in resentment as a result of changes to the child's life in light of the parent's mental health difficulties or age gaps between children.

Katie and Boldielocks Mum: Yeah, course she does, I know for a fact she does, Boldielocks, if Boldielocks wasn't here, if Boldielocks wasn't the way she was, our house would be so different, our lives would be more

different, you'd have more time, you'd be less stressed Mommy, it'd be nicer, my friends would be (?) be embarrassed to bring her friends over, wouldn't be embarrassed to go places, it was very bad here for a few years, you couldn't go even go shopping with Boldielocks

Some parents felt that difficulties in sibling-relationships was the norm in families:

Boldielocks and Katie Mum: It's family dynamics, not everyone is going to get on.

Josh's Mum: A normal brother sister relationship.

And minimised the difficulties their children experienced, suggesting that children are resilient and adaptable:

Katie and Boldielocks Mum: Katie does resent Boldielocks, because she was the number one bean until Boldielocks was born and then after I had Boldielocks I got depressed and she blames her for all of that too, and that's kids they learn to grow up and get on with it,

Some parents presented conflicting views of their children's relationships with siblings describing them as both positive, negative and normal during the course of the interviews:

Josh Mum: I suppose, when [sister] was born it was you know, I was afraid because there's such a big age gap, but it was fine, he was very good with her and he is still very, very good with her, but he teases her a lot, he calls her a lot of names, you know, I think they just have a normal brother sister relationship but she's a lot younger than him as well you see, so I suppose, she does be annoying him

At a later point mother contradicts the above description of their relationship:

Josh Mum: He's very good with other children, except his sister, he's very good, no he's very good that way. I don't know what else.....

Parents also reported difficulties in managing siblings and their relationship difficulties. In general time presented as a significant factor in terms of how parents viewed their children's behaviours presenting in the sibling relationship. Children reported having to compete for their parents' attention with siblings as difficult. Similarly parents identified this as a source of contention in the sibling relationship. In response to what was a factor that would prevent parents from spending time with their child one on one, *siblings* and *financial matters* were cited by parents as factors. Parents also

noted sibling jealousy, vying for parental attention/time and age differences as factors affecting the sibling relationship. Some parents attributed their child's behavioural difficulties as the reason for difficulties in the sibling-relationship.

Josh Mum: [Sister]! It was always even say with social workers that was one thing that Josh and myself put up front, that we wanted to do things together, even if it's just for half an hour without [Sister] it's rarely possible. I suppose, it's because, oh the little oneeen is there and she's always, she gets awful jealous because, and it's like she senses it, you know it's as if she senses it. It seems to be when I want to do something with Josh, she just goes completely whingey and wants Mommy mommy mommy

Katie and Boldielocks Mum: Definitely she takes everybody's time, everybody's time

Some parents linked the difficulties between siblings as directly related to their mental health difficulties and the subsequent changes to family life as a result. The impact of the sibling relationship for Katie is acknowledged by both Katie and her mother. In her mother's view it is linked directly back to the period of post-natal depression experienced following the birth of Boldielocks:

Katie and Boldielocks Mum: She resents Boldielocks because the way she is. She's not a normal everyday sister, and she is bloody hard work yeah of course she does, she did she resented Boldielocks from the first day I had her, and even more so because I went to hospital because I had her. She resented her because it ruined her whole family unit, and in one sense it did.....,

One parent experiencing significant difficulties in the sibling relationship presented as being in a constant state of fear and having to pick which child to protect.

Petey Mum: I suppose I've spent most of the last few years getting in a dog fight with the two of them and having to pick, like things that shouldn't be asked of me.....That [Brother] is going to run away, I have to choose the smaller one to protect in the now and let him go cause I can't keep the two of them...

This is reflected on as a hugely emotional and distressing decision that she has had to make in light of a lack of professional support and input in managing her sons and their behavioural difficulties, despite both children being involved with the CAMHS services.

Section 7.4.3 The Importance of Pets

All but two children reported they had pets in the family home. All children who had pets identified them as hugely important in terms of their social and emotional well-being. Children largely referred to their dogs, but some children also had cats, tortoises and rabbits. Some children distinguished between the supports they perceived receiving from their pets, considering some pets as more anthropomorphic than others:

Blue Rose: I wouldn't really talk to the rabbits though, because rabbits don't really react, and you can't really hug them neither

All children who had pets viewed them as sources of support, someone to talk to when sad or upset, companions and as providing protection and a sense of safety to them. Many children reported a sense of importance in that they felt they were being listened to by their pets and that what they had to say was of value. Children also reported pets as helpful when their parents were too busy.

Blue Rose: She means a lot to me and I can talk to her when I'm feeling sad, or when my mum and dad are busy I'd usually talk to her instead....

Josh: She was always there for me when I hurt myself, she's always there whenever I'm bored. If I'm upset she's there as well. I talk to her about everything. It's easy to talk to her. She listens....

Some children reported pets as important for their emotional well-being as a form of relaxation and stress relief. Some children saw their relationship with their pets as bi-directional and reported:

Kathy: They are special and make me happy, when they run around and when they're happy, I get happy cause it's almost like I've made them happy, so I'm happy when they're happy

Ishthara: The cats mean so much to me because they're so generous and so nice to be around if you're feeling sad or just want some company....

Children also distinguished between how they thought their pets perceived them and their parent:

Blue Rose: like my dad's the master, but I'm like the companion of all of them.....

Petey: Mums [dogs] favourite cause she's the one that brings her for the walks always, most of them....

Children also reported pets as sources of support when they did not want to be around other people. Some children linked this to not wanting to feel judged.

Kathy: the four legged animals are company when I don't really want to talk to anyone, or someone's annoyed me or something. They don't really mind, being told what to do, and they won't say anything back, like – 'I think you're wrong or something' (laughing) and they always look like they're listening....no judgemental cats....

Section 7.5 Environmental Level – School

The second environmental level is school, which is considered below. Also included in this section are children's perspectives of their peer relationships.

Section 7.5.1 School

From the perspective of children, the idea of school as a support was presented in mixed terms. Some children reported school as a place that they felt supported but, some children reported significant difficulties in school. Most children reported having experienced difficulties in school. This was usually in reference to being bullied by other children and some parents included school teaching staff as the bullies. Only two children gave no reports of experiencing being bullied.

Boldielocks: Well, being bullied about my teeth

Kathy: I get sad maybe if someone said something to me in school

Kathy Mum: The principal was a bully and Kathy was being bullied by her teachers as much as she was by the other kids and I just thought this is ridiculous, but Kathy herself didn't call it bullying because she didn't realise that she was unhappy at school because she'd nothing to compare it too.

Two children had experienced significant difficulties resulting in their expulsion or removal from the school by the parent. One child was home schooled as a result of being bullied. A minority of children reported largely positive school experiences. These were generally related to social aspects of school i.e. being able to see friends. This suggests that it is not the schools directly that children feel supported by but rather that school facilitates a space for children's peer relationships which are the source of support. For children who had moved schools due to difficulties, this was reported as a

very positive although difficult transition. Some children reported school was somewhere they felt safe, with one child stating it was the only place they felt safe.

Kathy: I feel safe there yeah, the building made me feel safe, but I got a little bit nervous around all the people that I didn't know....

In terms of children whose parents identify them as having behavioural difficulties school is identified as a space where there is an observable improvement in children's behaviour. Both Petey and Boldielocks are engaged with the CAMHS services and both receive support from SNAs in school their mothers reflect on how their behaviour presents more positively in school as Boldielocks mum notes:

Katie and Boldielocks Mum: Last year was a good school year in the sense her behaviour in school was good, but her behaviour at home was horrendous. She does her damdest to behave in school. To get her to school in the morning is a nightmare but she calms down when you put her in school.....

Similarly, Petey's mother considers his behaviour to improve within the school context and the rationale she provides is that it is a 'controlled environment'. She reflects on the impact the school environment has on his behaviour in terms of behavioural, social and academic improvements. She also associated the difficulties he experienced in school as linked to difficulties in the parent-child relationship and since moving schools speaks of a *repair* in their relationship partly attributed to the ethos of the school and for accepting her and Petey and not judging them.

Petey Mum: I have a little boy now that I didn't have when he was at [former school], he's happy and content somewhere....

Parents who had difficulties with schools and perceived them as largely responsible for the difficulties their children experienced or difficulties in the parent-child relationship felt that school staff were not sufficiently trained or that they didn't have sufficient understanding of their child's behavioural and educational needs. Some children reported mixed experiences of teachers as a source of support. Some children reflected on differences in primary and secondary teachers in terms of support:

Josh: no, cause they don't really care. It's secondary schoolyeah, but it's like, if you tell a teacher in secondary school they'll call you a baby and tell you to (gestures his two fingers)

Many children's negative school experiences were linked to their experiences of being bullied.

Boldielocks: and sometimes like I'm getting laughed at by the 5th and 6th

However, for some children their school experience was hugely positive. Children's positive school experiences were generally linked to a specific teacher. Many children perceived the support they received from teachers as helping them with their work, while others described more the emotional support they had experienced. Some children included their teacher as their role model:

Katie: Well my maths teacher, I really really struggle with maths, like it's one of my weakest points, if there's anything like she'll give me extra work, and something to work on, if there's anything, she knows I got right, she like takes me at break time like as well, what's wrong what's your weakest question, or she'll spend time with me and it really helps like

Kathy: well she's my old teacher and she's just ehm, I just, I love her so much and yeah, but she tried so hard to make me happy in schoolFor a while this year I hadn't been happy in schoolso we, she, we had a lot of meetings with them, me and Ms G and the principal and my mum and she'd always ask me what I wanted to do, like if I had a magic wand and I could do anything what (laughs) what I'd do to change it and then for the last few months in 4th class I was happy in school, well I don't know I was just, I felt like I was behind in the work and almost like I didn't belong in the class because most of them had been together for 6 years

Overall, children reported mixed experiences of school as a support. Parents were more likely to emphasise the positive support of school as opposed to children.

Section 7.5.2 Friends

All children in this research reported having friends. Some children reported having only one friend. All children valued their friendships highly as sources of support with some children identifying their friends as family. Children reported the support received from their friends in making them feel 'accepted', 'encouraged', 'protected', 'special', and 'understood'. They provided 'companionship', and were someone children would 'talk to' and

'feel listened by'. They were also seen as sources of *'fun'* and associated with feelings of *'happiness'*.

Blue Rose: they stand up for me, em, they make me happy when I'm feeling sad

Kathy: I have a friend and she kind of treats me like family

Josh: well they pretty much eh like, if someone's bullying me they help me

Boldielocks: actually my friends from 4th class, they understand me,

Many children valued themselves as friends to their peers also. Some parents and children differed in their views of their child's friendships. Some parents cited their child as not having any friends, however this was not acknowledged by their children. Lack of friendships was hugely concerning for parents. Some parents reported their child's behavioural difficulties and need for control as the cause of their child's difficulties in forming peer relationships. Many parents reported that their child's behavioural difficulties resulted in their exclusion from peer related social activities such as birthday parties. One parent reported this as a significant concern and feared that without professional guidance her child would not *survive socially*. Some parents felt the need to pick their child's friends for them and some viewed their children's friendships as very short-term. There is a sense of anticipatory failure for their child's social outcomes.

Petey Mum: I don't know, I mean if you look at his friendships, he's developed a friendship with a kid up the road here but again you have to pick, he's not going to get on with a dominant character or a challenging character.....

Boldielocks Mum: I know it won't last, I know it's going to end like it did before Boldielocks will kick off and the other kids don't want to play with somebody that's not nice, that won't play nice, you know what I mean, share and play fair. She wants it all her own way.....

Despite the significant support children report receiving from friend's children in this research presented with a reluctance to talk about their parents mental health difficulties with peers. Children reported *'age'*, *'lack of understanding'* and *'difficulties in explaining'* what was wrong with their parents as reasons. Some children extended their friends to include adult friendships and identified *'second families'* and specific adults in their parents

and their support networks that they would talk to about their parent particularly if they had a professional understanding of mental health issues as children felt they would have a greater understanding and identifying them as *'knowing what to do as well'*. Some children considered their parents' friends as their role model.

Section 7.6 Environmental Level - Community

This section looks at the interactions of children and parents within their communities. It focuses specifically on their experiences of interacting with services as a result of their parents' mental health difficulties and shares their advice to others.

Section 7.6.1 Child's Interaction with Adult Mental Health Services

Children in this research by and large had little interaction with services and professionals working with the parent with a mental health difficulty, including psychiatrists, doctors, mental health nurses and social workers as summed up by Blue Rose's mother: *'They are just not in the equation'*. The majority of children report not having spoken to any doctors involved with their parent. One child reported meeting their parent's doctor while one reported meeting the mental health nurse involved. However, both reported this as merely perfunctory and that there was no conversation and they received no explanation or significant interaction with the professional. Some parents actively sought support for their child from adult mental health services in light of difficulties stemming from the parent's mental health difficulties:

Blue Rose Mum: I know there was a stage where I had asked Blue Rose, do you feel you probably would want to talk to somebody other than Dad and Myself about all this and Blue Rose said yeah she'd like too and Blue Rose's Dad mentioned it to the [mental] health nurse, he asked a few times but nothing ever came out of it, Blue Rose never had anybody and she actually mentioned it when she came here and I asked, why are you looking forward to coming and she said oh, it's nice to be able to talk to somebody about this she said. She never really had anybody professional or something talk to her about it, which I find is a, probably a bit of a let-down really....

Parents described their children as invisible to services and felt that regardless of whether the issue of the parent's mental health difficulty was

significant for children or not they should be considered and their opinions valued:

Blue Rose Mum: You know obviously she wouldn't have to be in for long meetings or something but it would be nice if she would have been heard a bit more, as well, that she would have been asked a bit more, about all this. I mean I find pretty much that Blue Rose anyway, I can't obviously talk for all children, but Blue Rose for the mental health services are pretty much out of the equation, she's not really in there.

Children's perceptions of their parent's treatment were also largely negative. Children reported staff as uncaring, unhappy in their jobs and not doing enough to help their parent:

Kathy: they should have helped her. I don't think they cared enough about them. Like they really didn't like their jobs

Issthara: yeah they should have helped her more like they should have mm I don't know they might have recommended a therapist or something..

Issthara's reflection on recommending a therapist also highlights the lack of alternative support for available for parents, suggesting services continue to be focused on a medical model as opposed to person-centred recovery.

Many children shared the view that it is not the place of professionals to speak with them about their parents' mental health difficulties, preferring their parents to discuss this with them. One child reported being informed by their grandparent; however, she also perceived that this information would have been better coming from her mother and father. This was despite not having had any contact with her father. Children reported professionals not knowing them enough as the primary reason for this, again highlighting the invisibility of children to mental health services.

Kathy: well like I wouldn't like a stranger telling us that something was wrong with our mum cause it's like they don't know us and they don't really understand

Issthara: they don't really know how to handle it, my mum handles it a certain way,

For both adults and children who were engaged in mental health services the primary reported form of support received from professionals was medication. All parents reported a significant lack of alternative

treatments or interventions for parents or children such as therapy or even simply having a professional ‘check in’ on the child. Where children were experiencing difficulties medication was also the most common intervention offered. Some parents challenged the pharmacological interventions offered for their children while other parents viewed medication as the only option for their child in light of the difficulties they were experiencing.

Katie and Boldielocks Mum: No, I refused to do the medication route, until they had a proper diagnosis ta bloody tell me, they say your child has ADD or attention deficit disorder and there's something else there. Find out what it is first before you try and put medication on it. That's the first thing they said – Oh, Just medicate her!, It was like, NO! I refused, I looked into the information in it, I said there's other ways around it there's other things you can do, there's behavioural therapies that you could do with her because as I said, you can't just medicate over a problem you have to deal with the problem itself. You have to teach her skills to deal with it, cause she's gonna have whatever it is, it's gonna be there for the rest of her life

Petey Mum: ehm, he's a bit calmer, but Jesus like he's like a wild thing in the morning before he has it [medication] he actually just does himself no favours, you know, just counting down the minutes until it kicks in, and taking him off it isn't a possibility and we've tried it's just, it's actually not fair on him cause he ties himself in knots. I just hope as he gets older it's my hope that we can wean him off of it, he'll have better ways to manage himself

Some parents sought support for their children privately:

Kathy and Issthara Mum: They have, we have [professional] on speed dial, he's a child psychologist who's fabulous and they've been to see him a couple of times each, but, I think after about 2 or 3 sessions he sorts them out, but they know that he's there if ever they needed to and he's great in terms of you don't have to wait forever to see him

Section 7.6.2 Parents' Experience of Adult Mental Health Services

Parents perceptions of services for themselves were presented as archaic, deficient, uncaring and judgemental. One parent described inpatient facilities as a joke:

Katie and Boldielocks Mum: Mental health services is a joke, it really is. I remember being in hospital not being properly supervised and people swapping pills. I never seen more people having behind the door sex in my entire life than I did in mental health hospital.....

All parents expressed having negative experiences most notably with regard to inpatient facilities describing their experiences as ‘horrible’ and

services as 'not very nice'. Parents spoke of having to 'fight for services'. Some parents referred to needing to be supported by services as parents and helped to be there for their children and needing guidance from professionals.

Blue Rose Mum: We really had to fight a lot for counselling, a lot of stuff was medication and em, really always saying this from a parenting background because I mean medication wouldn't have done anything for us to be there for Blue Rose, and to be parenting well whereas being able to deal with our stuff in our own time and letting Blue Rose getting on with her stuff, she didn't need to deal with the stuff we dealt with and its very important and I think in the public health service it's still not very present it's not really done. It still takes a lot of coaxing

Blue Rose Dad: ah there was years of just pure medication that was it, nothing else to be honest I mean I can't remember half the time cause I was on so much that, Blue Rose's mum probably explained to you yesterday, that was, I I've lost so much memory because of it em, but no it's good now that I've gone through it and I'm still going through some stuff, but I mean, yeah there's years lost, and then you think about the years you've lost and what Blue Rose and Blue Rose's Mum would have had to put up with that could have been avoided maybe, em what's the word, if things were, came in a bit earlier like, support for, you know psychological support maybe that could have been earlier and then maybe that would have, and maybe we would be talking today like it was three years ago and you know there's certain stuff then that would have been, I made a lot of mistakes,

Katie and Boldielocks Mum: I got nothing , I went to my G.P for a year to tell him how badly depressed I was and how I was coping, they just upped my Lexapro and didn't refer me to any services just upped the medication. I got nothing through the G.P absolutely nothing....

The gatekeeper's perception of service provision to families was also highly critical and echoed that of parent's experiences:

Gatekeeper: When you ring the mental health nurse and say I've had Josh's Mum on the phone and she's off somewhere, I'm not exactly sure where she is, that she was near water somewhere and nobody could find her but she's threatening too..... 'Oh that's Josh's Mum!' – I rest my case, so that was the response I got he said 'oh that's Josh's Mum'. When she asked to come off the meds 'ah, we don't think it's the right time now, it's not time to deal with all your problems right now' doesn't suit them to deal with anything that's going on

The gatekeeper's narrative suggests that in terms of service provision it is not person centred but rather professional centred. Overall, parent's expressed feeling isolated, unsupported and let down by services that lacked understanding of their needs and experiences or that of their children, by and

large leaving families to fend for themselves. All parents were highly critical of service provision in terms of their own needs and the needs of their children. Despite parents experiencing significant difficulties with their children some parents report the response from services as ‘*reactionary*’, they also point to the delayed nature of supports for families which ultimately exacerbated difficulties for both parent and child resulting in significant distress for both. One parent referred to continuing *God Issues* from the top down in her experience of Irish mental health consultants and their inability to communicate. Some parent alluded to the siloed nature of child services:

Petey’s Mum: Very disappointing like you’ve teams all over the place and nobody will work with each other, child services particularly.....

Katie and Boldielocks Mum: There’s nothing there for kids as far as I can see, nothing.....

Petey’s Mum: it comes from the top down because you know institutions are rotten from the top to the bottom, its why I think medics in this country, and consultants, god issues went on for such a long period of time. Because I was treated badly I’m going to treat my interns badly, and were going to talk to patients in language that they can’t understand cause we’re better than them,... and it’s starting to shift a little, not fast enough obviously,

The gatekeeper reflects on the fact that despite service engagement with families that she feels it’s ‘*nearly too late*’ for the Josh. She also feels that children’s services are lacking and in light of the difficulties Josh is experiencing she highlights her fears for him as a result of not having early intervention:

Gatekeeper: There could be huge things there and why they haven’t decided to do a full psychological assessment before this I just don’t know cause he’s nearly getting too old....

Some parents and the gatekeeper acknowledge the difficulties services face in light of being under-funded, under-resourced and over-stretched. Some parents reflect on the recent referendum on children’s rights in Ireland and view as little more than a tokenistic gesture to children with no real tangible difference evident in terms of service provision. This is reflected on not solely in terms of child mental health services:

Kathy and Issthara Mum: This ridiculous Child and Family Agency that's been set up banging on about children's rights, and again I say we signed up to the UN Convention on Children's rights – We have done nothing! You can still beat the shite out of your children and it's perfectly fine! And why wouldn't you! We're so dismissive of children, we're told 'oh children are so resilient' as an excuse for treating them badly! What the fuck?! Or you try and point out and they go 'well it's worse in [daughters country of origin]!'. That doesn't make it all right, no you're missing the point, people still miss the point

Petey's mother reflects on the implications of the lack of services and early intervention for children experiencing difficulties:

Petey's Mum: you know and this country isn't set up for mental illness, especially in children, the interaction is too late. Petey is beautiful cause it's happened early and I think that's why there's a lot more hope. I would hold out a lot more hope for Petey

While Katie and Boldielocks mother highlights the extensive waiting lists for services for children in crisis. She further highlights the reactionary response received from services when children are in crisis:

Katie and Boldielocks Mum: I rang up CAMHS I was in crisis here with Boldielocks, it had gotten to the stage, I did not know what to, I was afraid of her doing, killing herself, hanging off a curtain pole, she was self-harming herself, it was 6 months before they seen me, I rang in, week after fricking week and looked for emergency appointments, said I was in cri..., 'oh we'll take her into care', before they even seen me, or spoke to me, we'll put her into care, that's what they said to me over the phone, what fricking good is that? Yeah I'm in crisis we sent out a social worker ok that's great what's the social worker gonna do? Take them into care, that's not the fricking answer, that does more damage than good

Some parents feel professional support should have been available to help their children process the emotions they may have been feeling as a result of their parent's mental health difficulties:

Blue Rose Mum: I don't think she would have ever needed counselling, big counselling or something but just maybe somebody a bit more neutral, would be able to listen to her, who'd be able to explain things to her, I mean as much as we try as parents we always, we won't always get it 100% right,

Kathy and Issthara's mother was highly critical of her experience with services in both child and adult services describing it as 'a lesson learnt':

Kathy and Issthara Mum: I certainly wouldn't invite them in and around my children, because their clueless, even the public health nurse, is a fucking edjit! They're idiots! (Laughs) not that I'm given to generalisations, but their all gobshites, because the HSE is still probably

very much stuck in the 1940s because it's still very patriarchal the notion of you know, there's still very much a paternalistic approach to mental health and I know that I've said this before, I said this at the conference, you know I challenge their heuristics, because they really didn't know what to do with me, except try and punish me for not being what they'd expect me to be, by threatening to take the children from me for example, and it's very much a bio medical model they don't have much to offer you, other than tablets, and when you appear and they can't prescribe a tablet for you because you don't have something prescribable they get very flustered by that notion, and they just don't inspire confidence, to be honest

She continues:

Kathy and Isithara Mum: She just wasn't doing what the text book said that she should, so therefore she was a problem, and I thought ok then, let's pathologise her too then shall we? but there's nothing wrong with the child you know, so I just didn't go back then, I thought, no I have the right not to go back, I mean they questioned the fact that I was raising vegetarian children. I was like god do I really have to go there, that you're so ignorant, and they just are, they're just stuck in the 1940s, if you're not having meat there's something wrong with you? You know and they had no clue around anything really (laughs) Trying to tell me constantly that my children were under weight and malnourished, and I was kind of going no, there actually not, you need to look at more than just what the scales is saying, because the overall child, look at how interactive they are, look at their skin, look at their teeth, look at their hair, look at their development, you know, and then come and tell me there's a problem, you can't do that apart from their eyes is the wrong shape! (Laughs)

Both children and parents largely view services provided to the parent as inadequate. They present them as focusing solely on the parent with the mental health and not looking at the family context also. They describe a medical model of service delivery and a lack of alternative care and support options. There is a sense of professional avoidance in dealing with the issues that families experience.

The gatekeeper similarly reflects that child services focus too much on solely children and forget the context within which they are living. She highlights how parents are overlooked by child services unless there is a significant crisis and then also suggests a reactionary approach from services. She highlights how a solely child-focused approach can be damaging for parents who are already vulnerable and sees this as the fundamental problem with services for families in Ireland:

Gatekeeper: I think services focus too much on the child and not on the parent, especially if it's mental health. They tend to zone in on the child and to hell with the parent we'll work with the child, the parent needs to figure it out, but I think the parent needs to be empowered, because mental health in itself it was just you're on medication thrown to one side, it's not unless a child kicks off that anybody gets in there to help, and then it's totally focused on the child. All the attention gets put on the child in particular with social work, always straight in with children and they really don't care about the parent. 100% and this is where I think it's going wrong

She highlights how overwhelming a blame approach towards parents can be which see views is how a child-focused approach may feel for a parent with a mental health difficulty. She also alludes to the bi-directional impact children can have on parents and alludes to a professional culture of blaming parents in stating that:

Gatekeeper: sometimes it's not their fault, sometimes it is, but a lot of the time I'm finding the parents get more overwhelmed, where you have these people coming in and working with the child and nearly telling them that they're bad for want of a better word....

Section 7.7 Future Directions

This section considers the advice children and their parents have for families in a similar context. It also provides an insight into their 'expert' views on what would help families experiencing difficulties.

Section 7.7.1 Children's Advice to Other Children

The messages children wanted to share with other children living in this context included not feeling they were alone and not to worry or to feel sad. Ishtara found it helpful to remember the episodic nature of her mother's mental health difficulties in acknowledging that it will not last forever. While children also found it helpful to find ways to support their parents, be it practically or emotionally. Boldielocks and Katie refer to the need for children to stay strong. Both conceptualise 'staying strong' in terms of keeping things to themselves and not sharing worries or concerns. Katie expands on this:

Katie: keep your head up, show that you're there but like keep it to yourself. Like let them know that you're there for them, so if you keep strong for them they'll be strong and they'll be able to get through it better knowing that you're always gonna be there for them, that helps too. That'll help them pull through

Children felt a strong obligation to be there for their parent and at times viewed this as more important than their own needs as evidenced in the following:

Ishthara: Keep trying to help them, and don't think that you're that it's your fault or anything, cause, it probably isn't, and they're trying their best to help you so you should just keep going and help them as much as you can. Just try and help them as much as possible and if it means, like not going to somebody's house for a day, because they want you to help out, then I think you should just stay at home, cause you can go to their house any day, if your mum or your dad really needs help. I think you should just think about them more than anybody else....

The emphasis children placed on their parent's well-being and the need to help their parent is linked by some children to their own feelings of wellness. Some children linked the need to be strong for their parent suggesting that their strength can somehow transmit to their parent in turn reducing their parent's mental health difficulties.

Katie: stay strong and believe in yourself. Keep your head up.....Like let them know that you're there for them, so if you keep strong them they'll be strong.....and they'll be able to get through it better.....knowing that your always gonna be there for them, that helps toothat'll help them pull through...

There is a sense of isolation in Petey's understanding of his mother when asked if he had any message to give to other boys and girls he commented:

Petey: no I don't know anyone.....but I don't know ANYONE that has a sick mum

This may be linked to the silent narrative surrounding his mother's mental health difficulties and the uncertainty and isolation he experiences. He reiterated this in his advice to other children:

Petey:(blurts out) that my mom's like that as well and that you don't need to be sad that I don't think it's just you, loads of people have it, oh and there's a massive spider there as well and that [names pet], and that all you need to worry is about getting a nice bro, [names breed of pet]

Many children referred to the need for children not to worry about their parent and provided their advice in terms of reassurance to other children:

Kathy: Not to worry and also to help out maybe learn a few recipes cause sometimes they'll just stay in bed. I mean easy things like Greek salad or something that you can eat pasta and not to worry about them a lot, too much cause I think I do that

Section 7.7.2 Parental Advice to Parents Experiencing Mental Health Difficulties

Most parents reflected on their mental health difficulties as difficult journeys and highlighted the importance of remaining strong. Their advice sought to bring reassurance to parents who were actively unwell and struggling with their mental health:

Josh Mum: Don't ever give up, the road is long and it is hard

Many parents reflected on the need to ask for help, they acknowledged this could be difficult for parents to do. Some suggested that parents needed to put their own needs first in order to be able to provide for their children. Some parents spoke of not *hiding* their illness:

Katie and Boldielocks Mum: be honest with yourself, don't hide behind the illusion – 'I'm fine, I'm ok, I can deal with this', - you can't. If you need help, take the help and take all the help that's given, for your kids, because you can't take back that time when you're older, when you look back. Make that sacrifice it's easier said than done. Think of yourself, put yourself first. If I am well everything else will come, if I feel well I can deal with my children, I can be there for my children. That's the only thing I would say.....

Kathy and Isithara Mum: Don't try and hide your difficulties from your children, you know as age appropriately as possible just let them know where you're at, even if that's just something as simple as saying to your three year old, 'Mummy's really sad today'

However, in light of previous experiences with services, one parent noted that asking for help was a fruitless task:

Kathy and Isithara Mum: I was going to say ask for help sooner rather than later but as I say that, I'm aware that there's shockingly little help available, so asking for help is a bit of a stupid thing to say really when the help isn't there

Reflecting on their advice to other parents was a difficult task emotionally for one parent highlighting her own personal sense of struggle and despair. Petey's mother became visibly upset in providing her advice to other parents, there was a sorrow and pain in her tone, and her narrative

reinforced the significant difficulties she was experiencing and highlighted her fragility:

Petey Mum: I don't know, just try and keep going (getting increasingly upset) no it's just, you know one foot in front of the other. Just I suppose I think the hardest thing for someone who has mental health issues is to not take things personally, or just I just take it so personally and it just rattles around in my head, and I'm always just trying to figure it out, how to make it better for them, and I get so wounded then when he's angry at me or he doesn't see what I'm doing, you know, so just every day, just you got to leave the previous day behind you, and that's hard to do. That's hard to do cause I think we're punitive creatures by nature you know, like yesterday was really bad, it's a really easy thing then just to batter yourself with yesterday, so I think, it's just important to wipe away the days, and that's hard to do, it's really hard to do. (big exhale)

Section 7.7.3 What Would Help?

Parents largely agreed that supports should be offered to them and their children. Parents largely promote a more holistic family model for professionals working with adult mental health service users. Many parents acknowledged that not all children will need support, but in the event that they do felt strongly that services should offer support in light of their difficulties. However, some parents felt it was important that children were at least offered the choice of whether they would like support or not:

Blue Rose Mum: and again this involves families it is about getting and I think it is about taking time for the kids not necessarily to go and to barge in there and to give counselling to the kids, not every child will need counselling I'd say, but to actually take your time and not just once or something just check in here and there, How are you? How do you feel? How is this going for you? and maybe even tell parents, give parents a bit of advice on how to deal with the issue

Katie and Boldielocks Mum: there should have been something provided as a need, and for Katie whether they allocate play therapy or something, to that age group, somewhere she could express and have a proper qualified individual 'well has this impacted on this kid?' and if it has what can we do to help them deal with it and move on, or if they don't need intervention ok that's ok, but have something in place, if they do and if they don't step back if they don't cause you'll make the situation worse. Step in if they need it

Josh Mum: They should be more involved. If there was a person in the mental health service who would sit down the children and explain in a proper way what's happening and that they don't need to be afraid so they can actually hear from another person, except their parent

Some parents, however, felt their children needed significant support, this was more linked to their perceptions of the child's social and behavioural

difficulties than to their child's understanding and experience of parental mental health:

Petey's Mum: I think he'll probably need a lot of one on one work of somebody qualified being with him, while he tries to move into groups. I don't think it's something that he can do alone

Many parents reflected on the need for increased information for children and awareness and interest from professionals into the difficulties experienced in families where there is a mental health difficulty:

Blue Rose Mum: I think it's about giving people choices, telling people what's there, it's being holistic and open to what families need

Supporting parents in their role as parent was also considered important in light of having a mental health difficulty whereby parents may not as a result of their illness be able to interact or communicate with their child:

Blue Rose Mum: If you had like activity groups maybe, where you have parents with mental illness having the day with their children, do activities with them, which is hard for somebody who is let's say depressed. They will find it very hard at home to pick up the energy to do something

Josh Mum: that's what I was saying, like if I was suffering from depression, I wouldn't know what to say to my children, I wouldn't be able to put it into words the way I would be feeling so I think if there was a way of saying to children in a proper way or in a playful way just to let them know that, well to explain to them it's by no means their fault, that it's just a thing that can happen

Katie and Boldielocks Mum: I never found it hard to be a parent, I just found it hard to make my emotional connection

The gatekeeper felt that giving hope to families was needed and that services need to broaden their minds in working with families where a parent was experiencing mental health difficulties. She refers to the current approach of services as abnormal and unrealistic and feels strongly that 'we have to shake up the system' and give more consideration to the needs of parents:

Gatekeeper: The whole service, I think needs to be turned. I think that's what they need to start looking at. They've gone very book based. They've gone very put people in boxes, but sorry sometimes you can have a square but they might not fit into that box and I believe when it comes to mental health that's where it's gone wrong and I think that's following through with the child then

This need to *'shake up the system'* is also referred to by Katie and Boldielocks mother:

The whole system needs to be completely re-looked at, re-sat down and actual thought and consideration put into it

Section 7.8 Linking the Findings to the Study Objectives

This section reflects on the main findings of the study as presented above, in light of the research objectives as outlined below. As noted at the beginning of the Chapter for the purposes of this section, given the overlap in findings from Objective 1 and 2, they are considered collectively below.

Objective 1 To explore the subjective experiences of a small sample of Irish children living with a parent with a diagnosed mental health difficulty.

Objective 2 To illustrate factors which these children identify as impacting on their social and emotional well-being while living with a parent with a diagnosed mental health difficulty.

Findings from this study highlight that children's subjective experiences of their parent's mental health difficulties were wide and varied. Some children found it a difficult experience while others presented it as manageable but difficult at times. While some children chose not to share their experiences explicitly suggesting that they found it difficult to share their experiences. There were a number of factors that appeared to mitigate children's experiences, primarily linked to children's understanding of what was happening with their parent and children's sense of freedom in being able to talk to their parent or someone close to them about their experiences.

Differences emerged in parental perceptions of children's understanding of their mental health difficulties. Some parents chose to be open with their children and encouraged open discussion, whereas other parents did not feel this was appropriate and felt this would only contribute to their child's social and emotional difficulties. Some parents also did not consider their child as having any knowledge or understanding of what was wrong with their parent, however, children's narratives reflected this was not the case. All children were implicitly or explicitly aware that their parent was experiencing difficulties.

Children whose parent's openly encouraged discussion around their mental health difficulties tended to view it as episodic and more manageable although still acknowledged that it was difficult at times. Children's experiences thus appeared to be mediated by parental openness and encouragement in discussing emotive topics with their children, although many parents also acknowledged that this was something they found difficult to do.

All children highlighted the emotional difficulties they experienced as a result of their parents mental health difficulties. These were largely referred to in terms of loss, sadness, rejection and abandonment. Some children experienced significant emotional difficulties evident in the silent narrative adopted in relation to their parent. However, some children also suggested an awareness of temporality in that the difficulties were manageable and not definitive. Children who appeared to manage their experiences of their parent's mental health difficulties better by and large reported a wider network of support outside of the parent-child relationship, including support from other adult and peer relationships and support from interests and activities with which they engaged. Children who had more difficult subjective experiences reported, poorer social relationships, poorer sibling relationships and poorer parent-child relationships. All children who had pets highlighted the significant role their relationship with their pets played in managing more difficult experiences and this was largely linked to their perception of pets as being easy to talk to. The importance of pets to children's social and emotional well-being was not reflected in the narratives of their parents.

Emotional difficulties children experienced were alleviated through interactions with others, with pets, and in engaging in altruistic behaviours to help their parent. In such instances children largely associated their social and emotional well-being with that of their parent which was presented as inseparable. Children whose subjective experiences were more positive reported more positive relationships with their parents and this was reflected largely in their own positive self-concept. Where the parent-child relationship was characterised by openness, sharing and parental encouragement for

children to talk and express emotions. Where parent-child relationships were reported more negatively this was largely linked to difficulties parents reported experiencing in managing their children's behavioural difficulties which appeared to be linked to an aversion to discussing emotive or sensitive topics with their children such as the parents' mental health difficulties.

Children who were managing better emotionally also presented as managing better socially, whereas those who were struggling emotionally reported experiencing significant social difficulties. These difficulties were reported to present by and large as a result of the child's behavioural difficulties through which the behaviours manifested. Such emotional difficulties manifested behaviourally and in turn exacerbated children's social difficulties resulting in significantly difficult experiences of social exclusion primarily within their peer group.

Children's emotional responses to difficulties thus appeared to manifest behaviourally which in turn increased difficulties for both parents and child. However, this also appeared to be mediated by external environmental factors from outside the parent-child dyad, suggesting that some children had conflicted experiences which may be representative of their uncertainty in self, the parent-child relationship and their wider social relationships and experiences. The sibling relationship was also presented as a significant factor in terms of children subjective experiences of their parents' mental health difficulties. Where sibling relationships were largely positive children presented with more positive social and emotional well-being. Children reported being able to share their concerns with their siblings and found this helpful in alleviating difficult emotional experiences. However, where sibling relationships were contentious and difficult children's social and emotional difficulties appeared to be compounded.

Many children reported significant changes and disruption to their lives when their parent was experiencing a period of poor mental health. This was moderated in instances where there was a second parent and the relationship between that parent and child, and between the well parent and parent experiencing difficulties was perceived by the child to be positive.

Where children did not perceive their parents' relationship positively these changes and disruptions for children increased their difficulties and many experienced significant difficulties emotionally and socially. This appeared to be linked directly to children's sense of safety, security and uncertainty and when this security was perceived to be challenged children experienced increased difficulties emotionally and socially, which for some children manifested behaviourally which appeared to exacerbate their social and emotional difficulties.

Objective 3 To reflect on differences and similarities in children, parent and gatekeeper perceptions of the social and emotional well-being of the child in this context.

Similarities were evident in parental narratives of children and children's self-concept. Where parental narratives about children were largely positive children held more positive self-concepts and presented with higher social and emotional well-being. Where parents held more negative concepts of self as parent and of their child, children in turn appeared to present with more negative or conflicted concepts of self and presented with poorer social and emotional well-being.

Similarities in parent and child reports of the child's social and emotional well-being were evident where both parents and child reported close and open relationships. Children whose parents encouraged sharing and emotion talk reported similar perceptions of the child's social and emotional well-being be they positive or negative. Differences in reports presented in relationships where there appeared to be less interaction between parent and child, less time spent talking or doing things together and less shared interests.

Parents who had a greater insight into the impact their mental health difficulties had on themselves and their child were more open to the positive and negative impact on their child socially and emotionally. In turn children who were encouraged by their parents to openly talk about the parents mental health difficulties and share their concerns similarly expressed their experiences both positive and negative more openly. Some parents despite the close relationship with their child had underestimated the difficult

emotional experiences of their child which appeared to be linked to children not wanting to increase the worry their parent was already experiencing.

This highlighted children's efforts to protect their parents' emotional well-being to the detriment of their own. The similar efforts to protect each other emotionally was a significant finding in this research and highlighted that despite the closeness of the relationship that the emotional well-being of parent and child were separate but not separable. Children's protection of their parents and link between their social and emotional well-being and that of their parent also emerged in children's advice to other children in a similar context. Many children offered advice of looking after the parent and putting parental needs before their own, which they reported had a positive impact on their emotional well-being.

Differences emerged in parent-child relationships characterised by a lack of closeness, as parents appeared to know little about their children as unique individuals. This presented more in parents who appeared to be more actively ill or consumed by their mental health difficulties and perceived failings in their role as parent. Such parents presented as experiencing difficulties in separating their mental health difficulties and the difficulties they experienced as a parent. These parents also reported that their children were experiencing significant difficulties socially and emotionally, whereas their children did not report this. Such parents however, also presented with little or no social or emotional support themselves, and their children presented as following suit in that they had shut down emotionally and were unable to engage with, regulate or manage their emotions which appeared to exacerbate their difficulties leading to poorer behavioural responses to social and emotional experiences.

Children and parents also appeared reluctant to directly associate difficulties as being linked to the parents' mental health. From both the parent and child perspective this may be associated with a sense of protection. Protection for the parent linked to fear of how this may be perceived externally i.e. the parent not being 'good-enough' and for children a sense of protection towards their parent similarly as being a 'good' parent. Majority

of children emphasised and focused on the positives of their parent and were reluctant to reflect on any negatives.

Further differences emerged in the emphasis of the role pets played in supporting children socially and emotionally. The majority of children placed their pets as significantly important in terms of their emotional and social well-being, with some children placing their importance above that of humans in their lives. Whereas, the majority of parents did not acknowledge the importance of pets to their children in terms of supporting their child's emotional well-being.

Differences also emerged in parent and child reports of who should talk to them about their parents mental health difficulties. Many parents felt this was the role of professionals involved with the parent, however, children largely reported that they saw this as the role of their parent. Children cited that professionals didn't know them well enough and argued it would be more difficult to hear this information from an outsider who lacked an emotional closeness or understanding of the families experiences. This difference in perception highlighted that parents are struggling to talk to their children about things that are emotionally difficult for them. Highlighting a significant gap and valuable role for professional services to support parents in having this conversation with their children.

Objective 4 To examine the implications of existing policy and practice for children living in families where parental mental health is a factor in Ireland.

The findings of this research highlight a dearth of services and supports available for either parents, or children or families in general. Adult and child mental health services were reported by parents and children in a negative light as inadequate, limited solely to medical support, and with a lack of attention paid to prevention and early intervention. The families in this research expressed having to have reached a point of crisis prior to receiving any form of formal support from services, which when offered by services was characterised as inappropriate, individualistic and medically based. The primary sources of support reportedly offered to children and parents was that

of medication, or the removal of the child from the home. Parents reported an evident lack of support in carrying out their roles as parents and were largely treated in isolation.

Similarly, where children were experiencing difficulties the dominant response was medication or removal from the care of the parent. Parents and the gatekeeper reported little evidence of working with both parent and child in the context of their relationship, their experiences, and the context of the family as a whole. Despite the emphasis of policy in Ireland for parents and children promoting a rhetoric of support for parent and child, there was little evidence of this in practice reflected in parental narratives. This was further supported in reports from the gatekeeper, who highlighted an individualistic approach to family intervention treating parent and child as separate, services were presented as offered only in crisis, and furthermore promoted a culture of judging and blaming parents based on their history and an overemphasis on the needs of children neglecting the needs of parents.

All parents reported being let down by services, and some children also reported that they felt their parents had been let down by mental health services. Professional responses were reported as reactionary and archaic in their approach. Parents, gatekeeper and children reported that services should support parents in their role. Many parents and the gatekeeper eluded to the need for a more parent focused approach as opposed the current emphasis on children, arguing that if parents are supported their children will experience improved overall well-being.

Section 7.9 Chapter Summary

Children's experiences of parental mental health difficulties are wide and varied and are influenced by a range of factors on an individual and environmental level. Positive narratives of parent's experiences of parenting, a positive parent-child relationship, positive sibling relationships and access to other individuals and activities for support were identified in children who had positive social and emotional well-being narratives. Children experiencing greater difficulties had more negative or conflicted conceptualisations of self and reported increased difficulties in their

relationships with their parents and siblings. These children were also perceived by their parents to struggle more socially and were frequently conceptualised as behaviourally abnormal.

Moreover, parents that held a more negative perception of their child also reported significant difficulties in their role as parent. These findings support the need for a family focused approach to working with families where parental mental health difficulties are a factor, and that parents and child should be offered support by services within the context that their relationships are constructed. While on a policy level it suggests there needs to be a clear mandate for professionals engaging with families experiencing difficulties in supporting both parent and child. Moreover, clinical best practice guidelines are a significant gap in current policy and service provision in Ireland.

Chapter 8 - Discussion

Section 8.1 Introduction

As discussed in Chapter 1, little is known of children's experiences of living with a parent with a mental health difficulty. Much of the research in this context stems from an etic perspective and only recently has research begun to include children. Consequently much of the literature highlights a dominant discourse of risk attached to such children which may be premature. Moreover, much of the literature fails to consider the significance of the bi-directional influence of the parent-child relationship. Despite the implications of mental health difficulties for parent and child in this context, there is a dearth of research pertaining to this topic in Ireland. Considering this fact, the overarching aim of this study was to *explore the social and emotional well-being of children living with a parent with a mental health difficulty*.

In Chapter 2 and 3 a comprehensive review of the key literature pertinent to the research objectives was presented. This focused on the areas of child well-being, parenting and parenting with a mental health difficulty. Hamilton's and Redmond's (2010) dual classification of social and emotional well-being based on two interrelated levels, the individual and the environmental, was then used in Chapter 7 as a conceptual lens through which to view the data collected to address the objectives of this study. The underlying premise of their model is that addressing the needs of both child and parent and considering the socio-political context of families will result in improved outcomes socially and emotionally.

The purpose of this chapter is to discuss a set of high level findings taken from Chapter 7, in light of the theory from Chapter 2 and 3 and the objectives of the study. In doing so, the process will answer the 'So What?!' question with regard to this study. The chapter will bring forth and present evidence of how the study has added to the theoretical knowledge base on children's social and emotional well-being, in the context of their experiences of growing up with a parent with a mental health difficulty in Ireland.

Section 8.2 Discussion of Findings in Relation to The Objectives

Prior to elaborating on the key findings from the research the four objectives of the study are reiterated below:

- Objective 1 To explore the subjective experiences of a small sample of Irish children living with a parent with a diagnosed mental health difficulty.
- Objective 2 To illustrate factors which these children identify as impacting on their social and emotional well-being while living with a parent with a diagnosed MHD.
- Objective 3 To reflect on differences and similarities in children, parent and gatekeeper perceptions of the social and emotional well-being of the child in this context.
- Objective 4 To examine the implications of existing policy and practice for these children living in families where parental mental health is a factor in Ireland.

For ease of discussion, the four objectives are collapsed and discussed collectively below. It was felt that a collective discussion would retain a more contextualised understanding of children's social and emotional well-being.

Section 8.2.1 Discussion of the Findings in light of Objectives 1 to 4

Given the level of detailed data presented in Chapter 7, it is not possible to discuss each and every finding with the theory in this discussion chapter. Instead, after a detailed review of the results in Chapter 7, the author identified five high level findings for discussion. It is the view of the author that when considered together, they shed light on the overall research aim of this study,

- (1) Children's concept of self
- (2) Child's understanding and experience of parent mental health difficulty
- (3) The parent-child relationship
- (4) The importance of the sibling-relationship and
- (5) The importance of pets.

Children's concept of self

Children's self-concept is thought to be learned through their interactions with those in their immediate environment, principally their parents. Personal narratives told by others in the presence of children play a key role in the emergence of individual differences in emotionality and in how emotional experience is represented in their 'extended' and 'conceptual selves' (Neisser and Fivush, 1994, p.184). Research suggests that there are similarities in adult's personal narratives and how young children structure their personal narratives. Parental narratives and how these are communicated to children provide a scaffold which reinforces aspects of experience that they deem important to codify and remember through the questions they ask and comments made (Fivush and Hudson, 1990, Nelson, 1989). Parents help children to learn narrative skills through the conversations they have with them about past events. It is through such interactions that children's autobiographic memory is constructed providing them with a rudimentary story of self.

Children's personal stories serve two important functions. Firstly they play a role in children's self-regulation of affect, and secondly they reveal what children choose to share about their self and as such are *self-presentational* (Goffman, 1959). Children's emerging sense of self also draws on children's insights from their dispositional emotional qualities and how they manage emotional experiences (McAdams and Pals, 2006, Shiner, 2010). Early self-concept is thus likely to partially reflect children's temperaments (Brown et al., 2009). How parents respond to and help children to interpret these characteristics is also important (Miller and Mangelsdorf, 2005). Parents socialise different patterns of emotional elaboration and evaluation with their children (Fivush, 1991, Fivush et al., 2006). In general girls are socialised into creating a more emotional and interpersonal self-concept than are boys (Fivush and Buckner, 2003, Reese and Fivush, 1993). Gender differences were also evident in this research whereby boys presented with having greater difficulties in expressing their emotional and interpersonal self-concept than girls. Furthermore, they presented with more negative social and emotional well-being. This suggests that both

temperament and parenting contribute uniquely and simultaneously to children's social and emotional adjustment and that gender may also be a factor, but more detailed research would be required in this regard.

Findings from this research suggest that children indeed socialise the parental narrative in terms of their self-concept. Parental narratives that were more negative were reflected similarly in children's negative conceptualisations of self, and children's negative self-concept appeared to be amplified when gatekeepers supported parent's conceptualisations. Children whose parents displayed patterns of emotional elaboration and evaluation with their children had more positive conceptualisations of self. To put it another way, children whose parents invited and encouraged children to talk and share their feelings were able to regulate their emotions and had a more positive concept of self. These findings are important as they highlight the importance of considering the impact of parental narratives in children's developing sense of self and support the evidence of *reciprocal role relationship* and the assertion that:

the script is clear: children need to grow up and, in the interim, need to be looked after by a carer. This creates a reciprocal role relationship. Each actor in such a role relationship will attempt his or her individual and unique interpretation of the script. The entire script can only be enacted with a wider cast, which includes not only the child and a parental character but also a network of other actors whose presence is necessary in order for children to grow up in reasonable mental health. (Gopfert et al., 2004a)

It is clear that this study has uncovered critical findings with regard to children living in this context and how it impacts upon their self-concept. All of which have several implications for the practice, policy and research communities, namely:

- Practice: Findings suggest that practitioners should have an awareness of parental narratives towards their children and support parents to engage in parenting that supports children's emotional expression and regulation (Bernard et al. 2007, Denham et al. 2009). Moreover, practitioners should engage in reflective practice as a means to being aware of the parental narrative and its possible influence on how they perceive the child.

- Policy: Findings support the need for parents' to be supported in engaging in emotional talk with their children (Bernard et al. 2007, Denham et al. 2009). As in light of the parents' role in socialising patterns of emotional elaboration this may be more difficult when a parent has a mental health difficulty (Duncan and Reder, 2000, Cleaver et al. 2011, Suveg et al. 2005). This may be included as a component in parenting programmes.
- Research: Future research could explore further the role of gender in children's emotional expression when living with a parent with a mental health difficulty. As although this study included only two boys, both appeared to be experiencing difficulties socially and emotionally.

Child's Understanding and Experience of Parent's mental health difficulty

Talking about a parent's mental health difficulty can be an emotive and difficult task. Mental health difficulties can often impact on a parent's affective and behavioural presentation which may be difficult for children to understand, leading to increased distress or confusion. Moreover, children with little understanding of their parent's mental health difficulties may often hold themselves responsible for contributing to their parent's poor health. Research highlights the role of resilience in understanding. Children who identify themselves as resilient understand that their parent's mental health is episodic and they viewed themselves as independent of it (Beardslee et al., 1998a, p.67). Similarly this study suggests that:

Over time [some children] had come to accept the fact that they could not cure their parents, although they could in certain important ways contribute to their well-being.

Many children in this research linked their well-being directly to that of their parents, and reported better well-being when they felt they contributed to their parent's sense of well-being. However, this was not always the case and some children reported that in denying that their parent was experiencing difficulties was a protective factor.

Providing children with space and time to discuss and talk about their parent's mental health difficulty is thought to be helpful in addressing children's fears and concerns (Cooklin, 2013). Much research with children frequently reports that children would like to have more information on their

parent's mental health difficulties. Previous research has highlighted the difficulties children experience in this context including: a lack of information and openness; unpredictability and instability; fear; loneliness and loss and sorrow, findings which are supported by the conclusions of this research. Many children expressed similar difficulties in terms of managing when their parent was actively unwell. Enabling parents to talk to their children about their mental health difficulties is thought to have an empowering effect on parents (Marston et al., 2014). This finding is also supported in this research whereby despite the difficulties in having this conversation Blue Rose's father for example, reflects on the positive outcomes for the family as a whole.

Despite this, many parents struggle to speak to their children about their difficulties, commonly citing age and inappropriateness for their child (Ueno and Kamibeppu, 2012). The lack of information children in this study received regarding their parent's mental health led to significant concerns for some children resulting in fear, confusion and self-blame. Findings from this study support research in that children with a greater understanding of their parent's mental health difficulties presented with improved social and emotional well-being and higher resilience. However, having these factors present supported further by a parent-child relationship characterised by open communication, children continued to experience emerging concerns during active episodes of their parent's difficulties. However, when these concerns were expressed and children were assisted in understanding their parent's difficulties children reported worry for their parent reduced.

Many parents in this research identified their difficulties in talking to their children and linked this to their own uncertainty as to what was happening, and to their child's age and the perceived inappropriateness of the conversation. Despite this many parents reported that this was a role for professionals to either have the conversation with children themselves or to assist parents in having the conversation with their children. In contrast to their parents, children by and large felt that this was a conversation that parents and not professionals should have with children. This highlights there is a clear role for professionals engaging with families where a parent has a

mental health difficulty in supporting parents to talk to their children about their mental health difficulties.

It is clear that this study has uncovered critical findings with regard to how mental health is understood within families, both by parents and children. All of which have several implications for the practice, policy and research communities, namely:

- Practice: Findings indicate an evident need for practitioners working with families where a parent has a mental health difficulty, to consider the needs of both parent and child as a means to improving outcomes for both. This would be supported by increased interagency collaboration between adult and child services. This supports Gopfert et al. (2011, p. 63) concept of the *Family Interest Principle* which is inclusive of children and recognises that where the parent-child relationship is viable, the whole of the family is more than the sum of its constituent parts. However, currently parental capacity assessments focus on the needs of children (Kellett and Apps, 2009), and similar to other research, findings from this study suggest there may be an unwarranted perception of risk for these children with the dominant means of support offered through medication or the child's removal from the parents' care (Aldridge, 2008, Kohl et al. 2011, Franzen et al 2008).

This study highlights that in practice parents who are experiencing difficulties are not being supported by services with 'the upbringing of their children in order to maximise their child's potential' (Gillen et al. 2013, p. 1). Rather, their experiences appear to contradict the dominant policy rhetoric of policies for individuals with mental health difficulties, parenting support and children alike (Government of Ireland, 2010b, Government of Ireland, 2000, DCYA, 2011a). Their experiences do not promote a universal, holistic and integrated approach to working with families experiencing difficulties but rather suggest a reactive and uni-dimensional service (Independent Monitoring Group, 2012b).

- Policy: Findings support the need for a shift in policy focus for families where parents have a mental health difficulty towards a *Family Model Approach* (Falkov, 1998, 2012). This integrated framework should be considered by mental health services when responding to the needs of families in this context. Research highlights that parent's feel supported when they are acknowledged in their roles as parents and feel the needs of their children are being met (Diggins et al 2011, Cowling, 2004).
- Research: Adopting a child-centred approach to the research highlighted that children hold a different perspective as to who should inform them about their parent's mental health difficulty. Future research must explore further how parents themselves feel they could

be best supported in talking to their children about their mental health difficulties which in turn could inform practice with families in this context.

Parent-Child Relationship

The importance of the parent-child relationship and parenting styles to children's social and emotional well-being is widely recognised. A positive parent-child relationship characterised by high parental responsiveness with age appropriate boundaries is considered optimal for children. It is primarily within the context of the parent-child relationship that children's emotions are socialised. While supportive parenting is conducive to building social competencies in children and young people (Casas et al., 2007). The ability of a parent to be fluid and adaptable to the needs of their child is important to children's well-being. For parents with a mental health difficulty their ability to function effectively in their role as a parent can be challenged.

Findings from this research show the pivotal role of the parent-child relationship to the social and emotional well-being of children. Many children reported a positive relationship with their parent with a mental health difficulty which was viewed as crucially important as a source of support. Many of these children attributed positive social and emotional experiences to their relationship with their parent. Children were more likely to report positive experiences of the parent-child relationship, and to view parents as sources of support where the relationships were characterised by open communication and validation of child as an individual social and emotional agent. Children expressed more positive social and emotional well-being when they perceived their relationship with their parents as bi-directional i.e. children perceived themselves as having a fundamental role to play in their parents well-being which was acknowledged and validated by parents.

Some children in this research held conflicting or uncertain views of their relationship with their parents and as such expressed reduced social and emotional well-being. The attachment relationship begins with the parent-child relationship, and is the foundation on which all future relationships are formed (Denham et al. 2009). The nature and security of the attachment relationship are linked to a range of social and emotional competencies.

Findings in this study suggest that ‘intermittent parenting’ was experienced by all children albeit for varying time periods (Anthony and McGinnis, 1978) while the literature suggests a significant correlation between parents’ with mental health difficulties and poor attachment relationships with their children, with children more likely to express anxious or avoidant attachment at a young age (Hall, 2004). Reduced social and emotional well-being increased when external factors such as their experiences within peers groups reinforced this uncertainty (Beardslee et al 1998b). Some children felt responsible for the deterioration in their relationship with their parent and experienced significant feelings of self-blame. These findings support research that children’s relationships with their parents are central to their social and emotional well-being and that the manner in which parents communicate with their children through their parenting styles and practices is important to children’s social and emotional well-being (Denham et al. 2009, Bowlby, 1977).

Many parents in this study alluded to not being good enough parents, highlighted through narratives of regret, loss and guilt. Parents who feel ‘good enough’ know that they are helping their children develop appropriate skills, knowledge and qualities often in the light of many impediments. Bettelheim (1987) suggests that there is no right way to parent. Instead, parents should respond to their child in such a way to make them become the person they want to be rather than creating a person the parents want. Few parents in this research referred to their children as unique individuals, and many reflected on similarities, mostly negative, between themselves and their children. In some cases it seemed parents were engaging in self-fulfilling prophecies for their children, likening their own negative experiences of childhood/adolescence to their children’s current experiences and pre-empting negative outcomes for their child’s well-being and well-becoming.

Parents need to be supported in their role as parents. Parents with mental health difficulties may experience increased difficulties in fulfilling their roles as parents. In turn these can cause complications in the parent-child relationship. Similar to Solem (2013, p. 63) this study highlights that parenting should be considered as ‘situated and situation specific’. Adopting

a family model approach to working with parents and children in the context of their parent's mental health would enable parents fulfil their role more effectively, thus supporting a more positive parent child relationship which in turn would increase the likelihood of more positive outcomes for children socially and emotionally in line with policy recommendations that promote improving outcomes for children through parenting support (Government of Ireland, 1998, Best health for Children, 2002, Daly and Abela, 2007, DCYA, 2011a, Gillen et al. 2013).

It is clear that this study has uncovered critical findings with regard to the importance of the parent-child relationships. All of which have several implications for the practice, policy and research communities, namely:

- Practice: Findings suggest that practitioners must be cognisant of the *Family Interest Principle* and work with both parent and child within the context of their relationship. The importance of the parent-child relationship to children in this context has been highlighted in previous research (Slade, 2006, Fonagy and Target, 2006) and is further supported in this research. Children must be made visible and be given information to alleviate their concerns (Marsh and Dickens, 1997, Garley et al. 1997). Despite policy directives in *AVFC* and *Children's First*, children in this research were invisible to services. Although this was not identified directly as a difficulty by all children, many children reported finding value in taking part in the research as it gave them a chance to have their voices included.
- Policy: Findings support the need for a *Family Model Approach* (Falkov, 1998, 2012). The link that children presented between their own well-being and is supported by this model which highlights the bi-directional influences of parent and child. Adopting this approach where the parent child relationship is viable would support an early intervention approach and the vision of policies for children and parenting support in Ireland.
- Research: Future research could explore further the role of having a 'well' parent as research suggests that they may function as a protective buffer for children in this context (Downey and Coyne, 1990. However, due to the limited number of second parents in this study this is difficult to ascertain.

The Importance of the Sibling Relationship

The sibling relationship is hugely important for children in light of the emotional intensity of the relationship and the amount of time spent together it is considered a fundamental social context for development (Feinberg et al.

2012). Despite this the sibling-relationship is often overlooked in research with children and families (Kramer, 2004, Whiteman et al., 2011). Sibling relationships are likely to be subsumed under the umbrella of family (Hanafin and Brooks, 2005). Findings from this study highlight that many children reported significant difficulties in their relationships with their siblings. This suggests that for many children their siblings were a significant source of stress in their lives in their lives (Kim et al., 2007) which impacted directly on their social and emotional well-being (Feinberg et al., 2012). The sibling relationship was also perceived to impact on the parent-child relationship in terms of parents being able to cope with the different needs of their children developmentally and temperamentally. There were more reports of negative sibling interaction when there was a greater age difference in siblings or when siblings were engaged with Child and Adolescent Mental Health Services (CAMHS).

Even for children who did not have siblings their perception of sibling relationship was stressful. Difficulties children reported in their sibling relationship included feeling unsafe, and not being able to spend time with their parent as a result of the demandingness of their sibling. Parents also largely perceived sibling relationship negatively and usually attributed this to children's perceived negative behaviours (Perlman and Ross, 1997). Parents reported the ability to manage sibling relationships as causing significant difficulties in the family home and in terms of their own mental well-being (McHale and Crouter, 1996). Where sibling relationships were positive, siblings were a source of practical and emotional support for children which became increasingly important when their parent was experiencing a period of poor mental health (Perlman and Ross, 1997, Siddiqui and Ross, 2004). This is supported in the literature which highlights the importance of positive sibling relationships in a number of well-being domains (Bank et al., 2004, Melby et al., 2008). Positive sibling relationships are thought to buffer young people from the impact of stressful life events (Gass et al., 2007). They are also thought to support children to share intimate thoughts and learn how to understand the feelings of others' and support successful conflict resolution (Howe et al. 2001). In this study positive sibling relationship were not only

positive in terms of children's social and emotional well-being but also in promoting the well-being of their parents. This finding again supports the notion that a family model approach to working with children and parents that includes focusing not only on the parent-child relationship but also on the dynamics of the sibling relationship can be significant in terms of the social and emotional well-being of parents and children (Feinberg et al. 2012).

It is clear that this study has uncovered critical findings with regard to the role of sibling relationships for children living in this context. All of which have several implications for the practice, policy and research communities, namely:

- Practice: Practitioners must be aware of the importance of the sibling relationship in terms of both the well-being of the child and the well-being of the parent (Feinberg et al. 2012). Parent's struggle in managing the levels of adaptability required when managing more than one child, each with their unique needs. There is an evident need for parent's to be supported in this regard, particularly where there are difficulties in the relationship.
- Policy: A *Family Model Approach* is again proposed as a means to account for the differing relationships within families. By acknowledging the significance of relationship dynamics as between two individuals but within of the overall dynamics of the family context may support improvements for parents and their children.
- Research: Future research needs to explore further the role of the sibling relationship in children's well-being. The current model of well-being in Ireland (Hanafin and Brooks, 2005) considers this relationship under the broader term family. Due to the significant role it plays in child well-being the sibling relationship should be considered separately.

The Importance of Pets

By and large research until recently has neglected to consider the importance of pets to children's well-being (Melson, 2003). Some research has been carried out highlighting the personal attributes children use to characterise their relationship with their pets, while the companionship that pets provide can be a significant source of social support to children, especially during stressful or adverse situations (Nagengast et al., 1997). The literature on children who live with parents with a mental health difficulty identifies that children experience significant concerns when their parents are

ill (Knutsson-Medin et al. 2007). It further suggests that children in this context need someone to talk to (Bilsborrow, 2015, Maybery et al. 2015, Fudge and Mason, 2004), however are largely invisible (Trondsen, 2012).

All children who had pets in this research (the majority) placed significant emphasis on the support they received from their pets. Many children included their pets in their definition of their family and valued them as companions and someone to talk to when feeling sad or upset (Mason, 2003). This is supported by findings from Foer (2006) who found that a significant number of children reported pets as who they would turn to when feeling sad, angry, happy or wanting to share a secret. Many children in this study also identified that they felt listened to by their pets and that they did not feel judged by their pets either. Only one parent made reference to having pets in the house and highlighted that it was something that could be a shared activity for parents and children. Clear differences emerged in terms of the importance of pets for children and parental perceptions of the importance of pets.

Despite reported difficulties in their social and emotional well-being, all children who had pets indicated that they were a significant source of support and they linked their relationship with their pets directly to improving their social and emotional well-being (Foer, 2006). In terms of the Family Model Approach to parental mental health difficulties, findings from this research suggest that positive relationships between children and their pets could be included as protective factors within the family which may improve and support the social and emotional well-being of children. It also suggests that pets may also function as an important support for the parent-child relationship as a shared activity and interest. However, further research is required.

It is clear that this study has uncovered critical findings with regard to the importance of pets for children in this context. All of which have several implications for the practice, policy and research communities, namely:

- Practice: Practitioners need to be aware of the importance of pets to children and findings from this research suggest pets may play an important role in engaging in child-centred practice with children.
- Policy: Children view their family relationships as inclusive of their pets. A *Family Model Approach* which considers and where appropriate includes pets and children's relationships with them should be implemented.
- Research: Future research must explore further the significant role that pets play in the lives of children as sources of social and emotional support, particularly where children are experiencing difficulties.

Section 8.3 How has this Study Added to the Theoretical Knowledge Base?

This research sought to explore the social and emotional well-being narratives of a small sample of Irish children. In doing so it has added to the research knowledge base in three ways, each of which is considered separately below:

- a) Increased knowledge on children living in the context of parental mental health difficulties
- b) Increased methodological knowledge on how to access children and parents in this context
- c) Future implications for practice and research in working with families in this context.

a) Increased knowledge on children in the context of parental mental health difficulties:

The study adds to the knowledge base in highlighting the difficult subjective experiences children have to contend with in the context of their parent's mental health difficulties. For some children this resulted in difficult emotional experiences typically linked to their experiences of 'intermittent parenting' (Anthony and McGinnis, 1978) and confusion as to what was happening with their parent. Adopting an ecological lens highlighted that there are many factors at play which impact on children's social and emotional well-being narratives. In the context of talking about their parents mental health difficulties children's narratives were by and large presented as emotionally challenging. Children experiencing greater difficulties tended to

struggle more with their emotional well-being narratives, adopting instead an ambivalent or silent narrative.

Parental narratives also highlighted that parents struggled in talking with their children around the topic of their mental health, however children's narratives reflected a preference that it was parents and not professionals who had this conversation with them. Children who expressed a greater understanding of their parents mental health difficulty presented with more positive parent-child relationships. Findings further suggest that the sibling relationship can contribute to children's social and emotional experiences within the family. They also highlight the importance of pets in terms of children's emotional well-being, supporting the need for further exploration of the role that animals can play in terms of supporting children when they are experiencing difficult social and emotional contexts. It also highlights that children should be supported and encouraged in understanding their parents' difficulties.

b) Increased methodological knowledge on how to access children and parents in this context

In adopting a creative mixed method narrative approach the voices of children and their parents were brought to the fore. Engaging in child-centred research for this study promoted the multi-dimensionality of perspectives, facilitating a broad and in-depth insight into children's experiences in this context. Adopting a mixed methods approach enhanced children's engagement with the research process. Moreover, for children who struggled with the measurement scales and aspects of qualitative tools a flexible child led approach facilitated further their engagement, allowing them to share what they were comfortable sharing in ways they were comfortable to share e.g. while playing with pets or playing soccer. This supports Lambert and Glacken's (2011, p.782) assertion that in order to facilitate children's inclusivity research must be carried out 'using methodologies/methods meaningful to them and which support their intellectual and social abilities'. The use of the embedded mixed methods narrative design facilitated access to the typically invisible voices of children in this context.

However, the nature of this research also presented difficulties in terms of accessing children and families deemed ‘hard to reach’ and as the research involved a ‘sensitive topic’ (Snyder, 2013). The lack of gatekeeper perspective may be reflective of the lack of a family focused approach evidenced in Ireland (Cusack and Killoury, 2011, Independent Monitoring group, 2012). It further complicated access to the population of interest as many professionals working in this context opted to answer for families, or declined participation as they ‘*did not know the child well enough*’ highlighting further children’s invisibility for professionals working with parents. This suggests an even greater need to promote and support practitioners in adopting a family focused approach to improve outcomes for children and their parents.

c) Future implications for practice and research in working with families in this context.

It is evident from this research that future direction in policy and practice for children and parents where a parent experiences mental health difficulties must adopt a *Family Model Approach*. The rationale for this research was based on professional experience of observing the invisibility of children whose parents experienced mental health difficulties. Children experienced significant disruption and received little in terms of information about their parents. This research highlights that from the experiences of participating parents and children little appears to have changed in this regard and children by and large remain invisible particularly in the context of adult mental health services.

It is acknowledged that challenges exist for professionals trying to balance the role and well-being of parent, patient and child. Many children in this study linked their emotional well-being to that of their parents highlighting the bi-directional influence of the parent-child relationship. Therefore, there is an urgency for services to collaborate with families and adopt a ‘whole family’, and not just a whole child or whole parent approach. Parent’s need support in their roles as parents and children need support in understanding their parents mental health difficulties. Services must engage with families pre-crisis in line with policy rhetoric of early intervention

approaches in order to meet the diverse needs of parents and children in this context. However, narratives of both parents and their children highlighted that service provision in Ireland remains uni-dimensional, inadequate and medically based and as such fails to support parents in their role as parents and in improving outcomes for children. Parental narratives identified a need for professionals to adopt a family model approach to working with children and parents in this context in order to improve outcomes for both.

Section 8.4 Chapter Summary

This research highlights the wide spanning conceptualisation children have of their social and emotional well-being. It shows the centrality of emotional connections and interpersonal relationships with family and friends in terms of their social and emotional well-being. Findings from this research emphasize the significance of the parent child relationship for children's social and emotional well-being, which held for both younger and older children. Findings from this research support those of Brannen et al. (2000) which highlighted the importance of parental love, emotional security and affective support as significant in family relationships. Children in this research who felt loved and emotionally supported by their parents had more positive social and emotional well-being than children who did not.

Most parents in this research expressed concerns about meeting their children's health and developmental needs. Many parents in this research questioned their skills and ability as parents, which has been identified as important in terms of parental capacity (Cann, 2004). What this research highlights is that it is not so much the capacity of parents which is called into question, but rather the capacity of services, professionals and policies to meet the needs of parents and children in this context. Many parents acknowledged seeking support from professionals and services in order to ensure their children's well-being needs were being met, and all parents reported that services failed significantly in their capacity to support either parent or child.

The findings support the need for more focused studies in enhancing understanding of children's social and emotional well-being particularly

within specific contexts in light of its' importance across a range of well-being domains in the present moment and their future life trajectory. This research highlights a need to shake up the system and adopted a family model approach towards working with children and their parents when a parent has a mental health difficulty. In doing so current conceptualisations of child well-being must be 'rooted in the interplay of a series of factors on the micro level, framed by the social structures of society' (Ben-Arieh et al., 2014a, p.3) and 'directly related to the perspectives and needs of the individual understood within their social milieu' (ibid, p. 5) and especially the parent-child relationship. By treating children as 'experts' in communicating their daily realities (Yardley, 2011) and by facilitating their voices this research provides a critical starting point towards informing the development of child centred policies and practices responsive to and reflective of their needs (Fernandez, 2011, DCYA, 2014)

Chapter 9 - Conclusion

Section 9.1 Introduction

In this chapter an overview of the thesis and the arguments contained within it are provided. This section concentrates on the research question that was addressed over the course of the study. It begins with a reiteration of the aim and objectives underpinning the research and the broad field it looked to investigate. It outlines the scope of the thesis and a summary of the gaps in the literature. Section 9.2 recaps on the methodological design employed. Section 9.3 discusses the research findings in light of the objectives of this study and offers recommendations for policy and practice in working with families where parent's experience mental health difficulties. Section 9.4 considers the implications of the research for practice. Limitations of the study are presented in Section 9.5 and recommendations proposed for future avenues of research. Section 9.6 concludes emphasising the need to adopt a Family Model approach in Ireland to meet the needs of children and parents.

Section 9.1.1 The Aim and Objectives of the Thesis

The aim of this thesis was to explore the social and emotional well-being narratives of children who live with a parent with a mental health difficulty. The underlying rationale was to provide an insight into their subjective experiences and provide a space for their invisible voices to come to the fore. Moreover, this study was set against the background of the dominant narrative of risk attributed to children in this context across a number of well-being domains. This risk narrative is usually informed by the etic perspective and reflects the invisibility of children's voices and lacks insights into the subjectivities of their experiences. It was also positioned against the literature on conceptualizations of children's social and emotional well-being which highlights the significance of the parent-child relationship as the context within which children's social and emotional well-being develops. Finally, it sought to contextualize children's experiences within current policy discourse that, firstly, advocates supporting parents in their role as parents and, secondly, seeks to promote the well-being and welfare of

children in Ireland, especially those considered to be at risk of poorer outcomes.

From this a number of broad questions were generated that acted as a catalyst for this work: what are the subjective experiences of Irish children growing up in families where a parent has a mental health difficulty? What are children's understandings of their parent's mental health difficulties? How are these similar or different to their parent and practitioner understanding of children's experiences? How do children conceptualise their social and emotional well-being in this context and what supports do they identify as important? How does the parent-child relationship contribute to children's social and emotional well-being? What are these families' experiences of receiving support from practitioners in Ireland?

Section 9.1.2 The Scope of the Thesis

With these general questions in mind, this study was framed as an exploration of the social and emotional well-being experiences of children living with a parent with a mental health difficulty. It sought to situate children's narratives within the context of their family and the parent-child relationship, and to reflect the bi-directionality of influences within this dyad. It sought to examine the *invisibility* of these children within the context of adult mental health services and the influence this can have on the social and emotional well-being of children and their parents.

In light of this three inter-related areas were considered which provided the theoretical basis central to this study. Firstly, how children's social and emotional well-being has come to be conceptualized over time, reflecting on the influence of adult perspectives the influence of social indicators and the changes that emerged with an increased focus on increasingly child-centred and inclusive approaches. This change in direction highlighted the centrality of emotional connections and children's interpersonal relationships to their well-being. Secondly, the importance of parenting to children's social and emotional well-being was explored reflecting on the bi-directional influence of parenting and the parent-child relationship on children's emerging social and emotional well-being. Finally,

consideration was given to how parenting with a mental health difficulty is thought to influence children's well-being overall.

Section 9.1.3 Gaps in the Literature

As highlighted in the literature review the dominant and recurring gap in the literature is the lack of the child's perspective. Firstly, by and large research making claims to the welfare of children in this context appears not to have included children in their investigations. This is a significant gap in light of research into children's well-being highlighting that it must include children as experts. Furthermore, where research did include children, much of the information elicited was through adult-centred methods, again highlighting a significant gap in light of the differing communicative abilities of children. This study, thus, looked to incorporate the perspectives of children through a child-centred framework of methods.

Section 9.2 The Research Methodology

This research was underpinned by three key premises. The first premise was that meanings are socially constructed and part of an on-going process of revision and renegotiation (Bruner, 1990; Burr, 2003; Gergen, 2009). This research used an epistemological perspective that is inherently interpretivist in nature with a focus on the exploration of shared social meanings as understood by the families in the study. It was also considered that the most appropriate way to capture complex meanings would be to analyse child, parent and gatekeeper interviews using a hybrid model of narrative analysis (Fraser, 2004) and phase II of Framework analysis (1984).

The second premise of the research was that children and their parents are located within a specific social, physical and time specific environment (Bronfenbrenner, 1979; Bronfenbrenner and Morris, 2006). The main themes explored with children included their feelings, the parent-child relationship, friendships and sibling relationships. These themes can be understood as interrelated and profoundly influenced by both local and broader social networks and factors that change over time i.e. school, parent's mental health (Bronfenbrenner, 1979).

The third key premise of this research was a focus on the child as social actor. In tandem with a paradigm shift in how children are conceptualised there has been a surge of interest in the fields of sociology, psychology and social policy to include and acknowledge children's rights to be considered 'beings' and not 'becomings' (Greene and Hogan, 2005). Throughout this study children are considered as competent social actors, capable of participating in research and who are facilitated by the research methodology, in the case of this research the mosaic approach, to express their views on their own experiences and understanding (Clark and Moss, 2001).

A mixed-method narrative approach was used in this research to gather the data necessary to address the overall aim and objectives of the study. As Denzin and Lincoln (2000) state, a wide range of interconnected methods are necessary in order to get '*a better fix*' on the subject matter at hand (2000:2). Methods of data collection were informed by the literature surrounding children's well-being and sought to promote the different communicative abilities of children, to include subjective and objective measures and to include multiple informants. The methods selected sought to provide children with control and the space to share their subjective experiences and emphasize their inter-personal relationships.

The research approach adopted has a number of strengths. Firstly, it captures the views and perspectives of those centrally involved at the interface between children and the formal and informal nature of their relationships. It provided children with a safe space whereby they could share their perspectives and communicate their views and facilitated the exploration and discussion of sometimes sensitive and distressing experiences of children and parents. It offered a contextualized insight or snapshot of children in this context. However, as with any research study, there were also a number of limitations discussed in Section 9.4.

Section 9.3 Key Research Findings

Findings from this study highlighted several high level findings which were detailed in Chapters 8. In relation to objectives 1-3 of the research these included: Children's concept of self; their understanding of their parent's

mental health difficulty, the parent-child relationships, sibling-relationship and the importance of pets. Findings emerging under the fourth objective included: the invisibility of children in this context to services and the dominance of reactionary and medical based approaches to working with children and parents. Overall, in light of the aim of this research the findings highlight the broad spectrum of social and emotional well-being experiences children have in this context and the significant lack of a family model approach in working with families experiencing difficulties.

Section 9.3.1 Objectives 1-3

This research highlights that children's social and emotional well-being experiences are influenced by a range of factors on an individual and environmental level. Within the overall patterns emerging from this research the social and emotional well-being narratives of children are contextually located within the family context and in particular the parent-child relationship. Children's subjective social and emotional well-being narratives were largely situated within and influenced by their immediate environments and proximal relationships including their relationships with siblings, peers and pets.

A significant contributing factor to their social and emotional well-being narratives was the narrative of their parent and siblings, with children's narratives largely reflecting the narratives of their parents communicated through the parent-child relationship. Children's social and emotional well-being narratives were presented as embedded within the context of their families and highlighted the significance of their immediate attachments and sense of connect with their parent, siblings and pets. Children in this research highlighted the significant emphasis they placed on attaching their sense of well-being to that of their parent highlighting the philosophical thread of eudaimonism as significant to their social and emotional well-being. This was also reflected in the narratives of parents highlighting the bi-directionality of influence in terms of the social and emotional well-being of both parents and children. Attachment relationships between parents and children reflected gendered roles in terms of children's social and emotional well-being

whereby boys and their parents reported it as more difficult to express or engage in emotional narratives in the relationship. While on the surface the boys in this research presented as emotionally detached and parents reflected this emotional detachment as not problematic, a deeper understanding of the function of this detachment suggests it functioned as a protective mechanism in the context of their relationship with their parent.

No children in this research had received information from professionals about their parent's mental health difficulties. This was the case even when parents specifically asked the professional to provide support to their child. Some parents attempted to discuss their difficulties with their children, although this was presented as very challenging and emotionally difficult for parents. Children who had a greater understanding of their parents mental health presented with more positive social and emotional well-being than those who did not. Some children linked the lack of knowledge and understanding of their parent's difficulties and the subsequent impact on them and their family lives directly to reduced emotional well-being as a result of confusion and misinterpretation. However, some children reported the lack of knowledge as a protective positive.

Children also placed a significant emphasis on their relationships with their pets in terms of their social and emotional well-being. This was increasingly so in the absence of other humans as sources of support. The influence of pets in terms of children's social and emotional well-being in this research was presented as hugely positive with pets functioning as companions and non-judgmental listeners whom children felt free to express their feelings to. The importance of pets to children's social and emotional well-being appeared greater for children who reported experiencing greater difficulties in their relationship with their parents and siblings.

Section 9.3.2 Objective 4: Key Recommendations for Policy, Practice and Research

Three key findings were explored in light of the fourth objective of this study these included: the invisibility of children who live with parents with a mental health difficulty to mental health services until a crisis point

has been reached. This appeared to result in families receiving reactionary and solely medically based responses from services to working with children and parents. Findings also supported the need for a family model approach that supports both parents and children leading to improved outcomes for all.

For children in this context the majority depended on their parents as sources of positive social and emotional well-being, although this was not always the case. Many children linked their social and emotional well-being experiences directly to those of their parents. While many parents reported that their well-being was also largely dependent on that of their children and their experiences of parenting. Parents with mental health difficulties must be considered as more than patients and their roles as parents acknowledged by services and they need to feel supported and not judged as deficient.

The research points to a need to put policy rhetoric into practice. The stark reality for the families in this research is that parenting was not supported, children's relationships with their parents were not considered important and service provision was siloed and largely reactive to an unconfirmed assessments of *risk*. Parents experiencing difficulties were largely left to fend for themselves, or simply offered medication or to have their child taken into care when they reported to services they were experiencing difficulties.

Children were largely ignored and warranted little consideration from adult mental health service providers. The findings from this study extend and enhance our knowledge about children's lives and place them centre stage in policy debates around childhood in Ireland. In particular a practical outcome of the study findings would be the creation of best practice guidelines, founded in a family model approach, for professionals working with families in this context. Further research into the perspectives of service providers in fulfilling the recommendation outlined in *AVFC* should be considered in understanding the underlying reasons as to why adult services appear not to implement this aspect of the policy document.

Section 9.4 Implications for Practice

Based on the findings of this research and in line with a family model approach (SCIE, 2009) a series of recommendations should be incorporated into practice and services to improve the assessment and outcomes of children in this context is provided.

- The research findings suggest the need for practitioners to adopt child-centred approaches when working with children as a means to understanding their experiences within each child's unique context.
- Child-centred tools should be the norm in practice as a means to enhancing the participation and inclusion of children in matters that concern them.
- Practitioners must offer children the time and space to share their experiences of living with a parent with a mental health difficulty in ways that are meaningful to them.
- Practitioners must develop their awareness and be attuned to the narratives of children, their parents and the family as a whole. They must also develop an awareness of their own narratives towards families and practice reflexively.
- Multi-dimensional tools should be adopted in working with children and multiple perspectives considered in assessments of their social and emotional well-being.
- Multi-dimensional tools should be used to capture the wide spanning ways in which children conceptualise their SEWB.
- Assessments of children's outcomes should adopted a systemic approach and should incorporate the strengths and protective factors present for children, their parent(s), the family and the wider social context within which they are situated.
- Practitioners must explore children's understanding of their parent's mental health difficulties and share accurate and age-appropriate information with children with regards to their parent's specific mental health difficulties to alleviate some of their concerns and enhance their ability to cope.

- Practitioners should support parents in discussing their mental health difficulties with their children.
- Practitioners need to be aware of the bi-directional influence of parent on child and child on parent.
- Parents and children should be included and supported to share their views of services to inform, develop and evaluate practice and service development.
- Multi-agency engagement and information sharing is an important factor in contributing to appropriate and accurate assessments and both child and adult services have a significant role to play in terms of ensuring the best outcomes for children and their parents.
- Multi-agency engagement and information sharing is important to ascertain the level of needs of children and their parents which in turn should be considered in terms of access to appropriate services in order to improve and maintain outcomes for the family as a whole.
- Increased access for parents and children to a range of services and interventions based on the levels of need are paramount, and not solely reactive and medically based approaches.
- Protocols should be developed for multi-agency engagement and information sharing should be developed for child and adult services.
- Practitioners need to move away from thinking that parents with mental health difficulties lack parental capacity and assumed inevitability of risk needs to be questioned. They must also maintain an awareness of the risk to parent and child and the multitude of factors that may impact on parental capacity when parents have a mental health difficulty. Thus, increased training of practitioners is needed to reduce reactive responses to the needs of child and parent.
- Joint assessments between services should be used and staff training provided to increase awareness and understanding, practitioner confidence and ability to engage with families where a parent has a mental health difficulty.

- Availability and access to a wider range of services and interventions should be prioritised for families.
- Adult mental health services must acknowledge that many patients are parents and as such they have a duty of care that extends beyond solely the person as patient. As a starting point this involves asking patients if they are parents.
- Adult and child mental health services need also to consider the role that children can play in terms of parent's mental health difficulties as both a protective or debilitating factor and how this can impact on parental capacity.
- Services need to adopt a family model approach to improve outcomes for children and their parents, to enhance multi-agency engagement and reduce the siloed and reactive nature of service provision.

Section 9.5 Limitations and Challenges

All research has limitations, the following section looks at the primary limitations of this research study. The first and most notable limitation of this research was the difficulties encountered in accessing children and seeking their participation. Children's participation was dependant on the decisions of gatekeeper and parent, raising questions about children's true participation in research involving sensitive topics. The discourse of the vulnerable child and the power dynamics at play between adults and children was reflected in efforts to recruit children. A second limitation was the lack of gatekeeper perspective. This research had sought to include the perspectives of gatekeepers in keeping with a *whole child* approach; however, in practical terms this was not achieved. This was due to several factors, but primarily because the parent and/or child chose not to include the gatekeeper due to lack of familiarity with the child.

Some gatekeepers declined to participate as they felt they were not familiar with the child. In one instance following the recruitment of a family, through a gatekeeper working in the CAMHS service, the researcher was unable to contact said gatekeeper despite numerous attempts to contact them

via phone and e-mail. This was much to the dismay of the mother involved who was very keen for the gatekeeper to be involved. It also raised ethical questions as this gatekeeper had signed both the consent and declaration form for participation. As a researcher it raised the question of continuing the research with this particular family. Ultimately, it was decided to continue as the mother and child were keen to continue and it was felt it would be unethical at this stage to deny them this opportunity to share their experiences. It also raised questions as to the validity of a gatekeeper approach as a means to protect and ensure the well-being of *vulnerable participants*. Moreover, the lack of gatekeeper participation overall in this study emphasised the *invisibility* of these children for practitioners highlighted in previous research with this population.

Another challenge in this study was the recruitment of and access to families. This was largely attributed to the method of recruitment employed i.e. the gatekeeper approach. This method of recruitment was deemed an ethical prerequisite in light of the perceived vulnerability of parents and children in this context. Many gatekeepers appeared to make the decisions for families depending on their perception of competence and vulnerability in terms of the implications of talking about a sensitive issue and concern for overall participant well-being. This resulted in a large number of families not being informed by practitioners about the research. This may be linked to difficulties practitioners experience in discussing children with adult service users of mental health services highlighted in previous research. Other factors which affected gatekeepers' decisions to participate/inform families was their lack of professional time to work with families in the role of gatekeeper. The response from gatekeepers overall from a personal and professional perspective was highly disappointing; however it may be reflective of a lack of resources and staffing. However, it also highlighted a dearth of practice that adopted a family model to working with children and parents who experience mental health difficulties previously evidenced in the literature (Cusack and Killoury, 2012, Independent Monitoring Group, 2007, 2008, 2009, 2010, 2011, 2012).

This research also had inclusion and exclusion criteria. Children who were in the care of the state following legal proceedings were not included in this study. This decision was made as the focus of the research was to explore the experiences of children while *living* with their parent. However, it is acknowledged in the literature that children in state care as a result of their parent's mental health difficulties may have experienced greater difficulties and exposure to more distressing situations.

Thus, children who may be experiencing greater difficulties socially and emotionally are not included. As such, future research might look to encourage gatekeepers to engage in child-centred research as a means to enhancing their practice and understanding of the children they work with, and secondly include the perspectives of children who have been removed from the care of their parents and reflect on the implications of this separation for the well-being of these children.

The use of multi-perspective research can also be considered a limitation in terms of presenting *the voice of the child*. Efforts to limit this *crisis of representation* included children leading the conversations, and the use of self-reflective practice throughout. The researcher engaged in a process of self-reflections throughout the research process recording digitally (later transcribed and included in analysis) or in writing their reflections on the process of data collection (Rose, 1997). Despite efforts to place the child at the centre, the research acknowledges that the research process is:

influenced by, and embedded within, both our own situations and positions as researchers, as well as the specific places in which we conduct research, and all wider familial and institutional power relations within those spaces (Barker and Weller, 2003, p.223).

A further limitation of the research was the absence of the paternal voice, for both fathers with a mental health difficulty and those without. Only one father who had a mental health difficulty engaged in this research which limited understanding of possible differences in maternal or paternal mental health difficulties and children's experiences of same. While the lack of participation of fathers without a mental health difficulty meant the research could not fully reflect mediating influences of their involvement on children's

social and emotional well-being experiences. Relying solely on the perspectives of mothers (only one of whom did not have a mental health difficulty) may not fully or accurately capture parental perspectives on how children were doing socially and emotionally in this context.

There are several limitations to small qualitative based studies most notably in terms of generalisability. However, the purpose of this study was not to generalize findings to a wide population. It was anticipated from the outset that an in-depth study and exploration of a small sample of families in the context of Ireland would be the key outcomes of the research. In particular, to explore how children understood and experienced their parent's mental health difficulty and how they were doing socially and emotionally because of these experiences.

This research sought to focus on a small sample of children seeking a depth of data, although this prevents findings being generalised, this approach fits with the theoretical assumption that there are multiple realities and childhoods. Sample size was also decided based on a recognised limitation of mixed-method research – time and money (Johnson and Onwuegbuzie, 2004). As a Ph.D. candidate these are both practical and important factors for consideration in planning research. Time was a significant factor in terms of participant recruitment resulting from a gatekeeper approach. It is acknowledged that the findings of this study are not representative of the experiences of all children and parents in this context; however, it provides a snapshot of their daily experiences in the context of parental mental health difficulties.

Further challenges related to more practical aspects of the research when interviewing children collectively or when there were other children present who could not take part in the research due to age limitations. Their presence although at times offered interesting and perceptive insights into some of the dynamics in sibling and parent-child relationships it also at times was distracting and made the transcription process more difficult. This alongside other distractions such as mobile phones, visitors calling and

mothers making dinner all contributed to the difficulties in transcribing but were highly valuable in capturing the everyday messiness of family life.

Qualitative approaches are largely subjective. The acknowledgement of our own subjectivities in the research process can increase the validity of findings (Kvale, 1996). The decisions that are made of what to represent in the research process are decided by the researcher who has their own assumptions, values and background which influence the decisions made. As Etherington (2004) suggests, all research texts are incomplete and partial and the stories which they represent are negotiated by their narrators and interpreted subjectively by the researcher. Similarly, Reissman (1993: 23) acknowledges that ‘the construction of the work bears the hallmark of the person who created it’. Credibility can be enhanced by ‘being reflexive about how we bring meaning and focus to the research’ (Daly, 2007: 255). What is necessary is to focus on knowledge as a social construction rather than a mirror of reality (Daly, 2007). This is further enhanced by presenting results in a truthful and transparent manner and continuous personal reflexivity (Etherington, 1994).

Section 9.6 Chapter Summary

This chapter has summarised the background to the study, the aim and objectives of the research, its key theoretical underpinnings and the methods used for data collection. It has also considered the implications of the findings for informing future research. The bi-directionality of influence of individual and environmental factors on children’s social and emotional well-being and in particular the parent-child relationship in the context of parental mental health highlights the need for a *family model* in working with both children and their parents. Service provision in Ireland continues to focus solely on individuals as decontextualized subjects, which findings from this research refute.

The significant role that parents play in terms of their children’s social and emotional well-being has been highlighted alongside the significant role children play in the manifestation of their parent’s mental health difficulties is obvious. This study based on the perspectives of key actors in the lives of

children describes the reality of their social worlds. The emerging picture, while multi-faceted and complex, is one of a significant mismatch between the rhetoric of Irish policies and services provision in supporting parents to promote the well-being of their children and the reality as experienced by children and their parents. Overall, this research highlights an urgent need for a family model approach in working with children and parents in families where a parent is experiencing mental health difficulties.

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Appendix A:

Typology of Ten Constructs of Childhood (Sorin and Galloway, 2005)

Image of Child	Image of Adult	Power of Child	Power of Adult
Child as Innocent: Carefree, good, incompetent, vulnerable, ignorant, naïve, a blank slate	Adult as Protector: Loving and caring nurturers of children who act in the “child’s best interest”	Little Power	A lot of power from their (assumed) capacity to guide and protect children and limit the child’s environment
Child as Evil: Original sin, innate evil “an untamed threat” (Corsaro, 1997). Destructive threat to the social order; driven by their own needs, desires and pleasures	The Adult as Good/Moral: Controllers of children. Adults have gone from an evil stage to a more mature stage//// they are “good” an keepers of moral order	Children have little power since they are “driven”	Adults have power to control the child (as opposed to the environment above)
The Snowballing Child: Seems to be in charge of the adults around them. Makes inflexible demands of adults for their own short term gratification	The Deferring Adult: Does not set limits therefore opportunity to negotiate power and autonomy is denied	The child has illegitimate power – they get a little power and it snowballs	Could have power, but they hand their power, authority and influence over to the child
The Out-of-Control Child: Uses power in a negative way, for example by being violent, to get the	The Ineffectual Adult: Feels defeated by the child. Feel as if they have little	Power is used in a negative way by the child. When the	Their power is ineffectual. They feel defeated by the child.

Image of Child	Image of Adult	Power of Child	Power of Adult
parent to do what they want them to do. Eventually they feel out of control as if no-one is there to help them regain their control	power and influence and/or do not know how to regain influence with the child	child is not sanctioned they eventually feel out of control.	
The Noble/Saviour Child: Beautiful and beloved, can save people, look after others e.g. Jesus, Harry Potter	The Dependant Adult: The adult depends on the child to get their needs/wants met.	Power is assumed through circumstances. The child is neither agentic nor innocent.	Adults absolve themselves of responsibility or literally cannot undertake that which is expected of them (by the child, by society, by themselves)
The Miniature Adult: Children are the same as adults	The Adult: The mature being	Power of the child lies in their capacity to learn and participate in a world constructed for them by adults. The child is less knowing.	Power lies in their capacity to harness the abilities of the child to suit adult imperatives. Adults can be tyrannical or loving guides. Adults are knowledgeable.
The Adult in Training: Human becomings rather than human beings (Hutchinson and Charlesworth, 2000). Have future potential	The Teacher		
The Commodified Child: Child is an object to be used and consumed by adults	The Self-interested Adult: Adult exploits the child for economic gain	The child is powerless although they may have illusionary power as their image is manipulated by adults	Hold the majority of power
The Child as Victim: Child of famine, pandemic diseases, war and poverty	The Absent Adult: The Child's significant adults lack power. Adults who do have power turn a	Powerless	Powerless

Image of Child	Image of Adult	Power of Child	Power of Adult
The Agentic Child: Capable and competent. An optimistic construct. Rather than “becoming”, the child is a social actor (James, Jenks & Prout, 1998)	blind eye to what is happening to children Co-Constructor of Being: Helps the child on their life journey, as the child helps the adult on their journey	Power is negotiated and shared	Power is negotiated and shared. The adult lends their power, strength and resources with the child rather than imposing on the child.

Table A.1: Typology of Ten Constructs of Childhood (Sorin and Galloway, 2005)

Appendix B:

Table of Policy & Legislation – Children, Parenting and Mental Health in Ireland

Policy and Legislation Children		
Legislation & Policy - Children	Aim	Key Themes
Child Care Act, 1991	Provides the legislative basis for dealing with children ¹⁸ in need of care, protection and the promotion of the child's welfare. Children should be brought up within their own families and families should be supported in achieving this. The welfare of the child is of paramount importance and specific responsibilities lie with the Health Service Executive and An Garda Siochana in ensuring this.	<ul style="list-style-type: none"> • Best Interests of the child. • Family Support • Child Protection and Welfare
United Nations Convention on the Rights of the Child, 1989	To recognise the specific rights and vulnerabilities of children and to promote greater protection. It is underpinned by four basic principles aimed at successful outcomes for children and their families and the role of states in enabling and guaranteeing these rights. These include 1) Protection against discrimination; 2) The best interests of the child; 3) A child's right to survival and development; and 4) A child's right to be heard.	<ul style="list-style-type: none"> • Child rights and Welfare • Best interests of the child • Child's right to participation and inclusion. • Parental Responsibility • State Responsibility
National Children's Strategy – Our	Established a cross-governmental approach to improving children's lives. It identified 3 national goals, 1) Give children a voice in matters that concern them; 2) Improve understanding of their lives; and 3) Provide quality support and services. To create an Ireland where children are respected as young citizens with a shared contribution to make and a voice of their own, where children are	<ul style="list-style-type: none"> • Children's Rights • Best Interest of the child • Child participation

¹⁸ A child is defined as a person under the age of 18 who has not married.

Legislation & Policy - Children	Aim	Key Themes
Children – Their Lives, 2000	cherished and supported by family and the wider society, where they enjoy a fulfilling childhood and realise their potential.	<ul style="list-style-type: none"> • Child well-being • Family Support • A whole child perspective
The Ombudsman for Children Act, 2002	Established the statutory office of the Ombudsman for Children in Ireland. The main functions of the Ombudsman are to promote the rights and welfare of children and to investigate complaints made by children on their behalf against public bodies, schools and hospitals. It also provides advice to the Government encouraging the development and review of policies, practices and procedures, the monitoring and review of relevant legislation and seeks to promote the rights and welfare of children highlighting issues of concern reported by children.	<ul style="list-style-type: none"> • Children’s Rights • Child welfare and protection • Participatory and inclusive • Advocacy
State of the Nation’s Children Reports	A biennial report that emerged in fulfilment of the Government’s commitment in the NCS (2000) to provide regular reports on key indicators of children’s well-being. It draws on available administrative, survey and census data and aims to describe the lives of children in Ireland, Track changes over time and benchmark progress in Ireland relative to other countries. Several reports are available ranging beginning in 2006 and the most recent available 2012.	<ul style="list-style-type: none"> • Child centred • Evidenced based/Outcomes focused
Children Act, 2001	Provides the legislative basis for dealing with children found in breach of criminal law. Children in conflict with the laws should only be detained by the state as a last resort. It places a focus on community based interventions, raised the age of criminal responsibility and reviewed the grounds for which convictions can be removed from the record.	<ul style="list-style-type: none"> • Best Interests of the Child
The Agenda for Children’s Services: A Policy Handbook, 2007	A broad policy framework aimed at advancing policy at a national level evidenced by improvements in outcomes for children and young people. It sets out the strategic direction and key goals of public policy in relation to children’s health and social services in Ireland.	<ul style="list-style-type: none"> • Child well-being • Child participation • A whole child perspective • Children as social agents • Evidenced based/Outcomes focused
Children First: National Guidance, 2011	To promote the safety and well-being of children. To assist people in identifying and reporting child abuse and neglect and deal effectively with concerns. Emphasising that the needs of children and families must be at the centre of service provision, and that the welfare of children is of paramount importance. It highlights the roles and statutory responsibilities of the HSE and An Garda Siochana and provides guidance to community and voluntary agencies working with children and families.	<ul style="list-style-type: none"> • Child welfare is paramount • Early intervention and prevention • Family Support

Legislation & Policy - Children	Aim	Key Themes
		<ul style="list-style-type: none"> • Child's right to be heard • Parental rights • Child must be understood within the context of its family • Multi-disciplinary approach • Separation from parents as a 'last resort'.
<p>Toward Recovery: Programme for a National Government, 2011-2016</p>	<p>Outlines a range of Government commitments towards improving children's lives. Including provisions for a constitutional referendum on children's rights, the establishment of the Child and Family Agency and implementing a number of reforms in health and education and investment in children's mental health. It also proposed the development and publication of a National Data Strategy on Children's Lives.</p>	<ul style="list-style-type: none"> • Child well-being • Child protection and welfare • Children's rights • Educational outcomes
<p>National Strategy for Research and Data on Children's Lives, 2011-2016</p>	<p>The strategy seeks to coordinate and mobilise research and data across a range of important bodies in order to achieve a better understanding of children's lives. It presents a set of objectives for improved understandings of children's lives and a detailed action plan to initiate achievement of this goal. It provides a framework for improving understandings of children's lives across all sectors, including policy makers, service providers, researchers, children, families and communities.</p>	<ul style="list-style-type: none"> • Children's lives are complex and multi-dimensional – Ecological approach • Children's social realities are multi-systemic • Inclusion of Positive and Negative aspects • Focus on the children's subjective experiences • Favour the voice of the child while including perspective of key stakeholders

Legislation & Policy - Children	Aim	Key Themes
Child and Family Agency Act, 2013	Brings together of a range of existing children's services into one key agency the Child and family support Agency. The function of the CFSA is to maintain and develop community based support services for children and their families. To provide leadership to relevant statutory and non-statutory agencies, to ensure that the conditions needed for children's well-being and development are fulfilled.	<ul style="list-style-type: none"> • Prevention & Early Intervention • Crisis Intervention Supports • Best interests of the child • Child and family participation. • Child Welfare • Family Support & Empowerment • Strengths-based & Inclusive
Better Outcomes, Brighter Futures, The national policy framework for children & young people, 2014-2020	The purpose of this framework is to co-ordinate policy across government with 5 national outcomes and to identify areas that have the potential to improve outcomes for children and young people (0-24 years) and to transform the effectiveness of existing policies, services and resources. With the aim of Ireland being the best small country in the world in which to grow up and raise a family, and where the rights of children and young people are respected, protected and fulfilled; where their voices are heard and where they are supported to realise their maximum potential now and in the future.	<ul style="list-style-type: none"> • Children's lives as multi-dimensional • Parental support • Early intervention & Prevention • Children's Participation & Inclusion • Children's Rights • Evidence based/Outcomes focused • Cross-government and interagency approach • Strengthen transitions • Quality service provision • Outcomes focused
Children First Bill, 2014	To strengthen the safeguarding of children by placing children first guidelines on a statutory footing and through the introduction of mandatory reporting for key stakeholders in children's lives	<ul style="list-style-type: none"> • Best Interest of the child

Legislation & Policy - Children	Aim	Key Themes
		<ul style="list-style-type: none"> • Children's Rights • Children's participation and Inclusion

Policy & Legislation - Parenting

Policy and Legislation	Aim	Key Themes
Domestic Violence Act, 1996	Offers a number of interventions and legal instruments available to the courts including: the protection of spouses, children, dependents and other domestic relationships where their welfare or safety is in jeopardy because of the conduct of another person in the domestic relationship; an increase of powers for Gardai; judicial hearings linked with other hearings will be held simultaneously; and a range of orders relating to barring, protection and safety of individuals.	<ul style="list-style-type: none"> • Best Interests of the child • Family support. • Child protection and welfare
Strengthening Families for Life, 1998	Highlighted the need for public policy to focus on preventive and supportive measures to facilitate and enable families in their responsibilities and promote the continuity and stability of family life.	<ul style="list-style-type: none"> • Family as fundamental unit • Prevention & early intervention • Strengths based • Parental support • Family Support
The Family Support Agency Act, 2001	Established the Family Support Agency. Functions of the agency include, providing a family mediation service, support, promote and develop the provision of marriage/relationship counselling and family support services, to support, promote and develop the Family and Community Services Resource Centre programme and to undertake research on family issues.	<ul style="list-style-type: none"> • Accessibility • Community-based • Family Support • Prevention and Early Intervention
Investing in Parenthood, 2002	The purpose of the strategy was to identify a strategic approach to supporting parents in order to achieve best health for children. It also proposes to support, reinforce and act as a vehicle for the implementation of relevant aspects of existing national strategies that pertain to supporting parents.	<ul style="list-style-type: none"> • Children's rights • Children's Well-being • Parents as experts • Parental support • Accessible services

		<ul style="list-style-type: none"> • Partnership approach • Interagency
Investing in families, supporting parents to improve outcomes for children, Parenting Support Strategy, 2013	First national policy strategy on parenting support for child and family services in Ireland. Parenting support is defined as <i>a set of activities that provides information, advice and assistance to parents and carers in relation to the upbringing of their children in order to maximise their child's potential</i> .	<ul style="list-style-type: none"> • Universal/Targeted support • Needs based • Child as paramount • Early intervention • Outcomes focused • Evidenced based service delivery • Multi-disciplinary • Based on Human rights and social inclusion
The National Action Plan for Social Inclusion, 2007-2016	Sets out a programme of action to address poverty and social inclusion, adopting a lifecycle approach. It outlines services providing family support. It will facilitate the greater co0ordination and integration of structures and procedures across government. It provides improved reporting and monitoring mechanisms. The ultimate aim of this document eliminate <i>consistent poverty by 2016</i> .	<ul style="list-style-type: none"> • Outcomes based • Monitoring progress • Multi-disciplinary approach • Person centred

Policy & Legislation - Mental Health

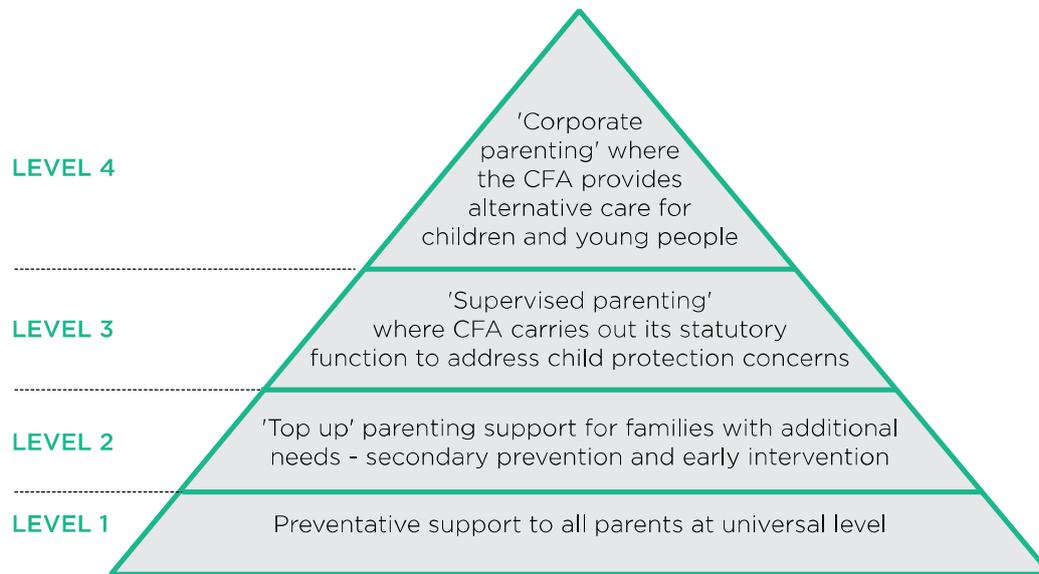
Mental Health Policy & Legislation	Overview	Key Themes
Mental Health Act, 2001	Brought Ireland's mental health legislation in line with international human rights standards. It provides a safeguard for individuals who are involuntarily admitted and detained in approved centres, and puts in place mechanisms for the regulation and inspection of mental health services through the establishment of an Independent body known as the Mental Health Commission. The primary function of the MHC is to promote, encourage and foster high standards and good practices in the delivery of mental health services and to protect the interests of patients who are involuntarily admitted.	<ul style="list-style-type: none"> • Best Interests of the individual • Participation & Inclusion • Rights based

A Vision for Change, 2006	To provide a comprehensive model of mental health service provision for Ireland. Provides a frameworks for building and fostering positive mental health across the entire community and for the provision of accessible, community-based, specialist services for people with mental illness.	<ul style="list-style-type: none"> • Holistic view of mental health • Integrated multi-disciplinary approach • Person-centred • Collaboration with service-users and their families at all levels of service provision • Community-based • Evidenced based and best practice driven • Recovery Model
The National Disability Strategy	Underpins the participation of people with disabilities in Irish society. The strategy builds on existing policy and legislation and has been endorsed in the social partnership agreement Towards 2016. The key elements of the strategy include the Disability Act (2005) the Citizens Information Act (2007) and the education for person with special educational needs (2004). It is designed as a whole of government approach to promoting equality and inclusion of people with disabilities	<ul style="list-style-type: none"> • Participation and inclusion • Person-centred • Multi-sectoral approach • Inter-agency collaboration • Collaboration with service users
The Disability Act, 2005	Part of a broader Government initiative to create a framework of legislative measures which support social inclusion. It provides a multi-sectoral approach to individuals with disabilities and provides a basis for the independent assessment of individual needs. It seeks to advance and underpin the participation of people with disabilities in society by supporting the provision of disability specific services and improving access to mainstream public services, and establishes a centre for excellence in Universal design.	<ul style="list-style-type: none"> • Participation and inclusion • Person-centred • Non-discriminatory
UN Convention on the Rights of Persons with Disabilities, 2007	The aim of the convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and to promote respect for their inherent dignity. Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.	<ul style="list-style-type: none"> • Equality and non-discrimination • Best interest of the child • Voice of the child • Accessibility

		<ul style="list-style-type: none">• Family support• Quality needs based services and supports• Participation• Outcomes focused
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Appendix C:

TUSLA Parenting Support Strategy based on a Continuum of Need (Hardiker, 1991)¹⁹



¹⁹ CFA refers to the Child and Family Agency.

Appendix D:

Six Research Strategies for Mixed-methods Research

<i>Strategy</i>	Design	Key Features	Pros	Cons
<i>Sequential</i>	Explanatory	<ul style="list-style-type: none"> ➤ The collection and analysis of quantitative data followed by the collection and analysis of qualitative data. ➤ Priority is usually given to quant data and qualitative data assists in explaining and interpreting the findings. ➤ Focuses on explaining and interpreting relationships ➤ No set guiding theoretical perspective 	<ul style="list-style-type: none"> ➤ Straightforward and easy to implement ➤ Clear process ➤ Easy to describe and report 	<ul style="list-style-type: none"> ➤ Time consuming
	Exploratory	<ul style="list-style-type: none"> ➤ The collection and analysis of qualitative data followed by the collection and analysis of quantitative data. ➤ Priority is given to qualitative data and quantitative data assists in explaining qualitative findings. ➤ Findings are integrated at the interpretive phase ➤ Focuses on exploring phenomenon. ➤ No set guiding theoretical perspective 	<ul style="list-style-type: none"> ➤ Straightforward and easy to implement ➤ Clear process ➤ Easy to describe and report. ➤ Useful when developing and testing research instruments. 	<ul style="list-style-type: none"> ➤ Time consuming ➤ Difficulties can occur in building from qualitative analysis to subsequent quantitative data collection.
	Transformative	<ul style="list-style-type: none"> ➤ Two phase method where priority is given to neither qualitative nor quantitative methods. ➤ Results are integrated at the interpretation stage. ➤ Guided by theoretical perspective and methods are employed accordingly. 	<ul style="list-style-type: none"> ➤ Straightforward and easy to implement ➤ Easy to describe and report. 	<ul style="list-style-type: none"> ➤ Lack of guidance on how transformative strategies guide methods. ➤ Lack of clarity on moving from one phase to the next.
<i>Concurrent</i>	Triangulation	<ul style="list-style-type: none"> ➤ One phase approach ➤ Different methods are employed to confirm, cross-validate or corroborate findings within a single study. 	<ul style="list-style-type: none"> ➤ Findings are well-validated and substantiated. 	<ul style="list-style-type: none"> ➤ Requires expertise to concurrently use two methods

Strategy	Design	Key Features	Pros	Cons
		<ul style="list-style-type: none"> ➤ Uses separate qualitative and quantitative methods in order to off-set the weaknesses of one method with the strengths of the other. ➤ Priority can be given in practical terms to one method or the other ➤ Findings are integrated at the interpretation stage. 	<ul style="list-style-type: none"> ➤ Short time required for data collection 	<ul style="list-style-type: none"> ➤ Comparing results can be difficult ➤ Dealing with discrepancies when they arise.
	Nested	<ul style="list-style-type: none"> ➤ One phase approach. ➤ Data is collected simultaneously. ➤ A dominant method is selected and guides the research and the subordinate approach is embedded within it. ➤ Methods are mixed at the interpretive phase. ➤ Flexible theoretical perspective ➤ Is used to gain deeper perspectives, enrich the description of sample participants. Can describe data that cannot be quantified. ➤ A multi-level design using different methods. 	<ul style="list-style-type: none"> ➤ Data collected simultaneously. ➤ Single data collection phase ➤ Increases understanding through differing perspectives and different types of data. 	<ul style="list-style-type: none"> ➤ Data must be transformed. ➤ Little guidance for implementation. ➤ Little guidance on the resolution of discrepancies in the data. ➤ Can result in unequal evidence.
	Transformative	<ul style="list-style-type: none"> ➤ Heavily guided by theoretical perspective and methods are employed accordingly. ➤ It can be either triangulated or nested in design. ➤ Simultaneous one phase data collection phase. ➤ Priority accorded to data may be equal or unequal ➤ Integration can occur during analysis or interpretive phase. 	<ul style="list-style-type: none"> ➤ Straightforward and easy to implement ➤ Easy to describe and report. 	<ul style="list-style-type: none"> ➤ Lack of guidance on how transformative strategies guide methods. ➤ Lack of clarity on moving from one phase to the next.

Creswell (2003) Chapter 11 Mixed methods procedures p. 213-219.

Appendix E:

Considering Children's Participation

Article twelve of the UNCRC explicitly states that children have the right to express their views on matters that concern them. The UNCRC in tandem with the emerging perspective proffered by the new sociology of childhood have laid the foundation for children to gradually regain their right to autonomy and active status in society (Hill, Davis, Prout & Tisdall, 2004). It is now widely acknowledged that children are rights holders, active citizens, social actors and contribute valid worldviews as *experts* in their own lives (Camfield, Streuli, & Woodhead, 2008). This is especially evident in the world of research, whereby the participation of children is increasingly being sought throughout all stages of the research process from design to dissemination.

Schafer and Yarwood (2008 p.123) argue that the manner in which

adults construct and understand childhood and youth thus has a major impact on our understanding of the meaning of research and participation and on how we want young people to engage in research and political decision making (p. 6).

This has led to an obvious dyadic dilemma of participation and protection (Edwards & Mauthner, 2002). Thus, the minority status attributed to children and the dyadic dilemma raises the question about truly how participatory the research process can be, particularly when it involves *sensitive* topics such as parental mental health difficulties? (Holland, Renold, Ross & Hilman, 2010; Thomas, 2007).

As adult researchers and *very definite and readily identifiable other[s]* (Mazzoni & Harcourt, 2013: 5) engaging children as social actors in the research process can be a complex task (Wyness, 2008). Much depends on the phenomenon of interest, the design of the study, the target population, specific age range of the children and generally a prerequisite of parental/gatekeeper consent (Harcourt & Conroy, 2011). A primary factor for consideration with regards this research involves access to children. Hood, Kelley and Mayall (1996) purport that as a result of children's *sociopolitical positioning* (p. 126) they cannot be approached directly for participation, an

initial adult consent filter is required under the guise of the principle of *best interests*.

In light of the topic of the research and as a result of satisfying ethical concerns, access to and participation of children and young people is controlled by adults and determined by their conceptualizations of whether children have the capacity to fully understand the nature of the research process and make an informed choice on whether or not they wish to participate (Bessell, 2006). Moreover, in light of the lack of child research ethics committees the *best interests* of children and young people for this research in terms of participation was determined by adult academics from a range of disciplines, not a child in sight. Lansdown (2009) notes that:

children are denied opportunities for participation in decision making and the exercise of responsibility in many areas of their lives, because of extended social and economic dependency and an enhanced perception of the need for protection (p.16).

She further contends that the principle of *best interests* does not supersede that of children's right to participate in matters that concern them. Although acknowledging the need to balance participation and protection she cautions that 'erring too far on the side of protection denies children the right to be heard, inhibits opportunities to develop their capacities for participation and, indeed can serve, perversely, to heighten risk' (Lansdown, 2009: 18). Thus, immediately power dynamics are at play which can potentially reduce children's rights to participate in matters that concern them to nothing more than a tokenistic gesture, pending on the adults' perspective of the abilities of children.

Badham (2004) refers to research that is '*prescribed from above*', in that notions of child participation are generally contained within the parameters of adult conceptualizations of children, funder requirements, organizational constraints (Franks, 2011) and in the case of this research, research ethics committees. To satisfy the committee and obtain ethical funding a detailed and comprehensive ethics application was completed outlining the research design in minute detail. Therefore, despite my epistemological position I was required to function within a system which renders the whole notion of child participation as questionable, with regards children being invited to participate in an adult defined research agenda which

gives precedence to adult defined concerns rather than truly participating with children in their best interests, about matters that concern them (Prout, 2002).

In conclusion, despite a range of ethical and methodological considerations required when carrying out research with children; ‘to avoid asking the questions because they are ethically difficult, thereby excluding children from research, is an ethical position in itself’ (Morrow & Richards, 1996: 104). The more children are facilitated in participating in all stages of the research process from pre-fieldwork phases, fieldwork analysis and dissemination the more robust, valid and reliable the findings of the research will be (Casas, Gonzales, Navarro & Aligué, 2013; Casa 2010). In response to the growing acknowledgement that children are capable and should be engaged as active social actors in research, as researchers it is incumbent on us to give critical consideration to the ethical, methodological and theoretical approaches adopted (Fielding, 2004). Failure to do so serves to enhance power imbalances and status disparities in research relationships (Alderson, 2001) and makes questionable notions of participation.

As rights holders (Monds-Watson et al., 2010) and active agents (James & Prout, 1997) calls have been made for children and young people to be included as informants in order to achieve a greater insight into their needs, perceptions and daily realities while living with a parent experiencing mental health difficulties (Trondsen, 2012). Prout (2002) argues that ‘too often children are expected to fit into adult ways of participating when what is needed is institutional and organisational change which facilitates childrens’ voices’ (p.75). Sinclair (2004:116) echoes this in stating that what is needed is a move ‘to a position where children’s participation is firmly embedded within organisational cultures and structures for decision making’. In light of both the implicit and explicit power relations at play, and the constrained environments within which research occurs attempts to truly engage children as social actors in participatory ways during the research process remains a contentious issue, and *truly participatory* approaches remain to be found (Franks, 2009).

Appendix F:

Major Sampling Strategies in Mixed-Method Research (Onwuegbuzie & Collins, 2007: 285)

Strategy (Type)	Use
Simple	Every person in the sampling frame has an equal and independent chance of being selected for participation.
Stratified	Groups created that are relatively homogenous in one or more characteristics from which a random sample for each stratum is selected
Cluster	Selecting groups as representative clusters of individuals rather than choosing individuals
Systematic	Choosing individuals from a list by selecting every nth participant, where n typifies the population divided by the preferred sample size.
Multi-stage Random	Choosing a sample from the random sampling schemes across multiple phases.
Intensity	Choosing a sample because their experience relative to the phenome of interest are viewed as intense but not extreme.
Politically Important Case	The inclusion or exclusion of a sample based on their political links to the phenomena of interest.
Random Purposeful	Selecting random cases from a sample and randomly choosing participants.
Stratified Purposeful	Strata of relatively homogenous groups created from sample and a purposeful sample selected from each stratum.
Criterion	Selection based on sample as representing one or more criteria.
Confirming/Disconfirming	Permits the exploration of confirming or disconfirming cases and to develop a theory. Used after data collection started; an emergent design.
Critical Case	Presents the case that <i>dramatically</i> illustrates the situation and their inclusion provides the researcher with compelling insight about a phenomenon of interest.
Extreme Case	Used to describe particularly troublesome or enlightening cases through the selection of outlying cases and conducting comparative analyses.
Homogeneous	Describes in detail a sub-group who share similar or specific characteristics.
Maximum Variation	Helps to develop and to maximize a range of perspectives in a study.

Theory-Based	Used to generate theory or explore a concept
Mixed Purposeful	Selecting more than one sampling strategy and comparing results from both samples.
Opportunistic	Takes advantage of whatever case unfolds. A case is selected based on specific characteristics to capitalise on the case as it unfolds during data collection.
Snowball/Chain	Helps to locate people or sites to be studied. Used after data collection has started and a researcher conducts subsequent analyses to verify/contradict initial results.
Typical Case	Describes what is <i>typical</i> to those unfamiliar with the case
Quota	Desired characteristics and quotas of sample to be included are identified.
Multi-Stage Purposeful Random	Sample chosen as representative in two or more stages in which all stages reflect purposive sampling of participants.
Multi-Stage Purposeful	Sample chosen as representative in two or more stages in which all stages reflect purposive sampling of participants.

Appendix G:

Inclusion and Exclusion Criteria for the Samples

Inclusion Criteria:

- Children aged 7-17 years of age
- Children living with a parent with a diagnosed mental health difficulty
- Parent(s) who have a diagnosed mental health difficulty
- Professional(s) involved with the parent/child as a result of the parent's mental health difficulty/or child well-being.

Exclusion Criteria

- Parent(s) with a substance misuse difficulty or dual-diagnosis
- Children under age 7 years and older than 17 years
- Children in the care of the state due to child protection concerns
- Children with chronic illness
- Children whose first language is not English

Appendix H:

Measurement Scales Child, parent and gatekeeper



Me & My Well-being

2013

**A booklet for doctoral research with the UNESCO
Child and Family Research Centre, NUI Galway**

Child and Youth Resilience Measure (CYRM)-28

What do I have to do?

Listed below are a number of questions about you, your family, your community, and your relationships with people. These questions are designed to better understand how you cope with daily life and what role the people around you play in how you deal with daily challenges.

Please complete the questions in Section One. For each question in Section Two, please circle the number to the right that describes you best. There are no right or wrong answers.

Section One

What is your date of birth? _____

What is your sex? _____

What is the highest level of education you have completed? _____

Who do you live with? _____

How long have you lived with these people? _____

How many times have you moved homes in the past 5 years? _____

Please describe who you consider to be your family (For example, 1 or 2 biological parents, siblings, friends on the street, a foster family, an adopted family, etc.)

People are often described as belonging to a particular racial group. To which of the following groups do you belong? (Mark or check the one that best describe(s) you)

- Aboriginal or Native
- South Asian (e.g., East Indian, Pakistani, Punjabi, Sri Lankan)
- South East Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese)
- West Asian to Middle Eastern (e.g., Armenian, Egyptian, Iranian, Lebanese) ; Asian (e.g., Korean, Chinese, Japanese)
- Black (e.g., African or Caribbean descent)
- White or European
- Filipino
- Latin American (e.g., Mexican, South American, Central American)
- Other (please specify): _____
- Mixed Race (please list all groups that apply): _____

People are often described as belonging to a particular ethnic or cultural group(s). (For example, Chinese, Jamaican, German, Italian, Irish, English, Ukrainian, Inuit, East Indian, Jewish, Scottish, Portuguese, French, Polish, Vietnamese, Lebanese, etc.) To which ethnic or cultural group(s) do you see yourself belonging? Please list as many groups as you want.

Section Three

To what extent do the statements below **DESCRIBE YOU?** Circle one answer for each statement.

	Not at all	A Little	Some-what	Quite a Bit	A Lot
1. I have people I look up to	1	2	3	4	5
2. I co-operate with people around me	1	2	3	4	5
3. Getting an education is important to me	1	2	3	4	5
4. I know how to behave in different social situations	1	2	3	4	5
5. My parent(s)/caregiver(s) watch me closely	1	2	3	4	5
6. My parent(s)/caregiver(s) know a lot about me	1	2	3	4	5
7. If I am hungry, there is enough to eat	1	2	3	4	5
8. I try to finish what I start	1	2	3	4	5
9. Spiritual beliefs are a source of strength for me	1	2	3	4	5
10. I am proud of my ethnic background	1	2	3	4	5
11. People think that I am fun to be with	1	2	3	4	5
12. I talk to my family/caregiver(s) about how I feel	1	2	3	4	5
13. I am able to solve problems without harming myself or others (for example by using drugs and/or being violent)	1	2	3	4	5
14. I feel supported by my friends	1	2	3	4	5
15. I know where to go in my community to get help	1	2	3	4	5
16. I feel I belong at my school	1	2	3	4	5
17. My family stands by me during difficult times	1	2	3	4	5
18. My friends stand by me during difficult times	1	2	3	4	5
19. I am treated fairly in my community	1	2	3	4	5
20. I have opportunities to show others that I am becoming an adult and can act responsibly	1	2	3	4	5
21. I am aware of my own strengths	1	2	3	4	5
22. I participate in organized religious activities	1	2	3	4	5
23. I think it is important to help out in my community	1	2	3	4	5
24. I feel safe when I am with my family/caregiver(s)	1	2	3	4	5
25. I have opportunities to develop skills that will be useful later in life (like job skills and skills to care for others)	1	2	3	4	5
26. I enjoy my family's/caregiver's cultural and family traditions	1	2	3	4	5
27. I enjoy my community's traditions	1	2	3	4	5
28. I am proud to be (Nationality: _____)?	1	2	3	4	5

Strengths & Difficulties Questionnaire

Please read the statements below and tick the box that is the most appropriate answer for you

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am restless. I cannot stay still for long.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get a lot of headaches, stomach aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually share with others (food, games, pens etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get very angry and often lose my temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am usually on my own. I generally play alone or keep to myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually do as I'm told	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>I worry a lot</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have one good friend or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I fight a lot. I can make other people do what I want	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other people my age generally like me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am easily distracted, I find it difficult to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>I am nervous in new situations. I easily lose confidence</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often accused of lying or cheating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other children or young people pick on me or bully me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often volunteer to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think before I do things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Not True	Somewhat True	Certainly True
I take things that are not mine from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get on better with adults than with people my own age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have many fears, I am easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>I finish the work I'm doing. My attention is good</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

Overall, do you think that you have difficulties in one or more of the following areas:
Emotions, concentration, behavior or being able to get on with other people?

No	Yes Minor Difficulties	Yes Definite Difficulties	Yes Severe Difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

How long have these difficulties been present?

< 1 month	1-5 months	6-12 months	+ 1 Year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do the difficulties upset or distress you?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do the difficulties interfere with your everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do the difficulties make it harder for those around you (Family, friends, teachers, etc.)?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your Signature

.....

Today's Date

.....

EAS-T & ME

Please read each statement and circle the number that represents the most appropriate answer for you.

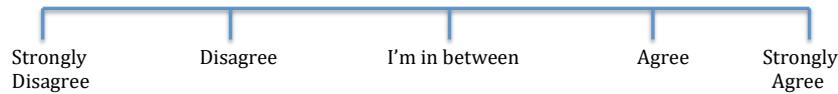
- 1 = Not characteristic/typical
- 2 = Occasionally characteristic/typical
- 3 = Somewhat characteristic/typical
- 4 = Characteristic/typical
- 5 = Very characteristic/typical

I tend to be shy	1	2	3	4	5
I cry easily	1	2	3	4	5
I like to be with people	1	2	3	4	5
I am always on the go	1	2	3	4	5
I prefer playing with others rather than alone	1	2	3	4	5
I tend to be somewhat emotional	1	2	3	4	5
When I move about, I usually move slowly	1	2	3	4	5
I make friends easily	1	2	3	4	5
I am off and running as soon as I wake up in the morning	1	2	3	4	5
I find people more stimulating than anything else	1	2	3	4	5
I often fuss and cry	1	2	3	4	5
I am very sociable	1	2	3	4	5
I am very energetic	1	2	3	4	5
I take a long time to warm up to strangers	1	2	3	4	5
I get upset easily	1	2	3	4	5
I am something of a loner	1	2	3	4	5
I prefer quiet, inactive games to more active ones	1	2	3	4	5
When I am alone, I feel isolated	1	2	3	4	5
I react intensely when upset	1	2	3	4	5
I am very friendly with strangers	1	2	3	4	5

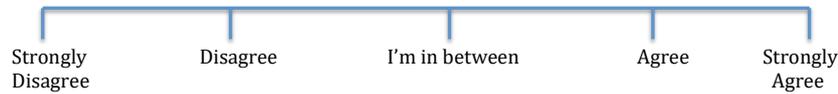
My Mum

How much do you agree or disagree with these sentences?

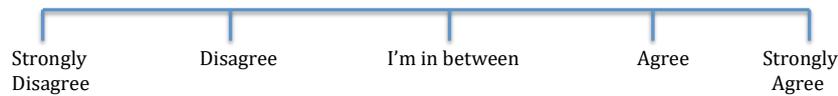
a) My mum really expects me to follow family rules



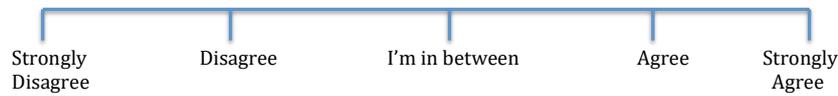
b) My mum doesn't really like me to tell her my troubles



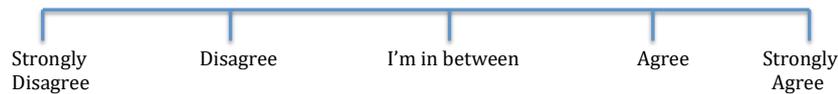
c) My mum expects me to dress and act differently in places like church or a restaurant than I do when I'm with my friends.



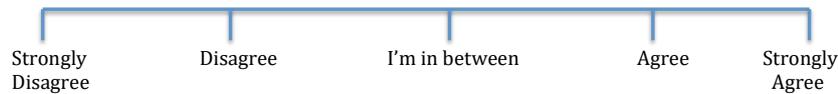
d) My mum tells me that her ideas are correct and that I shouldn't question them



e) Hard work is very important to my mum



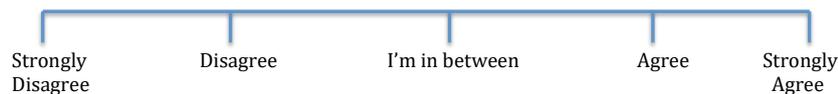
f) My mum respects my privacy



g) My mum hardly ever praises me for doing well



h) My mum gives me a lot of freedom



i) My mum really lets me get away with things

Strongly Disagree Disagree I'm in between Agree Strongly Agree

j) If I don't behave myself, my mum will punish me

Strongly Disagree Disagree I'm in between Agree Strongly Agree

k) My mum expects me to do what she says without having to tell me why

Strongly Disagree Disagree I'm in between Agree Strongly Agree

l) My mum makes most of the decisions about what I can do

Strongly Disagree Disagree I'm in between Agree Strongly Agree

m) It is important to my mum that I do my best

Strongly Disagree Disagree I'm in between Agree Strongly Agree

n) My mum encourages me to talk to her honestly

Strongly Disagree Disagree I'm in between Agree Strongly Agree

o) My mum doesn't ask me to change my behavior to meet the needs of other people in the family

Strongly Disagree Disagree I'm in between Agree Strongly Agree

p) My mum believes I have a right to my own point of view

Strongly Disagree Disagree I'm in between Agree Strongly Agree

q) If I don't act according to my mum's standards, she will do things to make sure I do in future

Strongly Disagree Disagree I'm in between Agree Strongly Agree

r) I can count on my mum to help me out if I have a problem

Strongly Disagree Disagree I'm in between Agree Strongly Agree

s) I would describe my mum as a strict parent

Strongly Disagree Disagree I'm in between Agree Strongly Agree

t) My mum points out ways I could do better

Strongly Disagree Disagree I'm in between Agree Strongly Agree

u) My mum pushes me to do my best in whatever I do

Strongly Disagree Disagree I'm in between Agree Strongly Agree

v) It's clear to me when my mum thinks I have done well

Strongly Disagree Disagree I'm in between Agree Strongly Agree

w) My mum pushes me to think for myself

Strongly Disagree Disagree I'm in between Agree Strongly Agree

x) My mum is strict about how I behave when I'm in shops, the library or some place where there are mostly adults

Strongly Disagree Disagree I'm in between Agree Strongly Agree

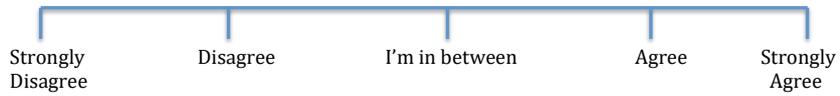
y) My mum makes it clear when I have done something she doesn't like

Strongly Disagree Disagree I'm in between Agree Strongly Agree

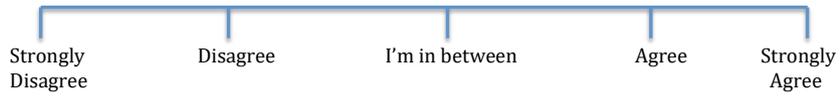
z) I can tell when my mum thinks I could have done better



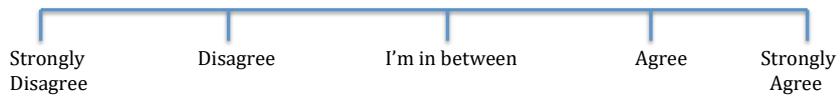
aa) My mum spends time just talking to me



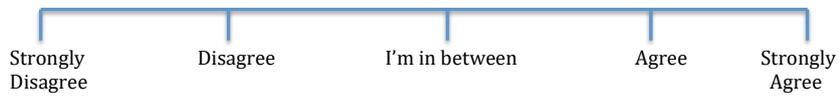
bb) When I do something wrong, my mum does not punish me



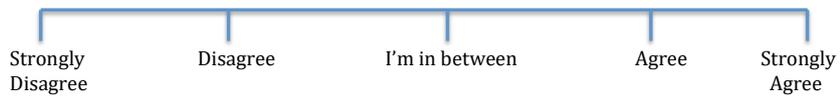
cc) My mum and I do things that are fun together



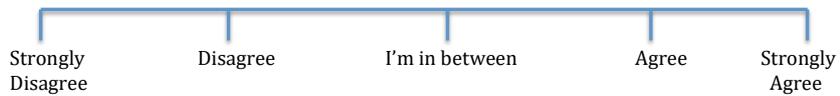
dd) My mum sets high standards for me to meet



ee) My mum gives me chores to do around the house



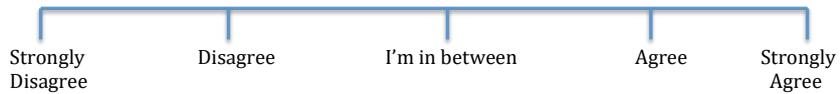
ff) When my family does things together, my mum expects me to come



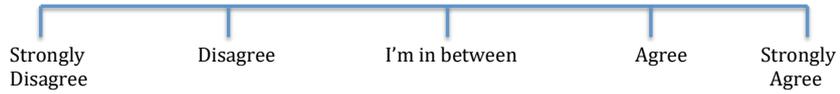
My Dad

How much do you agree or disagree with these sentences?

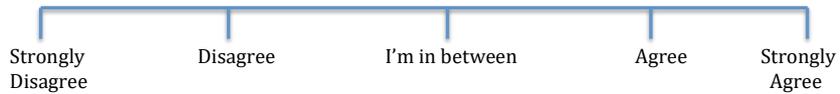
a) My dad really expects me to follow family rules



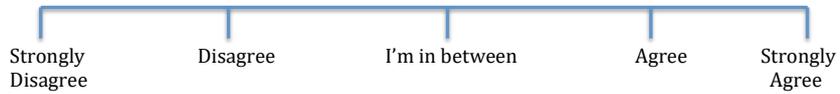
b) My dad doesn't really like me to tell him my troubles



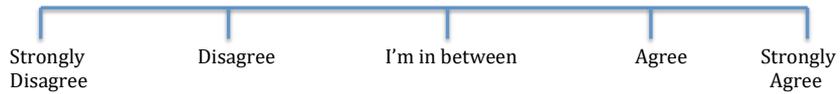
c) My dad expects me to dress and act differently in places like church or a restaurant than I do when I'm with my friends.



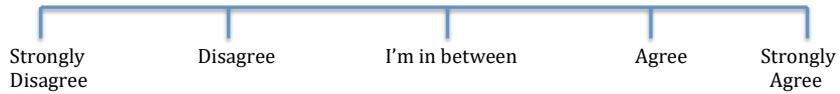
d) My dad tells me that his ideas are correct and that I shouldn't question them



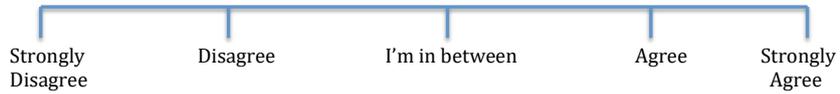
e) Hard work is very important to my dad



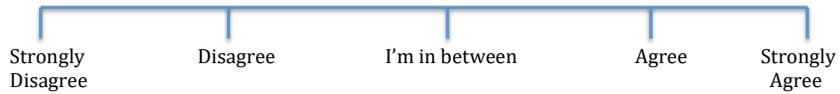
f) My dad respects my privacy



g) My dad hardly ever praises me for doing well



h) My dad gives me a lot of freedom



i) My dad really let me get away with things

Strongly Disagree Disagree I'm in between Agree Strongly Agree

j) If I don't behave myself, my dad will punish me

Strongly Disagree Disagree I'm in between Agree Strongly Agree

k) My dad expects me to do what he says without having to tell me why

Strongly Disagree Disagree I'm in between Agree Strongly Agree

l) My dad makes most of the decisions about what I can do

Strongly Disagree Disagree I'm in between Agree Strongly Agree

m) It is important to my dad that I do my best

Strongly Disagree Disagree I'm in between Agree Strongly Agree

n) My dad encourages me to talk to him honestly

Strongly Disagree Disagree I'm in between Agree Strongly Agree

o) My dad doesn't ask me to change my behavior to meet the needs of other people in the family

Strongly Disagree Disagree I'm in between Agree Strongly Agree

p) My dad believes I have a right to my own point of view

Strongly Disagree Disagree I'm in between Agree Strongly Agree

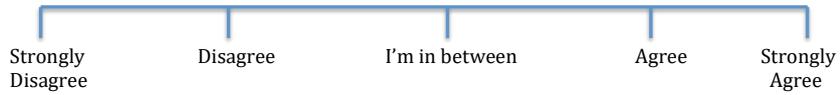
q) If I don't act according to my dad's standards, he will do things to make sure I do in future

Strongly Disagree I'm in between Agree Strongly

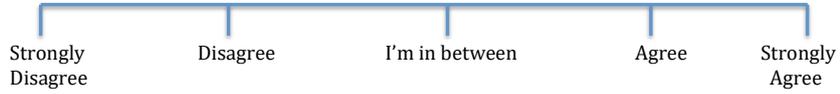
Disagree

Agree

r) I can count on my dad to help me out if I have a problem



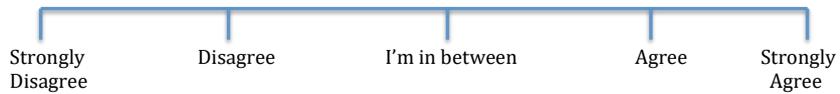
s) I would describe my dad as a strict parent



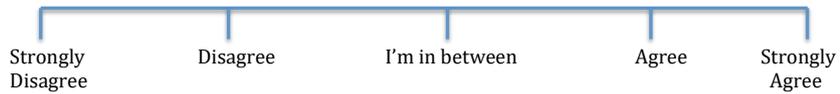
t) My dad points out ways I could do better



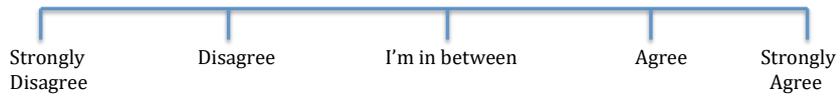
u) My dad pushes me to do my best in whatever I do



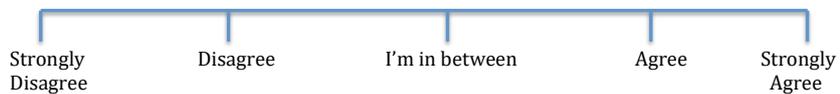
v) It's clear to me when my dad thinks I have done well



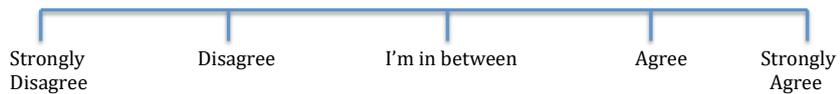
w) My dad pushes me to think for myself

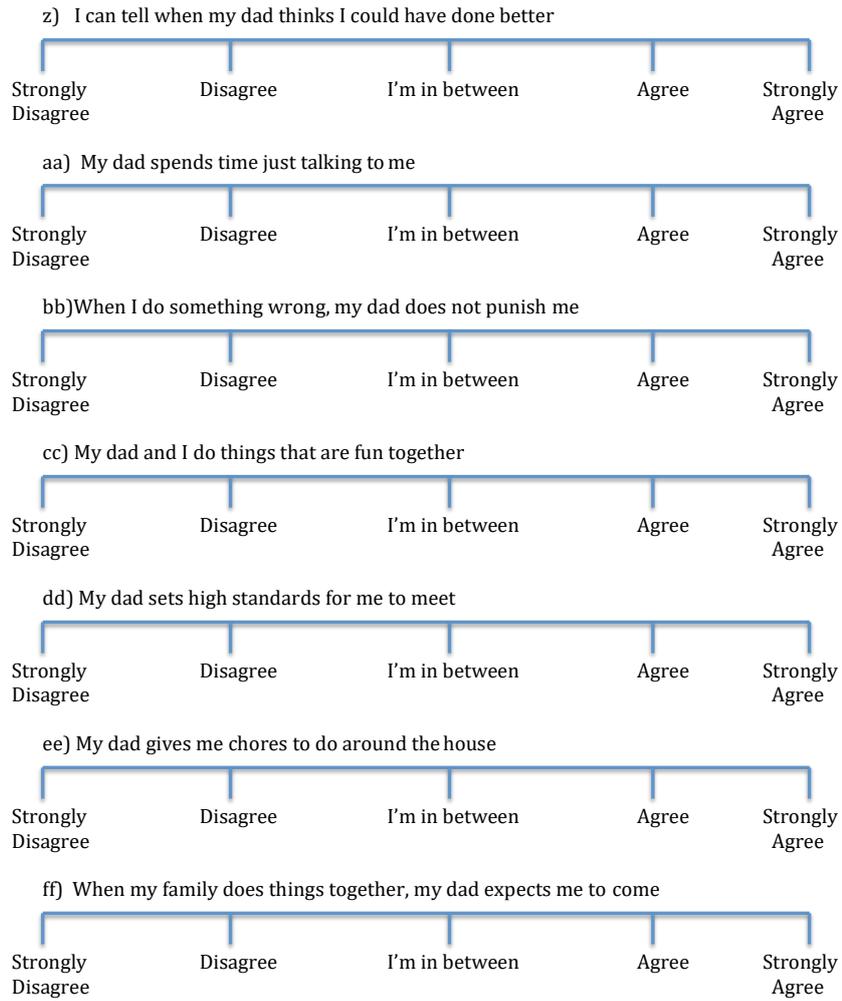


x) My dad is strict about how I behave when I'm in shops, the library or some place where there are mostly adults



y) My dad makes it clear when I have done something he doesn't like





Parent Scales

Strengths and Difficulties Questionnaire

Please read each statement and tick the box that best represents your child. It would help if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers based on your child's behavior over the last 6 months.

Child's Name: _____

Male/Female

Date of Birth: _____

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children (treats, toys, pencils etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often has temper tantrums or hot tempers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, tends to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally obedient, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Many worries, often seems worried</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Nervous or clingy in new situations. easily loses confidence</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	Not True	Somewhat True	Certainly True
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets on better with adults than with people my own age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

Overall, do you think that your child has difficulties in one or more of the following areas:
Emotions, concentration, behavior or being able to get on with other people?

No	Yes Minor Difficulties	Yes Definite Difficulties	Yes Severe Difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

➤ How long have these difficulties been present?

< 1 month	1-5 months	6-12 months	+ 1 Year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

➤ Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

➤ Do the difficulties interfere with your child's everyday life in the following areas?

Not at all	Only a little	Quite a lot	A great deal
------------	---------------	-------------	--------------

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HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

➤ Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature

Relationship to child

.....

.....

Date

.....

Emotionality, Activity, Sociability Temperament Survey

Please read each statement and circle the number that best represents your child.

- 1 = Not characteristic/typical
- 2 = Occasionally characteristic/typical
- 3 = Somewhat characteristic/typical
- 4 = Characteristic/typical
- 5 = Very characteristic/typical

My child tends to be shy	1	2	3	4	5
My child cries easily	1	2	3	4	5
My child likes to be with people	1	2	3	4	5
My child is always on the go	1	2	3	4	5
My child prefers playing with others rather than alone	1	2	3	4	5
My child tends to be somewhat emotional	1	2	3	4	5
When my child moves about, they usually move slowly	1	2	3	4	5
My child makes friends easily	1	2	3	4	5
My child is off and running as soon as they wake in the morning	1	2	3	4	5
My child finds people more stimulating than anything else	1	2	3	4	5
My child often fusses and cries	1	2	3	4	5
My child is very sociable	1	2	3	4	5
My child is very energetic	1	2	3	4	5
My child takes a long time to warm up to strangers	1	2	3	4	5
My child gets upset easily	1	2	3	4	5
My child is something of a loner	1	2	3	4	5
My child prefers quiet, inactive games to more active ones	1	2	3	4	5
When alone, my child feels isolated	1	2	3	4	5
My child reacts intensely when upset	1	2	3	4	5
My child is very friendly with strangers	1	2	3	4	5

Gatekeeper Scales

Strengths and Difficulties Questionnaire

Please read each statement and tick the box that best represents the child. It would help if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers based on the child's behavior over the last 6 months.

Child's Name: _____

Male/Female

Date of Birth: _____

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children (treats, toys, pencils etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often has temper tantrums or hot tempers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, tends to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally obedient, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Many worries, often seems worried</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Nervous or clingy in new situations. Easily loses confidence</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	Not True	Somewhat True	Certainly True
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets on better with adults than with people my own age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other comments or concerns?

Overall, do you think that the child has difficulties in one or more of the following areas:
Emotions, concentration, behavior or being able to get on with other people?

No	Yes Minor Difficulties	Yes Definite Difficulties	Yes Severe Difficulties
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes", please answer the following questions about these difficulties:

➤ How long have these difficulties been present?

< 1 month	1-5 months	6-12 months	+ 1 Year
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

➤ Do the difficulties upset or distress the child?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

➤ Do the difficulties interfere with the child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FRIENDSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLASSROOM LEARNING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LEISURE ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

➤ Do the difficulties put a burden on the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature

Relationship to child

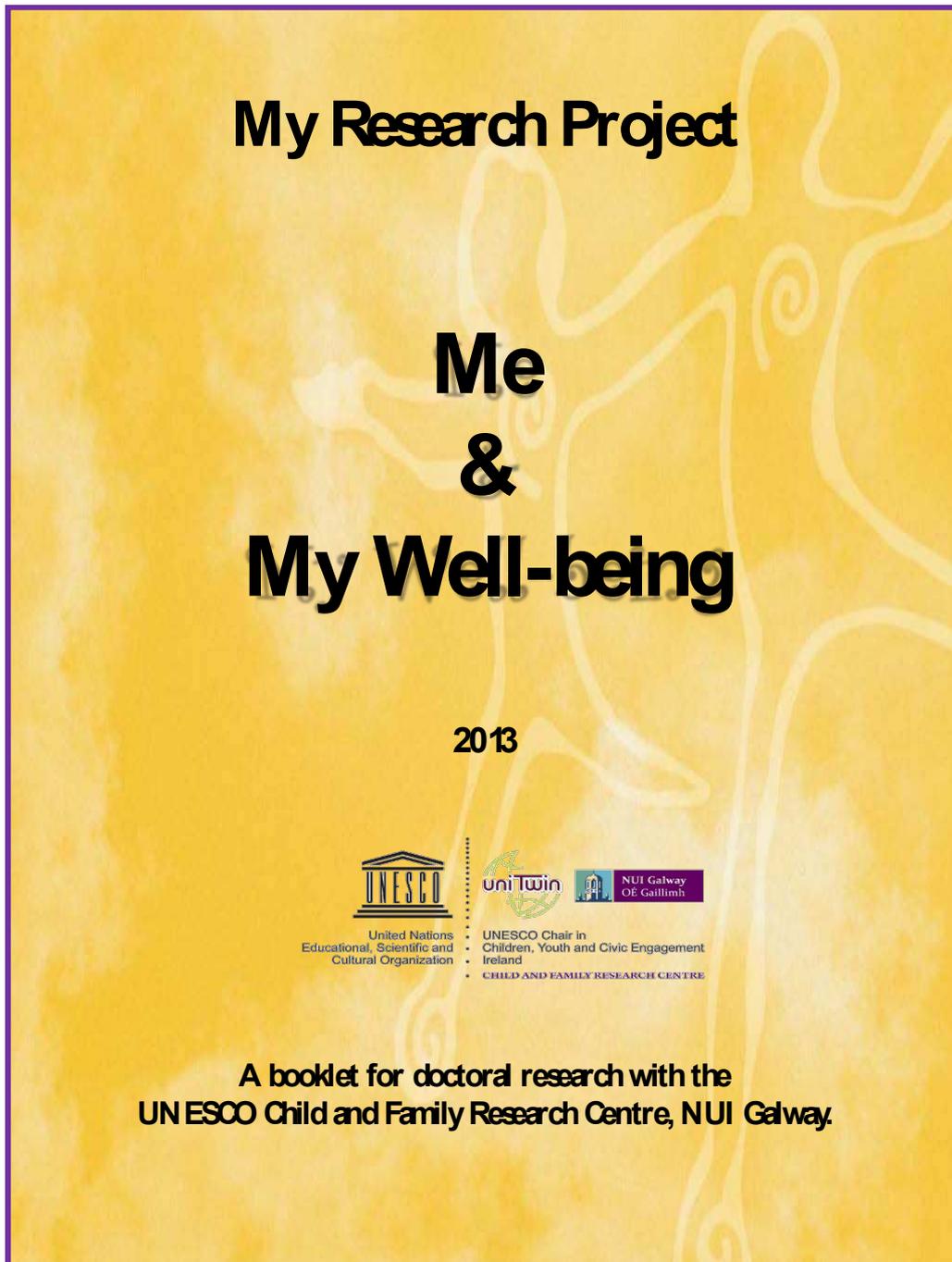
.....

.....

Date

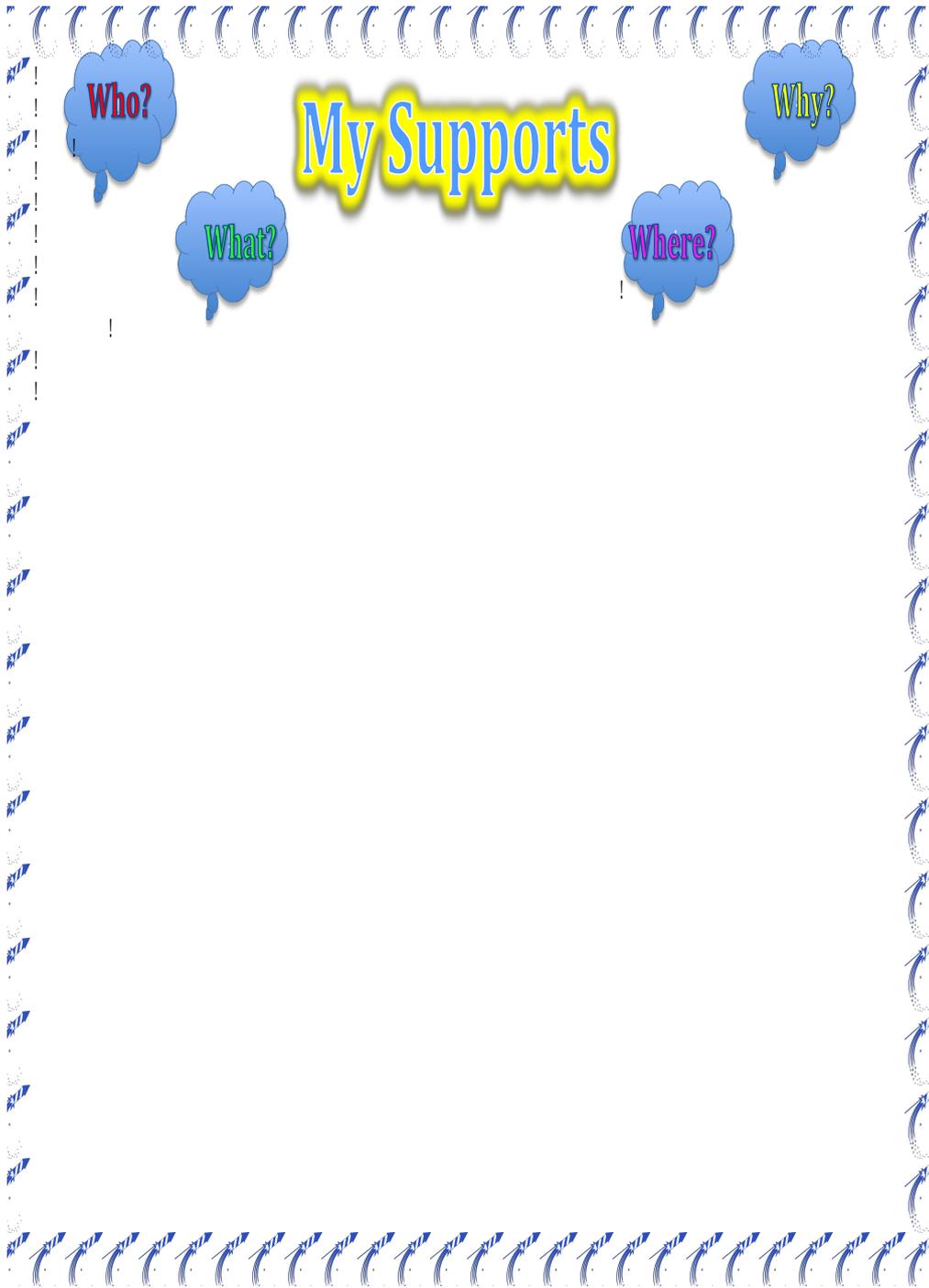
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**Appendix I:
Activity Workbook**

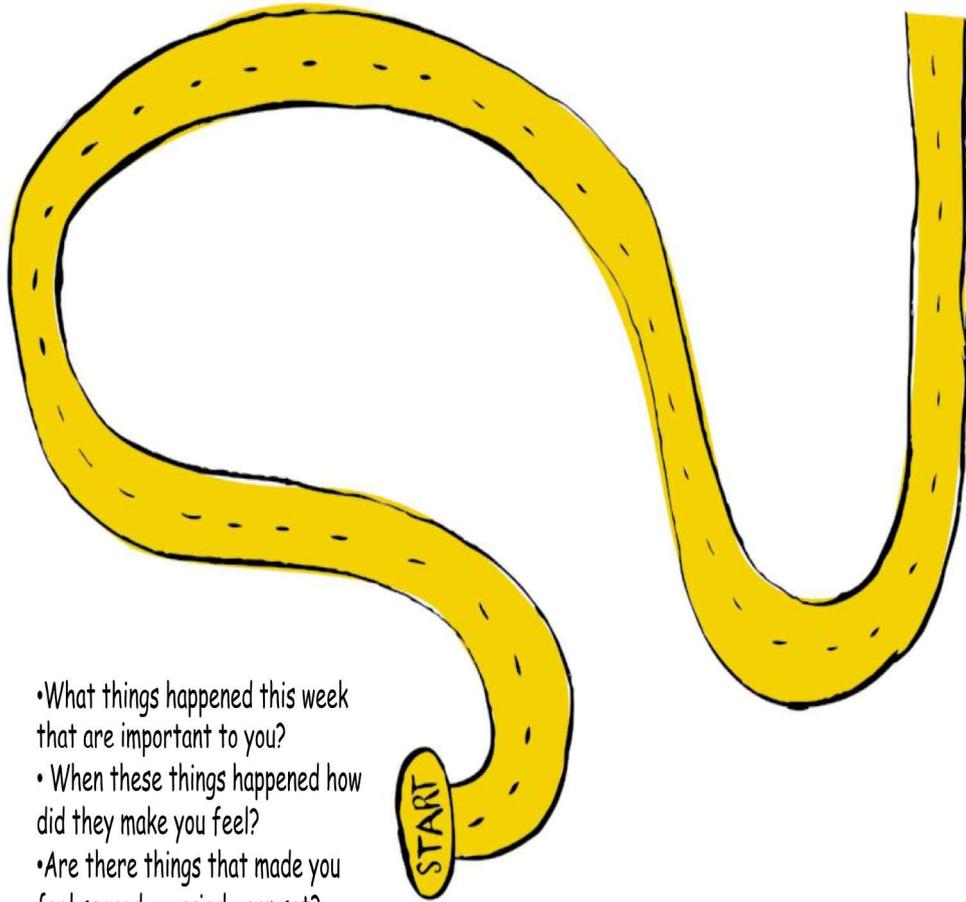


All about me!



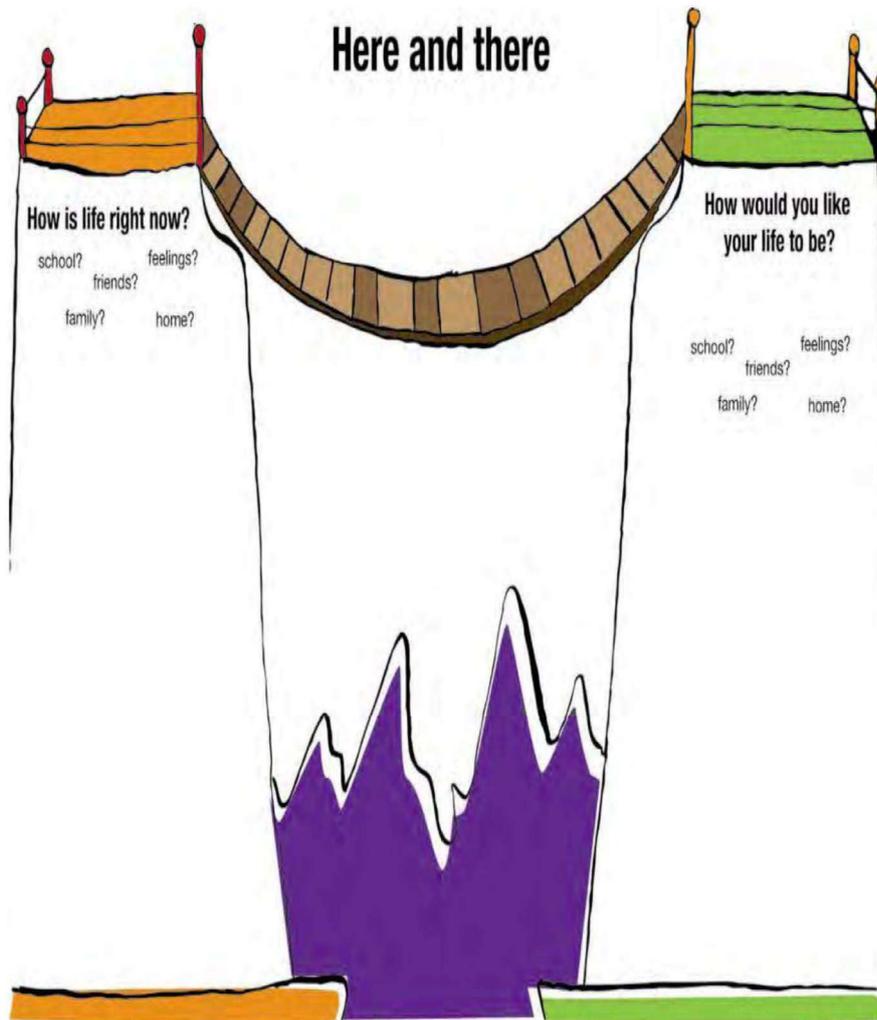


My Week of Feelings



- What things happened this week that are important to you?
- When these things happened how did they make you feel?
- Are there things that made you feel scared, worried or upset?
- Are there things that made you feel good, safe and happy?

Here and there



Appendix J:

Parent Interview Schedule

Child as individual?

Can you tell me about your child?

What type of child are they?

What words would you use to describe them?

What activities do they like to do?

Child as relational/social being?

Can you tell me about your relationship with your child?

What words would you use to describe your relationship with your child?

How do you think you and your child get along?

Do you and your child get to do things together?

What kind of things do you and your child like to do together?

When would you get to do that?

How often do you get to do this together?

What might stop you from getting to do this together?

How are decisions made within the family? Does your child get to have a say?

How does your child communicate and express emotion within the family? Can you give me any examples?

If your child was worried who would they talk to?

Child within context?

What do you think your child enjoys/dislikes about living in their neighbourhood/community?

Is your child engaged in community based activities? Can you tell me about these?

Does your child enjoy socializing with their peers in the neighbourhood? In school?

Can you tell me about your child's experience of school?

Parenting your child?

How would you describe being a parent?

What do you think are the good things about being a parent?

What do you think are the difficult things about being a parent?

What difficulties have you encountered?

What about being a parent might cause you worry or stress?

Do you think this might have an impact on your child? If yes, how might it impact?

Mental health difficulty?

What understanding do you think your child has about your mental health difficulties?

How do you communicate with your child about your mental health difficulties?

How would you describe your relationship with your child since your diagnosis?

Since being diagnosed, have you noticed any changes in your child socially, emotionally or behaviourally?

How do you think your child copes with having a parent with an illness?

Have you any concerns about how your mental health may impact on your child's well-being?

If yes, what supports do you feel may benefit your child? Your family?

Has your child received any professional support since you became ill?

Your child's future?

What hopes do you have for your child's future?

What do you think needs to happen for your child to get to do this?

What are your concerns for the future regarding your child?

Appendix K:

Socio-Demographic Questions for Parent (s)



Name:

Date of Birth:

Nationality:

Relationship Status:

Number of Dependent Children (under 17 years):

Highest level of Education:

Occupation:

Net household Income:

Mental Health Diagnosis of Parent(s):

Brief description of context at time of diagnosis:

THANK YOU!

Appendix L:

Gatekeeper Interview Schedule

- *Can you tell me what is your role in working with the family?*
- *What type of child is _____?*
- *How would you describe your relationship with [child] _____?*
- *How would you describe [child] _____ socially?*
- *How would you describe [child] _____ emotionally?*
- *How would you describe [child] _____ behaviourally?*
- *How does [child] _____ get on with their peers?*
- *What do you think [child] _____ likes/dislikes about living in this community*
- *Does [child] _____ get involved in community activities?*
- *How does [child] deal with things that might be worrying them?*
- *Have you any concerns about [child] _____ well-being?*
- *How would you describe [child] _____ relationship with their mum/ their dad?*
- *What do you think [child] _____ understands about their mum/dad's mental health difficulty*
- *It has been stated, that "children whose parents are mentally ill live with the symptoms, behaviors and expressions of mental illness. They see it and feel it" (Falkov, 2004; 55). What is your view of this statement?*
- *Do you think [child] _____ parent's mental health difficulty has had any impact on them?*
- *How do you think services can best support children and parents who have a mental health difficulty?*
- *How do you think policy makers can best support children and parents who have a mental health difficulty?*

Appendix M:

Gatekeeper Declaration and Consent Form



Research Project: An exploration of the social and emotional well-being narratives of children living with a parent with a mental health difficulty.

Researcher: Rebecca O'Shaughnessy

	YES	NO
I _____ have been consulted about the recruitment of participants for the above titled study.	<input type="checkbox"/>	<input type="checkbox"/>
I have reviewed the information provided, and have had the opportunity to ask questions which have been answered to my satisfaction.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that all participants involved in this study have the right not to answer questions, and to withdraw from the research at any time. This will not affect the care received by Parent/Child	<input type="checkbox"/>	<input type="checkbox"/>
I agree to partake in this research fulfilling the role of gatekeeper	<input type="checkbox"/>	<input type="checkbox"/>

Specifically, as Gatekeeper, I agree to:

- | | | |
|--|--------------------------|--------------------------|
| • Identify, approach and invite families, meeting inclusion criteria to be part of this research project | <input type="checkbox"/> | <input type="checkbox"/> |
| • To discuss the research project with potential participants (parent/child) that meet criteria for inclusion and answer any questions they may have | <input type="checkbox"/> | <input type="checkbox"/> |
| • To obtain verbal consent from families who wish to take part in the research | <input type="checkbox"/> | <input type="checkbox"/> |
| • To provide support as necessary to both parent(s) and children who agree to participate in the research | <input type="checkbox"/> | <input type="checkbox"/> |

Signed: _____ **Date:** _____

YES **NO**

I have been asked to take part in this research project

Specifically, I have been asked to:

- Complete questionnaires relating to the social and emotional well-being of child participants
- Take part in semi-structured interview, answering Questions about the social and emotional well-being of the participating child

I am satisfied with the information provided on the nature of this research project, including factors relating to:

- Informed consent
- Right to withdraw
- Safe-guarding protocol,
- Confidentiality and anonymity

I consent to participate in this research

Signed: _____

Date: _____

Appendix N:

Child (7-11 years and 12-17 years) and Parent Information and Consent Sheet

F.Y.I



Who am I?

Hello, my name is Rebecca and I am doing a project to help understand and better what your life is like.



What do I want you to do?

I would like to meet with you 4 times and talk to you about your life and the things/people/places that are important to you.

Some of the things I would like us to do together are:

- * *Take photographs of the people, places and things that are important to you*
- * *Make maps of the important people in your life*
- * *Make maps of your feelings for 1 week*
- * *Talking to you about what your life is like*
- * *Talking to you about the things you think would help when things are hard for you and your family*



NUH-UH.

YES-HUH!



Do I have to do this?

NO! It is really important that you know that you don't have to meet with me unless you want to. It is important that you understand that you should only say yes if you want to. You or your mum/dad won't get into any trouble if you say no, it will be ok. If at the start you say yes and then change your mind, that is ok. If you don't feel like talking or drawing that is ok too, just let me know.



What are the good things that might happen?

I can't promise that this project will help you or your mum/dad, but it might help other children like you in the future.



What are the bad things that might happen?

Sometimes talking about things that might make us sad is hard. If when you meet with me and what we are doing or talking about makes you feel sad and you want to stop, that is ok. You just have to let me know and we will stop.



Will other people that I was part of the project ?

No, no one will be able to tell that you were part of the project. What you tell me will stay between you and me. The only time I will have to share the things you tell me with someone is if you tell me that someone is hurting you. This means if someone hits you or touches you somewhere that is private or in a way that you don't like. If you tell me this happens I will have to tell someone in charge so that we can keep you safe.



What will happen to the things I tell you and maps and photos?

Only Rebecca and her boss will be allowed to look at the things you say or do for the project. Some of the things you share with me will be used in my homework for the project, but if I do use it no one will know it came from you.

You can keep all the drawings and photos you take during the project. I will ask you if it is ok to make copies of the work you do. To help make sure I fully understand what you tell me I will ask you if it's ok to record the times we meet and the things we talk about. If this is not ok with you that's no problem.

If you are worried about anything I have said in this page or don't understand the project and why I want to meet with you, talk to someone you trust. It is really important that you only say yes to meet with me if you are happy to.

Thank You!!

!

Wit h Your Permiss ion?



I _____ have been asked to be in this project. It is about children like me who live with a mum or dad with a mental health difficulty



I was given an information sheet explaining everything about the project. I was allowed to ask questions and had anything I did not understand explained to me

I understand and I will meet with Rebecca 4 times and she will ask me to do things like:

- * Take photographs - Of the things, places and people that are important to me
- * Draw maps - About my family, friends and relationships and how I feel
- * Talk - About the things that are important to me and that help when mum/dad aren't well
- * Fill in answers to some questions - all about me

I am happy to do the activities with Rebecca:



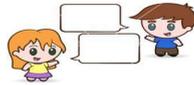
Drawing maps

Yes No



Taking photographs

Yes No



Talking

Yes No



Answering questions

Yes No



Understand that if I say something that makes Rebecca worry that I might not be safe or have been hurt that she will need to tell someone in her school

Yes No



Understand that I do not have to say yes to his research and that it will be ok. Understand that even if I sign his form that I can change my mind and decide not to take part in the project and that I can do this at any time.

Yes No



I am happy to meet with Rebecca and take part in the project

Yes No

SIGNED: _____

DATE: _____

Information and Consent Sheets 12-17 years



F.Y.I.

Introduction

I am asking you to join in a research project to help me understand better what life is like for children/young people who live with a mum or dad with a mental health difficulty.

Before you decide if you want to join in, it's important that you understand why the research is being done and what it will involve for you. Please read this leaflet carefully and if you need to talk to your family, friends or someone you trust about the research please do.



Why am I doing this research?

I am looking to talk to you so I can understand better what life is like for you living with a parent who has a mental health difficulty.

- I want you to tell me about the good and bad parts
- The kind of things you feel
- The things you do that help when your mum or dad has a mental health difficulty
- I want to hear what you think might help both you and your mum/dad



Do I have to take part?

No. It is up to you. You will have 4 weeks to think about this and say yes or no. I will ask you for your consent and then ask you to sign a form. I will give you a copy of this signed form to keep. Even if you say yes – you can change your mind at any time during the research without giving a reason. If you decide to stop, this won't change how your life is now or impact on your family.



What will happen if I take part?

I would like to meet with you 4 times and together we will do different things, such as:

- Taking photographs
- Drawing maps
- Talking
- Doing some worksheets
- Answering questions



What are the good things if I take part?

I can't promise that this research will help you or your mum/dad straight away, but it might help other young people whose mum/dad have a mental health difficulty in the future.



How will I feel?

Sometimes thinking and talking about things like mum/dad having a mental health difficulty can be upsetting. If this happens and you get upset I will ask you if you want to finish the meeting – if you do this is ok. If you want to continue this is also ok. The choice is yours. I will also give you information of services that might be helpful if you do get upset.



Will other people know what I say?

The things you tell me will be kept between me and you.

The only time I would have to tell someone else is if you tell me that someone is hurting you, or if you tell me that you are unsafe. I would have to tell the child protection person in the Child and Family Research Centre, but I won't do this until I talk to you first. This is to make sure that you are safe.

If you have any questions I have not answered please use the number/email below to contact me.

THANKS FOR YOUR TIME!



r.oshaughnessy4@nuigalway.ie
0857482992

With Your Permission



I _____ have been invited to be part of this project to understand what life is like for me living with my mum/dad who has a mental health difficulty.

YES

NO



I have read the information sheet I was given, telling me what the research is about, why I have been invited to tell my story, and what I will have to do during this research study if I agree to participate.



I understand that I can say no to the research if I want to, and that even if I say yes now, that I can change my mind at any time during the research project.



I understand that if I tell Rebecca that I have been hurt or plan to hurt someone, or myself she will have to tell the child protection persons in her University. I understand she will do this to make sure I am safe and well.

I understand and agree to participate in the following activities:



To take photographs of the people, places and things that are important to me



To draw maps of my family, friends, relationships and how I feel



To talk about what life is like for you, what are the good and bad parts, and who is there to help you when you need it



To fill in questionnaires asking questions all about me



I am happy to meet with Rebecca and take part in this research



SIGNED: _____

DATE: _____

Information for Parents

This is an information leaflet to help you decide about you and your child participating in a research project exploring:



The social and emotional well-being of children who live with a parent with a mental health difficulty

Who is doing the project?

Rebecca O'Shaughnessy, a PhD research student with the Child and Family Research Centre, at NUI, Galway. Our research centre works with children and young people from around the world to find out about things that matter to them and what they think can be done to make things better for them.

What is the project about?

This project wants to understand what children and young people have to say about living with a parent with a mental health difficulty. It wants to explore what are the good things and the not so good things for them. I am interested in hearing children's stories about what makes them feel happy or sad, where they get support from and the things they think would make it better for you both when things might be difficult.

Finding out these things will help us to understand better what the most important things are for children and young people and what areas they might need extra support in when you are not well. This will help adults who work with children and parents understand better how they can best support families like yours in doing the best they can.

In this research we value the ideas and information given to us by children as the most important part of the project. We also hope that the children we speak with will have some ideas for us to share with other young people. We hope to share these ideas with others by writing a report (including a PhD thesis) and by sharing what we learn at conferences and other meetings with people who can make a difference in the lives of children and families.

What will my child have to do if they take part?

If you decide with your child that it is ok for them to take part, then you will both be asked to sign a consent form. Your child will be invited to meet with Rebecca four times to do some activities. Your child will be given a disposable camera and invited to take photos of the people, places and things that are important to them. Your child will also be invited to complete an activity workbook including an ecomap which will show the important relationships they have with various people in their life. They will be invited to complete an emotion map which indicates the emotions they experience in a week. While these activities are being carried out Rebecca will listen to your child talk about the activities and some of the ideas they had during the activities and about the stories they have about the photographs they took and maps created during the activities. The meetings with Rebecca can take place in your home, where your gatekeeper works and/or the Child and Family Research Centre in NUI, Galway. So that I can remember correctly what your child says to me I will ask permission from both of you to use a digital recorder to record the activity sessions.

What will I have to do?

Rebecca would like to meet with you twice. Firstly, as an introduction to each other, and for a recap of the research and to sign consent forms. She will then invite you to complete some brief questionnaires used as guides to measure children's social, emotional and behavioural well-being. Rebecca might also ask you questions such as your age, marital status, education and income.

If you are happy to continue the next time you meet with Rebecca she would like to spend some time asking you questions about how you see your child's social, emotional and behavioural well-being. This may take between 45-60 minutes. Rebecca would also like to record her meetings with you, again so she can remember what was said.

Do we have to take part?

No it is up to you and your child whether you take part in this research or not. If you or your child do not wish to take part that is ok. It is a decision for you and your child to make. You do not have to give a reason for saying no. Before you agree you need to feel sure that the research is worthwhile. If you are not sure what to decide take time to think. You may want to talk to other people before you decide.

Even if you both agree to take part at the beginning, you (or your child) can change your mind and choose not to continue. You do not have to say why you changed your mind. All you need to do is let me or your gatekeeper know that you/your child do not want to take part in the research anymore. If this happens then none of the information gathered will be used in the project without your consent. If you refuse or withdraw from the research project you will still receive the best care possible from the service providers involved with you and your family.

Will anyone know that my child is taking part or hear about what they tell you?

The only people that will know that your child is taking part in the project will be the researcher, your parent and the gatekeeper. Your child will be asked to pick a nickname that will be used for all the activities they do and in any written work they do or give to the researcher. This is done so that no-one will know what information your child gave to the researcher. No child will be identified in any report or presentation that the research team makes in relation to this project.

The only time the researcher would have to break confidentiality is if a child tells them that they have been physically or sexually abused or neglected or that there was a risk that they would be harmed in the future. The researcher would also have to report if your child said that they planned to hurt themselves or someone else.

Is there anything that might make my child upset if they take part in the research?

Sometimes when people, children and adults remember things that happen in their lives, they might get upset. If anything you or your child do during the research causes upset the meeting can be stopped. Your gatekeeper will be informed and you will be given the names of people/services you and your child can talk to, if that is what you choose to do.

What will happen the information my child tells you?

The information your child tell us will only be used by Rebecca and the Child and Family research centre. No-one else will be allowed access or use the information you and your child share. Your child's information could be used with information from other children/young people who have participated in this project. This is done so we can see if there are similarities and differences across children living with parents with different types of difficulties. Some of the information might be used in reports or papers about the research. Anyone who agrees to take part in the project and share their views will not be able to be identified in any reports or papers.

Your child will be given their maps, photographs and other things that they make to keep and Rebecca will only take a copy if it is ok with you both. The copies of these drawings and the tapes from the interviews will be kept securely locked with only Rebecca and her supervisor having access to them. Once Rebecca has finished with the information, it will stay locked in the University, in accordance with data protection guidelines for 5 years, then it will be destroyed.

Thank you for your time!

If you have any questions about the research project or you would like further information you can contact me on 0*** or e-mail: r.oshaughnessy4@nuigalway.ie**

Parental Consent

Research Project:

An exploration of the social and emotional well-being of children who live with a parent with a mental health difficulty

Researcher: Rebecca O'Shaughnessy

	Yes	No
I confirm that I have read and understood the information sheet provided for this project.	<input type="checkbox"/>	<input type="checkbox"/>
I have had the opportunity to consider the information, ask questions and have had these answered to my satisfaction.	<input type="checkbox"/>	<input type="checkbox"/>
I understand that I do not have to agree to participate in this research, that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected	<input type="checkbox"/>	<input type="checkbox"/>
I have discussed the nature and purpose of the research with my child/children _____ (insert name(s)), and am satisfied that they understand the research process and what is involved.	<input type="checkbox"/>	<input type="checkbox"/>
I am happy for my child/children to be involved in this research project, once their written consent has been obtained.	<input type="checkbox"/>	<input type="checkbox"/>
I agree to:		
• Complete questionnaires about my child/children's social and emotional well-being	<input type="checkbox"/>	<input type="checkbox"/>
• Take part in a semi-structured interview about my child/children's social and emotional well-being.	<input type="checkbox"/>	<input type="checkbox"/>
I agree to take part in this project	<input type="checkbox"/>	<input type="checkbox"/>

Name (block capitals): _____

Date: _____

Signature: _____

Appendix O:
Child Certificate of Participation



Appendix P:

Sample of Completed Activity Workbooks



All about me!

The thing I like doing most is...
playing with my kaloo

Draw a picture of yourself

The thing that's most special to me is...
Kaloo

What I want most right now is...
Teddy's

My role model is...
Kaloo

When I'm feeling sad I talk to...
Kaloo

To feel safe I need...
Kaloo

One thing I am good at is...
soccer

I want adults to know that I don't like...
happily



My Supports

Who?

Who:
My mom
My Parents
My sister

What?

What:
I was upset
They support me by helping
find a solution to the
problem

Where?

Where:
at home
at school
at a friend's house
outside with a friend

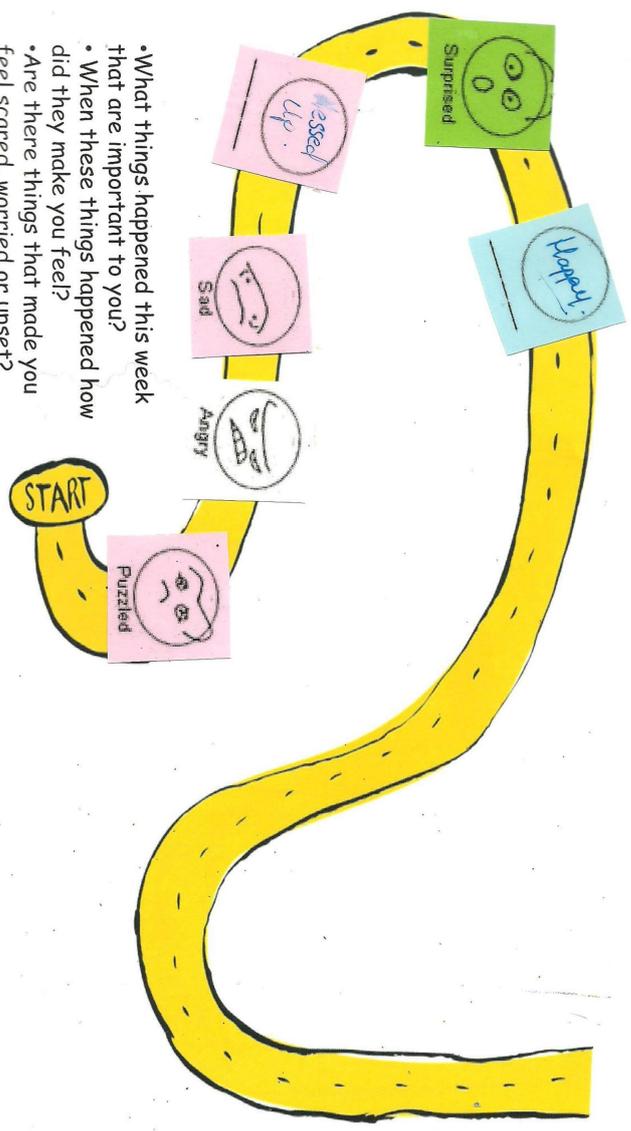
Why?

Why: They understand
what I am trying to
tell them. They care
always there for me





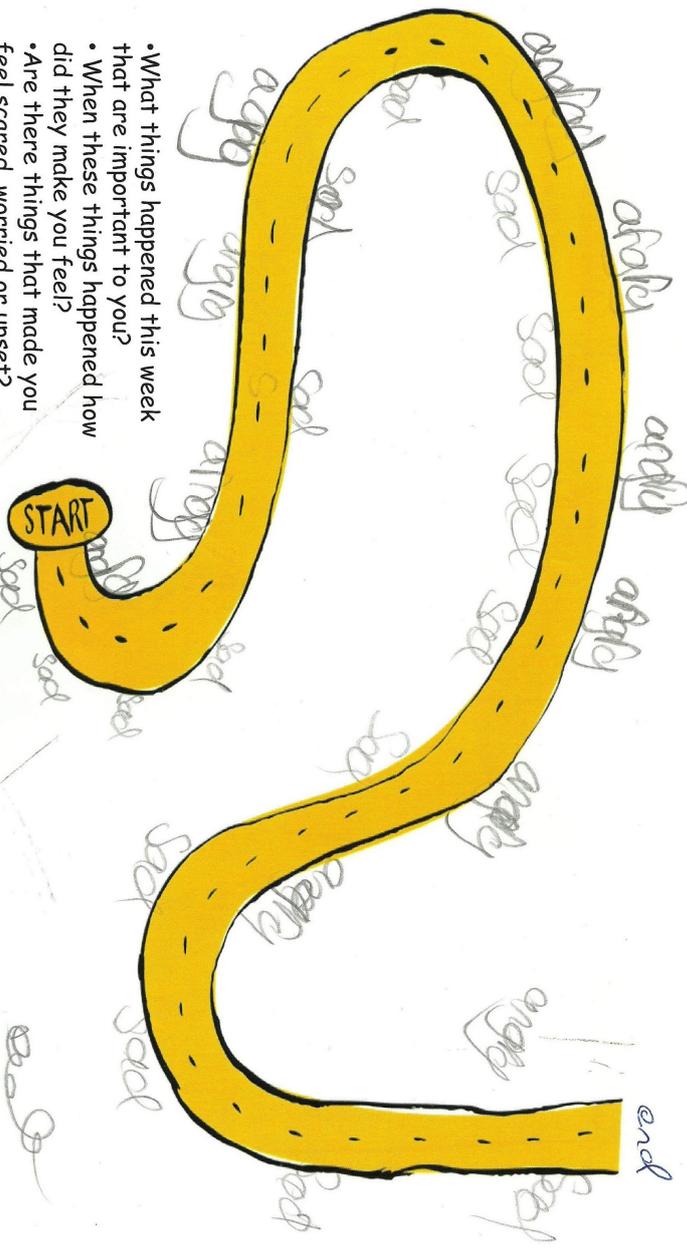
My Week of Feelings



- What things happened this week that are important to you?
- When these things happened how did they make you feel?
- Are there things that made you feel scared, worried or upset?
- Are there things that made you feel good, safe and happy?



My Week of Feelings



- What things happened this week that are important to you?
- When these things happened how did they make you feel?
- Are there things that made you feel scared, worried or upset?
- Are there things that made you feel good, safe and happy?



Here and there

How is life right now?

school? friends? feelings?
family? home?



HAPPY

How would you like
your life to be?

school? friends? feelings?
family? home?



I would
love
to be
different



22

Here and there

How is life right now?

school? friends? feelings?

family? home?

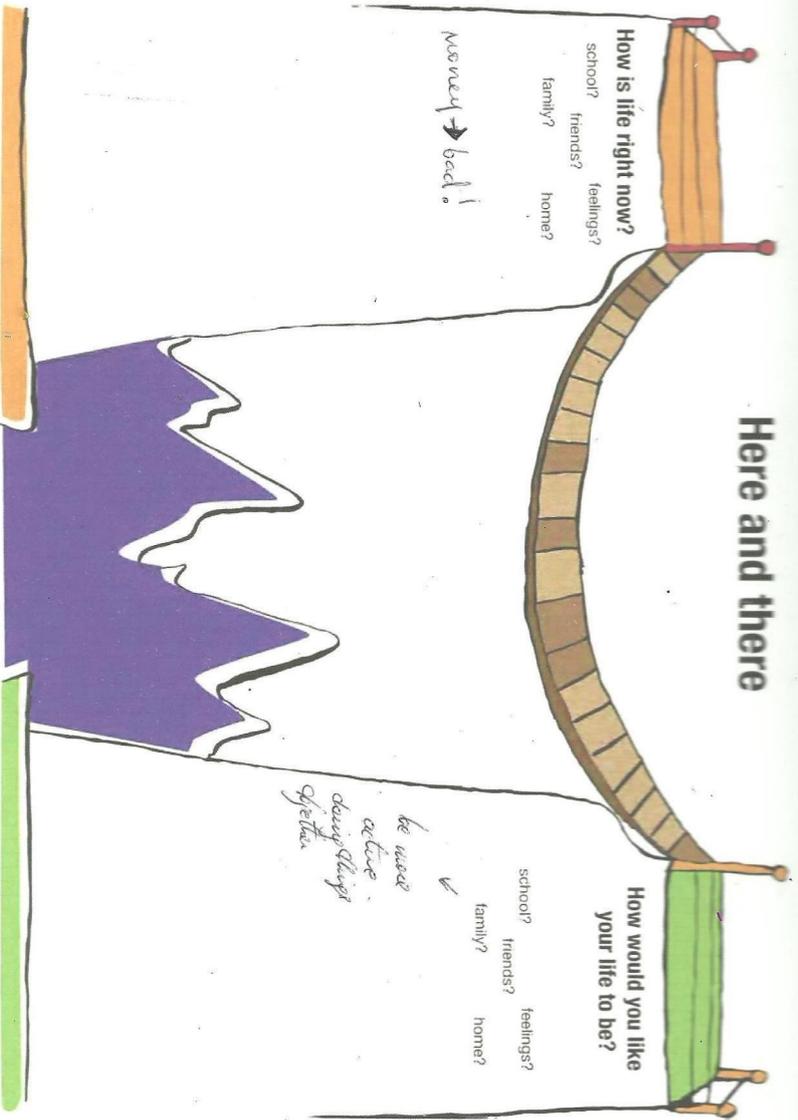
Answer → bad!

How would you like your life to be?

school? friends? feelings?

family? home?

be more active
doing things
often



Appendix Q:

Underpinning Ethical Guidance

DCYA Principles and current research project child participants

Key Principles	Considerations	Recommendations	Application for this Research
Minimise risk of harm	<ul style="list-style-type: none"> ➤ Potential harm (physical, psychological or social) that may arise from the research. ➤ Standard of ‘minimal risk’ – the anticipated probability and magnitude of harm/discomfort are not greater than those ordinarily encountered in daily life ➤ Children and their parents deemed a ‘vulnerable’ population 	<ul style="list-style-type: none"> ➤ Evaluate the potential risk/discomfort posed for children. Interpret minimal risk in relation to the normal experiences of average healthy children. ➤ Ensure measures are in place to mitigate potential harm arising from the research. 	<ul style="list-style-type: none"> ➤ Discusses sensitive topic in child centred manner. ➤ Child safe guarding protocol was drafted ➤ Fully informed verbal and written consent and on-going process consent used throughout the research ➤ Written and verbal explanations of potential risks and benefits to participation ➤ Creative and collaborative methods chosen for data collection ➤ Children controlled the data they shared and could choose not to answer questions ➤ Children retained the right to withdraw ➤ Gatekeeper recruitment process adopted with referral back to gatekeeper available should distress occur ➤ Participants had four weeks to decide on participation ➤ Researcher awareness of verbal/non-verbal indicators of discomfort/distress required (Cocks, 2006; Alderson, 2004) ➤ Children offered to have a trusted adult present or not present for data collection
Informed consent	<ul style="list-style-type: none"> ➤ Consent only valid if informed. 	<ul style="list-style-type: none"> ➤ Present info in a child-appropriate manner 	<ul style="list-style-type: none"> ➤ Age appropriate info and consent sheets were created and piloted within the age groups (Lambert and Glacken, 2011)

Key Principles	Considerations	Recommendations	Application for this Research
and assent	<ul style="list-style-type: none"> ➤ Parental/guardian consent ➤ Independent Informed assent – dependent on age and maturity 	<ul style="list-style-type: none"> ➤ Support children in the decision making process ➤ Adequate time period prior to decision ➤ Right to withdraw 	<ul style="list-style-type: none"> ➤ Children provided with the opportunity to read this with their parent, alone and again with the researcher prior to consenting. ➤ Process consent was used ➤ Children were given 4 weeks to decide whether to participate ➤ Children had the right to withdraw at any time
Confidentiality/anonymity	<ul style="list-style-type: none"> ➤ Data that include identifiable info on participants should not be disclosed without the explicit consent of participant²⁰. 	<ul style="list-style-type: none"> ➤ Data should be collected with participant consent. ➤ Principle of anonymity ➤ Adhere to provisions outlined in Data protection acts 1998 and 2003. 	<ul style="list-style-type: none"> ➤ Verbal and written consent was obtained prior to data collection ➤ Information on grounds for confidentiality and risk of disclosure provided verbally and in writing (prior to obtaining consent) ➤ Child participants were offered the choice of using their real names or a pseudonym for the purposes of the research. ➤ All data was stored in line with Data collection policies and legislation. ➤ Access to data limited strictly to the researcher and her supervisor and all transcribing carried out by the researcher
Child protection principles	<ul style="list-style-type: none"> ➤ Adhere to children's first guidelines 	<ul style="list-style-type: none"> ➤ Develop risk assessment ➤ Garda vetting and personnel checks ➤ Adequate skills/training and expertise in relation to child protection issues ➤ Carry out data collection in 	<ul style="list-style-type: none"> ➤ Child safe guarding protocol developed ➤ Adherence to Child Protection and Welfare Policy (CFRC) ➤ Researcher underwent Garda vetting process. ➤ Researcher is a qualified social worker and has over 10 years experience of working with children and families in a voluntary and statutory capacity. ➤ Choice of research environment offered to all participants and choice of whether children wanted parent present or not.

²⁰ With the exception of child protection concerns.

Key Principles	Considerations	Recommendations	Application for this Research
Legal obligations and policy commitments	➤ The right to participate	<p>environment where there is passive surveillance by a 3rd party.</p> <ul style="list-style-type: none"> ➤ UNCRC, 1989 – articles 12, 13 and 17 ➤ Government of Ireland, 1937 – article 40.3.1 	➤ Right to participate was respected through the chosen methodological tools.
Child-centred Inclusive approach.	➤ Successful participation and inclusion	<ul style="list-style-type: none"> ➤ Appropriate methodology ➤ Inclusion of children where appropriate ➤ Balanced use of rewards for participation ➤ Appropriate and accessible dissemination of findings for children ➤ Strive to ensure positive change for children is an outcome of the research. 	<ul style="list-style-type: none"> ➤ Mosaic Approach ➤ Children included in design stage through piloting tools for age appropriateness ➤ Children were permitted to keep photo scrap books and activity workbooks as mementos of the research and provided with a certificate of participation acknowledging their efforts. ➤ Narrative embedded case study allows for the accessibility of findings for children through their voices. ➤ Policy recommendations for children living in this context are provided.

Appendix R:

Child Safe-Guarding Protocol

Information for Parents



Research Title:

*Exploring the social and emotional well-being narratives
of children who live with a
parent with a mental health difficulty.*

This information sheet is to outline the ways in which your child and the information they share will be safe-guarded during the research project.

- The researcher has been approved through the Garda vetting process (police checks) a requirement when working alone with children.
- Ethical approval has been granted to ensure that your child will be at minimal risk of harm during the research.
- This research will promote the best interests of the child throughout in line with children's first guidelines (2011).
- All data will be maintained in accordance with guidelines outlined by the Research Ethics Committee, NUIG. Computerized data will be password-protected.
- Printed documents, drawings and photographs will be kept in secure filing cabinets, and all data, including audiotapes will be labelled with codes rather than names.
- Any identifying information will be removed and pseudonyms applied to participant information to ensure anonymity.
- Your child will be given a choice of three locations for the research to happen: The home, the University or the workplace of the gatekeeper.
- Meetings with your child will be tape recorded (with consent) from 'introductions to thank you'
- Your child can stop the interview at any time, either for a break or to finish the interview completely. They will have control of the tape recording device so they can stop it whenever they want.

- The information your child shares will be confidential and anonymous except in the following circumstances:
 - Your child discloses that they have been harmed or are at risk of harm by another person
 - Your child discloses that they intend to harm themselves or someone else

- If your child discloses they have been harmed or are at risk of harm the researcher is required to bring this to the attention of the designated child protection officer in the Child and Family research Centre.

If you have any further queries or concerns please do not hesitate to contact me on number/email provided.

r.oshaughnessy4@nuigalway.ie

08*****

Appendix S:

Analysing personal stories line-by-line (Fraser, 2004)

Phases of Analysis	Description
Phase 1 Hearing the stories, experiencing each other's emotions	Hearing the stories narrated and experiencing the emotions of participants. Important so as not to 'over intellectualise' personal stories. Requires reflecting on body language used and feelings described
Phase 2 Transcribing the material	Interview content is transcribed to achieve a 'closeness' to participants personal stories
Phase 3 Interpreting individual transcripts	Noting specificities of transcripts. May involve identifying types and directions of stories as well as contradictions. Narrative can be divided into sets of expressed ideas or by characterisation or chronology. It requires identifying the beginning, middle and end
Phase 4 Scanning across different domains of experience	Particularly relevant when trying to unearth insights about how people interact with different dimensions of their environments. Personal stories may be analysed on 4 levels: intrapersonal (body-mind experiences e.g. I thought/I felt) interpersonal (involving other people) cultural (groups of people/cultural conventions) and structural (public policy/social systems).
Phase 5 Linking 'the personal with the political'	Attention is deliberately given to references made to popular discourses (e.g. good enough mother/Mary Poppins). Attention paid to use of metaphors, sarcasm, humour and irony in personal stories
Phase 6 Looking for commonalities and differences	Examining transcripts for commonalities and differences among and between participants. Highlighting findings that are inconsistent, counter-intuitive, surprising and/or anomalous
Phase 7 Writing academic narratives about personal stories	Ensuring the written analyses produced correspond to the stories told as well as to the research objectives.

Appendix T:

Stages of Framework Analysis (Ritchie and Spencer, 1984)

Stage of Framework	Description
Familiarization	Researcher becomes familiar with the range and diversity of data. Gains a general overview of the material gathered achieved through immersion in the data: listening to tapes, reading transcripts, memos, and observational notes. During this stage the researcher makes a note of key ideas and recurrent themes beginning the process of abstraction and conceptualization
Identifying a thematic framework	The list of key ideas and themes provide a thematic framework or index which the researcher then sifts through and sorts. Refining themes that are a priori, emergent and analytical. The creative and conceptual skills of the researcher are then required to refine themes. It involves making judgements about meaning, the relevance and importance of issues and about implicit connections between ideas (p. 180), framed by the original research questions.
Indexing	The researcher applies the thematic framework to data. All data is then read and annotations made based on the framework. This stage also requires judgments on behalf of the researcher as to the meaning and significance of the data. Multiple indexing can occur highlighting patterns of association within the data.
Charting	Data is then lifted from its original context and rearranged according to the appropriate thematic reference (p.182). Charts are devised with headings and subheadings drawn from either the created thematic framework or whether analysis is to be thematic or by case depending on the research aims and objectives. Crucial to this stage is that cases are always kept in the same order for each subject chart, so that the whole data set for each case can be reviewed with ease. Each annotated form of data is then reviewed and a distilled summary of it is entered on the chart.
Mapping and Interpretation	Once data has been charted according to core themes a holistic approach is then employed by pulling key characteristics of the data together which are then mapped and the data set interpreted as a whole. The

**Stage of
Framework**

Description

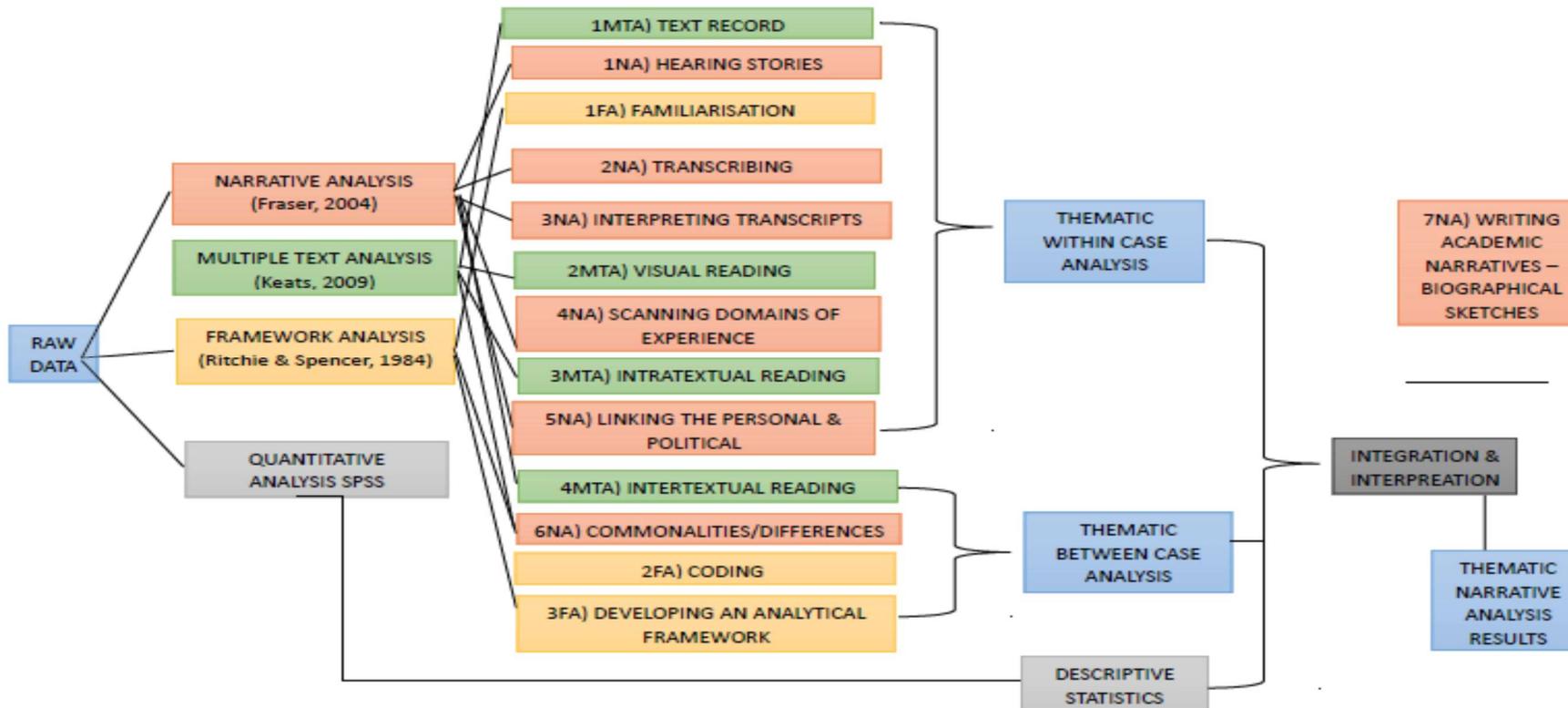
	basic process involves reviewing charts and research notes/memos, comparing and contrasting the perceptions, accounts or experiences present. Searching for patterns and connections within and across data and seeking explanations for these internally within the data. Structure rather than multiplicity of evidence is crucial at this stage (p. 186).
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Appendix U:

Summary of Data Types Collected – Text Record (Keats, 2009)

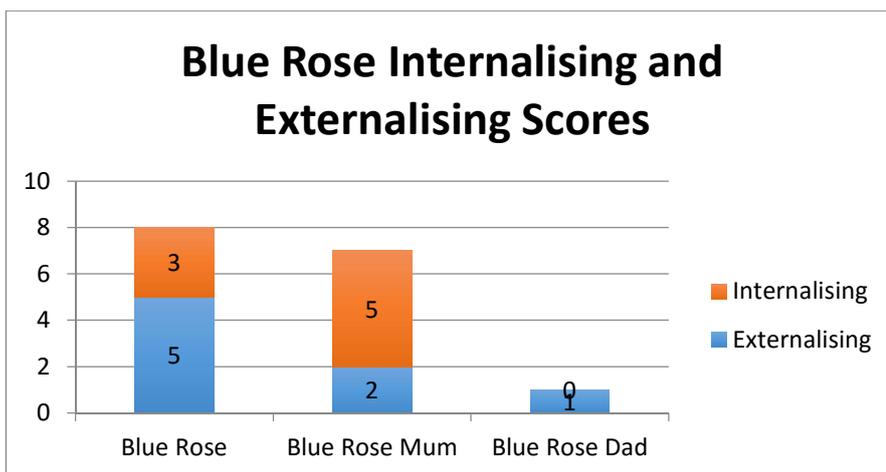
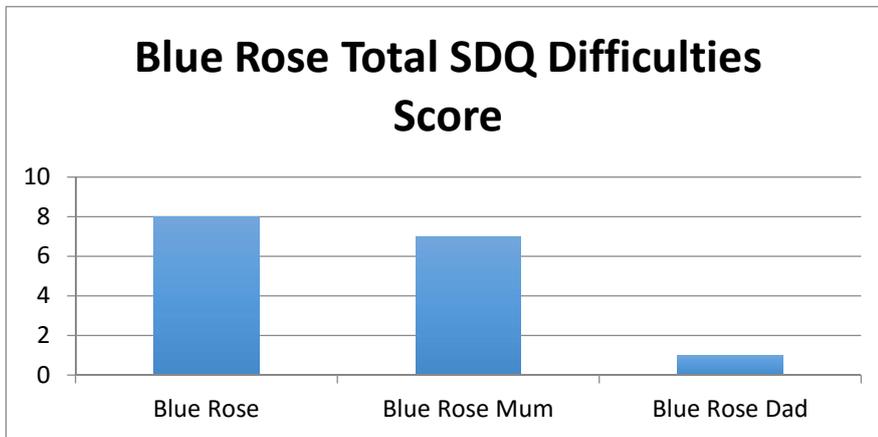
	SDQ	EAST	CYRM	PSI-II(M)	PSI-II(D)	All about me	My Supports	My week of feelings	Here and There	Photo Scrapbook	Interview
Family 1											
Blue Rose	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Mum	☑	☑	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	☑
Dad	☑	☑	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	☑
Gatekeeper	-	-	-	-	-	-	-	-	-	-	-
Family 2											
Joshua	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Mum (J)	☑	☑	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	☑
Gatekeeper (family support)	☑	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	☑
Family 3											
Katilyn	☑	☑	☑	☑	-	☑	☑	☑	☑	☑	☑
Boldielocks	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Mum (K)	☑	☑	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	☑
Mum (B)	☑	☑	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	☑
Family 4											
Petey Pie	n/a	n/a	n/a	n/a	n/a	☑	☑	☑	☑	☑	☑
Mum	☑	☑	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	☑
Family 5											
Kathy	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Ishthara	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Mum (K)	☑	☑	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	☑
Mum (I)	☑	☑	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	☑

Appendix V: Implementing the Analytical Strategy

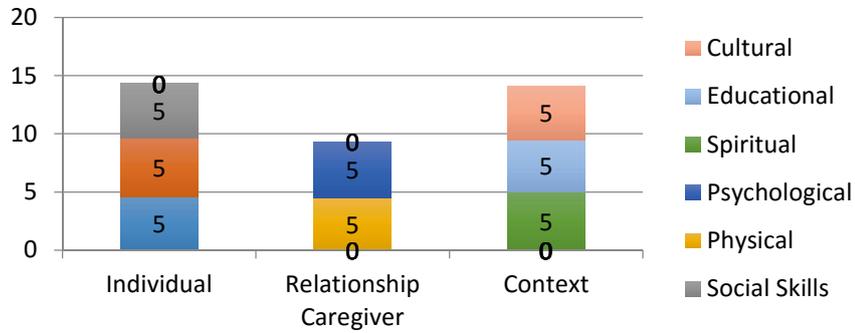


Appendix W: Participant Scale Scores

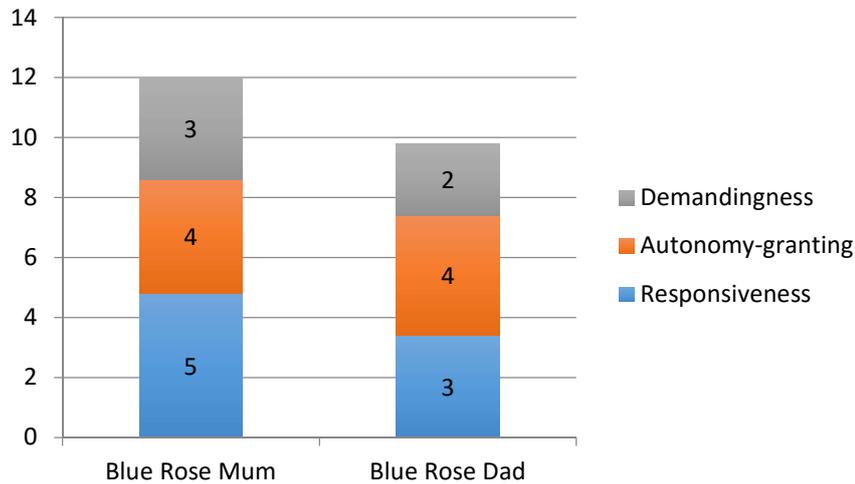
Blue Rose



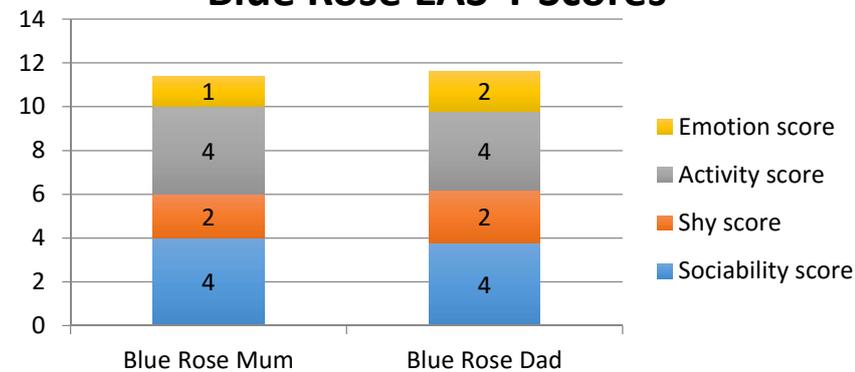
Blue Rose Mean Scores CYRM-28 Broken Down by Subscale and Subcluster



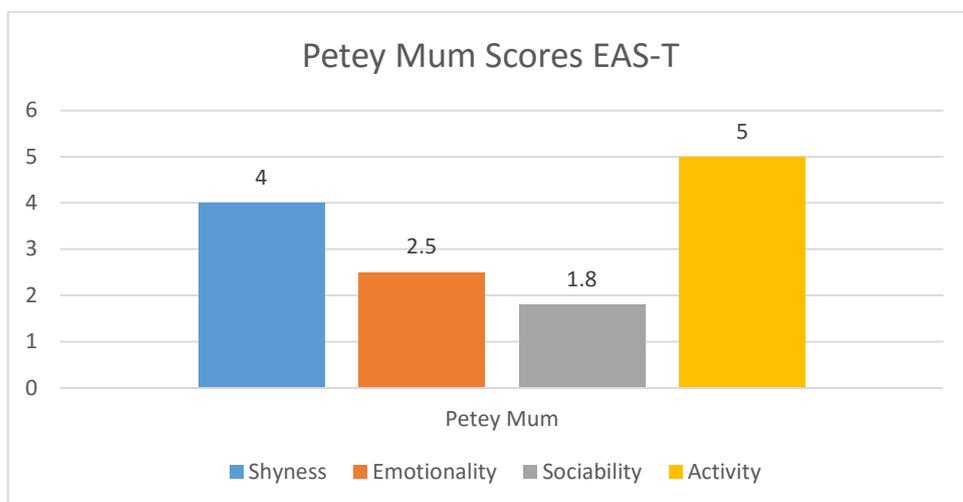
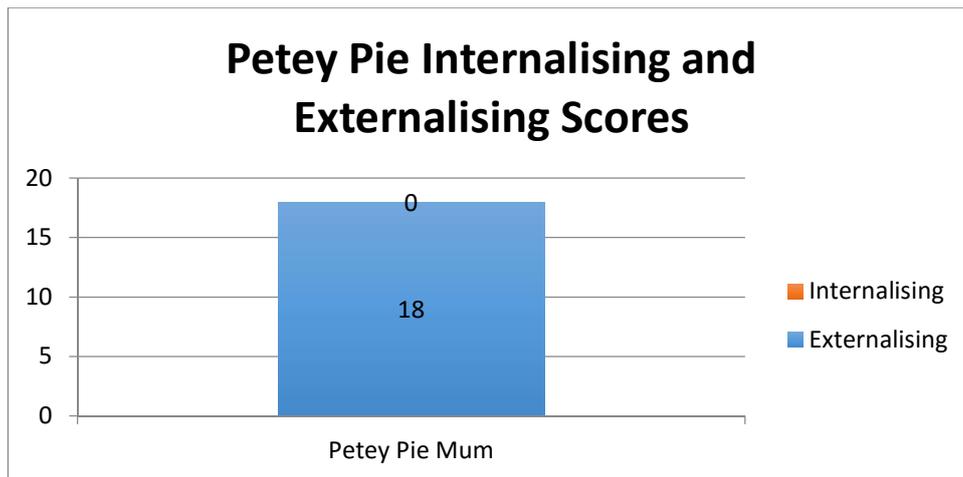
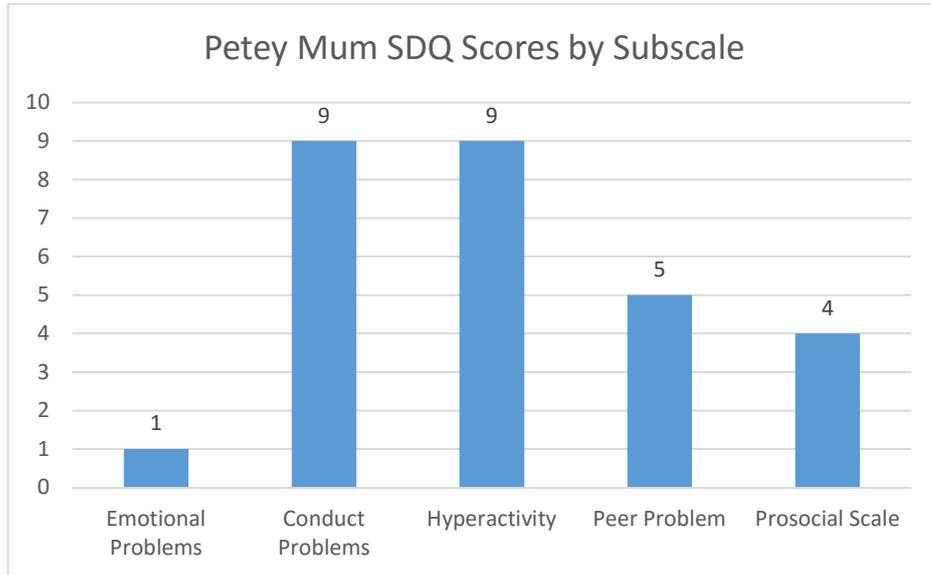
Blue Rose PSI-II Scores

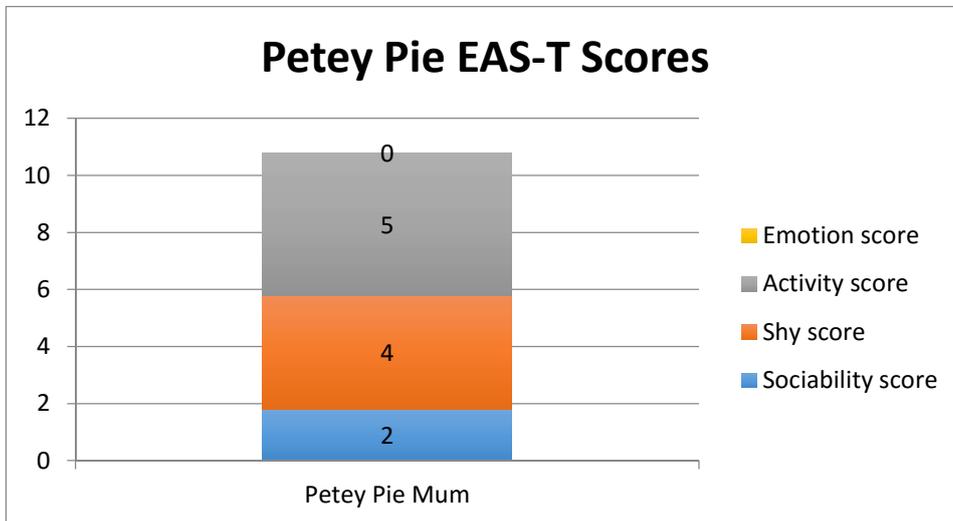
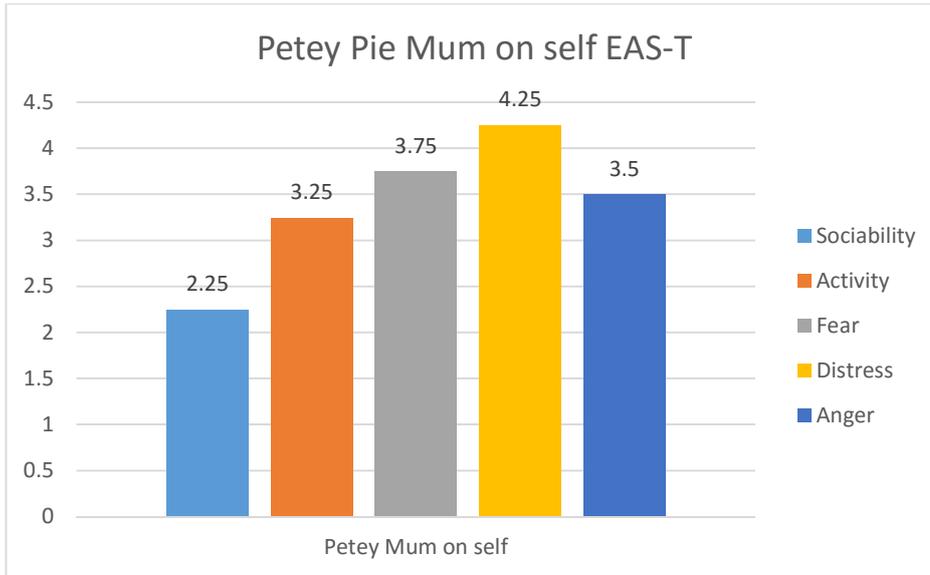


Blue Rose EAS-T Scores

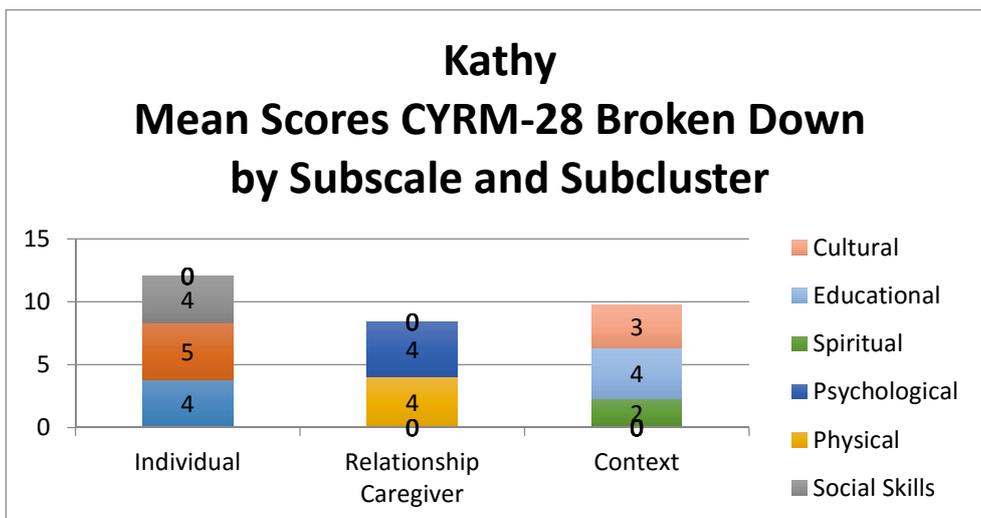
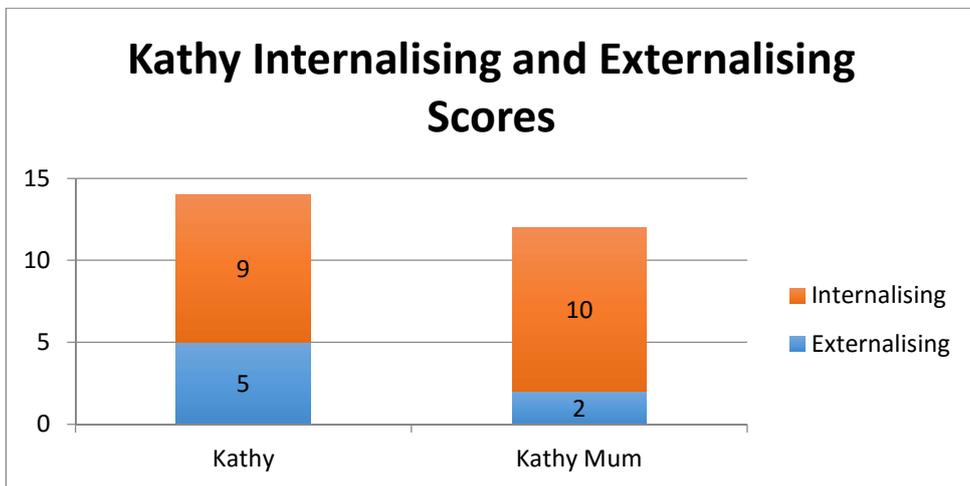
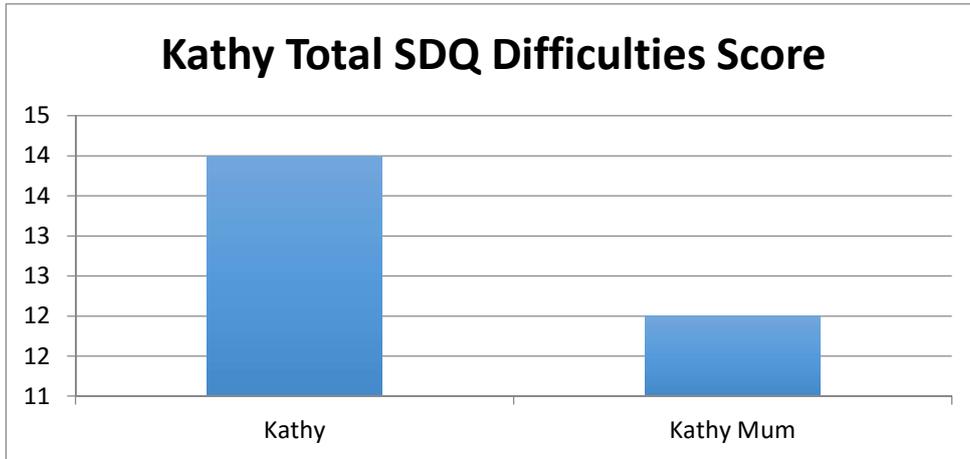


Petey Pie

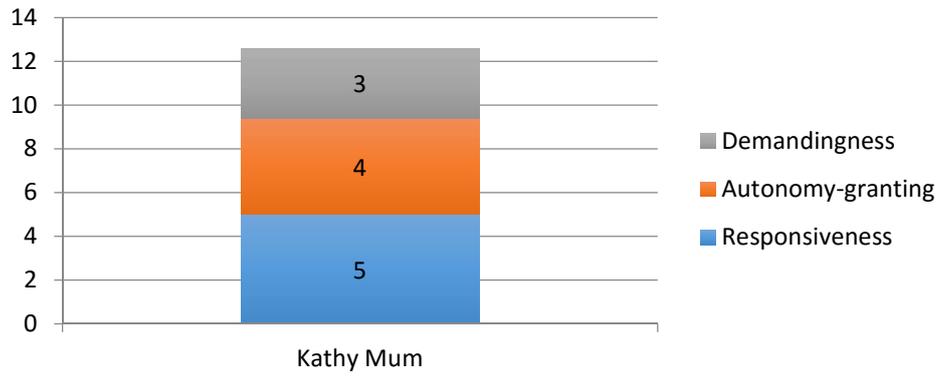




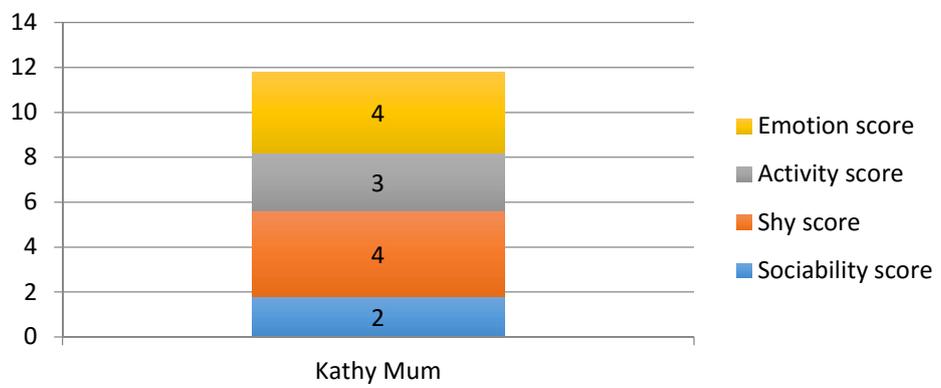
Kathy



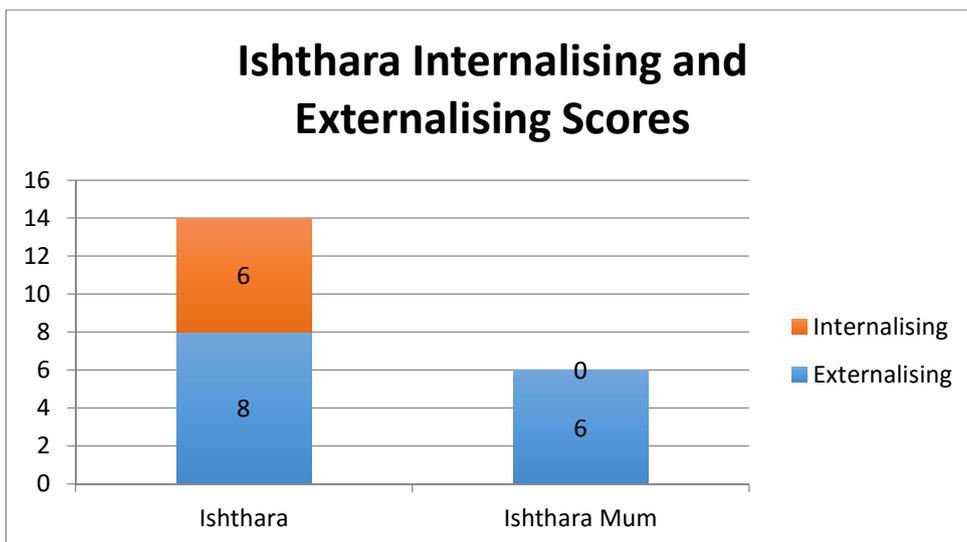
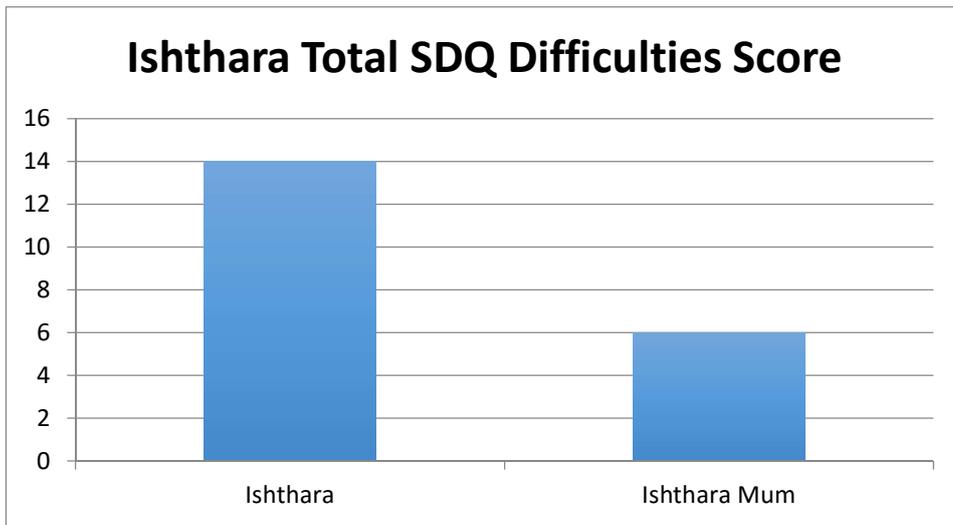
Kathy PSI-II Scores



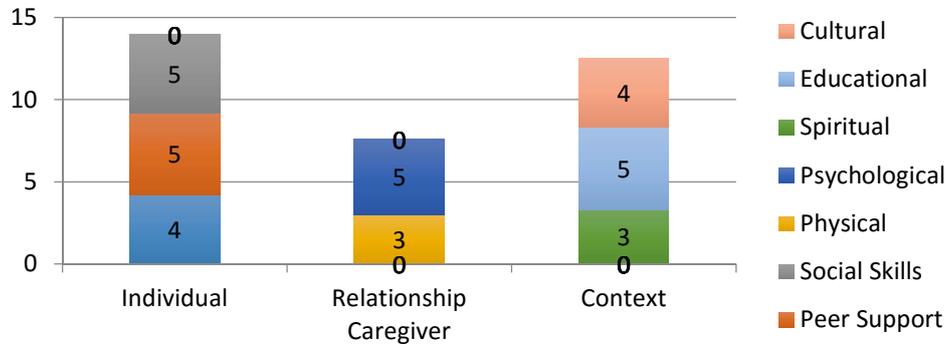
Kathy EAS-T Scores



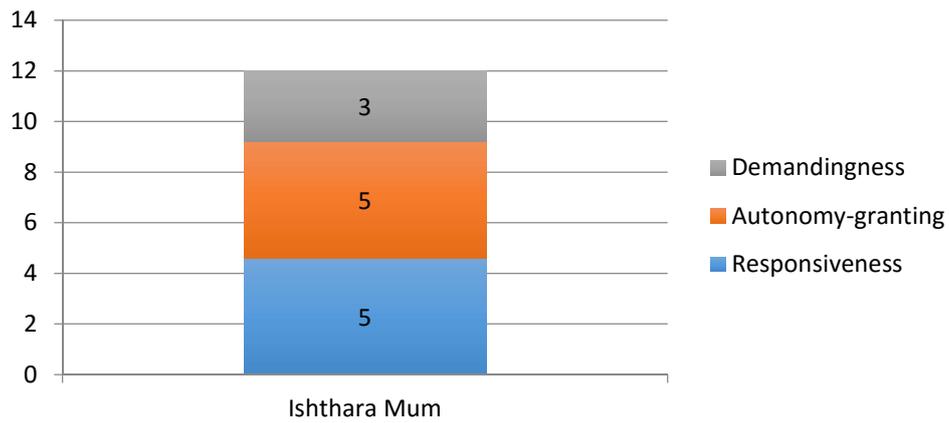
Ishthara



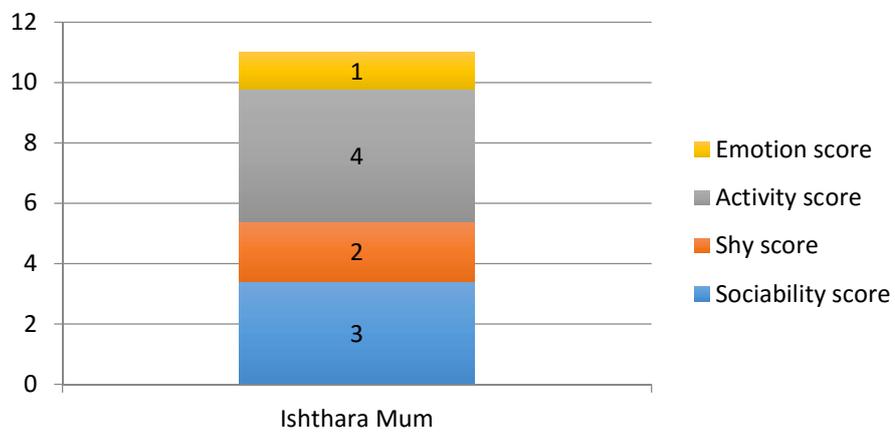
Ishthara Mean Scores CYRM-28 Broken Down by Subscale and Subcluster



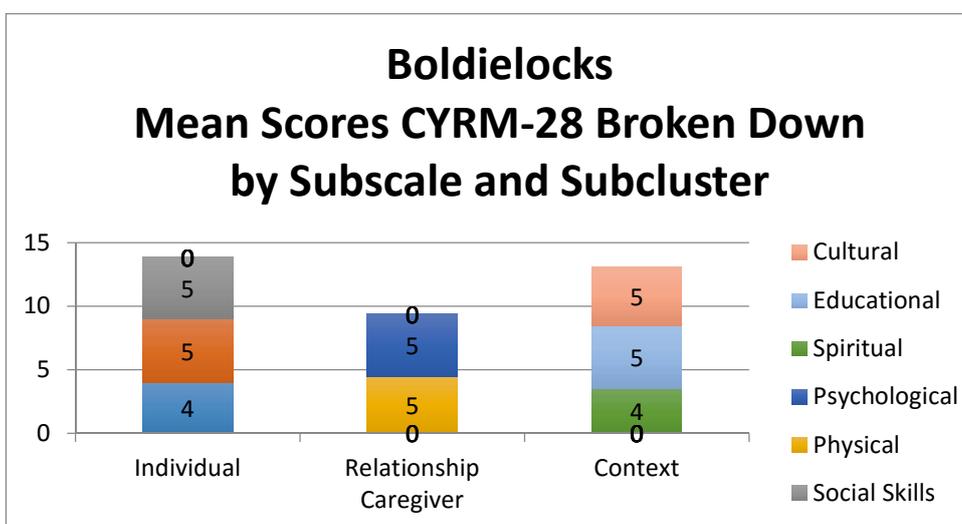
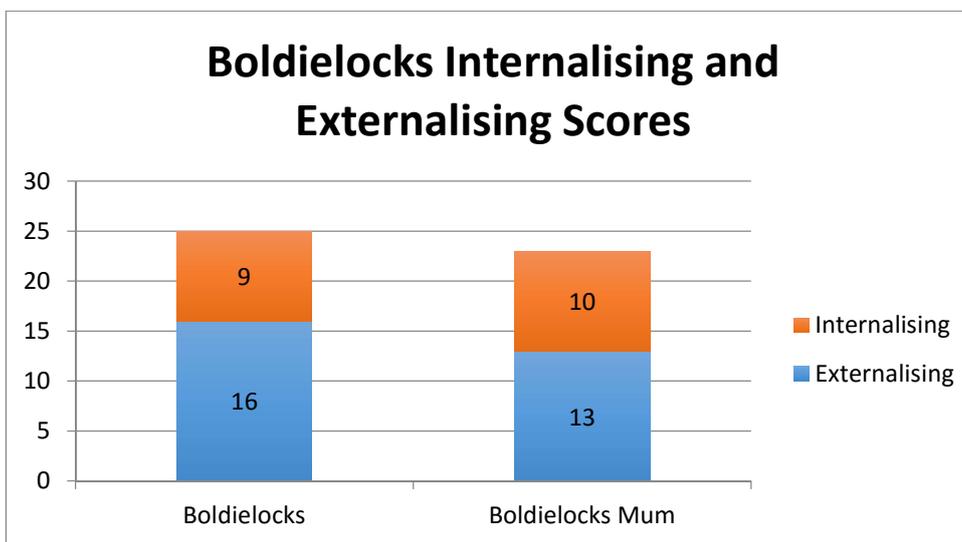
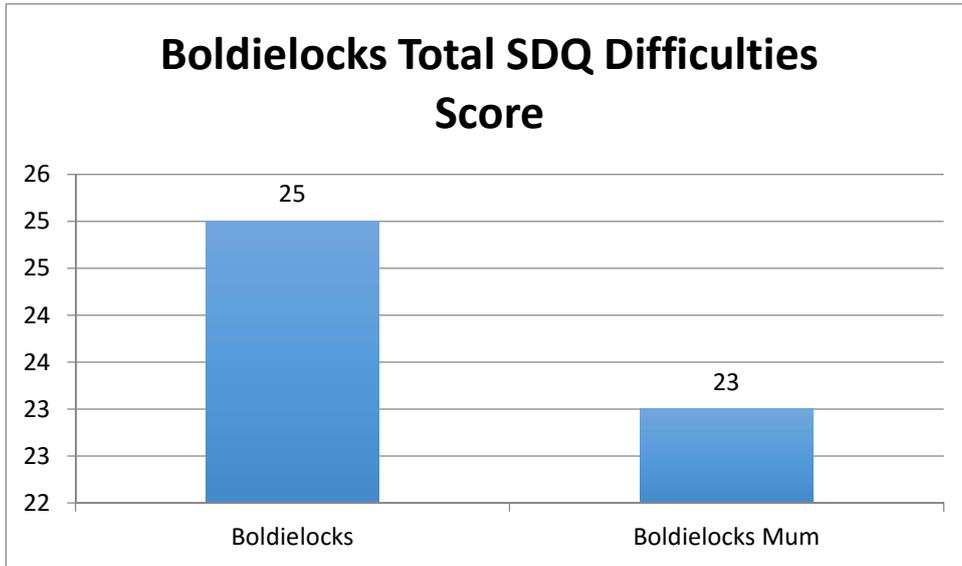
Ishthara PSI-II Scores



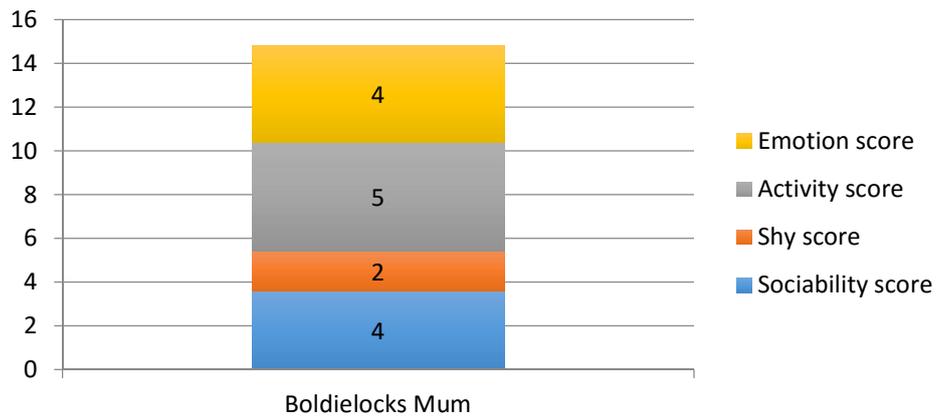
Ishthara EAS-T Scores



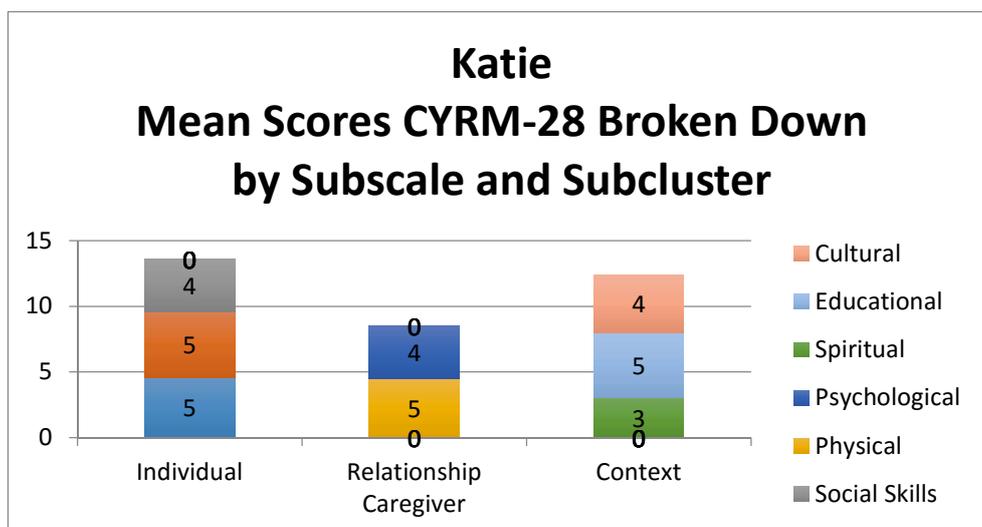
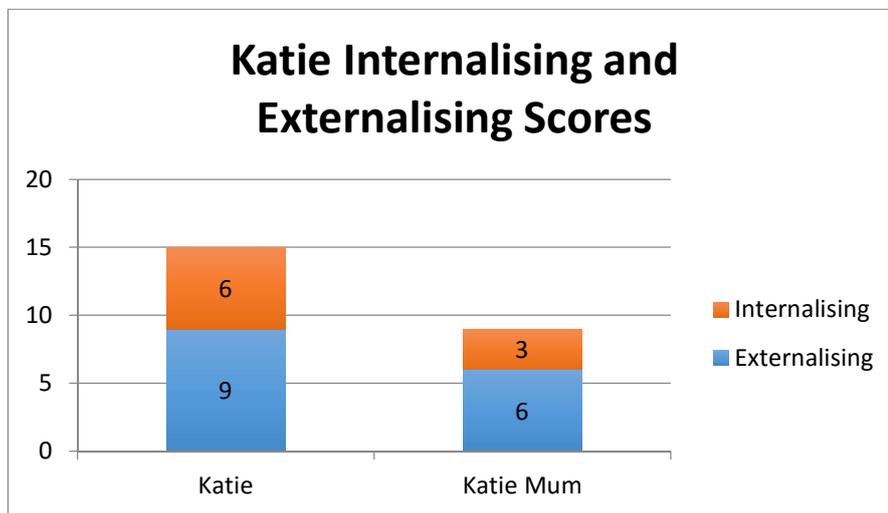
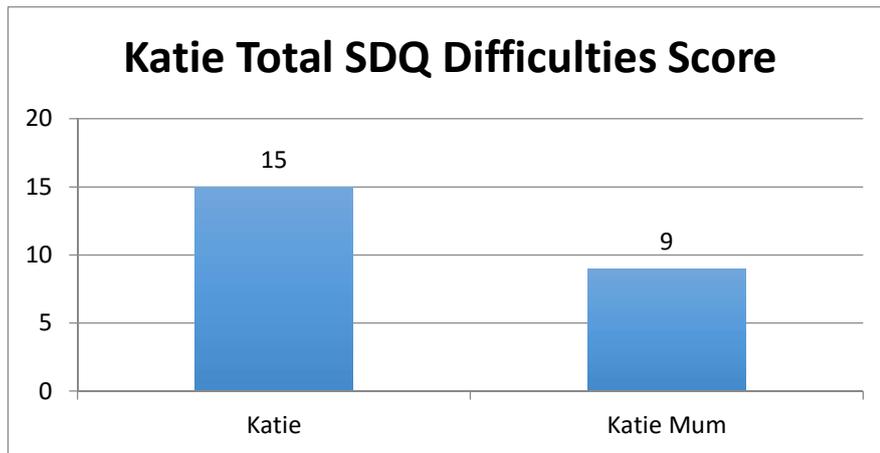
Boldielocks

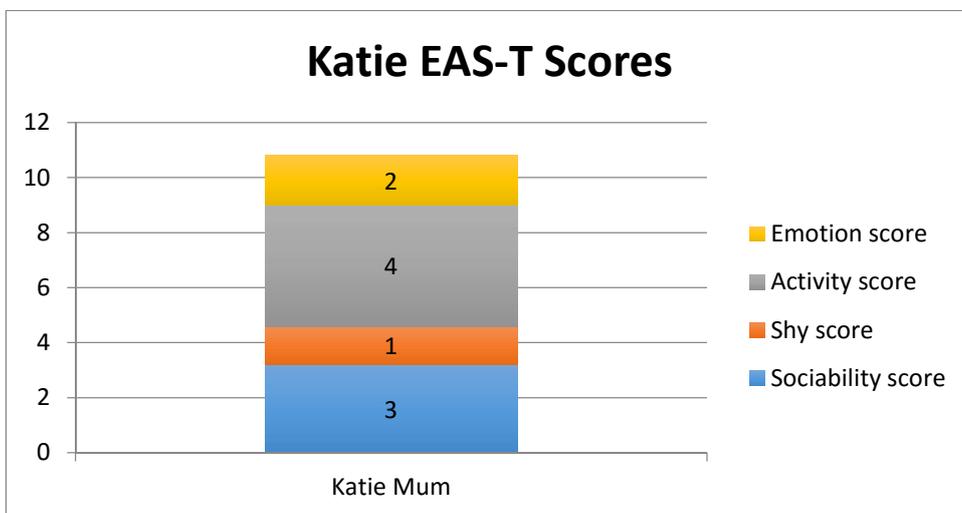
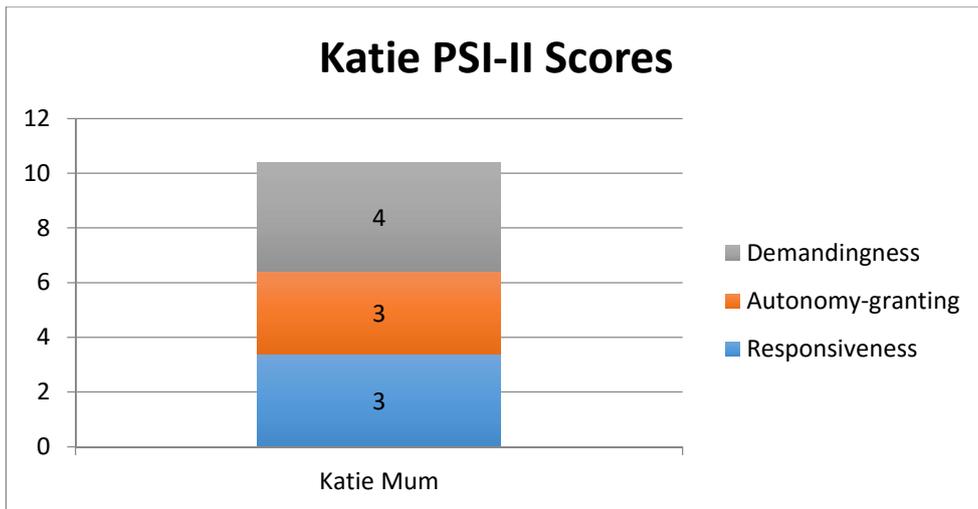


Boldielocks EAS-T Scores



Katie





Josh

