“ALL IN THE SAME BOAT”: AN ANALYSIS OF A SUPPORT GROUP FOR CHILDREN OF PARENTS WITH MENTAL ILLNESSES

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
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Abstract

Thesis Title: “All in the Same Boat”: An Analysis of a Support Group for Children of Parents with Mental Illnesses

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The effectiveness of psychoeducation and peer support programs for children of mentally ill parents is frequently measured by demonstrating children’s ability to meet program goals according to pre-defined categories determined by adults. Little is known about how children respond to these goals, whether they share them, and how, or if, their needs are met. I conducted an ethnographic study of one such group for school-aged children. I examined how specific discourses framed the content of the program manual designed to educate and support children and I observed how children responded to the program. My study is rooted in Goffman’s (1959) dramaturgical analyses of the reciprocal influence individuals have on one another in face-to-face encounters. From a critical dramaturgical perspective the participants were expected to conform to behavioural expectations of the setting, itself framed by broader arenas of interaction in which shared institutionalized meanings govern (often idealized) presentations of self. Data collection included: 1. a critical discourse analysis of the program manual; 2. participant observation of interactions during the eight-week program; and 3. children’s evaluations of the program in a separate group interview.
Being identified as “as all in the same boat” was meaningful and consequential for children who were expected to learn mental health/illness information because, “knowledge is power”, and to express difficult feelings about being a child of a mentally ill parent. Children could be said to have achieved the goals of the program because they developed a mutual understanding about how to interpret and give meaning to their circumstances; “recognizing” unpredictable behaviours as signs of illness and becoming responsible for managing only how “their own story would go”. Children were not expected to care for ill parents, even when they wanted some responsibility, and were strongly discouraged from turning to friends for support. Children strategized to negotiate and resist group expectations and challenge assumptions about being “all in the same boat”. Suggestions are made for determining what constitutes “good” mental health literacy based on children’s preferences for explaining their circumstances in ways they find relevant and for supporting children’s competencies to manage relationships that are important to them.
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INTRODUCTION
Introduction

The Research Problem

One in five Canadians will have a serious mental illness\(^1\) at some point during their lifetime (Public Health Agency of Canada, 2002), and many more are affected by a family member’s illness (Public Health Agency of Canada, 2006). Although mental illnesses affect people of all ages, onset usually occurs in late adolescence and hospitalization rates are highest for those between the ages of 15 and 44 years (Public Health Agency of Canada, 2006).

Although it follows that mental illnesses must affect Canadians who are parents, the actual number remains to be determined (Mordoch & Hall, 2002). This fact may reflect the erroneous assumption that persons with mental illness either do not have children or do not parent them (Hetherington, Baistow, Katz, Mesie, & Trowell, 2001). The incidence is likely significant because most adults with mental illnesses live in the community, are sexually active, and have fertility rates that are similar to the general population (Montgomery, 2005; Seeman, 2004).

Although the parenting status of adults using mental health services has not been routinely recorded in most countries, this is beginning to change. In Sweden, a one-day cross-sectional survey of psychiatric in- and out-patients found that 36% (n=137) had children under 18 years of age (Östman & Eidevall, 2005). Similarly, a United Kingdom report described prevalence based on findings from national surveys of psychiatric conditions, which predicted that approximately 10% of women and 6% of men are parents (Parker et al., 2008, p.8).

According to Australian population estimates, 23.3% of all children have a parent with a non-substance mental illness, 20.4% of mental health service users have dependent children and 14.4% of community study participants report having at least one parent with a mental illness (Maybery, Reupert, Patrick, Goodyear, & Crase, 2009). One hundred Canadian patients were surveyed regarding their psychiatric history, diagnosis, treatment, and the ages and history of their children’s mental health contacts (Vanharen, LaRoche, Heyman, Massabki, & Colle, 1993). Forty-seven percent were parents and thirty-two percent had children under 18 years of age.

More recently, Israel (2009) conducted a month-long chart review of emergency visits to a Canadian psychiatric facility and found that among 332 unique patients, 28% (n=93) were identified as parents. Fifty-one were parents of children sixteen years and younger and of these,\(^1\)

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\(^{1}\) This usually refers to mental illnesses of significant duration and intensity, which interfere with the individuals’ everyday life; diagnoses include anxiety, mood, personality and obsessive compulsive and eating disorders, and schizophrenia (Public Health Agency of Canada, 2002). Hence I use the term, mental illness(es) throughout, however I also recognize other ways of thinking about such phenomena in the use of such terms as psychiatric disorder and disability, or more general references to mental health problems and difficulties.
twenty-nine were living with their children. Based on national survey data Bassani and colleagues (2009; 2008) estimated that 12.1 % of all Canadian children under 12 had a mentally ill parent, almost 570,000 were exposed to one or more psychiatric disorders, and 78.5% of their parents reported receiving no mental health care.

Much of what is known about these children is based on research about their relatively high risk for developing a mental illness or behavioural disorder (e.g. Hall, 2004; Rutter & Quinton, 1984; Smith, 2004; Somers, 2007). Compared with their peers, considerable evidence indicates that they are more likely to feel negatively about themselves and experience excessive guilt and social difficulties. They also tend to have relatively poor cognitive development and many have learning disabilities. The identification of cognitive, emotional and behavioural difficulties can lead to diagnosable and treatable psychiatric disorders (Abosh & Collins, 1996; Beardslee, Versage, & Gladstone, 1998; Göpfert, Webster, & Seeman, 1996, 2004). However their “at risk” status follows them into adulthood, and their defence mechanisms and coping strategies may have negative consequences for adult social life (Andres-Lemay, Jamieson, & MacMillan, 2005; Mordoch & Hall, 2002). Furthermore, some researchers have found that the direct effects of parental mental illness are less detrimental than the social adversity associated with mental illness (Hall, 2004; Rutter, 1989). Even though research espouses a genetic etiological model, researchers acknowledge the significance of family context and social circumstances to children’s health and well-being (Beardslee et al., 1998; Nicholson, Sweeney, & Geller, 1998a, 1998b; Rutter, 1989; Rutter & Plomin, 1997). Finally, cumulative findings from several studies indicate that many of these “at-risk” children remain healthy, and that the best predictors of positive functioning in adulthood are indices of good functioning and adaptive ability in childhood (Beardslee & Podorefsky, 1988; Judge, 1994; Richmond & Beardslee, 1988). In summary, it appears that children are affected directly by parental mental illness through genetic predisposition and coping patterns that may have lasting effects. However, these children also are indirectly affected by broader social processes associated with mental illness such as stigma and poverty.

Little research has been conducted to determine how children’s daily lives are affected by a parent’s mental illness (Leverton, 2003). However, this knowledge gap is beginning to be addressed through retrospective autobiographical accounts, and artistic works (Allan, 2009; Byrne et al., 2001; Duncan & Browning, 2009; Fortin, Mizgala, & Randolph, 2003; Greenwood, 1999; Hinshaw, 2004; Kinsella, Anderson, & Anderson, 1996; Lyden, 1997; Marlowe, 1996; O'Connell, 2008; Roberts, 1996; Stjernswärd & Östman, 2009; Toews, 2001) through which
adults depict frightening, embarrassing, or passive, preoccupied, and unoccupied parental behaviour. Some describe the trauma of being separated from the parent, while most describe frequent, unsettling disruptions to everyday life. Many recall persistently feeling afraid, angry, abandoned, isolated, guilty and ashamed. Hinshaw (2004) described children’s very real concerns about their risk of developing a mental illness as being grossly underappreciated.

Clearly, there is reason to be concerned about preventing negative short and long term outcomes of parental mental illness on children, and to evaluate strategies designed to help children and their families. Although early intervention and prevention programs have been recommended, few provide direct support regarding strategies to manage the difficulties children face. Programs that do exist typically use a group format to focus on education about mental illnesses, emotional support, and the development of positive coping skills (Orel, Groves, & Shannon, 2003; Pitman & Matthey, 2004). These groups are not considered primarily therapy groups because they encourage children to help each other by sharing ways to deal with challenging circumstances (Rimington, Forer, Walsh, & Sawyer, 1999). By combining peer support and sharing personal experiences with structured content on mental illness, these programs are intended to prevent mental health problems by increasing children’s coping skills (e.g. Hargreaves, Bond, O'Brien, Forer, & Davies, 2008; Hargreaves et al., 2005).

In this thesis I examine one such support group, the Children’s Group. This is an eight-week program, which is part of an organization located in a large urban centre in Ontario that supports families living with a mentally ill member. The Children’s Group is a multi-modal program for children aged 7 to 13 years, who have a parent with mental illness. At the time of this study, two groups occurred each spring and fall, with weekly, 90-minute evening sessions. There was no cost to participants to take part in the program, which is supported through the larger organization that is funded by the provincial Ministry of Health and Long-Term Care and charitable donations. The Children’s Group partners with community and child protection agencies, and staff from these organizations have received training to work as co-facilitators of the groups. Referrals predominantly come from child protection agencies, although some children are referred directly by family members. Promotional literature describes the program as assisting children by encouraging them to ask questions about mental illness; identifying and expressing their feelings; exchanging information; developing personal support networks, and sharing coping strategies.

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2 This is a pseudonym for the group, which I use to protect the participants’ confidentiality and privacy.
3 Full programming details will be provided in subsequent chapters.
The development and implementation of programs similar to the Children’s Group have been described in detail (e.g. Katz, Gintoli, & Buckley, 2001; van Doesum & Hosman, 2009), and positively reviewed in “in-house documents” of community organizations (see for e.g. in the Canadian context, Gryba & Chovil, 2004; Havula, 2004; MacNaughton, 2004; Ratzlaff, 2004; Whitfield, 2004). However, because few have been evaluated systematically, valid and reliable evidence to support claims about beneficial outcomes is lacking. Where programs have been studied, information was elicited primarily from adults (service providers and parents), and effectiveness was measured by demonstrating children’s ability to meet the goals of the program as determined using pre-defined categories determined by adults (Orel et al., 2003; Pitman & Matthey, 2004). Program evaluations have been designed to ask children supplementary, open-ended questions concerning their likes and dislikes. Children have tended to answer in positive, but truncated and vague ways, rather than giving in-depth, complex descriptions of their experiences. Therefore, it is difficult to determine how children respond to the goals of programs, whether they shared these goals, and how, or if, their needs were met.

The purpose of my study was to examine children’s behaviours in and responses to the Children’s Group. Specifically, I asked how: 1. the support group affected children’s knowledge, feelings and actions pertaining to their everyday experiences of parental mental illness; and, 2. the children responded to the program.

**Organization of the Thesis**

In *Chapter One*, I analyze and synthesize two streams of empirically based published research relevant to this investigation. First, I examine studies addressing children’s everyday experiences of parental mental illness; and second, I review evidence of the efficacy of psycho-educational and support group interventions for these children.

In *Chapter Two*, I describe the conceptual framing of the study to show how the Children’s Group is conceptualized as a type of dramatic performance. Drawing on Erving Goffman’s (1959) analyses of the reciprocal influence of individuals’ actions on one another in face-to-face encounters, I outline four core dramaturgical concepts pertinent to the conceptual framing. From a critical dramaturgical perspective, participants are said to be expected to conform to behavioural expectations of the setting, itself framed by discourses in which shared institutionalized meanings govern (often idealized) presentations of self. I describe
contemporary discourses about mental health/illness, and children, which are examined in this study.

In Chapter Three, the overall ethnographic case, sampling and recruitment procedures are described and I provide details about data generation for the study using participant observation, informal interviewing and photographic fieldnotes. I describe data management techniques, and analytic strategies including critical discourse analysis, which were used to analyze the Children’s Group program manual. Finally, I detail strategies to establish rigor based on research and analytic practices and procedures.

In Chapter Four, I present the results of a critical discourse analysis of Bridges to Understanding (BTU), the Children’s Group program manual. By analyzing the work “language does” in this document I show how discourses about mental health/illness, and children were formulated and used in BTU. Because I conceptualized face-to-face interactions in the Children’s Group as a performance, BTU was considered a script used to guide the performance. Through this analysis I describe what was expected of the Children’s Group performance.

In Chapter Five, the results of the performance (Part I) are presented. I begin with a descriptive overview of the Children’s Group participants and the setting, followed by an analysis of the way the script was received by participants as they performed “mental illness talk”.

In Chapter Six, the results of the performance (Part II) are presented. My analysis shifts to a performance of “mental health talk” that reflects a turning point in the script as participants are directed to talk about difficult emotions and to be “mentally healthy”.

In Chapter Seven, I discuss how being identified as “all in the same boat” was meaningful and consequential for children and describe how they strategized to negotiate and resist group expectations. Suggestions are made for determining what constitutes “appropriate” educational content based on children’s preferences for explaining their circumstances in ways they find relevant and for supporting children’s competencies to manage social relationships that are important to them. I discuss future research with children as “users” of mental health services and critical dramaturgy as an approach to studying children’s mental health services.
CHAPTER ONE: REVIEW OF RELEVANT EMPIRICAL RESEARCH
In this review I analyze and synthesize two streams of empirically based published research relevant to this investigation. First, I examine studies addressing children’s everyday experiences of parental mental illness; and second, I review evidence of the efficacy of psycho-educational and support group interventions for these children.

A. Children's everyday experiences of parental mental illness

The studies reviewed in this section are organized into three themes. Although there is overlap, they describe the impact of parental mental illnesses on daily life, and the ways children cope with everyday experiences and understand mental illnesses. I reviewed twenty studies published between 1997 and 2010, ten focus exclusively on children’s and adolescents’ descriptions of everyday experiences—the remainder also elicited adults’ perspectives on children’s lives. Detailed information about the participants, research design, and summary of key findings for each study are included in Appendix 1.

The impact on daily life

The impact on daily life describes positive and negative effects of parental mental illnesses on children’s lives, including disruptions due to the unpredictability of parents’ illness-related behaviours. Children reported a range of responses to parents’ illnesses, although parents and children described outcomes for children differently. Study participants explained the impact of the illness on familial and peer relationships, school life, and problems with “fitting in” and stigma in the community.

Many positive as well as negative aspects related to children’s life at home have been reported, with a particular emphasis on familial relationships and children’s physical health and well-being. Handley and colleagues’ (2001) report parents wanting to remain emotionally connected to their children; keep the family together; have their children understand more about mental illness and not feel guilty; and know that they are physically and emotionally healthy. Parents in another study described their children as physically healthy and as having positive feelings toward the family (Somers, 2007). Similarly, Stallard and colleagues (2004) asked parents to identify the effects of their mental illness on their children. Almost half felt the illness strengthened family relationships, drawing parents, children and siblings closer, and reported

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4 In this review I consider only those study results that focus on children and their experiences of parental mental illness, although several include findings about the experiences of service providers and parents as well. I also exclude studies solely based on the perspectives of ‘adult or grown-up children’ (e.g. Knutsson-Medin, Edlund, & Ramklint, 2007; O'Connell, 2008).
relationships as good, or very good; children were not asked this question. Children in another study, who were considered actively involved with their parents, valued these relationships, and those who “did better” were described as being more attached to their parents (Mordoch & Hall, 2008). Moreover, children and parents worried about being separated from one another because of the illness, either through hospitalization, or because a parent was deemed incapable of caring for the children (Aldridge & Becker, 2003; Garley, Gallop, Johnston, & Pipitone, 1997). In a recent study, children expressed love and admiration for their parents, and did not want to describe them unfavourably (Fjone, Ytterhus, & Almvik, 2009).

Children described the disruptive and changeable nature of the overall experience, conceptualized as comprising “good days and bad days” (Cogan, Riddell, & Mayes, 2005; Fjone et al., 2009; Riebschleger, 2004) and as the “ups and downs” of daily life (Östman, 2008). “Good days” referred to instances when parents interacted more frequently with children, and accomplished more daily tasks (Riebschleger, 2004). Parental withdrawals were perceived either as “bad days” (Riebschleger, 2004), or as protective of the child (Cogan et al., 2005). Children in Cogan and colleagues’ (2005) study described parents trying to conceal problems and suppress negative emotions when they were present; sometimes this involved withdrawing from the family altogether. However, in another study about the effects of parental schizophrenia, children described difficult or “bad” behaviours that they found embarrassing or frightening—e.g. hearing voices or having strange visions and ideas—and parents failing to take medications or keep appointments with mental health services (Caton, Cournos, Felix, & Wyatt, 1998).

Evidence suggests that parents’ illness-related behaviours have a direct impact on children, although children report positive as well as negative effects. For example, parents with schizophrenia describe their children as having more emotional and behavioural problems (Somers, 2007). Parents in a similar study also reported negative child outcomes, but the child participants described experiencing both negative and positive outcomes (Stallard et al., 2004). Valiakalayil and colleagues (2004) conducted a pilot study of parental schizophrenia to examine adolescents’ perception of burden. They described feelings of sadness, loss, fear, anger, resentment and frustration, and parents who were emotionally unavailable to them. Consequently, they were mistrustful, had a hard time with intimacy, and felt they had no safe outlet for negative feelings. At the same time they reported feeling close to their parents and that they had learned important life lessons, greater communication skills and increased understanding of the limitations imposed by illness. Such findings have been corroborated by
children in other studies who described valuing “inner growth” despite life’s difficulties (Pölkki, Ervast, & Huupponen, 2004), and love for their parents even though there were constant difficulties associated with parents’ instability and managing the “ups and downs” of everyday life (Östman, 2008). Participants in Östman’s (2008) study compared their lives unfavourably to other “healthier” families, but they valued their circumstances as an opportunity to mature and develop self-esteem.

In many studies I found it difficult to sort out whether the feelings described by child participants were directly related to the parent and parental behaviours, or expressions about self, the parent/child relationship, and/or the illness. For example, while sadness was described frequently in these studies, anger was a common response to “the illness” itself. Children have reported being scared of the parent on “bad days”, however when asked to describe “bad days”, they often began by describing their own behaviours (Riebschleger, 2004). They have also described sadness and persistent worry about parents’ safety and well-being (Handley et al., 2001; Stallard et al., 2004), parental separation and divorce (Garley et al., 1997), not having enough money, moving house often and not being looked after properly (Stallard et al., 2004). Sometimes children blamed themselves for the situation, but they were also confused and uncertain about the illness (Handley et al., 2001). In a study of parental schizophrenia negative and positive symptoms affected children’s emotions differently (Somers, 2007). When parents withdrew and were sad, worried or lethargic, children reported feeling sad and angry. Their responses to parents’ strange thoughts or odd behaviours were reported less often, but children felt frightened by delusional thinking and hallucinations. Fjone and colleagues (2009) described children’s management of stigma, highlighting feelings of shame, embarrassment, guilt, and fear.

Other researchers concluded that fear is a dominant emotion among children. It was associated with feeling frustrated, worried, anxious, confused and angry. Children had different reasons for feeling afraid and sometimes accounts varied according to those given by “younger” and “older” children (Pölkki et al., 2004). Older children’s fear was associated with isolation and the expectation that they keep their situation secret from extended family members and friends. Because younger children had difficulty expressing emotions the researchers described using children’s “body language” to interpret their emotional responses to being asked to talk about their parents. Children were described as confused, nervous and afraid, and this was particularly so when they discussed parents’ well-being. Fear was exacerbated during illness episodes, and its unpredictability compounded children’s worry and anxiety (Östman, 2008).
Some tried to avoid thinking about these feelings or resisted getting too involved. Children described experiencing violent parental behaviours including assaults, which were also directed against siblings and the “healthy” parent. They responded with anger at parental behaviours, but also at the parent. The most frequent comment concerning fear was the possibility that the parent would attempt suicide (Östman, 2008). Common fears included those related to recurring illness and re-hospitalizations (Somers, 2007), and that parents would never recover, although some hoped for a cure (Cogan et al., 2005). Meadus and Johnson (2000) thought that children’s fear and frustration was made worse by children’s general lack of knowledge and understanding about the illness, its chronicity and their worries about becoming mentally ill themselves.

Children in most studies expressed a fear of becoming ill like their parents (Garley et al., 1997; Handley et al., 2001; Riebschleger, 2004; Somers, 2007), and it surprised the authors of one study when participants did not (Stallard et al., 2004). Not all children expressed their feelings openly. For example, in one study children described the onset of illness as very dramatic, with “huge” emotions, including fear, guilt and shame but claimed that “everybody kept their emotions inside” (Pölkki et al., 2004).

All studies reported that disruptions triggered children to engage in caregiving activities when parents were unable to continue to support the family financially or stopped participating in everyday routines (Caton et al., 1998; Maybery, Ling, Szakacs, & Reupert, 2005; Meadus & Johnson, 2000; Pölkki et al., 2004). In contrast, a recent study found that children did ordinary kinds of household tasks, and few said that caring tasks isolated them from school activities or friends (Somers, 2007). However, this study was conducted in Ireland where most children lived full time in two-parent families so that the burden of care may have been experienced quite differently. Stallard and colleagues (2004) described positive parental responses to their children’s caring activities, but the authors reported concerns about a lack of clarity regarding the level of caring described, and if caring activities would be considered within “normal” boundaries for contemporary western children.

This last point is important because the context for conceptualizing caregiving can vary considerably. For example, studies in the United Kingdom focused more directly on “young carers” as a formally recognized role because caregiving is not ascribed solely to an adult status (Aldridge & Becker, 2003; Cree, 2003; Thomas et al., 2003). Positive and negative findings about the impact caring for parents has on children were common. More than half of the participants in Aldridge and Becker’s (2003) study wanted to help more and contribute to the
family and did not simply feel obliged to do so. Children valued parental and filial closeness, as well as their own developing maturity, understanding and empathy (Aldridge & Becker, 2003; Thomas et al., 2003). Children in these studies described similar worries about parents’ health as well as their own and had concerns about how others treated their families. They worried about money, where they would live if they had to move, who would look after them in the future, and being bullied at school. However, Cree (2003) found it difficult to sort out differences between general life concerns and those directly related to the impact of caring for the mentally ill parent because there was a high incidence of family violence, poverty, homelessness, drug abuse and loss over and above caring challenges. Fjone and colleagues (2009) described similar difficulties differentiating between everyday life concerns and those brought on by parental illness. Overall the “young carer” studies, and those that examined the children’s caregiving more generally, concluded that children felt their caring work, needs, knowledge and opinions were not recognized—by other family members, school personnel, and professionals working in health care and social services.

Findings across studies described the impact of parental mental illnesses on children’s educational and leisure activities and relationships with peers and friends, in schools, and in the wider community. While some parents and mental health professionals tended to see children as socially isolated (Stallard et al., 2004), a significant number of children emphasized the emotionally supportive role their friends played, even when they did not talk about difficulties at home (Maybery et al., 2005; Meadus & Johnson, 2000). Stallard and colleagues (2004) found that parents thought their children worried about being embarrassed and were reluctant to bring friends home, and reported that their children were becoming distant from their friends. The authors do not describe how children responded to questions about peer relationships. In Somers’ (2007) study few children spoke about their situation outside the family, but when they did it was most often with close friends. Cree (2003) found that children described their friendships as complex and difficult. Adolescents and young adults in another study described their situation as a “shameful secret” about which they were not allowed to talk to friends or extended family members (Pölkki et al., 2004). However, “younger” and “older” children sometimes differed on this point. Younger children talked about being allowed to socialize with peers, whereas adolescents and young adults tended to report being more isolated from friends and relatives, and said that the family did very little socializing outside the immediate family (Pölkki et al., 2004). These findings are significant because of the impact positive relationships
outside the home may have on children. For example, despite the presence of a “well” parent, long considered a protective factor in terms of the “at risk” child, many still experienced distress because that parent was often preoccupied, working longer hours outside the home, worrying about finances and their own situation (Pölkki et al., 2004).

School was described as a “breathing space” or “refuge” where children could stop thinking about the situation at home (Ahlström, Skärsäter, & Danielson, 2009; Cree, 2003). Although some felt there had been little impact on their school work they described feeling guilty when they failed to effectively manage everyday life (Ahlström et al., 2009) and worried when the parent was at home alone (Cree, 2003). In multiple studies children reported being bullied at school and that their academic performance had been negatively affected. They described disruptions to school routines, low grades and expulsions, and falling asleep in class because they were exhausted (Cree, 2003; Garley et al., 1997; Mordoch & Hall, 2008; Pölkki et al., 2004). Children in two studies described avoiding public contexts where they might be embarrassed by their parents’ behaviours (Fjone et al., 2009; Valiakalayil et al., 2004). Some were acutely aware of stigma and felt ashamed (Handley et al., 2001), believing that parental mental illnesses should be hidden (Somers, 2007). In one study, participants said that they did not feel shame and pointed out that the problem—referring to friends or strangers—was other people’s reactions (Meadus & Johnson, 2000). Children in Östman’s (2008) study knew that their families were looked at differently, and described how neighbours, relatives and others perceived their families as abnormal, particularly when parental behaviours instigated stigmatizing attitudes. Children thought that other people’s negative beliefs were pervasive and explained that most people were afraid of mental illnesses. Aldridge and Becker (2003) concluded that positive aspects of home life were often compromised by discriminatory attitudes outside the family that were attributed to a lack of understanding and the failure to see that children needed help. According to Fjone and colleagues (2009) children described feeling different or that something was wrong, and even those who had little information to explain these feelings “covered up for the parent”, or hid the situation from friends so they wouldn’t risk losing them. These children wanted to be “normal” because they saw themselves as “discreditable” and experienced “self-stigma”, particularly in school settings.
Coping with everyday experiences

Coping with everyday experiences refers to the myriad ways children managed their circumstances—including the positive and negative effects parental mental illness had on children’s lives as well as their parents. Different terms were used to describe coping as for example when participants talked about: managing; saving the situation; monitoring; adjusting; taking stock; being helpful; withdrawing; avoiding; and, “just” talking.

A pervasive theme across the literature suggested that children spent a lot of time and effort managing, or even trying to “save” the stressful situation they were in (Ahlström, Skärsäter, & Danielson, 2007; Ahlström et al., 2009; Mordoch & Hall, 2008). Ahlström and colleagues (2007, 2009) studies describe how families managed day-to-day life when a parent had major depression. A main finding was that children were aware of their parents’ depression, involved in managing everyday life, and very much affected by illness manifestations and sequelae. All family members talked about “saving the situation” by trying to help one another. Children also described acting independently, endeavouring to be helpful, devising protective strategies to avoid conflict or making things worse, and canceling activities when they were needed at home. For example, some children tried to protect siblings from difficulties related to the illness, and took the initiative to cook, clean and take care of other family members. Children coped by being quiet, writing down “bad” feelings in poems or letters, and using school activities as a diversion.

Mordoch and Hall (2008) used a symbolic interactionist, grounded theory approach to understand how children manage the experience of living with a parent with a mental illness. The authors developed a substantive theory about the social processes in which children focused their time and energy on relationships with parents by: 1. finding the rhythm; and, 2. maintaining the frame. The first process referred to the ways children monitored and adjusted to parental behaviours to maintain family security, stability and connection. The second describes children’s strategies to maintain a safe and comfortable (psychological and physical) distance between themselves and their parents to preserve a sense of self, maintain their own identity, and “have a life of their own”. Children described strategies including: getting away; living my life; selective sharing; flying solo; and, opting out. Children gauged the efficacy of such efforts by comparing themselves to other children, and the parent’s present status to past illness experiences, as well as the family’s overall experience over time. Children’s comparisons of their family to other families were described by other researchers. Although this strategy created
difficult feelings (Pölkki et al., 2004), comparisons helped some children feel better about the positive aspects of managing their situations well (Östman, 2008), including strategizing how to “fit in” with others (Fjone et al., 2009). Comparisons seemed to be easier to live with when differences were interpreted as idiosyncrasies; children reconciled deviance when they compared themselves to other “normal” families (Aldridge & Becker, 2003).

“Managing” included taking stock of the situation by considering the impact of the illness on the parent—for example, by recognizing and acting on signs of impending illness—but also on themselves (Garley et al., 1997; Mordoch & Hall, 2008). For example, Garley and colleagues’ (1997) central theme of managing the illness, was categorized further as four sub-themes: coping with the impact of the illness on the self, and on the parent; perceptions of what helps the parent; and, recommendations for other children in the same situation. Children described friends as important even when they chose not to talk with them about mental illness. They coped by distracting themselves with other activities like reading, watching television or playing sports. Garley and colleagues (1997) described children as being overburdened by managing parents’ symptoms, and “role reversal” with parents was a pervasive finding. Children cared for the ill parent, sometimes by protecting them. For example, children refrained from asking too many questions about a parent’s hospitalization. Managing the impact of the illness on the parent and on the self was a complex, difficult balance to achieve, and there was conflicting evidence as to whether or not children were successful, depending on who and how determinations were made. For example, some children described “detachment” as a coping strategy (Meadus & Johnson, 2000), whereas others who were described as doing better than their peers reported being more attached to the parent (Mordoch & Hall, 2008). How attachment was defined, measured and understood was not explicit.

Children in multiple studies described strategies for observing parents’ illness-related behaviours and regulating or altering their responses to maintain personal and family stability (Ahlström et al., 2007, 2009; Garley et al., 1997; Mordoch & Hall, 2008). This often involved learning how to stay out of the parents’ way when necessary (Somers, 2007)—being quiet, withdrawing from the family home to spend time with friends, or using school and sporting activities as a distraction. However, withdrawal, avoidance and distancing activities have also been considered evidence of “unhealthy” coping (Maybery et al., 2005). On the other hand, rather than avoiding or ignoring the parent, or withdrawing altogether, children sometimes felt they had to do more. For example, to reduce family stress children increased caregiving activities (Riebschleger, 2004). Across studies children described undertaking various
instrumental and *emotional* caring activities that involved for example, reminding parents to take medications or see a doctor, and being extra nice and making efforts to cheer them up, offering comfort and/or watching over them for signs of illness, or simply just “being there”, doing household chores and looking after siblings.

Parents and children in Maybery and colleagues’ (2005) study had significantly different views on this issue. Parents talked about children’s extra roles during illness exacerbation in terms of “taking on the mother role”, and described children’s attempts to “normalize” the experience and bring some order to the chaotic situation. Children talked about additional household roles in terms of being quiet when the parent was ill, and taking on tasks like cooking and cleaning, but few described “looking after” the parent. Parents and mental health professionals often perceived children’s caregiving in negative terms such as burden or as evidence of child “parentification”. For example, parents felt children worried too much about them, and wanted to take care of them, and the authors described this as evidence of “parentification” and “adultification” (Handley et al., 2001). Aldridge and Becker (2003) studied the changing needs of young carers of mentally ill parents in the United Kingdom. Few children described their caring responsibilities in terms of role reversal, and most differentiated between the nature of their adult-type caring tasks, and their filial relationship with the parent. All children said they took on emotional caring tasks, for example by “just being there”, talking to an upset parent, and/or trying to cheer them up. Children described helping with medications, and other responsibilities that fluctuated according to the level and type of demand, particularly because their parents’ mental illness symptoms were unpredictable and episodic. The authors found that “discrimination by association” was perpetuated by health and social service professionals who assumed children were “at risk” due to the caring responsibilities they had assumed. This led parents and children to hide the illness, and children to hide caring tasks from others. Consequently, they were excluded from interventions that may have been helpful (Aldridge & Becker, 2003).

In some studies children spoke about the negative consequences of caregiving activities as for example, when they felt their responses were ineffective, despite parents’ emotions eliciting “caring feelings” (Somers, 2007), when they had to give up work or school activities or curtail free time (Caton et al., 1998). There were differences between “younger” and “older” children. The latter often felt helping their parents was “their duty” but only one child participant in this study described herself as “the mother of the mother” (Pölkki et al., 2004). While some parents and mental health professionals wanted to lessen children’s responsibilities,
children expressed a desire to be recognized as important to their parents’ well-being, and many valued what they perceived to be a growing maturity, and ability to be empathic and understanding. Evidence suggested that children wanted to help and contribute more, though some felt obligated, acted more out of a sense of duty, and found it difficult to identify their own needs over and above those of their parents. “Older” children and those with more resources described how they had preserved a sense of self while managing a relationship with the parent, and coped with the illness and its sequelae, balancing their own needs with those of others in the family including the “ill” parent (Mordoch & Hall, 2008).

In addition to solitary, individual coping strategies like prayer and journal writing, children reported talking to siblings, friends and other family members as important (Valiakalayil et al., 2004). In one study children managed by seeking solitude and developing artistic expressions, and also through public processes that involved seeking equality with others, and avoiding unnecessary exposure (Fjone et al., 2009). For example, children described seeking the company of children who appeared to be “different”. They wanted to associate with others who they deemed “potentially devalued” by society like themselves. This helped children to feel “normal”. Some stayed away from home to prolong feeling “normal”. They also tried to be “invisible” so that their behaviours did not attract unwanted attention, controlling how much personal information they shared because, even with best friends, they could “risk” feeling normal for only short periods of time. In some studies family members reported that neither friends nor relatives offered support, health care professionals did not ask about the children, and sometimes family members did not talk about their situations with each other (Ahlström et al., 2007, 2009). There were differences between adults and children who placed more emphasis on the importance of peer relationships as a form of support than did parents or mental health professionals (Maybery et al., 2005). Talking to others was an important source of understanding, which helped them to cope with the situation (Meadus & Johnson, 2000). For example, when asked, children recommended other children not only get help earlier, and to go to counseling and realize that “it’s not your fault”, but also to find somebody to trust and, “just have friends” (Riebschleger, 2004). However this was not always easy, because “it” was often a family secret, and while there were children who talked about the situation with friends, most were acutely aware of others potentially negative reactions (Riebschleger, 2004). To talk about parental illness outside the home was considered risky because children were unsure how others would respond, or if they would help, and did not want to be perceived as different (Mordoch & Hall, 2008).
At the same time, friends were important confidants, especially if they had had “similar experiences”. Children felt it was important to know “you are not alone”, indicating the value of having contact with other children in similar situations. They wanted to talk to other children but did not know how to accomplish this safely and suggested providing children with a safe place to talk (Mordoch & Hall, 2008). Similarly, children who participated in a study using focus groups, described how it provided a “safe forum” to talk about “it”, and they liked the fact that they were not the “only ones” in this situation (Garley et al., 1997). Moreover, children advocated support groups for parents that were similar to the kind of group experience they experienced in this study. They felt other children would benefit from groups like this too, because it was considered a safe place to raise questions and concerns. According to one participant this was important because children didn’t usually talk about “it” at home. A similar finding in Somers’ (2007) study suggested that children wanted someone to talk to, and to meet other children in a similar situation, and that many were surprised to meet so many others “like them” during the course of the study because they had assumed they were the only ones (Somers, 2007).

A study by Östman (2008) presented a thematic analysis in which “conversation” referred for example, to the importance of talking as a way of relieving pressure. Even those who struggled to talk about their experiences mentioned that they appreciated the experience of being interviewed about the parent’s illness. The children stressed the importance of trusting those with whom they talked, which were often friends, relatives and the “well” parent. But most participants lacked someone to talk to, and described being left on their own with their thoughts and feelings, with no one to listen or explain what was happening to their families. Some wanted to talk to a health professional about symptoms, or parental behaviours. The ability to talk about “it” was considered by some as an indication of healthy coping, and those who refused were either “in denial” (Garley et al., 1997), fearful or ambivalent, and protecting themselves (Stallard et al., 2004).

**Understanding mental illnesses**

Most studies described the impact of parental mental illness on daily life in biomedical terms referring to illness. Children rarely used medicalized terminology. They observed parental behaviours to *understand* what was happening, and few were taught about the causes and treatment of mental illnesses. Consequently, children’s current knowledge was considered
inadequate and/or inaccurate; a lack of understanding influenced how well children were able to cope and whether they felt they were to blame or had unrealistic expectations about their parents’ recovery.

An important finding across studies concerned children’s understanding of parental behaviours in biomedical terms related to symptoms. Mordoch and Hall (2008) concluded that children managed with little information about parental illnesses or help from others, and reported knowing something was wrong even when this wasn’t acknowledged. In the studies reviewed children were able to describe very detailed observations of parents’ symptoms despite the fact that parents tried to hide or suppress them—to protect the children. Overall, children had inadequate, incomplete or inaccurate information about the causes and symptoms of mental illnesses (Ahlström et al., 2007, 2009; Cogan et al., 2005; Mordoch, 2010; Pölkki et al., 2004; Valiakalayil et al., 2004). Mordoch (2010) described children’s lack of understanding as “having part of the story” and attributed it to a continued silence around the problem and misinformation and vague explanations about illness (p. 21). Children understood mental illness by observing patterns of parental behaviour, which included departures from routine where life became unpredictable and sometimes chaotic.

One study reported how children spoke about mental health problems, and whether or how they used illness language (Cogan et al., 2005). The researchers elicited children’s knowledge about the causes of mental illnesses, and how they had developed their current beliefs in order to understand how this might influence coping strategies. Children of mentally ill parents used terms such as: problems, bad days, stress, sadness, depression, illness, being unwell and sick to talk about mental health problems. The authors found evidence of “medicalization” in the children’s use of the last three terms. Those who had visited the parent in hospital were more likely to interpret the problem as an illness. Children attributed mental health problems/illnesses to social and environmental causes (Cogan et al., 2005). They referred to past “abuse”, and “where you live”, “if it’s boggin (unclean)”, and stress. They attributed causation to painful or traumatic life events such as divorce or the death of a loved one, difficulties in childhood, and stressors like parental separation, the loss of housing and, just “things building up”. A few gave biological explanations such as “something wrong with the brain”, and one child thought it was hereditary. Children drew on personal experiences to form their beliefs, which resulted in most children holding few stigmatizing views of mental health problems. They described “it” as more difficult to understand than physical illness or disability because
mental illnesses are intangible, and not like “having a broken leg” or “being in a wheelchair”, adding that they are “hard to see”, and that it was “hiding inside a person”.

Children in Riebschleger’s (2004) study had not been told directly about their parents’ illness unless they had entered a prevention program, and they rarely used symptoms or diagnostic labels to describe their parent’s illness. Most gave behavioural descriptions such as “you act weird”, or “you have to take medicine”, and some reported having learned slowly over time by comparing their families to other families. Unlike the participants in Cogan and colleagues’ (2005) study, when asked about psychiatric rehabilitation, most children linked mental with physical health and illness. However, they had limited knowledge about medications and knew even less about hospitalization. In one study efforts to see mental illness as an “illness like any other” was also described as a coping strategy by participants (Meadus & Johnson, 2000).

According to Östman (2008), knowledge about mental illness and its impact on the parent mitigated children’s feelings of uncertainty and painful emotions associated with blaming themselves for the illness. Sometimes children believed that they had caused the illness, reporting that the “healthy” parent blamed their bad behaviour for its onset. There were instances where children blamed themselves, for mismanaging the situation at home and/or failing to create an atmosphere that would help the parent recover (Östman, 2008). Limited understanding of etiology and symptoms also led to confusing, unrealistic expectations and emotional turmoil. For example, children thought that parents would “snap out of it”, or were just being lazy (Valiakalayil et al., 2004). Children across studies worried that parents might not get better (see for e.g., Garley et al., 1997).

Garley and colleagues (1997) described children’s struggle to understand the illness and their ability to recognize signs of impending illness. Children described learning about the causes of illness from the “well” parent, and believed the illnesses were caused by low self esteem, sexual abuse, and oppressive childhoods. Children had biomedical and/or environmental views of causation, and talked about being people being “born with it” or that mental illness was related to stress. The authors concluded that participating children were “hungry” for information about mental illness, but felt they were often dismissed as being too young to understand. To make sense of parental behaviours they tended to seek answers elsewhere. For example, one child searched for answers about her father’s illness during library class at school. The ability to recognize signs of illness enabled them to frame them as illness-related. Most were aware of the chronic, intractable nature of affective disorders and spoke about them as
controllable but not curable through medications and therapy. Similarly, few of the participants in Caton and colleague’s (1998) study had spoken about the illness with a mental health professional. They had not been told that their mother had schizophrenia and did not receive any form of counseling. However, the majority understood schizophrenia as a chronic illness and did not believe that their parent would recover (Caton et al., 1998). Some children learned about mental illness through a range of sources from parents and extended family to school counselors, printed materials and the media (Mordoch, 2010). Most often they learned sporadically, finding out information by “chance” or “overhearing adults’ conversations” (p. 22).

Children who attributed illness behaviour to external causes like drug or alcohol addictions were described as particularly vulnerable by Valiakalayil and colleagues (Valiakalayil et al., 2004), because they were unaware of the “heritability factors” and their own susceptibility. In other studies children expressed confusion and worry about their genetic risk of developing a disorder (Garley et al., 1997; Meadus & Johnson, 2000). Differences between the perspectives of young children, and those of older children and adults were reported in relation to children’s current knowledge, how they accessed information and how much, and what kind of information they wanted or needed, and what might motivate them to learn more (Mordoch, 2010; Pölkki et al., 2004). The majority of participants in Valiakalayil and colleagues’ (2004) study wanted more information about the illness, and to learn practical skills to manage acute illness episodes. Mordoch (2010) concluded that children “needed enough information about MI to help them live with their circumstances, avoid unnecessary emotional duress and give them hope for the future” (p. 21).

A majority of parents in another study concluded that children didn’t understand mental illness, and that more information would be helpful, especially to correct misperceptions that made children feel responsible for the illness (Stallard et al., 2004). Children reported that no one had ever talked to them about mental illness, and they wanted to know what caused the illness, and to understand more about symptoms and treatment. There was some concern amongst parents and children that more information might become burdensome. A few parents thought there was nothing more for their children to know, or that their children were too young to be more fully informed (Stallard et al., 2004). Parents reported being afraid of upsetting their children further and avoided the subject to protect them, or denied the impact of illness on their children because they felt ashamed and guilty. Pölkki and colleagues (2004) found that “older” children, adolescents and young adults expressed a need for more information as the illness had
not been explained to them as children. Almost all reported not knowing how to ask for help, and complained about not receiving information about the illness. Similarly, participants in Meadus and Johnson’s (2000) study reported that they had not received explanations about mental illness, even when they were living in the same household, and this created more worry especially during a parent’s hospitalization (Meadus & Johnson, 2000).

While children in Somers’ (2007) study had met with professional health and social services staff, only one reported having had schizophrenia explained to them. The “well” parent most often had been the children’s source of information. Both parents and children wanted more information and advice on ways to cope. Children wanted more support and information so that they would know how to help. Handley and colleagues (2001) reported that parents wanted their children to understand more about mental illnesses but were concerned that they might be too young to understand and that they worried too much about the parent. They described evidence of “parentification” and “adultification” in the data, which suggested that parents may have wanted to distance their children from further involvement. Parents described children’s difficulties talking about the illness situation with anyone, and worried that they felt embarrassed about the illness. Children indicated that they struggled to understand and recognize impending signs of illness exacerbations, and to find ways to manage the illness, including the impact of hospitalization. Children described feeling afraid, confused and uncertain about the illness. They worried about their parent’s safety, felt they were to blame, were embarrassed by the illness, and afraid of becoming mentally ill themselves. They are described as “hungering” for information, but thought others (especially teachers) were reluctant to talk about mental illnesses. Although they wanted more support from other family members, they found it difficult to cope when they were given little, or conflicting information. They thought individual counseling and support groups for children were a good idea. The most frequently mentioned strategy amongst service provider participants was to educate children about mental illnesses. Finally, Maybery and colleagues (2005) concluded that while some parents thought children knew something about the illness but would benefit from more education, others said that their children didn’t want to know what was wrong with them, or didn’t believe that there was a problem. Parents also wanted more community education about mental illness and children’s needs, particularly in schools. In contrast, the children did not discuss education as being an important issue, either for themselves or others.

More than half of the child participants in a study said they had been told about “their parent’s situation” by their parents, extended family, or by professionals (Fjone et al., 2009).
Those who knew very little described a process of coming to realize something was “different” about their parents. The process unfolded in stages—taking behaviours for granted; making social comparisons; constructing differences as deviance by comparing themselves to peers; wondering if they could talk about it; and finally, being able to verbalize differences to others.

In the first stages of realization children separated parental distress from their own problems, and in the next, they recognized their own competence. They attributed these developing abilities to the opportunities afforded them in having to deal with mental illness, which other children did not have.

**Summary**

In the last decade, children’s everyday lives with mentally ill parents have been studied to describe: the impact on children’s emotions, education, leisure activities, home life and friendships; management strategies; and to assess their well being and understanding of mental illnesses. A pervasive finding across studies suggests that children spent a lot of time and effort managing, or trying to mitigate the effects of their parents’ illnesses on their own lives and those of their families. This was a complex, difficult balance to achieve, and there is conflicting evidence as to whether or not children were successful, depending on how these determinations were made. For example, in most studies parents and mental health professionals perceived children’s caregiving activities negatively, but children did not. And while some adults wanted to lessen children’s responsibilities, children expressed a desire to be recognized as important to their parents’ well-being, and many valued what they perceived to be a growing maturity, and ability to be empathic and understanding. Children reported frequently experiencing fear, worry, anxiety, and confusion, due to the unpredictability of the illness and its impact on daily life. And while adults tended to see these children as socially isolated, a significant finding across studies was the emphasis children placed on the emotionally supportive role friends played, regardless of whether or not they talked with peers about their difficulties at home. School and peer relationships provided some children with respite and distraction from problems at home.

Another important finding across studies was children’s observations and interpretations of parental behaviours, explained for the most part by researchers in biomedical terms related to symptoms of illness. Most children were able to describe very detailed observations of symptomatic behaviours, despite the fact that some parents tried to hide symptoms. Children referred to parents’ difficult behaviours vaguely as “problems” or “a bad day” rather than using medicalized language. Some talked about the causes of mental illness in terms of social factors.
Researchers concluded that being knowledgeable about the illness was important to help address erroneous beliefs, confusion, uncertainty, self-blame, unrealistic expectations, a lack of awareness of heritability factors, and to mitigate painful emotions. However, children said that they were rarely given explanations for the difficulties the family was experiencing, either by extended family members, the parents’ mental health professional, or at school. Overall, the evidence was unclear as to the type and amount of information, knowledge and understanding children currently possessed. There was a lack of clarity about when (which age) and from whom (the well parent, extended family, schools and/or mental health professions) children should acquire more information. Evidence suggesting why children should be educated about mental illnesses was contradictory. For example, children reported wanting to know how to help more, but parents wanted their children to feel less guilty. Many children, parents and professionals recommended some form of (psycho) education and support for children. Most researchers agreed that primary prevention could enhance coping strategies, which included children’s understanding of mental illnesses. Learning how to talk about “it” was stressed to help children express negative emotions, feel safe and reduce guilt about betraying “the family secret”. More indirectly, it was hoped that this would also help to decrease stigma and discrimination more broadly.

B. The efficacy of interventions to support and educate children

I reviewed 7 studies published between 2003 and 2009, 6 examined the efficacy of specific psycho-educational and support group interventions for children of parents with a mental illness. The seventh comprised a “snapshot” of several Australian programs (Reupert & Maybery, 2009b) captured in an interview-based study with program facilitators. As Parker and colleagues (2008) found in a systematic review of interventions for families of mentally ill parents, most research was conducted with mothers, or parents, and few involved children directly. Children’s perspectives were elicited most often when researchers were conducting “pilot” work for future development of services, and children were not participating in a

5 In this section I review peer-reviewed, published studies of group interventions for children living with parental mental illness rather than the family as a whole. See Cooklin (2006); Fraser et al., (2006); Reupert & Maybery (2007) and Tunnard (2004), for reviews of interventions that focus on the family. See also Cowling & Garrett (2009) on “child & family inclusive practice”, and the influential work of Beardslee and colleagues who developed intervention strategies to prevent depression in children by increasing families’ understanding of affective disorder (e.g., Beardslee, Gladstone, Wright, & Cooper, 2003; Beardslee & Podorefsky, 1988; Beardslee, Salt, Drezner et al., 1997; Beardslee, Salt, Versage et al., 1997; Beardslee et al., 1998; Beardslee, Versage et al., 1997; Focht-Birkerts & Beardslee, 2000; Place, Reynolds, Cousins, & O’Neill, 2002; Riley et al., 2008).
formally recognized capacity as users of service (e.g. Garley et al., 1997). Program details for all 7 studies and information about participants and methods are described in Appendix 2.

Fraser and Pakenham (2008) studied an Australian program called the Koping Adolescent Group Program (KAP). They argued that previous evaluations of similar programs were limited by small sample sizes, inappropriate measures, no control group and/or follow-up study designs and failure to consider adolescents’ caregiving activities. They concluded that overall, post-program comparisons with the wait-list control group failed to show statistically significant intervention effects. To explain the fact that both groups improved in life satisfaction and knowledge and awareness of mental illness the authors speculated that wait-list participants searched for information about mental illness while waiting. The treatment group however did show slightly more improvement in mental health literacy (described as knowledge of mental illness and awareness of parent’s mental illness), “prosocial” behaviour and life satisfaction. Depression and emotional symptoms also decreased from pre-treatment assessment to follow up and treatment gains were maintained 8 weeks later. The treatment group reported an increase in behavioural and emotional difficulties during the intervention, which may have been due to increased sensitivity to the challenges and issues identified in the sessions. The treatment group reported satisfaction participating in KAP because “it helped them talk about their feelings and problems” (p. 1048). They reported a slight decrease in caregiving responsibilities, that they felt less isolated and more able to do things outside the home. The researchers concluded that KAP decreased adverse impact of adolescents’ caregiving activities. They report a small sample size, the lack of randomization, and use of a wait-list control group that may have been “primed” for change as study limitations. The researchers also noticed a trend for the treatment group participants to have more seriously ill parents. However despite “modest” support for the program, they recommend ongoing revisions of KAP, and continued evaluations of similar interventions that include both qualitative and quantitative data. The discrepancy between participants’ satisfaction and subjective experience of the intervention and the “quantitative change data”, suggested that the KAP intervention had beneficial impacts on domains (e.g. self confidence) that may have been captured by qualitative methods.

Goodyear and colleagues (2009) report the results of an evaluation of Children and Mentally Ill ParentS (CHAMPS), an Australian pilot program offered in two formats (school holiday and after school peer support programs) to groups of children aged 8 to 12 years. The authors argue that this evaluation was different from others because it explored targeted aspects of children’s wellbeing. Well-being was evaluated at the beginning of the program and 4 weeks
after completion. Standardized measures were used to examine changes in self-esteem, coping skills, and positive and negative connections to family members and people in the community. Significant improvements were reported in all areas, although the impact on well-being differed according to program format. The school holiday program (delivered over four consecutive days, with a particular focus on recreation in addition to education and building resilience) showed the largest improvement in “problem focused” coping relative to the after-school program (2-hour weekly sessions over a school term). Problem focused coping described children’s ability to adapt themselves to difficulties, and/or make changes to their environment.

The authors concluded that the intensity of the 4-day program appeared to have led to greater change at follow-up. Connectedness outside the family did not improve for children attending either group format, and the authors expressed surprise because of the “peer support” offered. They did allow that relationships may not have continued beyond the duration of the program. Findings suggested that strategies should be developed to improve children’s social networks outside the family. The authors argued for longer term follow-up assessments and the use of standardized measures and control group study designs to allow for comparisons within and across programs.

Grant and colleagues (2008) studied children’s responses to an intervention for “young carers” who were “looking after” parents with mental health problems in the United Kingdom. Findings centred on four main themes. First, children’s caregiving activities were described as “family-centred work”. Children’s attachments and obligations were considered part of interdependent relationships. Second, the importance of developing trusting relationships within the support group was emphasized. Third, one-to-one work was significant because it ensured dependability, consistency and continuity of relationships. Project workers were described as being almost like “surrogate parents”. They stressed finding ways to solve problems in a creative, fun atmosphere where participants felt some control. Fourth, the group itself was considered an important strategy for forming friendships, creating a feeling that “we are in this together”, and providing respite from problems and recognition of their caregiving activities from those outside the group. The authors concluded that it was important to pay attention to “pacing”, which referred to the early stages of the group in which labels such as depression were avoided, and signs and symptoms were discussed only as aspects of a parent’s behaviour. For example, a parent might be described as taciturn, rather than avoidant and the parent’s desire for privacy might be acknowledged and discussed, rather than being given a psychiatric label. The authors argue that it took time, patience, respect for privacy, empathy and absolute trust for
children to feel comfortable talking about their experiences. Once they did, all participants expressed the importance of “just talking”, especially because they had felt let down by peers and the education system, and viewed inconsistency and disappointment as typical of their lives. Participants valued feeling in control, knowing that they could withdraw from the group at any time, or contact a worker privately. All participants were very enthusiastic about group work, and appreciated the opportunity to form friendships, as many had lost friends, or had little time outside the home to maintain friendships. The group helped to “reconstitute friendships and to bond through affirming, common identities” (p. 278). Association with peers living in similar circumstances helped children to understand their own experiences, and to appreciate they were “not alone” or unusual.

Grant and colleagues (2008) concluded that young people have agency and can articulate their experience despite their vulnerability. Sometimes it took months for participants to become confident enough to speak freely and feel they were not betraying family secrets. Unlike other support groups reviewed here it was not clear whether participation was time-limited. The authors stressed the importance of a “salutogenic” perspective that recognizes the nurturing capacities that allow people in very stressful circumstances to achieve a sense of coherence in their lives by understanding and managing things, and by being able to make sense of what it all means to them” (p. 279). Challenges, which were beyond the scope of the intervention included, children’s desire to see the parent recover, or make healthy life changes by learning to adapt better to their circumstances. Rather than seeing these observations as wishful thinking, the authors thought that the children were able to point to things that helped stabilize the parent’s situation, which in turn helped them. The children themselves were acutely aware of the failings of health and social care services, including instances where they were excluded from involvement in the services designed to help their parent. Other systemic challenges included the pervasive social consequences of living with persons who are mentally ill, and structural impediments like the impermanence of demonstration projects such as the one studied. While the authors reported findings similar to other carer research, they highlighted a particular issue for fuller study, which was to recognize the “symbiotic nature, and needs and dependencies of both the young carer and the parent” (p. 247). Although findings underscored the value of one intervention, the authors argue that lessons learned are transferable to other projects.

Orel and colleagues (2003) reported on the effectiveness of *Positive Connections*, an education and support group program for children and adolescents developed in the United States. Children’s improvement (and therefore, program effectiveness) was determined by
measures of positive changes in children’s self-esteem, knowledge about mental illness and life skills. The majority of children achieved the goals of the program by demonstrating an understanding of different types of mental illnesses (and that “their parents had an illness, rather than simply being out of control, and that they were not responsible for their diagnosis or behaviour”), were able to verbalize and/or demonstrate a crisis plan, express feelings about the situation with one another, which indicated self-confidence, and were able to both give and receive support (p. 120). Children showed the least improvement in the area of “personal security” on the self-esteem measure. The authors argue that the children likely saw their parents as too overwhelmed to protect them from real or perceived environmental harms and that this fact should be noted and addressed in future programmes, especially where identified support persons might offer psychological and physical protection (pp. 120-121). Children responded positively to the group overall, reporting that they liked the other children and the facilitators, felt they had learned coping skills, and that they were not to blame for their parent’s illness. While children did not report disliking anything in particular, few liked learning more about mental illness.

While parents rated family dysfunction higher in the areas of role performance and family involvement than children did, Orel and colleagues (2003) speculated that this may be due to children’s increasing independence stemming from their participation in the program. In observations of the children’s performance obtained from the program’s Big Brother/Sister mentors, seventy per cent of the children demonstrated an increase in self-confidence. This increase was evident in children’s “ability to express feelings, make decisions, develop interests/hobbies, and articulate future goals” (p. 119). Moreover the positive support networks provided by the program led to “feelings of academic competence”, as well as report card evidence of improved school performance (p. 120). The program was considered successful to the extent that further programming was suggested that addresses their needs for education and support. The researchers described the study as a pilot, and recommended studies with larger numbers to explore the effects of other variables such as parental diagnosis, living arrangements, gender, and age and how these might impact outcomes. They also recommended the use of a comparison group to determine if group effects were due to the program or other sources, like mental health assistance provided independently to parents, and to reduce observer biases. They recommended a longitudinal design to measure change over time, the development of groups for “older” children, and further empirical evaluation of interventions to support children.
Pitman and Matthey (2004) also reported on the effectiveness of a support program for children and adolescents in three intervention settings, two in Australia, and one in Canada. As in the study by Orel and colleagues (2003) children’s improvement and therefore the efficacy of the program as a whole, was measured by positive changes in children’s knowledge about mental illness and life skills. Overall, Pitman and Matthey (2004) argued that “open-ended” data was evidence of the program’s effectiveness even though the measures used had not been psychometrically tested. For example, the authors highlight particular statements made by the children such as, “I know a lot more”; “it was fun”; “I’m not the only one who has a family member who is sick”; “It’s not Dad’s fault”; “I liked the games and meeting new people”; “I learned it’s not our fault”; and, “I learned that illegal drugs don’t help” (p. 386). Negative comments were few, but did include feelings of embarrassment upon arrival in the group, having to sit for too long and to listen to others talk about their parents and filling in forms. Some stated that they would like a longer program. Less than half of the families returned their feedback form but those that did found the program helpful. Parents commented that children were more caring, showed a greater understanding of the limitations imposed by the illness and knew what to do when they were not feeling well. Children who learned to recognize symptoms were able to help others understand the situation better. For some families this was the first time they were able to discuss mental illness as a family. The researchers consider the findings limited to some extent by a small sample size, and recommend future studies using longitudinal designs to measure change over time.

Riebschleger and colleagues (2009) reported the first phase of a pilot pre/post group intervention study in community settings in the United States: “Youth Education and Support (YES). Data revealed a significant increase post intervention on the knowledge scale because there were more “correct” answers. The most significant items included knowledge about prevalence, recognition of illness, treatment avoidance, efficacy of medication and counselling and that “psychiatric illness is caused by the brain not working right”. Prior to the intervention participants correctly answered questions about stigma, signs of recovery, suicidal symptoms. Non-significant declines pre/post intervention knowledge included confusion about treatment efficacy, and how much is known about causes of mental illness. No significant change was reported in overall coping, but youth reported significantly increased use of two coping skills post-intervention: avoiding problems and relaxing. Longer interventions with more emphasis on coping, parent-inclusion, and larger samples using randomized, experimental designs were suggested in addition to completing psychometric testing of the knowledge scale. The authors
suggested that the “treatment dosage” of six group sessions may not be enough to improve coping, and recommended longitudinal research to learn more about youth knowledge, coping and functioning over time, (in the “quest for developmental resilience”), and increased access to prevention programs for youth.

Reupert and Maybery (2009b) provided a “snapshot” of Australian programs for children and adolescents whose parents have a mental illness (COMPI). They conducted interviews with 18 program facilitators responsible for 26 programs. They described intervention strategies that reflect goals across programs and include structured/unstructured discussion groups; psychoeducation; fun activities; exercises to enhance coping and resilience. Five programs provided additional parent support and education; however, three focused “just on kids” because facilitators felt that it was more helpful to avoid involvement with the adult mental health system. Five involved young people as peer support leaders. Many did not collect information regarding the mental illness diagnosis of the parents or the child participants; one facilitator explained that this was not relevant to the program content. Theoretical bases for programs were ill defined; some referred to strength-based theory; resilience; attachment; psychodynamic theory; and, facilitators’ own clinical experience. Seventeen facilitators relied on practice knowledge, their own and other facilitators’, to implement programs, often based on program evaluation reports. Seven used organizational needs surveys, and five described “professional intuition” to decide which strategies to employ.

In order of importance, facilitators wanted to “change/enhance/target”: resiliency; understanding of mental illness; isolation, confidence, self-esteem and coping; and the children’s risk of developing a mental illness. They described programs as a form of “immunization” against issues connected to parental mental illness by teaching children to cope, for their own “well-being”. Most evaluation measures were designed by the facilitators or an umbrella organization, and consisted mostly of child outcome measures matched to program goals. For example, a general knowledge questionnaire was used to identify children’s understanding about mental health and/or whether children were satisfied with the program. Many used a pre/post design, including standardized and non-standardized measures for child outcomes. Control/waiting groups were not used. Most programs did not collect information about the mental illness diagnosis of the parent. Thirteen facilitators reported meeting program goals based on increased coping skills, peer support and knowledge about mental illness. The authors agreed with Fraser and colleague’s (2006) finding that evaluation design and measures were simplistic and lacked the “rigor of standard evidence procedures” (p. 131). Overall, Reupert and
Maybery (2009b) found that programs provided opportunities for peer support, psycho-education, respite from caring responsibilities and new ways of learning to cope. However they argue that because mental illnesses impact on children in different ways, more research is required to understand whether there are subgroups of children who require different interventions and supports according to parents’ psychiatric diagnoses, and other factors related to mental illness severity, chronicity, and the availability of family and community and mental health support.

Summary

Most studies evaluated group interventions for children between the ages of 8 and 18 years. When parental diagnoses were reported they varied, and children in some groups were assessed for mental health problems. Children were referred through mental health services for children and youth, as well as those for parents. For the most part, children lived with the “ill” parent. Participant involvement in the interventions varied considerably, depending on the length of the program and how it was organized, ranging from 18 hours of programming implemented in 6-hour sessions over 3-week intervals, to a 3-day program delivered during school holidays. The “young carer” intervention group did not appear to be time-limited. Most groups consisted of between four to ten participants, and were co-facilitated by adults, although a few included peer group co-facilitators.

Overall effectiveness—although program distinctions make some comparisons difficult—was usually measured by the extent to which children fulfilled the goals of the program, and demonstrated achievement according to pre-defined categories and objectives. However, the way phenomenon were conceptualized influenced program design and evaluation, determining who was asked to participate, what was measured and the outcomes reported. For example, mental health education/literacy was assessed by scoring children’s knowledge about mental illness, and/or awareness and recognition of a parent’s mental illness. Knowledgeable children were those who could describe “signs and symptoms” of illness and differentiate amongst diagnostic categories and had an awareness of how the illness affected the parent. Children achieved understanding because they recognized illness as the cause of unpredictable behaviours and therefore accepted that neither they, nor their parents were responsible for them. Children in one study rated “family dysfunction” less of a concern than did the parents. And even though children said they “liked” the programs overall, few reported a predilection for learning more about mental illnesses. Children who improved most could articulate specific
information about the prevalence of mental illness, appropriate treatments, and the idea that illness is caused by “the brain not working right”. However, one study of “young carers” explicitly avoided psychiatric labels, and discussed parental behaviours without using medicalized language. In some groups children who were educated were those who could verbalize a crisis plan, express feelings and give and receive support.

One program that used a “resilience framework” evaluated efficacy in terms of established risk and protective factors. The program’s limited success was attributed to a decrease in participants’ caregiving responsibilities, which allowed them to feel less isolated and able to pursue friendships and activities outside the home. However, another reported young people’s caregiving in terms of a “salutogenic” perspective that recognized interdependent familial relations and attachments, and young people’s “nurturing capacities” as attempts to manage and find meaning and coherence. While a significant aspect of the program philosophy rejected established “at risk” thinking, the researchers described many difficulties associated with multiple caregiving demands facing children. The group context itself was explicitly evaluated to consider peer support in terms of participation in a long-term intervention, and how it helped participants form friendships, create a sense of “being in this together”, and ensure continuity of relationships that were consistent and dependable. Of note, adolescent participants in these two studies with different approaches to “caregiving” reported appreciating the opportunity the group itself afforded to “just talk”, about their feelings and problems.

Most researchers did not describe a conceptual framework to guide the evaluation, and the methods used were most often quantitative measures supplemented with “open-ended questions”. However in one study, when measures failed to show statistically significant intervention effects based on wait-list comparisons, the authors described other “subjective” data that suggested participant satisfaction with the intervention. When asked directly, most children reported predominately positive, but vague responses to whether or not they liked being part of programs. The data elicitation techniques seemed problematic because the questions, which were designed to obtain children’s responses, appeared to lead to truncated rather than in-depth or complex descriptions of experience. Therefore, the findings may not fully describe how children responded to program goals, whether they shared them, and how or if, they meet their needs.
Summary and gaps in the two groups of studies reviewed

It is clear that considerable information has been accumulated about how children’s lives are affected by parental mental illness\(^6\). However, the evidence across the two groups of empirically-based research indicates that there is considerable variability in findings, and a number of tensions remain. Children described managing daily life in terms of striving for a balance between coping with the illness and maintaining their relationships with others, as well as using strategies to preserve a sense of self. They acted on their recognition of signs of illness and/or monitoring of parents’ behaviours using different strategies such as adjusting their own behaviours in response, withdrawing and doing less, or doing more to help the family. However, whether they were coping well, or their management strategies were considered “healthy”, depended largely on how such determinations were made. For example, whereas some parents and professionals perceived children’s caring activities quite negatively; most children did not. There was tension between children’s perceptions about what they wanted or needed—for example, many wanted to be recognized as important to their parents’ well-being—and adults’ desires to see children protected from the burden of more responsibility.

The evidence varies as to the type and amount of information, knowledge and understanding about mental illnesses children currently possessed, and the purposes, timing and resources that were considered most appropriate to help them acquire optimal types and amounts. While some adult participants thought children were too young to understand what was happening, children of all ages reported knowing something was wrong even when parents tried to hide or suppress difficulties. Most children found ways to act upon this knowledge, which caused concerns about how this influenced how they managed or coped with problems at home and in school. This was the case even if “it” was rarely discussed explicitly in the home or with professionals, and despite the fact that most children lacked appropriate medicalized language to label the problem as “mental illness”. Children and parents had different motivations for wanting more education too. While children wanted to learn how to help more effectively at home, parents felt that education about mental illness would make them feel less guilty and responsible for family problems. Many children worried about their own risk for developing a mental illness, but only a few had a rudimentary understanding of heritability factors.

\(^6\) There are many references to a pervasive knowledge gap in the literature concerning children who have a mentally ill parent, in addition to the studies I reviewed because they were most relevant to this investigation. See for e.g. Leverton (2003).
Children tended to attribute causes to social/environmental problems and their understanding was informed by observing parental behaviours. There were differences between the way children developed their understanding and knowledge based on personal experience, and a more biomedical approach to the problem as “illness”. This made it difficult to assess children’s overall knowledge and understanding, and whether or not it was problematic and to decide what they most needed in terms of (accurate) information and education. Nevertheless, children who were judged knowledgeable were considered to be those who were better able to cope with the situation because they could interpret parental behaviours as signs of illness, and adjust their own behaviours accordingly. The ability to recognize impending illness provided a context for unusual and challenging parental behaviours and helped address the uncertainty and disruption that accompanies the experience, and to mitigate painful emotions. However, being able to talk about “it” was not just a matter of learning appropriate, medicalized language. Many children said they valued talking about their situation with others, and based on the evidence, this helped children develop a sense of comfort, cohesion and identification with each other in a process that normalized the experience and validated their perceptions.

This cumulative evidence was a key reason for the development of support group interventions for children. However, children tended to place more emphasis than adults on the emotionally supportive role of friends and peers, whether or not they talked about difficulties at home. One intervention was determined a “success” precisely on this point because it was able to demonstrate a reduction in children’s caregiving activities, which helped them spend more time outside the home with friends. Comparing interventions was difficult because programs were organized differently, and the length of time participants were expected to be involved varied considerably. Study purposes, and the way phenomena were conceptualized influenced how studies were designed to determine efficacy, including what was measured and how outcomes were reported. Interventions were not considered effective by measuring the extent to which they fulfilled children’s goals but rather efficacy was demonstrated according to pre-defined adult categories and objectives such as, improved mental health literacy and coping strategies, and making connections with others, as well as good emotional and behavioural adjustments to their circumstances. Children reported predominately positive, but vague responses to open-ended questions about what they liked about the program, and what they thought was helpful. These findings did not include descriptions of what children thought about the goals of the program, whether they shared them and how, or if, they met their needs.
Although most children and young people who participated across studies were between the ages of 7-18 years, age was not considered problematic. For example, in studies of children’s everyday experiences of parental mental illness, participants were often referred to as “older” or “younger”, or accounts were actually retrospective by adults who had grown up with a mentally ill parent. Less than half of the studies involved children younger than nineteen years old. On the whole, it was difficult to know whether the analyses presented in several studies were based exclusively on data from child participants, “older children” or adults (parents and professionals), unless it was explicitly stated. The potential biases introduced by using parents as a source of information about their children’s experiences was only acknowledged in one case, and the point made that while children’s perspectives are not the only salient ones they are often under-utilized in research. Many authors expressed concerns that participants may not have been representative because they were “too well adjusted” or had “too few difficulties”. Also, parents who may have had insight into their illness, and valued their parental roles—and agreed to have their children participate, might not represent children whose parents were less involved with their care, or able to advocate for them. With rare exceptions, participants had been recruited through their parents’ in-patient acute care settings, outpatient services, or community-based treatment settings. Exceptions occurred most often in the United Kingdom where child participants were recruited through projects established by legislative and social policies directed toward “young caring”. However, securing participants was complicated. Some researchers felt that this limited the methods they used, such as theoretical sampling. Others speculated that research recruitment challenges might mirror those that would occur in developing and implementing psychoeducational interventions for children.

Children’s living arrangements were not always reported, and those that did indicated the majority lived with a lone parent, most often the “ill” parent. Exceptions included two studies: one in which ‘living with’ the ill parent was an inclusion criteria, and the other conducted in Ireland where two-parent families are the norm, and health and social problems are a familial, rather than a state responsibility. Studies also differed regarding whether or not they reported children’s problems as psychopathology, with diagnoses established according to a biomedical model of illness, or a less explicit description of behavioural and emotional problems. Others excluded children on this basis, ensuring they did not meet formal criteria for a psychiatric diagnosis. Researchers have focused almost exclusively on parental—particularly maternal—diagnoses of mood disorder, although some included other psychiatric diagnoses like schizophrenia.
With one exception (Grant et al., 2008), researchers assumed a biomedical approach to studying the experience as one of “illness”. On one occasion the authors referred to psychiatric “disability” (Riebschleger et al., 2009). Most studies did not report using an explicit theory or conceptual framework to support the research design and data analyses. Overall, the lack of conceptual frameworks makes it difficult to judge how assumptions about mental health and illness, and children influenced the research findings reported. Studies used quantitative methods exclusively, or incorporated a mix of survey instruments and open-ended questions. In the latter case these often seemed to be “add-ons” to supplement the survey material when no further description of the method was forthcoming. Data collection techniques used seemed problematic because the open-ended questions, designed to obtain children’s responses only yielded truncated descriptions of experience. Some studies reported using focus groups or interviews but the majority lacked detail about research designs, including analytic methods employed and challenges encountered. Several authors described limitations such as small sample sizes—particularly those that used a qualitative or “open-ended” approach—and the lack of a comparison group or longitudinal designs. Without knowing how the various authors determined study limitations, as for example in a phenomenological study, or a “qualitative” study, it is difficult to judge what may be intended by reference to a “small sample size”.

To address some of these gaps, in the following chapter I describe the conceptual framing of my study, designed to examine an intervention to educate and support school-aged children who have a parent with a mental illness. Program goals were similar to those used in the studies evaluated: children were encouraged to ask questions about mental illness; identify and express feelings; exchange information about mental illness; develop personal support networks, and share coping strategies. However, I examined the intervention as more than a straightforward, information sharing and emotional support session. Rather than measuring children’s ability to meet these goals only according to pre-defined, adult categories, I used a critical interpretive approach, rooted in symbolic interactionism, to consider their responses to a discursive set of assumptions about how they should think, feel and act because they have a parent with a mental illness.
CHAPTER TWO: CONCEPTUAL FRAMEWORK
Symbolic Interactionism

My goal was to study a children’s support group in an innovative way to understand how it was helpful to program participants. I examined children’s responses to the activities that had been designed to help them cope with having a mentally ill parent by observing their interactions in the Children’s Group. My observations were guided by a critical dramaturgical framework, which I developed beginning with George Herbert Mead’s (1934) sociological formulation of symbolic interactionism, and as it was expanded upon by Herbert Blumer (1969). Symbolic interactionism strongly influenced Erving Goffman’s (1959) conceptualization of social interaction as dramaturgical, which I draw on to further develop the conceptual framework.

Herbert Blumer (1969) elaborated three important elements of symbolic interaction which emphasize how interaction emerges from people’s ability to confer meaning on situations: 1. they act toward things on the basis of the meanings that things have for them, 2. the meaning of things arises out of the social interaction people have with others and, 3. the meanings of things are constructed and modified through an interpretive process in dealing with things encountered. Symbolic interaction assumes that ascribing meaning to behaviour and things is central to human life, shaping individuals’ interpretations of themselves, events, environments, and others. These interpretations are said to influence how people respond to situations, regardless of the objective reality of the situation itself (Charma in McLeod & Lively, 2007, p. 281). Using these ideas I conceptualized children in my study as actively involved in interpreting, defining, and evaluating their own and others’ actions and interactions in the Children’s Group.

Because the creation of meaning is central to a symbolic interactionist perspective, it is considered a dynamic social process involving: the potential for change as individuals develop new understandings (McLeod & Lively, 2007); and, the enactment of power between those engaged in social interaction (Clarke, 2005). A meaningful act is something that has resonance for people who share an interpretation and can be said to “speak the same language” (Mead, 1934). Differing attitudes and beliefs coalesce around the use of symbols that are significant to those involved in particular situations (Wallace & Wolf, 1999). Symbols include words, actions, or images that signify the meaning of behaviours for all involved (Mead, 1934). Gestures or signs are integral to symbolic interaction’s assertion that individual actors take on or imagine the role of the other, interpret or define others’ actions, and perform, respond and behave on the basis of these interpretations (Blumer, 1969). Furthermore, meanings are said to be socially
produced, and to shape how actors interpret and respond to particular situations, and to each other. Individuals anticipate what others will think and do, and draw on their background knowledge about others’ expectations to respond appropriately. This process is described as drawing on knowledge of a “generalized other”—a coalescence and internalization of social norms, values and expectations (Mead, 1934). Consequently, societies exercise control over how individuals behave and respond to situations, and the “self” is said to be socially produced and structured. Mead argued that the self comes into being because “one has to be a member of a community to be a self” (Mead, 1934, p. 163).

A symbolic interactionist perspective is particularly apt for considering how individuals come to understand stressful life situations by experiencing the scrutiny of others (real or imagined), and alter their responses to subtle, sometimes unrecognized social comparisons, or through confrontation and conflict (McLeod & Lively, 2007, p. 287). Individuals see themselves as they imagine others would and adjust their behaviours in line with how they believe they are supposed to react or believe others would in their place (e.g. Hochschild, 1983; Thoits, 1985). Therefore, meaning changes as individuals develop new ways of thinking about situations, as situations change, or through individuals’ interactions with real and imagined others (McLeod & Lively, 2007). As a result, actions and interactions are considered dynamic, reciprocal, and emergent. Blumer (1969) described social interaction as ‘joint action’ to theorize how actions fit together. It is less important analytically to understand what individuals have in common than to ask how actions are initiated, interrupted, abandoned or transformed. For Blumer (1969) uncertainty, contingency and transformation are potentially part of all social interaction. Following from this, it is not difficult to see how symbolic interactionism is consistent with Erving Goffman’s (1959) notion of social life as dramatic performance.

I conceptualized the Children’s Group as a type of performance in which meaning arises out of adult and child participants’ interaction. This performance is handled in and modified through a joint interpretive process within which individual actors seek to influence one another. Goffman (1959) emphasizes the dramaturgical aspects of face-to-face encounters as, “…the reciprocal influence of individuals upon one another’s actions when in one another’s immediate physical presence” (emphasis added, p. 15). His analyses of interaction demonstrate how social environments are settings of mutual monitoring (Clarke, 2005) because individual beliefs and interpretations are influenced through social intercourse as participants attempt to manage how they and others respond to the situation.
This symbolic interactionist perspective aligns with the recognition that children, despite their vulnerabilities, are full participants in social life, and whose behaviours are competent, rational and purposeful (Mayall, 2000; Qvortrup, 1985). This view of children as social actors does not judge their behaviour according to criteria of normative psychological developmental stages, coping and adjustment (Dixon-Woods, Young, & Heney, 2002). Instead, children’s behaviours are considered “practical achievements” of social interaction, albeit, contained, shaped and bounded by the contexts in which they live (Hutchby & Moran-Ellis, 1998, p. 14). From this perspective social competence is not “a psychological property of an individual, but a relational constitution or attribution that is socially constructed and negotiated” (Christensen, 1998, p. 189).

In the remainder of the chapter I describe face-to-face social interaction in the Children’s Group as a critical dramaturgical enterprise to consider how power is exercised, however implicitly, in social situations. I outline four core components based on Erving Goffman’s (1959) approach to the presentation of self in everyday life as a dramaturgical enterprise, in order to metaphorically cast support group meetings of the Children’s Group as performances.

**Critical Dramaturgy**

Goffman’s critics argue that his dramaturgical approach neglects power relations by ignoring the effects of hierarchical social arrangements (Gouldner, 1970). Others counter that Goffman’s work is a micro-politics of social order, wherein the analytic treatment of power is present although almost entirely implicit (Dixon-Woods et al., 2006; Rogers, 1980; Williams, 1986). They argue that far from neglecting power, much applied interactionist research is actually about power relations and their enactment (emphasis in the original Dennis & Martin, 2005, p. 197-198). Goffman sensitizes us to a politics of experience through an examination of the dynamics involved in negotiating the intricacies of institutionalized social relationships (Paolucci & Richardson, 2006). Flaherty posits that:

A critical dramaturgy would examine how the power of social institutions and norms of interaction can limit and manipulate actors, even if the “utter banality of this coercion renders it nearly invisible to our awareness” (Flaherty in Paolucci & Richardson, 2006, p. 336).

The following paragraph is quoted in full because it refers to the entirety of Goffman’s work to envision dramaturgical interaction, and suggests that the exercise of power involves larger social and institutional discourses:
Shared institutionalized meanings become frames of reference, or “definitions of a situation [that] are built up in accordance with principles of organization which govern events—at least social ones—and our subjective involvement in them” (Goffman, 1974:10). Frames direct attention to which part of reality we notice, facilitating cognitive exchange of shared experiences. Because institutionalized expectations and practices frame interactive settings, macro forces can bind and shape actors at the micro level (Adams & Sydie, 2002:169). Presentations of self are then, in part, products of structural power, even if the actor is ‘unconscious’ or only dimly ‘conscious’ that this is part of the business he is in (Messinger, Sampson, & Towne, 1962:106). Though free agents, actors may be compelled by social relationships as social facts (Durkheim, 1982:51), whether these are norms endorsed by authorities (Goffman, 1983), total institutions (Goffman, 1961), or others in face-to-face settings (Goffman, 1959, 1969) (Paolucci & Richardson, 2006, p. 333).

Dennis and Martin (2005) argue that existing definitions of power fail to deal systematically with contradictory views of power as both repressive and coercive, and productive and enabling. However, it has been argued that interactionist studies of power don’t look like conventional studies of power (Dennis & Martin, 2005, p. 196). For example, in analyses of social settings, Goffman (1983) argues that the management of social reality is made manifest by studying social arrangements favoured by those with institutional authority (parents, teachers, psychiatrists, police, priests, government leaders, media operators and so forth) “who are in a position to give official imprint to versions of reality” (p. 17). So while his work focuses on the behavioural expectations of settings and the actions of actors, his analyses of institutionalized norms, which compel conformity, demonstrate how actors are not free to attribute just any meaning to situations (Paolucci & Richardson, 2006). Instead, actors strive to ensure a creditable performance by engaging in idealized presentations that conform to others expectations, represented in part, by institutionalized meanings (“frames of reference”) that govern social events and our subjective involvement in them.

In Goffman’s (1959) earliest writing on face-to-face dramatic interaction, the idea of power is suggested by terms used to describe actors’ strategies to influence, manage, manipulate and control their situations. As a type of interaction, influence and its variants, involves one-sidedness, intentionality, and behavioural modification which are concentrated among targets of that influence (Rogers, 1980, p. 107). This idea of influence is central to the notion of thinking about social life as performance. According to Goffman (1959):

A performance may be defined as all the activity of a given participant on a given occasion which serves to influence in any way, any of the other participants (p. 15).
The notions of influence and control are important to understanding power as an interactional phenomenon. Williams (1986) argues that while individuals activate or invoke their resources to influence a situation, “conformity to a given person’s or group’s preferences, in the absence of direct influence, is the empirical referent of control” (Williams, 1986, p. 360). Goffman’s work is often described as focusing on micro-political contexts, in which the interest is on the conditions of interaction, as well as their situated aspects (Rogers, 1980, p. 128). Rogers (1980) argues that the intention with which individuals interact to control information, influence others, and manage impressions, are expressions of inter- and intra-personal power. Moreover, dramatic interaction is always strategic, and therefore an enactment of power, because it involves a mutually assessed, mutual assessment (Goffman, 1969 in Lemert & Brananman, 1997, p. 143).

Actors strive to gain from evaluating, and potentially manipulating, the expressions played out before them because:

Regardless of the particular objective which the individual has in mind and of his (sic) motive for having this objective, it will be in his interest to control the conduct of others, especially their responsive treatment of him. This control is achieved largely by influencing the definition of the situation which the others come to formulate, and he can influence this definition by expressing himself in such a way as to give them the kind of impression that will lead them to act voluntarily in accordance with his own plan (Goffman, 1959, pp. 3-4).

Goffman’s (1969) emphasis on strategic interaction qualifies instances of social interaction where individuals’ intentions to act involve calculated measures to prevent embarrassment or disruption. The notion of intentionality implicitly serves to specify a conceptual boundary separating power and closely related phenomena from other phenomena which are commonplace in social interaction (Rogers, 1980, p. 104):

…strategic interaction is a type of mutual impingement in which each party must make a move and where every possible move carries fateful implications for all parties (Goffman, 1969, p. 127).

Goffman’s actors however, have differential capacitites to influence or affect others’ behaviours. For example, the concepts of dramatic and directive dominance are used to convey contrasting forms of dramaturgical power. One group may work together to dramatically realize, that is convey meaning about an activity, which is otherwise obscured. However they will be directed to do so by others who control how this takes place by exercising responsibility for bringing into line any actors whose performance is unsuitable; planning for possible disruptive contingencies in advance; and, exemplifying accredited social values, and so forth. Moreover,
Goffman (1959) argued that power is limited to the specific situation, and performers who may enjoy power as a form of dominance or authority in a particular setting, may not do so in others. An individual’s power in a given situation is said to be a function of both “individual-based and situation-based factors” (Rogers, 1980, p. 105). For example, his core concept of a front to be described in detail later — refers to both the stage, and the person of the actor, as the embodiment of a generalized reality that can be understood intersubjectively — is imbued with notions of power because it supports the definition of the situation. Overall, Goffman’s analyses consistently imply a concept of power as “the capacity or potential to act effectively, and to affect the behaviours of others in social situations” (Rogers, 1980, p. 106).

**Institutional Framing of the Children’s Group: Critical Discourse Analysis**

Because Goffman’s actors engage in idealized presentations that conform to others’ expectations — represented in part by institutionalized meanings or “frames of reference” that govern social events — one way to analyze power is to examine discourses that are relevant to the situation. Discourse analysis (DA) is a viable method for considering the *politics of experience* (Paolucci & Richardson, 2006), and the social processes through which power is enacted and institutionalized in real situations (Dennis & Martin, 2005). DA involves moving beyond actual words to examine the emphasis an issue is given within a group, community, or document and the connections that are made among meanings, power and knowledge (O’Connor & Payne, 2006). Language is considered more than descriptive, and is rarely politically neutral, rather it is highly symbolic in shaping the way an issue or phenomenon is viewed or defined (p. 830). Consequently, it is inherently meaningful, and “not simply a transparent medium for the relay of information” (O’Connor & Payne, 2006, p. 829).

Written texts are said to represent aspects of social reality in certain ways, and to play a part in the construction and maintenance of reality. The image of an object, as represented in a text, is formed according to the frame or focus that determine what is to be seen, challenging the notion that texts are “neutral and value-free receptacles or conveyors of information” (Cheek, 2004, p. 1145). Texts are shaped discursively, in that discourses frame the assumptions that every text makes with respect to how it will be understood (Cheek, 2004, p. 1145). This idea that issues are framed in ways that direct our attention to a particular part of reality, as Goffman’s body of work suggests (Paolucci & Richardson, 2006), is important to a dramaturgical analysis of discourse. For example, Goffman (1959) described dramaturgical
strategies for conveying meaning about an activity that is obscured or unapparent to an audience, and for controlling expressions in order to incorporate officially accredited social values. In his later work he emphasized that social experience is organized by frames, defined as “principles of organization which govern the subjective meaning assigned to social events” (Goffman, 1974, p. 11). Framing is a social process described as, “schemata of interpretation (that) also govern the ways in which individuals locate, perceive, identify, and label occurrences as meaningful within their life space, and the world at large. By rendering events or occurrences meaningful, frames function to organize experience and guide action, whether individual or collective” (Snow, Burke, Steven et al., 1986 in Hollander & Gordon, 2006, p. 194).

Discourse, as objects of analysis, are another way of thinking about how issues are framed or “schemata of interpretation”, and how this functions to organize experience, and guide behaviours. However, the various ways academics use the term discourse, reflects different theoretical and disciplinary standpoints (Fairclough, 1992). Despite this heterogeneity three assumptions characterize most approaches to discourses as objects of analysis: 1. language is structured to produce and constrain sets of meanings; 2. the social world can only be accessed and interpreted via language; and, 3. this therefore means that it can only be studied via an approach that explores the work done by language (Alldred & Burman, 2005, p. 178). The idea that language does things indicates the performative nature of language (Barinaga, 2009), which is consistent with Goffman’s (1959) dramaturgical vision of face-to-face social interaction.

According to Fairclough (1992):

Discourses do not just reflect or represent social entities and relations, they construct or ‘constitute’ them; different discourses constitute key entities (be they ‘mental illness’, ‘citizenship’ or ‘literacy’) in different ways, and position people in different ways as social subjects (e.g. as doctors or patients), and it is these social effects of discourse that are focused upon in discourse analysis (p. 3).

Following Lupton, in my research I define discourse as a “group of ideas or a patterned way of thinking, identifiable in textual and verbal communications, and located in wider social structures” (Lupton in Cheek, 2004, p. 1142). Moreover, the constructive effects of discourses are evident in the ways they contribute to the construction of social identities, or subject positions (ways of being in the world); construct social relationships between people; and, contribute to systems of knowledge and belief (Fairclough, 1992, p. 64):

Texts are regarded as cultural representations rather than as transparent facts, and are always shaped by other discourses in a chain of intertextuality. As such, texts do not
provide direct access to experience or truth, but rather representations constituted by interpretation and cultural values (Crowe, 2005, p. 57).

Fairclough (1992) distinguishes critical discourse analysis (CDA) by the particular orientation it takes to the constructive effects of discourse and notions of power:

Critical approaches differ from non-critical approaches in not just describing discursive practices, but also showing how discourse is shaped by relations of power and ideologies, and the constructive effects discourse has upon social identities, social relations and systems of knowledge and belief, neither of which is normally apparent to discourse participants (p. 12).

Fairclough (1992), and others have influenced the use of CDA in combination with the work of contemporary critical social theorists. The term “critical” signifies a departure from strands of DA viewed as merely descriptive by exploring the “ideological underpinnings of discourse that have become so naturalized over time that we begin to treat them as common, acceptable and natural features of discourse” (Gee in Smith & Gallo, 2007, p. 61). Moreover, CDA sees discourse as central to the functioning of power in social processes (van Dijk, 1993). CDA attempts to examine processes of power and how these processes use discourse in subtle, yet controlling ways. Discourses are viewed as instrumental in the reproduction of power within a given social situation (van Dijk, 1993).

In my study, rather than seeking to understand children’s responses to the Children’s Group solely through my observations of their interactions in the group (the performance), a CDA of the program manual text (the script) was undertaken. CDA guided my understanding of what was expected of the performance according to those who define children’s experiences of parental mental illness in order to provide mental health education and support. It was my intention to analyze how the language used to shape the portrayal of specific information about mental health and illness in the context of being a child of a mentally ill parent was itself shaped by discourses external to the text (Taylor & Ussher, 2001). Therefore, I examined three discourses that express current ways of thinking and writing about mental health and illness, and children. I deliberately set out to describe these influential social practices (the institutional and organizational circumstances) that are connected to the text (Traynor, 2006, p. 71), because they constitute a starting point for examining the discursive practices of text production and interpretation in the CDA of the program manual to follow. In the next section I outline contemporary discourses about mental health and illness, and children, as they are described in publicly available documents at the time of writing my dissertation.
Contemporary discourses about mental health/illness

In Canada mental illnesses are officially characterized as alterations in thinking, mood or behaviour associated with significant distress and impaired functioning over time (Public Health Agency of Canada, 2009)\(^7\). Troublesome thoughts, feelings and actions are seen as signs and symptoms of underlying pathology; the designation of these states as “signs and symptoms” is the quintessence of the medical model (emphasis in the original, Aneshensel & Phelan, 1999, p. 6). Moreover, while it is acknowledged that emotional distress is experienced by all individuals and is therefore considered “normal”, an individuals’ functioning over time in response to difficult situations indicates their potential for developing a mental illness. This is described in the following excerpt from the Public Health Agency of Canada:

People learn to cope with difficult feelings just as they learn to cope with difficult situations. In some cases, however, the duration and intensity of painful feelings or disorienting patterns of thought may interfere seriously with everyday life. Ordinary coping skills are overwhelmed and people may need help regaining balance and restoring their fullest functioning (PHAC, 2009).

Mental illnesses are also considered chronic because there is no known cure.

The brain is central in most discussions about the causes of mental illness even though the connection between the disordered brain and mental illness is not entirely understood. This is exemplified in the following excerpt:

Research suggests that mental illnesses are the result of a complex interaction of genetic, biological, personality and environmental factors, however, the brain is the final common pathway for the control of behaviour, cognition, mood and anxiety. At this time the links between specific brain dysfunction and specific mental illnesses are not fully understood. (emphasis mine, PHAC, 2009).

Specific illnesses such as depression may be explained by “stress” in response to environmental factors such as problematic life events, but even here the emphasis tends to be on biology and the brain, and aetiology descriptions refer to biochemical imbalances and/or genetic predispositions (Canadian Mental Health Association)\(^8\). A strong case for a genetic connection that “runs in families” and is a “biological disorder of the brain” is made for schizophrenia (CMHA, 2009). Recently brain imaging technology has been considered a potentially valid means for detecting objective “differences” in brain structure and functioning.

While treatment can include a variety of interventions, medications currently play a leading role because of the treatment emphasis on rectifying pathological brain functioning pharmacologically:

Treatment must reflect the complex origins of mental illnesses. A variety of interventions, such as psychotherapy, cognitive behavioural therapy, medication, occupational therapy and social work, can improve an individual’s functioning and quality of life. Since mental illnesses involve disorders of brain functioning, medication often forms an important part of treatment (emphasis mine, PHAC, 2009).

Among health professionals with shifting perspectives and agendas regarding causation and intervention in mental health and illness, it is psychiatry and allied bio-medical sciences whose causal conceptions and intervention stratagems that have been most widely disseminated and supported over many years (Pearlin, Avison, & Fazio, 2007, p. 33). Pearlin and colleagues (2007) trace the current dominance of “biological psychiatry” to an ongoing emphasis on a search for etiological factors within the body, and for “interventions that are primarily aimed at pharmaceutically modifying its’ biological substrata” (p. 35). This is not unlike a more general view of biomedicine, which Robertson (1998) argues is characterized by a dominant discourse of scientific medicine with its principles of specific aetiology and nosology of diseases, particular clinical and diagnostic and treatment protocols.

In Poole’s (2007) Canadian study of “recovery” discourses she differentiates between competing, but concurrent models of the way we “think, talk about and do” mental health. While these include medical, moral hygiene, psychosocial (psychiatric) rehabilitation, empowerment and recovery models, she concludes that the medical model remains most persistent—and powerful. Others have suggested that reasons for this include: recent advances in genetics, the neurosciences and pharmacology based on the “ascendancy of the natural sciences in contributing to understanding of the body and behaviour…and the predominance of genetic and biochemical understandings of mental disorder” (Busfield, 2000, p.543); efforts to establish psychiatry as a strictly medical field by establishing diagnostic standards and alliances with various bio-medical allies to provide “hard science” evidence for disorders defined as a biological problem demanding medical expertise and somatic intervention” (Pearlin et al., 2007, p. 42); and psychopharmacology as the appropriate means of medical intervention, which has scientific and lay acceptance due to the effectiveness of various psychotropic medications in

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9 Recovery discourse rejects the notion that those with mental illnesses can never be ‘well’, claiming instead that with self-care, pharmacology, choice and hope, clinical trajectories can be improved and lives reclaimed for more productive ends (Poole, 2007, p. ii).
conjunction with the actions taken by psychiatry to formalize diagnostic criteria to enhance its scientific base within medicine (Aneshensel & Phelan, 1999).

It is not surprising then that the “broken brain” metaphor is used to describe how to think, talk about and “do” mental health and illness. For example, in Poole’s (2007) research the “broken brain” is used by one key informant to explain why it is “just so much easier” to think about mental health issues as just having “to find the right cure or pill” (p. 50). Moreover, the rise of “Big Pharma”, and the thinking supported by the “broken brain” image are mutually reinforcing. Another informant linked what she described as the rise and supremacy of the broken brain at her health care institution to the high level of funding they had received from pharmaceutical companies. Poole (2007) posits that while recovery discourses may challenge the medical model’s emphasis on the chronicity and incurability of mental illness, in other ways, and at a more local level, it may actually reinforce the model:

…we still feel the presence of a decidedly biomedical approach to how mental health is thought about and done. That approach is threaded through psychiatry, evidence-based medicine, ‘Big Pharma’ and ‘broken brain’ thinking. With the results suggesting the biomedical is only becoming more powerful at local organizations like the Centre for Addiction and Mental Health (although no one talks about it)...it becomes clear that the so-called challenge of recovery and its local discourses have not slowed that growth. (Poole, 2007, p. 218).

Speaking of illnesses more generally, Freund and colleagues (2003) describe the “machine metaphor” as an implicit assumption of the medical model–the “broken brain” extends this concept in talk about mental illness by locating the malfunction in this particular part of the body, and the “fix” as the purview of psychiatry, the medical specialization that focuses its work here:

Accordingly, the body is a complex biomedical machine, and disease is the malfunctioning of some constituent mechanism (such as a “breakdown” of the heart)….Modern medicine has not only retained the metaphor of the machine but also extended it by developing specializations along the lines of the machine but emphasizing individual systems or organs to the exclusion of an image of the totality of the body. The machine metaphor further encouraged an instrumentalist approach to the body: the physician could “repair” one part in isolation from the rest (pp. 6; 222).

In sum, despite the acknowledgement that other factors play a part in the development of mental illnesses, it is the brain, the “final common pathway” for controlling individual behaviours, thoughts and feelings that is the primary focus for managing mental illnesses. In the next section I describe how contemporary discourses have formulated ideas about the prevention of illness, and the maintenance of mental health.
Preventing illness/ maintaining health

The social determinants of health are talked about pervasively now in the field of mental health and illness. This phrase refers to those factors that are said to determine or promote and maintain mental health, and prevent future illness (Centre for Addiction & Mental Health, 2009\textsuperscript{10}; PHAC, 2009). Building on the principles of the Ottawa Charter for Health Promotion (WHO, 1986), subsequent efforts to develop specific mental health promotion (MHP) policy and practice take a population health approach (Robertson, 1998). This approach targets the entire population using public health, community health, and health promotion strategies (CAMH, 2009). A 1996 international workshop at University of Toronto’s Centre for Health Promotion, held in partnership with the Mental Health Promotion Unit of Health Canada, defined MHP as: “the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health” (CAMH, 2009). As the following excerpts indicate, individual and system-level interventions are consistent with current definitions of MHP in relation to the social/psychological determinants of mental health and illness:

At the level of the individual, such factors as secure attachment, good parenting, friendship and social support, meaningful employment and social roles, adequate income, physical activity, and an internal locus of control will strengthen mental health and, indirectly, reduce the impact or incidence of some mental health problems.

At a system level, strategies that create supportive environments, strengthen community action, develop personal skills and reorient health services can help to ensure that the population has some control over the psychological and social determinants of mental health (PHAC, 2009).

To state what may be obvious at this point, mental health promotion discourse redirects attention to issues of health rather than illness. The discourse concerns cognitive and/or emotional “well being”, not just the absence of mental disorder (Canadian Alliance on Mental Health & Mental Illness, 2008\textsuperscript{11}; CAMH, 2009). As a result a kind of “hyphenated-talk” has evolved to refer to the bio-psycho-social approaches to mental health—that signals an emphasis on the social and psychological, as well as biological aspects of illness, where medical/clinical perspectives are considered only “one piece of the picture” (PHAC, 2005\textsuperscript{12}).


countervailing discourse to the biomedical version of illness, mental health promotion does not regard body and brain pathology as the sole cause and/or expression of mental illnesses. The social causes of illness and the experience of the ill individual is given greater priority, and as argued in the following excerpt, biological mechanisms are understood to be important because they are triggered and shaped by “life conditions”:

...an uncritical embrace of mechanical biological causation is beginning to weaken....evidence is likely to accumulate that expression of genetic and other biological dispositions in mental disorder, to the extent that they exist at all, depends on exposure to stressful life conditions....Whatever the inherent biological dispositions of the species may be, their activation and expression is shaped by their social and experiential milieu. (emphasis added, Pearlin et al., 2007, p. 48).

The discourse, and resulting social practices highlight the concept of stress as something brought about by the conditions of everyday life. In that stress is ubiquitous, in health promotion texts no one can be exempted from taking care of their own mental health. For example, a recent publication by the Canadian Mental Health Association (CMHA), Take Control of Stress (2009) describes stress as a “fact of life” and defines it broadly as, “any change that we have to adapt to”. Taking control of stress in everyday situations is different when it becomes chronic, and here the association with mental illness is more keenly drawn even though ‘the link’ between stress and mental illness is not fully understood. Chronic stress is described as having a “debilitating effect on our overall health” because it can produce physical, emotional and cognitive ill effects (CMHA, 2009). The following excerpt describes the totalizing effects of stress:

Physically it can contribute to migraines, ulcers...more than doubles the risk of heart attacks....Persistent stress also affects us emotionally and intellectually and can cause decreased concentration and memory, confusion, loss of a sense of humour, anxiety, anger, irritability, fear....the link between stress and mental illness is yet to be fully understood, but it is known that stress can negatively affect an episode of mental illness (CMHA, 2009).

Learning how to manage stress is considered important and is reflected in the concept of “taking control”. Individuals are implored to recognize the signs of stress so they know what to take control of as stress depicted in this CMHA (2009) document, is more like the biomedical view of illness because the problem inheres within us. Once individuals have recognized the signs of stress they must learn how to manage their negative thoughts (including those about external life events), by changing how they think and talk about it. Most importantly, learning how to “share
“troubles” may help individuals feel that they are “not alone”. These ideas are expressed more fully, and prescriptively, in the following excerpt from the CMHA (2009) document:

…much of our stress comes from within us. How we interpret things – a conversation, a performance review, even a look – determines whether something becomes a stressor. Negative self-talk, where we focus on self-criticism and pessimistic over-analysis can turn an innocent remark into a major source of stress….external stressors, like bereavement or career changes, can be managed over time with the support of family and friends. Internal stressors, caused by our own negative interpretation, require changes in attitude and behaviour….Talk about it, share your troubles with a friend, it may help you put things in perspective and to feel that you are not alone. You may also learn some other ways to manage stress (CMHA, 2009).

This idea of control is important because mental health promotion discourse is premised on two central concepts that distinguish it from overall health promotion: that is, power and resilience (CAMH, 2009). Power is connected to the idea of taking control, or learning mastery over one’s life and also to the idea of resilience, as having power/control over adversity, with its implications for present as well as future well-being. These ideas are presented in the following quote from a Health Canada document posted on the website of the Centre for Addiction and Mental Health as follows:

Power is defined as a person’s or a group’s or a community’s sense of control over life and the ability to be resilient (Joubert & Raeburn, 1998). Building on one’s existing capacities can increase power and control. Resilience has been defined as “the ability to manage or cope with significant adversity or stress in ways that are not only effective, but may result in an increased ability to respond to future adversity (Health Canada, 2000, p.8, in CAMH, 2009).

Resilience, recovery or the ability to “come back”, as it is described in a mental health promotion campaign, is influenced by factors that determine whether the person (or community) is either ‘at risk’ or ‘protected’ from adversity. Risk factors can be ‘in’ or ‘outside’ the individual (or community) and have an impact not just on the health of the individual, but on everyone in the community, as described in the following excerpt taken from the Centre for Addiction and Mental Health website:

Resilience is influenced by risk factors and protective factors….Risk factors are variables or characteristics associated with an individual that make it more likely that he or she will develop a problem (Mrazek & Haggerty, 1994). Risk factors can be biological or psychosocial, and may reside within a person, his or her family or social network, or the community or institutions that surround the person. They occur in innumerable contexts, including perinatal influences, family relationships, schools, and workplaces, interpersonal relationships, media influences…. (and have impact on) the physical health
of the individual and the physical, social and economic “health” of the community…. (CAMH, 2009).

Protective factors are the mirror image of those that put individuals and communities “at risk”. However, they are also couched in talk about stress and emotional well-being, and the language of coping with everyday life and/or “dealing with” stressful situations:

…protective factors buffer a person “in the face of adversity and moderate…the impact of stress on social and emotional well being, thereby reducing the likelihood [that] disorders will develop [CDHAC, 2000, p. 13]. Protective factors may be internal (e.g. temperament, cognitive abilities) or external (e.g. social, economic or environmental supports). They enable a person to protect his or her emotional and social wellbeing and cope with everyday life events (whether positive or negative). Protective factors act as a buffer against stress and may be drawn upon in dealing with stressful situations (CAMH, 2009).

Resilience can be improved by helping individuals to develop better coping skills, thereby reducing risk, and promoting those things that are protective. However, better coping skills are premised upon an underlying idea of “belief in oneself”; having “control over what happens”; and being able to “give deeper meaning to the situation” (CAMH, 2009). In the following quote from the CAMH website, resilience is used as adjective to describe particular kinds of “children” and “young people” who cope better because they perceive themselves to have control, and can attribute “deeper” meaning to their difficulties:

Some research suggests…resilience can be enhanced by improving his/her coping skills, reducing risk and improving protective factors….Resilient children and young people believe they can cope with adverse events because they have some control over what happens and are able to give deeper meaning to the adverse event (Silliman, 1994, in CAMH, 2009).

In summary, I have described the dominant ways of thinking and talking about mental health and illness in Canada today. Discourses shaped the design and execution of the Children’s Group I studied. Mental “health” and “illness” are mutually constituting and reinforcing discourses; hence, I referred to mental health/illness as a sub-heading for this section. People are encouraged to be and stay mentally healthy by redirecting their attention away from the problem of illness—symptoms of underlying, individual pathology signified by the “broken brain”—, toward the notion of cognitive and emotional “well being”, and the power of “positive thinking”. Individuals are implored to be responsible for learning to recognize signs of stress as a first step in taking control over and responsibility for their mental health. Discourses postulate that without proper management, chronic stress can produce physical, emotional and cognitive ill
effects. Over time, this can develop into a mental illness, although the link between mental health and illness is currently considered not well understood.

**Contemporary discourses about children**

In Canada, as in most European and North American countries, children are cast as those who have not yet reached puberty, or the “age of majority”. Accordingly, a child is a human being who is not yet able to reproduce sexually, or is someone who is legally considered a “minor”, which is currently 18 years of age. The way we think and talk about children is usually based on chronological age, and/or a particular stage of human, biological development based on scientific ideas about maturation of the physically changing body. Decisions about who is considered a child depend upon the particular social practices, that is the institutional and organizational arrangements and circumstances, which dictate this to be the case. Discourses about how we think and talk about children vary then across time, place and culture. For example, age criteria for decision-making about compulsory education, employment, marriage and military involvement is used in different ways in Canada. The age at which children are considered responsible for themselves or their actions varies, and in Canada today it is possible to find references in both popular and scholarly presses that show how the standards for defining childhood, and its status as one of dependency, are in flux with a myriad of concomitant legal, medical and social implications.

However, defining what it means to be a child tells us something also about what it means to be an adult and how social relations between these ways of being in the world, are expected to play out. The following excerpt describes dominant ways of thinking about children and childhood as a particular time in human life in which protection is emphasized primarily because of a concern with what the child will become—that is, with an adult future:

Dominant perceptions of childhood in Europe and North American cultures can be summarized as follows: childhood is ascribed special meaning as a phase in human life; *the child is surrounded with care and concern* which endeavour to prepare and protect the child; at the same time these perceptions attribute value to childhood and the child mostly in relation to *a future adult life* through the status of ‘non-adult’; the child is more valued as a being in process, that is, being socialized towards a goal through which to take his or her place in society, than in his or her present state…. (emphasis added, Christensen & Prout, 2005, p. 45).

A recent Ontario government policy document provides a good example of the forgoing description of childhood as a particular, preparatory stage of human development. By implication, it also shows that adults are required to care for and protect children so that they can
attain future adult status. *Realizing Potential: Our Children, Our Youth, Our Future (2008)*\(^\text{13}\), is described as a “strategic framework” created by the newly formed Ministry of Children and Youth Services (MCYS) to envision “an Ontario where all children and youth have the best opportunity to succeed and reach their full potential” (p. 2). The “strategic goals articulated in the framework are for continuous improvement that encompasses the entire children and youth service system form policy development and program design through to program management and frontline service delivery” (p. 3). The MCYS is an amalgamation of programs and services for children and youth formerly organized across the Ministries of Community and Social Services, Health and Long-Term Care, and Community Safety and Correctional Services. Among the services and programs provided, those most salient to this discussion are: early identification and intervention services; child and youth mental health supports; and, protection services. The strategic framework describes a “Ministry Vision” based on a developmental model of childhood need, where the ultimate goal of the combined efforts of social, health and correctional services is geared toward the ongoing production of (future) productive adults as described in the following quote:

> In 2003, The Ministry of Children and Youth Services (Ontario) was created to make it easier for families to find the services to give kids the best start in life, make it easier for families to access the services they need at all stages of a child’s development, and help youth become productive adults.\(^\text{14}\) (emphasis added)

The language used in the document’s title suggests that children and youth possess untapped, hidden or latent possibilities, but that they must be made apparent, or brought to fruition. Moreover, children and youth are cast as “ours”, implying a kind of communal responsibility for young people because they represent “our” future. A core principle guiding these services is that they must be “developmentally appropriate”, and the action plan describes children and “youth” along a continuum of stages from birth to early and middle years, adolescence, and finally, the “transition to adulthood” (p. 3). Two strategic goals articulated in the framework argue that, “every child and youth has a voice” and, “every child and youth is resilient” (p. 5). First, clients (children and “youth”, as well as families) are described here as “users of services” who can “provide a valuable perspective and play a key role in identifying and supporting service improvements”, and “influence how the services they receive are designed and delivered” (p. 8). However, while the strategic direction to create opportunities to involve clients in program

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\(^{13}\) [http://www.gov.on.ca/children/graphics/244264.pdf]

\(^{14}\) [http://www.children.gov.on.ca/htdocs/English/about/index.aspx]
design, implementation, delivery and assessment may be laudable, as the following quote illustrates, in order to participate, young people must learn to develop competencies that are assumed lacking, and they are not considered decision makers in their own right:

To meaningfully participate in discussions related to policy development and program design, clients must have key competencies. Accordingly, as an element of increasing client engagement in decision making, we will work with children and youth to help develop and enhance their leadership skills. (p. 8).

Second, resilience is used in a way that is reminiscent of the mental health and illness discourses described previously. Resilience is defined as, “the capacity that allows people to adapt and persevere in the face of adversity” (p. 11). However, because the focus here is on young people, the developmental model of childhood is brought into play in this description of resilience as something inhering in the individual child, who is able to respond positively, make successful transitions “through life”, and have better overall outcomes. In the following quote resilience is also talked about as being implicitly about the “at risk” child, for whom this vision is “particularly important”.

It is a prerequisite for making successful transitions through life because it enables young people to overcome challenges, manage difficult issues and reach out to new opportunities. Resilient individuals have better schooling, health and social outcomes. Although early childhood is a crucial window of opportunity, research situates the building of resilience along a continuum that applies to all ages and stages of development. Because it equips young people to respond to challenges in a positive way, resilience is particularly important to young people in our child protection and youth justice service systems (p. 11).

Finally, resilience is not only conceptualized as a priority for all young people but the emphasis is on moving beyond current “issues” in young people’s lives to “prevention-focused services” where the idea is that they will develop “strengths and assets” to avoid more intensive services or “break the cycles of behaviours that led to a need for intensive services in the first place” (p. 11).

In summary, current discourses about children and childhood, which together with discourses about mental health and illness, framed the portrayal of information in the *Children’s Group* I observed. Discourses about children, as conveyed in the provincial government document examined briefly here, and those promoting mental health, were linked through a mutual focus on the concept of resilience as: mastering adversity by building on one’s existing capacities and attending to risk and protective factors; through individual and system-level interventions; and with an eye to developing and implementing prevention-focused services that would ensure future well-being for “all”. These discursive practices encouraged individuals to
be and stay mentally healthy by redirecting their attention away from the problem of illness—
symptoms of underlying, individual pathology signified by the “broken brain”—, toward
resilience, and the notion of cognitive and emotional “well being”. But first, they had to learn to
recognize signs of stress, and take control over and responsibility for their mental health;
because without proper management, chronic stress was thought to produce physical, emotional
and cognitive ill effects. Furthermore, adults were tasked with protecting children by teaching,
encouraging, and promoting these ideas, particularly with “at risk” children.

My examination of these contemporary discourses constitutes a starting point for what
became my critical discourse analysis of the support group program manual, which I considered
a script for the Children’s Group 8-week performance. In the next section, I describe four
dramaturgical principles of social interaction (Goffman, 1959) to cast the Children’s Group
meetings metaphorically as performance.

**Four Core Dramaturgical Components**

Shared staging problems; concern for the way things appear; warranted and unwarranted
feelings of shame; ambivalence about oneself and one’s audience; these are some of the
dramaturgic elements of the human situation. (Goffman, 1959, p. 237)

The components most salient to my dramaturgical study of the Children’s Group include: the
performers, the stage/setting, the performance and the arts of impression management.

**The performers**

The Children’s Group is comprised of a cast, or group of individuals, upon which the
performance depends. The cast must work cooperatively to define the situation before them. The
term social actor refers to individuals who take part in social action with a focus on their
qualities, feelings, intentions and understandings, and on the social constraints (including other
actors) acting on the individual (Abercrombie, Hill, & Turner, 2006). Dramaturgically however,
it is not just the individual but rather the collective, whose coming together in face-to-face
interaction that is of foremost concern, as Goffman (1959) emphasized in the following excerpt:

…the definition of the situation projected by a particular participant is an integral part of
a projection that is fostered and sustained by the intimate cooperation of more than one
participant… (and) it is often the case that each member of such a troupe or cast of
players may be required to appear in a different light if the team’s overall effect is to be
satisfactory (p. 79).
Goffman (1959) uses the concepts of reciprocal dependence and familiarity to describe how performers sustain and support cooperation. Performers depend on one another, even where there are social cleavages, because they become accomplices in how things appear to others. This requires a kind of closeness, a familiarity that is however, an ‘intimacy without warmth’, which helps to foster a satisfactory, overall effect that will maintain a collective agreement about how the situation is defined (Goffman, 1959).

An important question then, is to whom is the overall effect being addressed so that the definition of the situation is sustained? Goffman (1959) was interested in dramatic interaction. He focused on dialogue between performers, rather than on singular voices belonging to individuals, or even individual teams. A more useful analytic than that suggested by theatre performers and their audiences, is to think of a team of performers *who put on the show*, while the other team, *puts on a show in response*. Consequently, Goffman (1959) emphasized interaction and dialogue when he described studying people encountering one another in actual settings. As suggested by the following example, it is as if the performers, acting in consort, constitute a single voice represented by a “team” who participates in the interaction and dialogue:

Now when we study concrete social establishments, we often find that there will be a significant sense in which all the remaining participants, in their several performances of response to a team-show put on before them, will themselves constitute a team. Since each team will be playing through its routine for the other, *one may speak of dramatic interaction, not dramatic action, and we can see this interaction not as a medley of as many voices as there are participants but rather as a kind of dialogue and interplay between two teams*…whatever the number of teams, there will be a sense in which the *interaction can be analyzed in terms of the co-operative effort of all participants* to maintain a working consensus (emphasis added, pp. 91-92).

Goffman’s (1959) “working consensus” refers to a level of agreement in which all participants play a part in contributing to a provisional definition of the situation, where certain claims are privileged over others, and conformity trumps any display of explicit inconsistency:

…there is a kind of definitional division of labour….not so much a real agreement as to what exists but rather a real agreement as to whose claims concerning what issues will be temporarily honoured. Real agreement will also exist concerning the desirability of avoiding open conflict of definitions of the situation (Goffman, 1959. pgs. 9-10).

However, interaction is also a matter of *strategic* achievement, as members of a team are likely to be concerned with the show they put on for one another, whether an audience is present in the flesh or not. The performers recognize what Goffman described as a ‘mutual fatefulness’ and
therefore, act with “a calculative awareness of the interdependence of outcomes” (Goffman, 1969 in Lemert & Branaman, 1997, p. 144):

In every social situation we can find a sense in which one participant will be an observer with something to gain from assessing expressions, and another will be a subject with something to gain from manipulating this process…. Courses of action or moves will then be made in the light of one’s thoughts about the others’ thoughts about oneself. An exchange of moves made on the basis of this kind of orientation to self and others can be called strategic interaction (Goffman, 1969 in Lemert & Branaman, 1997, p. 143).

While it may be arbitrary as to which team puts on the show and the show in response, in order to more fully understand dramatic interaction one should also consider: how the social setting in which the interaction occurs is assembled and managed, who contributes more activity to the interaction or plays the dramatically prominent part in it, and sets the pace and direction which both teams follow in their interactive dialogue (Goffman, 1959, p. 101). As described earlier, these ideas speak to power as a significant component of dramaturgical interaction in Goffman’s work, particularly if we consider strategic interaction as highlighted here in reference to opponents who use mutual assessment and enumeration, and manipulate the process in order to gain something.

Finally, performers are also said to play to unseen audiences. Even when alone individuals can interact with imagined others (Hollander & Gordon, 2006). The individual may be taken in by her or his own act, both performing and observing their own show. This is reminiscent of Mead’s (1934) concept of ‘self-interaction’ as a kind of rehearsal for future action with others. As described earlier, individuals anticipate what others will think and do, and draw on their comprehensive knowledge about others’ expectations to respond to the situation. This process has been described as drawing on knowledge of a ‘generalized other’ in which the individual internalizes a set of social norms, values and expectations (Mead, 1934) that are reflected in discourses. A critical dramaturgical view also posits that the power to define knowledge of the generalized other rests with dominant individuals and institutions that generate what may become internalized as norms and values (Wallace & Wolf, 1999).

The stage/setting

In order to more fully explicate the nature of face-to-face interaction Goffman (1959) formulated a second principle stipulating that performances depend upon the segregation of social space into regions. It is important to consider an analysis of the social setting in which the interaction occurs and how it is assembled and managed by the performers. The front region (or
stage), is where the performance is given, and standards are maintained. These standards or social definitions, norms and values that apply to this situation can be thought of as the script that is given and responded to in particular performances\textsuperscript{15}. Back regions are places where impressions fostered by the performance may be knowingly contradicted. In my study, I focus on the front/stage, particularly as a social setting in which the interaction occurs, how it comes together, and is managed by the performers. However, according to Goffman (1959) there is no ‘true’ backstage in most social settings because wherever more than one person is present to another, there is always a (front-of-stage) performance. Therefore, in the same way that performers can be approached analytically as both players and audiences, the stage as a social setting for interaction, may be used simultaneously as a front/back staging area. Back stages matter only if there is an audience present so that individuals may for example, try to hide contradictions in the performances they give, or step out of character. Performers who both put on a show, as well as one in response might engage in ‘self-interaction’, and/or put on a show for others who may or may not be present “in the flesh” (Goffman, 1959). Similarly, backstage activity for the management of inconsistencies may be more complex than that suggested by an arbitrary or concrete division of social space as discretely organized arenas of interaction. In sum, I considered the lines between performer and audience, and back and front stage activities to be fluid and at times, uncertain.

\textit{Performances}

Performances constitute the third component of social interaction. Performances include: a ‘front’, which refers both to the social space or staging, and to the person of the actor, and efforts made to dramatize the action. For example, Goffman (1959) used the terms, “dramatic realization” and “idealization” to describe some of these efforts that bring the performance to life.

Performances require a front, that is, a setting or scenic parts. Performers also have a “personal” front, that is, expressive features such as gender, age, size, appearance, posture, speech patterns, facial expressions, bodily gestures, clothing and so forth. Social spaces or staging include: the furniture, décor, physical layout and other background items. The front refers to the scenery and stage props that support the action performed and render it intelligible. In the theatre, a prop is an article or object used by an actor in a performance to support, that is

\textsuperscript{15} Although not a core concept in Goffman’s (1959) dramaturgical social interaction, I consider the script as a kind of discursive arrangement of norms and values, which I described earlier in the chapter.
“prop up”, and dramatize the action performed. Metaphorically, this can be used more broadly to consider how props might support something (perhaps a belief, value or norm)—that is, make dramatically “real”—in order to sustain the definition of the situation being performed. An analysis of the front and the props used as particular objects yields information about whether and how, the performance sustains a particular definition of the situation. According to Goffman (1959) fronts all have standardized equipment, that is things performers use to define situations in a generalized or fixed way, which can be applied in a any number of different acts using the same fronts. For example, a performer wearing a white lab coat may be a clinician or the “cosmetic girl”; the important thing to note is that these perform or produce generalized representations that people can understand intersubjectively in relation to the context. Two other aspects of performances include the signs used to convey meaning about an activity that may be obscured or not easily understood by other performers, which Goffman (1959) refers as ‘dramatic realization’. A second performance technique is ‘dramatic idealization’, which is the use of expressive control and coherence in a performance to incorporate and exemplify officially accredited social values, including concealing any inconsistencies.

Impression management strategies

A final dramaturgical principle of social interaction is the ‘art of impression management’. According to Goffman (1959) performers must act with “expressive responsibility to prevent the many, minor but inadvertent acts that happen to be well designed to convey impressions that are inappropriate” (p. 208). Consequently, performers require strategies that will convince others that they are behaving in accordance with the rules, the main purpose of which is to prevent disruption during interaction, particularly if it will lead to embarrassment and jeopardize the performance. Performer attributes must find expression in practices employed to save the show. Goffman described these as, dramaturgical loyalty, discipline and circumspection. Performers practice loyalty by developing team solidarity, and accepting certain moral obligations to one another. For example, they must keep team secrets, either out of self interest, principle, or simply through discretion. Loyal performers do not stage their own show, or denounce other team members. Finally, they must be willing to accept minor parts as directed by the entire team. Performers must also exercise discipline. Disciplined performers are engrossed by the activities before them, but they do not forget that they are also playing a part in the situation. They have the “presence of mind” to cover up violations or inappropriate behaviours should the situation demand it (Goffman, 1959, p. 216). Disciplined performers
show restraint in expressing emotions for the sake of the overall performance as described in the following excerpt:

He can suppress his emotional response to his private problems, to his team-mates when they make mistakes, and to the audience when they induce untoward affection or hostility in him. And he can stop himself from laughing about matters which are defined as serious and stop himself from taking seriously matters defined as humorous. In other words, he can suppress his spontaneous feelings in order to give the appearance of sticking to the affective line, the expressive status quo established by his team’s performance, for a display of proscribed affect may not only lead to improper disclosures and offence to the working consensus but may also implicitly extend to the audience the status of team member. (Goffman, 1959, pgs. 216-217).

Moreover, disciplined performers can take part in a show reassured by the trust they will have in their own performance. They have learned to act with expressive responsibility by being disciplined in practices designed to bring this about; the actor’s body is particularly significant for displaying such control over feelings that may not accord with the performance. When individuals encounter one another they want assurances that they can trust one another to convey only those impressions that are considered appropriate because they are part of the same show, as illustrated in the following example:

Perhaps the focus of dramaturgical discipline is to be found in the management of one’s face and voice....Actual affective response must be concealed and the appropriate affective response must be displayed. Teasing, it often seems, is an informal initiation device employed by a team to train and test the capacity of its new members to “take a joke”, that is, to sustain a friendly manner while perhaps not feeling it. When an individual passes such a test of expression control, whether he receives it from his new team-mates in a spirit of jest or from an unexpected necessity of playing in a serious performance, he can thereafter venture forth as a player who can trust himself (Goffman, 1959, p. 217).

Performers practice circumspection by planning in advance how to best stage a show. Dramaturgically prudent performers adapt their performances to the information conditions under which they must be staged. Information conditions refer to sources of information external to the show that will influence the interaction. This might involve the amount and type of information available to performers concerning one another. Such information may be obvious at the outset when they encounter each other, and in some cases it may be known in advance of the interaction. Information may become available during the interaction, and performers adjust their performances accordingly. Circumspect performers know that they must fashion a character out of the kinds of props and tasks that are available. Depending on the consequences that staging a show may have for performers, individuals express circumspection
in different ways. For example they may restrain or relax appearances, adjusting their performances to what is required. Circumspect performers prepare in advance for unforeseen events by: choosing loyal, disciplined team-mates; laying out the expectations for each performer in advance; and, rehearsing routines so that loyal and disciplined performers can safely practice their parts under circumstances that are manageable, particularly if inadvertent acts are to occur. For example, Goffman (1959) outlined two possible strategies in the following excerpts:

Another method is to prepare in advance for all possible expressive contingencies. One application of this strategy is to settle on a complete agenda before the event, designating who is to do what and who is to do what after that (p. 228).

A third application is to rehearse the whole routine so that the performers can become practiced in their parts and so that contingencies that were not predicted will occur under circumstances in which they can be safely attended to (p. 228).

A final point here concerns the protective practices associated with audiences who have “tactful tendencies” to help the performers save their own show. Although Goffman (1959) described these separately for the purpose of thinking about their analytic value, he stressed that defensive and protective practices were most often employed in tandem. For example, while performers may control certain aspects of the setting, others who are present will also control how they enter front or back stage areas, being careful not to intrude, and seeking permission when they want to do so. They may appear tactfully inattentive as for example when restaurant patrons take care not to appear to be listening to others conversations at nearby tables (Goffman, 1959). At other times individuals discreetly hold in check their own performances, so as not to inject too many contradictions, interruptions or demands for attention into the show. The motivation to act tactfully comes about because performers identify with one another; all performers want to avoid a scene. Individuals may also ingratiate themselves to those putting on the show for other, more exploitative reasons (Goffman, 1959). Goffman (1959) describes two further strategies concerning “tact about tact”. The first involves the performer being able to pick up on cues from others who will let them know, however discreetly, that the performance is not acceptable and must be changed if it is to be saved. The second strategy involving “tact about tact” concerns misrepresentations of the facts, which must be such that any help provided to save the show does not involve undue difficulty. The following example illustrates this second point and suggests how humour may be used to mask intentions that might otherwise be called into question:
In telling an untruth, the performer is enjoined to retain a shadow of jest in his voice so that, should he be caught out, he can disavow any claim to seriousness and say that he was only joking…the performer is enjoined to use a method that allows of an innocent excuse. (p. 234).

Finally, despite these many strategies for managing others’ impressions, and acting with expressive responsibility, performers may lose control over how others see them, especially because they lack power over the way in which the performance is framed more broadly. The consequences are quite bleak, as performers experience feelings of shame being unable to contradict such impressions, and even contributing further to the false picture others may have of them. No longer believing in the performance that they continue to give, performers may end up feeling estranged not only from themselves, but also from others:

Knowing that his audiences are capable of forming bad impressions of him, the individual may come to feel ashamed of a well-intentioned honest act merely because the context of its performance provides false impressions that are bad. Feeling this unwarranted shame, he may feel that his feelings can be seen; feeling that he is thus seen, he may feel that his appearance confirms these false conclusions concerning him. He may then add to the precariousness of his position by engaging in just those defensive manoeuvres that he would employ were he really guilty. In this way it is possible for all of us to become fleetingly for ourselves the worst person we can imagine that others might imagine us to be. And to the degree that the individual maintains a show before others that he himself does not believe, he can come to experience a special kind of alienation from self and a special kind of wariness of others. (p. 236)

In conclusion, actors are said to possess both defensive and protective attributes, and to engage in practices to manage impressions so that the show will “come off”. These strategies may be addressed to ‘real’ individuals present in the setting, or an imagined audience. Certain techniques of impression management – “learning and practicing the script”, for example – may be more difficult to explain by an obvious division of performer/audience or front/back stage as described earlier. For example, as the theatrical metaphor would suggest, scripts are learned off-stage, without an audience, in a region where performers can drop their fronts and step out of character and be themselves, without being scrutinized. On the other hand, the front region (or stage) as I have described it, is where the script is taken up, the performance is given and the standards, or discursive social definitions, norms and values are maintained. Performers who cannot easily step out of character because they are on stage and always present to one another, must learn to manage how they express themselves and respond to the performance as indicated by the script they are given.
Summary

I draw these strands together in a conceptual framing that casts child members of the Children’s Group as competent—“expressively responsible”—actors who: actively engaged in social interaction with others in the group; shaped and were shaped by this dramatic context; practiced impression management strategies to influence, manipulate and control how information was presented and expressed. Children were cast as script-following actors. They acted toward the activities of the group on the basis of the meanings that these activities had for them; moreover, meaning was developed as it was handled in, and modified through an interpretive process involving group interaction. The Children’s Group was conceptualized as a type of dramatic performance drawing on Goffman’s (1959) analyses of the reciprocal influence of individuals’ actions on one another in face-to-face encounters. From a critical dramaturgical perspective, the Children’s Group participants were also expected to conform to behavioural expectations of the setting, itself framed by broader arenas of interaction in which shared institutionalized meanings govern (often idealized) presentations of self. The Children’s Group program manual, the text used by the adult facilitators to deliver the activities of the group, functioned as a script that guided the performance. This script represented an institutionalized set of meanings, or discourses that helped to define children’s experiences and support needs when they have a parent with a mental illness. I examined how discursive assumptions were made meaningful and consequential during interaction in the Children’s Group performance, and how children responded to these assumptions.

I used a critical dramaturgical approach, and discourse analytic techniques to examine how: 1. the support group affected children’s knowledge, feelings and actions pertaining to their everyday experiences of parental mental illness; and, 2. the children responded to the program. The following research questions were used to guide the study:

Research Questions

1. How do discourses pertaining to mental health/illness, and children, frame the content of Bridges to Understanding, a program manual designed to support and educate children experiencing parental mental illness?

2. How do participants in the Children’s Group use impression management strategies to respond to discourses pertaining to mental health/illness, and children, in performances scripted by Bridges to Understanding?
CHAPTER THREE: RESEARCH DESIGN AND METHODS
The purpose of this study was to examine how: 1. the support group affected children’s knowledge, feelings and actions pertaining to the everyday life experiences of parental mental illness; and, 2. the children responded to the program. To these ends I conducted a focused ethnographic case study of the Children’s Group. My three-stage, iterative process included: 1. a critical discourse analysis of the program manual, Bridges to Understanding (BTU); 2. participant observation of participants’ interactions during the eight-week program; and 3. children’s evaluation of the program in a separate, group interview during the last session of the program. Ethnographic research was considered particularly suitable because it is consistent with viewing children as individuals who can be studied as competent interpreters of the world; facilitates engagement between adult researchers and children; and requires researchers to appreciate the ways and degree to which children shape their social worlds and are shaped by them (Emond, 2005; James, Jenks, & Prout, 1998). 

Focused ethnographies are a distinctive kind of qualitative inquiry that involve observation sessions in a compressed period of time for intensive data collection (Knoblauch, 2005). Ethnographies are both processes and products, and are ultimately a theorized account of cases studied (Delamont, 2004). Case studies explore bounded systems, defined by the specific time and location in which they are situated (Schram, 2006; Stake, 2000), but it is possible to derive knowledge of a wider phenomenon from them (Yin, 1994, p. 44). This speaks to issues of the generalizability of findings, not as statistical representation as conventionally understood, but as a function of the regularity of the phenomena observed (Gobo, 2004, p. 453). My analysis and interpretation of data, and the subsequent, theorized account of the case based on Goffman’s (1959) concepts of social interaction—a critical dramaturgical and discursive analysis—provides a perspective which is general enough to yield insights about analogous support groups for children. Accordingly, it is hoped that findings based on an analysis of general patterns (rather than single observed events or practices) that are examples of an overall structure, will allow for comparisons between my findings and children’s responses to other group-based interventions designed to meet their needs.

16 As a research coordinator at a mental health centre I worked on two studies in partnership with the umbrella organization that sponsors the Children’s Group, led by a different executive director. I also volunteered for two years as a facilitator for a parent support group for “adult” children who had a mental illness in this organization. Consequently, I developed a working relationship with the Children’s Group program workers when they began the program in 1999/2000, when I was invited to observe the first meetings of the children’s support groups. These initial experiences contributed a great deal to the design of my study and my interest in the Children’s Group program.
The ethnographic case and sampling strategies

One, eight-week program of the support group constituted the ethnographic case. Social interactions amongst participating children and adults (the facilitators and the researcher) were observed during this time. The unit of analysis was the interaction among participants in the sessions, longitudinally over the program’s duration. On a practical level, studying children in the Children’s Group was an effective way of reaching them. As noted by many other researchers, this is a population that is hard to reach and engage. My sampling unit differed from my observational unit (i.e. the participants) because I prioritized social relations and social processes rather than individuals as is more typical in much social science research (Gobo, 2004). The advantage of this sampling strategy, which emphasized a dynamic unit of analysis, is that these types of units are easily detectable and observable and therefore, allow a more direct and deeper analysis of observable characteristics (Gobo, 2004. p. 443). This is also consistent with symbolic interactionist perspectives, and Goffman’s (1959) conceptualization of social interaction as dramaturgical. Sampling “social interaction” in this way aligns explicitly with my conceptual framing and practical aims; in this sense the sampling strategy for this study is purposive (Lincoln & Guba, 1985; Patton, 1990). It was intended that a potential benefit of this sampling strategy would be to help offset participants’ feelings of being evaluated or judged as individuals because it is designed to yield data on a range of common social interaction patterns in a particular setting rather than a detailed analysis of individual behaviours. Whether this was conveyed in practice in how I explained the study, handled observations and informal discussions and questions was not discussed with the participants however.

Sampling time and events: Following Brewer (2000), I sampled both time and events in order to describe interactions that occurred during Children’s Group sessions by eliciting data about the group’s full range of routines and activities. Accordingly, I attended all sessions of the support group during the eight-week program. Each session ran for 1.5 to 2 hours, with an additional 30 minutes at the beginning to accommodate those who arrived early. This informal half hour and breaks for snacks and physical activities were important opportunities to observe and chat informally with participants, and to observe social interaction in addition to that which occurred in the more formal part of the program. In Goffman’s (1959) terms these times and events were also opportunities to observe activities that could be considered as both front and back stage activities, as places where the lines demarcating social space, and the differences between those who put on the show and those who put on the show in response, were blurred.
Events were sampled according to the programmed activities of the group and linked the conceptual framework using an observational guide I designed (Appendix 3).

*Children’s Group characteristics and settings:* The ideal *Children’s Group* was described to me by the program staff as having up to eight children, none of whom are siblings. Although siblings are encouraged to attend separate groups, this is often impractical for the parent/caregivers and guardians responsible for bringing children to the group. Children came into the program through an intake process coordinated by the only full-time staff person working for the *Children’s Group*. This was done so that at least one person, in this case the program coordinator, had knowledge about the history of each child. Prior to the beginning of the new group sessions an “intake meeting” was scheduled between the coordinator, and the facilitators of the upcoming sessions, to review each child’s history. I was asked by the coordinator to attend this meeting, which occurred two weeks prior to the first session. The venue for the program changes for each group, depending on available space and the geographical population targeted. The *Children’s Group* operates mainly in the suburban areas of a large metropolitan area. Common settings for groups have included private, single, nondescript rooms that are part of larger office spaces, a general hospital, or a community and/or health (but not mental health) service agency. On occasion physical activities have to take place in additional hallway space, or outdoors when spaces are cramped. Each group varies depending upon the children who participated in a particular session, which could vary according to: gender; age; number of siblings (some of whom may be present in the group) and the parental disorder. Children also differ based on the gender of the ‘ill’ parent; cultural background and living arrangements (e.g., foster care; lone or two-parent families or they live in a family where there is a “well” adult present in the home). The facilitators use a standard manual to guide the activities of the group. I considered this document an important source of data and submitted it to a critical discourse analysis. Because discourse analysis involves examining why the particular text was chosen (or sampled) for analysis (Crowe, 2005) I will explain and describe this more fully in the first results chapter in my analysis of the “program script”.

**Recruitment**

*Inclusion/Exclusion criteria:* To be eligible for the study, children had to be enrolled to attend the *Children’s Group* for one full session (n=8 weekly sessions). Exclusion criteria were the same as those set for the group. Children were excluded if they were: less than 7 or more than 13 years of age; diagnosed with severe disorders (such as “severe depression or bipolar
disorders”, but not otherwise defined) or had serious behavioural problems (not defined); and/or had a parent with a temporary (i.e. drug-induced) mental health problem or a dual diagnosis (mental illness and developmental disability). Although siblings were encouraged to attend separate groups this was not always practical and children from the same family often attended the same sessions. Children also agreed to participate in a separate group interview on the final night to evaluate the program.

**Recruitment and consent procedures:** Institutional ethics approval was obtained from the Hospital for Sick Children and the University of Toronto. The Program Coordinator described the study to individuals who referred children to the program, slated for 2006. As the person responsible for educational outreach about the *Children’s Group Program*, the coordinator did an intake assessment on each referred child. She used an information script I created to convey the purpose of the study to adults referring children the program (Appendix 4). These adults were family members (often the “well” parent) or legal guardians, or professionals working with child and youth mental health and/or protection services. If the individual agreed to hear more about the study I was given permission to contact them directly. I contacted the referring individual in the manner they preferred, by telephone or email. If they were interested in the study, we agreed to meet at a mutually convenient time and place, which was most often the family home where the child lived. At this time I explained the study further to adults and children who were present, obtained written consent from the parent and/or legal guardian and assent from the child, and addressed questions. To give participants time to consider the study procedures, the potential harms and benefits and ask further questions, and not interfere with the activities of the first session, I tried to complete the recruitment and consenting process one week prior to the first group session (see Appendix 5 for consent/assent forms). Anticipating refusals the opportunity to attend a concurrent program session located in a different setting was offered. This may have been less convenient for the child and the family; however it was not ethical to exclude children from the *Children’s Group* program because of the study, this alternative was developed in conjunction with the family organization that sponsors the *Children’s Group*. However, no one who was approached refused to participate in the study. Those who agreed to participate were told that they could leave the study at any time, for any reason, however this would entail joining the concurrent session, and data collected to this point would be analyzed. The group provided a dedicated area for children to take time out of the group. This was called the Quiet Space and the children were told that I would not observe them while they were using this space.
I informed the coordinator and the two adult facilitators about the study, and provided them each with a private opportunity to ask questions. All three provided written consent to participate in the study.

Remuneration: Participants were not remunerated, however the children were given a “pizza party”, pens, and key-chains to thank them for their participation at the end of the Children’s Group program.

Data Generation Strategies

Participant observation and informal interviewing

I conducted anticipatory fieldwork during the last session of the program that occurred just before the one I studied, to pilot the observational guide (Appendix 3). Formal data collection took place in 2006. Observation was my primary method of data collection; however I also participated by making casual comments and asking questions informally during group activities. I conducted participant observation for 8 weekly sessions, 3 hours each evening from 6 p.m. when the facilitators began “dressing the stage for the performance” until 9 p.m. when the scene was dismantled. However observations of all participants, including the children, typically occurred between 6:30/7:00 p.m. until 8:30 p.m. I relied on a dialectic research strategy (Agar, 1996, p. 158), that involved both observing and inquiring into the activities and interactions of the participants (Schram, 2006). This involved talking to all participants, albeit in a less formal manner that is usually associated with individual or group interview strategies, and was participant-led wherever possible (Brewer, 2000; Delamont, 2004). I maintained a casual, conversational approach through participating in activities, conversations, or “interviewing by comment” in which I elicited information by making general, broad statements in response to events rather than asking direct questions (Snow, Zurcher, & Sjoberg, 1982). For example, in one session a participant objected vehemently to one of the books on mental illness that he had found in the “Quiet Space”. Prior to the beginning of the events scheduled for the evening, I was able to engage with him in an informal conversation about what he found so repugnant in the title of the book, which was written for children who have a mentally ill parent. I also asked him to imagine what kind of book he might write instead, and this gave me interesting insight into why he felt offended. One of the facilitators overheard this conversation and decided to incorporate it into the following week’s session so that she could have all the children imagine what kind of a book they would write for other children who might be in “similar situations”.
Information gathered in this way has been considered apposite when dealing with sensitive issues, stigmatized persons and/or activities described as “backstage” or “hidden” activities of various kinds (Roschelle & Kaufmann, 2004; Snow et al., 1982). In discussions with the facilitators of the *Children’s Group*, they agreed to work with me to raise questions for informal group discussion with the children, based on my observations and analysis; this was one example of how this worked.

However, I also agreed to avoid any “off topic” areas identified by the facilitators. I was asked not to mention the research to the children during the fifth session in which they discussed children’s fears. I had wanted to remind the participants about the study at different points over the course of the program in an—“ethics as process” (see for e.g. Grant et al., 2008)—effort not to be complacent about one-time only consenting procedures but was obligated here to defer to the facilitators’ demands. Overall, I hoped to work more with the facilitators to convey questions to the group, which would allow me to “interview” participants in a less direct manner, and in a way that complemented observations and potentially validated emerging interpretations. In reality there was not enough time to do this in a concerted or systematic way. The facilitators were operating under time constraints to deliver as much of the program content as possible, and I found it time consuming to transcribe volumes of observational data, and perform even a cursory analysis between weekly sessions. I provided all participants with my personal contact information (e.g. telephone number and e-mail address) so that they could make comments or ask questions outside of the group context, however no one did. I also created a “question box” for the participants to use in the sessions to ask questions and make comments about being part of the group, which was designed also as an opportunity to provide anonymous and potentially negative and critical feedback (Punch, 2002). It was located in the “Quiet Space”. It seemed that a number of children used the “question box” judging by the different handwriting, but it is impossible to quantify because the responses were anonymous in most cases. These comments were included in my data analysis.

**Group discussion**

I facilitated a separate discussion with the child participants only, to ask them what they liked and didn’t like about being part of the group. The discussion involved observing interaction among participants who had been together for eight weeks, which was consistent with the way I conducted the first phase of the study. Children have voiced a preference for group discussions as a research method and familiarity amongst participants who have “stuff in
“common” is considered optimal in carrying out such a discussion (Hill, 2006). Group discussions are thought to: reduce the power differential between adult researchers and child participants; allow children to achieve a level of safety and comfort amongst peers; reduce pressure on individuals to respond to every question; and provide a complex account of the beliefs, perspectives and experiences of participants as they build on interaction between participants, rather than relying on a single interview with one participant (Hennessy & Heary, 2005; Hill, 2006).

The group interview was conducted during a pizza dinner that preceded the regularly scheduled activities on the eighth and final evening of the program. Eating together created a celebratory mood. I covered the tables with parcel paper so the children could draw while we talked. This was consistent with artwork activities that they were accustomed to doing during the sessions, and seemed to relax participants, particularly once they realized they were free to draw for no purpose other than their own pleasure. I also felt that drawing provided some children with a kind of “cover” so that they could talk and comment without always having to maintain eye contact with me or the other participants, and this seemed to be the case especially when sensitive or difficult subjects were raised. The group interview was audio-taped, and I asked the children to check periodically to make sure the equipment was working, which they seemed to enjoy and take pride in because they were “helping me out”. I began the discussion with a “topic starter list”, which young people have identified as being important in group interviews (Lightfoot & Sloper, 2003). This mostly took the form of questions that were pre-written on a large sheet of paper and propped up on an easel so that they were visible to everyone in the room (Appendix 6). This also mimicked the agenda the facilitators posted each evening, so the children could have a sense of what was expected to be covered over the course of an evening. And, as had become custom by this point, individual children began asking me if they could cross questions off the list once we all agreed that the question had been sufficiently answered. I found that the participants responded more enthusiastically, and talked more, when I re-phrased questions by asking them to complete a statement. For example, instead of asking: “What will you miss about coming to the group?” I reformulated it to read, “Next week when I don’t come to the group anymore, the thing I’m going to miss is…..” and the children filled the missing information according to their own beliefs, opinions etc. They seemed very excited by this shift in how they were questioned, and I wondered if it seemed more like a challenge, almost like a game. At the end of the group discussion participants were given an opportunity to respond privately and anonymously, using a form I had developed for this purpose. I made the
form colourful, decorated it with an enormous “speech bubble” and asked them to answer one last question by completing the follow phrase: “Other things I think about this group are….” (Appendix 7).

**The program manual and other documents**

While I have described CDA as part of the conceptual framing of this study I actually decided to do this only after I had completed participant observation and informal interviewing. During a preliminary phase of analysis using these data, I began to ask myself what might constitute a “script” for the observations I was thinking about as a performance. Although I had clear dramaturgical concepts to help guide the observations and subsequent analysis, I could not account for questions I had related to expectations about this performance, without thinking about them as a kind of script, a logical extension of an extended dramaturgical metaphor I was using to examine interaction. As a matter of course I had already incorporated text from the program manual into my fieldnotes. I was using it as background information for my weekly observations so that I would come prepared each evening knowing what the facilitators planned to do.

At this point I returned to my conceptual framing, research questions and study goals to consider this new dimension. As a result I incorporated CDA into my methods. This allowed me to articulate the idea that the *Children’s Group* performance was guided by a *script*, the standards and social definitions, norms and values that applied to this particular situation. I became interested in the language and text that constituted this *script* as a form of discourse, constructing how participants should think and feel about themselves and others, as well as how they should act in relation to this (Crowe, 2005, p. 56), and I developed CDA as a strategy to examine some of the taken for granted assumptions about mental health and illness and children in the program. As an interpretive process CDA fit nicely with my overall approach, and although multiple interpretations are always possible the CDA was rigorously supported by the conceptual framing, which provided the basis for the interpretation I propose in the thesis.\(^\text{17}\)

Following Wolcott (2005), I included other sources of data gathered during the fieldwork, which included: public documents used to develop community awareness of the program, and other publications associated with the group; copies of the children’s art-work produced during group sessions; and a collective letter written to the in-coming group of children

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\(^{17}\) A detailed description of the *Children’s Group* program manual is provided in the next chapter in which I present results of my critical discourse analysis.
by current participants. I anticipated that these documents would be important in several respects. For example, the public education documents and handouts helped me to think about the goals of the *Children’s Group* differently from the way they were conceptualized in the program manual. The children’s drawings, produced during the regularly scheduled program activities, became an alternative way of examining participants’ responses to the program that didn’t involve “talk”. Moreover, the artwork was used to both “show and tell” children’s experiences during the performance, and this became another source of data. Nothing further was asked of the child participants in regards to the collection of documents or any other forms of data for this project outside of my observations, informal discussions with the participants, and access to the artwork and documents produced during the course of the group.

**Data recording**

*Fieldnotes and reflexive notes*: Field observations constituted the primary data for this study; they are considered a central method of participant-observation-based ethnography (Delamont, 2004; Emerson, Fretz, & Shaw, 2001; Wolfinger, 2002). Fieldnotes can fix these accounts, no matter how ‘partial’, in examinable forms that may be read, considered, selected and rewritten in order to produce an ethnographic analysis (Emerson et al., 2001, p. 365). Fieldnotes were produced in the setting and described participants, settings, interactions, talk, documents, personal experiences, and observed events. I sat as unobtrusively as possible near the discussion and the action, so that I could observe and take notes without disrupting the routine set by the facilitators and children. Sometimes I was asked to participate in activities, and I did so when it would have drawn too much attention to me to refuse. I also participated in those activities where appropriate, meaning that they were not associated with having a parent with a mental illness, such as, competing in a liquorice eating contest, just for fun. Other activities were more pointed and will be described in the results chapters. I chose to work more as observer than participant because the formal, didactic teaching style used by the facilitators afforded such a role. This made recording written notes quite unobtrusive, meaning that it did not interrupt the action or make the research too obvious, at least as far as I was aware. As neither a child participant, nor facilitator I didn’t want the children to see me as they saw the other adults. I wanted them to feel that they could talk with me about the program more easily as an outsider. I found it amusing in one of the later sessions when a child named me, “Seen but not Heard” as she named each of us, indicating where we were to sit, having been given a rare opportunity to do so by the facilitators. I also played a cat-and-mouse game with one of the boys...
who liked to “pretend” he was trying to read my notes. He seemed to be teasing me, and to have
fun, but I also wondered whether he or others were curious about what I was writing. Another
boy seemed incredulous that I would “write all this stuff down”. I was secretly glad that my own
handwriting was atrocious because there was no danger anyone could decipher my jottings. I
was particularly concerned about keeping confidentiality in the setting as I recorded what
children said, and what they did in response to teachings and activities.

I recorded the time, date, location and other exigencies and circumstances involved in any
instances of the group (Brewer, 2000). I tried to capture short but complete vignettes of
observed activity and conversational exchanges in enough detail to allow me to report directly
from my notes, verbatim (Wolcott, 2005). I wrote approximately twenty pages of single-spaced,
handwritten notes based on my observations of each session, for a total of approximately 160
pages. I elaborated further on these notes when I left the “field” each evening, and during the
transcription phase. Fieldnotes were recorded during the consent process, the intake meeting, a
meeting to discuss facilitators’ feedback to the referrers 6 weeks after the last session of the
group, and following the focused group discussion I had with the children, which was audio-
taped and transcribed verbatim. The final data set includes a detailed description of the
ethnographic case and the Children’s Group program manual, including relevant demographic
characteristics related to the participants (see Appendix 8). The program coordinator agreed to
fill in this form for every participant, providing me only with the information pertinent to this
study.

I also audio-taped my thoughts prior to and after each session in the field as a kind of “out-
of-the-field diary”; I used these records to note emerging trends, hunches, and insights and ideas,
and to keep an account of data related to decision-making, methodological details and day-to-day
activities relevant to the study from its inception (Delamont, 2004, p. 225). This reflective
method also helped me to attend to my own processes as an observer (see for e.g., Delamont,
2004; Wolcott, 2005). Reflexive notes also included personal reactions, or thoughts that may not
make it into any permanent written record of the study, but helped to recapture important aspects
of the overall observations made (Wolcott, 2005). Finally, I recorded ideas as they emerged in
the setting over the course of time. I began writing reflective, analytic memos early, coupling
analysis with observations in an iterative process that provided the means for developing and
working through new conceptual connections and analytic understandings (Emerson et al., 2001,
p. 355).
Photographic fieldnotes: I used a digital camera to photograph the setting, and some of the activities conducted in the group. For example, although I was given copies of the children’s artwork at the end of the sessions, I was able to photograph them, which meant I could use them as data in my preliminary and emerging analysis early in the process. These photographic fieldnotes also proved to be valuable in ways I did not initially anticipate. For example, there was a disagreement in one of the sessions between a facilitator and a participant over what had been said the week prior, but when I examined a photo of her artwork it became apparent that the participant had in fact said what she claimed, but in words that appeared in her drawing. In this way photographic fieldnotes can also be said to fix these accounts, no matter how ‘partial’, in examinable forms that may be read, considered, selected and rewritten in order to produce an ethnographic analysis (Emerson et al., 2001, p. 365). I did not photograph any participants.

Data Management

Transcription, scene summaries and dialogic scripts

All fieldnotes based on my observations and reflexive notes were fully transcribed from a handwritten format into an electronic format for data management using a qualitative software package (QSR NVivo 2.0, 2002). Following Miles and Huberman (1994) I developed a more specific data management strategy in alignment with the study purposes. The first two steps, data reduction and display, involved transcribing and translating “raw” data—handwritten field notes, photographs, drawings and so forth—into a manageable format. I used a digital format so that data could be managed electronically. To reduce and display the data I began by constructing descriptive summaries for each of the eight sessions. Summaries were useful to check my emerging analysis against when dealing with enormous amounts of data. I considered each session a dramatic scene, comprised of two acts, using dramaturgical concepts to organize the summaries—so for example, session one became Act 1, Sc. 1, and session 7 became, Act 2, Sc. 7. This process helped me to think about the data dramaturgically. In order to aid the analysis of social interaction I developed a system for transcribing fieldnotes into a ‘dialogic’ format. The observational data—the handwritten notes already transcribed into a digital format—were further transformed to reflect what participants said to each other, and what they did together. The observational data transcripts then resembled a theatrical script, allowing me to follow how participants responded to one another verbally, and what they did with each other during other non-verbal activities. These dramatic (re)workings of the observational data
included text that would function much like the stage directions in a play indicating scenery, props, and all the background information necessary to perform the action of the scene. Moreover, these (trans)scripts resembled those produced using focus group methods, and shared the same potential to look at dramatic interaction between participants, thus enabling me to move beyond simplistic analyses of data (Kitzinger, 1994). Finally, I transcribed the audio-taped group interview into a textual electronic format.

**Analytic Strategies**

**Thematic analysis**

Consistent with my critical dramaturgical stance and research questions, I conducted an interpretive thematic analysis aimed at revealing latent levels of analysis. This involved a progression from a description of the data—organized to show patterns in the semantic content—to an interpretation, where underlying ideas, assumptions, and conceptualizations are identified and theorized as shaping or informing the semantic content (Braun & Clarke, 2006, p. 84). Analytic practices of this kind recognize the interdependence of conceptual and theoretical thinking, and empirical observation (Bulmer, 1979). Consequently, a coding schema derived from the conceptual framing governed the analysis and interpretation of the data. The coding schema included dramaturgical concepts of social interaction (Appendix 3), as well as indigenous terms and categories of participants as they emerged from the data. I followed a classic set of coding strategies for qualitative thematic analysis as outlined by Braun and Clarke (2006) and described here as follows: 1. I familiarized myself with all the data by transcribing, reading and re-reading them, and keeping track of initial and emergent ideas (using extensive memo-writing); 2. I generated initial codes by labelling interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code; 3. I searched for themes by collating codes into potential groupings, gathering all the relevant data; 4. I reviewed these groupings, checking to see if they were consistent with coded extracts (Level 1), and the entire data set (Level 2), generating thematic ‘maps’ of the analysis (see for e.g. Appendix 9); 5. I (re)defined and (re)named themes to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme; and 6. I produced a written account, selecting compelling extracts, exemplars, and relating the analysis to the research questions and relevant research literature (p. 87).
Critical discourse analysis (CDA)

I hypothesized that discourse(s) pertaining to mental health/illness, and children would be manifested in the program manual. First, I describe the general tenets of discourse analysis before I detail the approach taken in a critical discourse analysis (CDA). Discourse analysis always pertains to texts—both written and spoken—and involves an interpretation of the way language functions in a given context (Smith & Gallo, 2007, p. 60). Fairclough (1992) describes three interrelated objects of discourse analysis, which include the text, and the discursive and social practices associated with the text:

Any discursive ‘event’ (i.e. any instance of discourse) is seen as being simultaneously a piece of text, an instance of discursive practice, and an instance of social practice. The ‘text’ dimension attends to language analysis of texts. The ‘discursive practice’ dimension, like ‘interaction’ in the ‘text-in-interaction’ view of discourse, specifies the nature of the processes of text production and interpretation, for example which types of discourse (including ‘discourse’ in the more ‘social-theoretical sense) are drawn upon and how they are combined. The ‘social practice’ dimension attends to issues of concern in social analysis such as the institutional and organizational circumstances of the discursive event and how that shapes the nature of the discursive practice, and the constitutive/constructive effects of the discourse…(p. 3-4).

Discourse analysis may focus on combinations of words and other symbolic forms, such as visual images (Fairclough, 1992). The analyst examines language to reveal underlying assumptions in argument showing how the use of metaphors, rhetorical strategies and visual images shape the portrayal of information (Petersen, 2001, p. 1258). Analysis involves examining how information is (re)presented in a text depending on the use of key words, phrases, themes, metaphors and analogies. Furthermore, words, objects and images are examined to understand how ideas, and patterned ways of thinking are imported from elsewhere, and evoke a larger meaning through a connection to other discourses (Hollander & Gordon, 2006).

To conduct the CDA I used a specific method to analyze the program manual based on Fairclough’s (1992) argument that a text should be analyzed by considering three aspects: 1. the context in which it was produced; 2. the details of the text itself; and, 3. the way the text is received. These corresponded to my data analysis in which I described and analyzed: 1. the context in which the program manual was produced; 2. the manual itself; and, 3. the way the participants received the text during the sessions I observed. Moreover, they can be linked back to my research questions. First by analyzing the work “language does” I show how discourses shape the portrayal of information in the manual, and ultimately in the Children’s Group. This
first step answers my research question: 1. how do discourses pertaining to mental health/illness, and children, frame the content of *Bridges to Understanding*, a program manual designed to support and educate children experiencing parental mental illness? The final step answers my second research question by examining how the manual was received in the *Children’s Group*: 2. how do participants in the *Children’s Group* use impression management strategies to respond to discourses pertaining to mental health/illness, and children?

I used the following questions based on Crowe’s (2005) approach to critical discourse analysis to guide my analysis of the context in which the program manual was produced, and details about the text itself:

1. How, why, when and where was the program manual produced?
2. How is the authority to speak about mental health and illness, and being a child of a mentally ill parent established in the text? How are connections made between discourses to support these claims?
3. What key concepts are developed in the text? How is value attributed to some ideas but not others?
4. How are ways of being in the world, and social relations constructed by the discourse(s) in the text? How are assumptions made about children’s normal or appropriate subjectivities?
5. What implications do the systems of knowledge and belief, subject positions and social relations constructed by the discourses have for the way children should think and feel and behave in the context of having a mentally ill parent?

I followed a similar set of procedures as described above for thematic analysis. In thematic discourse analysis the process of working with codes is also recursive, involving a movement backwards and forwards between the entire data set, coded extracts of data, and the sources for analysis and interpretation that are drawn upon outside the study data itself (see for e.g., Taylor & Ussher, 2001).

**Establishing Research Rigor**

To establish the quality of my ethnography, I aimed to ensure that it was rigorous in three senses: research practice, analytic/theoretical rigor and procedural rigor. Research practice as rigor referred to a reflexive process that involved attentiveness, reflection, conscientiousness and sensitivity to context. Tacit knowledge, the largely inarticulate, contextual understanding I had was made explicit by accounting for how I knew what I claimed to know, and regarded and treated as empirical matters, and how my choices affected the overall research findings. This reflexive approach involved thinking about how my theoretical stance had potential ideological and political implications. These practices were intended to establish my integrity by outlining: the grounds on which knowledge claims were justified, such as the length of fieldwork, my
access pathways, and discussions of the extent of trust and rapport developed with the participants; a brief reference to my experience in the setting and topic; my experience during all stages of research, especially any constraints imposed on the study and an analysis of the strengths and weaknesses of research design (Brewer, 2000).

*Analytic rigor* refers to generalizing from a particular empirical instance to a theoretical one. The analysis and interpretation of the data provide theoretical insights, which are sufficiently generalizable as to allow projection to comparable contexts (Gobo, 2004). Lincoln and Guba (1985) described this as the transferability of findings to other contexts. My analysis can be used to establish a wider relevance of the setting and topic, and identify the grounds on which empirical generalizations might be made, such as establishing the representativeness of the setting or its function as a special case study with a broader bearing (Brewer, 2000). The significance of the study results are as important to establish as the quality of the data (Brewer, 2000, p. 48). As Lincoln and Guba (1985) argue readers of my ethnography will be able to judge whether or not my analysis and interpretation is transferable to other contexts based on my detailed presentation of results.

*Procedural rigor* refers to specific strategies to establish the ‘trustworthiness’ of findings (Lincoln & Guba, 1985). I determined that the data were authoritative by: being transparent about the grounds on which the categorization system was developed and used to interpret data; identifying whether the data/codes were indigenous words and phrases used by participants or analyst-constructed, and how the analysis was justified; and, providing sufficient data extracts to allow the reader to evaluate inferences drawn and interpretations made (Brewer, 2000). Emergent findings were verified using specific strategies traditionally known to enhance *credibility* (persistent observation and prolonged engagement, including reasonable time spent with participants, and the overall development of the thesis); *dependability* (an audit trail established through fieldnotes, extensive memo-writing and reflexive notes, tracking decision-making) and *confirmability* (debriefing involved the committee as multiple reviewers of the analysis, interpretation and representation of the data).

**Establishing rigor in CDA**

Many of the principles for establishing rigor in CDA overlap with those used for thematic analyses. Discourse analysis is an interpretive process, and although multiple interpretations are possible, not all are equally plausible. My study is bounded by the conceptual framing, which provides a basis for my analysis and interpretation. The analysis put forward provides sufficient
evidence for the interpretations I make, and reflects my overall epistemological and ontological position (Crowe, 2005). First, methodological rigour was established by assuring that: the research question was suitable for a discourse analysis; the interpretive paradigm was thoroughly and accurately described; the gathering and analysis of data was accomplished in ways that are congruent with the interpretive paradigm and with enough detail so that the processes are clear; and the methods are detailed enough to enable the reader to follow and understand the overall context of the study (Crowe, 2005, p.61). Second, interpretive rigour was established by: adequately describing how the discourses and the findings were linked; including adequate verbatim text to support these findings; creating plausible interpretations that were linked to the discourses described, which are also supported adequately; and, demonstrating how the findings were related to existing knowledge on the subject (Crowe, 2005, pgs. 61-62). An important point in establishing a good discourse analysis is to do more than summarize themes in the text and talk (emphasis in the original, Traynor, 2006, p. 70), which is also the case in the thematic analysis more broadly.
CHAPTER FOUR: RESULTS—THE SCRIPT
Introduction

In this chapter I present a critical discourse analysis of *Bridges to Understanding* (hereafter, *BTU*), the program manual used to guide the *Children’s Group*. By analyzing the work “language does” in this document I show how discourses about mental health/illness, and children are used in *BTU*, particularly how metaphors, rhetorical strategies, and visual images shape the portrayal of information (Petersen, 2001). Because I conceptualize face-to-face interactions in the *Children’s Group* as a performance, *BTU* was considered a script intended to guide the performance. Consequently, CDA was an appropriate strategy for thinking about what is expected of the *Children’s Group* performance.

While Goffman (1959) argued that loyalty and discipline are attributes required of all those who work to “sustain a show”, circumspection (or dramaturgical prudence) is an important strategy for those whose responsibility it is to exercise foresight, and plan in advance, how to “best stage a show”. For example, circumspect actors have to adapt the show to take into consideration certain “information conditions”, as they pertain to a particular situation.

Information conditions refer to external sources of information that may influence interaction and may or may not be known prior to the performance. And the question of what or how much is known about a situation is particularly important in situations where participants do not know each other because “careful” performances are required. However, while circumspect actors prepare for unforeseen events, they also prepare to take advantage of opportunities afforded them. For example, a strategy for planning in advance for contingencies can be employed by actors who agree to a complete agenda before the event, designating who is to do what and who is to do what after that. I argue that *BTU* is designed to provide such an agenda, so that the adult facilitators responsible for leading the group can act with circumspection as to how to “best stage” the performance.

I argue that an analysis of the work that language does in *BTU* demonstrates its function as a kind of “working consensus” writ large, because it represents an overall definition of the situation, not so much a real agreement as to what exists, but rather a real agreement as to whose claims concerning what issues will be temporarily honoured (Goffman, 1959). *BTU* can be read as a set of claims about mental health and illness, and what it means to be a child of a mentally ill parent, as well as a collective agreement about how overall definitions should be maintained.

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18 For clarity I refrain from using theatrical terms in the results sections so that there is no confusion between the language used in the text and during group interaction, and my dramaturgical framing of the study as a whole, which will be taken up in the discussion.
and supported through the intimate cooperation of those facilitating the program, and the strategies they use to convince others that they are behaving according to these rules. I used discourse analytic strategies to answer the research question: How do discourses pertaining to mental health/illness, and children, frame the content of *Bridges to Understanding*, a program manual designed to support and educate children experiencing parental mental illness? By examining the institutionalized set of meanings, or discourses, that stipulate how children should behave, think and feel about having a parent with a mental illness I show how participants are expected to act in relation to these constructions in the performance.

I begin with a brief introduction to *BTU* to establish some background information and brief history of the text, as well as to provide a good sense of what the document looks like, and how it is constructed. Finally, I present the results of my analysis of *BTU*, using Crowe’s (2005) steps for CDA as subheadings to organize the findings19.

**Bridges to Understanding (BTU)**

*BTU* is a 72-page instruction manual that had been used by the facilitators20 of the children’s support group for six years prior to the sessions I observed21. It was developed and implemented by the senior facilitator involved in the sessions I observed. The facilitator gave me a copy of the manual so I could follow along as she delivered the program. In the introduction, *BTU* is described as “a guide designed for adults helping children to cope with having a family member with a mental illness” (*BTU*, p. 4). It is described as especially useful for trainees facilitating a group for the first time (*BTU*, Introduction). In this way *BTU* aims to bring new facilitators into alignment with the overall assumptions, principles and practices of the *Children’s Group* program. And in doing so, *BTU* helps to construct a kind of mutual dependence among facilitators who despite differences (for e.g. between experienced and trainee facilitators), must be able to count on each other to act as a team, and with the familiarity of “persons in the know “ who are “accomplices in the appearance of things”22. This is important because the facilitators are expected to develop and sustain collective agreements about how mental health and illness and being the child of a mentally ill parent are framed for attendees.

The manual is a repository of educational information about mental illness, and strategies for

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19 I outlined these steps in the method chapter; they will be repeated to introduce each section of analysis.
20 Facilitator is the term used in the text and by the adults who manage the *Children’s Group*.
21 A brief history of the program is presented shortly, in my analysis off the context in which *BTU* was produced.
22 Goffman(1959)described familiarity of this type as one “without warmth” because it does not require the passage of time but is automatically extended and received in formal relationships when individuals take their place on a team (pp. 82-84).
supporting children in this context. More specifically, the manual is purportedly designed to help the facilitators achieve a “working consensus” about the following objectives: “to deliver mental illness education and support to children in a safe, non-judgmental place: where they can identify and express their feelings about mental illness; recognize they are not the only ones living with a parent with a mental illness; and, come to understand that they can cope with it.”

Martha told me she had drawn on several sources to develop BTU, including prior experience working with children in bereavement groups, and having a family member with a mental illness. BTU can be considered a work in progress because it is revised as information is updated, activities are revamped, and concepts are reworked and/or added to the text. For example, the document I analyzed included changes made prior to the beginning of the first group session I observed. Many statements were crossed out and other words were pencilled in to replace them, or on “sticky-notes” that covered over discarded ideas. In the summaries I created for each session I included an introductory section I called, “setting the stage”. It was here that I observed a lot of “talk about the text” between Martha and Amy, the facilitator-in-training who co-led the group I observed. Comments about changing the text or reordering the activities of the session were directed to me as well. These discussions concerned making changes to the planned sequence of activities in particular sessions, or more fully detailed explanations for why certain activities or discussions were going to occur (often directed to the trainee facilitator); and, on a couple of occasions, entirely new ideas and activities were added to the text. In this way BTU was adapted to take account of “information conditions” as they varied in each Children’s Group, and as the facilitators adjusted their plans in accord with these changes.

A general overview of BTU’s appearance, organization and content is provided in Table 1.

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23 This is a condensed version of the overall goals of the Children’s Group program. They were created for use in community development work, to educate others about the program, and engage potential participants.
24 All names used in this thesis are pseudonyms, to protect the privacy and confidentiality of the participants.
25 Martha tells me this information during the anticipatory fieldwork I conducted for the study; in the first session she will tell the children that she has a family member who has a mental illness.
26 Talk about text is an important part of discourse analysis; in this chapter I include only the BTU text itself in the analysis. I report ‘talk about the text’ as it pertains to my analysis in the next chapter of results on how BTU was received by the participants.
Table 1 General description of *Bridges to Understanding*

<table>
<thead>
<tr>
<th>Appearance</th>
<th>black and white, type-written, three-hole punched white paper, inserted into a binder</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>allows facilitator to remove portions of document for easy reference, and only as needed in each session; handling smaller amount of material gives the impression that not everything is directed according to a preordained lesson plan</td>
</tr>
<tr>
<td></td>
<td>text and numerous illustrations including, sketches and animated drawings</td>
</tr>
<tr>
<td>Organization</td>
<td>eight chapters, each referring to one complete session of the group;</td>
</tr>
<tr>
<td></td>
<td>every chapter begins with a page including: the session number, a title/heading alluding to the goals of the session, a black and white illustration that supports these goals, which are also written out at the bottom of the page in bold typeface (see Appendix 10, a sample script based on session three to show how information is organized)</td>
</tr>
<tr>
<td>Content</td>
<td><strong>Acknowledgements page:</strong> contributions by other facilitators including a long-time co-facilitator; other trainees, mostly social workers and health and social service professionals working in community mental health agencies and child welfare and protection agencies; design, editing and artwork credits; 3 copyright notices for material used in program sessions</td>
</tr>
<tr>
<td></td>
<td><strong>Table of contents:</strong> lists eight separate chapters for each “user friendly” session (Appendix X)</td>
</tr>
<tr>
<td></td>
<td><strong>General introduction:</strong> 1. main program goal: “to help children learn about mental illness and express their feelings about it”; 2. the program philosophy; 3. acknowledgement of child alumna of previous groups for “many ideas and suggestions”; 4. description of a standardized format to structure the sessions, for e.g. “facilitator sessions notes” provide useful “tips”, especially for trainees, and include a rationale for a particular action or activity, questions asked by children, behaviours that occur and other “practical suggestions”; 5. rationale for use of support groups and suggestions for ideal group size, duration and location.</td>
</tr>
<tr>
<td></td>
<td><strong>General guidelines:</strong> notes the requirement for intake assessments on each child with parent/guardian and permission to attend the group; a “model letter” for parents with time, place, directions and “general program outline”; general advice/“rules” for facilitators, often duplicated in individual chapters, for how things should go and why. For e.g. guidelines about: posting an agenda to give members a sense of “how things will go”; why artwork remains anonymous, to allow children “freedom to express ideas without worry about anyone outside the group seeing it”; and how each group “will have its own identity”, and topics might need to be tailored accordingly, although the eight sessions reflect the “needs of children with whom we have worked”.</td>
</tr>
<tr>
<td></td>
<td><strong>Chapters 1-8:</strong> educational material, scripted dialogue for the facilitators’ use; games and activities to support information promoted, based on program goals; visual images (sketches and animated images) to support key messages</td>
</tr>
<tr>
<td></td>
<td><strong>Key resources:</strong> information about locating supplies and how to construct “props”, for e.g. to demonstrate “neurotransmission”; lists of books/pamphlets for children’s use in the “Quiet Space”; references for adult facilitators, for e.g., on conduction support groups</td>
</tr>
</tbody>
</table>

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27 This is important to note here because expertise is an important concept for understanding how discourses circulate in the text, particularly those associated with principles and practices of mental health promotion, and the ways the text makes claims about what it knows and the beliefs it promotes. For example, BTU has developed through informal evaluations of children’s responses to the group, and the adults who facilitated different sessions of the group. This includes adults who work as professionals in mental health, and child welfare and protection agencies. Moreover, personal experience is valued in BTU because of the work that meeting others who are in similar situations is expected to do, by providing informal education and support through sharing personal stories. For example, participant stories are used in BTU to direct others about how they might feel and be expected to act because they have a parent with a mental illness. The *Children’s Group* is envisioned as a particular kind of setting, a place where children can “meet other children in similar situations, and learn from other children about their experiences (session 1).
A Critical Discourse Analysis of BTU

Producing the text

1. How, why, when and where was BTU produced

   While BTU explicitly states that it is a “guide for adults, helping children to cope with having a family member with a mental illness”, BTU was also produced for other purposes that influenced the way it developed. Having a sense of the context and purposes for which BTU was produced and continues to develop is important because it is a strategy the facilitators use to exercise foresight and design in advance, how to “best stage” particular Children’s Groups. Moreover, the discursive formulations in BTU can be thought of as a type of “information condition” for the performance, because they are external sources of information that have a significant impact on the group interaction. Similarly, as a “working consensus” they demonstrate how a collective agreement as to whose claims about mental health and illness, and what it means to be a child of a mentally ill parent have been privileged, and how they have come to take the particular shape they have in the document.

   i. The organizational context

   Although BTU was developed to guide and standardize the educational information and support activities of the Children’s Group, its production can be understood within the organizational context of an umbrella organization.28 The group is run according to the auspices of the sponsoring organization that supports families who have a relative with a mental illness. This umbrella organization is itself nested within institutional arrangements for community-focused mental health promotion activities and is mandated to provide advocacy, education, counselling and referrals to its members. It was developed in 1989 in response to a policy framework document aimed at supporting individuals with mental illness in the community (Canadian Mental Health Association, National Office, 1989). The program expanded in the early nineties to provide services in multiple locations in the same urban area in response to families’ requests. The umbrella organization receives core funding from the provincial government, and financial support from other community agencies as well as individual donations. The day-to-day operations are carried out by a small remunerated staff, many of whom are family members of individuals with mental illnesses in addition to volunteers. At the

28 Information pertaining to the umbrella organization is from a website promoting the organization, accessed during the data collection phase of this study 2006-2007.
time of my study there were approximately 800 members in the organization. It offers monthly educational and support group meetings for parents, spouses and young people. While support groups are the primary mode of help provided, the children’s program is different from those focused on other family members because it requires pre-registration, is time-limited, and its educational and support activities are standardized through the BTU manual.

Because the umbrella organization provides funding and staff support for the group and BTU was developed and implemented by the organization, the principles and practices associated with it are of particular interest. For example, the umbrella organization offers support to “family members where any mental illness is an issue by providing education, resources and coping strategies” (emphasis added). This means that the program does not use diagnostic criteria for membership, unlike other groups like the Schizophrenia Society and Mood Disorders of Ontario. Consequently, members of the organization have experiences with a range of mental illnesses. This may be because the umbrella organization explicitly purports to align itself with a mental health promotion (MHP) approach to support families rather than a medical approach to individual illness and disease prevention. Although talk about MHP was just beginning as the umbrella organization was being developed almost twenty years ago, this way of thinking about and doing mental health was part of the organization’s philosophy from its earliest days. Founded by a group of families with connections to the Canadian Mental Health Association, the organization was a pilot project of the Etobicoke Mental Health Services agency under the auspices of a relatively new mental health policy document, Framework for Support. The authors of this document, currently in its third edition, write about it as a model that anticipated many of today’s tenets of (mental) health promotion. In the following excerpts from the 2004 version of Framework for Support, MHP is linked to health promotion more generally, and it is argued that the policy was a precursor to a MHP model for people with mental illness:

In the past several decades, health promotion has become an increasingly accepted approach to health and wellness. Growing out of the health promotion tradition is a concept of mental health promotion that builds on the same principles of individual and community choice, control, and participation in decisions about health issues and ways to address them.

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29 CMHA is a national, voluntary organization whose “mission is to promote the mental health of all people… (it) is unique in Canada as a non-governmental organization with an explicit mandate for mental health promotion and education.” (www.cmha.ca/mh_toolkit/intro/pdf/intro, accessed, February 12, 2009). A Framework for Support: 3rd Edition is available at: www.cmha.ca/data/1/rec_docs/120_Framework3rdEd_Eng.pdf. All references here are to this document.
The Framework model, although developed largely outside the mental health promotion field, has many elements in common with mental health promotion. It recognizes the importance of the knowledge and experience of people with mental illness and their families, emphasizes participation in decision making as well as power and control, and focuses on the promotion of mental health and the journey to recovery rather than simply on treating the illness. It can accurately be seen as a mental health promotion model for people with mental illness (emphasis mine, p. 5).

The important point here is the emphasis on experiential knowledge and the role of individuals, including family members, in decision making with regards to mental health services and support that moves beyond medical treatment. The language used is like that of the MHP model, which stresses individual and community power and control over health.

The Community Resource Base (CRB) is a central feature of the Framework for Support policy document. It argues for a rethinking of “the traditional approach to mental health policy and service development, by assuming the perspective of the person in the centre: the person who is actually living and coping with a serious mental health problem” (p. 7). More germane to my dissertation, it considers families and friends as integral to this new approach by recognizing them “the largest group of caregivers…(who)…when organized have the potential not only to support their ill relative, but to provide support to one another and to other families as well” (p. 9). This approach constructs families’ roles alongside generic services and supports. Moreover, the ideas expressed use the language of “working together” and providing “mutual support” to counter the traditional image of a formal mental health system with its role focused on “maintenance and control” of symptoms rather than “recovery” from illness. Furthermore, self-help and mutual support represent an alternative to traditional mental health services in which “…people’s own strengths and capacities (are) sources of help for others. Based on principles of shared experience, joint ownership…a fundamental tool to allow people to work together and take charge of their own lives. (p. 8). The “CRB implies a shift from the service paradigm to the community process paradigm”, and families come into particular focus as this change takes place—and as professional responsibility and accountability is reallocated.

In the following excerpt from the umbrella organization website, in a section titled “Who We Are”, the ideas that form the basis of the Framework for Support document, and those upon which the umbrella organization was founded, are still very much in evidence. For example, the excerpt begins by describing an idealized presentation of the family as the bedrock of society, and as the purveyor of support and connection for its members. Of particular note, because of the emphasis they will be given in BTU, are ideas about: the importance of understanding based
on the notion of having “been there”; the focus on stress brought about by having to cope with a mentally ill family member, and the emphasis on ‘having a voice’ based on a self-help model that “respects and supports family expertise”:

**It's about the families.**
We believe families make up the basic social structure of our society. Family members provide ongoing support and connection for many of our life experiences. This is particularly so for persons who are vulnerable or ill.

**We understand because we've been there.**
As an organization brought together by families, we have a thorough understanding of the challenges and emotions experienced in supporting a family member with a mental illness.

**Reduce the stress of coping.**
‘The Family Organization’ is organized for and by families to reduce the stress of coping with mental illness by strengthening and supporting family members in our role as caregivers. We can provide advocacy, education, referrals and counselling to families that have a mentally ill relative of any diagnosis.

**Families have a voice.**
‘The Family Organization’ works hard to ensure that families have a strong voice within their communities. We are based on a self-help model which respects and supports the expertise that families have regarding their mentally ill relative and their experience in the system. (emphasis in the original, excerpted from umbrella organization web site)

The concept of “community” and its association with MHP principles and practices in Canada today, speaks to a much wider context for understanding the ideas and beliefs promoted in *BTU*. These can be summarized in a more generic way as: an emphasis on the needs and expertise of individuals who are involved, and on the community settings of “everyday lives”; a focus on control by individuals as “members of a community” because they must work together to influence change, and exert control over problems affecting their lives; the importance of the concept of self-help in this process; and therefore, a collective rather than an individual response to crisis, as support is shared and individuals become accountable to one another, and do not operate isolation.

As I will suggest in my analysis to come, these ideas about being able to cope or manage as a form of protection, linked to notions of power and control over potentially adverse circumstances or risk, are especially important to thinking about (resilient) children who have a parent with a mental illness, and the goals of the *Children’s Group* program. The umbrella organization is modeled on the principles of self-help. The program philosophy casts family members as the ‘real experts’ on the needs of an ill relative, and on the service system itself. The organization identifies its role in line with the principles of mental health promotion because
it advocates interventions to help families reduce the stress of managing life with a relative who has a mental illness:

[The umbrella organization] respects and supports the expertise that families have regarding their mentally ill relative and their experience in the system. It is run for and by families with a mandate to reduce the stress of coping with mental illness by strengthening and supporting family members in their role as caregivers.\textsuperscript{30}

While MHP discourses as taken up by the umbrella organization acknowledges that adult family members require support to cope with an ill relative because of their caregiving role, there is no mention of children caring for a parent with a mental illness in \textit{BTU}\textsuperscript{31}. In this case “family member” refers to a parent, who may be caring for an “adult” child with a mental illness. And while \textit{BTU} acknowledges that children have knowledge and experience related to having a parent with a mental illness, children’s independently acquired knowledge, skills and coping mechanisms seem to be considered evidence of maladaptive thoughts, feelings and behaviours. This deficit-based model of childhood argues that children like “these” can improve their current knowledge and ability to cope, a major objective of the \textit{Children’s Group}. The MHP discourse that circulates in the umbrella organization and in \textit{BTU} has several underlying interconnected principles that are important to the analysis reported in the remainder of the chapter. In sum, they emphasize a “working consensus” about the value of:

1. a collective rather than individual response to the problems of everyday life.
2. the needs of individual families living in adverse circumstances due to mental illnesses.
3. a focus on active participation (and citizenship) to influence change and exert control over a problematic situation
   i. an increase in “personal control, empowerment, self-determination, and resilience…to maintain positive mental health”.
4. a sense of belonging and the idea that the child is “not alone”.
5. the ability to “bounce back from adversity” by managing obstacles to (mental) health.
6. the ability to work together, share problems, identify needs, set priorities, control and implement change.

\textsuperscript{30} This is taken from ‘the umbrella organization’ website; however for confidentiality reasons the website cannot be referenced here.
\textsuperscript{31} Martha does talk about ‘parentification’ because children’s caring is considered a risk factor. She discusses this in relation to specific children in the group. This will be reported in the next chapter on the results of the \textit{Children’s Group} performance.


**ii. Why was BTU produced?**

Having described how, when and where *BTU* developed, I turn my attention to ‘why’ it was produced. In addition to the explicit rationale provided in the text—“as a guide designed for adults helping children cope with having a family member with a mental illness”—I suggest other less obvious reasons *BTU* was developed. It is important to understanding how discourses about children, and those about mental health and illness operate in the text. First, I describe how *BTU* was produced to help adult facilitators manage the participants, activities and the setting. Second, I describe how *BTU* is used as a guide to help the facilitators manage information—the mental health and illness education and support provided to the *Children’s Group* members. To manage all of these components a strategy was required to allow the facilitators to prepare in advance for expressive contingencies. *BTU* is such a strategy, a more or less complete agenda settled upon in advance, designating who is to do what, and in what order activities should occur.

*Managing the Children’s Group*

The program philosophy is based on traditional discursive formulations about children and beliefs about how to help this particular group of children. As it is explained, the philosophy was a catalyst for the development of the *Children’s Group*. The following excerpt appears directly after the statement that *BTU* was developed as a guide to help adults help children cope with parental illness:

```
The fundamental belief underlying the program is that all children have their own, innate resiliency skills. Often the child is not aware of the skills and coping mechanisms they have developed to adapt to their situation. This program is designed to build on their pre-existing knowledge and skills, and to introduce and encourage safer and more appropriate coping skills in the future. (*BTU*, Introduction)
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Although the passage expresses the belief that *all* children possess “innate resiliency skills”, and have “existing knowledge and skills”, I believe that the words are actually directed toward the specific children, for whom the group was developed. These are children who may have developed unsuitable and risky ways of “adapting” to “their situation”, even though these circumstances are undefined and ambiguous at this point in the text. Moreover, children are assumed to be naïve about their own abilities to cope because they are said to occur naturally—that is, innately. Their knowledge and skills are said to be potentially inadequate to deal with the position they find themselves in, and so they must be helped to manage in a way that is
considered “safer” and more “appropriate”. By more appropriate, the program emphasizes a notion of “being safe”, which I will show is a way of talking about learning self-protection and preservation. These changes are necessary because the philosophical orientation is to current and future concerns.

*BTU* next outlines recommendations for the ideal group size, duration, and location. It includes a description of an ideal setting, emphasizing the physical layout of the room, and the differentiation of space for various uses. This includes incorporating beliefs about children’s need for respite from group activities, by providing a space where they can opt out of the group temporarily, as well as beliefs about this space as a something that children should find “feel(s) like their own”. The following excerpt describes the ideal location:

The best place to conduct the sessions is in a room that is airy and spacious and informal, not institutional. The room should be big enough for the children to sit around a table comfortably, while also providing enough space for active games, as well as quiet space for those who need time apart from the group. There are some small activities that can help the children take ownership of the room and create a space that feels like their own. (*BTU*, Introduction)

In other words, in addition to the practicalities involved in determining functional space, an ideal space or “front/stage” should foster children’s sense of belonging, and meet their need to have some control over the setting. This idealized presentation of suitable spaces—which should be casual and relaxed, not institutional—is important because it is linked to a major objective of the *Children’s Group* program, to provide a “safe, non-judgmental place where each child can identify and express their feelings about mental illness” (*BTU*, Introduction). In the following excerpt, a number of reasons are given for keeping the ideal group to six children. This recommendation guides the facilitators on how to structure the group, and reveals why this is considered the ideal. Beliefs about what *these* children are like and assumptions about what they will need govern this choice. The numbers must be small enough so that children will learn to trust the adult facilitator, and be willing to share their stories with the group.

There is an assumption too that in coming to the group, children will be talking about their circumstances for the first time. This belief is so central to *BTU* that any time constraint on their ability to talk about their situation is considered “antithetical” to the overall objectives of the program. Moreover, what is known about *these* particular children requires careful planning because it is assumed that their needs will take up more of the facilitators’ time—in order to share their stories and develop trusting (safe) relationships:
(They) will have learning disabilities, difficulties with social skills, a high need for attention (and consequently)...a group of six allows for more time for each child to develop a relationship of trust with the facilitators, and to share their personal stories with the group...for many children this may be their first time they have ever talked about their situation to another person, and any time constraints which limit their chances to do so would be antithetical to the aims of these sessions (BTU, Introduction).

The future is an important concept in BTU. The idea of futurity is commonplace in discourses about children and childhood, and finds expression in this program in relation to these children, who must be managed in order to help them develop better coping skills for the future. In the day-to-day operation of the group, time must be managed to accomplish these goals. Ideally session time should be unrestrained to promote and foster children’s ability to talk about their circumstances. However, facilitators are given very precise time limits for each of the sessions (see the sample script, Appendix 10), so that while it is recommended that each session last only ninety minutes, they are warned that it is “often difficult to get through all the material” (BTU, Introduction). A potential conflict exists between an ideal of unfettered time that gives children a chance to talk and develop trust with others in the group, and the reality that restricts the amount of time facilitators have to deliver program content. Facilitators are instructed to choose program content that is most salient for the particular group they are working with because they will find themselves running out of time. Moreover, BTU suggests in several instances that each group will have its own identity, so it is the job of the facilitator to know the group and to customize the content to meet their specific needs.

To manage the Children’s Group facilitators are instructed to help the individual child become part of the larger group once they enter the program. The rationale proposed for using a support group format is couched in language that suggests that there are salutary effects in being part of a collectivity. BTU is explicitly based on the belief that a group format is an ideal way to educate and support children who have a parent with a mental illness as described in the following excerpt:

Rationale: Children’s support groups focused around a specific issue can accomplish many objectives that a one-on-one situation cannot. Corey and Corey list the following positive outcomes of support groups. Support groups:

- Give support when needed
- Let children know they are not alone
- Teach coping skills
- Reinforce children’s need to talk and deal with their feelings
- Help them deal with emotional and behavioural concerns so they can reach their
According to *BTU* the benefits of group work outweigh those of “one-to-one situations” for several reasons. First “situations” refers to therapeutic contexts. *BTU* cites authoritative evidence for the efficacy of group work, in comparison to individual therapy, by referencing a textbook by Corey and Corey\(^{32}\), authorities on group therapy with children. One of the ways support groups can accomplish more is by connecting the purposes of the group to the structure of a group format. For example, a group is an ideal way to “let children know that they are not alone”. This phrase is ubiquitous across health and social care contexts, particularly in speaking about the positive aspects of support groups. Numerous web-based sources demonstrate how problematic situations, from living with cancer to mental illnesses and addictions, adopt this concept to promote the benefits of belonging to a particular group. As a normalizing discourse it is meant to reassure those who may be isolated by their experience that “they are not alone”, because they now belong to a community of other individuals who share the same problems. A support group can accomplish this by bringing people together in face-to-face contexts.

The group also symbolizes a collective focus on solving the problems of everyday life, one of the basic principles of the MHP discourse I described previously. Social networks—an integral form of social and emotional support for those living with stressful life circumstances—that involve “similar others”, are an important source of interpersonal support. The notion of “being with” reinforces the idea that learning to talk about, and deal with feelings is best accomplished by communicating with other individuals who share similar experiences. One of the purposes of the group format is to “help children open up to other individuals”. This is important because children are said to need to learn to talk, in order to manage their emotions. Support groups are ideally suited to teaching and practicing forms of emotion management. In *BTU* beliefs about the importance of communication—through talking and sharing personal stories—are connected to the idea that the children who come to *Children’s Group* are no longer alone. For example, when they first arrive in the program they must learn to say in unison, “we are all here because we have a parent with a mental illness” (session 1). But this weekly refrain does more to aid the development of group solidarity by teaching the new members what is expected of a loyal and disciplined group participant—by teaching them that they have a moral

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obligation to one another. Moreover, participant stories are said to do more than help individual children learn to talk about their experiences by teaching them expressive responsibility for each other, and for the “affective line and expressive status quo”33 of the group. The group’s attention is thus directed toward the appropriate ways to talk and feel about their situation, and how to express these ideas and emotions in the stories that they are urged to tell one another about their experiences. Finally, the group format is considered efficacious because it can help children to reach their full potential—reinforcing an orientation toward the future.

Managing mental health and illness information

In addition to being a means to provide recommendations for managing the participants and the setting of the group, BTU was produced to help the facilitators manage information. This is important because they must sustain a collective agreement or working consensus about mental health and illness and being a child of a mentally ill parent that is consistent with the objectives for the group. For example, like a theatrical script, BTU includes specific dialogue, as well as ‘tips’ and ‘prompts’ for facilitators to use in each session to explain information and conduct activities. There are separate directions detailing how individual sessions should unfold; options for dialogue to be used, related to the goals and actions expected of that session; stage management and directorial notes to guide the action; and, a list of set decorations, including props, to support the informational content and accompanying action in each session (Appendix 10). However, as illustrated in Table 2, superimposed over each session is a standardized structure, a set of subheadings that include both explanations for activities, and helpful hints about things children might do or say, but also expectations about how and why information should be managed in specific stages.

An important component of the program is the inclusion of games and artwork purportedly to augment the information provided to meet the activities and goals of each session. Individual children complete artwork and use these to share stories with the group. This helps them show and tell, during group interactions. Artwork is not taken home, but is kept by the group. However, there seem to be implicit beliefs about ideas and feelings that may be too dangerous for overt expression to anyone but members of the group because all work remains anonymous. Parents sign consent forms allowing the program to keep the children’s artwork for “educational purposes”. The reason given for anonymity is that it allows children

33 Goffman (1959).
Table 2: Standardized Structure for Each Session of the *Children’s Group*

| Facilitator Session Notes | -especially useful for first time facilitators  
|                          | -includes reasons for actions taken; activity suggested; questions children might ask;  
|                          | behaviours that might occur; other practical suggestions  
| Opening Time             | -early part of the session, prior to formal activities  
|                          | -useful for discovering what has been happening in children’ lives between sessions;  
|                          | review material from previous session; answer questions that required research,  
|                          | consultation with other professionals  
| Working Time             | -includes an introduction to session topic, with prompts for facilitator’s use  
|                          | -can include important points to make, relevant questions to assist processing  
|                          | information; directions for activities, games  
| Closing Time             | -brings session to a close  
|                          | -often rushed due to lack of time, so children can enjoy snack while processing what  
|                          | they’ve learned  
|                          | -children may have questions at this time because so much material to cover  
| Affirmation Statement    | -used at the end of the session to encourage children, and develop self-esteem by  
|                          | helping them recognize their knowledge & skills and contributions to the session  

“the freedom to express ideas and feelings without having to worry about how someone outside the group will respond” (*BTU*, Introduction). The text does not say anything further about who these outsiders might be, although the ill parent and other family members are probably significant “unseen audiences” and “imagined others” children (and facilitators) are said to worry about. The cautious, prudent facilitator must manage children’s cognitive and emotional expression responsibly. The following excerpt is representative of the kinds of art activities described in *BTU*:

Hand out a sheet of drawing paper and markers to each child. Ask them to fold the paper in half vertically. “On the left side of the paper, draw how your family member with a mental illness looks or behaves when they are healthy. On the right side of the paper, draw how they look when they are not healthy, or when they are displaying one of the symptoms of their illness. The symptoms can be ones that appear on our list, or other symptoms that your family member has experienced”, ask the children to share the kinds of experiences they have drawn in their artwork, explaining that this can be very helpful for the other members. Discuss the “not healthy” half of the drawings and figure out whether or not they are, in fact, symptoms of mental illness (*BTU*, session 4).

In addition to conveying information about the fluctuation of symptoms, the intention of this activity seems to be to help children identify with each other. By eliciting symptom stories they may have in common, a sense of belonging may also be created. The artwork aids facilitators in evaluating children’s knowledge about mental illness, and directs other participants as to how they might think and feel in relation to these stories. Similarly, games are used to create a sense of belonging by providing an opportunity for individuals to act as a team. In this way *BTU* is
intended to simultaneously manage mental health and illness information and foster cohesion amongst group members. Games are also used to help to manage children because it is assumed that they will have “a surplus of physical energy, and/or an inability to pay attention for any length of time” (BTU, Introduction). However, although games or ‘energizers’ as they are sometimes called, are explicitly described as a practical convenience for the facilitator— who may determine that children need a break from difficult material or to “release their energy” (BTU, session 2)—they are also used in an analogous way to underscore certain points about the topic under discussion, as demonstrated in the following example:

Twister game (10 minutes) At this point, we suggest you take a break and play a game of twister. Simply play it as it is normally played. One child can be the spinner, or if you have too many volunteers, let them take turns. This game acts as a good introduction to the next discussion about the THINKING PROCESS and TWISTED THINKING. (emphasis in the original, session 3)

The main content of BTU is a detailed, 8-week session plan that includes mental health education and support activities designed to realize the several, explicit goals of the group. While these goals are highlighted in the text, the title of each session uses ‘bridges’ as an extended metaphor to convey an underlying and broader purpose for each of the eight sessions, and the activities that support them (Appendix 11)34. The metaphor can be interpreted as a symbol for the connections that BTU expects to make, and/or the obstacles it intends to overcome. For example, the first session is entitled, Bridges to New Places. The goal of this session is to have group members establish relationships with one another, in an atmosphere that will help members “feel comfortable talking about mental illness” (BTU, session1). This is a new place because children are assumed to have been isolated, and unable to talk about their experiences with anyone prior to attending the group, and they now have an opportunity to connect with others like themselves. The purpose of BTU is to help overcome this obstacle. Session five is entitled, Bridges to Courage. The goal of this session is to help children recognize that it is okay to be frightened by the unpredictable behaviours of a parent with a mental illness. This is said to take courage because children are assumed to be unable to acknowledge or express negative feelings related to parental illness and this obstacle can be overcome. Moreover, Bridges to Understanding in its entirety could be interpreted as an analogy

34 The goals are reproduced verbatim in this appendix. Synopses of the activities to support these goals are based on the eight sessions as described in BTU.
for an overarching program objective, based on three dimensions of understanding in which children are assisted by: 1. making their circumstances intelligible, applying concepts that explain the situation and create insight; 2. developing an informal, but mutual agreement, about how to interpret and give meaning to their situations; and, 3. helping them to become more tolerant of and/or sympathetic towards it. In this way children who participate in the Children’s Group could be said to become understood, and to have gained understanding about mental illness.

The several explicit reasons why BTU was developed, which are described in the eight sessions—further divided into two overarching themes related to education (sessions 1-4), and support (sessions 4-8)—constitute the content of the Children’s Group program (Appendix 11). These are summarized as a single objective, which is: “to help children learn and express feelings about mental illness” (BTU, Introduction). The first four sessions provide education about mental health and illness, followed by those which focus on supporting children in the context of parental mental illness. These sessions were reorganized prior to the group I observed, so that education about mental illness was provided first. The facilitators said they felt that children were more likely to be specific about their individual experiences and talk about their feelings, once some of the larger educational and informational questions were covered.

Claiming authority in the text

2. How is the authority to speak about mental health and illness, and being a child of a mentally ill parent established in the text? How are connections made between discourses to support these claims?

In this section I describe how BTU establishes its authority to speak about mental health and illness and being a child of a mentally ill parent, and the underlying concepts that are part of these discourses, such as risk, safety, prevention, rights and responsibility. I also show how discourses are connected to each other as part of a claims-making activity to substantiate these ideas. I conclude that: 1. the way BTU is structured contributes to the ongoing construction of these discourses in particular ways; and, 2. the content itself is legitimated by incorporating specific kinds of expertise to give authority to the beliefs and information it promotes about children, and mental health and illness. To put it otherwise, establishing the authority to speak

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35 These dimensions refer to the way “understanding” is defined, see for e.g., (“The New Penguin English Dictionary,” 2000).
36 This information was conveyed to me through ‘talk about the text’ during the anticipatory field work I conducted six months prior to my observations for this study.
reflects how a collective agreement about defining this situation is reached through a “working consensus” that privileges certain claims over others, and a “real agreement as to whose claims concerning the issues” of mental health and illness, and being a child of a mentally ill parent will be honoured at this time and in this way.

i. **The authority to speak through form and structure**

In my introduction to *BTU* I provided a good sense of what the document looks like and how it is constructed (Table 1). Here I want to draw on construction techniques to describe how *BTU* makes the text appear credible. For example, I referred earlier to a standardized structure used in each of the sessions, and how this provided order and consistency for the delivery and management of program content across all sessions (Table 2). I argue here that the *opening, working* and *closing times* provide a narrative structure to each session in which the facilitator can expect certain things to happen in an orderly, logical, timely and linear fashion—each session has a beginning, middle and an end, dictated by the facilitators. The sequential unfolding of events gives rise to literal expectations about how activities will take place. But this narrative also operates more figuratively, suggesting how the ‘story of the group will go’. The structure also imposes these expectations. So for example, *opening time* is an opportunity to begin by gathering personal information about children’s lives outside of the *Children’s Group*, and to provide “an appropriate response” to any outstanding questions the children may have through professional consultation (*BTU*, Introduction). In this way the facilitator can assess the “information conditions” that precede and influence the interactions to follow.

The middle part of the narrative or *working time* is the longest part of each session. This is where children learn about mental illness and how to express their feelings about it. The facilitator is directed to manage the participants and certain activities, and is given specific lines of dialogue to accomplish this. The narrative for each session concludes with a formal *closing time* in which children are expected to “process” what they’ve learned, and facilitators answer any lingering questions, especially if they are running out of time—often while they are eating the evening snack. As a kind of denouement, the tensions or conflicts associated with unanswered questions, or difficulties “processing information”, are supposed to be resolved before the children leave the particular session. This format is expected to be played out each and every week. Finally, the *affirmation statement* is used to conclude the narrative by making declarations about the children at the end of each session. This is meant to acknowledge children’s “knowledge and skills and contributions to the session” in order to encourage them,
“building self-esteem” (*BTU*, Introduction). These statements also encourage children’s loyalty to the group by showing that they all have a part to play, and reinforcing how they are learning to do this with confidence, as disciplined players who can trust themselves.

The *BTU* text has an unseen but seemingly omniscient narrator whose “voice” is meant to be authoritative and knowledgeable about mental health and illness and children, directing the facilitators to do and say certain things in a given activity. In this way the facilitators are also managed, so that they can better handle the group by following rules about how emotions should be felt and expressed, learning an “appropriate” emotional vocabulary for these feelings, and learning to make connections between emotional elements to do with physiological arousal and situational cues. For example, in the fifth session the facilitator is told to: “Ask them (the children) to think about how their body feels when they are frightened. Write their responses at the appropriate anatomical spot on the gingerbread man”. Similarly, the following dialogue is given to help the facilitator explain a concept about embodied emotions: “The physical symptoms of fear are called EARLY WARNING SIGNS (EWS). Early warning signs are the body’s way of telling us that we *may* be in a dangerous situation and to be cautious” (session 5).

These directives guide the facilitator not only about what they should say, but also how they should say things. In this way the narrative concerning how children should think about and express their feelings about mental illness can be expected to unfold in a way that is manageable because it is quite intentional. *Facilitator Session Notes* substantiate why certain things are done or said, providing a rationale for the actions and dialogue described. However, facilitators are not so tightly scripted that they fail to anticipate the unexpected. The notes are meant to help them prepare for unscripted moments, if only vaguely, by suggesting they think about “potential questions children might ask”, and other unnamed “practical suggestions” (*BTU*, Introduction).

Other signs that indicate that the text should be considered trustworthy and direct the facilitator’s attention to certain ideas include bolded, capitalized, italicized and underlined words (Appendix 10). This is also accomplished through many sketches and animated drawings used to illustrate and support the messages of in the words used to describe key ideas. A good example of this is the profile of a human head illustrated in figure 1, superimposed with a set of cogs and wheels operating smoothly to support the idea of the properly functioning, as opposed to the broken, brain (session 3). Overall, the way *BTU* is structured by the form it takes provides a grander narrative that
superimposes its own kind of authority on the text itself, a story where things are not out of
place, or told the wrong way round. This too implies a subtler message that the challenges of
having a mentally ill parent, and those of teaching and supporting children who do, are
manageable.

**ii. The authority to speak through content**

*BTU* draws on contrasting kinds of expertise to establish its authority to speak about the
education and support needs of the children. However, professional knowledge dominates
claims about what is known about both. The authority to speak reflects a “working consensus”
that privileges certain claims over others, and reflects certain “information conditions” that
precede or are external to *BTU* and the *Children’s Group* program. The *Children’s Group*
ultimately supports the development of children’s knowledge so that they too can become
experts about their experience in order to act as better managers of the received view of mental
health and illness, in order to help themselves, but also “others who are in similar circumstances”
(*BTU*, Introduction).

The flexibility of the text is important because it can adapt to new and presumably more
current and correct information. This is one of *BTU’s* main objectives: to deliver accurate and
up-to-date mental illness education to children. In order to ensure this, *BTU* draws on the
expertise of those outside the program—various professionals who speak about mental illness as a
medical problem, and children’s experiences of parental illness as a problem of child welfare and
protection. For example, the facilitators are given advice about how to initiate a discussion
regarding the causes of mental illness. The rhetorical structure of the dialogue is noteworthy
because, although it states that no one ‘really knows’ the answer to why individuals become
mentally ill, ‘scientists’ and ‘researchers’ have found—using the language of discovery—
something reasonably trustworthy to make a case for aetiology:

**POSSIBLE CAUSES.** *Possible causes* (15 min.). Use the following prompts to begin a
discussion about the causes of mental illness: “Have you ever wondered what causes
mental illness? The answer is: *Nobody really knows what causes mental illness.*”
“Mental illness can happen to anyone, anywhere, *but not everybody gets it.*” “Scientists
and researchers have found that there are three possible reasons why a person might
develop a mental illness.” (emphasis in the original, session 3)

In the next session the children learn about symptoms of mental illness, the diagnostic process,
and various forms of treatment, including the concept of side effects. The facilitators are
couraged to seek expertise to answer challenging questions from the children because “mental
health education is (now) on the (Children’s Group) agenda”. Although this is left somewhat ambiguous referring also to “some thinking” that may be required. Examples of questions posed by children in previous groups are given so that the facilitator can do their homework:

_Facilitator session notes:_ 1. many of the group members ask questions that _may need research_ or some thinking as to how to respond. Now that the focus is on mental illness education, you may need to spend some time at the beginning of this session to respond to the children’s queries…. 2. the children often open up in this session and share the symptoms they have seen. Discussing symptoms can lead to a lot of challenging questions. Here are some recent examples: Can you die from a mental illness? How many mental illnesses are there? Why is it called a mental illness? (session 4)

Props for this session support medical education about mental illness, including psychotropic medication posters from a pharmaceutical company, and brochures published by the Centre for Addiction and Mental Health in Toronto. The brochures—with titles like, “When a parent has experienced psychosis…what kids want to know”—are written by medical experts for parents so that they can answer questions children are purported to have about mental illnesses, although it is not clear how these questions were determined. The capitalized letters in this excerpt emphasize the belief that children have many questions. Note how children’s knowledge is portrayed in the introduction to the brochure as potentially inaccurate, and/or dangerous. Parents are positioned as mediators between professional knowledge and children’s need to know, and they must decide if children can ‘manage’ the information provided based on their age and ‘ability’:

CHILDREN HAVE A LOT OF QUESTIONS WHEN someone in their family is sick. When children don’t have answers to their questions, they tend to come up with their own, which can be incorrect and scary! Each parent and child’s first conversations about psychosis will be different. How you address the subject will depend on the child’s age and ability to manage information—you know your child best. This brochure will help prepare you to take the first step in discussing this disorder with your child.

In other instances _BTU_ teaches the children that they must be hopeful because scientific, research-based knowledge will improve how illnesses are diagnosed, causes are understood, and treatment outcomes are made better. Continuing on from the passage quoted above, the facilitator is directed to teach information about the medical process for diagnosing mental illnesses. _BTU_ mentions the _Diagnostic and Statistical Manual of Mental Disorders (DSM), an_

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37 Martha does not like these brochures but they have so few medical resources, she keeps them on hand. More will be said about this in the results reporting on the way _BTU_ is received in the _Children’s Group_ sessions.

38 Available from the R. Samuel McLaughlin Addiction and Mental Health Information Centre, Centre for Addiction and Mental Health, Copyright 2005. 1-800-463-6273.
authoritative text used to categorize behaviours as illnesses that require medical intervention. The text carefully points out that the DSM can only be used by someone with medical training, who knows how to distinguish between symptoms (behaviours) as distinct illnesses:

….there is a full sheet with the title, Diagnosis, at the top and the following: the doctor: 1. first rules out physical reasons for having a mental illness such as a brain tumour or other diseases; 2. will assess the symptoms/behaviour your family member is displaying; 3. will determine if your family member has a mental illness and decide what kind of illness they are suffering from according to the DSMIV, which provides guidelines for making a diagnosis. To use this manual you need medical training because even though there are many different kinds of mental illnesses when the illnesses are severe they share many common symptoms.... (session 4)

In addition to the biomedical approach that authorizes what children need to know about having a parent with a mental illness, BTU also uses other professionally-based sources of knowledge to legitimize beliefs about the nature of children’s risk, need for protection and the potential to prevent future psychiatric illnesses. I highlight two examples, beginning with copyright notices that appear on the acknowledgements page of BTU. BTU is linked to an Australian manual Martha uses for some of the material in the fifth and sixth sessions of the Children’s Group, which focuses on children’s feelings, and the safe and appropriate management of fear. The Australian manual describes concepts such as: risk, safety, prevention, protection and rights, which are taken up in BTU.39 Similar to the CAMH brochures described earlier this is a good example of how texts, and discourses, are interconnected in what Fairclough (19920 describes as a ‘chain of intertextuality’. It is used here to establish the authority to speak about children, and mental health and illness in terms of risk and protection, but the language is explicitly about “safety”, “protective behaviours” and “rights”. Because it is a publicly accessible document, the Australian manual allows the Children’s Group facilitators to draw on the ideas it promotes, shaping the way the concepts are expressed in BTU. For example, in the following excerpt the Australian consultancy group advocates for children’s rights to safety through its ‘Protective Behaviours Program’ (PBP):

Over the past ten years there has been an increased awareness of all areas of children's safety, particularly that of children's personal safety. We are now aware that children are more likely to be harmed by someone they know, than by someone they do not know….It is important that children develop personal safety skills from a well presented and well structured personal safety program. Protective Behaviours can be used by both children

39 Copyright material reproduced in Sessions Five and Six belong to The Right to Feel Safe: A Protective Behaviours manual, written and developed by The Protective Behaviours Consultancy Group of NSW inc. (Australia, 1994). ISBN 09588803390. For more information contact the group at: www.protective-behaviour.or.au. Used by permission.
and adults to help keep themselves safe and work towards reducing violence in the community. It can provide the basis for helping children be safe at school and take pleasure from their learning. It can also help everyone learn to stay safe from the risks that surround us in our everyday life. Children may experience a wide range of situations which put them at risk and causes them short-term and long-term harm which is both physical and emotional and violates children's basic rights… (the goal is) to empower people with the right to feel safe and act to keep themselves safe (PBP).

The point of view is implicitly assumed to be progressive; valuing the idea that new knowledge is trustworthy because it advances our thinking—because ‘we are now aware…’ children are potentially at risk not only of physical but also of emotional harm. Moreover, safety is considered a right of all children and this can be realized by developing safety skills in a formally structured program. Of note, once the idea of risk is recognized and legitimated by the ‘we’ who ‘now know’, it is portrayed as being everywhere, and also as, personal and pertaining to the private worlds of individuals. There are echoes of mental health promotion discourses at work here too. Once the individual is ‘empowered’, this can be extended to include the whole community. The Children’s Group is designed to be such a well structured program, both in the content it provides as described in the protective behaviours program, and also in the format the program takes, as described earlier.

A second copyright notice acknowledges material adapted for use in BTU from a guide written for ‘educators and other professionals’ who are working with school-aged children. The authors of this text draw on their own experiences working with children who have parents with addiction problems, to advise others on the therapeutic effectiveness of support groups for children. The 4C’s is a significant activity adapted from this book to establish an important goal of the Children’s Group program:

**BTU goal:** For each child to understand that they did not *cause* the illness, nor can they *cure* or *control* it, but they can *cope* with it. (session 3).

In a later session, the children do artwork that represents what they learned about this goal:

The 4 C’s Art Activity (10 min.), Hand out a copy of the 4 C’s text for each child. (You will find this at the end of the chapter.). Ask the children to decorate the margins by using stickers or designing their own personal border. Hand out a picture frame to each child to hold the decorated sheet. This artwork can be taken home. (Session Seven)

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The message is important, signalled by the fact that the artwork (and also the message in a discursive way) is framed, and the children are allowed to take it home. Unlike artwork produced by the children during the course of the Children’s Group this is literally a “take-home” message, a rule of the group that is impressed upon them. The message is also reinforced in one of the last sessions of the group. The children are reminded that while they can’t change the parent’s illness, they can change themselves, in order to have a better future. In the following excerpt the propositional phrasing of the concluding sentence, suggests that once children accept the idea that they are not responsible for the illness, then they will be able to take charge of their own future:

Working time (45 min.), “In this last session together we are going to spend some time looking at our future. But first, let’s recap a few things we’ve learned. 1. You know now that you did not cause the illness that your family member suffers from. 2. You know that you cannot control or cure it. 3. You have also learned that it takes a combination of different factors for anyone to develop a mental illness.” “Has any of this new information affected the way you view your future? Because when you know you can’t change anything about your family member’s illness, then you can begin to think about what you would like to do and what you can do in the future. (session 8)

This reframing of responsibility for oneself rather than the parent’s illness is an important lesson taught by BTU. Children are not supposed to be able to fix these problems and they are not the “helpers” in this situation. This point is also made by medical experts in the CAMH brochures referred to earlier because they emphasize it is the adult’s duty to make things better, and to mediate and discern what help is required:

Is there anything I can do to make my mom or dad better? Family support is really important, but it is the adults who are responsible for being “helpers”, not the kids….It is best to talk with other adults in the family, or to the health care workers caring for your mom or dad, to see what would be most helpful.41 (emphasis added).

A final comment concerning the processes BTU uses to establish its authority pertains to a moment in the following excerpt when children are completing the teaching about mental illness education in sessions 3 and 4. Once children accept and understand the information, presumably becoming more literate themselves, then they can teach others what they know. The child’s expertise is professionalized in a sense, and can be harnessed for the common good by challenging stigmatizing and discriminatory ideas about mental illness:

41 Available from the R. Samuel McLaughlin Addiction and Mental Health Information Centre, Centre for Addiction and Mental Health, Copyright 2005. 1-800-463-6273.
Let’s take a few minutes to talk about what most people think about a person with a mental illness. What are some of the words or phrases that people use to describe someone with a mental illness? Write their responses on the paper (in handwritten notes, crazy, loon, nuts, weird are suggested). Why do you think people use these words to describe a person with a mental illness? People tend to use labels when they don’t understand the problem or the situation. Now we will learn what mental illness really is and what causes it. Then you can explain this information to anyone who doesn’t understand what mental illness is and may feel afraid of it or have wrong ideas about it. (session 3)

This idea that children’s knowledge is professionalized and medicalized through participating in the Children’s Group, is interesting because ambiguity remains in how expertise is taken up in BTU to make claims about its authority to speak and write about children, and mental health and illness. I have described the prominence of medical and other professional knowledge used to ascribe credibility to the informational content of the text. And yet there is an underlying current of claims-making that values the idea of having “been there” to suggest that BTU is trustworthy. For example, in describing the wider context in which BTU has developed as part of the umbrella organization, I detailed how family expertise is considered important, and a vital link to talk about mental health promotion. Slogans such as, “We understand because we’ve been there”, suggest that there are those who can make ‘truer’ claims about whose knowledge counts because they have first hand knowledge and understanding of the “challenges and emotions experienced in supporting a family member with a mental illness”. Moreover, the expertise of non professionals is integral to the umbrella organization in conjunction with the underlying beliefs of mental health promotion, because of a reliance on the concept of “self help” and the role of individuals in decision making with regards to mental health services and support that move beyond a singular focus on medical treatment for illness. People’s own strengths and capacities are conceptualized as a source of help for others, based on principles of shared experience and mutual support.

The idea that “families have a voice” is also central to these efforts. “Having a voice” signals respect and support for “the expertise that families have regarding their mentally ill relative and their experience in the system”. 42 The preface to BTU acknowledges contributions made to the text by previous co-facilitators, trainee facilitators, and alumna child participants; this includes the value Martha places on her experience with children’s bereavement groups, and her family history of mental illness, which helped her develop BTU. Taken together, current and

42 ‘the umbrella organization’ website.
past Children’s Group members constitute a greater collective of engaged and active participants who are “the experts” on the problems and needs of children who have a mentally ill parent. In this way children become part of successful mental health promotion efforts that require active citizen involvement, which begins when they take their part in helping to create a sense of belonging amongst ‘community’ members. And while BTU acknowledges that children have relevant knowledge and experience, children’s independently acquired knowledge, skills and coping mechanisms are assumed to be evidence of maladaptive thoughts, feelings and behaviours. Consequently, as evidenced in the affirmation statements at the end of each session, value is attributed to children’s independently acquired knowledge once it is reframed by the Children’s Group program.

Constructing systems of knowledge and belief

iii. What key concepts are developed in BTU? How is value attributed to some ideas but not others?

In the following section I begin to describe in more detail the text itself (Fairclough, 1992). The section is organized according to two of the central discursive formulations that concern this analysis—mental illness and mental health promotion—and include central ideas/concepts that contribute to the construction of these formulations such as risk, resilience, protection, responsibility and so forth. These central ideas constitute the “working consensus” of BTU, particularly the ways in which these ideas contribute to an ongoing collective agreement about how children should learn to manage their own mental (emotional) health (and prevent mental illness).

Mental illness

The first four sessions purport to introduce children to “accurate and up to date mental illness education” (session 1). However, BTU assumes it will be difficult for participants to talk about mental illness, probably because it is for the first time. To manage potentially negative feelings associated with this assumption the facilitators are encouraged to begin by creating a “comfortable”—i.e. secure— atmosphere. Because an important priority is to establish a “feeling of safety” so that the children will be able to take in the teaching about mental illness. BTU begins by advising the facilitator to ask the participants to repeat in unison the phrase, “We are here because we have a parent with a mental illness”. The phrase is used as a strategy in other sessions where it is repeated to remind the children that this is the focus of the group, but I argue that it helps to ensure group solidarity, including the formation of their collective identity as a
particular group of children. It is not surprising then that children come to the group because the difficulties they may be experiencing are defined by a biomedical discourse that assumes the problems are illness-related.

Mental illness is defined in BTU as an illness “like any other”, but also as an illness with unique characteristics that set it apart. It is said to be within the purview of medicine because as in the case of other illnesses, physicians have the responsibility and training to look for signs of illness and make recommendations for treatment. However, aberrant, deviant behaviours, abnormal statements and behaviours are signs and symptoms of illness. Mental illness is not like having a “cold” or “pneumonia”. Behaviour is a significant aspect of mental illnesses because unlike other illnesses, there seem to be no biological markers to signify them. On the other hand, mental illnesses are also considered chronic, because like some other illnesses there is no cure. The comparison to other illnesses is made in the following passage about medical diagnosis and treatment. Notice that there is no acknowledgement of the contradictions the comparison suggests:

DIAGNOSIS: (the doctor): 1. first rules out physical reasons for having a mental illness…2. will assess the symptoms/behaviour your family member is displaying; 3. determine if your family member has a mental illness and decides what kind of illness according to the DSMIV; 4. needs to know how long the symptoms have been going on. For example the doctor will need to know how long your family member has been feeling sad, worried or confused; 5. needs to know how intense (strong) the symptoms are. For example when you have a simple cold you may have a few symptoms like a cough and a sore throat. But if your symptoms are more severe such as a high fever, headache, sore chest, you may have more than a simple cold. You may have something serious like flu or pneumonia.; 6. needs to know how the symptoms are affecting your family member’s life, such as their ability to work, go to school or look after their home; 7 sometimes a person can have more than one type of illness. This is true for physical illness as well as mental illness. For example a person can have asthma and diabetes or be deaf and crippled….Treatment (10 minutes), “Many illnesses have a cure, but at the moment there is no cure for mental illness. It is what they call a chronic illness, one that you have for your whole life. There are a number of diseases like this: diabetes, asthma, allergies, heart disease. There is however, treatment that can ease the symptoms. A doctor or psychiatrist can recommend a treatment plan that will help ease the particular symptoms of the illness. (emphasis added, session 4).

Similar explanations of mental illness as an illness “like any other” are found in the brochures published by CAMH described earlier, which are used to answer children’s questions about mental illnesses as described in the following excerpt:

The brain contains many chemicals that help us think, feel and act. When a person has psychosis, his or her brain works differently because the chemicals are out of balance.
This imbalance also happens with other disorders in the body, such as diabetes and high blood pressure. (emphasis added)

The kinds of problems associated with a mental illness can require hospitalization for reasons unlike other illnesses as demonstrated in this excerpt from BTU. An ill parent’s behaviours can be so difficult that the parent requires hospitalization to protect themselves and/or the child:

Hospitalization, “Sometimes the symptoms come back, or are so severe, that your family member has to stay in the hospital”. “A new treatment plan might be necessary”. “If and when the symptoms return, it is important to keep your family member safe, as well as protecting the rest of your family” (session 4).

As indicated in the first half of the earlier paragraph, the symptoms of mental illnesses that the doctor is interested in tend to be about potentially disordered thoughts and emotions. Despite the inherent contradictions in this message, mental illness as an “illness like any other” normalizes the experience for participants who are probably more familiar with diagnostic and treatment practices for physical illnesses, so that the facilitators can inculcate the idea that parents’ mental illness is manageable, but only through medical means.

Mental illnesses as defined in this text, are situated in the individual body: 1.) because they have a “physical property” (session 3); and, 2. in “the brain”, because this is where disorder originates (session 2). The brain, depicted as a functional, mechanistic organ, is also capable of breaking down like a machine, and this can lead to what is described as unhealthy, ‘twisted’ thinking – or mental illness. The illustration included earlier, depicting ‘cogs and wheels’ working smoothly together, represents this idea of a properly functioning brain next to the definition of mental illness in the text. Mental illnesses are said to develop because of a process in which a “broken brain” leads to distorted thinking. The process is largely linear because distorted thinking influences emotions, and emotions affect behaviours. The brain and its capacity for thought impacts how people manage what they feel, and what they do.

This process, beginning with accurate and healthy thinking, mediates not only how emotion and behaviours are immediately experienced, but also how individuals ultimately “experience the world” (session 2). In the following two excerpts an illustration of the differences between healthy and unhealthy thinking are depicted. In the first, the goal is to define mental illness as unhealthy thinking, and to distinguish between what the eyes see and the brain ‘thinks it sees’, so that the source of dysfunction is in the brain. The dialogue suggested

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43 Available from: R. Samuel McLaughlin Addition and Mental Health Information Centre at the Centre for Addiction and Mental Health, copyright 2005.
here is to help draw participants into the experience of what it is like to think this way, and how
this might explain outward behaviours as manifestations of “twisted thinking”:

To illustrate the difference between healthy, accurate thinking versus twisted thinking we
use the pictures of a cat and a lion; “When you family member’s thinking becomes
twisted what their eyes see and what their brain thinks it sees are different.” “For instance
when we see a cat (show cat picture) your family member thinks they see a lion (hold up
lion image). When we see this elastic on the table they think they see a snake. 1. “How
might you act if you saw a cat? What might you do if you saw a lion? Twisted thinking
can affect how you act or behave in a situation. Twisted thinking is unhealthy thinking.
This is why we call it mental illness” (emphasis mine, session 3)

In the second excerpt, the workings of the brain and thinking process are dramatized using props
to support neuroscientific explanations about healthy and unhealthy thinking, and the impact on
behaviour. An extended metaphor—a literal and figurative bridge—is used to explain the
physical properties of mental illness by showing how neurotransmission works if there is
structural integrity and no impediments to the natural processes of the brain. This metaphor is
pervasive because it includes the entire program under the title, “Bridges to Understanding”. As
the metaphor suggests, there are obstacles or hindrances that must be overcome and connections
that must be made to achieve appropriate understanding about the situation—to go from ignorance
to knowledge:

The Brain/Bridge Analogy (10 minutes), Place the props on the table in front of the
group. Put the islands (neurons) down and place the bridge (neurotransmitter) between
them. Place the car (thought/message) on the first island. “Thoughts travel through the
brain from one neuron to another, through neurotransmitters. These islands represent
neurons, and this car represents a thought of message that needs to get from one neuron,
or island to another. The thought car goes over the bridge, which represents a
neurotransmitter, and easily arrives at the next island because the bridge is there and the
bridge is in good condition. (Illustrate this action a few times to ensure they understand
the process.)” “When the brain is not working properly, it cannot send the message across
the gap, from one island to the other, because there are problems with the bridge. The
thought-car may start to cross the bridge, but there may be cracks in the bridge or big
bumps and the car begins to skid. Maybe it even does a 360 and falls off the bridge!
Sometimes the thought car gets damaged and bits of it fall off. Maybe the car loses a tire,
or its windscreen, and arrives at the second island all twisted and out of shape. The
message that started out as one thing gets damaged and changed in the process of crossing
the bridge.” “Sometimes the bridge might totally collapse, and then the thought- car can
never leave the island at all!” Repeat this process until the children understand the
difference between a healthy and an unhealthy neurotransmitter. Allow time for
questions. Do not move on from this discussion until the children understand fully that
mental illness has a physical property. (emphasis mine, Session Three)
In order to teach participants about mental illness as it is defined in *BTU*, the facilitator must also define thinking, feeling and behaviour as three concepts that support an overall understanding of the process that leads to developing a mental illness. I have already described how ‘thinking’ is considered an important component for understanding how mental illness is a process that begins in the body and in the brain in particular. Moreover, the following prompt underscores the significance in *BTU* of ‘thinking’ for being able to understand our experiences in the world, and forming beliefs and opinions, and making decisions:

*Thinking* is very important to every one of us. It is the way we form an idea in our heads, or understand the world around us. Thinking takes place when we dream, when we use our imaginations, when we wonder about a thing, make decisions, remember something, or try to solve a problem; can produce an idea, a belief, or an opinion about something, about a person, or even yourself (session 2)

*BTU* defines ‘feelings’ as embodied, as physical sensations located in the body, for example as illustrated in the next excerpt, they are “in the chest” and “where your heart is”. Feelings are also personal or individual, because, one person’s feelings may be different from someone else’s feelings. The second excerpt, taken from a later session, illustrates the emphasis on the personal and physical aspect of ‘feeling’ as it is associated here with mental illness and parental behaviours. The importance here is for the child to learn how to recognize the subjective—“personal, physical signs of fear”—bodily sensations that signify negative emotions, by learning the emotional language that describes the experience and the logic that connects physical arousal to situational cues:

*Feelings* can be physical or emotional. You might feel hot or cold. You might feel tired or you might feel pain. These are physical feelings. Emotions, on the other hand, are more invisible. They may seem to come form somewhere in your chest, where your heart is, for e.g. when you feel angry, happy, worried, excited or shy (session 2).

Draw the outline of a gingerbread person on the easel board paper. Ask the members what kinds of things they like to do that are scary, for example: riding a roller coaster. List their suggestions on one side of the paper. Ask them to think about how their body feels when they are frightened. For example: Do they start to shiver? Do they get butterflies in their stomach? Write their responses at the appropriate anatomical spot on the gingerbread person. When the list is complete, emphasize that fear is a personal thing. What one person is afraid of, another person may think is fun or okay. Also let them know that not everyone has all these physical symptoms of fear, some may have butterflies, some may sweat a lot, but *if is important to recognize your personal physical signs of fear.* (emphasis added, session 5)
Behaviour is defined at first rather innocuously, as “another word for our actions, the things we do, like playing games, reading our books, making our beds” (session 2). But the text focuses for the most part on inappropriate and abnormal feelings and behaviours. Behaviours are also described as ‘symptoms of illness’, or things that ill parents do when their thinking becomes twisted or unhealthy and they are not able to distinguish what is real from what is not because of a “broken brain”. Furthermore, parents’ feelings and behaviours are mercurial because they are unpredictable when they are not well. Erratic behaviour and volatile emotions cause children to feel afraid—especially because neither the parent, nor the child, has control over these symptoms of illness as described in the following example:

The symptoms of a family member suffering from a mental illness can be very unpredictable. They can see, hear and feel things that are not real. Their feelings can change quickly and so can their behaviour. At times, living with a family member with a mental illness can be scary, because you don’t know what they might say, feel or do. You don’t have any control over their actions, and you don’t know how long their symptoms will last. During this session, we are going to learn how to listen to our bodies. We will learn how to recognize when our bodies are telling us that we are afraid. (session 5)

Having defined ‘thinking’, ‘feeling’ and ‘behaviour’ as concepts that are important to understanding mental illness, the facilitators are instructed to help participants realize the interconnections between these concepts, though they may appear different. The participants are told that thinking can affect feeling, and feeling can affect thinking, but that thinking and feeling together, affect behaviour. BTU describes three strategies to help the facilitator demonstrate this connection.

First, they conduct a drawing exercise to help children represent their feelings and thoughts about having a parent with a mental illness on paper. Children are asked to use abstract images to symbolize their thoughts and feelings. The facilitators show them how they used their thoughts and feelings to perform the activity. The strategy has the advantage of telling the facilitator something about how the child feels and thinks about the parent’s illness:

…encourage children to understand their thoughts and feelings, and to help the facilitators get a sense of how living with a parent with a mental illness affects them. (Before they start the activity, remind them that there are no good or bad feelings. It is how they choose to act or behave when they are feeling a certain way, that may be inappropriate). (session 2).

Unlike the definitions about thinking and behaviours the additional directions in parenthesis indicate that feelings are considered neither good nor bad because they are neutral. In other words, individuals may have a choice over how they behave and these may be evaluated as
“good or bad”, but they may not have a choice about how they feel. This is relevant to the mentally ill parent because thinking helps control and manage feelings and behaviours. Another concept initiated here and developed later in the program is that individuals have to learn that they have a choice or control over some things, but not others; this will depend on whether the person is “mentally healthy” or not.

Second, the interconnectedness of these concepts is reinforced using an ‘interactive game’ in which children choose to respond to statements read out loud by running to a sign on a wall that best describes whether it as a thought, feeling or behaviour as illustrated in the following excerpt. The teaching strategy is to help children understand the relationship between these concepts by enacting the experience of choosing between them. There is a trick however, and this involves realizing that many of these statements can be read as all three options, so that making no choice at all is actually the better understanding because it represents the link between them. While several of the statements used in this exercise seemed to me to be rather mundane, others are likely to be more evocative because they concern the children’s experiences of parental mental illness:

*Thoughts, Feelings and Behaviour Game (5 min.)*, Preparation: place a THOUGHTS, FEELINGS AND BEHAVIOURS sign on three different walls in the room. 1. ask the children to stand in the middle of the room. 2. explain that you will read a sentence out loud and they have to decide what category it belongs to: a thought, a feeling or an action/behaviour. When they know the answer, they are to run to the appropriate sign on the wall. Here are some sentences you can use: I’m going to the cupboard to get some cookies. I’m excited about my new puppy. I wonder why my dad doesn’t want to do anything with me anymore. I can’t decide between nachos and cheese, or tortilla chips and salsa. I’m tired because I stayed up late to finish my homework. I like eating pizza. I’m embarrassed by my mom’s behaviour. I like listening to music in my room. I’m angry because my sister lied to me. I’d like to go on a trip to Disneyworld. (session 2).

When the children realize that some of the statements qualify for all three categories, they may opt to stand in the middle of the room. *If they do this, then they have understood the interconnectedness of thoughts, feelings and action/behaviour.* (emphasis added, session 2)

Third, the facilitators are directed to “add a bit of comedy into the session” by literally acting out the impact of thinking on feeling and behaviour. In the first scenario they act out a ‘bad day’ depicting how things can spiral out of control, and the sequence of events, beginning with ‘thinking its going to be a bad day’ leads to dire consequences because thinking affects how someone feels and what they do in response:
IMPACT OF THINKING (15 min.), Get the children to imagine the following scenario: you wake up in the morning and you trip getting out of bed. Maybe you have a math test you’re worried about. You think it’s going to be a bad day. Thinking it is going to be a bad day will affect how you feel and act that day. You may be so worried about failing the math test that you find it difficult to concentrate. You may fail, and think it’s because you are stupid. But it’s not because you’re stupid, you failed because you were so worried you couldn’t concentrate.

The facilitator completes the scenario on a happier note by reversing the chain of events and acting out a ‘good day’:

Now let’s take the same example and change it to a good day. You wake up in the morning and remember that you are going to a friend’s house after school. You feel that it is going to be a good day. You are relaxed for the math test and you do well on it. You see your friends laughing and you run up to join them, to find out what it’s all about. If someone pushes you, you understand that it was an accident. People will enjoy your company and want to be with you. You, in turn, will enjoy their company and feel able to encourage, or even compliment them. These two e.g. show how your thoughts can affect your feelings, how your feelings can affect your behaviour, and how your behaviour affects the way you experience the world. (session 2).

A number of strategies involving demonstrations, games and artwork are used then to make an impression on children about what it is like to have a “broken brain”. The scenario described here, which involves acting out a good day/bad day, shows not only the importance of managing thoughts and feelings, but because it is supposed to be carried out with humour it calls for an immediate ‘emotional’ response from those watching while also communicating indirectly what is expected of the audience—that efforts are best directed toward having a “good day”.

**Promoting mental health and preventing illness**

The conclusion I reached at this point in my analysis is that once the participants realize the impact of thinking on emotions and behaviour, and come to realize that mental illness is caused by faulty thinking based on a “broken brain”, they can learn to manage problems by becoming disciplined performers who can change their thinking (and their feelings and behaviour), to protect themselves from developing an illness. This cognitive work to summon up and evoke the right thoughts (and emotions and behaviours), is part of learning how to manage and take control of stressful situations. The child’s difficulties may not be the mental illness per se, but the negative thinking that is assumed to be part of the experience, and it is this that can be controlled or managed because they still have properly functioning brains. Several strategies for doing so are suggested in the following excerpt, which comes toward the end of the session. For example, the text includes tips on modifying behaviours, ways to distract
themselves from negative thoughts and encouragements to engage in positive “self-talk”. All of this may take time and preparation, as a final affirmation statement exhorts children to practice managing negative thoughts and presumably, given these teachings, their feelings and behaviours will follow. Moreover, like all circumspect and disciplined performers who plan in advance for unforeseen events, like responding to unpredictable behaviours—these strategies are best achieved under manageable circumstances where routines can be rehearsed ahead of time:

Did you know that there are ways to change your thinking? When you start to have negative thoughts you can say STOP! (A stop sign is illustrated. At this point the facilitator can hold up a stop sign to demonstrate the point more effectively). And you can do something to distract yourself, like clapping your hands. You can ask yourself some questions that will help you replace your negative thoughts with more positive thoughts. You can ask yourself: are these thoughts really true? What evidence do I have that proves these thoughts are true? Would my friends think the same way as I do? When our brain is working properly we can usually stop our negative thoughts by asking ourselves questions that can change our thinking. When we can change our thinking, we can change our feelings and behaviour. When our brain is not working properly, it becomes harder to control our thoughts and feelings and behaviour. (session 2)

Affirmation Statement: You did a great job today recognizing the differences between thoughts, feelings and actions/behaviours. We know that you can learn to stop your negative thoughts; it may just take a bit of practice. (emphasis added, session 2)

The children are now assumed to be much better positioned to manage their thinking, feeling and behaviours given their understanding of how the broken brain works and affects behaviour, in contrast to their parent, whose mental illness prevents them from controlling the process and knowing what is real or not:

Their brain isn’t working properly; they cannot stop their thoughts or change them very easily…and, this in turn will affect how they feel. They may feel sad or stupid, even if it isn’t’ true. They may also feel angry. These feelings may make them act in a weird way, what are some of the weird ways your parent has acted? (session 2)

The stakes are much higher too for the child who has just learned this information, and who with “a bit of practice” using cognitive and behavioural strategies to exert control over the immediate and long-term consequences of “negative thoughts”, can now also manage how “they experience the world” (session 2). Moreover, as I described previously, the children are now positioned to educate and give advice to others who may have inaccurate ideas about mental illness having been exposed to mental health education through BTU:

Closing time (10 min.), At this point, a snack is served. “Imagine you are 40 years old and want to write a book or direct a film about your life as a child living with a family
member with a mental illness, what would you think is the most important piece of advice you would pass on to other children in the same situation?" (session 7)

While neuroscientific explanations clearly define mental illness as a brain disorder, BTU seems less certain about causes of mental illness. This may be because the underlying but as yet unarticulated goal of the script is to talk about risk for developing an illness rather than the specific causes of illness. For example, the following prompt supported the belief that no one really knows what causes mental illness, yet the potential for developing an illness is depicted as being widespread. At this point BTU, implicitly at least, begins to formulate ideas about risk and particularly those about being ‘at risk’ as a precursor to talk about promoting health and preventing illness. Mental illness can happen everywhere, to anyone, but will not happen to everyone:

Use the following prompt to begin a discussion about the causes of mental illness: “Have you ever wondered what causes mental illness? The answer is: Nobody really knows what causes mental illness. ” “Mental illness can happen to anyone, anywhere, but not everybody gets it.” “Scientists and researchers have found that there are three possible reasons why a person might develop a mental illness.” (emphasis in the original, session 3)

Despite the lack of knowledge about the causes of illness, the sentence beginning with “scientists and researchers have found…”, gives the impression that there is some evidence about possible causes that are worth considering. The prompt also foreshadows risk as an important idea underlying the causes of mental illness. While the chances of “getting it” apply to everyone, BTU uses an exercise to help children understand the genetics of mental illnesses by dramatizing the concept of heritability, so that children are able to see that not everyone who has a parent with a mental illness will “get it”.

In BTU the causes of mental illnesses are classified as physical, social and/or hereditary. Physical causes include those resulting from brain damage through head injuries, tumours and strokes, and infections or diseases associated with other illnesses like diabetes or heart disease. Social causes focus primarily on a notion of “stresses” as an underlying mechanism for the development of a mental illness. However stress is both something that happens to the individual, because it is caused by life events like war or bereavement, and something that must be managed by the individual, who must help themselves by “talking openly” with someone who is considered trustworthy:

Social causes: “Mental illness can develop in response to events that happen around you. For instance, depression can be caused by living through a war, or experiencing the death
of someone close to you, or witnessing a violent situation.” “Mental illness can develop when something bad or stressful happens to you. For instance, you might become mentally ill after being attacked by someone, or from living in a difficult situation.” “It is important to talk openly about the problems you are having, because this can help relieve your stress. Try to find someone to talk to who you can trust, a relative, a friend, a teacher of a counsellor”. “Many people who live in difficult situations do not develop a mental illness” (emphasis added, session 3).

This excerpt includes a caveat that not everyone who is faced with a difficult situation—or is considered ‘at risk’—will develop a mental illness. There is an allusion here also to the concept of resilience, the notion that many people remain healthy despite living with adverse circumstances.

As a precursor to explaining the hereditary aspects of mental illness the children are taught general information concerning genetics in a discussion about inheriting physical characteristics as illustrated in the following excerpt:

We inherit physical and temperament traits through genes. Genes are little molecules of DNA that live inside your body and help to determine all of your characteristics: your physical appearance, your temperament and your health. In the same way that a person might inherit, through their genes, their mother’s eyebrows, or their father’s red hair, they can also inherit a weakness or a disease, like high blood pressure or arthritis. A person can also inherit a mental illness.” “Research has discovered, however, that it takes a number of different genes to inherit a mental illness not just one gene, as in the case of hair colour, or a temperament trait like curiosity, but a combination. This makes mental illness harder and less likely to be inherited than hair colour.” “Genetics alone will not cause a mental illness. If a mental illness “runs in the family”, you might have a (crossed out: ‘slightly’) higher chance of developing the illness (session 3).

One of the central messages is that not everyone who has a genetic, familial predisposition will develop a mental illness because research shows that it takes a complex set of genes to do so and even this only indicates an increased risk. In the following excerpt the facilitator is instructed to use props to demonstrate the statistical association with the development of specific psychiatric diagnoses, and to dramatize the overall concept of genetic risk:

Clothespin Doll Demonstration, Place a hundred (100) mini clothespin dolls in front of you. Put twenty (20) dolls over to one side and explain that twenty (20) out of every hundred (100) people have some sort of mental illness. Take ten (10) dolls out of the group of twenty (20)…. (numbers given for different diagnoses)…. “When you have a family member with a mental illness you have a slightly higher possibility of developing a mental illness yourself. Just because there is a slightly higher chance of you getting a mental illness does not mean that you will get the same illness or have serious symptoms. The majority of people with a mental illness can carry on living fairly normal lives when they follow their doctor’s treatment plan. Emphasize that they have a much higher
chance of not getting the mental illness, as represented by the seventy (70) clothespin dolls that do not get a mental illness. (emphasis mine, session 3)

The climax of this session occurs when participants realize that they have only a minimally greater risk for developing a mental illness compared to the general population. The demonstration emphasizes the idea that they have a 70% chance of not becoming ill, rather than a 30% risk that they might. This framing is supposed to be positive as it is a precursor to a growing emphasis in the text on health rather than illness, and on the children’s chances of remaining so by learning strategies to stay “mentally healthy”. The message is itself a strategy for selectively interpreting the “facts” in order to summon up and invoke the right kinds of thoughts and emotions about being “at risk” for a mental illness. Moreover, the text concludes with a health promoting and recovery-oriented message that even if they develop an illness in the future, the good news is that medical treatment can help individuals to “carry on”, and “living fairly normal lives” (session 3).

Previously I described discourses circulating in BTU that are connected to others located elsewhere. I am referring here to the way risk is conceptualized in Right to Feel Safe: A Protective Behaviours Manual from the consultancy group in Australia, which Martha used to develop material for sessions five and six. The Australian manual emphasizes the concept of risk—although ‘harm’ is used interchangeably with risk—as something ‘personal’. This connotation reflects the idea that children are supposed to be most at risk from someone they know. While these relationships put children at risk, mental illness is not the focus of the more general concept of risk being described here. However there is also a concept of risk as ubiquitous as we have seen it described in BTU. The Australian site lists a number of potentially risky circumstances and comes closest to risk associated with mental illnesses as portrayed in BTU, when they describe the problems of “emotional abuse and threats to personal safety” as sources of risk.

The authors of the Australian program suggest further that because the scope for being at risk is quite broad, many situations that children face may be in violation of their rights—and here they are referring specifically to the “right to feel safe”. This rights discourse is universal in the sense that it conceptualizes all children as having the right to protect themselves from risk—by learning to be safe—and to pursue courses of action that will lead to positive health and wellbeing. In having the right to feel safe actions can be taken to prevent the negative outcomes or behaviours associated with situations that put individual children at risk. To exercise the right
to feel safe children are encouraged to develop protective behaviours, or “personal safety skills” in a structured, formal program—a significant objective originating in The Protective Behaviours Program, and adapted for use in BTU. BTU also uses the concept of resilience—a corollary to risk discourse associated with preventive and protective discourses—describing it as both a natural characteristic of all children, and as a personal skill to be developed by individual children. In the following excerpt referring to BTU’s program philosophy, children are conceptualized as having inborn resiliency skills they use to adapt to ‘situations’, although these situations are not described here as particularly problematic. As described, resiliency skills are interchangeable with mechanisms for coping, so that resiliency and coping skills appear to be one in the same. The important point is that there is something wrong with these natural, inborn abilities, and a significant objective of the Children’s Group is to transform these skills so that they are more appropriate, and safe:

The fundamental belief underlying the program is that all children have their own, innate resiliency skills. Often the child is not aware of the skills and coping mechanism they have developed to adapt to their situation. This program is designed to build on their pre-existing knowledge and skills, and to introduce and encourage safer and more appropriate coping skills in the future.” (BTU, Introduction)

One of the main goals of the Australian program is to teach children to talk about their problems as a safety mechanism in risky situations. But first, children must be given permission to talk about their problems, and recognize that there is nothing that cannot be talked about no matter how ‘bad’. The shift in the “working consensus” of BTU based on this external source of information is now toward thinking about risk in terms of emotions and the management of negative and stressful emotions. Learning to talk about feelings is considered particularly important, because it is assumed that those who can express their emotions can learn to act on them. Those who can act on the appropriate expression of emotion can learn to “feel safe”. An important objective of BTU is “to provide a safe, non-judgmental place where each child can identify and express their feelings about mental illness” (BTU, Introduction). In the following excerpt the facilitator empathizes with the participants by literally giving voice to what they imagine children’s mixed feelings might be in coming to the Children’s Group for the first time, and the necessity of “getting these feelings out, right from the start” as if they reside inside the person and can be physically extricated (session 1). The facilitators are told to plan for emotions that are assumed to be part of making first impressions in a new group, but also the anger and loss of control that is assumed to be part of children’s experience in being coerced into attending
Children’s Group. The rule here is that there is no judgement about feelings because they are all acceptable. The following scripted dialogue shows how the facilitators are expected to manage anticipated feelings at the same time that they are initiating children into ways of managing their own emotional responses to situations, beginning with some “body work” that will produce the required response to “get them out”:

I wonder how you felt when you first came in the room. I know that I have more than one feeling when I first meet a new group: I feel excited about meeting new people, but I also worry about what you will be like, and what you will think of me. Some members here may be angry because they had no choice in attending the group, others may be happy about coming. Whatever you may be feeling is acceptable here. If some members are angry about attending, it is good to get these feelings out, right from the start. (session 1).

A central message of BTU is not to prevent risk by measuring it objectively in individual children, but to help children develop their own subjective evaluation of whether or not they are safe. Having dispensed with risk in terms of fears about heritability, the focus is on learning how to express feelings about parental mental illness and the dangers it poses through difficult behaviours, so that children can learn how to act or behave in ways that “feel safe”. An important step seems to be that “getting feelings out” is helping to manage them in some way. The programming in the remaining four sessions of BTU switches from an emphasis on education about mental illness to one devoted to supporting children by helping them to express fear, and learn what it means to be safe. To put it another way, the focus shifts from managing how children think about mental illness to managing how they feel about it—this is important because they must learn to cope by learning to manage their own thoughts and feelings in response to their parent’s illness-related behaviours. The goals of sessions five and six are excerpted here because they indicate that BTU assumes “fear” is the dominant emotion for these children because their parents’ behaviours can be unpredictable, not well-managed and even out-of-control:

Goals: to recognize that it is okay to be scared by the unpredictable behaviour of a family member with a mental illness; to recognize the physical signs of fear; to learn there are ways to work through their fears (session 5).

Goals: to learn about their personal feelings of safety; to know when coping skills are working for them; to develop a personal feeling of safe people and places (session 6).

In the following exercise, a statement excerpted from the Australian The Right to Feel Safe manual is used to explain the concept of feeling safe to the Children’s Group participants. By taking each of the component parts of the statement in turn, and using it to interpret the
meaning behind these bolded words, I show how BTU begins to establish a concept of the responsible individual (that is the disciplined performer) whose right to feel safe obliges them to account for their own feelings of safety and protection and ultimately to take responsibility for their own health and well-being. I quote the passage in its entirety, followed by a discussion of each of the component parts as highlighted in the text:

“IT IS IMPORTANT THAT I FEEL SAFE ALL OF THE TIME. I –Safety is a personal thing. Just as your feelings are personal, so too is the feeling of safety. Feeling safe varies from person to person. Some of you may feel safe in this group, while others may not. Some of you may feel safe or comfortable with certain symptoms of mental illness, while others may feel unsafe. There is no right or wrong way to feel about safety. You simply feel the way you do. FEEL SAFE – “No one can guarantee safety for anyone else. I can’t make your life safe. There are lots of things that happen in life that are not safe, for example: hurricanes, car accidents, falling off your bike. But you can help yourself feel safe in a number of different ways. You can try to think ahead and try to prevent bad things from happening in the future. For example: when you ride in a car, you wear your seat belt to help reduce the chances of being hurt in an accident. The driver sticks to the speed limit. They make sure the car is working properly. These things help prevent an accident and make the people in the car feel safe. At home, you might want to take similar precautions. Develop an action plan: know ahead of time where to go in an emergency. Know the phone number of someone you can call for help. Find out where the nearest police station is. Know how to get to a friend’s house nearby.”; ALL OF THE TIME – “Feeling safe is a basic need, like having clothes to wear, or a place to live, or food to eat. If you are afraid all of the time, this puts a strain on your body. Tension or stress can lead to bad eating habits or not getting enough sleep, so that your health is affected. Having a plan and a way to cope with an unsafe situation or person, gives you some control and choice about what to do.” (emphasis in original, session 6)

I: By using the first person pronoun the concept of ‘feeling safe’ is immediately introduced as something highly individualized, personal, subjective and natural. The idea that everyone feels things differently indicates that this will be true also of how they feel about ‘feeling safe’. Furthermore, because feelings are described as neutral and individuals’ responses as unique—even in situations as different as participating in the Children’s Group, or experiencing the symptoms of parental mental illness (of course the children in this group share similar experiences of both circumstances)—there are no right or wrong ways to feel about or respond to situations regardless of their similarity. In other words feelings are not subject to evaluation or judgement as good or bad. This is important because circumstances, which can be changeable and volatile, like the weather, must be evaluated for safety. When things change, especially for the worse, feelings can help take the measure of a potentially dangerous situation. Emotions help individuals evaluate changes in their environment as illustrated in the following statement:
There are no good or bad, right or wrong feelings. Feelings just are. Think about your feelings as if they were a thermometer. Where a thermometer tells you what the temperature is outside, your feelings tell you what the temperature is on the inside. Are your feelings hot or cold? Do you feel sunny or rainy? Calm or stormy? (session 1).

When external circumstances are shifting in ways that may not be controllable—that is, those related to the unpredictable behaviours of a parent—children are cast as able to learn to use what they feel (neither good, bad, wrong or right) to help them decide what to do. By learning to listen to their bodies they can exercise discipline over their behaviours, or how they respond and what they do under certain circumstances. *BTU* draws on biological discourses to explain further how emotions are embodied, and can act as physical warning signs to predict, manage and sometimes prevent negative outcomes from dangerous situations. In this sense fear can be “good”, validated by a long, evolutionary history in which fear has helped humans cope by protecting them against threats to well-being. In the following passage fear is a positive “symptom” because the body speaks as a protective measure to warn about potential danger:

The physical symptoms of fear are called EARLY WARNING SIGNS (EWS). Early warning signs are the body’s way of telling us that we may be in a dangerous situation and to be cautious.” “These EARLY WARNING SIGNS have belonged to human beings for millions of years. They have protected people from many different kinds of danger: storms, dangerous animals, the threat of violence. These signs have helped humans survive for thousands of years, so when you feel them, you should feel strong, because they are proof of a healthy survival instinct.” “Your body undergoes physical changes when you become afraid. A chemical substance called adrenaline is released by your body to prepare it for emergency situations. For instance, when you heart beats faster, more oxygen is sent to your lungs so that you can run faster. Also, your blood becomes thinner when your heart is beating fast, so that if you get hurt, you will bleed less” (session 5)

However, in the following example, *BTU* stresses that if nothing is done about prolonged exposure to fear the body will become stressed and rather than protecting the person, it can lead to serious problems including physical and mental illnesses. Repeated here is the idea that mental illness is an illness like any other, albeit on the extreme end of a continuum of negative outcomes. Therefore, the individual must take responsibility for knowing when they have been afraid for too long, so that physical signs of fear are useful indicators that they need help. These “symptoms” should act as a barometer for knowing when a situation is not safe; although how one responds and the ability to do something about it is highly individualized because it is dependent upon a person’s character and how much support is available in the situation:
“If you continue to feel afraid, your body triggers the resources it needs to run or fight the scary situation. Your body becomes stressed and this uses up a lot of energy. After the adrenaline wears off, your body becomes tired and as a result you may get a flu or a cold. When you are frightened for long periods of time or live in an unsafe situation for a long time, your body is using up more energy than it can produce. At this point you may develop a serious illness like allergies, asthma, migraine headaches or even a mental illness.” “Remember everyone reacts differently to challenging situations and how they deal with situations will depend on their temperament, their support system, and their environment.” “When you become aware that you are experiencing one or two of these EARLY WARNING SIGNS, look around and see what may be bothering you. When you have more than two of these signs, think about leaving the place where you are, and finding someone you trust” (session 5).

**FEEL SAFE:** In this section children are depicted as being responsible for feeling safe. They are told that they are supposed to protect themselves, not just from more obvious signs of danger or risk, but also problems that are simply described as, “bad things that might happen in the future”. These dangerous or risky situations can be something catastrophic, or an everyday event, like falling off a bike. All risk is normalized by a prevention discourse in which planning is important for all kinds of problems, and precautions must be taken, just like preparing to avoid a traffic accident. In essence, we all have to become circumspect performers who plan for the possibility that bad things will happen to us.

For children who have a parent with a mental illness this means taking precautions in the home that start with learning how to work through their fears—working through fears is a process of identifying them and learning to deal with them as illustrated in the following excerpt:

*Working Through Fears (15 min.), “The hardest thing about working through your fears is identifying them, so you’ve done the hard part already!” “Prepare to deal with our fears by coming up with a plan to deal with them. We will talk more about what this means next week.” “Practice your plan so you know what to do when you feel afraid” (session 5).”*

And while participants are urged to come up with a plan so that they know what to do when they are afraid, they are not expected to be able carry out certain plans, for reasons that are beyond their control. In the following paragraph the emphasis is not so much on the practical reasons that may determine whether the child can successfully protect themselves, but on the problems anticipated with acting as a loyal member of the family. Most notably, the individual child may feel responsible to protect other family members, including the ill parent, from outside interference, and may also fear angry reprisals for betraying the family should they take action to get outside help. By posing this as a question the facilitator can help the participants cognitively
work through a “what if” scenario, helping them to acknowledge these feelings and reinterpret or remind them that the problem is really the “out-of-control and unsafe behaviour” behaviour of the parent, which (reminding them again) requires medical help. The child can help only themselves in this situation:

The children need to know that there are times when their plan may not work, and that if their plan does not work that it may not be their fault. “Sometimes your plan may not work because: 1. the symptoms that may be threatening to you come about so quickly you don’t have a chance to try your plan out to see if it works.; 2. it might be too dangerous to carry out your plan.; 3. there are other people you have to protect, or 4. you might be trapped.” “You may feel that you will get into trouble by asking someone outside of your family to help you, that other family members or even your friends will get angry at you. What do you think are some of the reasons for this anger?” “You may feel that it is disloyal to your family member to come up with a plan. If you call 911, your family member might get in trouble or that your family members may be angry with you for getting help. The police may come or your family member may be taken to hospital without their consent.” “When a family member ‘is out of control, displaying unsafe behaviour’, it usually means that they need medical help. It is important that you seek help for yourself when you feel unsafe (emphasis added, session 5).

Ultimately, children are told they are responsible only for developing a personal safety plan, an individual plan that will protect them and help them to feel safe, quite apart from the situation or the people involved. Through imaginary exercises described in the following excerpt, BTU helps children rehearse and practice acting as if they feel safe. To do this they must learn to listen to their bodies, which will produce the required feelings once they have mastered creating a PERSONAL SAFE PLACE:

When they build their safe places, their imagination creates ice forts, gingerbread houses, castles, secret hideouts and more. Some examples of a child’s description of their place give us insight into their world: “I have four doors, so I can always get out.” “I have no walls so I can see in all directions.” “My safe place is a police station.” “My place has bars on all the windows so no one can come in.” Often the children wish to visit each other’s safe places. Teaching boundaries can be part of this exercise as each child has the right to allow or disallow anyone from visiting their PERSONAL SAFE PLACE. The important discovery we want the children to make in this session is that they can learn to protect themselves when they feel afraid, by developing a plan and certain coping skills. We want them to learn to persist with these plans and strategies until their body tells them they are safe again (emphasis added, session 6).

The program targets strategies for learning how to read bodily expressions of fear and safety. It also gives participants an opportunity in a make-believe environment to experience what it is like to have control over their personal safety by making choices about who can enter their imaginary space. The notion of ‘rights’ related to personal safety is hinted at here, and is taken up further
in the last section of this statement described below. Rehearsing what fear feels like in a safe and controlled environment is important because emotions must be regulated or managed, in a process that allows for their expression over time. These ideas are expressed too in the following explanation about the artwork planned for session five:

When processing the DOOR OF FEAR activity, it is important to discuss the responses to the question about the colour of fear before moving on to the next question. Processing in this manner helps the child talk about their fears bit by bit, and gives them a chance to regulate their emotions before they respond to the next fear question (session 5).

Being able to plan and act prudently—or to cope with and manage a situation, is said to involve having a choice and a degree of control over a situation. However, choice and control are not straightforward propositions in the context of having a mentally ill parent and may be the very things that are most compromised in the situation:

It is important to explain to the members that taking part in a scary thing is fun because: a) they have a choice about what they want to do; b) the scary fun thing has a known time limit and c) they have control over whether they actually participate in the scary and fun activity. “One of the features of living with a family member with a mental illness is that you have no choice in the matter. You didn’t choose to have a family member with a mental illness. There is also no time limit with mental illness. Your family member might struggle for long periods with depression or hearing voices, and you don’t know when the symptoms will improve. Finally you have no control over the symptoms (behaviour) of your family member” (session 5)

In the following excerpt the facilitator is advised to address the difficult feelings participants may have over not having a choice about attending the Children’s Group. The passage demonstrates how the concepts of choice, control and the ability to cope are interrelated, and an individual who cannot choose or control their life circumstances may only be able to choose how they feel and act in relation to those circumstances—regardless of the parent’s diagnosis or symptoms. Again, the opportunity to pretend—to practice or act as if—they feel something different than they do about coming to the group, is a choice participants are expected to make, and an opportunity to learn how they might do so in other, unpleasant circumstances:

While the facilitator can empathize with the frustration any of the members may feel about not having a voice or not being in control, we have found that explaining how they can make a choice about their own behaviour provides a good model for dealing with unpleasant circumstances. We give the resistant members the choice of sitting in the group and not participating, pretending that they wanted to come, or going to the quiet corner and reading books about mental illness. In other words, there are some things in life you cannot choose, but you can always make a choice about your attitude to the situation. (emphasis added, session 1).
This is followed by a discussion of lack of control in decision-making, which is supposed to give children the opportunity to voice frustration and ease some anger and resentment “they might want to direct at the facilitators or other members of the group” (session 1). Following this, the facilitators show the participants a number of ‘feeling posters’ that are tacked up on all the walls around the room, and they are encouraged to identify how they felt when they first arrived, by choosing to stand in front of the one that best represents their emotions. Children are asked to repeat the exercise at the end of the session, so that the facilitators can determine whether their feelings changed over the course of the session, and determine “how comfortable, or safe they feel, talking about mental illness in the group” (session 1). The facilitators are told that any residual anxiety must be addressed so that there is a feeling of safety in the group before moving on to the presentation of mental illness education, which begins in the second session. Feelings of safety, expressed as positive bodily sensations, are also said to be signals to help children determine whether people are trustworthy as illustrated in the following excerpt. Good feelings help to distinguish who is reliable; this is especially important for making safety plans with adults:

When your PLANS are working, your body will feel the same as it felt in the safe place you created. If you don’t feel physically safe with your action plan, it may mean that you need to find some different ways to deal with the situation. You may want to go and talk with a trusted adult to work out a new action plan.” “How can you tell if you are safe? Remember the good feelings your body had when you were in your PERSONAL SAFE PLACE? That was your body sending you information to tell you that you were safe. If you have those same good feelings around a person, it probably means that you can trust them. If you feel relaxed and calm around a person, it probably means that you will be safe with them (session 6).

**ALL OF THE TIME:** The concluding portion of the above statement establishes the idea that children have a right to feel safe, just like they have a right to accommodation, food and clothing. Children’s rights to feel safe, secure and protected are presented as concomitant with their responsibilities to take care of their health by learning how to manage their emotional responses—feeling afraid and feeling safe—to people and situations in order to prevent illness, especially illnesses due to effects of prolonged exposure to stress. Most importantly the individual who learns how to cope well is said to also learn how to exercise choice and control over his/her actions/behaviours. This is a fundamental premise of BTU because a significant objective of the program is: “for each child to understand that they did not cause the illness, they can’t cure or control it, but they can cope with it” (session 6). Knowing the difference between what they can and cannot control, is presented as part of learning how to cope with parental
mental illness. It is also part of learning how to act in a disciplined manner and manage life and take responsibility for one’s own behaviours.

Learning how to cope in the right way is integral to BTU’s goals. It is part of transforming current abilities so that the future will be safer, because the skills learned will be more appropriate. In the final sessions content is devoted to exercises designed to elicit children’s hopes and dreams for a future, and help the facilitators make recommendations about their needs to referral agencies. As illustrated here, each child is given a personal letter written by the facilitators, encouraging children to see themselves in a positive light despite their difficulties:

Many of these children rarely receive praise and affirmation from their family member with a mental illness, so we like to write them a letter of encouragement and give it to them at the end of the sessions. The letter is our way of acknowledging the difficulties they face, recognizing the strengths we see in them (we try and give concrete examples from our note-taking), and provide them with a positive outlook for their future. For a more personal touch, the letter can be handwritten on stationery that might appeal to children. The letter also serves as closure for the facilitator (session 8).

In the final sessions BTU draws on examples of individuals who have been successful despite living with the adversity associated with a parent with a mental illness. The following excerpts are taken from the beginning and end of the seventh session, in which children are shown a film clip about a young girl living with a mentally ill mother:

―What do you think happens to Aviya in the future?‖, Some groups may need some prompting. For example: I wonder if she went to live with her aunt? After the group members have imagined what happens to Aviya, tell them what really happened. ―Gila Almagor is Aviya’s real name.” “Gila was born on July 22, 1939, four months after the death of her father.” “Her mother developed a mental illness and Gila spend most of her early life growing up in children’s institutions.” “She became a professional actress when she was seventeen, and is now one of Israel’s most famous movie actresses.” “She studied ballet and music.” “She has written four children’s books.” “Two of her books have been turned into films and received several awards.” “Gila plays her mother Henya in the video.” (emphasis added, session 7)

The dramatic effect of the surprise ending is meant to encourage the children to think of themselves as having a successful future just like Aviya, but only if they choose this outcome with determination and decision making about what it will look like. The sequence ends with a message akin to “the power of positive thinking” and an appeal to wanting to have a “good” and “happy” life as a measure of success:

*Affirmation Statement:* “Each of you has your own story. You can decide how your story will go, and choose what your future will look like. Every time you try something new, or
meet new people, you add something new to your story. Aviya’s situation did not prevent her from getting on with the story of her life. She wanted to be happy and have a good life. You can do the same if you set your mind to it.” (session 7)

Moreover, the future is cast as a story that the individual can create/control by choosing how it will go. By inference, this narrative can be different from that of the mentally ill parent, as long as children do not let the situation they face prevent them from getting on with their own life.

**Constructing social identities and social relations**

**iv. How are ways of being in the world and social relations constructed by the discourse(s) in BTU? How are assumptions made about normal or appropriate subjectivities?**

*BTU* is as a guide written for and by adults, who are said to have the authority, expertise and responsibility for “helping children manage the experience of having a mentally ill parent”. Correspondingly, adults and children occupy particular subject positions in the text, based on expectations about social relations between children and adults, and those children have with each other. First, some adults are described as unsafe, or a risk to the child. The mentally ill parent poses a risk, not so much because of a heritability factor, but because they behave in ways that are unpredictable. Beliefs about mental illness as a brain disorder in which dysfunctional thinking, uncontrolled emotion, and unmanaged behaviours, casts the relationship between the child and parent as potentially unsafe. Parents who have a mental illness may also pose a genetic risk to the child, but this idea is played down in order to shape a picture of the future and help children construct potential subjectivities—in a positive light.

Second, adults—for example, the facilitators and other adults who may have a responsibility to care for and protect children, including other professionals—are positioned as trustworthy. Referrals and permissions to attend *Children’s Group* are made by adults, either by the ‘well’ parent or a legal guardian, or often by mental health professionals, and child welfare and protection agents. Knowledge and beliefs about mental health, and psychiatric treatment are shaped for the most part by adult expertise, including those who contributed to the production of *BTU*, as well as that of a particular version of medical, scientific knowledge and research expertise, which informs the content of *BTU*. *BTU* stresses that the adult facilitators have responsibility for children’s well-being. In the following excerpt the rules of the group are laid out, and while children are implored to protect each other’s privacy, the adults have a special responsibility to break a confidence if necessary because they are liable for children’s safety while in the group:
GROUP RECIPE (10 minutes), should be written in poster form for children to read, TO HAVE FUN, we will be using activities, art and videos…there will be time for games and snacks, CONFIDENTIALITY, whatever any member says in the group must stay in the group, can tell others what you did or said, but not what somebody else said or did. This includes a sister or a brother, SAFETY, adults in group called facilitators, they have a legal responsibility to keep you safe, if you tell them something that makes them concerned for your safety, they will report it (emphasis added, session 1).

Third, children’s relationships with each other are premised on the idea that although they are each unique individuals, they also have many things in common. Children are made accountable to one another in terms of keeping each other’s confidences in the group, including those shared by siblings. When siblings come to the same group, the facilitators are instructed to take precautions to ensure that “…each child is encouraged to have their own thoughts and feelings” (BTU, Introduction). This is because participants are responsible for learning how to trust their own thoughts and feelings in order to know whether a relationship with an adult is safe or not. A central focus of BTU positions support group members as children who can cope with the experience of having a mentally ill parent. Children are considered potentially competent managers of their own thoughts, feelings and behaviours once they learn how the broken brain works, and what mental illness “really is”. They are taught how to use cognitive and behavioural strategies to exert control over the immediate and long-term consequences of negative thinking—so that “they can have some choice over how they experience the world”. They are told they must learn how to manage their own emotional responses to people and situations, particularly those that are unsafe or risky and to take responsibility for their own health by protecting themselves from too much exposure to stress. As potentially competent managers of their thoughts, emotions and behaviours they are cast as persons who have some control and choice over what they do—in contrast with their mentally ill parent whose behaviours are cast as unpredictable, and whose lack of control effects how they experience the relationships around them. Hence the children in the support group are ultimately positioned as decision makers regarding their personal stories and how these will “turn out”, whether they will have a future that includes a “happy and good life”.

Children’s Group members are also said to have a special relationship to one another because, they are children, and because they have a parent with a mental illness. As children, they are assumed to be innately resilient but their coping skills require fine tuning so that they act “appropriately”. As children, it is assumed that they cannot sit still for long periods of time taking in information, so many of the physical activities in BTU are rationalized on these
grounds. As children, they do not refer themselves for help, but are dependent on the intervention of influential adults, which includes meeting other children who are in a similar situation. As children of parents with mental illness, they are suspected to have learning disabilities, difficulties with social skills and a need for attention. BTU assumes also that these children are not like other children, and that they have not met others “like them”. This may be based on other assumptions about their hidden-ness, isolation, secretiveness, and invisibility. BTU says that children will not arrive at the Children’s Group in “the usual way”. This means that facilitators must be welcoming rather than punitive, because children are escorted with drivers arranged through welfare and protection agencies, are often late and attend erratically and because children are generally described as having little control over how their time is managed by others. BTU presumes that they may not have had access to some of the “normal” activities of childhood. For example, BTU rationalizes playing games not only because they “provide facilitators with information on group members, their social skills, whether they join easily with others, have difficulty following the rules or prefer to watch” but also because they may “…even show whether a child has played games at all” (emphasis added, session 1).

Fourth, children are positioned to help each other, and this includes other children outside the Children’s Group. After being exposed to mental health illness education and taught coping skills to manage their thoughts, emotions and behaviours, members are said to be in a position to educate and give advice to others—including other children who have a parent with a mental illness—who may have inaccurate, and sometimes stigmatizing, ideas about mental illness. Although coping is said to be individualized, because risk is conceptualized as inhering in intimate, private relationships with adults, prevention is more than a personal strategy for overcoming difficulties. Recognizing risk and identifying and dealing with emotions require the supportive presence of other individuals. The rationale BTU provides for using a support group format emphasizes the efficacy of therapeutic group work where personal troubles become public matters of concern. The presence of others helps not only to focus on the problem of children’s assumed isolation by providing support through the presence of other adults and children, but also to normalize their experiences by showing that they “are not alone”. This idea that individual group members should coalesce around a common identity begins in the very first session when participants are asked to recite the phrase together as a group: “we are all here because we have a parent with a mental illness” (session 1). This is a refrain that the children are asked to repeat at several points over the eight sessions, reinforcing beliefs about who they are and why they are participating in Children’s Group.
The following excerpts describe how children should take part in group activities that symbolize this shared identity. Particular props are used to reinforce this interconnectedness. For children who are described as being angry, resentful and resistant to coming to the Children’s Group, various activities, games, artwork, and props are organized to support the idea that they are not alone, and that they belong because they have something in common. This shared identity is supposed to override difficult feelings by establishing relationships amongst group members who are encouraged to see their predicament as the same. BTU describes this as a strategy to consolidate the group because, “getting to know other children and learning that they come from similar situations help(s) to build cohesiveness” (BTU, Introduction):

We are all in the same boat (15 minutes), a group activity. Ask one child to draw a big boat, think of words that describe things they have in common, for e.g., school, children, mental illness, write these inside the boat, then think of things that make them different, write these outside the boat (emphasis added, session 1).

The person-to-person game: on separate pieces of paper, write or print each phrase below, and place these pieces of paper in a brown bag. Toss them in the bag and shake. . in this bag are pieces of paper with an action written on each one.; 2. each piece of paper will be pulled out of the bag and read one at a time.; 3. follow the instructions on the paper and do the action. For example, if the papers says: “elbow to knee”, then touch an elbow to a knee.; 4. hold that pose….continue to hold as many positions as you can, while adding the new actions, until you lose your balance. Continue to play the game until the instruction: “person to person” is read out. Don’t explain the phrase, let them figure it out. Eventually the children may get the idea that everyone doesn’t have to do all the actions individually. They can do the actions with each other. For example, one person can put their elbow to another person’s knee. (emphasis added, session 4)

The participants, positioned as having a common identity that normalizes their experiences and constructs their status as “no longer alone”, also extends this subjectivity to include children who will participate in future groups. At the end of the eighth session, the children are asked to welcome the next group of children by writing an open letter to them as illustrated in the following excerpt. The children are encouraged to remember what it felt like when they first came to the group so that they can send a reassuring message to the newcomers. They will see that they too are no longer alone because there are other children who have a mentally ill parent:

Group Welcome Poster, (15 min.), “You talked earlier about how you felt when you first came to these sessions. It is important for everyone who attends this group to understand that they are not the only person who has a family member with a mental illness.” “As a closing activity I would like you to draw a group poster for the next group of kids who will attend these sessions. I will lay out a large sheet of paper for you to write on. You can write some words or sentences on that you feel will welcome and encourage future members. (session 8).
Once the children have been taught what it means to feel safe, it is assumed that these skills can be transferred to help others learn how to be safe, which is in keeping with thinking about protective behaviours and mental health promotion as a way to help reduce problems in the wider community, and reduce risk that is assumed to be pervasive in “everyday life”. And safety, or the prevention of “risk” for whatever reason, including the circumstances of having a mentally ill parent, is portrayed as an individual’s “right” and responsibility for the self, and for others.

**Summary: Implications for the performance**

v. *What implications do the systems of knowledge and belief, subject positions and social relations constructed by the discourses have, for the way children should think and feel and behave in the context of having a mentally ill parent?*

*BTU* constructs mental illness as a chronic “illness like any other”. But it is also said to be an illness with an unknown aetiology. Mental illness is cast as particular to a part of the body because it is a brain disorder. In keeping with biomedical explanations of abnormal behaviours as illness symptoms, parents’ problematic behaviours are described as symptoms of a mental illness; they are a consequence of having a “broken brain”. This helps to explain the outcome of a process whereby mentally ill parents are presumed to behave in ways that are frightening, by tracing their actions back to problems that originate in the brain, not with the child. The logic of this argument begins with a concept of “thinking”, “feeling” and “behaving” as interconnected processes. *BTU* posits thinking as having a direct affect on emotions and together they influence how people behave. Consequently, a parent with a mental illness, who has a “broken brain” is not able to think clearly. Because ill parents’ thinking is “twisted or unhealthy”—and they are not in control—they cannot manage their emotions well either. The lack of control over thoughts and feelings can lead to unpredictable behaviours. Unpredictable behaviours are potentially frightening; this is posited to be especially true for children who have a parent with a mental illness. Therefore, mental illness requires medical intervention by professionals because it is considered a biologically based process with social consequences. While there is no known cure, *BTU* is aligned with current dominant medical discourses that regard mental illness as a chronic condition that can be managed, albeit through treatment regimens administered and supported by trained, medical experts—but not by children.
While *BTU* explains that the causes of mental illness are not well understood, it argues that scientific research suggests three sources of risk for developing an illness. These include physical, hereditary, and environmental causes. The good news according to *BTU* is that hereditary risk is only slightly greater for children of mentally ill parents than the general population. “Real” risk for mental illness on the other hand, comes from prolonged exposure to the stress of living with frightening and unpredictable parental behaviours. Accordingly, this kind of stress is said to lead to physical and “even” mental illnesses. To remain healthy, children are instructed that it is okay to be frightened by parents’ behaviours, but they must express their feelings, “get them out”, and learn to ask for help. Although they have knowledge and skills, including a “natural” ability to cope with adversity, they are assumed to have learned to manage in ways that are inappropriate and unsafe. In this sense *BTU* assumes that children’s maladaptive behaviours are a “risk” to them. Consequently, it is necessary to undo these problematic ways of coping. One approach is to teach children how to stop negative thinking. A second is to teach them how to distinguish between safe and unsafe feelings. Because feelings are located physically in the body—for example, they are “in the chest”—, and described as neither good or bad, they are cast as a barometer for testing whether a particular situation, or person, is safe (or a risk). They are taught an important overall strategy for managing to cope well in the face of adversity is to learn to judge what feeling safe (and not “at risk”) feels like. Moreover, because children are taught that they did not cause the parent’s illness, and cannot cure or control it, they can learn to manage—that is have some choice and control over—how their own lives will go.

Like all circumspect and disciplined performers who plan in advance for unforeseen events—such as responding to unpredictable and frightening behaviours—these strategies can be best achieved under manageable circumstances, where routines about how to think, feel and behave, can be rehearsed ahead of time, in a safe environment, with trusted others to help facilitate the process. In this way *BTU* comprises a surrogate context for practicing these beliefs about mental health and illness, and rules about how to behave as a child of a mentally ill parent. Significantly, children are expected to shift how they see themselves, so that they can become responsible managers of their own mental health and of their futures more broadly because they have some control over “how their stories will go”. But they can also help others, by learning to manage their risk they can contribute to the common good, and on a more practical level they can share what they’ve learned with others, and correct inaccurate, potentially stigmatizing ideas about parental mental illnesses.
CHAPTER FIVE: RESULTS—THE PERFORMANCE: PART I
In chapters five and six I present an analysis of how *Bridges to Understanding* (*BTU*) is received—that is, how *Children’s Group* participants respond to the discursive messages about mental health and illness, and ways of being a child of a mentally ill parent they are taught. This analysis answers my second research question: how do participants in the *Children’s Group* use impression management strategies to respond to discourses pertaining to mental health/illness, and children? My conceptual framing led me to posit that participants are taught to act as *loyal* and *disciplined* performers to help sustain the expectations of this performance—as well as to “save” it when inadvertent acts threaten to disrupt the planned story-line. Goffman (1959, p. 228) would argue that there are disadvantages to performances like *BTU* that are so highly scripted that untoward events do not allow the performer to pick up where the unplanned sequence has been disrupted. Hence, participants must enact strategies that demonstrate restraint over their thoughts, emotions and actions to convince others that they are behaving according to the rules set out in *BTU*.

I begin with a descriptive overview of the *Children’s Group* participants, and the setting that was used by the group I studied. I provide pertinent background information such as the children’s ages, gender, parental disorder, and the family context in which they were living at the time of the study (Table 3), based on the demographic form created for the study (Appendix 8). I do not describe the children individually to preserve their anonymity and because the focus is on children’s collective identity as a team who perform to “put on a show, as well as one in response”.

**The Children’s Group participants**

Seven children participated in the support group, four boys and three girls, including two sets of siblings. Two participants did not have siblings. Most children were referred to the group by their “well parent”, one child was referred by her grandmother who was her legal custodian. A close family member working in the mental health field helped initiate the referral process for another child. Two siblings were referred by the umbrella organization that sponsors the *Children’s Group* because the older child received one-to-one counseling support from the organization. The seventh participant was referred through the Children’s Aid Society.

I observed a meeting in which background information about each child was discussed prior to the first session; this included information about why they had been referred to the program. To my knowledge, children were not asked if they had concerns they wanted addressed in the program. A father was angry with the “system” because it had not helped his
children their mother’s “worsening symptoms”. He wanted his son to know “it’s not his responsibility to take care of Mom, and make things better”. He wanted his other son to attend the group to address his behavioural problems, which he described as “acting out” and “being very needy”, although the boy had seen a psychiatrist regarding a diagnosis of ADHD. A third boy was referred through a child protection agency because he was said to “run the household”, considered aggressive and to be extremely isolated. He also had “symptoms of paranoia, like his mother”. A custodial grandmother wanted her granddaughter “to realize she is not the only child with a mentally ill parent and to build her confidence”. Another participant was referred because his family member felt that he needed “space just for himself, and to see he does not need to always be taking care of the family”. The step-mother of another wanted her child to understand that her mother’s difficult behaviours were part of “delusional thinking” and “symptoms of a mental illness” and that the child wasn’t to blame.

The consent procedure did not work out as planned, that is it was to be undertaken one week prior to the study. One child was not available to me until the evening of session one and a parent was quite anxious because his children did not want to attend the group and did not want to “upset” them by introducing the study too early. I sent him information about the study, and consent/assent forms by email and conducted consent/assent procedures on the first night of the program. Of particular note was this father’s objection to the consent/assent form letterhead because it included a hospital name. This implied to him that there was “something wrong” with the children, and he said he worried that this would put his children off further from attending the program. I was sensitive to his concerns, especially because it reminded me of my own concerns that these children are being labelled “at risk”. I could not remove the “offending” words for reasons to do with my ethics agreement and in the end he accepted the decision.

Finally, one child was referred to the program through the Children’s Aid Society on the afternoon of the first session, and so I worked with the social worker to describe the study to the boy’s mother, consent and assent were given just before the group began.

Six children had mothers diagnosed with a mental illness. Children had been living with parental mental illness from one to more than eight years. However, this information was difficult to verify beyond that which was given to me by the program coordinator (who used intake case histories to complete the demographic forms), as a specific parental diagnosis was not a prerequisite for attending the group. Table 3 includes background information on each of the children, with a brief overview of the family context.
Table 3: Participant Background\(^{44}\) (n=7)

<table>
<thead>
<tr>
<th>Participant</th>
<th>Parent Disorder</th>
<th>Family Context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colin* 10 yrs.</td>
<td>Mother/bipolar disorder</td>
<td>brothers live with custodial father; mother hospitalized</td>
</tr>
<tr>
<td>Eliot* 12 yrs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Augusto 11 yrs.</td>
<td>Mother/schizophrenia</td>
<td>lives with ‘unwell’ mother; CAS involved; extended family out of country (no siblings)</td>
</tr>
<tr>
<td>Mark 13 yrs.</td>
<td>Father/OCD; depression; anxiety</td>
<td>lives with parents &amp; sister; father ‘unwell’, not accepting treatment; parents separating at time of study (sister not present in group)</td>
</tr>
<tr>
<td>Ayanna 7 yrs.</td>
<td>Mother/depression</td>
<td>lives with custodial grandmother; mother has not been seen for 9 months; father remarried with new baby; large extended family on maternal side (no siblings)</td>
</tr>
<tr>
<td>Becky* 8 yrs.</td>
<td>Mother/depression, changed to schizophrenia</td>
<td>siblings with father, brother, step-mother &amp; 4 step-siblings; ‘unwell’ mother trying to have supervised visiting rights reinstated in the courts</td>
</tr>
<tr>
<td>Michele* 13 yrs.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*siblings

According to intake case histories reviewed at a meeting prior to the first session, all the children were doing well in school and four were described as ‘A’ students. During the course of the study, six children reported having their “own lawyers”, and when Martha asked them to elaborate, lawyers were involved with custodial issues arising from parents’ separations, or divorces. Two children had lawyers because of child protection issues and all children had had involvement with the Children’s Aid Society, ranging from a very brief involvement of a day or two to long-term relationships of several years.

The Children’s Group setting

The setting was described by the program coordinator\(^{45}\) as a “space for the children”. Parents and other adults were only allowed into this space briefly, to drop off or pick up their children. I asked about this practice, because it seemed to me that the facilitators were anxious to keep parents out of the room as much as possible. I was told that adults—indicating parents who have a mental illness—“have their own places to get help”. The goal of distinguishing adult and child spaces also pertained to “well” parents, who were told about spousal and other kinds of family support groups offered by the umbrella organization. For example, at the beginning of the second session, Amy spent quite a bit of time with a father suggesting he might find the

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\(^{44}\)To reiterate, all participant names in the thesis are pseudonyms.

\(^{45}\)The coordinator provided community education about the program, and performed intake assessments for each child attending the group, as well as general oversight of the group. She did not facilitate the group I observed.
spousal support group helpful. The setting I observed was located in the Boardroom of a community centre and large recreational complex situated in a residential neighbourhood on the outskirts of the city. The complex was quite large and busy with activities of various kinds. There was a hockey arena, exercise rooms, a pool, and a large foyer, replete with café tables and chairs. The only indication that the Children’s Group was housed here, was a small sign with the name written on it, and an arrow pointing down the hall to direct participants to the Boardroom. Parents (and a grandparent) would wait to pick up children at the end of the evening in a space that occupied a long corridor just outside the Boardroom.

The Boardroom was quite bright and airy, with a large bank of windows along one wall that allowed the activities on the distant soccer field to be seen as a back-drop to the BTU sessions. Later in the program these were covered by closing the blinds, ostensibly for warmth, but also to minimize distractions. Each evening began with an empty room, and the tables and chairs were (re)arranged for each session as dictated by the planned activities. The facilitators brought all necessary props with them each evening, using an industrial sized dolly to convey materials and food. Each night the participants were arranged differently around at the tables using nameplates the children were asked to decorate and personalize on the first night. The rationale for seating arrangements was usually discussed between the adult facilitators before the children arrived each evening. For example, in the first session, Ayanna was placed next to one of the facilitators, because she was “anxious” according to the case history notes from the intake meeting, and at age seven she was the youngest participant. I allowed the facilitators to position me at the table as they did the other participants; however, I never sat beside the facilitators, preferring to sit at the table amongst the children. There was a washroom inside the main boardroom, which Martha considered a particular bonus of this location because facilitators often “lost programming time” escorting children to washrooms located in other public spaces used by the group.

The Children’s Group sessions: How BTU was received by participants

In the remainder of the chapter I present the results of the way the discursive messages were received by the Children’s Group participants. These messages pertained to the beliefs and rules about mental health and illness, and ways of being a child of a mentally ill parent. The results are organized into two chapters (five and six) according to the three discourses I examined to show how children used impression management strategies to respond to the messages they contained.
Performing: Mental Illness Talk

“All our moms have a...have a problem”

Martha begins the first session by establishing that parental mental illness is the explicit reason children have been asked to attend the *Children’s Group*. Prior to the study I was told by Martha that many, if not most children do not want to participate in the group, and/or deny that mental illness is a problem in their families. However, children are supposed to come already having heard the words “mental illness” in relation to their parent’s problems. Thus facilitators are not responsible for introducing the concept for the first time. Martha told me prior to the first session that they used to spend a lot of time “pussy-footing” around the issue, so this “rule” is considered a practical way to save the facilitators’ time and energy. Before activities can get underway participants must come to a formal agreement that mental illness is the reason they have been brought together by acknowledging this verbally as a group. In the following sequence Martha opened the session by asking the children to speculate about why they had been asked to attend the *Children’s Group*:

<table>
<thead>
<tr>
<th>Martha</th>
<th>Does anyone know why we are here tonight?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eliot</td>
<td>To bake a chocolate cake? (snickering all around the table amongst the kids)</td>
</tr>
<tr>
<td>Martha</td>
<td>Okay, okay (somewhat impatiently), only one person speaks at a time…you know like school, but not school. (pause) So if you look up here on this piece of paper, the agenda, you can see the kinds of things we’ll be doing.</td>
</tr>
<tr>
<td>Augusto</td>
<td>But when do we eat?</td>
</tr>
<tr>
<td>Martha</td>
<td>What number is it on the agenda?</td>
</tr>
<tr>
<td>Augusto</td>
<td>eight? (small voice)</td>
</tr>
<tr>
<td>Martha</td>
<td>Then that’s when we’ll eat!</td>
</tr>
</tbody>
</table>

[Eliot pulls another chair up close and puts his feet on it, settling in comfortably, while Augusto slides down into his seat, slipping ¾ of his face down into his jacket, as if responding to ‘things are getting serious now’].

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46 This was certainly true in the group I observed. At the end of the first session Martha and Amy asked the children to fill out a brief questionnaire used to establish participants’ mental health knowledge; while doing this they asked about whether they wanted to come to the group and only Ayanna said yes. Moreover, most of the children told me at various points or during our group discussion that they had been pressured to attend, some more so than others. This involved persuasion by family members other than the ill parent or in one case, the Children’s Aid Society, which had an ongoing relationship with the family and provided transportation for the child to attend. Another participant told me that his father had lied to him, telling him that he had paid money to secure him a spot in the group. He realized this when he asked me “why they charged kids to come” and I told him that this wasn’t true. At the beginning of the group this child did not think his mother was mentally ill and he worried a lot about money problems in the family, so this tactic was clearly motivating but extremely coercive to him.
Martha (continuing)…you are all here tonight because someone in your family has a mental illness.

Augusto (loudly) What?
(murmurs indicating agreement with this statement around the table)

Martha (ignoring Augusto). Okay, so let’s all say this together (bringing her hands together like a symphony conductor)... I am here because someone in my family has a mental illness.

All (in unison, with loud voices; no one refuses or sits out) We are here because someone in our family has a mental illness. (Session 1)

Eliot’s sarcastic response suggests that he is not fully willing to go along with Martha’s opening request. Perhaps, sensing it is a rhetorical exercise in which he is being set up to produce a required response, Eliot resists her first question by coming up with an incongruous, funny image that elicits laughter from the other participants. He challenges and disrupts the opening sequence without giving away about what he really thinks, or feels, about attending the Children’s Group. The strategy helps him to avoid a direct answer to Martha’s question, but it also demonstrates to everyone present that Eliot is not readily compliant and may have suspicions about the Children’s Group agenda, and the expectations of this group, which is probably not anything so innocuous as “baking a chocolate cake”. It seemed to garner him social capital with the other child participants who “snicker” in response. Although it isn’t clear whether they read the situation in the same way, snickering is a suppressed form of laughter that can have a sarcastic edge, and it suggested to me that they were with him. Martha’s reaction was swift as she tried to regain control and manage any further distractions by instituting familiar “school” rules about speaking in turn, and drawing attention to the agenda. The agenda was a piece of paper listing how the evening should unfold. While Augusto may have been trying to challenge Martha with his question about eating, he has miscalculated the situation because she can point to the agenda to answer his question. This is a convenient example to reinforce her point that these are manageable circumstances and that there are answers to the question “how things will go”. When both boys slouched in their seats, Martha did not invoke rules about sitting up straight, perhaps because she seems ambivalent about whether to apply school rules in this setting. However, Augusto seemed intimidated rather than reassured after this encounter as his voice became quiet, and his body disappeared into his clothing as if to hide from this turn of events. Eliot on the other hand continued to appear relaxed and in control, as he settled into his seat, seeming to make himself “at home”, and to challenge Martha’s authority with his non-conforming posture.
Martha was able to manage how she wanted the session to appear at this point, even given these early disruptions, in part because her experiences have led her to expect negative reactions from those attending. She was also motivated by a concern to get on with establishing the group without wasting too much time, and had the advantage of knowing the script and what was expected of the performance at this point. Ultimately, she reasserted her authority and control over the situation by telling the participants that they were in attendance because “someone in your family has a mental illness”. The children obliged her, allowing her to lead the group in a recitation of a key phrase: “we are all here because someone in our family has a mental illness”. They were asked to repeat these words as a kind of mantra at other points during the Children’s Group sessions, reinforcing the reason they have come to the group and establishing it as common ground amongst group members. For example, a little later in the first session, Colin and Augusto find it difficult to use illness language, tripping over the words and showing a preference for referring to mental illness as a “problem”. In the following excerpt Martha is quick to correct them, making a distinction between mental illness as a “specific” (medicalized) problem, and those that are vaguer but “we” (meaning the children in the group) all have:

Martha okay…I want you to start naming things that you have in common…
All …we are all people…all human…we all like playing sports.
Colin we are all kids…all our Moms have a…
Augusto (interrupting)…a problem.
Colin a problem…yeah.
Martha (correcting them)…a mental illness, cause that’s more specific than problem…but yes, we all have problems. (Session 1)

In the second session Mark was introduced as a new member of the group, and when asked to review talk about mental illness for his benefit, Augusto continued to struggle over the use of illness language. None of the other children respond either to Amy’s entreaty to use the “right” words to describe the problem as mental illness, even though she allowed that it is another word for “disabled”. Even Mark could only agree by gesturing rather than using words:

Martha Can anyone tell Mark why we are here? (Augusto and Elliot raise their hands).
Augusto …kids who have parents with a…with a disabled…a disabled problem.
Amy …what’s another word for disabled? (no response) …well, mental illness.

[Mark nods his head indicating he gets the point]. (session 2)

47 Amy was a trainee co-facilitator for the group I observed.
While the children name “things they have in common” (and differences) Martha adds their comments to a picture of a boat Colin volunteers to draw on the agenda paper at the front of the room. And even though Martha thinks the children may still resent coming to the group, she used this opportunity to dramatic effect, labelling the picture: “We are all in the same boat” (Figure 2). The power of this phrase lies in the claims it makes on individual participants to see that they belonged here, and that this is good because they are no longer alone. Moreover, it dramatized a more implicit idea about having a shared identity in which children can depend on one another as loyal members of the same team who face similar challenges, and who with a little bit of cooperation, can learn to work together as disciplined players to successfully manage their problems. Children played a number of games throughout the Children’s Group to reinforce this idea, as for example, when they played “puff ping pong” in which a constant rotation of players reminded the participants that in the end, they all play for the same team. Early on Colin realized most games had a point; when asked by Amy about the motive for the “person-to-person” game, he replied, “you cannot do everything by yourself, you need someone to help you” (session 4). Although no one mentioned this at the time, when reviewing my photographic field notes I noticed that Colin had added a graffiti-like detail to the official picture of the boat, and in effect (re)labelled it, the “Titanic”. For Colin, a boy aged ten years, and most of the other children, this would be a familiar cultural image because the “ill-fated ship” was the subject of a popular American film. Here Colin used an ironic image to publicly—and perhaps politically—but silently, express difficult emotions about a situation he may actually consider “hopeless”. Even the lifeboat seems to offer little hope in this re-inscribed image, because although there may be acceptance of the premise that they are in the “same boat” and are “not alone”, they may be no better off if this is in fact, a sinking ship.

In a later session Martha shifts from encouraging children’s use of the words “mental illness” to describe their parents, and the problems the children have in common, to focus on how other people talk about mental illness. In the next excerpt Martha encouraged the children

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48 First described in the CDA results, chapter four, as scripted activities to symbolize they are “not alone”, can work as a team, and to symbolize a shared identity.
to describe different discriminatory concepts that are used to refer to people who have a mental illness. Initially the children seemed confused about what she wanted, perhaps because they had been busy adapting to the teaching about medicalized language as the correct way to talk about mental illness and the problems that brought them to the Children’s Group. The opposite or “wrong” way to talk about mental illness is represented in the following exercise in which Martha referred to “brown words” because they are using brown construction paper to write out inappropriate talk about mental illness (Figure 3). Amy cues the participants to what is really wanted by suggesting that they think about how mental illness is portrayed in “the movies or on television”. After the children had responded the words were collected and piled up dramatically in the centre of the table. Martha read them aloud, repeating words and after a pause, asking the children to speculate about why people use these words. The children demonstrated that they knew how to use both the medicalized language they’ve been taught, and the common, pejorative language used by others. They still retain a preference in some cases though for the term, “problem”, rather than mental illness:

[Martha hands out small rectangles of brown construction paper and asks the kids to write their words down on the paper]

**Figure 3: Brown Words**

| Eliot | [in an aside to the room, but no one in particular]. This is silly. I’m going to make up my own word. |
| Colin | What about anti-disestablishmentarianism? |
|       | [Colin is ignored. Mark remains quiet but begins studiously to write down words. The others join him.] |

| Martha | When you’re finished pile them in the centre of the table. [she begins to read them aloud one by one]. Okay Colin, ‘scary’. Then there’s sick, three times, and Ayanna, ‘weirdo’, ‘strange’ and ‘freaky’. Then we have crazy twice. Ayanna you also have ‘grumpy’. Becky, ‘cuckoo’. Mark, ‘unwell’ and Colin, ‘mental’. [Amy adds ‘psycho’]. Colin, ‘loony’ and Michele, ‘combobulated’ [which makes Colin laugh]. Michele you also have ‘emotional’. [Martha and Amy both add, ‘crazy’]. Amy can you make sure you collect all of these [some not read out] and put them away. Did you get his brown words? |
|        | [a long pause] |
Martha: So why do you think these words are used? Why are people called by these names?

Eliot: Because everybody is scared of them…No…I just made that up [in a quiet aside, again to no one, or everyone] I’m too smart for them…[and then to the kids at the table, probably his brother]…isn’t everyone scared of Mom [is he being sarcastic]?

Colin: [ignoring his brother, to Martha] Because they are ignorant. (session 3)

While Colin and Eliot initially resisted going along with the group exercise, playing off each other, indicating that they will go their own way, they actually ended up responding to Martha’s question by arguing for two common and complementary ways of thinking about why people use stigmatizing language: ignorance and fear. Without intending to, Colin and Eliot put their finger on two key concepts central to the Children’s Group teachings that involve learning how: to think and talk about mental illness appropriately, through education and, to recognize the emotions (especially fear) associated with behaviours they are taught to recognize as symptoms. Eliot’s first response was prescient, but he seemed uncomfortable and retracted his statement that “everybody is scared of them” rather quickly, pretending he “made it up”. He tried to change the subject by saying something ambiguous about being “too smart for them”, which I believe he was directing at the adult facilitators, possibly in an attempt to redirect the conversation toward the children, who by “sarcastic” implication must have been smart “enough” to answer his question. He turned instead to address the children at the table, and most probably his brother.

Eliot tried to provoke Colin into a discussion about whether people are afraid of their mother, but Colin ignored his challenge, preferring instead to coolly invoke his own response, redirected back to Martha: “because they are ignorant”. I wondered if Colin refused his brother’s entreaty because he sensed that this was a dangerous conversation. Colin seemed very protective of his mother, and he had commented more than once that she didn’t believe she had a mental illness (implying that he agreed with her I thought). Of course the participants were not very far into the program at this point either, so it may have been difficult to know if such a conversation could be trusted anyway—whether with the adults or the children in the room. I wondered why Eliot would want to have this conversation with his brother in this public way. It risked team discipline and loyalty by staging a separate show, and it seemed almost as if Eliot was trying to “out” Colin about some unspoken issue between them.

Martha continued talking about mental illness and stigma, using an exercise created in response to a conversation I had with Colin the week prior. He had expressed concern about the “ignorant” titles of some of the books provided for their use in the “Quiet Corner”. Martha used
this as an opportunity to talk not about “brown words”, but to have them imagine how they
would do things differently given the opportunity to tell other children “what it is like to live
with a mental illness”:

Martha  Yes, you mentioned that last week [going over to the books in the QUIET
CORNER and holding up two books, Edward the Crazy Man and Is Dad Crazy?... Remember these?  Okay, if you had to write a book for
children about what it’s like to live with mental illness, what title would you give to it?

[its quiet for a moment and then everyone has a hand up]

Mark  Why is My Parent Different?
Colin/Eliot  [together] That’s a good one.
Ayanna  Is My Mom or Dad Sick?
Eliot  What’s Wrong with Dad?
Colin  Mental Projections, Hah! [laughing] It sounds like a movie.

Ayanna  Is Mom or Dad Crazy?
Amy  But remember, we don’t want to use words like ‘crazy’ in the title.
Augusto  I don’t have a title.
Michele  Are They Feeling Okay?
Colin  I like Mark’s one. (session 3)

Even though the exercise with “brown words” and the creation of imaginary book titles occurred
in session three, some of the children retained a marked preference for language that wasn’t
illness-related, especially when they described their own situations. For example, both Colin and
Eliot liked Mark’s less medicalized but more ambiguous book title, ‘Why is My Parent
Different?’ perhaps because it emphasizes the behaviours that mark the parent as not like others,
and hints at the “real” difficulty of living with a parent with a mental illness that isn’t explained
by an illness model. On the other hand, Ayanna who is much younger did refer to sickness and
“craziness”—and had to be reminded of the rule not to use “brown words”. She did not seem to
be able to talk about her own experience in this exercise, and may have been trying to participate
by feeding back some of the words that had been used by others. Michele redirected the issue to
the parent and their “feelings”, but it seemed that she may have been trying to avoid talking
about herself, or engaging with the more personal aspects of this question. Augusto seemed
simply unable to participate. I watched him over several sessions, he appeared to prefer drawing
or playing games and was least enthused or motivated during “talking” sessions.

The “brown words” were set aside at this point so that Martha could use them in a new
ritual she developed for the last session of the program. Children were asked to stand in a circle
around a hastily drawn picture of a brain inside a human head. It seemed like a kind of graduation ceremony, which took place in the moments before everyone was asked to say a formal goodbye to one another. The “brown words” reappeared, which Martha now called the “myths about mental illness”, and were divided up amongst us (I was asked by Martha to take part). We each took turns reading aloud the one we were given, and then we were told to tear them up, and place the detritus on top of a drawing of a brain that had been taped to the floor in the centre of where we stood. New words, representing the culmination of the Children’s Group teachings—for example, beliefs about “confused thinking and the broken brain”—were written out on similar pieces of paper, in yellow, and we repeated the procedure, solemnly read each one out loud, but this time placing them, in tact, over the “myths”. This seemed to me to signify how everyone was expected to have overcome inappropriate and inaccurate “ways of thinking and talking about mental illnesses” by taking on a new language to explain and talk about the experience. The participants seemed willing to accommodate this idea, at least as far as participating in this ceremony at Martha’s request, playing their parts quite seriously. It was not enough that the children had learned how to talk about mental illness using the correct language, but also that they were equipped with some basic medical information that would establish the “problem” as an illness.

“But scientists know…it’s like a physical illness”

Martha initiated the first session with a question/answer format that she used in subsequent sessions to introduce the participants to more mental health information. However, it was also a strategy she could use to evaluate what the children already knew about mental health and illness—particularly the causes of illness—and whether or not it was “accurate”. Martha welcomed children’s questions, which were formally documented on a piece of agenda paper, and taped to the wall in each session. I referred to these in my observations as “a running list of questions” because they were added to each week. This had the effect of making the Children’s Group seem like a good place to ask questions about mental illness and find answers. But children’s questions also helped Martha and Amy assess whether children understood what they were teaching. On more than one occasion Martha complained to me how difficult and frustrating she found it to keep track of all the “important things children asked about” for future reference, so that she could make sure they received answers. Martha carefully instructed Amy to take this task seriously because as she said: “we have to remember them until we feel that we have answered all of their questions”.
There was an interesting assumption that children would have questions and that these must be answered, and also that *Children’s Group* would be able to answer *all* of these questions. It was as if children’s inquiries, problems, questions, potential doubts and so forth, could all be answered and were manageable. But even when Martha began a series of questions designed to produce certain answers, the children didn’t always respond as she may have anticipated, and some became wary, or expressed disappointment when the answers given didn’t meet their expectations. For example, in the next sequence Martha holds up a series of questions on laminated cards.\(^{49}\) Obviously these were highly scripted questions, prepared in advance (at least retrospectively it seemed obvious to me). They reminded me of cue cards used by actors to help them remember lines—because they were held up in front of the participants who were supposed to produce a set of responses about what is known about mental illnesses. Martha didn’t take the time to address incorrect information or misunderstandings—see for example, Augusto’s suggestion that mental illness is something that “you can catch”—because she was focused on establishing an important point, the consummate answer to the question of why people “get it”, which is that: “it happens in the brain”. Initially everyone was quite receptive to Martha’s first question, trying out different responses until she decided that enough time had been spent on this, and having made her point, she pre-empted further discussion concluding that there are, “many different reasons for why people get it”. Colin and Eliot reacted with obvious frustration and disappointment; at first expressed with non-verbal “groans” of disapproval before Colin explicitly challenged Martha’s answer:

Martha (picking up a laminated sheet with words written on it), “Why do people get it?”

Colin (over murmurs of everyone starting to answer)...you are born with it.

Eliot (almost at the same time)...a tumour or something...or a head injury.

Ayanna (following on immediately)...someone came to my school and had a disease and it’s where like...like you can’t walk or something?

Eliot You mean MS...like...multiple...multiple sclerosis, is that what you mean?

Ayanna yes, maybe yes that’s it.

Martha Yes that’s a kind of illness....

Augusto (interjecting)...it’s addictive.

Amy you mean it’s like having an addiction?

Eliot (interrupting)...it’s like being hooked on something.

Augusto it is like fevers and brain damage...it’s like you can catch it.

Martha okay, thank you...so there are many different reasons why people get it.

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\(^{49}\) These reminded me of the CAMH pamphlets that purported to answer questions to “What kids want to know...” but were written by adults speaking on their behalf.
[Colin and Eliot groan in response]

Colin That’s not really an answer, that doesn’t really answer the question about why people get it.

Martha yes, I understand your frustration, but we will be spending time over the next few weeks to try and answer this question. (holding up another laminated card she reads, ) “How do people get it?”

Colin But that’s just like the first question.

Martha Yes, it seems that way, but there are subtle differences…try to think about what they are.

Eliot a tumour?

Ayanna you are born with it?

Martha It happens in the brain. Okay, next question, “What is it?”

Eliot When someone is sick in the brain.

Ayanna (in a small, quiet voice). I don’t know.

Martha/Amy (together, enthusiastically) yes, yes, that’s a very good answer…. Martha that’s why we’re here at the Children’s Group to try and answer this question that even a lot of adults don’t know the answer to.…. Augusto (interrupting)…but scientists know…it’s like a physical illness.

Martha yes, in some cases. (holding up the last card), “Who gets it?”

Colin (quickly, without hesitation), anybody can get it…it’s just in somebody’s genes.

Martha yes, while anybody can get it, not everybody does get it. (emphasis mine, session 1)

Participants could ask questions—interrogative as well as those that functioned to cast doubt on something—but there were implicit rules about the timing. There clearly was a “right” time to ask a question, or to question, whether or not they were considered “good” questions. Those that were added to the list for future reference must have been good questions because they were legitimated by being written down. For example, in the previous sequence Colin accused Martha of not really answering the question about “why people get it” and Martha tried to persuade him that she would answer it over time, during the course of the program. But I wondered if Colin thought there was a simple, straightforward, direct and maybe even concrete answer to this important question. Did he feel deceived by the answer, and did Martha mislead everyone by indulging in an abstract exercise designed to introduce topics for discussion that couldn’t or wouldn’t be answered immediately, or ever really? Later Martha told me that she felt that the children come to the Children’s Group “knowing they need to know” this information related to questions about “risk” and the fear they may have of “getting it”. The questions she posed about how and why people “get it” may have been on their mind to the extent that this would have been a very frustrating exercise given the ambiguous answers that were actually given. Colin seemed suspicious throughout the remainder of the sequence, doubting the legitimacy of
Martha’s second question too. On the other hand, Eliot appeared to “stay in the game” and willingly responded by defining mental illness as “a sickness in the brain”, possibly signifying his acceptance of “it” as both an illness, and as something that originates in the brain.

However, it was Ayanna’s admission that she doesn’t know what “it” is, despite being told that “it happens in the brain”, that gets the most vocal reaction from the facilitators. Ayanna seemed to me to be giving up after all of this cycling back and forth between questions and answers, and may have been simply exasperated and now willing to admit that she wasn’t sure anymore. She may have also, however inadvertently, given voice to the possibility that no one in fact “knows” what mental illness really is. But whatever the interpretation Ayanna nicely set Martha and Amy up not only to make the point that “not knowing” is okay, and perhaps even expected, because an important goal of the Children’s Group is to try to answer questions that individuals are expected to have. The facilitators also appealed to those present by suggesting they might become more knowledgeable, that is, more expert than “even a lot of adults” who don’t have the answers to questions about “getting it”. However, Augusto was not ready to concede this point because he believes that that there are adults who know, those who have specialized knowledge. Moreover, this specialized knowledge is also the domain of (medical) science because as he argued, mental illness is “like a physical illness”. The idea that mental illness is an illness like any other was referred to in an earlier discussion, when Ayanna and Eliot talked about multiple sclerosis and Martha allowed that it too was an illness, like mental illness. By the end of the sequence Colin seemed to relent as he responded to one of Martha’s remaining questions about “who can get it” decisively and with confidence saying, “anybody can get it…it’s just in somebody’s genes”. Martha agreed with the first part of his statement because it allowed her to introduce mental health promotion concepts that she will develop more fully later based on a concept of risk as pervasive (because anyone can get it), but also as preventable (because not everyone does).

**Mental illness: “It’s all in their heads”**

In order to explain how and why people develop mental illness—as something that results in a “broken brain”—the children were taught how thinking and the brain are connected through explanations about neurotransmission. Martha also introduced the idea that the body and the brain in particular, are responsible for sending messages about pain. This became important later when the children are taught to understand (negative or “painful”) emotions as embodied experiences as illustrated in the following excerpt. This was important, not only to
explain the process of developing a mental illness, but so they would begin to grapple with their own feelings about their situations. I noted that Ayanna used her body in a prescient way during this discussion, swaying back and forth to show how she understood something about what the movement of messages might look like as Martha talked, although she told her she didn’t understand when asked. However, it seemed to me that the older children were very engaged in the following presentation because they recognized similarities to information they were learning about the body in school. They crowded around the pictures, leaning forward to get physically closer to her demonstration as Martha explained basic principles. Augusto helped by easily adding the word “cells” to complete her sentence, and Mark didn’t hesitate to explain to Augusto that “being dumb” has to do with brain functioning rather than size, which Martha asked him to repeat for emphasis to the whole group:

Martha  Yes. Well tonight we’re going to talk about thinking and the brain and your body is made up of….
Augusto (interrupting)…..cells.
Colin yeah I know about that we’re doing that in school.
Michele yeah, so are we.

[Martha holds up a drawing of a cell as she begins to teach how ‘messages’ are carried from one cell to the next, one ‘neuron’ to the next, and about synapses and how this works; the kids are very quiet and attentive, all are sitting forward into the table to look at the diagram. The older ones are ‘checking this against what they’ve learned in school’ in various quiet comments they make about the diagram. The younger ones, Becky and Ayanna are also paying attention, but are quiet. As Martha describes the movement of ‘messages’ along the cells Ayanna stands up in place and sways from side to side, with her arms over her head indicating how this might look. Martha begins to describe how messages about pain are ‘received in the body’].

Martha (to Ayanna) Do you understand?
Ayanna No.

[Martha repeats her explanation]

Martha I promise to bring some good pictures of the brain next week.
Augusto If someone is dumb, do they have a small brain?
Martha I don’t think that actually has anything to do with the size.
Mark Just how it functions. (Martha agrees and asks him to repeat this as he said it quietly at first). (session 3)

To demonstrate how faulty neurotransmission works when “something happens in the brain” (due to mental illness), Martha used props created specifically for the program. In the following sequence she laid out a Lego car and a small wooden bridge with two movable pieces of felt at either end, which represented islands. Eliot could not immediately see what the
problem was because as he pointed out, “there is a bridge”. This is important to keep in mind because “the bridge” was a significant metaphor for the entire program, and was used here to represent “the brain”. Initially Martha ignored Eliot’s observation that there couldn’t be a problem because there was a way across in order to continue her explanation:

Martha: So the car has to get from one island to the other.
Eliot: But there’s a bridge!
Martha: [continuing over him] So the car starts out on one side. [she holds up a laminated card with a picture of a cat]. And then the car hits a bump in the road, or breaks down [she holds up a laminated picture of a lion. The kids correct her when she points to the ‘lion’, saying no its’ a ‘tiger’]. A person who has mental illness, their thoughts are like the car, that can’t make it over the bridge. The breakdown means they see a tiger, but it is really only a cat.

[All are listening. Martha seems a little flustered, tired from all the talking. She repeats the analogy; but this time she uses a picture of a woman in Japanese dress and a monster].

Eliot: Hey, she has on a …what do you call it…a..a kim..kimono…

[Martha continues with the analogy; this time the breakdown causes the person to see the woman as a monster]

Eliot: [continuing in the background]…she turns to a fart on the other side.

[great peals of laughter from all the kids]

Becky: What if the car falls right off?
Colin: What if there is a boat there?

[Colin seems to like to complicate the stories and make Martha and Amy work for the explanation].

Martha: …the important thing is that it is the mental illness that causes the person to see things differently. Do you older ones get this?
Colin: No.
Martha: [suspiciously] Why?
Colin: Cause I didn’t get my sugar today [he is egging her on about getting the snack. Everyone laughs at his joke]. (Session 3)

Rather than responding to what Martha had been talking about directly, the participants took over the sequence with reactions of their own, some of them humorous. For example, Eliot worked the background to provoke laughter with his scatological joke, perhaps to undermine the “seriousness” of the moment, with the added benefit of possibly offending the adults. It was also a “childish” response to what may be perceived by the participants as a fairly straightforward,
but “childish” set-up. Both Becky and Colin challenged Martha’s explanation as the only valid one. At the time I felt there was an ironic, rhetorical tone to both of their questions as if they were playing off one another to trigger a response to ideas they had about other ways of thinking about the consequences for the car making not making it across the bridge. While I wrote at the time that Colin complicated the stories to make the facilitators “work for the explanations” I believe he did this with a purpose other than just to be disruptive, or challenge the facilitators because he knew he could. He may not have been easily satisfied with some of the answers he was given, but Colin also used questions to provoke others to react to the situation. While Colin’s response hints at the idea of rescue in answer to Becky’s question, hers imagines a much darker outcome, a total collapse of the message carrying system, which refuted Martha’s explanation of faulty neurotransmission as a momentary problem of confusion about reality. I was struck also by the idea that both of these responses might represent experiences of having a parent with a mental illness. For example Colin’s mother was in the much earlier stage of dealing with a diagnosis and hospitalization, where the idea of “rescue” might be important to how he interpreted what “happens in the brain”. In contrast, Becky had been living with mental illness for a long time and had no recent contact with her mother because supervised visiting rights had been revoked due to extremely aggressive behaviours. The concept of something that happens in the brain as “falling right off” might be a better way for her to describe her own situation. Martha did not reply to either of them, but as the following excerpt demonstrates, she expressed a concern to me later that the children might not really be “getting it” because of the way she was using these props to teach neurotransmission:

Martha: I saw that they get that the ‘car’ falls apart and can’t make it over the bridge, but they don’t get that there is something wrong with the bridge itself. So I’m going to do it again tonight. I went out and got a red piece of foam that’s the same size as the bridge and I put holes in it, so that the overlay on the bridge, the car will have to go over this…. (session 4, reflexive notes)

This response was relayed to me a week later while the children reviewed material from the previous session. She reworked the demonstration trying to show that there is something wrong with “the bridge” itself, now a more explicit metaphor for the “broken brain”, which causes faulty thinking. Martha also insisted that Colin use “scientific” language when reviewing this material and he tries, fumbling over the words but getting it right when reminded, “it begins with an N” (meaning neurotransmission). But most of the children seemed to ignore Martha’s renewed effort to teach them about the “broken brain”. They were resisting the script, busy with
their own agendas, making fun of one another and in once case, engaging in what seemed to be to be a growing flirtation between Michele and Eliot. Augusto seemed bored, asking when the candy game would be played only to be told to look at the agenda and figure it out for himself.

As the children continued to talk about the brain and the body, Michele made a connection between neurological processes, and potential explanations about mental illness as confused thinking in relation to her mother. She also named a specific psychiatric diagnosis, linking her mother’s confused thinking to a medical explanation about something that “happens in the brain”. Eliot was not as accommodating. While he agreed that his mother’s thinking was confused, he didn’t necessarily ascribe her situation to mental illness, or explanations about “broken brains”. Eliot talked about it as something ‘natural’ and normalized her confusion, saying, “She thinks that way, all by herself”. Even his mother’s overly optimistic attitude isn’t something he thinks of as odd or as illness-related. Martha did not challenge Eliot’s assertion, but used his comments to cue a discussion of other signs of mental illness and psychiatric diagnoses. Eliot himself seemed aware of common psychiatric diagnoses. For example, both Colin and Eliot seemed to know enough about obsessive compulsive disorders (OCD) to participate in the following conversation. Colin used a simile to describe the kind of behaviours associated with OCD as a “loop that doesn’t stop”, although he may have been (re)interpreting Mark’s description of his father’s behaviour from the week prior. However, the children knew less about schizophrenia, and they asked questions about it at other points in the sessions, often struggling to pronounce the word. Martha herself seemed flustered by the question about schizophrenia. Her explanation at the end of the sequence didn’t distinguish schizophrenia from other mental illnesses that were explained more generally as, “things seem real but are not really real”:

<table>
<thead>
<tr>
<th>Michele</th>
<th>That might help to explain depression…thinking, everything is all confused.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eliot</td>
<td>My Mom thinks that way all by herself and thinks the next day will be even better than the last one…sometimes it changes</td>
</tr>
<tr>
<td>Martha</td>
<td>Yes and with OCD people do things over and over and over and over.</td>
</tr>
</tbody>
</table>

[I watch Mark to see his reaction because his father has been diagnosed with OCD and last week he talked about repetitive behaviour. Did Martha put this out there for his sake?]

<table>
<thead>
<tr>
<th>Eliot</th>
<th>They wash their hands a lot and finally their hands get destroyed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colin</td>
<td>[while Michele has her hand up] It’s like obsessive/compulsive, like a loop that doesn’t’ stop.</td>
</tr>
</tbody>
</table>
[Mark says nothing to these offerings. Then someone asks, ‘what about schizophrenia?]  

Martha [struggling for a moment]…uh…it’s like someone feeling someone is out to get them…things seem real but are not really real. (session 3)

Although Mark said very little in connection to the teaching about “broken brains” and confused thinking and his father’s illness, he tried to rescue Martha who stumbled over the question about schizophrenia, by making the link between disordered perception and a dysfunctional brain in the following sequence. This helped both Ayanna and Augusto recognize the problem of confused thinking, and how not being able to distinguish between what is real or not, has contributed to their parents’ beliefs. They are excited and engaged because the explanation made sense to them and was directly relevant to their experiences. In the following interaction with the children Martha used examples to demonstrate differences between ‘Healthy’ and ‘Unhealthy’ thinking. Unhealthy thinking became another way of referring to mental illness by emphasizing it as a problem of a disturbed thought process, but one that is embodied and experienced through different bodily sensations:

[Martha pulls out a large sheet of flip-chart paper with the words, ‘Healthy Thinking’ written on top and starts to take the kids through examples of how a ‘healthy’ person’s thinking responds to their five senses. For e.g. ‘a healthy person sees an elastic band on the table and thinks it is an elastic band’. Everyone is listening, quiet, engaged. A second piece of paper reads: ‘Unhealthy Thinking’ and written on it are examples across three columns, Senses, Thinking and Feelings. Examples written are: see an elastic band…confused…think you see a snake; hear music….changes…think the music is telling you to do something; smell pizza…distorted…thinks they smell smoke; feels sand….unreal…thinks the sand is bugs; tastes something salty….twisted…thinks the salt is poison added to the food; and across the bottom: What the person sees, hears, tastes, touches and smells is not the same as what they think.]

Martha These are just examples, let’s read them through together [and they do, Martha reading and various kids joining in with her].

Mark [volunteering] They see it, but the brain would tell them something different.

Augusto/ Ayanna [at the same time, excited] My Mom is like that.

Augusto She thinks our place is poisoned.

Ayanna My Mom thinks the chicken is poison.

Augusto But, what if they smell smoke and it turns out to be pizza?

Mark [to Augusto] It’s like what Eliot said earlier, the brain is telling you something else.

Martha Yes, it could happen the other way around…yes, I think so. (session 3)
As this sequence continues Martha and Amy try to shift the children’s perceptions to see that “unhealthy thinking” causes peculiar, socially awkward and even extreme and dangerous behaviours. Moreover, bodily sensations are not trustworthy in this case, because thought processes are distorted. To make this real for the participants, they engaged them in a dramatic read-through of the material presented, which most seemed willing to do. Mark’s reminder that distorted thinking is about the “brain telling you something else” didn’t really get at Augusto’s question, which seemed to challenge the assumption that “real” danger is always something more than what might be, “just” in their heads. Although Martha acknowledged that her example could be turned around, she didn’t address this possibility and moved on to emphasize the consequences of distorted thinking as originally planned. Martha concluded with a story that made her point much more dramatically by emphasizing outcomes of distorted thinking as threatening and dangerous. She may have been spurred on too by Augusto and Ayanna, who found Eliot’s response to following “what if” scenario quite funny, although it isn’t clear this was his intention, other participants remained quiet:

Amy Well, what would it be like to think you smell smoke?
Mark You’d be swatting at it.
Amy Well…yes. And what if you put your hand in your pocket and felt sand, but thought you felt bugs?
Eliot I’d pull my pants off.
Amy Well, yes. And that’s what happens to people sometimes.

[Augusto is laughing at this image]

Ayanna Well, you would be your bum-self
[the others are not laughing, but not responding]

Martha I had a friend once, who is an artist and has bi-polar disorder and he was walking down the street and saw someone coming his way who had a package under his arm. He thought it was a bomb [Michele laughing in background]. He ran up to the guy and physically attacked him, and then the police were called. So you see, what we see might not be what is there…this man was a plumber and it turns out that he was carrying a pipe under his arm. (Session 3)

By asking the children to imagine what it would be like to “act as if” they were experiencing distorted thinking, the facilitators tried to summon up the right cognitive and emotional

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50 In the session just prior, Mark reasoned that difficult behaviours due to mental illness was “all in their (parents’) heads”. I discuss this further but highlight it here to make this analytic argument about children’s emphasis on the consequences of behaviours related to mental illness.
responses to the situation, so that children would learn what to do when faced with odd, but more so, difficult and even dangerous behaviours. This strategy of asking them to “act as if” they were inside the experience was intended to help them “understand” it; this was accomplished by making responses to signs and symptoms of illness intelligible, and also by asking the group to come to an informal, but mutual agreement about what they meant, and perhaps by helping them to become more tolerant or sympathetic toward the experience in the process. Both Mark and Eliot accommodated Amy’s questions appropriately, easily giving examples of how they would react if they thought something was real. It was not clear what made Augusto laugh and Ayanna tell her joke, other than the image provoked by Eliot’s “correct” interpretation of what might happen if the sensation of touch was confused by distorted thinking. Another example of “acting as if” was portrayed by Martha and Amy who take turns performing a “good day/bad day” scenario—an image often used to describe the episodic nature of mental illness—to demonstrate how thinking, feeling and behaviours are interconnected:

Martha [getting out of her chair]. I’m having such a bad day. My shower was cold. I didn’t study for my math test [goes up to Ayanna who is sitting in her seat at the table] Are you talking about me?

Ayanna [playing along] No.

Martha [to Augusto] I can tell you are talking about me. [coming out of character] So you see this is an example of how thinking can affect your feelings and behaviour. How do you all feel when I was walking around the table and saying all these things?

Mark [volunteering] You seemed mad…and I can feel the anger.

[in an aside, under his breath, but directed toward me Eliot groans says, “this is so horrible”. It isn’t clear if he means that the acting is so horrible, that he finds it embarrassing, or silly, or if he means the scene that is being depicted is horrible, or not realistic. Amy portrays a ‘good day’. She stays in her seat].

Amy I didn’t study for my math test today, but it’s okay. I’m feeling good today…hey, how are you? You guys doing okay? Isn’t it a great day?

[in an aside Eliot says to me, ‘you know, I still have homework to do when I get home tonight.’ I try to be sympathetic, nodding I understand].

Mark [to no one in particular] I usually get 97% in math [he seems to have overheard Eliot’s comment].

Colin [joining in] Yeah, me too.

Martha So what do you think the ‘good day/bad day’ is all about?

Mark/Colin [almost together, so its hard to decipher who says what] Yeah, I get it…yeah, its about thoughts affecting what you do.

Martha If you are mentally healthy you can stop and change…right? Does that make sense?...this is a negative thought, but I can change it. (Session 2)
Only Mark seems to have felt, or was willing to express the emotions that this scene was
designed to provoke. The facilitators were somewhat successful because Mark and Colin were
able to play back the message about interconnection, but they also appeared to placate her by
giving the “right” answer. Eliot was distracted by the performance, and as I noted in my
observations at the time, this may have been for a number of reasons including his aversion to
“play-acting”, or embarrassment at what may have seemed not very realistic. Ultimately though,
the scene seemed to remind him that he still has homework to do after the session. Amy’s “good
day”, which implies that studying is a waste of time as long as you “feel good”, did not mollify
Eliot. On the last day of the program, when I asked the group members what they were most
looking forward to when the sessions were over, Eliot replied, “Homework, I’m going to go
home and do homework” (session 8, group discussion). The timing of the group on a weekday
evening provoked the few negative comments children made about coming to the Children’s
Group. Mark explained this in terms of responsibilities he felt toward family and school work:

Mark: I don’t really like the time. Cause…well, it depends on when people have
dinner but it’s like when I come home from school and like I’m doing my
homework, but then my Mom is late at work and calls me and then I have
to start dinner, and then right in the middle I have to come here and then
when you get back from the Children’s Group, it’s late and you still have
homework and stuff to do…like maybe on a Saturday, but then not on an
afternoon because I have soccer so it would screw that up. (session 8,
group discussion).

He emphasized his point a few moments later when asked what he would tell other children
about what it was like attending the Children’s Group saying, “Get your homework done!”
(session 8, group discussion). Many of the older children worried about homework during these
sessions and told me so at different times. Colin told me that he often had to do his homework
over dinner in a restaurant before he came to the sessions, which seemed to add stress to his day.
Moreover, some children appeared to be high achievers. This was important to them, and to
impress upon others too, as Mark and Colin manage to make clear in the prior passage, and as
most of the participants conveyed to me in different stories about how well they were doing
academically and socially. The strategy of “acting as if” to foster understanding seemed to have
failed this time, at least for Eliot who wasn’t able to rise above the “negative” thoughts about
homework that the scenario produced.

This is interesting as the interaction shifted focus at this point as the BTU agenda
transitioned from an emphasis on understanding the parent’s situation as a problem of a “broken
“brain” (or mental illness), to teaching the children how to stop negative thinking, to be mentally healthy. The important point Martha made here is that “mentally healthy” people are able to change their “unhealthy” or negative thoughts. She argued that being able to come up with positive alternatives, or other ways of thinking about a “bad day” is a sign or evidence of mental health rather than illness. Her explanation foreshadowed the idea that mental health has something to do with having control over how we think about and therefore, how we manage our circumstances. However, Augusto seemed less convinced by the message of the “good day/bad day” performance, albeit for different reasons than those that seemed to influence Eliot. As Augusto explained, his mentally ill mother has good days, and bad days, and even when she had a bad day she didn’t necessarily behave badly because of it. He resisted the implication of this message, explicitly questioning Martha’s logic that suggested children could always “tell” bad days from the ways parents behave. This challenge was enough however to (re)engage Eliot (and Colin) in the conversation, although Colin poked fun at his brother, suggesting he may not have been part of the “we” Martha described as “mentally healthy”. I was reminded of the phrase, “we are all in the same boat”, which was supposed to show the children that they have things in common, and are in effect members of the same team. However, here they are drawn together, not by the assumption that they face similar challenges, but that they are “mentally healthy” rather than “ill”. The inference being that they are not like their parents as indicated in the following sequence. And to remain healthy they must learn to cope, first by recognizing that mental health is fostered by an ability to think positively. If they are to be disciplined as well as loyal members of this team, then they must also learn how to be responsible for the way they express their reactions to good and bad days:

Martha We are all mentally healthy because we can come up with positive alternatives.
Martha [ignoring him, continuing]…but when someone is mentally ill they can’t control this…
Augusto [interjecting]…My Mom can’t…but what if they have good and bad days? Or had a bad day and didn’t do anything about it?

[Colin and Eliot are listening, engaged].

Mark It’s all in their heads. (Session 2)

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51 This is a significant idea because it is a strategy for promoting mental health as I discuss in a later part of this chapter.
I interpreted Mark’s response as a double entendre because while mental illness is “in their heads” as had been described in the account so far of faulty neurotransmission, and “broken brains”, it may also be only “in their heads” as his reaction implies. Explanations about bad behaviours resulting from external circumstances, and a lack of control, may have been less than satisfactory for some children. Like Augusto, Mark may also have been questioning how much having a bad day really counts as an explanation for understanding what happens in “their heads”. This was a challenge for participants who were frustrated by trying to reconcile whether the symptoms (or behaviours) are real or not. In session seven, the following discussion took place after the children watched a film clip about a young girl’s experience of her mother’s symptoms of mental illness. Colin had trouble sorting out whether the mother’s symptoms described using specific imagery are real or “just a metaphor”, while his brother Eliot, was more pragmatic and accepted that it simply represented a tangible sensation:

| Ayanna | What did she have? |
| Martha | I don’t think they ever say what is the name of the mental illness. Are there any other comments before we move on? |
| Colin  | Why does she use a …it’s like a simile, but not a simile…ah…[as he struggles to come up with the word…] |
| Mark   | [interpreting his meaning] …a metaphor? |
| Colin  | Yeah!…that’s it, a metaphor…about the train, the train in her head. Is it a metaphor? |
| Martha | I think she is referring to the sound… in her head. |
| Eliot  | [breaking in…] Its just a loud sound in her head. [this answer seems to satisfy everybody, so Martha moves on. [session 7] |

Overall the teaching seemed confusing for the individual child who was expected to learn to take responsibility for their own well-being, because mental illness was explained as something “inside” a person’s brain and also as difficult behaviours caused by the social circumstances of everyday life.

**Showing and telling “symptom” stories**

In the following sequence Martha conceded that Augusto may have had a point because having good or bad days might not fully explain the actions of mentally ill parents. Without wasting any more time on the issue she asked the children to talk about instances when their parents behaved in abnormal or difficult ways. The children’s stories were used to demonstrate that they easily recognized problematic behaviours, so that mental illness may not be just “in their (parents’) heads” after all, or that whatever is in their heads has consequences for the children. There was plenty of talk and other ways of demonstrating how “symptoms” were
observed—a term used interchangeably with “behaviour” by the children, and has implications for individuals living with a person who has a “broken brain”. In these sessions I found that the participants were much more accommodating and less resistant to being asked to talk about and draw pictures of their parents’ symptoms and/or difficult behaviours. There were fewer incidences where they teased Martha, or joked with one another and interrupted the agenda, and they showed only an initial reticence to participate fully in an exercise designed to elicit talk about their parent’s illness behaviours. For example, in the following interaction the children drew easily on their experiences of what might be called parents’ “bad” behaviours and accommodated Martha’s request to tell more, with little hesitation. Colin and Eliot worked together to describe their mother’s behaviours, Eliot interrupting his brother only to clarify a detail:

Martha  Yes [looking at Augusto] it is possible to have a bad day without doing anything about it. Does anyone have examples of odd or difficult behaviour with your parent?

Colin  [readily] Normally when Mom meets a new guy…friend…they could be the best person in the world, and in two months….

Eliot  [interjecting] …two weeks….

Colin  [continuing]…they are the worst enemy. It was the same with houses. We moved 8 times….

Augusto  When I come home from school she is angry for no reason. And says, eat, eat! And I tell her I’m not hungry, I just had something to eat and that’s all she keeps saying, eat, eat and I tell her I’m not hungry and gets really angry…really mad.

Mark  My Dad asks lots of questions and it gets really annoying, and I answer, and he asks again, and again and again.

Martha  …and he just keeps asking you.

Ayanna  [joining in] She’s too funny and can’t do lots of stuff. She can’t think right.

Amy  Sometimes the stress makes things worse.

Colin  My Mom is overly dramatic and some things she does are unnecessary. Like when she is meeting someone for the first time, someone important and she knows they have a phobia…about snakes…and she says, ‘Oh maybe I’ll get a plastic snake and throw it at them’…and she thinks this is funny. (Session 2)

During the first sessions children were asked to make drawings depicting mental illness, and to describe their meanings to each other. Mark described his father’s illness as something that has overtaken him—as if he is some other, more dangerous and “monstrous” self (figure 4). He used illness language to name the problem, and gave it the correct psychiatric label making reference
to the difficult behaviours that prevent his father from behaving normally and being himself, especially a lack of control over what he does and says:

Mark

My dad has an illness and is not himself. He has OCD and he is always tapping things and so it is like somebody else in there…a monster.

[Mark has drawn a fiery coloured figure, with what looks like flames coming out of his head, very angry, with the letters OCD written across the figure and several speech bubbles (‘…..do this’; ‘blah, blah’; ‘I can’t…do it’; ….’do that’). There is a stop sign in one corner, and it has a title across the ‘top: Bothering, Annoying Monster].

Martha

Why have you drawn that stop sign?

Mark

It stops him from doing normal things. (Session 2)

When talking about her abstract drawing depicted in figure 4, Becky was reluctant to explain what her drawing meant using words. In the following sequence she resisted Martha arguing that this was an expression of how she felt, but was pressed further to reveal if how she felt was “good or bad”. In the end Becky conceded, saying that she had some ambivalence about her own understanding of mental illness. She was able to talk about confusion as part of her mother’s symptoms when Amy asked about a particular detail in her drawing. Becky also provided a clearer picture of the kind of difficulties she may have had because of her mother’s behaviours, given the “mean mouth” she described:

[Martha presses Becky for a word but she remains silent, looking down at her picture. And then, after a few minutes…]

Becky

I…I don’t know. Just a bunch of squiggles…that is…that is how I feel right now.

Martha [pressing] Is that good or bad?

Becky

both…mental illness, like I understand it, but I…I don’t [very quiet voice].

Amy

What about the eyes, the eyes that are underneath all the squiggly lines in the picture?
Becky	They are confused eyes. And that is a mean mouth. (session 3)

The fourth session was designed to help children talk about symptoms of mental illness as parent’s problematic behaviours. Before the children arrive, Martha talked about an on-going disagreement she has had with Maria, the coordinator of the program, about managing mental illness information and the issue of whether having too much information about all different types of mental illnesses might summon up difficult, wrong kinds of emotions. Martha sought co-facilitator Amy’s approval to do things a bit differently in this group, arguing that the “older” children might be less at risk of becoming “depressed” by being exposed to more clinical information about diagnoses. However, I did not observe any of the children reading the clinical outlines describing different illnesses that were taped to the walls during the session. I found it interesting too that the “Symptom List”, which was used as a prop in the next sequence to help the children tell their stories about parental behaviours (and distinct from the clinical descriptions posted around the room), was managed very specifically too, as if it contained private, confidential and also potentially “dangerous” information. It was kept rolled up, secreted away until it was needed, and then it is put away before the end of the evening when parents were expected to arrive to pick up their children.

After the “Symptom List” was affixed to one of the walls of the room the participants were asked to demonstrate which symptoms they recognize. They did this by raising their hands in response to Martha, as she read the number and name of each symptom (behaviour) aloud to the group. Martha told me ahead of time that she records their responses so that she can get a better idea of each child’s experience. Rather than sitting around a table as was our custom, we sat “audience style”, behind one another in two rows. At first, the children seemed reluctant to participate, perhaps because they wanted to retain some control over the personal information that they were being asked to share with the group. Perhaps, they were also resisting the notion that they were “in the same boat”, or negotiating what it meant to be categorized in this way. For example, most participants described to me how much they valued talking to each other because they shared an understanding of the experience others could not. Michele’s response was typical, but she articulated two significant, inter-related dimensions of belonging: they were similar ages and their understanding was informed by experience rather than prejudice and (mis)understanding:

Michele	I like it cause…although it’s kinda (inaudible)...its good to talk to kids around your age cause about things that…a lot of kids at school wouldn’t
understand, cause like you know your mom is (inaudible but something nasty seems to be said about parent)…. (session 8, group discussion).

A few minutes later Mark corroborated Michele’s view but seemed reluctant to be categorized completely the same way, reminding her that he had found his own way to resist responding to claims about having the entirely same experience of parental symptoms of illness. Michele tried to reconcile this by suggesting it is a matter of semantics and they still belonged to the “same category”:

Mark Cause you can talk to people who understand what you are going through. and in your experience have you felt that you were able to do that?
Me yep! (said emphatically).
Mark cause when we did that chart…like the symptoms for mental illnesses, most of the symptoms, everybody put their hands up mostly for the same ones….
Michele yeah that’s interesting…what was that (in reaction to something said at the table)?
Mark I recorded a half (he is referring to the fact that sometimes he only put his hand up to indicate he was ‘half’ in response to some of the symptoms)
Me yeah, I remember….
Michele they may not have agreed with everything but often the same category.

It is Mark who first expressed a reluctance to participate in the “Symptom List” activity, but he did so by making a game of it and the others joined him, saying things like “well a half for me” or “I’m a quarter on that one” and laughed at each other as they used fractions to respond to Martha, quantifying “how much” they could relate to the behaviour described. The game and laughter that ensued became a mutually reinforcing strategy that seemed to help the children manage what may have been an emotionally difficult, volatile and challenging task—whatever the underlying reason. Everyone became so absorbed by this strategy that it gave the impression they were only partially committed to what they are doing, resisting but also negotiating with Martha at the same time. But then things seemed to change, either because the children became more comfortable, and/or swept up by the process of telling stories. They appeared more engrossed in the performance itself having forgotten their initial reluctance to participate. Later Martha told me that she felt the activity “picked up momentum” as the participants began to recognize behaviours that were more relevant to their own experience. So for example, in the following sequence Eliot and Colin helped each other describe their mother’s fiscally imprudent behaviours that they allow is related to an illness. And Mark, who continued to use the “fraction
strategy”, employed it here to indicate how meaningful he found certain symptom descriptions saying that he is a “whole hand on this one”, and “two hands” on the next:

[Martha continuing…#12. acts impulsively, for e.g. gambles, spends money]

Eliot       Oh she spends lots of money….
Colin       [jumping in]….Yeah, she bought a boat once, and never used and sold it again, she’s bankrupt right now.
Augusto     She buys lots of groceries.

[no one asks him to explain further; it is unclear if he thinks there is something unusual in this, or if he wants to have a story to include with the others]

Mark        I’m a whole hand on this one…first there is the bread thingy, he goes out and buys the same bread, the same sandwich meat every day, even when we already have that at home [Mark’s voice is incredulous but also quite wry in tone) and then he says he is going to quit his job and he spends money and then he is says he is going to start his own business, selling houses…[his voice trails off and is inaudible).

[Martha continuing…#13. repeats same actions or words and before she is finished reading this Mark interjects….]

Mark        Oh, oh, I’m two hands on this one…everything I just said about the buying the bread…(session 4).

Once this happened, they began performing for one another, and Martha told them to turn around and face each other as they volunteered to speak, so that they were engaged bodily in telling each other symptom stories. See for example, how Martha introduced Michele in the sequence below with the words, “tah dah!” Sometimes the children had a different take on how symptoms were described, as Colin did when he said his mother did more not less chores when she was ill. They also elaborated further in some cases to suggest that these behaviours could have consequences for them. For example, Michele and Mark described having to do more household chores when their parents were ill. Sometimes Martha (re)interpreted how participants described their experience using clinical language as in the following sequence where “doing more chores” becomes “impulsivity”:

[Martha, continuing to repeat symptoms…Number: 17. does not do chores]

Michele     Oh, I have a story to do for this one….
Colin       [interrupting]…my Mom does too many chores, she doesn’t stop doing chores.
Martha: Well, yes it could be that way too, more like impulsivity… and so why don’t you turn around and face the audience to tell your story…[to Michele… she does, and Martha says with flourish]… tah dah!”

Michele: Well I don’t live with her now, but when I did she would sleep all day and be up all night on the computer and I would have to get breakfast and lunches and dinner, I would have to do everything… [her sister Becky is listening but does not comment].

Mark: My Dad comes home from work and says he’s not up to making dinner and then my Mom calls from work and says, Mark, ‘can you make dinner and so I say yeah I can make dinner’ [said with weariness]. (session 4)

At times siblings differed in how they interpreted parental illness behaviours. For example, Eliot and Colin disagreed about whether their mother ‘spends a lot of time in bed’; whenever this happened the participants were always reminded of the official Children’s Group rule: “we all have our own opinion” (session 4). Later Martha told me that she was glad Becky was sitting behind her sister Michele because she surmised that it was less intimidating for her to respond in her own way from this position.

For the remainder of the exercise the children described other experiences related to their parents’ behaviours. Mark explained that his father always threatened to “pack his bags and go and to quit his job” (session 4). Augusto said his mother threatened to ‘stab him’ if he refused to turn off the TV. This statement seemed to shock Eliot, and Augusto did not elaborate and was not asked to explain further. Colin described his mother’s obsession with a billboard ad she disliked, and the lengths she would go to try to have it removed. Augusto said that when he returns home with his mother she thinks someone has been in the apartment and dusted it with poison, and then she feels sick. Eliot and Colin agreed that their mother spent a lot of money. The children freely told stories about parents’ social isolation, divorces, anger, grudges against teachers, and insomnia. They also reported having to prepare meals and “do everything”.

Martha said to Mark who had just described his father’s compulsive behaviour and its effect on him, “its like he can’t change but you can” (session 4). Mark nodded in apparent agreement with her interpretation. As the discussion drew to a close Eliot reminded Martha that she had forgotten to cross stuff off the agenda. She told him to do this task while she introduced “more art that we are going to do this week” (session 4).

During the art exercise Martha continued to have the children talk about their parents’ illness behaviours. However she encouraged them to describe their own experiences using artwork to depict: “how you see this…, it can be a picture of a symptom… of how they behave”
(session 4). Martha held up a piece of 8x10 paper and folded it in half length-wise. She instructed the participants to draw pictures on both sides to represent their parent when they are well and unwell. The children were asked to represent how they understood their parents’ symptoms according to a temporal and dichotomous notion of being “well/unwell”. This reminded me of the “good/bad” day scenario used earlier to describe the episodic nature of mental illness. Becky, who loved to draw, began before Martha finished explaining. Although Colin asked if he could “use words”, he was told by Martha that she preferred “artwork” (an implicit rule being that artwork includes images but not text). He and the others readily set about doing what they had been asked to do. While they drew Amy took the Symptom List down from the wall as directed by Martha. I was told later that this was to prevent parents from seeing this upsetting information. This reminded me that children’s artwork is kept by the facilitators to protect others, an “unseen audience” of mostly family members (and of the children themselves), and their reactions to the things that are discussed and depicted in the group. In explaining their pictures in the following sequence they had to work quickly because Martha says frequently, they are “running out of time”:

[Martha announces that there is only time for each of them to take one minute each to tell about their pictures of symptoms and parents’ behaviour…the kids hold up their pictures and explain…]

Colin

We never moved to one house that was good enough. But they were getting worse and worse. One time she even wanted to move into an abandoned school house.

[Becky who is next to Colin asks to go last and Mark volunteers to go next].

Mark

Awesome…well…this side is when he is well and we play football on the weekend and we watch ‘Wise Guy’. But when he is unwell he just buys bread and says the same thing over and over again.

Colin

I have one more comment. [Martha nods okay]. Well first when she is well, she sees old friends and has money… but then in two weeks, she scares the person away, spends all the money and goes bankrupt!

Eliot

Well here…number one, she is gardening and then two…she is shopping a lot.

Augusto

Here she looks out the window and the friend is coming home with me from school and it is okay. Then the next day she sees the same guy and says, I will kill him. And it is the same person and she hates him.
Michele: Well I don’t see her much anymore. But when she was well we watched movies together on TV and when she was not, she would yell at me.

Becky: [speaking for the first time tonight. Her voice is odd, very deep and pitched in such a way that it seems strange. Amy comments on this later to me as well]. She cooks a lot and then…she plays games on the computer until 6 o’clock in the morning. (session 4)

Michele said that her mother “yells” at her when she is unwell, but upon closer examination of her drawing I realized that she had actually written, “I am calling the cops on you” in the speech bubble representing her mother’s words, and “what did I do”, in those representing her response (figure 6). Not only has she added words to the images but these words may say much more than might be apparent at first. Martha considered Michele to be very cautious and resistant to “revealing herself, or giving too much away” (reflexive notes, session 8). Martha felt that Michele saying her mother “yelled” was a kind of smokescreen for more difficult issues Michele had faced. She based some of this on the case histories discussed during the intake meeting, so that Martha’s assumptions did not seem unreasonable to me. However, in this drawing I believe Michele revealed more than she actually said through her drawing about a significant moment in her relationship with her mother, which she spoke about more explicitly later in the program.

Martha introduced the children to the importance of finding the “right kind of help” because symptoms of mental illness “affects people’s lives” (session 4). This meant that mental illnesses required medical intervention by professionals who would know best how to help. But this was tricky because, as the following dialogue suggests, although mental illness might be an illness like any other, it calls for unique and specialized forms of medical management. Martha began the session with talk about the diagnostic and statistical manual (DSM) that is used to define problem behaviours as an illness. Augusto seemed to agree that this was important when he neatly summed it up for Martha, “that’s how they finds the problem”:

| Martha   | How do you get to a doctor when you have a mental illness? |
| Eliot    | If it’s not so bad, you get a friend to take you.          |
| Colin    | But what if they feel they don’t need a doctor?            |
| Martha   | That’s a good question. Colin why don’t you put that up there on are list of questions? Thanks. Okay, so how do you know if you need to see a doctor? |
Augusto: You can see it.
Colin: You can take tests.
Michele: Maybe an MRI?
Martha: Well... it's not that easy. At least in the beginning.
Martha: The DSM is a big book where symptoms are written down. Doctors use it to diagnose illnesses.
Augusto: That’s how they finds the problem. (session 4)

Although Colin’s question was deemed valuable, there was no time for it here. As I observed in other instances, children’s questions were often managed by being added to the “running list of questions” to be answered at a time that was more convenient and less likely to disrupt the flow of program content. In the following dialogue children appeared knowledgeable about some forms of medical intervention and treatment, particularly medications, and the problem of side-effects. But it is the disruption Colin’s statement brings about (albeit unintentionally) with his description of his mother’s resistance to being diagnosed that was interesting because it allowed the children to talk about their own experiences, and things that were more important to them. It not only permitted Mark to describe his father’s reluctance to take medications—thinking they make things worse is a common reaction often discussed in medical terms as non-adherence or (non) compliance—but it allowed Colin to share the same concern. However Colin seemed disappointed when Amy didn’t explicitly confirm whether or not his mother was right in blaming her symptoms on a “thyroid” rather than a mental health problem. The problem of medication side-effects was acknowledged by Amy, but no one discussed the problem raised by the children about parents who think medications make things worse, or what impact this might have on their own lives. Augusto took a slightly different and more medically attuned approach to his mother’s experience. While he recognized the problems with medication that the others described, in the end he drew on first-hand experience to say that he believed it “works”:

Amy: Do you know what kinds of treatment there are?
Eliot: Education
Amy: Yes, and sometimes they call it psychoeducation because adults learn about living with mental illness, diagnoses... medications... symptoms...
Mark: My dad read a whole load of books about it.
Amy: Yes...and then there are important things like eating healthy and getting enough sleep.
Colin: My Mom doesn’t think she has bipolar, she says its her thyroid.
Amy: Well the thyroid can be part of it... but she is not accepting the other?

[Colin looks disappointed].

Mark: My Dad thinks the medications make things worse for him.
Colin  My Mom thinks they make her really tired and in fact she has had a car accident...and she buys lots of new cars...just like the houses, always looking for the perfect house.

Amy  These are sometimes called side-effects of medications. Who has heard of side-effects? [Mark, Augusto, Eliot and Colin put their hands up]...this can also mean other things like weight gain....

Eliot  My mother gained lots of weight. And yeah, she buys houses and gains a lot of weight.

Augusto  When she got the medicine it was really horrible, but then after about 8 weeks, it works.

Michele  Is it possible to be super healthy and still have a mental illness? (session 4)

In post-session talk Martha interpreted Michele’s question, which was not addressed at the time, as an indirect response to her worry about becoming mentally ill like her mother. Martha believed that Michele was expressing her fear about being “at risk” despite being “super-healthy” at the time. This interpretation reflects a turning point in the Children’s Group sessions that occurred between the fourth and fifth sessions. As the group segues into the final half of the program there is an intentional shift from a focus on illness to health, and from parents’ difficult behaviours as symptoms of illness, to children’s emotional responses to such behaviours. At the crux of the matter is the premise that children worry about risk, although it was rarely explicitly stated this way. This was a theme underlying much of the work of the Children’s Group, especially with regards to children’s emotions and their perceived need to learn how to manage feelings to better cope with difficult circumstances and lead healthy lives. In the following excerpt, taken from an informal, ad hoc interview with Martha, she corrected my interpretation about why children seemed so engaged by the educational material, describing instead, her own beliefs about the profundity of children’s fear of “getting it”. Even children who were reluctant to attend the Children’s Group relent in the end because as Martha sees it, “some part of them knows they need to know”. She meant that they “need to know” not only what the Children’s Group teaches about mental illness generally, but more so their chances of “getting it”, an emotional consequence of living with parental illness that she sees as their “worst fear”:

Martha  Because Ayanna had trouble understanding all the genetics I went out this week to the library and read all the kids’ books I could find on explaining genetics.

Me  It’s so amazing when we talk about that stuff in our group because the older ones, the ten to thirteen year olds are studying this stuff in school...and we never did much about that at that age...I mean when we did that stuff last week the kids were absolutely engaged, I mean Colin was up on the table, he couldn’t get close enough to the
demonstration…you know they’re hearing that in school, so you are getting them maybe saying, oh I know about this…its not that strange….

Martha: Some of it’s engagement…And even the kids that don’t want to be here, I think that there is some part of them that knows that they need to know this, you know? Because they all gather around like that.

Me: And every kid that you’ve taught, even the ones that really don’t want to be there, you think they want to know this?

Martha: Yeah, yep. …of course it’s both. But you know there’s something about…you know you are addressing their worst fear, when you are talking about causes and getting it. (emphasis added, session 4, reflexive notes)

This would be important too because although risk and the fear associated with living with parental mental illness is real enough, for many different reasons, BTU argues that it is the prolonged exposure to difficult, negative emotions and especially fear, which is the “real” risk for children’s mental health.
CHAPTER SIX: RESULTS—THE PERFORMANCE: PART II

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Performing: Mental Health Talk

In this chapter I present the results of the way the discursive messages were received by the Children’s Group participants as the focus of the script shifted from talk about illness, to talk about health. This changed the focus from parents’ difficult behaviours (as symptoms of illness) to those expected of a child who could cope and be “mentally healthy”.

Talk about risk: “What are my chances of getting it?”

In the next excerpt, the group discussed how someone “gets” a mental illness. The language of “getting it” was often used by both the facilitators and the child participants to talk about causes and risks. Colin’s remarks about the influence of genes was prescient as the concept of heritable risk was a major focus for Martha’s teaching in this session in which the focus of talk is shifting from parents’ illness behaviours to children’s emotions and especially what do to “feel” safe. This theme runs throughout the program and began when Colin offered a similar explanation to the one he gave in the inaugural session in response to Martha’s rhetorical question, “Who gets it”? He said, “Anybody can get it…it’s just in somebody’s genes”. Martha’s rejoinder at the time was “While anybody can get it, not everybody does” (session 1). Colin’s words implied a kind of resignation, or perhaps even a sense of not being responsible for “it”, because individuals are simply at hereditary risk. Martha corrected the impression this conclusion might give, declaring that while she agreed that “anybody can get it”, the way she sees things, “not everybody does”. In other words, the causes and risk for developing a mental illness will be accounted for in Martha’s version of genetic risk, in the space created between “anybody can”, but not “everybody does”. Here Martha drew on the received wisdom of biomedical and (mental) health promotion discourses within which everybody is subject to “risk” and “can get it” regardless of social position (i.e. social categories related to gender, age, culture and so forth), but not everybody does, as long as measures are taken to prevent “it” from developing.

Martha’s explanations about causes of mental illness were vague as she taught about causes and risks. For example, she described physical causes— as “something wrong with your body”—and social causes as something that “happens in your life”. Potential contradictions and even conflicts between biological and sociological explanations of causation—although there had been an emphasis to this point on the “broken brain” in particular—were not addressed. To my knowledge Martha was incorrect in bringing Augusto’s mother into this narrative as she had
suffered a stroke long after she had developed symptoms of schizophrenia. Nevertheless, even when she discussed physical causes Martha’s interest seemed to focus more on preparing participants to learn about the importance of prevention. She began by implying not only that a physical accident can lead to mental illnesses, but that children can learn to protect themselves just like they do for example, when they wear a bike helmet. The analogy should have worked because wearing bike helmets was likely the kind of prevention message that was familiar to children, as the participants indicated in this passage. However, Mark raised the stakes by taking the idea of “danger” associated with mental illness one step further, introducing violence as an example of “things that happen in life”. Amy responded rather quickly, steering the conversation in another direction seeming uncomfortable with this connection between violence and mental illness. Amy added that sometimes it is “just stress”, the ordinary everyday kind of stress like losing a job that can lead to someone developing a mental illness. The sequence began with Martha repeating one of the questions a child placed in the question box:

Martha: How do you get a mental illness? That was one of our questions in the question box from last week.

Colin: [immediately] I thought mental illness came from the genes of the two people… who were too close.

Martha: [who cannot hear well in one ear and wears an aid sometimes… she doesn’t seem to hear what he says and moves on without response]… well there are three different reasons. One, there can be something wrong with your body. Like when you were told to wear a bike helmet.

Eliot: [interrupting]… I know this kid who wore his helmet cause his mother insisted… and then he fell under a car, but he was okay, because of his helmet.

[This is surprising. Eliot facilitating rather than disrupting the teaching. Ayanna and Augusto have their hands up in excitement and eagerness].

Martha: If this is another bike example put your hands down. We’re running out of time tonight and we still have a lot to cover. [they put their hands down]. Another cause of mental illness is infection.

[Colin has his hand up]

Martha: Wait until the end. Stroke is another cause.

Amy: [looking at Augusto who talked about this last week but he is not looking responsive] Right Augusto, like your Mom?

Eliot: [Augusto is nodding and Eliot interrupts]… It has to do with a stroke… why people’s voices change.

Martha: yes… yes that can happen...
Martha [continuing]….Sometimes it has to do with what happens in life, in your home or family…or when people in other countries experience war, for example.

Mark or violence…

Amy Yes, or even just stress. The stress of losing a job.

[Colin is reading the program notes that Martha has in front of her. All the kids laugh] (session 3)

When I examined the passage as a whole this excerpt about causes, and “getting it”, may not have started out as Martha intended. It seems to me that the facilitators and the children struggled to control how the agenda (and the informational content it contains) would go. The sequence is introduced with a question, which is a typical way Martha set up her rhetorical approach to teaching. Presumably it is an important question because it originated with the participants, as Martha reminded them; it was taken from the “question box” that I created for research purposes. But here a child used it to ask a question anonymously. Moreover, there appears to be little room for the participants to go off-script because Martha seems constrained by time and by the agenda. For example, she moved on without acknowledging Colin’s answer to this opening question, or to correct his explanation about the “genes of the two people…who were too close”, although I observed at the time Martha may not have heard him. But Martha was also impatient with Ayanna and Augusto in the preceding sequence, assuming that they are going to repeat yet another “bike example”, and they were “running out of time”. She also told Colin to “wait until the end” when he raised his hand to respond.

It is Colin’s pantomime, coming almost unobtrusively at the end of this chaotic dialogue that I want to emphasize here. By mimicking Martha, reading her program notes, he took on her role and through this questioned and resisted the control being exerted. It seems he was successful, getting a laugh in response from the other participants who may have recognized this as ironic commentary on the programmed nature of group, where there was a script that none of the children had access to. In the following sequence (which precedes the one quoted above) Colin had already tried to engage Martha concerning the agenda, pushing her to commit to specific times for the activities, because as he points out, it is meaningless without the requisite information that will actually tell the participants how things will go. Martha claimed not to know either, but as he pointed out, they were already behind schedule. It may have been this previously unarticulated fact that added to Martha’s sense of urgency as the rest of the dialogue
unfolded. Finally, Eliot took over getting a laugh from the others by making fun of the length of the program itself:

- Colin: When is it snack time?
- Martha: Check the agenda. When does it say snack will be?
- Colin: [noticing that snack is listed down the page] Do you know what time that will be? [no times are listed on the agenda; without times the agenda doesn’t really tell him how long he has to wait].
- Martha: We don’t know ourselves. [She goes up to the agenda and tries to put times to each of the items using the ‘program notes’]. At least this is a clue as to when it might be.
- Colin: [retorts] So we’re already behind schedule?
- Amy: [interceding in this interchange decides to tell Michele and Becky about the QUIET SPACE and the ‘question can’. At this point Michele looks over at me and strokes her chin, mimicking someone being thoughtful].
- Colin: How many weeks will this group be together?
- Martha: Eight. Eight weeks.
- Eliot: [groaning playfully] We’re almost halfway through this torture. [everyone laughs and he seems pleased with this response]. (session 3)

Martha ignored Colin when he read her “script”, and continued teaching the children about prevention by launching a discussion about genetics and the statistical risk for developing a mental illness. Whether or not the information given was “correct” did not seem as important as the emphasis that was placed on a more “positive” message about risk. This became important because the climax in the following narrative was reached when Mark correctly interpreted the intended message: that as children of parent’s with a mental illness they only had a 30% chance of “getting it” (and most significantly for Martha’s purposes therefore, a 70% chance of remaining healthy) (figure 7). Mark did “get it” in the best possible terms, as he realized rather dramatically how BTU sees his chances of developing a mental illness.

I wondered about the theatricality around presenting the statistical relationship associated with heritability. Why did the facilitators use a complex activity to communicate what could be said in a more straightforward manner? Moreover, the participants also seemed to want to know about risk, but rarely asked about it explicitly, with the exception of the question from the anonymous “question box”, and the more obscure or disassociated way Martha felt Michele did, when she asked if it was possible to be “super healthy” and have a mental illness (session 4). One explanation has already been suggested—that this is as Martha claimed, their “worst fear” and also that “they know they need to know”—and so it might have been an emotionally laden and vulnerable question for all concerned. I thought also that there must be a rationale for

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52 Martha worried about the accuracy of this information, particularly because she did not focus on diagnostic specific information in the program.
leading the participants to discover, or come to realize these “facts” about being at risk in this way. Perhaps this method is more convincing and has greater impact because it gave the impression, as they followed Martha’s clues to a seemingly logical conclusion, that they had discovered something for themselves. On the other hand, I had the impression that the purpose of the following narrative was really to set the facilitators up to talk not so much about risk, but to put these “fears” to one side and establish the importance of thinking about prevention in light of other, perhaps more “real” dangers that had less to do with hereditary factors.

The dialogue began with an explanation about genetics, which Mark easily and willingly showed he understood by supplying the words, “parents” and “in your family” to round out Martha’s image of genetics as a “plan for how the body is made up”:

Martha …and then there is genetics, or the plan for how are body is made up, that can contribute to causes for mental illness.

Mark From your parents, in your family.

Martha For example, we all get something from our family. Mark, what have you got from your Dad?

Mark [long pause] ……some people say I look like my Dad.

Martha Yes, I look like my Mom.

Ayanna I look like my baby brother…[in a high squeaky baby-like voice]…both my baby brothers.

[Elliot and Michele laugh at Ayanna. She shrinks back. Martha shows her crooked baby fingers, which she inherited from her grandmother. Everybody begins examining their fingers.]

Martha So it happens with both physical and mental [word here is muffled]..that there is a slightly greater chance of inheriting traits from our parents or our grandparents….

Ayanna seemed embarrassed when everyone interpreted her responses to Martha as comical, even though she probably wanted to show that she could participate in the discussion. At this juncture in the conversation Martha carefully set up the idea that even when we are talking about the plan for the body, we only have a “slightly greater chance” of inheriting (anything) from our families, let alone when we talk about the risk for developing a mental illness, which she goes on to demonstrate. Amy clarified this by qualifying the numbers as relating to “lifetime” figures:

[While she speaks she pulls out the ‘clothespin dolls’ and begins to explain statistical relationships of risk.]

Martha …[continuing] So that out of 100 people [pointing to all of the ‘dolls’ laid out before her], 20 will have a mental illness.

Amy [interjecting] …at some point in their lifetime.
[Martha, as she says this sets 20 dolls to one side.]

Mark  HOLY!!!!
Martha  How many are surprised by this?

[all hands are raised].

Martha  [continuing] Ten will have anxiety, that’s when you are really anxious about things. Eight will have major depression. One will have bi-polar and one, schizophrenia.

Colin  What’s schizophrenia?
Ayanna  [overhearing] It’s when you have Skittles….

Becky, who is the youngest next to Ayanna, laughs at this joke using a popular children’s candy to describe schizophrenia]

Martha  [ignoring Ayanna, to Colin] We’ll get to that later…. [continuing]…What are your chances then, if you have a parent with a mental illness?

Colin  You mean born with it?

Martha  Well, I’ll tell you the answer. [She takes away ten more dolls from the original 100]. So that makes 30 now over here. So you have a 30 per cent chance… [Martha is a bit confused and stops, seeming unsure for a moment]….but look here [pointing to the remaining dolls]…there are seventy dolls without mental illness. Your chances are only 10 per cent more than these [pointing to the first 20 dolls that were removed].

Ayanna  But my Mom has a mental illness and her finger isn’t crooked and I don’t have it. (session 3)

Ayanna did not “get it” in the sense that she didn’t understand the concept of probability, although Amy took her to one side to try and clarify. Martha did not stop to answer questions about “being born with it” or “schizophrenia”. The children had to wait as Martha was concentrating on the momentum of her argument, and the resolution she wanted to reach about a positive message regarding hereditary risk. Although it was not clear to me why the participants were so surprised initially by Martha’s numbers—is the 20% who will have a mental illness a lot or a little, and what may they have expected to hear about risk?—I believe Mark’s voluble reaction indicated how significant this issue was for him. As the dialogue moved forward Mark demonstrated not only that he “got it”, but that he understood it as a positive, good news message. Mark might be described as one of the children Martha had argued “knows they need to know”, and he readily accommodated her explicit direction to focus not on the 30% of dolls “at risk”, but on the “seventy dolls without mental illness”, and to conclude that group
participants really only have a 10% greater chance of becoming ill than anyone else. This was confirmed in the group discussion on the last evening when Mark indicated how important this information was to him:

Mark: I got to learn stuff about what’s going on. Like I didn’t know that much about it. Well like my Mom told me some stuff and like my Dad would read these books like…but I didn’t know all that much stuff, like all this information.

Me: can you remember Mark, the kinds of things you learned that you didn’t know before that would help me understand?

Mark: that everybody has a twenty percent chance of getting a mental illness but…. Me: you were surprised by that Mark?

Mark: yeah…. (interrupted by Michele)

Michele: yeah, my Dad said fifty percent chance you might end up like that when you’re older.

Mark: yeah and then when you have a parent then…yeah a thirty percent chance.

Eliot: you have pretty much a fifty/fifty chance of anything happening, yeah.

(session 8, group discussion)

I found myself wondering if Eliot was really blasé about his own risk for mental illness, couching it as he did alongside risk of any and all kinds—or whether this was some kind of bravado; perhaps this wasn’t new information for Eliot. It contradicted what Michele’s father had suggested about risk, but she didn’t indicate whether this was problematic. In any event, all of this activity seemed to be designed to impress upon the participants that their biological relationship to their parents was not as much of a worry as they may have thought. However to my knowledge this was an assumption because the children were never asked about this directly, or whether they had wanted to know more about hereditary risk coming into the group.

Colin had quite a different response to information about the chances of developing a mental illness. The following dialogue followed quickly after Mark’s comments that suggest he had accepted this as a positive message. It seemed as if Colin was trying to pre-empt his comments:

[Amy takes Ayanna to one side to try and explain the confusion. This dialogue is not heard.]

Mark: Well when you put it that way…thinking about it that way, is a lot better.

Colin: [quickly, but it is not clear whether he is teasing Martha] What are you trying to do scare us?

Amy: [quickly shifting back to the group]. Well now they say if you get to the symptoms early enough, the better you will do. All kids should get this kind of information because most mental illnesses start before you are twenty. But it’s okay because people still work, and have good lives.
There are famous actors [naming someone I don’t know, a sports hero it seems, but the kids seem to get it] and so it doesn’t mean you can’t have goals in life [she lists some more people].

[the kids are very interested and surprised to hear the names of the famous people and Martha promises to bring in a list next week].

Colin [sarcastically] Amazing. (session 3)

As I observed at the time, it wasn’t clear whether Colin was explicitly teasing Martha, but he did seem to be challenging her “positive” take on things, at least the manner in which it was being presented. Although a thirty per cent chance of developing a mental illness is quite high, Colin may have been calling into question whether or not all risk talk is “scary” talk anyway, regardless of how the numbers are added up. Colin did not seem to be persuaded by Martha’s argument, or at least he may not have been willing to let Martha off the explanatory hook quite this easily. Perhaps he pushed back because he suspected Martha of avoiding talk about the negative implications of hereditary risk. Martha did not have a chance to respond because Amy quickly interceded, taking Colin’s remarks seriously (rather than ironically) as she turned her attention back to the whole group to give her version of a “good news message” meant to assuage anyone who has been “scared” by all the statistical information. Amy drew on a mental health promotion discourse to describe early intervention and prevention strategies that are considered helpful in the event that someone does develop a mental illness; the anonymous reference to “they say”, which she used to introduce her point, gives the impression too that there is something expert or evidentiary about this belief that by intervening “early enough, the better you will do”.

Moreover, the idea that “all kids” should receive mental health literacy information meant that these children were not singled out solely by their biological relationship to potential risk, but everyone in some way is “at risk”, because “most mental illnesses start before you are twenty”. Amy tried too to emphasize a more positive and recovery oriented concept to argue that mental illness does not mean that you can’t “work, and have good lives”. To bring this point home she also drew on a celebrity discourse to show how people can be highly successful in spite of having a mental illness. Colin did not seem impressed by this effort to put a positive “spin” on beliefs about what happens if someone does develop a mental illness either. Of course he had only to draw on the evidence that many of the stories he and others have already told
about their parent’s illness symptoms, for example, to argue against Amy’s interpretation of what it means to live “successfully” with a mental illness.

In the next session Augusto looked to Mark who was reviewing this information to help him understand as he puts it, “the point of all the dolls”. Martha was pleased that Mark performed so well because he could regurgitate the information well enough to feed it back to another participant. Augusto was not impressed and sees all this activity and having to “count all those extras (as) a waste of time”. It was not clear whether he had understood the probabilistic account, or if these numbers meant anything to him:

[Mark is still reviewing the material on genes using the clothespin dolls. His command of the statistics and obvious understanding about how to use the dolls in ‘tens’ to talk about percentages from last week, (e.g., 20% who get mental illness, 8% with anxiety, 1% with bipolar and so on, is truly impressive)]

Augusto [to Mark] So what’s the point of all the rest [of the dolls]?
Mark [without skipping a beat]…well that represents the chances that you won’t get it and if you look at all the rest, that seems more positive to me.

[It is not clear that the others are as impressed by this as Mark, who said the same thing last week. Martha looks pleased with his presentation. Augusto doesn’t respond to his comment and says something about having to count all those extras, a waste of time]. (session 4)

Colin may not have been the only one either who was still worrying about his chances of “getting it” despite Martha’s attempt to address statistical prediction of risk, and perhaps because of Amy’s message about early intervention and the belief that mental illnesses develop when individuals are young. For example, one of the children anonymously deposited a related question in the “question can” in session six, long after the previous dialogue occurred. In the following discussion it seemed that worry about developing an illness “at a young age”, was still on someone’s mind:

[Martha has incorporated a question on the agenda that someone had put into the ‘question can’ last week. It reads: “is it possible to get mental illnesses at a young age?” I notice that the writing is very different than in other questions I’ve had, so surmise this is coming from someone new; I wonder if this person worrying about risk for illness?]

Martha So what do you think? Is it possible to get a mental illness at a young age?
Mark Yes.
Colin [at the same time] Yes. [elaborating]…I know a couple of kids with a mental illness. They talk a little slurry.
Amy: Well with bipolar, and with schizophrenia, it’s not really until your teens or early adulthood that you might experience symptoms….

Colin: [as if to completer her thought]…cause when you are a kid nothing really all that wrong happens to you,[this discussion drops] (session 7)

Here Colin distinguished between what is meant by being in “your teens” and being “a kid”, so that he argued that “nothing really wrong happens to you when you are a kid”. However, I was surprised that no one responded to his statement. Not only can children be diagnosed with a mental illness, but as the children in this group have clearly demonstrated, a lot has happened in their lives that might be interpreted as being quite wrong. I wondered at the time whether Colin was testing the rest of the group, and Martha and Amy in particular, to see if anyone would contradict him, thereby provoking a discussion of this assertion about the sanctity and safety of childhood—but no one did.

**Talk about fear: “I can’t control it, I didn’t cause it”**

To introduce the fifth session and make the transition from the first act, which focused more on “facts and information” about mental illness, to “supporting” participants by helping them talk about their “feelings”, Martha began by reviewing earlier talk about difficult parental behaviours or “symptoms” of mental illness. However, the following dialogue shows how confusing this talk was when it was unclear whether the focus was on the parent’s or the child’s response to the symptoms of illness. The differentiation is important because the child’s reaction is a response to the consequences of illness-related behaviour, not an explanation for why the behaviour occurred in the first place. While the facilitators insisted that Michele’s mother behaved the way she did because she felt “suspicious”, Michele can only see it in terms of feeling “threatened” because those were the consequences of her mother’s actions for her. Martha and Amy do not ask her to clarify her meaning; I believe this resulted in a (mis)interpretation of Michele’s point, such that Amy tried to define “suspicion” in a way that may humanize her mother’s actions, and Martha tried to connect the two as if these responses were two sides of the same coin. This way they could stick with the script, and talk only in terms of the mother’s behaviour rather than the daughter’s feelings about that behaviour:

Martha: [to Michele] Can you remember what you talked about last week… about the cops and your Mom?

[Michele looks puzzled, wrinkling her forehead…]
Martha: Remember, you talked about how your Mom called the cops on you. [she nods in recognition]. Well that is also a symptom of mental illness. It could be under ‘suspicious’.

Michele: Oh, but I remember, I said that was ‘threatening’.

Amy: [jumping in…] Suspicion is often a way of worrying about things.

Martha: Yes, that’s true and sometimes the two are connected…’suspicion and threatening’.

Colin: My Mom is threatening.

Eliot: [with emphasis] No…she isn’t!

Amy: [quickly] Remember, you are allowed to have your own opinion.

Eliot: Yeah, well, he’s a liar” [but he says this very light-heartedly, joking, but without the edge of usual sarcasm, more like wanting the last word].

Martha: Up to tonight we have been talking a lot about facts or information, but tonight we are going to talk about feelings. Living with mental illness is unpredictable…do you know what that means?

Michele: [raising her hand] I know, you don’t know what will happen next.

Martha: How many people at the table feel like that?

[all raise their hands to indicate yes…] (session 5)

Any further disagreement between Michele and the facilitators was interrupted by Colin who uses this as an opportunity to say that he also found his mother’s behaviours threatening. Although his brother Eliot vehemently disagrees with this assessment they are both reminded, as is the case often with siblings who have different views of their situation, that they can each have their own opinion. Although Colin’s comments about his mothers’ threatening behaviours also went unacknowledged, Michele didn’t seem to be able to have her own opinion, at least without resisting how the facilitators wanted her to see her mother’s behaviour. I wondered whether this was because as they tried to convey to me after the session, they were worried about Michele’s attitude and interpreted her resistance not as an “opinion”, but as an erroneous belief, and that she would be better off if she could be persuaded to see things otherwise. Children may be considered more “protected” from the problem/risk when they are able to explain it as illness, and not as something they or the parent “did wrong”. This would put someone like Michele in a bind, unable to acknowledge something she felt her mother “did wrong” (calling the police on her) because it is explained as an illness. Of course Michele’s contradictory response is also a practical problem because it interrupts the flow of the talk here. Martha is reviewing last week’s material, not to evaluate how symptoms are experienced (that was done in the previous session) but to remind everyone that difficult parental behaviours are “symptoms of mental illness”. This is interesting too because the sessions from this point on tend to emphasize the effect of the illness, and particularly unpredictable behaviours on the children themselves. Michele’s
response is actually more about the effects of the illness on her (it was threatening), rather than on the symptoms or signs of her mother’s own experience as illness (she felt suspicious).

This was a turning point in the eight sessions because as Martha says, they were now going to talk more about “feelings” and the idea that living with mental illness is “unpredictable”. The concept of unpredictability was nicely encapsulated by Michele who said that living with mental illness meant, “You don’t know what will happen next”. It seemed to be a common experience amongst group members who demonstrated their agreement through a show of hands in response to Martha. And as if to illustrate this point about unpredictability, albeit unintentionally, the discussion itself suddenly became more volatile as the participants took it in a direction that both Amy and Martha seemed to find uncomfortable, and probably inappropriate:

<table>
<thead>
<tr>
<th>Eliot</th>
<th>What about if you are living with a murderer?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Augusto</td>
<td>[puzzled] Isn’t it the same thing?</td>
</tr>
</tbody>
</table>

[I think ‘by same thing’ he means ‘unpredictable’.]

| Amy     | [quickly in response to Martha who is starting to object to this change in the discussion] Maybe we can talk more about this at the end... |

[Martha appears unhappy with the idea of continuing at all. She objects with murmurs, grunts, but no words. It is a very tense moment at the table. It is difficult to know if Eliot is just being dramatic and looking for laughs with his extreme example. Either way, it has become more serious]

| Amy     | [continuing…]...because it is unfortunate but the incidence of violence associated with mental illness…statistics show that it is not how it is portrayed on TV |
| Colin   | [as if he didn’t hear Amy]…my Mom acts violent. |
| Eliot   | [sounding incensed, in a very demanding angry tone]…how? |
| Augusto | [before Colin can respond] So does she get a knife and stab you? |
| Colin   | [sounding like he is laughing but incredulously at Augusto’s interpretation] Noooooo…. |
| Martha  | [brings this to a close]…well we’re off topic, well not really…but…so as I was saying your body will tell you things…(session 5) |

Once again Amy confronted the association made between violent behaviours and mental illness, relying on some unspecified statistics as evidence that this was not an accurate way to think about mental illness. It was unclear whether Martha objected to this talk for similar reasons or was more upset by the interruption to her teaching. Her hesitation, “that we are off topic…but not really…” is telling because in many ways the issue of violence and extremely difficult behaviours that might frighten children is the official subject of discussion. While other
emotions are acknowledged throughout the sessions (such as worry, sadness, loneliness, feeling bad, anxiety, gloominess and happiness), talk about fear dominates because it is linked in BTU to assumptions about what it is like to live with difficult and unpredictable parental behaviours.

The other point I want to make is that “these children” are assumed to have a particularly acute sense of how others may be feeling, acting based on how they interpret the emotional reactions of others. For example, I made the following observations during the first half hour of a session when early arrivals could sit and draw or play games to pass the time while they waited for the formal part of the evening to begin. In this sequence it wasn’t only the children who may have been “reading” how others were feeling as Martha argues, but Martha herself had to manage what she described as an emotionally volatile situation:

[So far there are four kids here tonight. There has been lots of cooperative play. Becky can be heard to giggle now and then. I can see that Ayanna looks uptight for some reason. She appears very impatient with the way Becky takes her cards from Martha. As their game is drawing to a close and, as if to show her the ‘proper’ way, Ayanna carefully chooses her next card from Martha’s hand. Later Martha tells us that she felt Ayanna was getting very upset at the idea of losing, and that even Becky was picking up on this. Martha purposely loses to Ayanna telling me, “the last thing we need tonight is meltdown after the day we’ve had”. When we talk later, she remarks on how ‘attuned’ these kids can be to emotion in someone else, how ready to take the emotional temperature of a situation and how able they are often to do this as Becky has done with Ayanna. It is now 7:14 p.m.] (session 6)

As is apparent in the previous sequence, Colin, Eliot and Augusto had different ways of thinking about violent behaviours based on their respective experiences with their mothers. This is why Eliot wanted his brother to explain what he meant, although Martha intervened to redirect the discussion before he could say more. However differences in experience and interpretation, and the desire to express some of this became more evident amongst all the participants during an art exercise Martha called, the “Door of Fear”. The children were asked to draw something about their fears that had to be connected (as they have been continuously reminded) to “mental illness”. The words, “Door of Fear”, were never used to describe what Martha wanted them to do. In the following example we can see that participants expressed their feelings and thoughts about fear in very specific and individual ways—and in ways that contradicted discourses about

53 A meeting was suddenly called earlier in the day about a “breach of confidentiality”, as Martha described it to me. Some very personal and difficult information about one of the children had been shared with a parent by a sibling attending the Children’s Group. This broke a group “rule” about keeping one another’s confidences (except where adult facilitators were considered legally obligated to do so to protect a child), and a very emotionally difficult discussion ensued between the facilitators in consultation with Maria the program coordinator, about how best to deal with the situation and proceed with the group.
mental health/illness in BTU. Colin struggled to clarify that he was afraid of “the process of illness” rather than of any particular behaviours, and Michele made a distinction between feeling afraid of her mother’s anger, not of her mother. Augusto’s picture brought up difficult feelings for the facilitators who struggled to understand his challenging (and violent) images (figure 8). They tried to leverage an explanation from him, suggesting various interpretations about what his drawing meant in what seemed to be an effort to manage difficult feelings that may have been aroused for everyone in the room by this dangerous talk:

Martha [to Becky] Is it okay if I start talking while you finish your drawing? [nods its okay] Thanks…so, who would like to talk about their drawing?

[Augusto, Michele, Colin, Mark and Eliot all have their hands up at the same time. Augusto is chosen and he begins to explain. Everyone listens attentively. His picture is all in red with a larger devil figure in the centre and two other drawings that look like piles of red circles.]

Augusto My mother is a Christian and this is a picture of Satan and this is me and she thinks I am dying because there is lots of blood. [he points out different aspects of his picture as he describes it]…oh, but I forgot to put in my Mom crying. She’s crying because she thinks I’m dying.

[This description is followed by a complicated series of questions in which Martha and Amy take turns trying to pin Augusto down as to whether this is something real, a picture of Augusto’s fear or he is showing this because he associates it with his mother’s mental illness. It is awkward and confusing dialogue. The facilitators seemed concerned for Augusto, but also to clarify for the others some kind of a distinction between these different interpretations. None of the kids ask any other questions. Augusto responds making it clear that he and his Mom go to a church, that he believes that sometimes that he is dying, and that this is what he has drawn].

Martha Do any of you have any questions for Augusto, or responses to what he has said?

[She asks Michele but she nods her head to say no. Mark and Colin have their hands up.]

Mark [trying to interpret] I think what he may be trying to say is that she’s not spending enough time with him, or paying enough attention to him. (emphasis added, session 5)
The participants were often directed to ask questions of one another when they completed artwork, or talked about their experiences during other kinds of activities. This was a strategy to help children show and tell what they knew and how they felt about matters under discussion. In this sequence it took a few minutes to encourage the others to respond to Augusto’s drawing. This may have been because they sensed that this was a dangerous conversation, because of the images he described and the reaction any talk about violence had already incurred. But also “these” children as Martha has described them may be emotionally attuned to situations that demand cautiousness. Eventually Mark was persuaded to respond to Augusto’s difficult story and he offered a psychological explanation in very practical terms that may have been more reflective of his own experience. I wondered too if he was trying to rescue Martha and Amy, and the entire group, from the silence that ensued once Martha asked participants to begin responding to each others artwork. Colin decided he had nothing further to add either because he felt Mark’s explanation was good enough, or because he didn’t want to pursue the direction the conversation had taken. In the following excerpt, which continues the dialogue started in the previous sequence Augusto responded more readily to Martha’s invitation to ask questions. I thought that he drew on his own insight and experience to ask Michele if “stress” would reasonably explain her mother’s behaviours (figure 9). I wondered too whether this might explain why he didn’t ask Michele what her mother did when she was angry, perhaps because he assumed he already knew. Augusto was drawing on discursive formulations about mental health/illness that posit stress as precursor to developing illness-related behaviours:

![Figure 9: When she’s angry....](image)

| Michele | I’m not afraid of my mother, but when she’s angry, that’s something to be afraid of… |
| Martha | Do you have any questions for Michele? |
| Augusto | Is she like that when she gets stressed? |

[Her response is not audible.] (session 5)

In the next part of the same sequence Michele’s question challenged Colin to distinguish between feeling afraid for his mother as Colin indicated here, and feeling worried or afraid of what may happen to him. Her questioning highlighted for me a distinction that was first made by Colin when he asked Martha in the
inaugural *Children’s Group* session whether he was supposed to think about himself or his mother, on a brief questionnaire that asked children if they were “worrying about mental illness” (session 1). Martha had been startled at the time by this question because she had never been asked to characterize feelings in this way; she suggested that he answer it “both ways” (session 1). It also reminded me of the difficulty distinguishing Michele’s feelings of being threatened by her mother’s behaviour from her mother’s feelings as a way of explaining her behaviour as an illness. Colin appeared less willing to be explicit about his own feelings, preferring instead to ignore Michele’s question. His emphasis was more about trying to impress upon everyone that he is afraid of what happens when his mother becomes ill, which he describes as a process, rather than of any particular behaviour or emotion (figure 10). It seemed to me that Colin was anxious to make his experience of fear understood as something different than what had been talked about so far:

Colin  
I have three drawings [they are all in blue and labelled # 1, #2 and #3 and seem to be ‘faces’], Mine is more of a process… I’m afraid of the process when my Mom is not well. First, something goes the wrong way. Then she is confused and angry…and in between …nice. I think that I’m afraid of her temper…but of the whole process, when she’s confused she does things…I’m afraid of what the illness can do to her.

Michele  
Afraid for you? [but Colin doesn’t respond.] (session 5)

Colin’s lack of response might have indicated that he didn’t know, or wasn’t willing to talk about whether he was thinking about himself, or his mother—or both. As Mark took his turn to show and tell, he tried to use this as an opportunity for the others to ask him questions before he explained what his drawing meant. I wondered if Mark hoped that his picture would speak for itself in some way that he might have been able to capture something “true” about his experience that others would be able to read without too much explanation. He used familiar images, like a money symbol and a moving van, in contrast to Colin’s picture of illness as a “process” (figure 11):

Figure 10: *I’m afraid of the process....*

Figure 11: *My fear is about selling our house....*
doesn’t want to tell what his picture is about yet….It is not easy to see his picture because he is on the same side of the table, but there are several objects, using different colours and a Uhaul van in the centre.]

Mark [now in response as he decides to hold up the picture after all]. I want to see what you guys think first.

Michele Wow!

Eliot Well what does it mean?

Colin She moves a lot?

Someone? You spelled Uhaul wrong and what’s that in the corner?

Mark [deciding to end the ‘guessing game’] When your Dad can’t pay for things [indicating a large green dollar sign in the picture]…. and here it is about planning to move [the truck and a small map of another city] to [names another city]…so this is about my Mom divorcing my Dad and we are moving away…so my fear is about selling our house, then moving and then moving to [another city] and I will miss all my friends…and that’s what me and my Mom were talking about tonight on the way over here.

Augusto Are you worried?

Mark Yeah, talking to me… about divorce because her brother is here [he is explaining why this is coming up now]…and my Dad is not well and things are not going well.

Colin Wouldn’t it be sensible to stay with him especially when he is not well?

Amy [but before Mark can respond] Remember, we don’t’ have control, and we cannot choose. (session 5)

By asking the other participants for their comments Mark was also taking on Martha’s role, facilitating his own question and answer session, and moving on when this strategy didn’t help him tell his story. Colin’s question reflected aspects of his own situation. As he expressed a number of times in the group, his mother moved house continuously, and he wanted to help her feel better. Only Augusto’s question seemed to strike an emotional, responsive cord in Mark who was then able express his “worry” about those things he used to represent his fear in his drawing. Colin’s second question challenged expectations about what it means to care for and about someone who is “not well”—and more so, what it may mean to abandon them because of illness. But mental illnesses are not like other illnesses because as Amy intercedes to remind everyone one of the rules of BTU stipulates that participants have no control or choice over how a parents’ illness is managed. Mark is not responsible for how his family has chosen to respond to his father’s mental illness. Colin was trying to resolve some of these same family tensions. An important question is whether “the rules” or beliefs about how to care for and about a family member with a mental illness are different, or they are different because the participants are children.
As the talk about fear continued, the remaining participants Becky and Eliot described their drawings and this returned the group to the problem of talking about violence. Again Amy dismissed their responses by drawing on statistics as evidence that these are atypical behaviours. It is also pretty clear that talking about difficult, violent behaviours was no more welcome as the sequence neared its conclusion (despite Amy’s earlier suggestion that it might be discussed later). I was struck too that while Amy initially explained the perception of violence associated with mental illness as something fictional, because of the way it is portrayed “on television”, and as statistically unproven (by science), it seemed to me that the children wanted to talk about it as something “real” once they had been invited to do so, although they had different interpretations of what this might mean, given their individual circumstances:

[Martha asks Becky about her picture. It is a very detailed drawing with a figure in a bed, in room with a window and another figure standing over the bed.]

Becky [quietly but firmly] Behind my little door…she is trying to break into my room and kill me.

Martha [looking at Augusto] Can you relate?

Augusto Yeah.

Becky [continuing] She already broke into our house once.

Eliot [in an aside] How can you break into your own house? [but no one corrects him by telling him that Michele and Becky do not live with their Mom; but then neither does Eliot].

Martha [looking for clarification] Is that still now or when you lived with your mom?

[I watch for Michele’s reaction to her sister’s story which is much more dramatic and frightening than anything she has chosen to talk about. She seems very controlled, her face almost hardened. She watches her sister, but makes no comment.]

Becky I don’t know, I am just afraid she is going to kill me.

Amy [without a beat, to the group at large] You know that this is something that doesn’t happen very often. (session 5)

I was concerned at the time that Becky might have felt isolated by Amy’s response, being told that her experience was highly unusual, statistically unlikely, and all of this after she had just expressed her fears about her mother’s threatening and aggressive behaviours (figure 12). Was she being told that her fear was unreasonable? Was this a case where children’s fears indicate how their feelings and experiences, particular those about fear, may not be consistent with
mental health/illness discourses? Sometimes the participants’ questions reflected their own ignorance, and astonishment about the stories others told. This might have challenged the assumption that the children were “all in the same boat”. I was surprised that the facilitators did not help Eliot understand Becky’s situation. On the other hand, Martha outs Augusto as someone who would understand the more graphic violence depicted in Becky’s picture (putting them back into the same boat?). I couldn’t know whether Augusto minded being drawn into this story so explicitly at the time, but his one-word response seemed to satisfy Martha who asked nothing further of him. While Martha may be trying to establish whether Becky is in any real and present danger, her questions annoyed Becky. After all she has just shared a very significant and difficult story with the group. Moreover, she has done this in front of her sister, whose non-verbal response suggested she was listening, and this may have been quite risky for Becky as well. Although I was surprised by the way Martha drew Augusto into this conversation, in retrospect I wonder whether she did this to provide someone Becky could relate to, while managing the tension in the room. Amy’s response brought about an awkward silence in the room before Martha turned to Eliot to ask him to describe his picture (figure 13). His talk about his fear was complicated by his brother’s vehement disagreement with how he had interpreted their mother’s behaviour. Eliot did not respond to Colin. I was surprised that Colin appeared to take his mother’s explanation about whether she would harm herself seriously, given his own propensity for ironic statements. Eliot’s silence may have been an effort to protect them from arguing in front of the others, revealing emotions he may have wanted to remain private:

[There is what seems to be an awkward, silent moment. Martha turns to Eliot to ask about his picture]

Eliot: Well, there is a knife here, and her hand on it and she’s depressed and she might hurt herself or someone else…

Colin: [interjecting]…No, she said that when she thought about suicide…she said, ‘if I was going to do this I would have done it twenty years ago when I married your Dad.

[Colin does not respond.]

Augusto: [in an aside, but to himself] You never know when they’re going to do something. (session 5)

Augusto seemed resigned to rather than afraid of the unpredictability associated with his mother’s behaviours. His aside was an interesting conclusion to the discussion about what made
children afraid, linked to extremely troubled parental behaviour and described in BTU more generally as a belief about all children who live with mental illness. It may have been that Augusto and the other children who talked about some of the more “violent” behaviours accommodated these difficulties as part of their everyday experiences. Perhaps some behaviours were not as “unpredictable” for children who have become used to them. Martha told me later that Augusto had “normalized” these behaviours and that he needed to change so that he could see that they were problematic. Martha was keeping the rules of BTU because individual change is the focus of her teaching to help children manage or cope better.

According to BTU the next important step the participants must take in learning how to remain (mentally) healthy is to explicitly express how it feels to talk about fear as illustrated in the following sequence. Once the participants have accepted the premise that it is okay to be scared of what their parents might do, and they demonstrate this by being able to talk about—and show—what “symptoms” (or behaviours) of mental illness look like, Martha insists they examine not just the feeling of fear itself, but what it like to express difficult, negative emotions. However, when asked this question directly, Colin denied that he was afraid, perhaps because he couldn’t relate this question to the “illness process” he described earlier. But Michele responded sarcastically indicating that she didn’t believe Colin. Despite the different ways the children expressed their fears, both Michele and Mark singled out the Children’s Group as a particularly safe place to talk about it because they shared things in common. This was a place where “everybody knows what its like”, and because of this insider knowledge they are set apart from other friends who “don’t understand”. Even Colin is brought around in the end by this argument when he conceded that they have all experienced divorces—a significant factor in his own life that he has referred to several times, providing a kind of evidence for why he might agree that he belongs in the “same boat” as the other participants:

<table>
<thead>
<tr>
<th>Martha</th>
<th>Well, what does it feel like to sit and talk about your fears?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colin</td>
<td>[quickly responding] Well I don’t have any fear.</td>
</tr>
<tr>
<td>Michele</td>
<td>[looking at him says sarcastically] Oh yeah…right!</td>
</tr>
<tr>
<td>Mark</td>
<td>[to Martha] I like it. I’ve tried to talk to friends, but they don’t understand…and here all the parents have a mental illness and it is unpredictable.</td>
</tr>
<tr>
<td>Michele</td>
<td>Its better…friends don’t really know, here everybody in this room, everybody knows what its like to have a family member with a mental illness.</td>
</tr>
<tr>
<td>Colin</td>
<td>It seems all of us have had divorces….</td>
</tr>
<tr>
<td>Amy</td>
<td>The stats are higher that with mental illness there are often divorces.</td>
</tr>
<tr>
<td>Martha</td>
<td>What is it like to sit and listen to others’ fears?</td>
</tr>
<tr>
<td>Augusto</td>
<td>[without a beat] Amazed.</td>
</tr>
</tbody>
</table>
Michele  You can help them.

[when no one says more…]

Martha  The room has a different feel when people talk about fear.

Eliot  [in an aside to me, laughing] Want to buy a marker? (session 5)

So while the children may be willing to say that the *Children’s Group* is a “safe place” to talk, urging one another to see that they have a common identity that is protective, they also resisted Martha’s question as if there was something too difficult or dangerous in speaking directly about what it is like to express negative emotions. To have done so, given the tensions of the preceding scenes, may have felt unsafe for individual participants, and sticking together as a team at this point may have been a good strategy to avoid saying more. I wondered whether Mark reiterated the belief about unpredictability here, as a way of placating Martha. They seemed similarly non-committal when asked about what it was like to listen to “others’ fears”. Augusto’s “amazed” tells us very little about his own feelings, and so does Michele’s, “you can help them”, and Eliot ignores Martha altogether, starting his own “funny” scene with me about buying a marker. I wondered whether the children objected to showing and now having to talk more as well.

Martha’s final observation went unanswered, but it may have been prescient for other reasons. Something did feel different “in the room” once the participants began to speak about fear. And this may have had as much to do with the adults, as well as the children, who were present. There was increased tension and moments when the facilitators seemed flummoxed by the direction the conversation took. They tried to circumvent and/or suppress talk about violent, aggressive and volatile behaviours. But the altered affect Martha asked about was not confined to what was happening directly in the group. The following excerpts are drawn from my observations of post-session talk between Martha and Amy who were reviewing the events of the evening. Martha challenged Amy about a private discussion she had had with Augusto while the group was discussing their artwork. The excerpt demonstrates Martha’s beliefs about the importance of talking about fear, and also some of her own rules about the roles adults play in supporting this kind of talk. She had strong opinions that involve beliefs about respecting every participant’s story so that no one feels theirs is less significant—even, if as she says, it doesn’t meet the criteria for “their worst fear”. There may be some conflict in this preoccupation with determining levels of fear because as I described previously children’s feelings about being “at risk” had also been described as “their worst fear”. There appeared to be competing ideas about
what qualified as the “worst” fear. Martha took umbrage with Amy for using “stats” to undermine Becky’s story. But Martha also drew on expert medical knowledge to support her own beliefs. Amy was candid about her own difficulties in “just” listening to children say harrowing things about their experiences without being able to act to “fix” things. Martha’s rebuttal—that commenting on particular expressions of fear is disrespectful to all the children and may in the end be more about the facilitator’s feelings—speaks to the kind of emotional management they perform to deal with the feelings produced by listening to children’s stories. It seemed that Martha invoked an idealized set of rules about the facilitator’s job—given that both she and Amy have commented, and not just listened to children’s stories throughout—perhaps to try and contain and manage her own feelings:

Martha What were you talking about with Augusto regarding his picture?

[Amy gives a synopsis of what Augusto said…being Christian etc.]

Martha [after listening for a moment]…talking about stats is not a good idea. Whether they are talking about their worst fear or not, it is always pretty awful. Maria and I have consulted psychiatrists and psychologists on this…they have made it clear that our job is to listen and not comment.

Amy I understand,…but its hard to listen to a child say someone is going to kill them.

Martha [firmly, with conviction] That child is stating her fear, our job is respecting that…respecting her fear and not commenting….or it becomes about our fear. And also choosing to say something to Becky about her fear of her Mom killing her, but not to Eliot who also shared fear about suicide…so picking and choosing, again is a bad idea. We are labelling it ‘worst fear’, but they may not…even saying ‘worst case scenario’ you are making a comment about their fear and possibly slighting what others are saying; they may think, oh mine aren’t that bad…the fears here may be yours, not theirs (session 5, reflexive notes)

Martha also avoided medical or professional advice when it was contrary to what she believed was best for the Children’s Group participants. She argued that there was plenty of evidence from children themselves that they valued the opportunity to talk about fear, despite the fact that the group was short-term and because there were so few supportive programs for children. She used Mark’s responses as evidence that children find talking to each other helpful, especially because they had all “been there” in the sense that they shared similar experiences. No one discussed whether repressing such emotions in a group like this would have been possible, or desirable for that matter. Martha compared the Children’s Group favourably to another group in
which she rationalized *BTU’s* discussion methods as more impressive and correct because all the other group did, was “write about fear”:

[Martha goes on to explain further that when they consulted psychiatrists and psychologists about this session, they were told it was too dangerous to discuss fear at all, unless they had a long term working relationship with the children; because they can’t follow up with the kids.]

**Martha** But,…the kids really appreciate it, look at Mark’s comment tonight and that has been our experience. *Children’s Group* is on the referral list for CAMH because there are no programs for children. Once Maria and I went to hear some experts talk about working with children. But I thought they had ‘this crappy theory’ about talking to kids, so I wanted Maria to ask the panel the kinds of questions we get asked in the group. One kid said once to us, “you said talking helps, but sometimes it doesn’t help, so how do I know when it will help?” The answer the psychiatrist gave was that the child was right, it doesn’t help unless you are in a long term relationship. That was why I added the ‘process’ questions, asking kids about how it was to talk about it and what it was like to hear what others said. The only other group like this one I know is in London, Ontario. They get the kids to write down their fears, but they never talk about it…but I think that is wrong.

[This turns into a long, tense, difficult conversation between Martha and Amy. I have moved away and begun to tidy, to give some privacy and to try and capture some of this in writing.]

**Amy** It’s hard…to just accept what the fear is…. (session 5, reflexive notes).

Amy was right; it is hard to just accept children’s expressions of fear without knowing whether anything concrete or specific can be done to protect the children and change the circumstances that produce these emotions. I find this to be true as I write these words, feeling concerned about how they will be received by those who read this dissertation. In this respect I think that witnessing children talking about their difficult feelings does produce complex, and sometimes negative emotions for adults who may feel their impotence as persons who are supposed to care for and protect children. I found Martha’s response to the psychiatrist’s admonition about the problem of time-limited interventions curious as well because although the “process” questions included in *BTU* were supposed to “help” the participants practice emotion talk, the children in the group I observed resisted most of the opportunities they were given to do this. There is a question too about the tension between the advice of professionals for whom a criteria of “time” is important for managing difficult talk, and children who valued having others “like them” to...
talk to about their problems even though they recognized problems with the group in terms of
time limitations.

Talk about being safe: “I can cope with it”

Early in this chapter I described how the participants were taught the importance of
practicing positive thinking as a strategy for managing mental health. This was in contrast to
mentally ill parents who were depicted as having limited control over their (negative) thoughts,
and consequently, over their emotions and behaviours. A second strategy for managing mental
health—especially in response to living with difficult and frightening parental behaviours—was
to teach children what being safe would feel like. While fear has been the dominant focus of talk
about emotions thus far to teach children to recognize and work through these feelings, “feeling
safe” and learning how to protect oneself is now its corollary. In other words, the participants
must practice what it means to “be safe” but this is not easy because for example, instituting
personal “safety plans” are fraught with difficulties even though most groups like this one
include them in their regular programming.

The following sequence turned out to be a good, albeit unplanned example of the
difficulties Martha finds in talking to children about making explicit, concrete safety plans.
While she says that other programs promote “safety plans” as an important strategy, Martha is
sceptical—drawing on her experience of many years and after “supporting 20 or more groups of
children” as evidence for her views—because she feels they aren’t very realistic for many
participants. Moreover, she argued that the push to make “safety plans” likely functions to make
adults feel better about “doing something”. She considered them useless if children couldn’t
actually put them into practice as the following excerpt illustrates:

Martha  We are going to talk a bit more about ‘our fears’ while we eat.
Well…you’ve taken the first and most difficult step, identifying your
fears. So, so far you’ve done number one [reading the agenda].

[Augusto is vigorously moving his feet back and forth and is constant
motion.]

Martha  [continuing]…and the next thing, number two, is a plan, but some might
find it difficult to make a plan about…. Say Michele knows when her
Mom is working up to anger…she could go to a friends house….

Michele  But we are not allowed out of the house.

Martha  …okay…so she could go to her bedroom door and lock the door.

Michele   We don’t have locks on the door.
Martha: ...right...[continuing]...so it is something like at school, when you have a fire safety plan, although there are some things that are not practical for you to do, there are some things that are....

Amy: [interjecting]...and we will talk more next week about specific plans; sometimes it is too dangerous...or for example, with bipolar things can change just like that...

[<br>Elliot snaps his fingers as if to bring this point home...] (emphasis added, session 5)

Although Martha pointed out that the children had taken “the most difficult step” in identifying their fears, I think Augusto was agitated to learn that there was more to come when she pointed to “number two” on the agenda. He seemed less engaged, maybe even anxious or possibly bored by all this emotion talk. Also, identifying fears was not an easy step to take. And yet Michele’s responses to Martha’s statements helped to bring to the surface some of the reservations I knew Martha had about the feasibility of making “safety plans”. In fact Martha tips her hand as soon as she begins by saying, “but some might find it difficult to make a plan...” and Michele accommodated her qualification, unwittingly perhaps, by providing examples from her own life. However, this is followed by what appeared to me to be a confusing and halting description of “safety plans”. Martha tried to compare them to fire safety regulations in schools, but didn’t follow through with the analogy before Amy interjected with rather truncated comments about getting into this subject “next week”, but also something about “dangerousness” with no further explanation. Eliot obligingly snapped his fingers to dramatize the unpredictability of bipolar illness. Amy recovered her momentum as she and Mark appeared to be in synch in the presentation. He stepped in to affirm each of her examples of why these plans might fail, evidenced by his own circumstances, at least until they broached the topic of the dangers of speaking out about a parent’s mental health problem:

Amy: ...and sometimes you are the oldest ....
Mark: Yep.
Amy: ...and you have to look after a sister say....
Mark: Yep....
Amy: ...or the ill person....
Mark: Yep....
Amy: ...and sometimes if you speak out you worry about getting in trouble.

[At this point Martha gives an example of a ‘little girl’ in another group who told about calling for help and how the whole family wouldn’t speak to her.]

Eliot: Like ratting out.
Because families can see this as being disloyal and, so you can be in a
tight spot if you don’t feel safe, and you feel you are betraying your
parent.

You get mad at yourself.

You could be helping them even though it might not seem like it to them.

I think that’s really it…and sometimes they need to go to the hospital…or
need their medications changed.

My Mom’s in hospital right now and she’s taking her meds…she called
her parents and I got a call from my grandparents to tell me. She wanted
them to call me and tell me, she can’t call me…to tell me that she’s on her
medications and in hospital and she says thanks and she will get better and
then she will see us.

[Elliot listens and watches but does not comment.]

Mom thought she was well and if you tried to help she thought you were
trying to …do something different. (session 5)

A number of reasons are suggested for why making explicit “safety plans” may be impractical
including: parental rules that curtail what children can do; responsibilities as “the oldest” in the
home, for siblings and/or the ill parent; and, feelings of betrayal or “ratting out” for acting
outside the family, which may be real, or imagined. Augusto seemed to agree that children are
caught in a bind between being responsible for helping themselves, and/or their parents. Either
way, the consequences seemed to be anger directed at the self. Mark preferred to see “speaking
out” as a positive strategy rather than as a betrayal, because it could help the parent. While
Martha liked what he said she is very careful to draw all of these ideas about “helping the
parent” back to medical, professional interventions as the appropriate form of help. I believe
Martha’s statement was a caveat to warn against the idea that children are responsible for
helping their parents on their own. After all, the children have already been taught an important
Children’s Group lesson called the 4-C’s—they did not cause the illness, they cannot control or
cure it, but they can cope with it (with the implicit understanding that if they follow these rules
they probably won’t “get it” either).

In post-session talk Martha was more explicit about why she favoured learning to talk
about fears as an important adjunct to teaching children how to feel safe, and as opposed to
making explicit “safety plans”. I think that there is a subtle distinction here between “feeling
safe” and “being safe”. In other words, much of what is practiced in the Children’s Group at this
point is focused on teaching the participants individual, subjectively measured strategies that will
indicate when they are safe, in contradistinction to other ways of “knowing” what may be safe
and may be measured more objectively. And to further this point Martha resisted Amy’s notion
that children should be able to rely on external sources of support like protective programs, or professional advice, because the adults who work in them may not fully understand children’s practical realities and why they may not be able to keep themselves safe, or act in ways that make them feel they can do this successfully. According to Martha one of the problems, which didn’t arise in the previous discussion with the children, was that most children have little social support. Children were assumed to be isolated, not having “someone to talk to” about their problems. The *Children’s Group* was designed to be such a place, where participants could “get some of this stuff out in the open” as Martha described it:

Martha  We decided not to dwell a lot on safety plans. The London group spend an hour and a half on this but we’ve never had a group that was willing to do this. Maria and I reached this conclusion after many groups, based on what kids told us…that a lot of what we suggested was completely unrealistic in their situations. So we abandoned a formalized plan in favour of talking through some of this and some of what we do next week. We have serious symptoms…most have no support system…often no one to talk to…there isn’t anybody, and so they end up in this stalemate.

Amy  If it is an unsafe situation, that should be addressed before the group….at least half the kids have CAS involvement, right?

Martha  All situations…there is a plan that could be put into place…so for example, you talk to a psychotherapist and they say, ‘get out of there’. But what happens when they can’t and they end up feeling like they’ve failed?”…every kid in these groups usually put up their hands to say they feel like they betray their parents in speaking out…it is more important to give them a place to get some of this out in the open. (session 5, reflexive notes)

Because the *Children’s Group* was supposed to be a “safe”,—“comfortable”—place to talk about mental illness, it became a kind of stand-in for other social contexts where talking about problems might otherwise be considered disloyal or disobedient, and children are caught between their allegiance for example, to friends and/or family members.

While “safety plans” may be considered unreliable there are other strategies to help children practice what it is like to feel and be safe. First, they must learn how to listen to their bodies, because as Martha said, the body “will tell you things” (session 5). Moreover, there is an assumption that trusting other people is difficult due to their particular circumstances, so learning to assess whether they can trust someone or not is also vital. Accordingly, the body is a strategy to “tell you things” about places and people that are safe. But learning to listen to the body means learning to understand emotions as part of embodied processes. They began to do this in an exercise where the children were asked to label a drawing of a ginger man’s body with the emotions attached to the correct body part for example, “the pit in your stomach” for scary
feelings, or goose bumps for excitement and so forth. The next step involved learning what Martha called “Early Warning Signs” (EWS), which were described “like symptoms” because they would signify when something was wrong, to “help you survive”. These seemed comparable to illness symptoms because they functioned protectively as warning signs. In the following passage, which continues from the one above, Martha argued that this was a unique opportunity to teach the children something that most people didn’t know about being able to listen to the body as a self-protection strategy. The one qualification she insisted on was that although they would learn to be responsible for themselves in this way, it was still important to find the right kind of (that is, trustworthy) adult who would be able to help even if it took a number of attempts to find this person. She justified this idea drawing on anonymous experts (“they say….”) who have quantified these help-seeking attempts. An implicit point being underscored refers to an assumption about “these children” as isolated individuals who must be taught to know when they need to ask for help from an appropriate (adult) source. Moreover, children must persist in help-seeking as an exercise of their “right” to feel safe. And most importantly she depicted this practice of talking continuously—perhaps a refusal to be silent—as a strategy for claiming this right to feel safe:

[Interruption…continuing…] Most people don’t know what it is like, what the body feels like when we are afraid….and the other important point about safety is when we don’t’ trust anybody but are trying to find someone to talk to, what does that feel like, and the calm that comes when we do. You know…talking about statistics… [Martha has not been happy with stats talk tonight but acknowledges that it may have its place here in this discussion]…they have found that it takes kids talking to seven adults before anyone will listen to what they say, and the EWS’s are to help them, to learn to persist…that they have the right to feel safe and that to keep on talking until they feel safe. (session 5, reflexive notes).

Because the body was conceptualized as “telling us things”, the children were asked to build imaginary “safe places” to help them realize what the body feels like when it feels safe. Martha instructed the participants to build “real” or “made-up” places and the only rule was that they had to be their original creations because each person was supposed to find security and protection in unique ways. They were asked to choose any part of the room to construct their safe places using sheets, towels and pillow cases, and some tables or built-in structures in the room. Colin reclined on a table and wrapped himself in sheets, cocoon-like, with the help of Martha who taped his neck and feet when he asked her to help him. Later he said that he was a caterpillar and he edged himself along the desk once Michele helped him to remove the tape.
Ayanna asked Martha and Amy to help her create ‘Jamaica’ so that she could lie “with the sun at her head, and the ocean at her feet” (session 6). Both Michele and Becky chose fixed benches that ran underneath the bank of windows but Michele seemed annoyed that her sister was following her lead. Eliot laid face up on a table and asked Martha to run masking tape across the length of his body at varying intervals. He looked like he was being restrained. Augusto sat at a table pretending to play an electronic game using hand controls. He asked Martha to tape his wrists to the table.

Once Martha thought everyone was finished she moved to the centre of the room and began to question the children about what their bodies felt like, asking for example about other sensory experiences. She asked what they smelt or heard in their safe places. The children’s places seemed to be represented by either finding a way out of the situation—in sleep, in dreams or by traveling to another place—or by being restrained. I was interested in the ways the children altered the conversation about safe places by introducing their own ideas and/or challenging each other to prove that their places were safe. Before Martha had a chance to ask her questions about who could visit their safe places Michele introduced the idea by announcing that no one could enter her place. But Eliot quickly challenged her suggesting that she may not have control over “nightmares” when she’s sleeping in her safe place. Colin called his brother’s character into question when he responded sarcastically to Eliot’s vision of a dark, safe place by suggesting that Eliot would be too scared to go there. Colin ignored Martha when she asked everyone wait to ask each other questions, and she reasserted control by saying more emphatically, “no comments”:

<table>
<thead>
<tr>
<th>Character</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Martha</td>
<td>I’m going to start by asking you questions about your safe place. Are we all in our safe place?</td>
</tr>
<tr>
<td>Michele</td>
<td>No, I have to go to sleep in my safe place.</td>
</tr>
<tr>
<td>Martha</td>
<td>What does your body feel like in your safe place? Take a minute to think about this.</td>
</tr>
<tr>
<td>Ayanna</td>
<td>[volunteering] In Jamaica I am close to the sea, my head is near the sun and my feet are close to the waves [as she speaks she indicates where these are on the floor.] And in Jamaica it is so hot and sunny [you can hear the sensuous delight in her voice as she speaks]</td>
</tr>
<tr>
<td>Michele</td>
<td>[not waiting to put her hand up but picking up the turn] I am in dreamland and nobody can enter but me.</td>
</tr>
<tr>
<td>Eliot</td>
<td>What about nightmares?</td>
</tr>
<tr>
<td>Martha</td>
<td>Can we just hold that question for a moment? Thank you.</td>
</tr>
<tr>
<td>Augusto</td>
<td>I’m a blank space…its all kinds of video games.</td>
</tr>
<tr>
<td>Ayanna</td>
<td>How can you have all these video games?</td>
</tr>
<tr>
<td>Becky</td>
<td>[in a small voice] I am in my colourful dreamland.</td>
</tr>
<tr>
<td>Colin</td>
<td>I like being like a little cocoon…I feel safe in a shell.</td>
</tr>
</tbody>
</table>
Eliot: I am in a dark room, with nothing there. [Martha and Amy say later that he says something about meditating, but I did not hear this.]

Colin: [snorting with derision] Hah! You won’t even go into the basement with me.

Martha: [admonishingly] No comments. We will discuss these later. [pause] Tell me…what smells safe?

Michele: [without missing a beat] Nature

Ayanna: The ocean sea… (session 6)

Michele said that no one could enter her safe place, but other participants mentioned family members or friends who they would have invited into their spaces. In the following sequence Colin teased the adults in the room saying that “everyone, but them (pointing to me, Martha and Amy)” could visit his space. I smiled recognizing that he was probably making a point that wasn’t clear to me at the time (session 6). As illustrated in the following sequence, it was Augusto who reminded Martha of her promise to let him ask questions. Martha told me later that he was the first participant in more than 20 groups to have asked questions about the other children’s safe places. Augusto told me on more than one occasion that he was very fond of games, and I wondered if this was a kind of entertaining diversion for him as he had done something similar when questioned children about their artwork. Augusto facilitated the conversation from this point, asking questions and allowing the others to have some control over the agenda once Martha permitted it. I noticed how the children returned to challenging each other about similar issues that they had brought up in the earlier part of the sequence quoted above. They challenged one another’s ideas about how safe. Augusto asked Colin to consider what danger he might be in because other animals eat caterpillars. He questioned the practicality of Eliot’s place when no one could visit if they couldn’t find a door. And he repeated Eliot’s question to Michele, asking her about the safety of nightmares when she was asleep. Many questions seemed to be about the logic of their decisions and/or reflected concerns about how much control they had in the scenarios they constructed. Colin turned the tables on Augusto suggesting that his safe place might not be so happy once he ran out of games to play. His response to Michele about his safe place being something that can hurt even while it helps seemed quite philosophical, although no one commented further:

Augusto: [growing impatient] Can we ask the questions now?

Martha: Yes.

Augusto: Well, I have three…the first is to Eliot. How can someone enter when there is no door and how will they know when they want to come. And to Colin, Don’t animals eat caterpillars?
Colin [interrupting as Augusto isn’t finished] Well thanks for your support [laughing and ‘being funny’]…how to keep yourself safe? Don’t let them in [pointing to Martha, Amy and me.

Augusto [continuing] and What about nightmares Michele?

Michele [immediately] They don’t bother me!

Martha [interjecting] If it’s safe can you prevent nightmares? No, you have no control!

Colin For Augusto, if the game is over, are you in a happy place?

Augusto [not responding] For her [indicating Ayanna, who has not been here in a couple of weeks and some have forgotten her name]…how can air and sun make noise?

Ayanna I don’t know.

Michele [to Colin] How can that [indicating the sheets he has wrapped himself in and indicating a comment he made earlier about it hurting a bit] be safe, if it hurts you?

Colin It’s like a recoil, it can help but it can also hurt.

Martha Okay, thank you everyone one for your questions. It is time to put the stuff away.

[Michele rushes over to Colin to help him unwrap himself, like a ‘butterfly being born’ he enacts this; we all take part in cleaning up which consists mostly of heaping all the towels and sheets in the centre of the room.].

Becky [in a quiet voice in the hub-bub of clean up, it seems only Amy and I hear] How come nobody asked me any questions?

Michele [jumping in] Because you copied me.

[Amy tries to talk to Michele about why her sister might want to do that; I feel so bad and say something about ‘mimicry being the sincerest form of flattery’ and ask Michele if she gets this and she says she does. No one answers Becky’s question.] (emphasis added, session 6)

The children’s questions were quite reasonable but it seemed at times that they were competing with each other to see who had created the safest or most viable place. I wondered if this was why Michele was angry with her sister for copying her ideas, and I thought it unfortunate that Becky felt isolated during this activity and no one seemed able to address her question other than placating Michele’s feelings. Martha tried to rescue Michele when her comeback about not being afraid of nightmares didn’t stand up to scrutiny. She intervened reminding them about group rules about having no control over some circumstances (although a parent’s mental illness is not the explicit subject in this activity). I found this confusing because it wasn’t clear how the idea of control was expected to play out in these imaginary places and in the context of this rule. Colin’s jocular manner implied that Augusto was being disloyal by not supporting his choices about being safe. But he immediately followed this remark pointing to the adults present in a
clever reference to who the “real” culprits were when it came to safety, which was not other children or even poorly conceived safe places.

Colin’s comment however, he may have intended it, was perceptive, because as the next part of this sequence unfolded Martha began to talk about safe people and safe places. Most of the participants suggested friends who could help them if they were in trouble. But this was a point of contention for BTU and Martha who wanted the children to consider only adults in a help-seeking role. She began by arguing that the real problem was that adults don’t take children seriously enough. Consequently, children were urged not to give up until they could find an adult would listen to them. Martha substantiated her claim by beginning with the phrase, “it has been said…” to convey the idea that she was not making this stuff up. Colin’s dismissal of adults at his school as “mean” and judgemental was used to demonstrate that children must “keep telling”—the problem of power between adult and child relations was addressed only by telling the children to move on if they could not find a helpful adult. It was Becky who first suggested her friends as a potential source of help. I found her suggestion intriguing because of the assumption that most of “these children” were socially isolated with few friends:

Martha  Did you know that *it has been said* that it takes seven adults before a child is heard? Seven! So I want you guys to try and think of at least five adults that you could go to for help if you needed it.

Colin  That couldn’t be any of my teachers, some of them are mean…quick to judge.

Martha  [continuing] So you have to keep telling. You have to be persistent. So, how do you know, how do you know what is a safe place?

Michele  It depends on how safe you feel there.

Augusto  how you know the person.

Becky  My friends.

Martha  Maybe…if that person doesn’t have a mental illness…but you don’t know if a friend has it.

Becky  Find another place. (emphasis added, session 6)

The concept of “safe” friends/places was used interchangeably here, and it seemed a bit confusing. I think Martha wanted the children to think about safe adults typically associated with places children frequent like schools—despite ignoring Colin’s warning that they can be mean and judgemental. This confusion was amplified for me when Martha conflated the idea that friends might be helpful with the possibility that they might not be safe because they could have a mental illness. This was not a criterion for judging adults’ trustworthiness, and it seemed strange given the emphasis on “brown words” and discriminatory attitudes toward people with mental illnesses. Odd though I found her rationalization it may have been a strategy for
dismissing friends as an alternative for seeking help without denying this possibility overtly or appearing too dictatorial on the subject. Martha confided to me that she worried about children being realistic about planning for their own safety. I was less surprised by this outcome as it unfolded in the following sequence when children described friends in terms of getting help because they were “someone to talk to”. Having someone to talk to had been a significant draw in becoming part of the group, which children seemed to accept and enjoy. Even when Amy tried another tactic by being more specific about “getting help” as something more than just “talking”, the children insisted that friends were important. Augusto reasoned that friends make “you feel better”. It seemed to me that some of the confusion may have arisen out of a lack of distinction between “feeling” and “being” safe. On a subjective less tangible basis safety may be different from how we think about it in more concrete terms and in the ways we think about adults as being the ones whose job it is to provide something that is “really” safe. Michele tried to find a compromise suggesting that they could talk to the “parents” of friends. But Martha, perhaps fed up with this insistence on talking about friends, finally comes right out and asks, “but what about adults?” Augusto seemed so frustrated that he responded asking her why friends “don’t count”. Martha ignored his question and tried another strategy pointing to the safety plan—even though the usefulness of safety plans was questioned—to convince them to consider her point:

Martha: You use your body to tell you when you feel safe and when you do not. So who can you talk to?
Augusto: My best, best friend.
Eliot: Same.
Michele: A teacher.
Colin: My friend, S. [his brother Eliot laughs derisively at this, but makes no comment].
Ayanna: A friend.
Amy: What about to get help?
Augusto: [continuing with the friend theme] They make you feel better.
Michele: You can talk to their parents, your friends parents.
Martha: But what about adults?
Augusto: [insisting] But what about going to your friends house, why doesn’t that count? (session 6)

Finally, the participants seemed to give up and accommodate Martha by giving her the “right” answers. Together they read out loud a list had been taped to one of the walls in which potentially trustworthy and protective adults included: parents and grandparents, uncles and aunts, the school guidance counsellor and so forth. They were told again, that the rule is they must find five adults to call on for help. Michele showed that she knew what to do by repeating
the telephone number of the “Kids Help-Line” from memory. The children were given small laminated cards, which could be tucked into a wallet and contained several telephone numbers for the police, fire and ambulance; the Kids Help-Line; the local Children’s Aid Society; a mobile crisis team; a resource for “up-to-date mental health information”; and, a contact number for the umbrella organization supporting the Children’s Group. During our group discussion Colin said he had learned to be calmer because there were “responsible adults around me cause that’s what happens on the little card they give us and stuff” (session 8, group discussion). As this sequence came to a close the children easily rhymed off people and organizations who they must have guessed would be acceptable additions—for e.g. Children’s Aid and “the hospital”—in terms of what it meant to be realistic about seeking help (session 6).

**Being a Child (of a Mentally Ill Parent): “We are all in the same boat”**

The adult facilitators and the children occupied particular subject positions that are constructed by the discourses underpinning BTU. I was interested in understanding how the children managed these positionings, or ways of being a child—which necessitates also thinking about “ways of being an adult”—because they were influenced by expectations about social relations between children, and between children and adults. So for example, Martha insisted children’s friends “don’t count” as “helping” persons in the same way adults do, because adults have the authority, expertise and responsibility to protect children. In the group this meant that the facilitators’ job was to help children manage the experience of having a parent with a mental illness—so that when they completed the group they would be better able to protect themselves. Moreover, by teaching them to be protective it was assumed that they would also be able to preserve a sense of themselves apart from their parents’ problems. An important goal of BTU was to teach children to depend on “trustworthy” adults who would help them see their lives differently. To achieve this goal the children had to change how they thought and felt about: their parents’ difficult, unpredictable behaviours, explained as illness; and themselves, because despite the illness and the problems associated with it, they were encouraged to “have a life of their own”. This was essential to changing how they saw themselves as a particular group of children for whom having an independent life meant not being (a child who was) responsible for a parent’s mental illness and its’ sequelae. The unspoken belief was that once children managed to shift how they felt and thought about their circumstances they were expected to be able to see that they could anticipate a “good” future. Taking control meant that they had to learn to think
positively and take measures to be self-protective and responsible managers of their own mental health.

The *Children’s Group* was described as a “space for children” because adults were supposed to have places of their own to find help (*BTU*, introduction). Beginning with the very first session, participants had to acknowledge their commonalities as children, but also those things that set them apart because they were children of mentally ill parents. So as the opening sequence demonstrated, justification for coming to the group is premised upon being able to talk about their lives because as Amy instructed them, “having a mentally ill parent is only one part of our lives” (emphasis added, session 1):

Martha: Why do you think you are here tonight, in this group?
Colin: To talk about our lives.
Ayanna: To talk about people who are sick?
Eliot: To talk about things in general.
Martha/Amy (with enthusiasm and together): Yes, yes.
Amy: Because having a parent with a mental illness is only one part of our lives because we go to school, to gym…
Augusto: …(overlapping and taking up this talk) and the computer and TV….
Ayanna: …(shyly) we eat…
Colin: …(overlapping and repeating) eat, sleep and go to school. (session 1)

But this was the second time they were asked this question; the first garnered Eliot’s sarcastic response that they had come to the group to “bake a chocolate cake”. It seemed to me that everyone laughed along with Eliot because they thought that the answer was obvious even if they were not willing or ready to say this. Because Martha’s control over the group prevailed, she insisted that they respond together, and verbally—that they were in the group because they had a family member with mental illness. By asking the question a second time though, group solidarity—what is expected of loyal and disciplined participants who “play for the same team”—was shown to be dependent also on acknowledging what they had in common as children apart from the illness. The children answered this question easily: they go to school, and they use computers and watch television; and as Ayanna said, (they) “eat”. I wondered why it was important to begin the program by reminding them of the ordinary and even mundane aspects of being a child, especially because although Amy insisted parental mental illness was only one part of their lives, it was the focus of the program. It may have been a gesture to minimize labelling them solely in terms of their parents’ illnesses. But as the objective of the *Children’s Group* was to shift how children think about themselves in terms of “how their story will go”, they may have needed to be reminded that they have a life separate from that of their
parents and especially, the illness. As the sequence unfolded I was reminded of Shakespeare’s Shylock’s question to his inquisitors in Shakespeare’s, The Merchant of Venice. whose protest against being categorized in discriminatory ways found expression in the rhetorical question: “if you prick us, do we not bleed?” So that yes Ayanna is right, they do “eat”; it was an accurate way to describe what it means to be a (living, human) child, quite apart from other possible ways the children might be cast.

The facilitators were unified in their agreement, indicated by their enthusiastic “yes, yes”, that both reasons for attending the Children’s Group are “correct”—they are here to talk about themselves, and to talk about their parents (as “people who are sick”). BTU is divided similarly because the focus is on ways of being: 1. a parent who is mentally ill because of a “broken brain” that has resulted in “twisted thinking” and difficult, unpredictable behaviours; and, 2. a child who is at risk for illness but who can be taught how to manage and/or control the cumulative effects of stress to remain (mentally) healthy. This dual focus causes some confusion that was continuously negotiated by participants during mental health/illness talk in the day-to-day operations of the group. For example, Colin asked for clarification about whether he was supposed to think of himself or his mother when the group discussed worrying about mental illness in session one. In a later session Michele wanted to know whether Colin was describing himself or his mother when he talked about being afraid of the process of becoming ill. Even Martha has to ask for clarification in this next sequence that occurred toward the end of the sessions. Martha asked the participants to imagine their own futures and to give advice to other family members after they finished watching a clip from a fictional film about a young girl whose mother had schizophrenia:

<table>
<thead>
<tr>
<th>Martha</th>
<th>So, how do you imagine yourself 40 years from now? If you were to write a book or a movie about your experiences, what would you say to someone who had a family member with a mental illness?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark</td>
<td>[without hesitation] It’s not your fault.</td>
</tr>
<tr>
<td>Ayanna</td>
<td>I still love my Mom, but my Dad is over there…and my Mom? I don’t know where…And now my grandma and I are here. And we are all splitted.</td>
</tr>
<tr>
<td>Eliot</td>
<td>It is going to be over soon. It’s going to end eventually and it will all turn out…[and his voice trails off without completing his thought].</td>
</tr>
<tr>
<td>Martha</td>
<td>Is this for you, or for your Mom?</td>
</tr>
<tr>
<td>Eliot</td>
<td>I don’t know.</td>
</tr>
<tr>
<td>Augusto</td>
<td>I’m still thinking.</td>
</tr>
<tr>
<td>Colin</td>
<td>I pass.</td>
</tr>
</tbody>
</table>

54 Shylock’s question to his inquisitors in Shakespeare’s, The Merchant of Venice.
Whoa….whoa! [she is teasing him about passing. I am surprised by her
textbook because it seems a sensitive moment. It is very unusual for any of
the kids to choose to pass over the last seven weeks.]

I have something. Never be afraid of people who are bigger than you are.

But this is about mental illness.

People might be picking on him.

The child with a parent who has a mental illness. It’s not an easy question.

Don’t worry, its going to be okay.

Don’t give up hope.

Old one!

Remember, they say knowledge is power. So don’t forget about the 4C’s.

Amy’s statement was curious coming toward the end of the program. Despite all the educational
and support activities that have been directed toward teaching participants how to be a child of a
mentally ill parent, it seemed that this was still a complicated question to which there is no
resolution. As Amy says: the child with a parent who has a mental illness, it’s not an easy
question. Augusto’s advice to other children in similar situations did not comply with Martha’s
ideas about what constituted a problem about “mental illness”. But he challenged her, most
likely because he was drawing on his own experience of being bullied even though he spoke in
the third person. When Ayanna and Eliot tried to envision a more positive message about the
future Augusto challenged them for being trite—the idea of not giving up hope is as he says, an
“old one”. I found Eliot’s initial response sad too as he struggled to articulate his version of a
good ending but he seemed unable to convince himself. Martha asked him to clarify who he was
thinking of in reference to the future but Eliot couldn’t distinguish between his thoughts for
himself or his mother. This may have been because it wasn’t easy for the children to separate
their thoughts and feelings about themselves or their parent, whether it was about talk about the
future or other circumstances in their lives.

In the same passage Mark easily repeated the group rule, “It’s not your fault”, in giving
advice to other children, but it was Ayanna’s response that piqued my interest because despite
everything, she wanted us to know that she still loved her mom. Ayanna had not seen her
mother in close to a year when she came to Children’s Group. I wondered though why she
seemed to be apologizing for her feelings. It concerned me that in shifting how she was
expected to see herself there was a subtler message that she interpreted to mean she was required
to change how she thought and felt about her mother. Although unintentional, it may have been
a consequence of the confusion between talk about what it means to be a child and to be a parent,
particularly under these circumstances. I wondered whether changing how participants thought
about themselves and their responsibilities as children put additional demands on them to change how they were expected to think about caring for and about their parents. It seemed to me that despite everything, the children wanted to remain connected to their parents and be involved in very explicit ways in these relationships. By this point in the program “everything” includes a long list of difficult, unpredictable and even violent images of parental behaviours and different ways of feeling afraid, not to mention changes in material circumstances because as Ayanna says, her family is “all splitted”. This was made more clear in the following excerpt from our group discussion when the children suggested that maybe—and here it is only a momentary glimpse into the ways they resisted certain rules before they appeared to backtrack and began to give me the “right” answers—they could be more involved in “helping” their parents than rules about the 4C’s permitted (as a reminder these were: I didn’t cause and I can’t cure or control it; I can only cope with it):

Me  So the first question I have…What do you guys like about coming here every Thursday?
Ayanna …cause other kids that their parents have mental illness, want to learn how they…*help them cure (for) their mothers ’ and dads’ sickness.*
Me  oh, okay…but remember, what about a week ago when we talked with Martha about the fact that we can’t cure our Mom’s illness?

[in background there is general noise from everyone that seems to indicate they don’t agree with this idea].

Eliot  *you might.*
Me  you think so? [I am responding to this vague disagreement which continues in murmurs heard in the background around the room].
Mark  well, you can help, you can learn to cope with it.
Me  you can learn to cope with it, that’s what…but some of you guys think you can maybe cure it, how do you think you can do that?
Michele  well…[but she is interrupted by Ayanna who is shouting something inaudible].
Me  [silence for a moment], okay, but what about what Mark said, do you agree with that…remember the 4 C’s?
Eliot  cope….[struggling to remember]
Michele  oh, I have it all written down….
Mark  you can’t control it, you didn’t’ cause it…uhmmm…you can cope with it and you can’t cure it….
Michele  I have it written down.
Me  was it helpful to learn that?
Mark  yeah.
Me  really, it’s sounding to me like not everybody really believes that, sounds to me like people think maybe they can cure it?
Eliot  can I have another drink? [I tell him yes, he gets up from the table to get a drink].
Michele: it helps [she is interrupted by Ayanna who also wants a drink and tells me when I ask her to sit down at the table]…well I don’t really see my Mom anymore cause of what she said to me, but, but if I ever see her again, I’ll know what to do when I see her. (emphasis added, session 8, group discussion).

Mark’s comment suggested that there might be a way to have it both ways by combining the rule that they could “cope with it” with another that allowed them to individuals who “can help”. It seemed too that the children often used “cure” and “help” interchangeably so that it would have been important to ask whether these were similar kinds of things. Unfortunately Michele wasn’t able to say how she might have imagined what it would mean to “cure” because Ayanna and I interrupted her. After I reintroduced BTU “rules” about the 4C’s it was as if the children had to show me that they were good students either by trying to name them (albeit not always successfully), or because they had studiously written them all down and would as Michele says, know what to “do”. I thought that this was a distinctly different enterprise from what we started out talking about being able to cure mental illness or what helping might have looked like from their perspective.

Children had different expectations of their relationships with other children who were “in the same boat” compared to those who were not. Despite their initial reluctance, and even resistance to attending the program, toward the end of the sessions most described how much they valued “discovering” that they were not “alone”, and being able to talk to individuals who were expected to understand “what they were going through” (session 8):

Colin: yeah it’s good to know that you are not the only one….  
Me: yeah, can you tell me how that works? Cause everybody says that all the time, that it’s good to know that you aren’t the only one. But how does that work, why? Like I agree with you, but why?  
Colin: well if you fail, like a math test and somebody else fails…it makes you feel better, because…it just does….  
Michele: it takes the pressure off.  
Colin: yeah…I mean…yeah.  
Me: okay, so it takes the pressure off, anybody else?  
Eliot: the same thing…I like pizza!  
Me: you like pizza, okay (giggling all around)...okay Eliot (admonishment).  
Mark: well it helps to talk…like it’s harder to talk to people who don’t know about it because, well they don’t really know what to do, what to say, but people who do know about it, like they may have suggestions….  
Me: yeah, and has that happened for you here in this particular group?  
Mark: yeah. I think so.  
Michele: it’s also good cause like you can explain about the person with the mental illnesses and they won’t judge you because like , you know, oh there’s
The children explained that they appreciated having developed a mutual understanding based on being similar ages and having a shared experience. They felt this made them less judgemental. They thought they had fewer stigmatizing attitudes compared to other children, who although similar in age (like those at school), lacked the experience that would foster understanding. Being children who were in the “same boat” meant that they could develop a mutual “understanding”, because they were learning to rely on each other in ways that might be described as a “collective” way of being children. They developed and accepted (to some degree), a loyalty to one another based on a united way of thinking about how to interpret and give meaning to the challenges they faced, and they were disciplined enough to agree to cooperate with each other most of the time in this process, and be more sympathetic and tolerant toward each other. In this way I could say that children seemed to have developed an understanding, a moral obligation to each other that in Goffman’s terms could be considered, “members of the same team”. This was underscored for me in a very simple way when the children were upset when someone didn’t show up for a session, as Eliot did on the last night when he scolded Augusto in absentia for not being there, and Michele did on numerous nights when she waited anxiously for “the boys” (Colin and Eliot) to show up. But it was Colin’s reaction that was particularly resonant in terms of the influence being “in the same boat” had on shifting how he saw his mother as someone who was mentally ill. In the following passage he continued to struggle to name his mother’s problems as an illness, and it was Ayanna who dutifully supplied him with the “right” words:

Me Mark has talked about learning things, what about the rest of you, you guys on this side, does that matter to you guys? (yeah, yep, yeah, yes from Colin, Eliot, Michele) tell me something that matters to you? What did you learn about that you didn’t know before you came?

Colin well…well before I came I didn’t really think my Mom had a mental illness…that was uhm, that she wasn’t sick and that my Dad thoroughly reinforced that sometimes but…

Me and has that changed coming here?

Colin yeah.

Me how’d that happen?

Colin uh, cause I found out that a lot of different people have…. (sentence completed by Ayanna)

Ayanna mental illness.

Colin yeah.

Me and it made sense about your own Mom?

Colin yeah. Cause I wasn’t sure what to make of it…yeah.
Me: what kinds of things did we do that made you think maybe it was true?

Colin: well, a few minutes after I walked in the door everybody here, well everybody said that... had some... just... I didn’t know there was so many kids like us... like me (it is very quiet and there is no background chatter while he is talking) (emphasis added, session 8, group discussion).

Colin was the one who had originally inscribed “being in the same boat” as the “Titanic”. At the time I surmised that this may have been due to unspoken feelings of hopelessness he may have felt when he arrived in the Children’s Group. What I could not know towards the end of the group is whether accepting that he is like the other children—that is, he is in the “same boat” because there are “so many kids like us”—influenced or even changed how he may have seen himself or felt about his situation.

I asked the children whether being in this group had any impact on other social relationships and they talked about friends in a way that underscored the differences they perceived between children who had a shared “understanding”, and those who do not. But rather than describing this as supportive they talked more about worrying about how to explain mental illness to friends. They were concerned because their absences had been noticed on nights when they attended the Children’s Group. They worried about how friends would react if they did find a way to tell them about what they were doing, and sometimes they felt bad about keeping this as a secret from friends. I was curious why Mark qualified his worry about explaining his “secret” to friends not because it was “too hard”—assuming perhaps that he felt he had the required information—but because it would take “too long”. Difficulty and time may have been two ways of talking about a similar problem—and this may have been a reference to stigma, although the word was not used, Mark admitted he worried about friends’ reactions:

Mark: everybody always asks, how come you weren’t on MSN on Thursday? What were you doing? You weren’t talking on Thursday?

Me: So what do you tell them?

Mark: I’m at this thing.

Michele: yeah.

Mark: and then I just say I’m at this thing with some people and then, and then I just try to change the subject. But then they just like jump to conclusions, like ‘you’re keeping secrets from us, why are you keeping secrets from us?’

Me: and you don’t want to tell them because...?

Mark: it’ll be .....

Me: too hard to explain?

Mark: too long to explain it. And I don’t know how to explain it. And I don’t know what their reaction will be.

Me: okay. Okay, what about the rest of you? Do you have friends at school that you tell about coming to this group on Thursday night?
Colin: well, like with my friends, like my friend just discovered about two weeks ago, it was the same thing and I was just like, ‘I have to go to this thing’ and they say ‘what thing’?…so the same thing (as Mark)

Michele: I hate it when people do that and they’re like, where and with like, who? And it’s like, male or female? And I’m like I don’t really want to tell you.

Me: Eliot, what about you?

Eliot: they don’t really care actually.

Me: they don’t care, you say whatever (repeating what he has said but is not easily heard on tape). Okay, so would you say what you’ve learned and done here has it had any impact on your friendships or your relationships with friends or family? No (non-verbal responses)

Mark: (after a pause, but with certainty) I feel like I understand my Dad more.

Me: is that right?

Mark: Well like before, my Mom and my aunt were always giving us a hard time but the like, the more information they get, like the more information I get, the more I can understand, therefore they won’t give him a hard time, therefore adding to the problem by giving him a hard time. But now that they know about it they are like yeah….(tone of voice indicating that they are ‘onside’ ‘they get it now’).

Me: and how have they found out about it, through you, is that what you’re saying?

Mark: yeah, like my Mom is, ‘what’d you learn?’ and she thinks its useful information.

Me: oh so you’ve been telling her stuff about what you are learning here?

Mark: yep. (session 8, group discussion).

While Eliot claimed his friends didn’t care where he was on group nights, I pushed the children to consider whether coming to the group had had any influence on other relationships in their lives. It was only when I was met with mostly mute responses that Mark decided to talk (rescuing me this time perhaps) about the influence of the group on his relationship with his family and how the information he acquired helped him to “understand” his father better. If the Bridges to Understanding analogy is brought to bear on this question I could say that Mark has achieved understanding in three demonstrable ways: 1. his father’s illness, and his own circumstances, have been made intelligible and he has acquired insight; 2. he has come to an informal, mutual agreement with others about how to interpret and give meaning to their situations; and, 3. he has been helped to feel more tolerant and sympathetic toward the situation he and the other children are in. Mark described this “understanding” as having a domino-like effect because he now seemed to feel more responsibility for sharing this understanding with other people in his family. I didn’t have the impression that this was for their edification so much as a strategy he used to protect his father from being harassed, or given a “hard time”, by other family members. Mark was considered “parentified” according to the intake discussion.
and Martha’s comments during the group, so in this sense the program may have exacerbated Mark’s care and concern for his father in a way that may be interpreted as being “risky” rather than “protective” of Mark himself. This hinges of course on whether or not being a child who cares for, or “helps” a parent in this way is considered problematic.

As a final comment about “being a child” (of a mentally ill parent), and knowledge and beliefs about mental health and illness, I quote verbatim from an anonymous statement made at the end of my group discussion with the children. I asked the participants to reflect on their overall experience attending the Children’s Group. I asked them to respond privately, on a form created for the study, in which each of them completed the following sentence: “Other things I think about this group are....” (Appendix 7). I liked the way this particular response shifted discursive formulations about who children and adults are supposed to be and how they are expected to relate to each other—by making claims about children’s authority and experience to teach adults something meaningful about mental illness:

“Other things I think about this group are....”

That this group is great because it really shows interest about mental illnesses by including that most of the pupils (kids) turn out to be the teachers and the teachers turn out to be pupils – Anonymyse (session 8)

Whether this was “true” or not is not my concern here, because I draw on Goffman’s (1959) concept of a “working consensus” as a “real” agreement as to whose claims might be temporarily honoured (and not a real agreement about what actually exists) to discuss the results of this study.

In sum, according to Mead (1934), to be a “self” one has to be a member of a community. The children in my study were cast as particular kinds of selves. They were expected to perform as a team because they were identified as being “all in the same boat”. I argue that this discursive formulation signified who they were expected to be, and how they were expected to act toward each other during this 8-week performance. This represented a community of sorts, where children could rehearse being and acting as if they were “all in the same boat”. They were categorized (that is, identified and positioned) this way by systems of knowledge and beliefs about mental health and illness, and ways of thinking about children—which as Fairclough (1992) would argue, may not have been apparent to the participants. Somewhat paradoxically, as members of this group children were expected to separate themselves from the illness narrative that defined their parents, by identifying themselves as individuals who were responsible only for how their stories would go.
I argued in my critical discourse analysis of *Bridges to Understanding* that the script in its entirety could be read as an analogy for an overarching objective of the *Children’s Group*, which was to help children manage their circumstances better by: 1. making them intelligible, and helping to create insight; 2. developing an informal, mutual agreement about how to interpret and give meaning to them; and, 3. helping children become more tolerant and sympathetic toward parents’ behaviours as illnesses and the belief that they didn’t cause, and couldn’t control or cure the illness. These three dimensions of “understanding” aligned with Goffman’s (1959) concept of teams (or performers) who act strategically to manage impressions by putting on a show in response to the one put on by the facilitators who have the script; and also with a significant metaphor introduced early in the performance, when they were first asked to identify themselves as being: “*in the same boat*”. Table 4 shows the connections between the objectives of the script and the performance, and the strategies and practices performers used to act as if they were “*in the same boat*”.

### Table 4: Being in the Same Boat

<table>
<thead>
<tr>
<th>The Script, (<em>Bridges to Understanding</em>): three dimensions of “understanding”</th>
<th>Make circumstances intelligible; apply concepts to explain situation, create insight.</th>
<th>Develop informal, mutual agreement about how to interpret &amp; give meaning to situation.</th>
<th>Help to become more tolerant and/or sympathetic about situation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Performance: (&quot;<em>We are all in the same boat.</em>&quot;) three practices concerning what it means to be in “the same boat”</td>
<td>We work as a team because we face similar challenges.</td>
<td>We can remind one another that we are part of the same team (lest we forget).</td>
<td>We realize we need to cooperate in order to succeed.</td>
</tr>
<tr>
<td>The Performers: (to put on a show, or to put on a show in response) three impression management strategies to act as a “team” (Goffman, 1959).</td>
<td><strong>Discipline</strong>: expressive responsibility; maintain affective line of performance; laugh only at matters that aren’t ‘serious’; trust own performance; assurances to trust each other; use body, face, voice to display control.</td>
<td><strong>Loyalty</strong>: developing group solidarity; accepting moral obligation to one another; keep team secrets (self interest; principle or just discretion); do not stage own show or denounce others; accept minor parts.</td>
<td><strong>Circumspection</strong>: determine in advance how to best stage show; adapting performance to information conditions; prepare for unseen events: choose loyal, disciplined performers, rehearse routines/practice parts under manageable circumstances.</td>
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This multi-dimensional view of understanding represented a different set of unarticulated goals for the performance. Children who achieved them could be said to have understanding because they knew what was required of those “*in the same boat*”, but also to be understood.
because as members of a team of disciplined, loyal and circumspect performers they had acquired a new identity in which they were cast as being “all in the same boat”.
CHAPTER SEVEN: DISCUSSION
In this chapter I discuss how being identified as “all in the same boat” was meaningful and consequential for children who were expected to: i) learn mental health/illness information because “knowledge is power”; and, ii) express their feelings about being a child of a mentally ill parent who could manage only “how their story would go”. I pay particular attention to children’s use of humour as a strategy to manage how they responded to these expectations.

First, children who recognized and accepted that they were “all in the same boat” could be said to have achieved the goals of BTU because they developed an understanding about mental health/illness. Learning mental health/illness information was an important first step in developing a sense of belonging based on beliefs that they had control over some aspects of their lives, underscored by the adage “knowledge is power”. Being educated was supposed to be “empowering” because it helped children make sense of their experiences in particular ways. Consequently, knowledgeable children were said to be more resilient because they blamed the illness rather than themselves, or their parents, for their circumstances. However, this was a difficult distinction to make because children were confused about whether they were supposed to think about their parents, and/or themselves in response to teachings about mental health/illness—, which was not surprising given that mental health discourses emphasize psychosocial aspects of (families and persons) living with illness but they circulate in tension with a biological, medicalized view of treating individual illness. Nevertheless, there were orthodox ways to think and talk about problems as a consequence of illness, such that children who were “all in the same boat” would share a common—biomedical—interpretation of their experience, and find meaning in it through learning to “speak the same language” (Mead, 1934). Children used impression management strategies to negotiate but also resist what it meant to be categorized this way. Some children had preferences for talking about mental illness using other than the orthodox medical language they were taught, possibly because these alternatives explained their circumstances in ways they found more meaningful. Children used humour as a strategy to maintain what Goffman (1959) called the “expressive status quo” of a performance. Humour helped them say—and mean—more than they could explicitly express in serious conversation. They strategized to retain some control or power over the terms under which they were positioned as being “all in the same boat” and were expected to develop relationships with other members of the group. Humour allowed them to question the relevance of mental health/illness information to their own experiences.

Second, by being identified as “all in the same boat” children were supposed to learn to cope better by acknowledging their fears, because fear was assumed to be their dominant
emotional response to the troubling and unpredictable behaviours of their ill parent. However, they were also expected to agree that they could manage only how “their own stories would go”. This seemed to create tensions for example, between children’s desires to care for and about their ill parent and the assumption that to cope well and be mentally healthy, they had to learn to think only about their own futures. Paradoxically, while children were expected to identify with the group, ultimately they were encouraged to think of themselves as separate from others—especially their parents. According to Francis (1997), the primary objective of most support groups is to help participants manage stressful thoughts and emotions by reframing circumstances in such a way that members come to realize that they need to change. This is because the circumstances are considered less amenable to change. Critical discourse analysts would agree that participants are expected to change in ways that reflect the ideological position of the group (Francis, 1997). Children in my study were not considered responsible for caring for an ill parent even when they said they wanted to accept some responsibility. Despite vocal protests children were not encouraged to turn to friends for support other than those in this time-limited group. Instead, they were admonished to persevere until they found an adult they could trust.

i. *All in the same boat: “knowledge is power”*

*Learning biomedical information*

Toward the midpoint of the Children’s Group sessions, the participants were asked what they knew about treatments for mental illnesses. Brothers Colin and Eliot replied easily, “medications…therapy” and “education”. In this respect they demonstrated good mental health knowledge. Amy acknowledged this but added, “sometimes they call it psycho-education because adults learn about living with mental illness, diagnoses, medication, symptoms…” (session 4). In clinical settings psycho-education most often refers to teaching people how to manage mental illness by reinforcing their strengths, coping skills, and resources, in order to increase long term well-being—it is professional “talk” (the *they* Amy references) for a particular intervention to help individuals and their families *live with* mental illnesses through education. The premise is that having more knowledge about causes and effects of illness increases the likelihood of managing a chronic, incurable illness. The process of learning to

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55 This can also refer to “mental health literacy”, which I will discuss later but has been defined as the knowledge, beliefs and abilities that enable the recognition, management and prevention of mental health problems (see for e.g. [www.camimh.ca/files/literacy/MHL_REPORT_Phase_One.pdf](http://www.camimh.ca/files/literacy/MHL_REPORT_Phase_One.pdf), retrieved April 23, 2009)
“live with it” is one way that discourses about recovery and mental health promotion refer to mental health/illness, but this circulates in tension with medicalized views of individual “illness” and “disease” prevention. Education is supposed to help individuals accept psychiatric diagnoses and treatment options (and to seek help), and decrease feelings of helplessness. More generally, education is supposed to broaden perspectives on the experience and increase understanding in mostly positive ways. Until quite recently this thinking has been applied largely to individuals with mental illnesses, and their adult family members, but not to children. The participants in the Children’s Group received psychoeducation because they were identified as children of mentally ill parents. They were expected to accept that parents’ problems were due to psychiatric illness and that medical help was available, presumably to lessen their feelings of helplessness and increase their understanding.

Helping children who are experiencing parental mental illness to have a better understanding of the illness is considered protective. Bridges to Understanding assumed that children possessed “pre-existing knowledge and skills”. However, these needed improving along with children’s “resiliency skills” because the goal was to teach children to manage in a way that was considered safe and more appropriate. Acquiring “appropriate” information, having more knowledge, and better understanding, are all different, seemingly unproblematic ways of talking about mitigating the harmful effects of illness (see for example, Cooklin, 2006; Fraser et al., 2006; Riebschleger et al., 2009). According to Hammen (2003), the following statement is representative of how educating these “vulnerable” children is often justified: “It may be speculated that children who see their parent as ill may be less affected by maladaptive parenting because they are able to see it as due to the illness rather than to something bad about themselves or the parent” (p. 69). Being able to “see” a parent as ill is supposed to help children recognize and accept illness as an explanation, so that they feel less guilty about and/or responsible for the causes and the consequences of mental illness (see for example, Garley et al., 1997). Conceptually this is complicated because “seeing” could refer simply to children acquiring better or more appropriate “factual”, objective information. It could also refer to the development of knowledge and understanding based on meaning conferred through an interpretive, interactive social process (Blumer, 1969).

In previous research parents and mental health professionals have described wanting children to understand the differences between illness behaviour, and other behaviours—so that they will blame the illness, and not the parent, or themselves. There is considerable agreement that children who were knowledgeable about the illness were considered better able to cope with
it’s effects because they interpreted parents’ behaviours as signs of illness (see for example, Garley et al., 1997; Mordoch, 2010; Mordoch & Hall, 2008). In my study, behaviours and symptoms were referred to by BTU interchangeably, as if they were the same thing. BTU generally emphasized mental illness as an illness “like any other”. A possible consequence of misinterpreting parental behaviours as something other than symptoms of illness is that children will experience negative emotions. Michele was referred to the Children’s Group so that she would understand that her mother had “called the cops on her” because of “delusional thinking”. Her step-mother wanted Michele to know that “she wasn’t to blame”. My impression however, was that Michele was angry about this event, and more concerned about how her mother’s earlier actions had made her feel, than listening to explanations about what caused her behaviour. The facilitators found Michele cautious and thought she withheld information. However, she revealed more than she said by including words about her anger in her “unwell/well” drawing, although this went unnoticed at the time. Other children used strategies other than direct commentary to convey something meaningful. For example, Colin added the word “Titanic” and added a lifeboat to the “all in the same boat” drawing. Michele didn’t back down from how she interpreted her mother’s behaviours as “threatening”, even when the facilitators wanted her to change her mind to see her mother’s actions as a symptom of her illness, which they categorized as suspicion related to paranoia. Whether the facilitators were “correct” or not, I don’t think this would have mattered to Michele because attributing behaviours to illness did not seem to alleviate the difficult, negative emotions she was feeling. Explanations about illness seemed like a less than satisfactory way to for her to come to terms with her particular issue. This may have been a power struggle between Michele and the facilitators to define the problem, which showed how difficult and complex it can be to tease out whether talk about the illness—children’s ability to recognize and be knowledgeable about it—concerns it’s effect on the parent, and/or on the child, and what the consequences of such talk is, given the belief that education is considered protective.

The importance of educating children against “false beliefs” (Place et al., 2002), and providing “accurate, realistic information” about mental illness (Sands, Solomon, & Mannion, 2001), is premised on the idea that children should acquire information from reliable sources. This was an important goal of the first four sessions of the Children’s Group. However, the facilitators seemed burdened by the effort and time constraints involved in getting through all the required material in BTU. Despite carefully planned educational activities, Colin regularly teased Martha about always being behind schedule. There was real tension about the need to get
through it all such that they often moved on to new activities even though BTU described this as “antithetical” to what was expected of a good education where children had ample opportunity to digest all the material presented (BTU, introduction). The literature generally supports the notion that educational content should include “facts” about mental illness. Most often this pertains to information about genetic vulnerability, and the causes and treatment of mental illness. The struggle to define Michele’s situation made me rethink our assumptions about what it means to be knowledgeable about mental health and illness, from the perspective of children. Facilitators were expected to explain mental illness as if it was an unproblematic biomedical illness. I had questions though about this singular way of thinking and talking about mental illness as the only “appropriate”, “accurate” and “correct” way to educate children even though BTU certainly reflected contemporary biomedical discourses about mental illness. These assumptions may lead to a missed opportunity to listen to children and consider how and why they interpret their experiences in the ways they do, without discounting or pathologizing their “understanding” or simply seeing it as a means to “educational” ends. Michele’s example allows us to consider who decides which the more “correct” view is. A major rationale for teaching children about mental illness is to alleviate their guilt and blame. This may also be presumptive based on the roles adults have in being responsible for children’s safety, and making decisions about what is protective. At least two children had been referred to the Children’s Group by family members who worried that the children felt they were to blame for the situation. Unfortunately I don’t know whether the children would agree, because to my knowledge, they were never asked. However, during the group sessions no one overtly expressed feeling guilty about causing the illness, or claimed that anyone blamed them for the illness and problems. Interestingly, Mark wanted to know more about mental illness to protect his ill father from being the family scapegoat. By translating what he had come to understand about his father’s illness he hoped to influence other members of his family so that they would stop blaming him for family problems by attributing them more appropriately to the illness.

Learning because “knowledge is power”

Because the imperative to educate children is an important objective of the Children’s Group, and the objective is supported in the empirical literature, it seems redundant to question its significance. It may be more important to consider what “appropriate” educational content would look like. Reupert and Maybery (2009a) asked these questions in an interview-based study with adult facilitators of programs for children in Australia. The purpose was to “draw on
conventional wisdom and practice knowledge” as a starting point for other studies on this topic. Most programs they reviewed included an educational component, the few that did not tended to assume children’s lack of interest or that the material would not be engaging for young people. As I found in the Children’s Group, educational content was often described as informational because it included details about the signs and symptoms of mental illness and treatment. Some interviewees in Reupert and Maybery’s (2009a) study described teaching children how to manage feelings and deal with stigma, and access help, under the rubric of education. I analyzed Bridges to Understanding using Goffman’s (1959) concept of a working consensus, that is, a collective agreement about mental illness (and health), to argue that the educational and support content together constituted a single objective to teach mental illness in order to help children to learn to express their feelings about it. The division in the Children’s Group between Education content (sessions 1-4), and Support content (5-8) was organizationally useful for managing the group, but education seemed instrumentally useful as a means to “get to” more important aspects of the support component. Martha explained to me that they reversed the order of the sessions not long before my study because they felt that children would open up more about their personal experiences once they had some basic mental health information.

Most intriguingly for my purposes here, was a particular theme in a report by Reupert and Maybery (2009a) that explained a common rationale for educating children, which was expressed as: “knowledge is power”. This phrase referred to the kinds of educational goals espoused by the program facilitators, similar in many respects to those of the Children’s Group. The main rationale for including an educational component was the belief that knowledge would “empower” children by helping them understand and make sense of their experiences, by learning about the illness (and developing “realistic”, “positive” ways of thinking about it) (Reupert & Maybery, 2009a).

Amy used the phrase—“knowledge is power”—at the end of a long sequence of interaction, in which the children struggled to describe a hopeful, imagined future for themselves. Children seemed confused about whether they were supposed to think about themselves or their parent when talking about the future. Augusto was frustrated trying to convince Martha that he was being compliant with group rules that talk must be “about mental illness” when he advised other children to be careful about bullying. The children seemed dispassionate when they tried to send an encouraging message to children outside the group who

56 A “snapshot” of Australian programs is described in a paper by the same author team, which I draw on in my literature review (see Reupert & Maybery, 2009a).
might find themselves “in the same boat”, resorting mostly to platitudes like, “don’t worry” and “don’t give up hope”. Amy herself seemed caught up in the struggle to define a good future, concluding this uneasy sequence of dialogue with a tone of resignation when she said, “The child with a parent with a mental illness. It’s not an easy question”. Amy probably revealed more than she intended to, and she quickly tried to recover her responsibilities to the group by urging them to remember a well-established group rule: “Remember, they say knowledge is power, so don’t forget about the 4C’s”\(^\text{57}\) (session 7). Amy effectively linked knowledge/power to group rules in order to make things better, and to suggest something hopeful. Knowledge is power because by remembering and enacting rules about what they are responsible for, children should be able to trump the kind of indecision, complexity, confusion and even uncertainty about the future that was demonstrated in this sequence—understanding they can control only how “their story would go”. However it struck me that the rules may have been just as reassuring for Amy, who as an adult facilitating the program, was also responsible for managing or controlling the group. This included being accountable for reinforcing program rules or standards that supported the working consensus (Goffman, 1959), reflected in discursive formulations about mental health/illness and being a child of a mentally ill parent.

**Learning ways of talking about mental illness**

Education is described as having the power to “give young people a language” to talk about and explain their experiences, and articulate their needs and feelings (Reupert & Maybery, 2009a). This made me think about the ideological premise behind a commonplace phrase, “to have (or give) someone a voice”. The umbrella organization that supported the *Children’s Group* promoted principles of mental health promotion based on “families’ hav(ing) a voice in the community”. Particular emphasis was put on learning the “right” language in the *Children’s Group* so that there was a correct and most probably a universally acceptable way to talk about mental illness, and an obligation to use the specific words. From the beginning of the *Children’s Group* the participants were taught to use medicalized language to identify mental illness as an illness “like any other”. This was a way of learning to identify with one another by repeating the phrase: “We are all here because we have a parent with a mental illness” (used at various points in sessions 1-8). This phrase worked dramaturgically to convey specific meanings by framing the rationale for the group in a particular way, controlling how this was expressed so that it

\(^{57}\) As a reminder, the 4 C’s stipulate that children did not cause it, and they cannot cure it or control it, but they can cope with it.
incorporated certain accredited values—and as I argued in my analysis of the script, these values included knowledge and beliefs constructed (a form of accreditation) by current ways of thinking about certain kinds of problems in terms of mental health and illness. Language is powerful because it performs something meaningful, and not just as a simple, transparent or even neutral medium for conveying or teaching basic information (O'Connor & Payne, 2006). For example, by repeating this phrase—*we are all here because we have a parent with a mental illness*—the participants of the *Children’s Group* were taught to use medicalized language, to talk about their common experiences of parental mental illness in the “right” way.

In contrast, children were taught that there were “wrong” ways to talk about mental illness and these were mostly stigmatizing and discriminatory concepts used by others, who were afraid or ignorant of what mental illness “really is”. Because they had been educated to know better, they were asked to participate in a ritual during the final session where “myths about mental illness”, represented by “brown words” literally written out on brown pieces of paper, were ceremoniously torn up and placed on top of a diagram of a broken brain (a concept strongly associated with “mental illness” discourse). These words were replaced by new ones, “appropriate” ways to explain and talk about mental illness as they learned during the previous eight sessions. Consequently, in conjunction with more explicit and direct attempts to teach children “correct” mental health information, they were also given “this language”—not just “a” language—to explain, and talk about their experiences, and to articulate their needs and feelings, but in particular ways. By instructing the children to verbally acknowledge mental illness as the reason for attending the *Children’s Group*, they were initiated into a collective understanding about their individual circumstances, and asked to develop a mutually agreed upon way to interpret and give meaning to their experiences. This understanding was made intelligible by calling upon specific images and constructing concepts to explain their circumstances, but only in particular ways—they are now a “we” because they are “not alone”, they face similar challenges; and they are a “team” who can face these challenges, first by overcoming inappropriate and inaccurate ways of thinking and talking about mental illness, but most importantly, by recognizing that they are “all in the same boat”.

The children negotiated and also resisted other people’s attempts to define their situation, but in ways that didn’t necessarily contradict or even deny the assertion that they were “all in the same boat”. For example some participants in the *Children’s Group* tried to negotiate how they were expected to use medicalized language, or they resisted the language altogether as an adequate explanation for their own experiences. This was particularly evident when children’s
perspectives didn’t easily align with others’ interpretations. For example, I have already described how Michele struggled with the facilitators to define her mother’s challenging behaviours in ways that better explained her behaviours as “threatening” because this was how she was affected by them. Similarly, Colin and Eliot much preferred Mark’s imaginary book title, “Why is My Parent Different?” to other suggestions, including those that used “illness” terminology. It appeared to me that children preferred to interpret and label parents’ behaviours according to the impact these behaviours had had on their own lives. When Colin and Eliot chose “different” as a less medicalized way to talk about their mother, the real difficulty they seemed to be signalling was that problems were not necessarily explained by illness but by those circumstances that marked the parent—and probably the child and/or the family as well—as not like others. Fjone and colleagues (2009) described the stages in which children realized their parents were different from other parents. Although children reported never being medically informed about the parent’s situation they were able to describe an “awakening process” in which they realized something was comparatively different about their lives and they used this knowledge to try to mitigate the consequences of being different (p. 467).

**Humour: a strategy for managing group expectations**

Children used humour as a specific strategy to manage being identified and classified as being “all in the same boat,” in their response to the script, and in the way they put on a show in response to the one given by the facilitators. According to Goffman (1959) performers require strategies for demonstrating loyalty and exercising discipline so that they can successfully stage such a show. Loyalty or solidarity is fostered when performers recognize and accept that they have a moral obligation to each other. Team members exercise discipline by expressing things responsibly, to maintain what Goffman (1959) described as the “affective line” and “expressive status quo” of a performance. So for example, performers must learn to trust one another by laughing only at matters that aren’t considered serious. However, laughter does not always indicate whether a matter is serious or not, and humour can be a useful strategy for maintaining emotional and expressive equilibrium. Although humour is under-theorized in Goffman’s work (Paolucci & Richardson, 2006), an interesting comparison can be made with his notion of the manner in which “disguises” function to reveal more than they actually hide (Goffman, 1959). This is particularly so when interactive settings are expected to be orderly—“humour as a metaphorical, symbolic, paradoxical construction is capable of conveying powerful messages. In this sense, humour in interaction means more than what it says.” (emphasis in the original, Fine,
Furthermore, “everyday forms of communication such as anecdotes, jokes, loose word association may tell us much, if not more, about what people know” (Kitzinger, 1994, p. 109). Goffman (in Branaman, 1997) used the term ‘subversive irony’ to describe situations in which the expression of feeling must be sufficiently disguised to ensure its regulation in face-to-face encounters. As Goffman (1959) argues, the rules governing such interaction often allow difficulties to be expressed strategically rather than excluding communication altogether:

Given the dangers of expression, a disguise may function not so much as a way of concealing something, but as way of revealing what may be tolerated in an encounter. We fence our encounters in with gates; the very means by which we hold off part of reality can be the means by which we can bear introducing it. (emphasis added, p. 136).

Humour has been singled out as a particular kind of strategy for managing challenging situations and difficult emotions (Fine, 1984). It is distinctive from other forms of “serious” interaction because it calls for “an immediate response from others”, and contains meaning that may not be obvious, the implications of which can be denied without the speaker losing face (Fine, 1984, p. 84). Humour allows for the communication of otherwise inappropriate or even taboo ideas. It can be useful in situations that are dramaturgically stressful, particularly if performers are challenged to keep up appearances that are inconsistent with what they may be feeling (Freund et al., 2003). Moreover, as a special kind of emotive strategy that is intentionally used to foster certain kinds of impressions, it is also a form of power. “Jokes, teasing, sarcasm, and other forms of humour work to construct meaning, often by categorizing and labelling people or situations. Although seemingly playful, humorous interactions also carry weighty messages about what is expected from oneself and others” (Hollander & Gordon, 2006, p. 194).

The implicit meaning of a joke is comprehensible because of the context in which it is embedded and comprehended. Fine and DeSoucey (2005) argue that because group joking is embedded, interactive and referential it has power within the group context (p. 1). Humour was a useful strategy in the Children’s Group because participants recognized and used “cultural” references that were part of what they “knew”, about being a child of a mentally ill parent amongst other things, even though they did not know each other prior to attending the program. The Children’s Group could be said to form the basis for developing a kind of “joking culture”—that is a recognizable group of people who are aware of each other’s co-presence and social identity (Fine & De Soucey, 2005). Elements of a joking culture serve to smooth group interaction, share affiliation, separate the group from outsiders, and secure the compliance of group members through social control (Fine & De Soucey, 2005, p. 1). I discuss how humour
was used by the children to identify with each other and make claims on one another without saying anything too explicit. While humour revealed some of the dense layers of meaning about what it meant to be “all in the same boat”, it also allowed children to exert some control over being positioned this way by challenging assumptions behind this classification. In group contexts humour is useful for maintaining solidarity, navigating management strategies, and negotiating power (Wilkinson, Rees, & Knight, 2007).

**Language negotiations: “Why can’t they call it manic happiness…”?**

The opening sequences of the Children’s Group performance, and especially the “education sessions” (1-4), were described by Martha as “like school, but not school”. So there was some ambivalence about whether or not she expected this setting to be orderly and adult-led and controlled, like school. But the children would have been “schooled” or disciplined to expect certain things in settings where adults are the teachers. I noticed that in these sessions children were the most disruptive. However, they managed this with humour, particularly in their emotional responses. By doing so, the children constructed their own meanings, using irony or simple jokes to “hold off reality” as Goffman (1959) says, while simultaneously introducing some of their own challenging ideas. This occurred at the very beginning of the performance when Marthe asked her first rhetorical question about why they were asked to attend the group and Eliot responded, “to bake a chocolate cake”. I argued that this helped Eliot avoid revealing what he thought and felt about coming to the group. It showed the others that he may have had his suspicions about the group and its’ agenda, and this allowed everyone to question Marthe’s motives. The children had to understand what was (not) being said, at least enough so that they “got” the incongruity of Eliot’s remark in response to Marthe. They had to draw on their own insight about what he meant. I think they demonstrated this insider knowledge when they agreed with him, letting everyone in the group know they understood by snickering in response. It disrupted Marthe’s script momentarily, and introduced ideas that could not be said more seriously—unlike *baking a chocolate cake*, attending the group (which most of them had not chosen), and especially talking about the “real” reason they were there, may not have been something so innocuous, easy or desirable to do and the outcome might not be something that they were looking forward to either.

As a form of ‘subversive irony’ (Goffman, 1959), the response allowed Eliot to manipulate the situation, signalling something of his thoughts and feelings, perhaps also what he expected or hoped the other participants would think and feel too. But he could do this without
risking exposure for expressing potentially difficult or even inappropriate thoughts and feelings explicitly—about being in the *Children’s Group*, or having a parent with a mental illness. It allowed Eliot to subtly acquiesce that there was a real, and perhaps more dangerous-to-speak-about and emotionally charged reason that they were in the group, but only by appearing to hold off the “reality” of these ideas could he allow them to be subtly introduced. If Eliot hadn’t received a good response from his team-mates, or he was directly challenged by the facilitators, he could have retreated from the implications of what he was saying—because, he was only joking. I believe that Eliot’s response actually created the conditions for the group to begin to act together, because when they laughed along with him, there was a sense that they were acknowledging something familiar that they had in common in the things that were not said. Their response was a kind of initial commitment to each other. It was as if they were accepting what Goffman (1959) described as a necessary moral obligation performers must have for one another, to keep “team secrets” by expressing things discreetly, and not staging their own individual show. It was a way of managing the “affective line”, at least at this early stage of the performance. In contrast, Augusto’s attempt to do the same as Eliot, to take some control over the performance and align himself with the children by confronting Martha directly (about when they would eat) was not successful. His actions were too concrete; he had nothing to hide behind like Eliot’s joke. Martha could point to the agenda, showing him that there were expectations about how things would go, and they were written down—in essence, a truncated version of the script. Augusto acknowledged his failure by retreating into his clothes and slouching in his chair, his bodily comportment suggesting that he wanted to escape the situation.

Moments later, Martha introduced a game where they were expected to reveal something about themselves to get to know one another and to begin to identify more strongly with each other, but brothers Colin and Eliot interrupted the sequence. Colin jokingly asked if they were going to have a “food fight”, and Eliot said sarcastically, “if this is an educational game…I’m running for the door” (session 1). Martha’s response was to take him seriously saying that “no, this is supposed to be fun”. Eliot’s joke though less subtle than his opening salvo about “baking a chocolate cake”, could be interpreted as a suggestion that education was probably boring and something to escape from, but only by bolting because they had little choice or control over the matter. It seemed that Eliot was intent on communicating a concern on both counts that nothing about this experience looked as if it was going to be much fun. When Martha and Amy suddenly shifted the discussion in the middle of this “identity” game from more banal talk about everyday descriptions of themselves, to a confessional about why being in this group made them special or
Colin’s response was to ask rhetorically, “Why can’t they call it manic happiness instead of manic depression?” He smiled to himself as if in response to his own joke, which is why I thought he was being rhetorical. Colin revealed something more about himself in that he knew the correct terminology and this enabled him to make his joke because he had to have a fairly sophisticated understanding of bipolar disorder as a psychiatric category referring to behaviours as “mania” and “depression”. More importantly though, it allowed him to question how language is used to categorize behaviours by making fun of the grim emphasis of medical labels.

Individual group members were encouraged to see that they had things in common, and as the children participated in activities that symbolized a shared identity, specific games and props were used to support and reinforce this idea. This was important to establish early in the group, not the least because children were expected to be angry, resentful and resistant to attending the group. Their shared identity was supposed to override difficult feelings by establishing connections and relationships amongst group members who were expected to see their predicament as “the same”. The power of the phrase “we are all in the same boat” was that it made claims on individual participants to see that they were “not alone” and that they belonged in the group, and also to each other. From a dramaturgical perspective the actual drawing of the boat and the activity in which they named what they had in common supported a more implicit idea about what belonging meant, including a willingness to agree that they faced similar challenges, but that with a bit of cooperation they could learn to work together (in this group), as disciplined players who would learn to successfully manage their problems. At the time I hadn’t noticed that Colin (re)inscribed the picture of the “boat” with his own words, “the Titanic”. He also added a lifeboat to the picture. But it seemed that he had tagged or marked the picture with these words to suggest that simply “not being alone” might not be enough to help, if in fact the boat they were in was headed for disaster, and few of those on board would be saved even though there was a lifeboat.

As Goffman (1959) may have argued, Colin managed to hold off “reality”, that is questioning whether the children’s situation was really hopeless—despite the potential benefit that was supposed to be conveyed by the image of being “all in the same boat” —at the same time his words about “the Titanic” allowed him to introduce this very idea. His addition of a lifeboat to the picture may have signalled the possibility of escape (from the support group, or the situation more broadly), or underscored the hopelessness of a situation that might not be saved despite the promising image. To my knowledge no one noticed or commented on these
additional details, which made me think of his (re)inscription of the boat as a type of “graffiti”. Graffiti is often considered to be a random act of defacement, and particularly so if we think of the serious intent behind the construction of the “all in the same boat” image, but it is also a subversive way of communicating a more political message about a serious subject (Rahn, 2002). Graffiti is a way of tagging or marking territory to signify group (and more often “gang”) membership. I believe that these interpretations provide potentially different ways of thinking about what Colin’s words allowed him to do even if it was completely unintentional and he was unaware of these possibilities. By marking the illustration I could argue that he claimed this territory of being identified as “all in the same boat” for his own. He added his critique to those things that Martha directed them to include as a way of identifying with each other. It was humorous, and subversive, and because of this, it enabled Colin to “talk” about an emotionally difficult idea that might not be easy to do in a more “serious” conversation. Although it allowed him a degree of power over being defined solely by Martha’s directive, he didn’t have to challenge her directly. Because none of the players knew each other very well at this early stage of the performance, this statement could be said to speak for itself, without confronting anyone in particular, or demanding a response from the other participants.

Although I can’t determine what responses this (re)inscription would have garnered from other participants because no one acknowledged it, Colin seemed to be questioning what it might mean to be cast as being “all in the same boat”, and perhaps more practically, what being in the Children’s Group was going to require. Thinking back to this early incident Colin’s image seemed powerful too because by the end of the eighth session he told me that through the group he had come to accept his mother as having a mental illness. Colin wasn’t convinced so much by the educational information or the medicalized language he was taught but by his sense of belonging to the group. Belonging helped him identify with mental illness as a reasonable explanation for the issues his family had encountered. As he said to me during our group discussion on the last night of the program, “I didn’t know there were so many kids like us…like me”—although he was still resisting using medicalized language and preferred to speak about his mother’s “problems” rather than “illness”.

**Questioning explanations: “Is it all [just] in their heads…?”**

Children responded to, and made choices about, whether or not the mental health/illness information actually explained things in a way they found helpful and/or satisfying. But rather than questioning explanations directly, they relied on humour to help them “mean more” than
they could actually say. For example, Colin and Becky used an ironic, rhetorical tone to ask Martha questions about the way she explained mental illness as faulty thinking. Through their questions they effectively reworked Martha’s neurotransmitter demonstration by suggesting that the car representing “thoughts” that can’t make it across the bridge (analogous to the brain) might be rescued, or that total disaster might ensue in cases where the bridge itself collapsed completely. On one level their questions added to the general hilarity of the scene—Eliot said that faulty thoughts might be like a “lady turning into a fart” on the other side of the bridge—but I thought they helped children negotiate potential tensions because both propositions seemed to me to be reasonable, albeit alternative explanations for each of their respective situations. Colin’s mother was at an early stage of illness where the idea of rescue was a reasonable interpretation of what “happens in the brain”, but Becky had experienced parental mental illness for much longer, including very dramatic consequences for her life, so that complete breakdown of the message carrying system was not an illogical suggestion.

So while they managed to foster an impression that they were accommodating Martha’s brain/bridge analogy, Colin and Becky were actually able to question its usefulness to explain their own circumstances. Martha’s response was to see their interpretations as a problem of presentation and poor teaching, but an alternative explanation might have been that universally held, bio-medical explanations about parental behaviours were simply inadequate and what might be more important is whether or not information speaks explicitly to individual children’s experiences. This was the case when Michele was able to connect neurological processes and explanations about mental illness to her mother’s confused thinking, and Ayanna and Augusto recognized descriptions of distorted thinking that they found relevant to their own experiences of their parents’ feelings about someone “being out to get them”. These examples illustrate the difficulties and complexities involved in assessing talk about mental illness—as a way of evaluating children’s ability to recognize and be knowledgeable about it—because of the confusion between concerns about the effect of illness on the parent and/or the child, and the variety of ways children experience the illness and its sequelae. I wondered if thinking about children’s responses in this narrow bio-medical way might not also obscure the promise of a more complex understanding, and ultimately of the way we evaluate whether or not children manage their parent’s and/or their own circumstances well.

Most of the children in the Children’s Group could name some illnesses according to basic psychiatric nomenclature. The exception was schizophrenia, which children had a hard time pronouncing, although they asked on more than one occasion for a definition. And when
children did not know how to correctly label a problem, they were often able to describe
behaviours typically associated with it. This was the case even if it wasn’t something that their
parent had experienced, as for example when Colin talked rather poetically about obsessive
compulsive disorder (OCD) as: “a loop that doesn’t stop”. For the most part, children were
astute observers of parental behaviours and when asked, they had few difficulties talking about
“symptoms” (used interchangeably with behaviours in the script) and drawing pictures that
categorized behaviours, for example, as indicating the episodic nature of most illnesses, as being
well or unwell—or as “good days and bad days”. Overall, children portrayed daily life using
vivid, detailed observations, even when they lacked biomedical language. I observed at the time
that they were much more accommodating to being asked to talk about their parent’s
symptoms/difficult behaviours because there were fewer incidences where they teased Martha
and tried to get her to go off script, or joked with one another and just generally disrupted the
formal agenda. For the most part, they seemed to require fewer interactional strategies to
manage challenging subject matter and negative feelings. This may have been because they felt
more competent talking openly and therefore “seriously”, about parental behaviours as
symptoms—and because this occurred later in the performance they may have come to accept
their status, and one another’s, as persons-in-the-know.

An exception to the relatively smooth interaction that characterized the performance at
this point occurred when Mark introduced his “fractional strategy”, initially to resist Martha’s
request to personally identify with certain symptoms on the “Symptom List”. But the activity
gathered momentum as the children made a joke of quantifying “how much” they were willing
to identify with individual parental behaviours, they eventually accommodated Martha’s request
becoming quite engrossed in this aspect of the performance. I assumed at the time that they were
carried away by showing off for each other, but Martha had a more program-focused
interpretation. She thought their engrossment was because they recognized some symptoms as
more relevant to their own experience. And this explanation may have been accurate as
evidenced by my group discussion with the children on the last night of the group. Mark
reminded Michele that although he agreed that it was good to talk to “kids like them”—who
were similar ages and understood “what they were going through”—she shouldn’t assume that
this meant they shared all the same experiences. As Mark pointed out, he had only been “a
half”, in response to one of the symptoms everyone else had related to on the list. Initially I
assumed that Mark quantified “recognition” as a strategy to retain some control over divulging
personal information. The children’s laughter and the gamesmanship that the strategy provoked
also seemed to contribute to the orderly, ongoing interaction as the scene unfolded. But the strategy also helped Mark resist being categorized by others. It was as if he was implicitly critiquing who gets to decide what it might mean to be identified as being “all in the same boat”. It was a clever strategy that allowed him to question or even deny some aspect of belonging, which at this stage of the performance may have been awkward to do. It may have been interpreted as a form of disloyalty to the team, especially after so much effort and activity had been directed toward establishing common ground and the idea that they could claim a shared identity. Because the strategy Mark used was humorous, it allowed him to express his thoughts and feelings indirectly, without challenging or being called to account by other participants. However, I observed that Michele seemed to interpret his comments as a reluctance to be fully committed to the group, and she tried to reconcile this breach by arguing that any differences between them were only a matter of semantics. She said that although the participants may not have “agreed with everything” everyone said, they often agreed with what was “the same category”. I thought she was reminding Mark that he belonged; therefore he had a moral obligation to the rest of the team.

In previous studies children were often depicted as only understanding “part of the story” (Mordoch, 2010; Mordoch & Hall, 2008) when they did not recognize symptoms as illness, or had inaccurate ideas about their experiences such as thinking that hospitalization meant that a parent was dying (see also, Garley et al., 1997). I had the impression that whether or not the participants in my study had the “full” story, they experienced a kind of resignation, even pessimism, towards the kinds of things their parents did when they were ill. I sensed world-weariness in their responses as when Mark, frustrated by a discussion of “good days/bad days” to explain parental behaviours, dismissed “broken brain talk” as “all (just) in their heads”. I read his commentary as ironic and thought it allowed him to communicate feelings of frustration, and possibly resignation, but without having to say much more or to challenge Martha’s biomedical explanations as “just” making excuses for bad parental behaviours. I had a similar impression of Augusto’s summary of unpredictability when he said, “You never know what they are going to do next”. Martha thought that children’s resignation signified a lack of appropriate recognition of problems, and a normalization process in which children had learned to accept what was unacceptable about parents’ behaviours. In other words, resignation and normalization were problems because children had adopted unacceptable ways of thinking about and responding to circumstances that required change. I wondered whether their responses might be interpreted differently, challenging how we expect them to respond to problems that may not be adequately
addressed by current psycho-educational efforts and especially by those that target the child and not necessarily external circumstances for change.

It wasn’t easy to reconcile the confusion and contradiction inherent in explanations about mental illness as being “in their heads”, which teachings about “broken brains” underscored, with those that attributed the causes of bad behaviour to a failure to cope well with the stressful circumstances of everyday life—hence an inconsistency in explanations that may have led some children to question whether mental illness was in fact, only in their heads. The facilitators tried to foster empathy by explaining what it is like to experience unhealthy or distorted thinking and its affect on behaviour by “acting as if” for example, a hallucination was real and what it was like to have a “bad day”. They tried to introduce humour into the performance but overall the tactic didn’t seem very successful in terms of creating insight or helping the children come to an agreement about how they should interpret or give meaning to illness-related behaviours. Eliot found the “acting” excruciating to watch. The scenario reminded him that his “bad day” involved homework, still waiting for him to complete at the end of the night after the group was finished. This seemed to create more stress while doing little to help him feel control over his own negative thoughts and feelings, which ironically was the point of the exercise, to help him practice what it is like to think positively and be “mentally healthy”. It probably quashed any tolerance or sympathy that may have been created by the momentary glimpse they did seem to experience into what it might be like to mistake sand in your pockets, for bugs, or to think everyone is talking about you. Colin was still confused toward the end of the sessions because he couldn’t reconcile whether his mother’s behaviours were the result of symptoms that were “real”, or “just a metaphor” like those described by a character in a film they had been watching. Colin’s struggle was not unusual, people experiencing symptoms of mental illness have described how difficult it is to distinguish what they hear or see as symptoms of illness, and accept them as something that wasn’t “real”.

**ii. All in the same boat: managing “how my story will go”**

**[Mis]managing talk about “getting it”**

So far I have discussed the performance more in terms of how participants talked about mental illness; here I want to consider how they responded to being taught how to better manage their circumstances. They had to first demonstrate that they were willing to express their feelings about being a child of a mentally ill parent, which began with talk about being “at risk” for developing a mental illness although this was not said explicitly. Participants’ knowledge
about risk was limited, although talk about “getting it”—the language preferred by the facilitators and the children—was significant. It was a turning point in the performance that shifted talk about illness to talk about prevention and health, and from difficult parental behaviours to those that would be protective for children. For example, the script incorporated biomedical and (mental) health promotion discourses, to argue that while anybody can “get it” regardless of gender, age, culture and so on (genetic risk notwithstanding), not everybody does, provided the appropriate measures are taken to prevent it. Martha’s talk about risk was vague and sometimes confusing and difficult to reconcile as when she talked about the physical causes of mental illness as “something wrong with your body”, but also the social causes as “something that happens in your life”. Talk about “getting it” seemed to be on some children’s minds, although they asked about it in a roundabout way and struggled with Martha and Amy over this aspect of the agenda. I thought that Colin responded to this struggle indirectly by questioning Martha’s control over the script itself. He insisted that the agenda was meaningless without specific times to indicate how things were expected to go and used it to needle her about always running out of time and being behind schedule. Colin’s pantomime reading of Martha’s program notes at the end of a long, chaotic sequence of dialogue about causes and “getting it” was the first time anyone had confronted the idea that there was a script. The other participants laughed in response, which allowed them to join Colin in questioning expectations about who controlled the agenda without having to express this directly.

Children asked about risk without “risking” explicit exposure; they asked questions anonymously using the “question box”, and they also asked more vaguely about whether it was possible to be “super healthy”, or “young”, and still have a mental illness. The questions were spread out across sessions so that it seemed to me that it was an on-going, unanswered (or maybe even an unanswerable) concern. Mark was obviously happy about Martha’s optimistic message regarding heritability factors—he seemed to typify her argument that “kids know they need to know” risk information. But Colin was less convinced by the way Martha managed the numbers to suggest they should not worry about risk, prodding her with a sarcastic, “What are you trying to do—scare us?” Colin’s question was meant to challenge Martha’s script, not Mark’s response. But this time, the only reaction to his humorous provocation was Amy’s serious response to quickly suppress a potentially dangerous shift in the conversation (including letting the question hang not-so-silently in the air) by giving them another positive message that they could still live successfully even if they did develop a mental illness themselves. Talking about risk proved not to be easy to manage, despite the presence of a script. Most of the children
continued to be reluctant to talk openly about it, and the facilitators were unable or unwilling to allow a more open discussion to take place—one that may have addressed Colin’s question about being scared more directly.

**Managing relationships, managing my/self**

Children reported many positive aspects of their relationships with their parents, not unlike children in other similar studies (see for e.g., Ahlström et al., 2007, 2009; Mordoch & Hall, 2008). However children in my study rarely asked for concrete, practical advice and information about how to manage aside from some basic questions. For example, they wanted to know how people “get sick”; what happens when parents don’t think they need to see a doctor; and whether being happy all day still counted (as being ill). Underlying some of the *Children’s Group* interaction was a tension I have alluded to, which was that children wanted to know more so that they could help their parents. Mark described teaching his mother and sister about what he was learning in order to protect his father because he thought that once other family members understood more they would stop “making things worse for him” (session 8, group discussion). However, Mark was described by the facilitators as a “parentified child” based on background information shared during an intake meeting prior to the first session of the *Children’s Group*. He was referred to the program by a family member who was also a mental health professional, and who wanted him to have “space of his own, and see that he did not always need to be taking care of his family”. However, when Colin asked Mark whether it wasn’t “more sensible” to stay with his father when he was ill, Amy interjected to remind everyone about the rule that they could not control outcomes other than learning to “cope with it”. This was because a more encompassing objective was to teach children that “mentally healthy” children could manage only how their own—not their parent’s—“story would go”.

I thought that Colin’s question revealed his own worries about what it might mean to abandon an ill parent. He had been referred to the program for similar reasons to Mark, because his father “wanted him to know that it wasn’t his responsibility to take care of his mother and to make things better”. The predicament both boys faced made me think about beliefs concerning how mentally ill people should be cared for because unlike other illnesses, people are rarely asked to abandon those who are ill. The literature speaks to children’s anxieties about what will happen to a parent when they have to go to school, or can’t be present to “watch over” a mother or father—however, “making things better” usually involves emotional care rather than care for the body. I wondered whether the discursive “rules” for caring about family members who are
mentally ill are different from those for other illnesses, or if expectations about care were
different because the family member in these cases were children. I also thought that children’s
worries might be understood on a larger scale than that of an individual child/parent relationship.
For example, I wondered if children felt that they were being asked to forsake their parents when
urged to learn to manage only their own lives. I was concerned about how they dealt with this at
the same time that most seemed to express a desire to remain deeply connected with their
parents. I thought that this might help to explain why Ayanna seemed to feel she had to
apologize for feeling that she “still loved her mom”. Participants in Mordoch and Hall’s (2008)
study described how they negotiated this tension using different strategies to “preserve
themselves” while trying to “stay connected” (to their parents) (p. 1127). For example, they
“monitored” parental behaviours and then “adjusted” their own in response (p.1131). Adjusting
their responses was probably another way of talking about how children coped with or managed
the situation. While the Children’s Group did not explicitly address this tension between
wanting to stay connected with the parent, while also taking care of themselves, the educational
and support activities were weighted heavily toward reframing children’s experiences so that
“preserving themselves” became integral to thinking about a protective and less “risky” future.
The Children’s Group was organized to fulfill a primary function of support groups, which is to
help participants manage stressful circumstances by reinterpreting or reframing how they feel
and think about them, for example, by invoking positive thoughts and emotions (Bar-Lev, 2008;
Francis, 1997). This posed a dilemma for children who were instructed to remain “mentally”
healthy—by learning self-protection or preservation skills—and believe that a “good” future was
possible once they learned to tell a different story from that of their ill parent.

Managing difficult emotions

The Children’s Group focused primarily on fear as a dominant emotion children had to
learn to manage because of parents’ unpredictable negative behaviours. Children tended to agree
with this assessment although they had separate reasons for feeling afraid, describing a range of
concerns from worry about their parents’ physical safety, as well as their own, to being afraid of
a process of deterioration during illness and the disruption to everyday life. All the children
regardless of their differences were able to account in detail for their feelings either through
words, or their drawings. The focus on teaching children to express fear to the exclusion of most
other emotions was not surprising given that support groups usually target negative, difficult
emotions because they are considered more malleable (Francis, 1997). Addressing fear allowed
the *Children’s Group* program to emphasize the need to protect children by teaching them to be, and feel safe. The first step was recognizing parental behaviours as abnormal. In the empirical literature children’s misrecognition was considered a risk factor because children needed to see that some parental behaviours were unacceptable, although as I said earlier, all the participants in my study easily described such behaviours.

I found that each participant interpreted and gave meaning and expression to their feelings about parental behaviours differently. Mark used his “fractional strategy” to demonstrate that he responded to talk about symptoms in his own way and as a basis for rejecting Michele’s assertion that they should all be categorized as *exactly the same*. Colin had a similar reaction to the discussion about fear, and more so to talking about emotional experiences more broadly. For example, in the first session Colin asked Martha whether he was supposed to respond to a question about feeling worried in relation to his mother or himself, highlighting a problem I addressed about the challenge of distinguishing between the effect of the illness on the parent, and/or the self. While Martha was surprised because no one had ever characterized feelings for her this way before, I was equally surprised as it seemed to permeate my data. Colin was also intent on clarifying what being afraid meant to him by talking about and drawing a picture of the “process of illness”. And his description although particular to his story, did remind me of Mark’s drawing. Both boys described fear as a social process of deterioration at the individual and family level. Others described scenarios that involved violent images, a seemingly taboo or inappropriate subject that Amy made particular efforts to suppress by saying such accounts were either “fictional” because of media misinformation, and/or claiming a lack of statistical evidence to back this up. This was problematic for children like Becky who did express fear about violent aspects of her experience of her mother’s illness behaviours.

I interpreted Augusto’s aside about unpredictable behaviours in which he said, “You never know when they are going to do something”, as an indirect intervention in the argument between brothers, Colin and Eliot, concerning the seriousness of their mother’s suicidal threat. I interpreted his tone of voice and words as signifying resignation, and I wondered whether Martha was right that Augusto was “normalizing” such behaviours. The concern is that children must be able to recognize their parents’ behaviours as a consequence of illness, and as abnormal

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58 I observed a meeting with the facilitators and program co-coordinator to discuss recommendations made to those who referred children to the program. I wanted to note here that Becky’s situation was taken seriously—albeit “backstage” for the most part. They felt that Becky had good safety knowledge because she knew to “have a bag packed” and to “go to a teacher for help”, and recommended the family further develop an individual safety plan. Perhaps most importantly, they ensured Becky received one-to-one counseling help through referral to a regional children’s mental health centre and follow-up to make sure she received services and was not wait-listed.
and unacceptable, so that they can recognize their own need for help. However, another interpretation may have been that children “normalize” their responses because they become used to difficult experiences and adopt this stance in order to negotiate their everyday lives the best way that they can. I thought Augusto’s comment might be seen as simply being realistic about the relevance of the motivation for such behaviours, as if to say that the only thing they could ever be certain of was that unpredictability was predictable. Eliot said something similar when they were talking about statistical risks and he concluded, “You pretty much have a fifty/fifty chance of anything happening to you”. From this perspective beliefs about risk or danger and unpredictability support a pervasive theme about what it is like to experience parental mental illness. However, by appearing blasé or resigned it made it difficult to know whether or not a child needed help—depending to some degree on whether their statements are framed for example as a problem of “normalization”, or as a “realistic” response to circumstances they feel can’t be changed.

Mark and Michele described the group as a “safe place” to talk because others understood what the experience of parental mental illness was like, and Colin became a little more convinced that he belonged as someone “in the same boat” when he realized that “all of us has had divorces”. However, sticking together was a viable strategy for avoiding saying too much in response to Martha’s question about what it was like to talk about fear. By drawing on the idea that they have things in common, the children acted protectively, staying together and avoiding what they learned in previous sessions, which was that expressing negative, individual emotions could be dangerous, creating anxiety also for adults who suppressed such talk. I described this suppression as a way the adults managed their own feelings about the subject. So that although Martha asked the children what it was like to talk about fear, it was actually a conversation between the adult facilitators after the session with the children was over that revealed more in response to this question—specifically that they felt vulnerable when asking about children’s difficult emotions. Because this was backstage talk the facilitators did not have to keep up appearances; they didn’t risk looking like they were being disloyal to each other—they were “sticking” together too—, and could express concerns without worrying about being responsible for children present in the room. As Goffman (1959) argues, they could step out of character, and talk more frankly about their own reactions to what it feels like when children talk about fear. This was a safer and more protected space in which they could risk exposing their own vulnerabilities that included feeling worried and responsible for the children but also perhaps, that their own responses were inappropriate. However, even here the talk was
challenging and sometimes confusing, and there was contention between Martha and Amy over a number of issues. Hargreaves and colleagues (2008) have described one of the potential risks of programs like the Children’s Group is that they expose participants to disturbing information about mental illness from others in the group—although in that study the authors were referring to other children and not the adult facilitators.

*Managing being “safe”: “it takes seven adults to listen to a child”*

Martha invoked two rules about neutrality to help adults observe children talking about negative emotions which I paraphrase here as: 1. do not qualify emotional expression because there are “no worst fears, its all pretty awful”; and, 2. do not recognize individual emotional expression at the expense of the group so that everyone feels respected and believes that their story is important. However, it seemed to me that these rules were a strategy for managing how adults expressed their emotional responses to what they heard in the group and how they managed difficult interactions (session 5, reflexive notes). By saying that all fear had to be approached as if it was “the same”, and all children’s stories were considered equally valid, the concept that children were “all in the same boat” was reinforced. These rules had the added advantage of smoothing interactions that might become unpredictable or out-of-control because they were too individualized or because the expressions of fear were too differentiated from the rest of the group. The other difficulty for adults listening to children talk about fear was to consider to what extent “just” talking (and listening) was good enough, and at which point doing more to “fix” things was desirable, doable and/or necessary. This was complicated by descriptions of fear that ranged from explicitly dangerous situations and concerns for physical safety, to more ambiguous but “real” anxiety about the unpredictability of daily life. Martha was confident that children valued talking, and she used Mark’s comments as evidence of her beliefs. Mark had invoked the idea that because they were “all in the same boat” they understood one another better and that this made talking about their problems much safer compared to discussing issues with friends outside the group. Because Mark’s comments vindicated Martha’s faith in the importance of witnessing children’s difficult stories she made them more consequential as compared to statistical evidence, the opinions of mental health professionals and the teachings of other support groups that she felt failed to deal adequately with emotions because they did not “talk about them”.

The Children’s Group was created to be a safe place for the expression of difficult thoughts and feelings, so that once children were able to identify these they could take the next
step in planning how to manage them. The goal of the first session was “to create an atmosphere where members can feel comfortable talking about mental illness” (session 1). Toward the end of the sessions I had the impression that this was like preparing the children to take some of the performance practices and exercises they had accomplished to a new level by learning how to act like circumspect performers who would know what to do outside the group. This way they could take responsibility for tackling unseen events themselves by continuing to talk and speak up outside the confines of the group. This was especially important because to be safe they needed to be able to express difficulties so that they could access help. The empirical literature supports this concern about the difficulty of speaking up, which was expressed by Eliot when he described worrying about betraying the family because it was like “ratting out”. And Augusto, who talked about being in a bind because speaking up can make children mad at themselves, feeling that they are either hurting the parent if they do, or themselves, when they don’t. But “speaking up” is still the primary method the Children’s Group promotes to help children feel safe and access help. In the sixth session the children were given laminated wallet-sized cards with local emergency and health and social service contact numbers including a telephone number for the Kids Help-Line. They discussed potentially “safe” adults they could approach for help such as extended family members and/or teachers and others who are part of their local community. The creation of more specific, concrete “crisis” or safety plans, which most programs for children concentrate on developing (see for example, Riebschleger et al., 2009) were not considered realistic. Martha listed several reasons for this including family rules that curtail children’s abilities to act on their own behalf, and children’s responsibilities for siblings and/or the ill parent that prevent them from helping themselves. Martha felt that concrete “safety plans”, unlike those that help children learn to help themselves by speaking up, often do more to assuage adults concerns about child protection than actually protect children.

A great deal of emphasis was placed on convincing the children that they could gauge an adult’s trustworthiness by listening to their own bodies. Getting things out in the open, or purging feelings by expressing them were important strategies children learned in combination with “listening” to physical signals to help them know whether persons and places are safe. But once learned, there were rules about appropriate persons to whom children could talk outside the Children’s Group. For example, even though Mark seemed less worried (than Augusto or Eliot) about the problem of speaking up, because he saw it as a way to help his father, Martha made sure he was reminded that helping his father “really” meant turning to appropriate medical interventions—and not trying to do it all by himself. The thrust of Martha’s argument seemed to
be that children can’t easily turn to adults, because most adults don’t listen. Therefore it became children’s responsibility to be persistent, to create a continuous cycle of never-ending talk at least until they were taken seriously by someone. The children were led to believe this because Martha invoked a saying that began with the words, “they say”—“it takes seven adults before they will listen to a child”—to argue that this is a rule that everyone knows and accepts as true although she gave no evidence to account for the origins of this saying.

But the children were quite frustrated by Martha’s insistence that only adults and not other children or friends were considered appropriate sources of help. As I’ve described, Colin “jokingly” refused to allow us as adults to enter his “safe place”. Most of the children followed his lead excluding us but letting other children enter their spaces. Augusto’s questions allowed participants to challenge each other’s ideas about the nature of control, or the practical logistics of being safe, and it was at this point that Colin was able to point to the adults in the room to suggest that they might be the “real” culprits when places are not safe, and not children’s faulty reasoning or lack of control and powerlessness. Indirectly, he (re)frame(d) what was expected of child/adult relationships—which in this context were a direct challenge to discourses concerning the roles adults have to protect children. This was much more implicit than I might be representing it here, because shortly thereafter Amy insisted on questioning not only whether friends are the best source of help but whether “just talking” is the same thing as “getting help”. Augusto and the other participants were never given an answer to his question about why friends “don’t count”, and they basically stopped resisting, giving the facilitators the answers they expected to hear about what it would take to make them feel safe. I thought it ironic that adults in the group did not always hear or listen to what the children were saying when children’s comments or questions were ignored, and especially when they felt so rushed to get through all of the material, the tension between facilitators became obvious and they had decided that children’s questions and anecdotes were not germane to the topic.

*Bridges to Understanding* was somewhat paradoxical in that children were expected to receive support from peers while attending the program (and to the extent that they had to learn to act as if they were a team who were “*all in the same boat*”), but not after. The literature suggests that “similar others” are the best source of interpersonal support, because they can help (re)interpret difficult experiences (Thoits, 1985), and understand and “normalize” them by helping individuals to see that they are “not alone” (Mohr, 2004). Children in my study recognized and seemed to value the support of peers. Colin and Michele told me that it was good to meet other kids “like them” because, like finding out that other “kids failed a math test”,

it helped to “take the pressure off”. They described children of similar ages and had had the same kinds of experiences as less prejudicial toward mental illnesses. They described meeting each other as one of the things they liked best about attending the group. In this respect the group was successful because children were able to shift their thinking to identify less with their parent’s illness (although inadvertently perhaps, with their parents) and more with each other. At the same time they were expected to forge a separate and independent sense of themselves, to believe that they had to manage only how “their story would go”. I wondered though how much “dramaturgical” stress participants may have experienced over conflicts between what they thought and felt about their relationships with ill parents and with friends and the discursive rules about appropriate social relations that the script indicated were more appropriate (Freund et al., 2003). Support groups for children of mentally ill parents have been described as being potentially helpful, as much because of the peer support and social inclusion they offer, as the program content that is administered (Hayman, 2009).

Children have put more emphasis on the emotionally supportive role friends play in their lives (see for e.g., Maybery et al., 2005; Meadus & Johnson, 2000; Riebschleger, 2004), and these relationships can be quite complex (Cree, 2003) because quite apart from worrying, about betraying family secrets, talking is risky because of the uncertainty of others’ responses and the fear children have of appearing different (Mordoch & Hall, 2008). Fjone and colleagues (2009) argued that while they found that children who had mentally “distressed” parents wanted to be just like other children, what was less obvious were the kinds of strategies they used to manage relationships, and especially stigma, so that they could present themselves as “normal” and “equal” amongst their peer group. Sometimes this involved identifying with people they thought of as similar others, but these were children who were “different, in a potentially devalued manner” (p. 468). Children in this study chose friends who they categorized as being similar for reasons of being “discreditable” to outsiders (Goffman, 1963). These were friends with whom I would say, they shared a kind of (team) “solidarity”, although even when they were described as “best friends”, children still controlled how much information about their circumstances they shared with others (Fjone et al., 2009). Alternatively, children participated in activities with others, especially outside the home (for e.g. in school settings), that made them seem “normal”. Most of the participants in my study described friends outside the group and talked at length about their achievements in school, and/or sporting events, which may have been a way to fit in outside the boat for children in the Children’s Group as well.
I think that the participants in my study performed well as a team and ultimately accepted the parts they had to play in the *Children’s Group*. It helped to have others with whom they could identify and being with peers contributed to a feeling that the program was a safe and supportive setting, as recommended in other studies (Fudge & Mason, 2004; Garley et al., 1997; Mordoch & Hall, 2008). It was a protected kind of space because of their similar ages and because they saw themselves as having come to a common understanding about what it meant to be a child of a mentally ill parent that made them less judgemental. Although this idea of a safe place was also contradicted by the difficulties they experienced in talking about “violent”, threatening and dangerous parental behaviours. At the same time participants worried about how to explain their circumstances to friends outside the group and they felt badly about keeping secrets from them. Elsewhere children have reported similar worries about disclosing their experiences to peers, not knowing how they will respond (Fjone et al., 2009; Fudge & Mason, 2004; Mitchell-Lowe & Eggleston, 2009). Children in my study described having to account for their whereabouts every Thursday evening when they were attending the group. The *Children’s Group* did not address this problem, even though participants considered friends an important source of support because they helped them feel a sense of belonging in settings like school, but also in times of crisis. In other studies the importance of friends in everyday life and during more critical times has been described by children (see for e.g., Fudge & Mason, 2004) and sometimes children and adults have differed as to which kinds of support are best for children (Maybery et al., 2005). Maybery and colleagues (2005) argue that programs should take children’s views into account on these kinds of matters, and caution that it may be better to “empower” them in their own lives rather than create a reliance on outside sources of support that may not always be available or accessible. To this end they recommend that programs help children maintain and develop existing social networks by encouraging supportive relationships with friends and siblings. Another rationale for encouraging children’s current relationships is a concern over the “development of a subculture in which participants see themselves as different from normal young people” (Hargreaves et al., 2008, p. 49). Being cast as “*all in the same boat*” is not without its risks depending on which “others” are defined as “similar” and therefore as sources of interpersonal support rather than potential discrimination.

*“There are so many kids like us…like me”: managing ‘our’ story*

The expectation that children have to learn to “cope with” or manage very stressful circumstances suggests that their problems are the responsibility of the individuals involved...
rather than the social and cultural context from which they arise (Freund et al., 2003). Martha interpreted Mark’s description of his father’s behaviours by saying, “It’s like he can’t change, but you can”. I found her words prescient because although she intimated that it wasn’t “right” or perhaps even fair that Mark was expected to change, it was what was expected of the participants who attended the Children’s Group. Even though Amy argued that the children’s experiences of parental mental illness was only one part of who they were—which I found reminiscent of discursive formulations about mental health as “living with illness”—it was “these” children’s risk status, rather than the more mundane aspects of everyday life, that was of central concern. This was why they were identified as “being in the same boat” and had to learn early on to repeat the phrase, “We are all here because we have a parent with a mental illness”. The Children’s Group (re)framed risk from thinking about the dangers of heritability factors to consider the consequences of long-term exposure to stressful emotions. However Francis (1997) has argued that support groups teach participants to manage difficult, stressful emotions by focusing on who they are, and not directly on what they may be feeling. The role of the facilitator is to help participants see themselves differently.

When Colin concluded that his mother may be mentally ill, because as he said, “there are so many kids like us…like me”, he inadvertently signalled a potential tension between the identity claims we may make for others, and/or those we claim for ourselves. This is significant because choosing to belong, to be in the “same boat”, in the way Colin seemed to do over the course of the eight-week program is not the same as having an identity ascribed by others, as for example when children are classified by others as being “at risk” or “resilient” (Gladstone, Boydell, & McKeever, 2006). Having a choice about identifying with “these” children implies a process of exploration and decision-making, especially in contrast to discriminatory and marginalizing practices in which labels are applied and engender a sense of powerlessness (Bottrell, 2009; Wexler, Difluvio, & Burke, 2009). However, a significant question concerning dramaturgical, interactional processes and the discourses that underpin them, is to query not only how individual participants identities may be being (re)framed or re-imagined, but to consider in whose interest such a redefinition is being enacted (Francis, 1997). This is particularly troublesome in thinking about being positioned by discursive formulations, and whether or how choices can be made and control can be taken back over being classified, not to mention whether or not participants have an awareness that ways of being in the world are being constructed in this manner (Fairclough, 1992).
Wexler and colleagues (2009) argue that group affiliation can provide young people with a stabilizing resource and a shared platform from which to reconceptualize personal difficulties as politicized, collective struggles—making a case for personal/collective meaning making as part of resilience research in public health. But group affiliation by way of the Children’s Group was time-limited with an agenda to change individuals’ perceptions of themselves—by recognizing commonalities—as responsible for managing their own future(s). My observations ended on the last night of the group sessions, and so I cannot know how, or if, “being in the same boat” (developing a mutual understanding and a shared identity) had a longer-term impact on participants. There was no formal provision to help children keep in touch. Children told me that they were happy and excited by being able to return to things that were part of their “normal” lives. Many of them indicated this in our group discussion when they talked about being able to watch favourite television shows again and do their homework and talk to friends. They may have wanted to limit contact with each other after the group too for reasons I could only speculate about. However, almost every participant also felt that the group could have been longer, both in terms of frequency and the timing of individual sessions. For the most part they said that what they would miss most about the Children’s Group was seeing each other.

Resilience-building interventions similar to the one I studied focus on changing individuals, often by constructing new identities, which in the case of BTU literally involved replacing old “self-stories” with new ones (see also for e.g., Ungar, 2004b, p. 229) 59. However, there is a danger that support groups can actually reproduce inequalities and exacerbate existing power differentials. People use discourses to define situations without reference to power but in ways that result in power inequities (Holden & Schrock, 2007). This is more likely when education and support activities like those used in BTU conceptualize the responsibility for change only at the individual level. For example, if some of the psychosocial consequences of parental behaviours are that Colin had to move more than eight times in less than two years, and Mark had to juggle doing homework, making supper and worrying about the disruption to his everyday life, then whether these issues can be explained solely as the consequence of illness, may not be helpful or consequential. Without asking children what would help, we can’t take the next step to consider what kinds of resources might actually be of help. In arguing that children’s private problems should become public concerns, Fjone and colleagues (2009) suggest changing children’s environments so that schools and health and social services become more

59 See also the notion of a “double-storied” account in therapeutic work with individuals where difficulties are discussed in conjunction with an “account of life apart from the problem” (Pluznick & Kis-Sines, 2008, p. 18).
accepting and tolerant of what is considered “normal”. Others have argued for a similar shift in social responsibility for understanding and changing how children are expected to manage difficult circumstances. For example, Bottrell (2009) argues “…that interventions for resilience building need to recognize the embeddedness of resilience in social inequities, social processes and the differentiated societal and ideological expectations of young people” (p. 321). In this study Bottrell (2009) concluded that disadvantaged young people from “poor” neighbourhoods refused to accept the discriminatory ways they were labelled as acts of resistance that were actually a form of resilience. The outstanding issue for her was a lack of recognition that resistance itself might actually be protective for some social groups because of the normative expectations of much theorization about resilience.

When most of the children in the group told me that they still thought they could help their ill parents, despite being instructed to believe otherwise—and however much they prevaricated by stressing that they knew the rules about only being able to “cope with it but not control it”—, I wondered whether their response could be (re)framed as a form of resistance, to normative expectations about “appropriate” parent/child relationships. So that rather than being pathologized by being in the “same boat”, because Mark worried too much about his family and was considered “parentified”, there may be changes that could be made to support his growing competence and desire to take some responsibility for caring for his father. Reframing children’s goals this way does not discount their need for practical and emotional support—especially if we acknowledge that helping children cope better on their terms will involve removing structural and discursive barriers that are difficult to change. Actual changes in systems of knowledge and beliefs about mental health/illness and how we think about ways of being a child (and an adult) would require a shift in thinking, as well as changes in children’s material circumstances.

Implications

I discuss the implications of my study according to the primary objective of the Children’s Group program, which was to educate and support children of parents with mental illnesses. A number of questions are formulated and statements are made regarding future work with children of mentally ill parents across practice, policy and research contexts. Although there is overlap between them I organized my discussion according to implications for practice and policy, and research. Following a brief explanation I highlight each implication separately, in a bolded textbox, even though they share some similarities.
**Policy and practice implications**

**I. Educating children about mental health/illness**

The “knowledge is power” discourse obscures troublesome contradictions in current understandings about the “real” nature and consequences of mental illnesses, and the tensions that exist between competing explanatory claims about mental health/illness as a biomedical and/or a social problem. My study raises questions about “appropriate” educational content for children of mentally ill parents, whether it can or should be standardized, and how decisions about what constitutes optimal mental health/illness education should be made. My results support other research findings that children want to learn more, although some of their reasons may have differed from those of parents and mental health professionals who referred them to the program and were responsible for providing mental health/illness education. Their motivations to learn more may conflict with beliefs about what is “best” for children, as was the case when children wanted to know how to better help their parents because they worried about their well-being.

All “knowledge is (not necessarily) power” but should be evaluated to determine how current mental health/illness educational content is helpful to children.

One way to address the problem of conflicting claims about what constitutes “good” mental health literacy is to acknowledge that there are simply different kinds of knowledge(s) that should be taken into account (Boydell & Gladstone, 2002). This approach would recognize children as knowledgeable persons. However, as evidenced in the following excerpt, even when their views are taken seriously, “differences” can qualify what children know as potentially deficient and in need of change:

All children with mentally ill parents construct some form of understanding about the changes they observe in their parent’s behaviour. If professionals are to talk helpfully to a child about his parent’s illness, the talk needs to be a dialogue or dialectic between the different knowledge and understanding on the one hand and the professional on the other. In other words, it is no use just “telling” the child—the professional needs to try to find out how the child understands what is happening to his mother, father, brother or sister, to talk about how he has worked it out, then to fit the professional’s knowledge into the discussion.” (emphasis added, Cooklin, 2004)

Poor mental health literacy has been described as a risk factor for children of mentally ill parents, and I am not suggesting that children do not require better understandings and possibly
more education. However, they should be asked what they know currently, and what they want to learn about mental health/illness. While children are described as reluctant to ask for information, the participants in my study were fairly adept at using strategies—especially humour—to help them manage questions and critique educational information and its relevance but in a way that made it emotionally safe for them to do this. This may have been less necessary had there been a more explicit or formal mechanism to directly ask them what they thought about their circumstances and what may have helped them in terms of learning about the illness and what was happening more generally to them, and their parents.

Rather than just taking children’s views into account by “fitting” professional knowledge into imagined dialogues, clinicians, researchers and policy makers need to ask how children’s knowledge corresponds with the way “we” have worked things out, in terms of the discursive formulations about mental health/illness that has dominated our understanding. Children and adults, professionals and lay persons may have different “knowledges”, but they are not equally influential in making decisions about what constitutes “good” mental health/illness education. A recent proposed change to a definition of mental health literacy (MHL) in Canada recognizes decision-making as a problem about which knowledge(s) and beliefs comprise “good mental health literacy”. Moreover, they report that professionals tend to believe that lay persons should align their thinking with their own—even though an exclusive focus on medical perspectives is potentially disempowering.

Children should be asked what they know and want to learn about mental health/illness information. How they understand their situations should be taken seriously to inform decisions about what constitutes “good” mental health literacy.

*Bridges to Understanding* used a psychoeducational approach to mental illness that conceptualized mental illness as an “illness like any other”. The medical model is the foundation of this teaching and theories about brain disease and diagnostic labelling are dominant as compared to psychosocial causal theories. Categorizing problems as mental *illness* based on biogenetic theories about causation has been linked to public perceptions of persons with mental illnesses as individuals whose behaviours are beyond their control, and therefore as dangerousness and unpredictable (Read, Haslam, Sayce, & Davies, 2006). Children were taught similar information about mental illnesses and genetic heritability factors were downplayed to so

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that they would identify themselves as persons who had control over their own lives. Children agreed that parental behaviours were unpredictable and sometimes dangerous, but they did not find biomedical explanations very meaningful or relevant. It is important to consider presenting biomedical and genetic explanations as one way of thinking about the problem. Viewing psychiatric symptoms as understandable psychological or emotional reactions to life events may have a different impact and meaning for children in thinking about themselves, and their parents. It seems that psychoeducational groups could use a more balanced approach in which biological, social and psychological theories are given more equitable consideration. However, in the absence of universally agreed upon facts about the causes and consequences of mental health/illness it will be difficult to decide whose claims will be honoured about the best way to educate children and develop a better mental health/illness curriculum. Moreover, another dilemma is to think about how we talk to children about “facts” that we may not have or may be contentious across different disciplinary approaches to the problem of mental health/illness.

Children chose to speak about their parents’ “problems” and “differences” as alternatives to medicalized references to illness. Rather than equating these explanatory schemes with knowledge deficits it can be argued that they are more personally meaningful and relevant to children. Medicalized language seemed inadequate to explain worries about not “fitting in” and as a result most children chose to talk about their parent being “different” rather than ill. Understanding how young people construct alternative concepts about mental health and apply them in everyday life can be useful in advocating for change (O'Reilly, Taylor, & Vostanis, 2009). By examining the work that language performed in Bridges to Understanding I saw that concepts were not neutral constructions, words contributed to ways of thinking and talking about issues that could be challenged—and this has implications not just for suggesting how psychoeducational support groups should be conducted, but also for evaluating their effectiveness. Similarly, I would argue that education is not just an impartial method for providing children with the necessary linguistic armamentarium for communicating experience and need. Children developed shared preferences for describing their situations that enabled them to cohere as a group but they did this using medical and non-medicalized language that best suited their needs.
The Children’s Group psychoeducation and support sessions seemed very hurried. Most of the children commented on this as a problem during our group discussion; one child wrote anonymously that the Children’s Group was “too rushy, rushy”. Several suggested increasing the number of group sessions, although the two youngest did not want a longer group. The children responded to the hectic pace of the group by becoming anxious about responsibilities like completing their homework at the end of the night and the facilitators seemed burdened by trying to “get through” all of the mental health/illness information they were responsible for managing and teaching. One practical implication is to consider other ways of delivering “fact-based” information, for example through internet-based sources and hand-outs created for the group. This might provide an opportunity for creating more personalized information about specific psychiatric diagnoses that would be relevant to individual children. Other ways of “delivering” education that might be appealing and more exciting for children should be considered—see for example Von Allan’s (2009) graphic novel about growing up with a parent with schizophrenia. Access to certain resources for delivering education would require targeted funding and infrastructure and organizational support. For example, a “take-home” information booklet had been prepared for the Children’s Group but it was never published because of a lack of funding.

Finding alternative means of delivering mental health/illness education could help to alleviate the burden of trying to manage too much informational material, provide an opportunity to create more compelling and personalized information for individual children, and create a more relaxed, less rushed group experience. Extending the number of support group sessions may be helpful for some children.

II. Supporting children of mentally ill parents

Groups like the one I studied often organize education and support activities separately but reasons for this distinction and their outcomes are rarely examined. In the Children’s Group educational information was used strategically to assess children’s knowledge, and encourage them to talk about their own experiences with the purpose of learning to manage difficult

Understanding how language constructs the way we think and talk about mental health/illness can be a strategy to advocate for changing practice. This is important because children may have language preferences that explain their experiences and needs in ways that they find more relevant.
emotions. Children were taught about their risk for developing a mental illness because BTU assumed that this was a significant barrier to shifting their perceptions to see themselves as individuals who could be hopeful about the future. Because this was the agenda for the group there was not much attention given to discussing children’s current knowledge and worries about developing a mental illness. Even though they were reluctant to ask openly, children did use the “question box” to ask questions anonymously or worded their requests for information in such a way that they did not appear to asking whether they were “at risk”. Children used humour to disguise their “real” feelings and thoughts about the topic. This was worrisome because their concerns were never addressed directly, and the statistical information that was shared seemed to be misleading. The point of the statistical demonstration with the clothespin dolls activity was to have children “realize” that their chances of “getting it” were only marginally better than those who did not have a parent with a mental illness. The conversation required to fully understand statistical analyses regarding prediction, genetic heritability factors, and a more detailed description of “risk” in relation to particular psychiatric diagnoses was not part of the curriculum.

Rather than focusing on the full range of human emotions, support groups tend to emphasize the management of difficult, mostly negative thoughts and feelings (Francis, 1997). This suggests that a concern over children hearing disturbing information from others in support groups might be understandable (Hargreaves et al., 2008). This was the case in the support group I observed. However, the facilitators had fundamental disagreements about whether they were discussing “common-enough” fears or more sensationalist, media-driven anxieties about mental illnesses because they had presented material that was too “dramatic”. They did not share the same opinions about how to manage volatile discussions and whether or not “just talking” was appropriate and/or therapeutic. Part of the problem arose from conflicting beliefs about mental illnesses and how to help children who were talking about fear and whether or not they required more protection than just listening may have afforded them. I also felt that the adults experienced vulnerability when talking about difficult emotions. Furthermore, it was not clear how the facilitators understood children’s meanings when asked to talk about fear, because children described emotions that ranged from worrying about the overall unpredictability of everyday life and the disruption to familiar routines and relationships, to those that were associated with more difficult and sometimes extremely aggressive, illness-related parental behaviours.
Talking about difficult topics is challenging for children and adults. Strategies are required for making this easier for children while helping adults facilitate such talk in a way that they can manage. Particular topic areas like those associated with “risk”, “fear” and “violence” require more attention because there are conflicting beliefs about them and they provoke emotions that are hard to talk about and manage. More consideration should be given to evaluating whether or not “just talking” is helpful to children who attend support groups, and/or more concrete efforts are required to ensure their emotional/psychological and physical safety.

The *Children’s Group* was dedicated to helping children remain mentally healthy by helping them to see themselves as independent persons. Although a protective measure to avoid over-involvement with parental illness, I argued that this actually positioned children in a bind between wanting to help their parents more and the expectation they focus only on themselves. *BTU* did not address how children could be helped to better manage relationships with their parents and with friends, and foster compassionate and caring competencies and practical skills already possessed. However there is growing evidence that children’s ability to cope, that is children’s “resilience”, is influenced by social participation, particularly their capacity for negotiating support from others—however this might be defined in different social, political and economic settings and in terms of an expressed desire to “fit in” and normalize the overall experience (Fjone et al., 2009; Hargreaves et al., 2008; Maybery et al., 2005; Skovdal, Ogutu, Aoro, & Campbell, 2009; Ungar, 2008). These observations raise a number of troubling ideological and practical questions about children’s competencies and need for support, particularly when they say they want more control over the situation than current “rules” seem to allow. We might learn more about supporting children in this context from the practice and policy challenges described in the United Kingdom “young carer” literature, particularly those interventions that have considered children’s attachments and obligations as part of interdependent, beneficial relationships (see for example, Grant et al., 2008). One way for children to have a better sense of the future may in fact involve helping them to have a better sense of their own competencies and to support them in developing these abilities. It concerns me that by believing children can and should control only how their “stories should go” we are “let off the hook” in terms of an on-going responsibility to help them better manage their own lives and their relationships with others. Moreover, this leaves children vulnerable to blame if they do not succeed. An outstanding question remains as to the merits and drawbacks for dedicated groups like the one I studied, which was created as a space “just” for children because
it was believed that ill parents had more opportunities for receiving mental health services. In other jurisdictions it has been more common to help children and parents by integrating services that focus on the family in its entirety (Nicholson, Hinden, Biebel, Henry, & Katz-Leavy, 2007).

Researchers have suggested that peer support and social inclusion might be more beneficial to participants of support groups than the actual educational content provided (Hayman, 2009). Children described group members who were “like them” as more understanding and less judgemental than other friends. This convinced Colin that his mother had a mental illness though he still preferred to talk about “problems” and not “illness”. Although most participants did not initially want to attend the group, and some felt coerced, they spoke about having met each other as the outcome they valued most. And when the facilitators and the children had a volatile disagreement about the appropriateness of “peer” support in terms of assuring their “safety”, they seemed to pretend to go along with the rule that “friends don’t (really) count”. Other researchers have raised the issue of peer support and whether fostering in-group relationships occurs at the expense of helping children to develop and maintain important social networks outside the group (Hargreaves et al., 2008; Maybery et al., 2005). Children talked about friends outside the Children’s Group but they were unsure of how to discuss their problems about parental mental illness with them. Many felt extremely guilty about keeping their involvement in the group a secret from their friends and expressed a desire to find ways to tell them what they were doing. This seemed a lost opportunity to talk about stigma and discrimination and support children by teaching them how to negotiate the challenges involved in dealing with friends’ beliefs and attitudes because these were people who were important in their lives.

Support groups are an opportunity for children to learn how to better manage relationships that are important to them. Children value peer relationships but may benefit from learning how to talk about their experiences of parental mental illness with others. Children may want to continue caring for and about their ill parents at the same time that they learn how to live more independently. Consideration should be given to the benefits and limitations of peer support groups dedicated to children and how they differ from those that integrate services for children with their families.
Research implications

Future studies: Children as “users” of mental health services

Participants reported enjoying being part of the Children’s Group, most wanted it to continue longer and talked about ways to make the group better. Studies that go beyond identifying children’s problems to examine possible solutions have been recommended (Fudge & Mason, 2004; Maybery & Reupert, 2009). Research would benefit by including children to set the agenda for evaluating the efficacy of psychoeducational support groups—and in this way their views would be taken seriously when determining how to do things differently in practice. Children see themselves as having something important to contribute to understanding more about mental health/illness. As one participant in the Children’s Group said anonymously, “…[the group] really shows interest about mental illnesses by including that most of the pupils (kids) turn out to be the teachers and the teachers turn out to be pupils.” However, research tends to reflect evidence-based approaches that remain rooted in adult, professional definitions of what constitutes legitimate knowledge (Coppock, 2001; 2002). Moreover, most studies that include children as “service users” focus on evaluations of mental health services with participants who are currently receiving services (see for e.g., Darbyshire, Muir-Cochrane, Fereday, Jureidini, & Drummond, 2006; Dogra, 2005; Mitchell-Lowe & Eggleston, 2009). Although one exception includes children consulted about Australian government guidelines for mental health services because they have parents with mental illnesses (Fudge, Falkov, Kowalenko, & Robinson, 2004). Similar to my study, evidence from this research suggests that when young people are involved in evaluating programs they often have different expectations from parents and professionals about services and desired outcomes.

A question raised by my study was whether children who despite being “all in the same boat”, may have benefited from information and support targeted toward their different experiences of parents’ mental illness diagnoses, chronicity, and illness severity. Aside from funding, infrastructure and other practical implications for developing customized psychoeducation and support for subgroups of children, this would require further study to understand the various ways children’s experiences are socially mediated and differentiated—by age, gender, family and cultural context and so forth. It also raises the question of further dividing and categorizing children who are “all in the same [kind of] boat” but may experience this as a marginalizing discourse in terms of being “normal”. The benefits of programs dedicated to subgroups of children is suggested as a priority for future research (Reupert &
Maybery, 2009b), which should include children’s input. And there is a burgeoning literature on children’s participation in research—including a substantive focus on mental health issues (see for example, Claveirole, 2004; Darbyshire et al., 2006; Didkowsky, Ungar, & Liebenberg, 2010). In my study, children responded to and asked questions strategically and I found this surprisingly informative. My results demonstrate that asking for children’s input requires thinking about approaches that are less reliant on conventional methods like basic question/answer formats. I found that children became more engaged when I asked them to complete sentences instead of posing questions directly. Moreover, a rhetorical style of questioning—which was evident in educational sessions in the Children’s Group—can seem patronizing and signal that serious and thoughtful answers are not really expected. Strategies for asking questions warrant further consideration because they have implications for research and practice. I found this to be the case in my critical analysis of child/adult interactions and the concept of “power”—that is, the capacity of individuals to act effectively and to affect the behaviours of others. For example, I described how children (re)inscribed or used “graffiti” in their artwork as a form of subversive communication that allowed them a degree of power over what was “said”, without having to confront others openly. Similarly, they used humour to challenge the facilitators, and each other, but indirectly, and in ways that helped them test their ideas but avoid potential conflict. The “question box” and the individual response sheet I created for research purposes were used strategically. Children asked questions about “risk” without identifying themselves by using the “question box”, and together with the response sheet they were able to respond as individuals, and to make comments and ask questions privately and confidentially in the group context.

The cumulative findings from my study indicate the importance of taking children’s understanding about their situations seriously and incorporating them into the way we think and talk about mental health/illness and make informed decisions about what constitutes “good” mental health literacy and support. Future studies would benefit by including children in the development and evaluation of support groups. Of particular importance is the need determine what constitutes optimal mental health education for children, other modes for delivering educational content that is informative and appealing, and pragmatic issues regarding the appropriate length and timing of groups. There are a number of issues raised by my study that children have opinions about including: the benefits and challenges of receiving psychoeducation and support in a group context and whether, or how, they would like to be

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61 The use of a digital camera to take photographic fieldnotes allowed me to examine how children used their drawings more strategically than I first realized.
supported individually; the value of “just talking” compared to other ways of “getting help”; the merits of having formalized support to help manage significant relationships in everyday lives and to deal with stigma and discrimination. Research problems might be framed in ways that are more meaningful to children by reconsidering not just the questions we ask children, but the kinds of research questions we decide to study. For example, a study with children of parents who are “different” might focus on children’s social relations, social inclusion/exclusion and ways of being in the world that are not limited to a substantive focus on parental mental illnesses.

**Critical Dramaturgy: Studying children’s mental health services and research**

Critical discourse analysis was a useful method for showing how contemporary discourses about mental health/illness, and children, shaped the portrayal of information in the program manual, *Bridges to Understanding*, and how this was received by participants in the *Children’s Group*. Discourse analysis has been described as too remote from clinical practice to be of practical use because it focuses on language use in texts and talk that may make it too difficult to “…infer how to change behaviours because, arguably, texts merely describe phenomena rather than offer transformative possibilities” (O’Connor & Payne, 2006, p. 833). However rather than just describing phenomena I showed how words actively worked to construct knowledge and beliefs, and ways of being in the world. I used a critical dramaturgical approach, drawing on Goffman’s (1959) concepts about face-to-face social interaction, to consider how power was enacted as participants responded to each other and these various constructions. In discussing the results and implications of the study I have suggested a number of ways forward, both practical and ideological, and I would argue potentially transformative—demonstrating not only how discourses framed the psychoeducational and support content of the group but how children strategized to respond to beliefs about mental health/illness and how they negotiated and resisted what it meant to be children who were cast as “*all in the same boat*”. This latter point is important because “[T]he identities we take up, manage and resist carry implications not just for us but also for our relationships with others and for broader patterns of social actions” (Guise, McKinlay, & Widdicombe, 2010, p. 79). As I believe this CDA demonstrates, rethinking assumptions about the purposes for targeting behaviour change may lead to “transformative possibilities”—including assuming that practices solely focused on individual behaviour change are an adequate response to the material, social and ideological disadvantages children of mentally ill parents experience.
Because discourse analysis demands an awareness of words and their layered, symbolic meanings, it was a good method for questioning some of the taken-for-granted concepts that are commonly used in the children’s mental health field, shaping the way children’s services are conceptualized and evaluated. Harper (1995) argues that “…such a standpoint is extremely useful when studying phenomena like psychiatric categories which are produced almost entirely within language (e.g. in diagnostic interviews, manuals, ward rounds and so on)” (p. 348). For example: acquiring appropriate information, having more knowledge, and a better understanding were all different but seemingly unproblematic ways of talking about the importance of educating children against the harmful effects of parental mental illness. But the ways we think about the meaning of these words influence how we evaluate or “measure” what constitutes good mental health literacy. This is important given the emphasis on recognizing parental illness-behaviours as protective in terms of children’s risk for developing mental health problems. Risk is talked about in terms of future illness, but also as present “danger”. Different players will understand these words in their own way and this will have practical and ideological consequences for children and adults concerned with what it means also to “be safe” or in need of “protection”.

If education has the power to give children language so that they can explain their experiences and articulate their needs (Reupert & Maybery, 2009a), examining words as more than a neutral medium for conveying information is significant for understanding how language itself works to influence these articulations. One of the goals of the Children’s Group was to enhance children’s ability to cope with their situations, but language-in-use influences how we talk in practice, policy and research about children’s resilience—(Beardslee & Podorefsky, 1988; Bottrell, 2009; Focht-Birkerts & Beardslee, 2000; Grover, 2005; Place et al., 2002; Riley et al., 2008; Ungar, 2003, 2004a, 2004b, 2008; Walsh, 2009)—or the ways they cope, adjust, try to manage or save the situation, and respond to illness, and/or parental behaviours. Moreover, “[H]ighlighting the socially constructed character of currently dominant discourse on “mental illness” can deconstruct it’s taken-for-granted status and enable the articulation of alternative discourses on human distress, which can be more empowering for mental health service users” (Bilić & Georgaca, 2007, p. 170).
Considerations

I draw particular attention to three points in my concluding remarks. First, children demonstrated that they were competent and strategic actors who were able to negotiate and resist the terms under which they were positioned as “all in the same boat”, and the ways in which their experiences and needs were articulated according to contemporary discourses about mental health/illness. However, a significant question remains concerning dramaturgical, interactional processes, the limits of individual agency to attribute meaning to situations, and the power of particular beliefs (or discourses) that underpin and shape interactive settings. Goffman (1959) argued that power is limited to the extent that performers who dominate or have authority in one setting, may not in another. It is difficult to determine the limitations on individual children’s capacities to act independently of discursive formulations and consequently, to act effectively and affect the behaviours of others in social situations. Children might be restricted because they are not aware of, or do not have a choice and/or control over the way they are cast in other interactive settings in which expectations and other rules (or discourses) construct systems of knowledge and belief, social relationships and ways of being in the world that are different.

Moreover, I realize that my study is part of an ongoing process of constructing knowledge about children of mentally ill parents and that the epistemological approaches I take to thinking about mental health/illness and children are also ideological. Discourse analysis can potentially create “a self-referential circular process in which a text is produced by analyzing a text and the process goes on” (Crowe, 2005, p. 62). One way to mitigate this tendency is to test ideas or “deconstructions” as a set of assumptions that are made meaningful and consequential in other interactive settings. For example, the results of my study and implications described might be transferable to other contexts where children of parents who have chronic illnesses and/or disabilities require education and support—perhaps because the parent is also considered “different”.

Second, I was interested in children’s collective, interactive and performative responses to discourses pertaining to mental health/illness, and children, and the ways they influenced each other in how they interpreted the “script”. Other interpretive approaches might have focused on individual participants and used in-depth interview-based methods to study children’s subjective or “lived experience” of the group. Individual children may have had different responses if I had interviewed them outside of the group context, which might have been advantageous with siblings who attended the program together. I was not able to follow-up with participants to ask what they thought of the program after completing the sessions because my observations and
informal interviews ended on the last night of the program. A qualitative longitudinal analysis of the effectiveness of psychoeducation and support would be an important next-step for a study like the one I conducted. Third, My study was an in-depth analysis of one group over an eight-week period with seven children. It was conducted in a particular geographical location and health care context. I observed a diverse group of participants who varied by gender, age, number of siblings, including those who were present in the group, parental disorder (chronicity and severity), gender of the ill parent, children’s living arrangements, cultural background, reasons for referral etcetera—accounting for all the potential heterogeneity in groups such as the one I studied would involve complex research designs and larger numbers of participants than might be currently accessible in the Canadian context. At the same time, I believe that the goals of Bridges to Understanding and the Children’s Group were comparable to those of other support groups for children of mentally ill parents (see for example, Riebschleger, 2009). As a single observer in the setting I was limited by the number of observations I could reasonably make, given the countless number of interactions that occurred during the eight-week period. While some caution is always necessary in extrapolating the outcomes of a study to other participant groups and settings, I trust that the detailed documentation and analysis provided should enable readers to judge how my results are transferable to other psychoeducation and peer support group settings. Finally, while other analyses of primary data are possible and encouraged (Gladstone, Volpe, & Boydell, 2007), I have tried to include sufficient evidence for the present analysis and interpretation based on the critical dramaturgical approach taken in this study.

Conclusion

Research with children of parents with mental illnesses is an emerging field of interest. A number of years ago I tried (unsuccessfully) to secure funds from a leading Canadian mental health organization to conduct a study similar to the one completed for this dissertation. Since that time much of the research, and the practices and policies pertaining to children of mentally ill parents have developed in jurisdictions outside Canada. I have made a number of suggestions for future work that will require developing a sustainable capacity for research with children of mentally ill parents. I was fortunate to conduct an in-depth analysis of education/support for children, which would have been less likely had it not been part of my doctoral degree
requirements. Canada is currently developing a national strategy for mental health\(^{62}\), which includes a nation-wide framework for mental health. Of seven goals itemized in the current framework proposal one in particular stands out because it stipulates that, “The role of families in promoting well-being and providing care is recognized, and their needs are supported”. While “family” most likely refers to parents, the results of my study argue for broadening the narrow but powerful way we have framed the roles children are allocated when there is parental mental illness in the family, and the needs they have for education and support. Children contribute to the health and well-being of others, and many want to have some responsibility for caring for and about their parents, and to give and receive support from family and peers. They should be recognized for their efforts to promote the well-being of other family members and supported in ways that they find meaningful—not the least because it will have an affect on their own well-being. I conclude with words from one of the Children’s Group participants, which I repeat here because they demonstrate that “showing an interest about mental illnesses” is important to children, and that they see themselves as knowledgeable persons who have something important to add to how we talk about mental health/illness. Children’s claims should be “honoured” as part of a “working consensus” on what it means to be a child of parent with a mental illness because as Goffman (1959) reminds us, it is not a real agreement about what actually exists that matters, but a “real” agreement as to whose claims might be temporarily honoured.

“… [the group] really shows interest about mental illnesses by including that most of the pupils (kids) turn out to be the teachers and the teachers turn out to be pupils.”- Anonymyse (session 8)

\(^{62}\) See “Framework for Mental Health Strategy” at: www.mentalhealthcommission.ca


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APPENDIX 1: REVIEW SUMMARIES: CHILDREN’S EXPERIENCES OF PARENTAL MENTAL ILLNESS
<table>
<thead>
<tr>
<th>Study Authors &amp; Purpose</th>
<th>Country</th>
<th>Participants</th>
<th>Theory &amp; Method</th>
<th>Key Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ahlström et al. (2007)</td>
<td>Sweden</td>
<td>N=3</td>
<td>a “narrative” group interview, followed by individual interviews</td>
<td>themes: depression as a stealthy intruder; moving slowly to helplessness; saving the situation; protecting oneself, and others; conveying things that are beyond words; the dispersal of shadows</td>
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<td></td>
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<td>daughter 11 yrs.</td>
<td>question areas: 1. what family life is like at onset of depression; 2. what an ordinary day is like; 3. what it is like when depression dissipates</td>
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<td></td>
<td></td>
<td>son 19 yrs.</td>
<td>qualitative thematic content analysis; case study allowed complex picture to emerge</td>
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<td>mother 46 yrs., diagnosed with depression, university educated, unemployed; single</td>
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<td></td>
<td></td>
<td>N=3</td>
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<tr>
<td>2. Ahlström et al. (2009)</td>
<td>Sweden</td>
<td>N=18</td>
<td>7 group interviews to grasp family’s “shared meanings”;</td>
<td>themes: being forced to relinquish control of everyday life; uncertainty &amp; instability; living on edge of community; everyday life becomes hard; despite everything, a way out can be found</td>
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<td>9 parents, (7=F, 2=M, 35-52 yrs., median age=46 yrs., 5=single-parent families with ill mothers, 2=dual-parent, 1 ill mother &amp; 1 ill father)</td>
<td>1. tell me what an ordinary day is like with depression in family; 2. what happens in everyday life?; 3. what happens to family members?</td>
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<td>9 children, (5=F, 4=M, 5-26 yrs., median age =16 yrs.).</td>
<td>qualitative thematic content analysis.</td>
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</tr>
<tr>
<td>3. Aldridge &amp; Becker, (2003)</td>
<td>United Kingdom</td>
<td>N=120, T₁</td>
<td>in-depth semi-structured individual interviews (T₂ 10 months later)</td>
<td>young carers should identify nature/extent of caring needs; caring can help children feel involved &amp; needed; professionals must recognize caring contributions &amp; reconcile children’s fear of interventions &amp; family separation with need for formal support; children need to talk to someone they trust who understand both caring needs &amp; mental health issues; children need age-appropriate and reliable mental health information</td>
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<td>40 parents, (35=F, 5=M, 31-57 yrs., median age=40; 15=2-parent; 25= lone parent families; majority depression, N=35)</td>
<td>focus on the nature of parent child relationships, children’s role adaptations, and positive and adverse experiences of living with and caring for a parent</td>
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<td>40 children, (27=F, 13=M, 10-19 yrs., median age, 14 yrs., 35 caring for mother, 5 father)</td>
<td>caring defined as regular &amp; substantial, but also by participants; not necessarily ‘parentification’; less about role reversal or attachment disorder, but focus on role adaptation; emotional caring emphasized</td>
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<td>40 “key” professionals identified by families.</td>
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Findings reported here are those relevant to a review of children’s experiences of parental mental illness, and not for example, identifying prevalence of the problem (see for e.g., Handley et al., 2001), or assessment of children’s emotional or behavioural “disturbances” (see for e.g. Stallard et al., 2004).
N=65, T2
- 28 parents (25=F, 3=M)
- 28 children (17=F, 11=M, 25 caring for mother, 3 father)
- 9 “key” professionals

- discusses limitations of medical model of “mental illness” re. psychological, psychosocial & political outcomes for families


*Purpose:* to report on the childhood experiences, current life situation & level of adjustment, & prior mental health service use of “offspring of indigent people with schizophrenia”.

N=39
- adolescents & adults (majority female, 13-48 yrs., median age = 26 yrs.; majority maternal schizophrenia)

- descriptive stats to examine characteristics and experiences of offspring
- assessment measures included: current occupational/social functioning; psychiatric status; mental health service use.

- participants reported embarrassing & frightening parental behaviours; inability to support family; failure to take meds; doing nothing all day; being violent & assultive.
- many had never talked about illness with a professional & lacked information about illness; a “substantial minority” played a caretaking role.

5. Cogan et al., (2005) Scotland

*Purpose:* to explore the understanding and experiences of children affected by parental mental health problems (MHPs) compared to children of “well” parents.

N=20
- “affected” children (10=M, 10=F, 12-17 yrs., mean=13.81, 8=fathers, 12=mothers; parental diagnoses: affective disorder)

N=20
- “comparative” children of “well” parents (10=M, 10=F, 13-17 yrs., mean=14.72, 6=fathers, 14=mothers; no psychiatric diagnoses).

- interviews to examine understandings of: 1. mental health; 2. physical health & 3. positive well being (e.g. included questions such as: “what do you think a mental health problem might be?”)
- data analyzed using “the Huberman & Miles interactive model”

- “affected” group described parental behaviour as hiding problems, withdrawing, behaving erratically; they reported feeling scared, worried about chronicity but hoped for recovery; both groups attributed MHPs to social causes, but comparison group more likely to convey stigmatizing views, while “affected” group described multiple stressors, gave biological explanations & blamed themselves for problems at home; both groups described MHPs as more difficult to understand than physical problems


*Purpose:* to study “young carers” well-being based on Scotland

N=61 “young carers”, phase 1
- (34=F; 25=M, 5-16+ yrs., 75% between 10-15 yrs., 41% cared for 1 parent, 13%

- phase 1: a self completion questionnaire (“closed and open-ended” questions) for all young carers attending a project in the month of May; SPSS to

- participants reported worries about: the health of the person “cared for”; their own health; school work; others behaviours, appearance; money;
<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Sample Size</th>
<th>Sample Description</th>
<th>Purpose</th>
<th>Findings</th>
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<tbody>
<tr>
<td>7. Fjone et al., (2009)</td>
<td>Norway</td>
<td>N=20</td>
<td>children &amp; young people (14=F, 6=M; 8-22 yrs.)</td>
<td><strong>Purpose:</strong> to examine how children present themselves to avoid stigma and self-stigmatization and to be viewed as ‘normal’.</td>
<td>3 sub-topics presented: 1. feeling left out, feeling shame, realizing parent is different; 2. children’s impression management/actions to be like others; 3. children’s “self-exploration process” when they identified something is ‘different’ at home &amp; first talked about parental distress with the parent, with others</td>
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<td>8. Garley et al., (1997)</td>
<td>Canada</td>
<td>N=6</td>
<td>children (3=M, 3=F, 11-15 yrs., 2 brothers; 2 =mothers, 4 =fathers diagnosed with affective disorders; all separated or separating at time of study, except parents of 1 child).</td>
<td><strong>Purpose:</strong> a pilot study to elucidate subjective experience of “preadolescents/adolescents” living with parental affective disorder in order to guide the development of group intervention.</td>
<td>themes reported as children’s struggle to understand the illness, including their own concerns, ideas about causes &amp; access to information; recognizing signs of impending illness; concerns about hospitalization; and managing the illness by coping with its impact on self, and the parent.</td>
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<td>9. Handley et al., (2001)</td>
<td>Tasmania, Australia</td>
<td>N=12</td>
<td>8 parents (6=F, most diagnosed with major affective disorder)</td>
<td><strong>Purpose:</strong> reports on key recommendations &amp; findings from a study questions to identify types of supports needed as perceived by children, parents, service provider</td>
<td>children reported struggles to understand &amp; recognize signs of illness; and ways of managing the illness &amp; impact of parent’s hospitalization.</td>
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university/mental health services collaboration to formally study the needs of children with a parent/carer with a mental illness.


Australia  

N=24, component # 1  
- 12 parents, (gender not reported; 29-46 yrs., mean age=39 yrs.; 55% single parent families; various psychiatric disorders).  
- 12 children, (gender not reported, 6-16 yrs.).  

N=62, study component # 2  
- parents/children as above  
- mental health professionals, (16=M, 46=F as part of a larger “mental health worker study”).

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<th>Component</th>
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| #1 focus groups based on an “interpretive paradigm” with parents/children; asked about “good & not so good things” about the family; the effect of having an “unwell” family member; if treated differently as a family; what they did to cope; what others did to help & suggestions about what might be helpful  
#2, 7-item questionnaire completed at end of focus groups, & by professionals (as part of a larger study) regarding: support from family & “other adults”, a friend at school or a “similar situation”, having time out, learning more about “what’s wrong” analysis of “major themes” based on frequencies & statistical analyses of quantitative data.

- parent/child focus groups describe impact of major episodes, e.g. hospitalization; importance of siblings, children’s coping strategies  
- parents describe availability of external support, need for children’s education, community education.  
- children describe importance of friendships; extra roles assumed when parent unwell.  
- comparison of 3 groups on “things that might help”: children scored all items except “having a friend at school you can talk to”, considerably lower than parents and professionals.


Canada  

N=3  
- adolescents (17 yrs., all female; 1=single “ill” mother, 1=dual-parent family, “ill” mother & 1=parents separating at time of interviews, currently living with mother, but frequent contact with “ill” father).

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<th>Component</th>
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| phenomenology as philosophy & method.  
participants interviewed 2 times, 3 week interval.  
begin with: “tell me what it is like to be the daughter of a parent who is depressed or has manic depression”; interview # 2 expanded on this, or “validated data” from first interview  
audio taped, observational field notes  
analysis described as basic procedural method.  

- themes described as: experiencing a serious disruption in family life, which led to taking on parental roles & tasks; perceiving a lack of knowledge & understanding about the illness; trying to cope and make sense of the experience using a variety of cognitive/affective responses
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<td>• children (6-16 yrs., 11=6-12 yrs., 11=13-16 yrs.; 14=M, 8=F; 13 siblings; “living with” a parent part- or full-time in dual-, single-parent, extended &amp; blended families; various parental diagnoses, “ill” parent most often mothers).</td>
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<td>• 10=interviewed x2.</td>
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<td>• symbolic interactionism &amp; grounded theory using semi-structured interviews, participant observation &amp; drawing (provided as response choice); comments about drawings incorporated into overall data analysis; concurrent data collection &amp; constant comparative analysis described.</td>
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<td>• two basic social processes identified: 1. “finding the rhythm” in which children monitor &amp; adjust to parental behaviours to maintain connection with parents &amp; family stability; and, 2. “maintaining the frame” wherein children create safe distances between self &amp; parent, to preserve themselves while trying to stay connected.</td>
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<tr>
<th>13. Mordoch (2010)</th>
<th>Canada</th>
<th>N=22</th>
<th>Purpose: to understand how children living with parental mental illness understand mental illness &amp; what they want to tell other children</th>
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<tr>
<td></td>
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<td></td>
<td>• Children (6-16 yrs)</td>
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<td></td>
<td>• Qualitative secondary analysis; same participants as in Mordoch &amp; Hall (2008) study</td>
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<td>• qualitative secondary analysis; theory &amp; method as in 2008 study; investigation of category: “Monitoring”, children monitor cues in parents’ appearance, interactions, activities and moods; property of ‘monitoring’, having part of the story, prompted secondary research questions: how do children understand/learn about mental illness? What do they want to tell other children?</td>
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<td>• children had limited understanding of mental illness; received few factual explanations; limited information caused undue hardship; younger children worry about parent dying; older about developing mental illness; offer suggestions to other children</td>
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<td></td>
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<td></td>
<td>• children (10-18 yrs., 5=F; “ill” parent, 7=F, 4 = schizophrenia, 4 = affective disorder).</td>
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<td></td>
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<td>• interviews using open-ended questions concerning parent’s “disease”: children’s need for information; situations that are hard/easy to manage; reactions from relatives/friends; children’s need for support and help</td>
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<tr>
<td></td>
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<td></td>
<td>• thematic analysis described</td>
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<td></td>
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<td></td>
<td>• themes reported under headings: conversation; love; maturity; fear; blame; loneliness; responsibility; associated stigma</td>
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</table>

<table>
<thead>
<tr>
<th>15. Pölkki et al., (2004)</th>
<th>Finland</th>
<th>N=17</th>
<th>Purpose: to examine the needs and stress reactions of children of parents with mental illness, as well as their coping &amp; resilience.</th>
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<td></td>
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<td>• ‘narratives’ collected from female “grown up children” (15 yrs.- “late adulthood”; 11=ill mother; 15=2-parent families; parental diagnoses, psychosis &amp; “serious” depression;</td>
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<td></td>
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<td>• 1. data collected via a writing competition on theme: how my life changed after a member of my family became mentally ill; grounded theory analysis</td>
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<td>• 2. thematic interviews; questions included: how do the children experience mental illness and parenthood of their parent?; what kind of</td>
</tr>
</tbody>
</table>
|                          |         |      | • older children felt more isolated socially & expressed need for information; coped well using practical and emotional strategies, valued learning and inner growth, did well at school, some bullied; a “shameful secret”; some “envied healthy families”; mentioned parent “lost role as
4=parental suicides) N=6
- interviews with children, 9-11 yrs, 2 from same family. Stress reactions do children have?: How do children cope with daily situations?: What is the resilience of these children in the long run?: What kind of informal and professional help do the children need and get?


Purpose: to explore a “child’s eye” view of living day to day in a family that included a parent with a psychiatric disability in order to build practice knowledge from unique perspectives of a little researched group.

N=22
- children (5-17 yrs., mean age=9.36 yrs., 11=F, 11=M11; most were Medicaid recipients, implying limited household income; 12= ill mothers, 5= ill fathers, 5=both parents ill; 16=mood disorders, 4=schizophrenia, 1=PTSD, 1=unknown; 16=single-parent homes).

- a secondary analysis of an interview-based study (1993) of children’s needs, perceptions of psychiatric disability & rehabilitation
  - individual & focus group interviews to describe: behavioural responses, feelings & family events, on family’s and/or parents’ “good or bad” days
  - open, axial & selective coding procedures described.

- themes reported as: good days; bad days; views of psychiatric disability; and, perceptions of psychiatric rehabilitation.


Purpose: to explore the impact of parental schizophrenia on the child’s daily life.

N=37
- “subject” children, (8 – 16 yrs, 13.6 mean age, 20=M, 17=F; 26=ill mothers, 11= ill fathers, 35=dual parent families).

N=37
- “control” children (matched on residence in same mental health catchments area, age, marital and employment status of parents, type of housing & gender).

- semi-structured interviews with parents, followed by children alone
  - impact on child examined re: 1. children’s physical & emotional health (asked of parents only); 2. behaviours; 3. parent-child relationship; 4. time away from home; 5. contact with relatives & friends; 6. trouble in school, community
  - statistical analyses of quantitative data; open ended questions collated by hand & described using frequencies and percentages; combined analyses of child/parent perspectives.

- results categorized under child’s: lifestyle; experience of parental mental illness; awareness of symptoms; coping strategies; caring; and children’s and parents’ views of mental health services.
<table>
<thead>
<tr>
<th>Study</th>
<th>Authors</th>
<th>Year</th>
<th>Purpose</th>
<th>Sample Information</th>
<th>Methodology</th>
<th>Findings</th>
<th>Notes</th>
</tr>
</thead>
</table>
- 26 children, (6-17 yrs., 11.65=average age; 10=F, 16=M).  
- 24 parents, (21-54 yrs., 40.8=average age; 17 mothers, 7 fathers; 10=depression, 6=psychosis, 5=affective disorder, 1=chronic fatigue syndrome, 1=borderline personality disorder). |  
- describes qualitative information & emerging themes  
- semi structured interviews, series of open ended questions assessing parent’s current illness, children’s understanding, effects on education, care, behaviour, relationships  
- additional psychometric assessments of children’s behaviours. |  
- children worried about parent, little understanding of illness, most wanted more information; did not talk about risk of “getting it”  
- parents aware of negative impact of illness on children, some wanted children to know more about illness & perceived relationship with children as positive  
- barriers to identifying children’s needs.  
- parents/children do not always share the same perceptions. |
Purpose: this paper based on a government commissioned study of experiences of people identified as “young carers” as part of a wider review of carers needs/services. The paper concludes with an alternative definition of “young carer”.  
*note: does not differentiate findings based on parent as mentally ill | N=21  
- Young carers, (9-18 yrs., 13=F, 8=M).  
- caring for parents/siblings with physical disabilities; 3=self-identified as caring for alcoholic or mentally ill parent in a primary caring role & may involve looking after siblings; 4= unspecified caring situation. |  
- informal focus groups in young carer projects to develop questions for individual interviews  
- direct questioning techniques & activity-based materials based on “participatory research” with children  
- questions about everyday life experiences & role as young carers |  
- tendency for most difficult situations to involve children supporting parent with addictions or mental illness, or where both parents were chronically ill  
- main finding, the need to recognize young carer’s knowledge, opinions, work, needs, by families, schools, health services, social services  
- young people report: anxiety about parent, and reduced social mobility; positive feelings of closeness & development of life skills; lack of recognition by friends, teachers, helping agencies and “deficit in parenting”, a contentious issue; lack of support for emotional aspects of caring. |
Purpose: a pilot study to examine the types of burden described by adolescent children of | N=13  
- “family burden”; vulnerability & risk related to caregiving as “burden”, e.g. parentification etc.  
- a semi-structured interview, described as qualitative  
- questions developed based on a review of the adult “burden” literature |  
- children uninformed about illness & want information; difficulties dealing with symptoms; assumed household responsibilities; various emotions about illness behaviours; concern about parent’s future; no safe outlet for negative feelings |
| parents diagnosed with schizophrenia. | • questions about knowledge of disorder, relationship with parent, impact on personal life, coping strategies used, future concerns | • various coping strategies, often inadequate, want more support & to help parents & know how to get help  
• positive aspects include learning important lessons, greater communication, increased understanding & tolerance of limitations imposed by illness |
APPENDIX 2: REVIEW SUMMARIES: INTERVENTIONS TO EDUCATE AND SUPPORT CHILDREN
<table>
<thead>
<tr>
<th>Study Authors &amp; Purpose</th>
<th>Program Details</th>
<th>Study Participants</th>
<th>Program Theory &amp; Evaluation Method</th>
</tr>
</thead>
</table>
| 1. Fraser & Pakenham (2008); Australia | • 3, 6-hour, bi-weekly ‘thematic’ sessions for children 12-18 yrs.  
• 2 mental health clinician facilitators & use of program manual; 4-6 child participants  
• goals & activities: psycho education, mental health literacy; coping skills; group discussion; peer support; quizzes, crafts, art, videos & games  
• majority of referrals from child & mental health services | N=27 treatment group  
• recruited from 6 KAP groups in 2006.  
N=17 waitlist control group | • resilience based program to modify risk, enhance protective factors  
• pre-/post- treatment measures; 8-week follow up  
• examines 3 sets of dependent variables: intervention targets (mental health literacy; connectedness, coping strategies); adjustment (depression, life satisfaction, “prosocial” behaviour, emotional/behavioural difficulties); caregiving experiences.  
• 3 open-ended items: knowledge of signs/symptoms of mental illness |
| 2. Goodyear et al., (2009); Australia | • 2 peer support group formats: 1. school holiday (4 consecutive days) and, 2. after-school (2-hour sessions over regular time intervals, e.g. weekly over one school term)  
• peer support to offer a sense of belonging & acceptance, increase independence from parents & other adults, accompanied by parallel connectedness with peers  
• goals & activities: reduce isolation, improve social connectedness; provide recreational, social, creative skills; provide respite; support & age appropriate information about mental illness and emotional well-being; build on strengths, promote resilience | N=31, school holiday format  
7=M, 24=F; mean age= 9.0 yrs.  
N= 38, after school program  
13=M, 25=F; mean age= 9.4 yrs. | • a “strengths-based” peer support pilot program with a focus on multiple wellbeing outcomes (e.g. self-esteem; coping styles; connectedness)  
• pre/post measures taken upon entry into the program and four weeks after completion: Kids Problems & Kids Connections (measures all possible relationships, negative/positive, inside/outside the family); Kids Coping (3 factors, problem-focused, emotion-focused coping & social support); & the Self Esteem scale |
| 3. Grant et al., (2008); United Kingdom | • a project for children “looking after” parents with a mental health problems  
• goals & activities: share accurate mental health information; re-establish positive identity through supportive, long-term, trusting relationships; role playing, drama, videos, group work  
• pictorial/written work displayed as “evidence” of other children’s lives  
• enhance feelings of safety: can contact support worker any time; recognize risk to children | N=10, T1  
children, 11-16 yrs.  
7=F, 3=M  
N=7, T2  
all live with mothers; no explicit parental | • study reports only on data from face-to-face interviews from a detailed case study of one project within a larger study  
• program philosophy recognizes interdependent parent/child relationship & support needs of the young carer and the parent in parenting role  
• constructivist grounded theory & “ethics as process” study |
when they tell their stories & they have little control over what will happen, e.g. no adults will listen
• no time limit reported
diagnoses reported
• children assessed as having low self esteem, feeling responsible for parent’s problems, under-performing compared to peers; negativity reinforced by professional services

| 4. Orel et al., (2003); U.S.A. | children 8-13 yrs. graduate from a 5-week educational, to a 5-week support component, followed by mentoring support from Big Brothers/Sisters for at least 6 months
• goals based on children’s abilities to: name types of mental illnesses; verbalize a crisis plan; express feelings in a peer group; give/receive support; describe life with parental mental illness; spend scheduled time with a mentor outside the home; demonstrate increased self confidence by expressing feelings, making decisions, developing interests, having a sense of the future; improve hygiene & appearance; attend & actively participate in the group
• referred through parents’ mental health service provider

N=11
• 8-13 yrs., mean age=10.5 yrs., 8=F, 3=M
• various child diagnoses reported
• 8=live with mother;
1=father,
1=grandmother
• parental diagnoses: affective disorders & schizophrenia
• number of adults (parents & mental health professionals) not clear
• evaluation of one complete session
• measured children’s & parents’ perceptions of children’s self esteem & perceived family functioning; parent questionnaires re. children’s self-confidence, social competence & caregiving activities.
• group facilitators’ observations of children’s “performance”, e.g. learning assessed through role-play & behavioural demonstration
• qualitative “assessments” through analyses of caseworker notes, school grade reports & children’s journals & drawings shared with the group.
• children asked 3 additional open

| 5. Pitman & Matthey (2004); Australia & Canada | children 8-16 yrs. with a parent, sibling (schizophrenia or affective disorders), 3-day program; co-facilitated
• goals & activities: mental illness education; improve coping, resilience, self expression; increase self-esteem; reduce isolation; communication exercises, problem solving, art-work, music, interactive & relaxation exercises, peer support

N=25
• children, 5-15 yrs., mean age= 10.8 yrs., 2/3=F
• 15=lived with both parents, 7=“lone, “ill” parent, 2=“well” parent, 1=other relatives
• 3 settings:
2=Australia (N=19) &
• used “untested” instruments, e.g. What causes mental illness?
• pre-/post- questionnaire, e.g., “my ability to”: talk with people; listen to others; express good/bad feelings; recognize my strengths; be creative; solve problems; relax; feel good about myself; have fun.
• daily feed-back forms: program
• likes/dislikes; what else might have helped; & parent feed-back forms returned 2 weeks after end of program

Purpose: to evaluate Positive Connections, an education & support group for children 8-16 yrs.

Purpose: to evaluate SMILES (Simplifying Mental Illness=Life Enhancement Skills) program in three different intervention settings
6. Reupert & Maybery* (2009), Australia  
*program review article  
*Purpose:* to provide a “snapshot” of Australian programs for children and adolescents of parents with a mental illness (COPMI)  
- study aims: 1. identify aims/strategies of COPMI programs; 2. ascertain theoretical basis; 3. determine level & quality of evaluation protocols implemented; 4. draw on “practice wisdom” of program facilitators for future development.  
- N=18 program facilitators of 26 programs identified through COMPI websites, e-discussion lists & snowball recruitment;  
- 1-hour interview based on study aims; analyzed qualitatively  
- many programs target children 8-13 yrs., most don’t have psychological problems, live in urban areas  
- overall facilitators aim to promote peer interaction, enhance coping, self-esteem, understanding of mental illness & respite from caring; primarily supportive & preventative  
- most evaluated but measures not standardized and/or gauge children’s satisfaction  
- conclusion: facilitators require support, resources, training; program goals indicate measures required

7. Riebschleger et al., (2009); U.S.A.  
*Purpose:* to report early findings of a pilot psychoeducation intervention, Youth Education and Support (YES)  
- “youth” ages 10-16 yrs., parent with psychiatric illness; 6 “activity-focused” 2-hour sessions with 4 groups; co-facilitated by PI & mental health professionals  
- goals: getting acquainted, group rules & purposes; correct answers to knowledge scale, illness education, causes etc.; effectiveness of rehabilitation/recovery; stigma, more correct answers to knowledge scale; coping, crisis plans, people to contact, video of child/parent separation, talk about feelings/coping; youth goals, hope, future plans  
- draft manual written by PI, modifications per youth input: instructions, session objectives, sequence of activities, written materials to promote fidelity  
- majority recruited from public children’s mental health service agencies & middle-school siblings  
- N=17  
- “youth, 10-16 yrs., mean age= 13.06 yrs., 13=M  
- 7=siblings  
- all but two lived in home of parent “in recovery”; 11 single parent/grandparent headed households  
- majority parental diagnosis: mood disorder  
- held in community setting  
- youth-resiliency-related protective factors targeted for intervention; primarily consistent with “two decades of family psychoeducation programs”  
- pre/post measures: 1. A-COPE, published instrument, (coping skills e.g. optimism, social support, relaxing, solving or avoiding problems); 2. KPIRT, developed by first author, unpublished, untested instrument, (child knowledge, illness & treatment i.e. prevalence, causes, stigma, coping, hope)  
- purposive sampling
APPENDIX 3: OBSERVATION GUIDE
**Observational Guide**

The Education Sessions (program sessions 1 – 4)

The Support sessions (program sessions 5 – 8)

<table>
<thead>
<tr>
<th><strong>The Actors</strong></th>
<th><strong>The Backstage</strong></th>
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<tbody>
<tr>
<td>Two performing teams, principal and supporting characters</td>
<td>Setting</td>
</tr>
<tr>
<td>Personal front (clothing, manner etc.)</td>
<td>Physical layout</td>
</tr>
<tr>
<td></td>
<td>Actors</td>
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<td></td>
<td>‘Unscripted’ events</td>
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<thead>
<tr>
<th><strong>The (Front) Stage</strong></th>
<th><strong>The Plot or Action</strong></th>
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<tbody>
<tr>
<td>Setting</td>
<td>Arts of Impression Management</td>
</tr>
<tr>
<td>physical layout</td>
<td>(to avoid embarrassment/disruption to interaction)</td>
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<tr>
<td>furniture</td>
<td>Circumspection</td>
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<tr>
<td>stage props</td>
<td>Discipline</td>
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<tr>
<td></td>
<td>Loyalty</td>
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<tr>
<td></td>
<td>Dramatic Realization</td>
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<td></td>
<td>Signs to convey meaning</td>
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<tr>
<td></td>
<td>Dramatic Idealization</td>
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<tr>
<td></td>
<td>Signs of expressive control/coherence</td>
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<td></td>
<td>Signs of inconsistency in performance</td>
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<tr>
<th><strong>The Audience</strong></th>
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<td>those present in the setting versus an ‘imagined’ audience</td>
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<tr>
<th><strong>The Director</strong></th>
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<tbody>
<tr>
<td>Stage manager</td>
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<td>Other support</td>
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<tr>
<th><strong>The Script</strong></th>
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<tr>
<td>Activity/dialogue related to program plan</td>
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<td>Improvisation</td>
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<td>Non-verbal expression</td>
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APPENDIX 4: RECRUITMENT SCRIPT
Recruiting script (to be used by the Children’s Group intake coordinator)

Dear Mr./Mrs._________

An important study will be taking place this fall. The purpose of this study is to find out what children think about the Children’s Group. During the eight weeks that your child will be attending the Children’s Group, a student researcher from the University of Toronto will be observing the group and asking the children some questions about what she sees and hears during group activities. She will not change the program in any way. Her name is Brenda Gladstone and she used to be a volunteer working here at (the umbrella organization). On the last night of the program Brenda will provide a pizza dinner for the first hour of the session to talk with the children about what they thought about the group, the things they liked and did not like and their suggestions to make the program better. This study is important for three reasons: First, children and adolescents have important things to say about services that are designed to help them. Second, there may be things about the Children’s Group that could be changed to make it better. Third, the Children’s Group leaders need information from children to be sure that the programs meet their needs.

If you are willing to hear more about the project to decide if your child should be asked if she or he would like to participate, I will give your phone number to Brenda Gladstone, who will discuss the project with you in more detail. If you decide you do not want to be part of this study then I can offer you a place in another Children’s Group (details….to be filled in by the Children’s Group intake coordinator).
APPENDIX 5: CONSENT AND ASSENT FORMS
Research Ethics Board

Parent/Guardian Consent Form

Title of Research Project: A Study of a Support Group for Children who have a Parent with a Mental Illness

Investigators:
Brenda M. Gladstone, PhD (candidate), Public Health Sciences, University of Toronto
Katherine Boydell, MHSc, PhD, Associate Professor, Departments of Psychiatry & Public Health Sciences, University of Toronto and Sick Kids
Patricia McKeever, RN, PhD, Professor, Faculty of Nursing, University of Toronto.
Mary Seeman, MDCM, FRCP, FACP, Professor, Department of Psychiatry, University of Toronto.

Purpose of the Research:
The purpose of this research is to find out kids responses to and evaluations of the Children’s Group, a support group for children who have a parent with a mental illness. We do not know if this group helps children because no one has asked children themselves. I will attend the Children’s Group to watch what happens and ask some questions about what I see and hear. On the last night of the program we will have a pizza dinner and talk about the things kids liked and didn’t like and how the program could be improved. It is important to know kids’ opinions and responses to this group for three reasons: First, kids will have important things to say about the Children’s Group. Second, there may be things about the program that could be changed to make it more suitable for all children. Third, the Children’s Group workers need information from kids to be sure that the Children’s Group is meeting their needs.

Description of the Research:
If your child chooses to participate in this study, he/she will:

1) Meet with me, Brenda Gladstone in your home or a place of your choosing, and I will tell you and your child more about the study, answer your questions and ask you to sign this Consent Form.
2) Your child will see me at each session of the group. I will be watching and listening to what is happening with all the children who are participating in the group. Sometimes I will be writing things down so that I do not forget things that are important to describe. I might ask questions about things that happen in the group.

3) If your child wants to tell me something about what it is like to be in the group, but wants to do this in private, he/she can phone me or e-mail me. My phone number and e-mail address is listed at the top of this consent form. Your child can also write out a question or message and put it in the message box I will bring with me to each session. Your child does not have to put their name on these questions or comments.

4) On the last night of the program, we will have a pizza supper and a group discussion before the session starts. I will ask the group some questions about what kids liked or did not like about being part of the Children’s Group. I will also ask for advice about what might make the group better. This discussion will take about one hour and will be tape recorded. A separate consent to be audio-taped must be also be completed.

**Potential Harms:**
We know of no harms associated with participation in this study.

**Potential Discomforts or Inconvenience:**
Your child may feel uncomfortable talking about some experiences during the group interview. The group discussion on the last night will take approximately 1 hour before the last session begins.

**Potential Benefits:**
Your child may not benefit directly from participating in this study. If you or your child would like to know the results of the study when it is finished, a summary will be sent to you.

The results of this study will be given to the people who work at the Children’s Group and to other people who work with children in groups to help them design better groups. Articles will be written for the special magazines that people working in mental health read.

**Confidentiality:**
We will respect your child’s privacy. No information about who your child is will be given to anyone or be published without your permission. The only time we would tell anyone what your child said would be if we thought your child’s health was in danger. If this happened we would tell the Children’s Group coordinator.

The data produced from this study will be stored in a secure, locked filing cabinet. Only me and my supervisors (who are named at the top of this form) will have access to the data.

During the group interview on the last night of the program I will remind everyone that the information shared is private and should not be repeated outside the group. I cannot be sure other kids in the group will not share information about you with others.
My research records may be inspected by the HSC Clinical Research Office Monitor, however you will be given a unique identifying number in the data and therefore you will not be identified by name.

**Participation:**
Participation in research is voluntary. If you or your child chooses not to participate, your child will be given an opportunity to participate in the other *Children’s Groups* running at the same time as the one that is part of this study, in a different location. If your child decides at any point during the *Children’s Group* that they want to withdraw from the study, your child will be given the option of switching to the other group that is currently running at the same time as the group under study, or to be placed in the next available *Children’s Group* that will be offered. You will be given a copy of this consent form for your records. In no way does signing this consent form waive your legal rights nor does it relieve the investigators, sponsors or involved institutions from their legal and professional responsibilities.

**Consent:**
By signing this form, I agree that:
1) You have explained this study to me. You have answered all my questions.
2) You have explained the possible harms and benefits (if any) of this study.
3) I know what I can do instead of having my child take part in this study. I understand that I have the right to refuse to let my child take part in the study. I also have the right to take my child out of the study at any time. My decision about my child taking part in the study will not affect my child’s participation in the *Children’s Group*.
4) I am free now, and in the future, to ask any questions about the study.
5) I have been told you will give no one information about my child, unless you thought my child’s health was in danger.
6) I understand that no information about my child will be given to anyone or be published without first asking my permission.
7) I have read and understood pages 1 to 3 of this consent form. I agree, or consent, that my child______________________________ may take part in this study.

__________________________________________
Printed Name of Parent/Legal Guardian

__________________________________________
Signature & Date

__________________________________________
Printed Name of person who explained consent

__________________________________________
Signature & Date

__________________________________________
Printed Witness’ name (if the subject/legal guardian does not read English)

Witness’ Signature & Date
Title: A Study of a Support Group for Children who have a Parent with a Mental Illness

Investigators:
Brenda M. Gladstone, PhD (candidate), Public Health Sciences, University of Toronto,
Katherine Boydell, MHSc, PhD, Associate Professor, Departments of Psychiatry & Public Health Sciences, University of Toronto and The Hospital for Sick Children,
Patricia McKeever, RN, PhD, Professor, Faculty of Nursing, University of Toronto.
Mary Seeman, MDCM, FRCPC, FACP, Professor, Dept. of Psychiatry, University of Toronto.

I hereby consent to my child being audio-taped during participation in this research project. These tapes will be used to ensure that the researchers have an accurate record of what my child has said in the interview. All of the information collected during this study will be held confidential and secured by the Co-Principal Investigator, Ms. Brenda Gladstone. Audio-tape recordings will be stored in a locked cabinet by Ms. Brenda Gladstone and the tape destroyed upon completion of the project. I understand that I am free to withdraw this consent for audio-taping at anytime without penalty.

In addition, I give permission for my child’s audio-tape and photographs to be used for:

1. Other studies on the same topic □ Yes □ No
2. Teaching and demonstration at professional meetings □ Yes □ No
3. Not to be used for anything else. □ Yes □ No

I understand that I am free to withdraw my permission for these additional uses of my child’s tape/photographs at any time.

_______________________________
Printed Name of Parent

_______________________________
Parent’s signature & Date

_______________________________
Printed Name of person who obtained consent

The person who may be contacted at Sick Kids about the research is:
Brenda Gladstone

_______________________________
Signature & Date
Research Ethics Board

(Adult Facilitator) Participant Consent Form

Title of Research Project: A Study of a Support Group for Children who have a Parent with a Mental Illness

Investigators:
Brenda M. Gladstone, PhD (candidate), Public Health Sciences, University of Toronto.
Katherine Boydell, MHSc, PhD, Associate Professor, Departments of Psychiatry & Public Health Sciences, University of Toronto and The Hospital for Sick Children.
Patricia McKeever, RN, PhD, Professor, Faculty of Nursing, University of Toronto.
Mary Seeman, MDCM, FRCPC, FACP, Professor, Department of Psychiatry, University of Toronto.

Purpose of the Research:
The purpose of this research is to find out kids responses to and evaluations of the Children’s Group, a support group for children who have a parent with a mental illness. We do not know if this group helps children because no one has asked children themselves. I will attend Children’s Group to watch what happens and ask some questions about what I see and hear. On the last night of the program we will have a pizza dinner and talk about the things kids liked and didn’t like and how the program could be improved. It is important to know kids’ opinions and responses to this group for three reasons: First, kids will have important things to say about the Children’s Group. Second, there may be things about the program that could be changed to make it more suitable for all children. Third, the Children’s Group workers need information from kids to be sure that the Children’s Group is meeting their needs.

Description of the Research:
As a facilitator of the Children’s Group program that is being studied, by signing the consent you choose to participate in this study and you will:
1) Meet with me, Brenda Gladstone, and I will tell you more about the study, answer your questions and ask you to sign this Consent Form.

2) You will see me at each session of the group. I will be watching and listening to what is happening with all the group members who are participating in the sessions. Sometimes I will be writing things down so that I do not forget things that are important to describe. I might ask questions about things that happen in the group.

**Potential Harms:**
We know of no harms associated with participation in this study.

**Potential Discomforts or Inconvenience:**
You may feel uncomfortable knowing that I am observing and listening to what happens in the group.

**Potential Benefits:**
You may not benefit directly from participating in this study.

The results of this study will be given to the staff at the Children’s Group and to other people who work with children in groups to help design better groups. Articles will be written for the journals that people working in mental health read.

**Confidentiality:**
We will respect your privacy. No information about who you are will be given to anyone or be published without your permission.

The data produced from this study will be stored in a secure, locked cabinet. Only me and my supervisors (who are named at the top of this form) will have access to the data.

My research records may be inspected by the HSC Clinical Research Office Monitor, however you will be given a unique identifying number in the data and therefore you will not be identified by name. It may be possible, particularly with the small number of adult participants, to identify you.

**Participation:**
Participation in research is voluntary. You may withdraw from the study at any time. If you decide to withdraw from the study you will be given an opportunity to facilitate the parallel Children’s Group operating at the same time as the one under study. You will be given a copy of this consent form for your records. In no way does signing this consent form waive your legal rights nor does it relieve the investigators, sponsors or involved institutions from their legal and professional responsibilities.

**Consent:**
By signing this form, I agree that:
1) You have explained this study to me. You have answered all my questions.
2) You have explained the possible harms and benefits (if any) of this study.
3) I understand that I have the right not to take part in the study and the right to stop at any time.
4) I am free now, and in the future, to ask any questions about the study.
5) You will give no one information about me.
6) I understand that no information about who I am will be given to anyone or be published without asking my permission.

7) I have read and understood pages 1 to 3 of this consent form. I agree, or consent, to take part in this study.

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<tr>
<th>Printed Name of Participant</th>
<th>Participant’s Signature &amp; Date</th>
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<th>Printed Name of person who explained consent</th>
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<th>Printed Witness’ name (if the subject/legal guardian does not read English)</th>
<th>Witness’ Signature &amp; Date</th>
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If you have any questions about this study, please call Brenda Gladstone.
Title of Study: A Study of a Support Group for Children who have a Parent with a Mental Illness

Investigator(s):
Brenda M. Gladstone, PhD (candidate), Public Health Sciences, University of Toronto and Research Coordinator, The Hospital for Sick Children.

Katherine Boydell, MHSc, PhD, Associate Professor, Departments of Psychiatry & Public Health Sciences, University of Toronto and The Hospital for Sick Children.

Patricia McKeever, RN, PhD, Professor, Faculty of Nursing, University of Toronto.

Mary Seeman, MDCM, FRCPC, FACP, Professor, Department of Psychiatry, University of Toronto.

Why are we doing this study?
We are doing this study to find out what kids like and dislike about being a part of the Children’s Group. We don’t really know if this group is helpful because we haven’t asked kids what they think about it. I (Brenda Gladstone) will be attending the Children’s Group to watch what happens in the group and sometimes ask some questions about what I see and hear. On the last night of the Children’s Group we will have a pizza dinner and talk about the things you liked and didn’t like and how the group could be made better. It’s important to know what kids’ think for 3 reasons. First, you will have important things to say about the Children’s Group. Second, there may be things about the Children’s Group that could be changed to make it better for all children. Third, the Children’s Group workers need to know if kids like the group and think it is helpful.

What will happen during the study?
If you decide to be part of this study you will:

1) Meet with me, Brenda Gladstone. I will tell you and your parent/guardian more about the study, answer your questions and ask you to write your name on this form. This
form is called an Assent Form. If you sign the form it means you will be part of the study.

2) I will be coming to the group every week. I will be watching and listening to what is happening in the group. Sometimes I will be writing things down so that I do not forget things that are important to describe. I might ask questions about things that happen in the group.

3) If you want to tell me something about what it is like to be in the group, but by yourself and not in front of everyone you can do three things. You can phone me at the number on the top of this form. You can e-mail me at the address at the top of this form. You can write out a question or a message and put it in the message box I will bring with me each week. You do not have to put your name on these questions or comments.

4) On the last night of the Children’s Group we will have a pizza dinner together and a group discussion. I will ask you what liked and didn’t like about the Children’s Group. I will also ask you for advice about what you think might make the group better for all children. This discussion will take about one hour during the first part of the evening. I will audio-tape our discussion so that I can remember correctly what we talked about.

**Are there good things and bad things about the study?**
There are no bad things about the study. The good thing is that your ideas may help make groups for children the way children would like them to be.

**Who will know about what I did in the study?**
No one will know what you tell me. Your answers will be mixed with the other children’s and no names will be on them. The only time I would tell anyone what you said would be if we thought your health was in danger. If this happened, we would tell the Children’s Group coordinator.

**Can I decide if I want to be in the study?**
Yes. It is up to you if you want to be in the study or not. Nobody will be angry or upset if you do not want to be in the study. If you start the group and decide later you do not want to be part of the study, you will be able to join a different group. I will talk to your parents/caregivers about the study. You should talk to them about it too.

**Assent:**
I was present when ____________________ read this form and said that he or she agreed, or assented, to take part in this study.

Name of participant____________________________________

Participant’s Signature _________________________________

Printed Name of person obtaining assent_________________

Signature & date_______________________________________
APPENDIX 6: GROUP DISCUSSION GUIDELINE QUESTIONS
Group Discussion Guideline Questions

1. What do you like about being in this group?*

2. In what ways have you found this group helpful?

3. What do you not like about being in this group?

4. What kinds of things would you like help with, that haven’t been discussed in this group?

5. What would make the Children’s Group better for other children?

6. If you had a magic wand, what would you change?

7. Do you think being part of a research study like this is helpful? Why, or why not?

*prompts to encourage responses to these questions:

- based on feedback of preliminary analysis of participant observation data
- based on ‘topic starter list’ identified by anticipatory fieldwork
- related to conceptual framework (performance & dramaturgical strategies) and goals of the Children’s Group program (education & support) for e.g.
  - The script
    - Education sessions
    - Support sessions
  - The other actors
  - The playwright, director, stage manager, audience
  - The stage (s): the space/setting/physical layout
    - Backstage: time-out; privacy; ‘offstage’ activity
  - The plot (activities and events related to the program sessions).
APPENDIX 7: “OTHER THINGS I THINK ABOUT THIS GROUP ARE....” FORM
OTHER THINGS I THINK ABOUT THIS GROUP ARE....

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Children’s Group
APPENDIX 8: PARTICIPANT BACKGROUND INFORMATION FORM
Participant Background Information Form*

Date:

Participant identification number:

Age:

Date of Birth:

Country of Birth:
  Child:

  Parent:

Language spoken at home:

Current living arrangements:

Current postal code:

Gender of parent diagnosed with a mental illness:

Diagnosis (or nature of illness):

Family context (presence of other parent; extended family members; siblings):

Referral to the Children’s Group:

Participant diagnosis (if applicable):

Name of school:

Grade at school (include any special educational arrangements):

*Note: to be completed by the Children’s Group coordinator.
APPENDIX 9: EXAMPLES OF THEMATIC MAPPING
Mapping Concepts

We are here because...

In the Body

Brain Disease/Mechanical Dysfunction

an illness like any other

stress

as Chronic

DSM/Treatment

Unpredictable

in the Same Boat

You are not Alone

Choice/No Choice

Feeling/Emotion

Control/no Control

Thinking

Behaviour/Action

Twisted Thinking

Symptoms

Febrile

As Chronic

You, others, collective

Talk

Accurate Information

Prevention

Me or I, individual

Have a Plan

Responsibility

Protection

Risk/Safety

People

Places

Future

Time

Stage/Setting

Identity

You, others, collective

Me or I, individual

Have a Plan

Responsibility

Protection

Risk/Safety

People

Places

Future

Time

Stage/Setting

Identity

You, others, collective
APPENDIX 10: SAMPLE BTU SCRIPT
Sample Script

*Bridges to Understanding*

Goals
- To learn accurate and up-to-date information about the causes of mental illness
- To understand how the thought processes works in a person with a mental illness
- To understand that the child did not cause the mental illness. [pg. 28]

The next page begins with a text box at the top, which includes a list of materials required for the session, followed by the facilitator session notes and so forth.

FACILITATOR SESSION NOTES

i. There is a lot of information in this session. You may need to prioritize what is most important for your particular group.

ii. In our experience, group members are very interested in the causes of mental illness. The following section, which covers the causes of mental illness, can take a lot of extra time, because members often have a lot of questions around this issue. The facilitator can decide whether to start or finish with this section.

[there are nine further items in this section advising the facilitator on how to use neurotransmitter posters, and the decorated clothespin dolls to teach mental illness information; when to give snack, and how to judge the need for physical activities so the children can take a break] [end of pg. 29]
[picture of a door opening] OPENING TIME (15 minutes)
Recap what was learned in the last session about how thoughts can influence feelings and action/behaviours. Ask the children to give a personal example of how their thoughts influenced their feelings or actions in the past week.

Ask the children if they tried to STOP their negative thoughts.

Address any issues that may have arisen with regard to the GROUP RECIPE or confidentiality.

Ask the children if they have more questions about mental illness that they would like to add to their question list form session one.

WORKING TIME (60 minutes)
Inform the group that this session is designed to explain what mental illness is and some of the possible causes for it. We want the children to have accurate information, to dispel some of the myths and misunderstandings, and to help them understand how to deal with the illness in a more appropriate way.

GROUP ACTIVITY (10 minutes)
Post a sheet of easel paper on the wall so that a list can be written on it.

⇒ Let’s take a few minutes to talk about what most people think about a person with a mental illness. What are some of the words or phrases that people use to describe someone with a mental illness? (Write their responses on the paper).
⇒ Why do you think people use these words to describe a person with a mental illness? People tend to use labels (the word, “names” is crossed out) when they (“are afraid and” is crossed out) don’t understand the problem or the situation.
⇒ Now we will learn what mental illness really is and what causes it. Then you can explain this information to anyone who doesn’t understand what mental illness is and may feel afraid of it or have wrong ideas about it”.

THE THINKING PROCESS (15 minutes)

(“accurate thinking” is crossed out)
⇒ When the brain is doing its job correctly, a person sees what is really there. When your eyes see a cat, your brain thinks and says to itself, “I see a cat.” (Show the group a picture of a cat.)
⇒ When you see this pencil on the table, if your thinking is accurate, your brain will recognize it as a pencil. When your eyes see an elastic, your brain thinks and says to itself, “I see an elastic”. [pg. 30]  [illustration of a head in profile, cogs/wheels turning inside ‘the brain’]

[there are three other points of a similar nature made in this section]

Twisted Thinking
To illustrate the difference between healthy, accurate thinking versus twisted thinking we use the pictures of a cat and a lion.
When your family member’s thinking becomes twisted *what their eyes see and their brain thinks it sees are different*. [ink drawing of neurotransmission]

[continues in this vain for the entire page]

**TWISTER GAME (10 minutes)**

At this point, we suggest you take a break and play a game of twister. Simply play it as it is normally played. One child can be the spinner, or if you have too many volunteers, let them take turns. This game acts as a good introduction to the next discussion about the THINKING PROCESS and TWISTED THINKING.

**THE BRAIN/BRIDGE ANALOGY (10 minutes)**

Place the props on the table in front of the group. Put the islands (neurons) down and place the bridge (neurotransmitter) between them. Place the car (thought/message) on the first island.

⇒ Thoughts travel through the brain form one neuron to another, through neurotransmitters….[goes on to explain neurotransmission]

⇒ When the brain is not working properly, it cannot send the message across the gap, form one island to the other, because there are problems with the bridge. The thought-car may start to cross the bridge, but there may be cracks in the bridge or big bumps and the car begins to skid. Maybe it even does a 360 and falls off the bridge! Sometimes the thought car gets damaged and bits of it fall off. Maybe the car loses a tire or its windscreen, and arrives at the second island all twisted and out of shape. The message that started out as one thing gets damaged and changed in the process of crossing the bridge.

⇒ Sometimes the bridge might totally collapse, and then the thought-car can never leave the island at all!”

Repeat this process until the children understand the difference between a health and an unhealthy neurotransmitter.

Allow time for questions. Do not move on from this discussion until the children understand fully that mental illness has a physical property.

[small drawing of a lightening bolt] **ENERGIZER (5 minutes)**

At this point we suggest you take a break and do a quick energizer – running on the spot, star jumps, hopping etc. This could also be a good time to service snack. They can eat snack during the following discussion on POSSIBLE CAUSES.

**POSSIBLE CAUSES (15 minutes)**

[pages 32 to 36 complete the session with scripted dialogue to talk about physical, social and hereditary causes; demonstrate genetic links to mental illness and statistical risk using a ‘clothespin doll demonstration’]

**CLOSING TIME (10 minutes)**

At this point snack is served.

⇒ Ask the members: what was the most helpful information for you in this session?
AFFIRMATION STATEMENT:
⇒ You have listened really well today and asked some really good questions. Keep asking and talking!
Say goodbye to each of the children as they leave.

[the chapter concludes with some optional information on: twin studies and the relationship to understanding risk for illness; the idea that ‘the majority of people living with mental illness live fairly normal lives’; and other kinds of energizers that can be used in this session].
APPENDIX 11: SUMMARIZED CONTENT OF BTU SESSIONS
### Bridges to Understanding

<table>
<thead>
<tr>
<th>Session 1</th>
<th><strong>Bridges to New Places</strong></th>
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<tr>
<td><strong>Goals</strong>: to establish relationships among members, including facilitators; to create an atmosphere where members can feel comfortable talking about mental illness. <strong>Activities</strong>: participant introductions; children encouraged to see they are not alone; group ground rules, ‘keeping confidentiality’; begin to answer basic questions about mental illness</td>
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<tr>
<th>Session 2</th>
<th><strong>Bridges to Discovery</strong></th>
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<td><strong>Goals</strong>: to understand each member’s perception of their particular situation; to learn that thoughts can influence feelings/actions; to understand the parent with a mental illness has difficulty managing their thoughts. <strong>Activities</strong>: discuss ‘thoughts, feelings and behaviour’ and how this influences parents behaviour (or ‘symptoms’)</td>
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<tr>
<th>Session 3</th>
<th><strong>Bridges to Knowledge</strong></th>
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<td><strong>Goals</strong>: to learn accurate &amp; up to date information about the causes of mental illness; to understand how thought processes work in a person with mental illness; to understand that the child did not cause the mental illness. <strong>Activities</strong>: recognizing difficult behaviours as symptoms of mental illness; concrete demonstration to ‘show what mental illness is’, how neurotransmission works, and demonstrate genetic possibilities of ‘getting a mental illness’</td>
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<th>Session 4</th>
<th><strong>Bridges to Awareness</strong></th>
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<td><strong>Goals</strong>: to learn about mental illness symptoms, and those experienced by group members; to learn about diagnostic processes; to learn about forms of treatment &amp; the concept of side-effects. <strong>Activities</strong>: Discuss specific symptoms, diagnoses, psychiatric hospitalization, treatment and side-effects of medications.</td>
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<th>Session 5</th>
<th><strong>Bridges to Courage</strong></th>
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<td><strong>Goals</strong>: to recognize it is okay to be scared by the unpredictable behaviour of the parent with a mental illness; to recognize the physical signs of fear; to learn ways to work through your fears. <strong>Activities</strong>: to see fears as manageable experiences, to separate symptoms from the person who is experiencing them; concrete demonstrations to help the children learn to interpret when they feel fear; group discussion about fears, but also ‘good’ and positive experiences with their family.</td>
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<th>Session 6</th>
<th><strong>Bridges to Safe People &amp; Places</strong></th>
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<td><strong>Goals</strong>: to learn about their personal feelings of safety; to know when coping skills are working for them; to develop a personal feeling of safe people &amp; places. <strong>Activities</strong>: children are encouraged to create a ‘safe spot’ by building tents with sheets as representations of their individual places of safety; facilitators ask questions about their ‘imaginary structures’; children are invited to visit one another’s safe spaces, but only after receiving permission.</td>
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<th>Session 7</th>
<th><strong>Bridges to Coping</strong></th>
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<td><strong>Goals</strong>: to have members recognize the coping strategies used by a child in a film about parental mental illness; to assess the safety of member’s coping skills. <strong>Activities</strong>: the children watch a film clip about a young girl’s experience of her mother’s mental illness; discussion to help children understand and accept that they have a life independent of the ill parent.</td>
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<th>Session 8</th>
<th><strong>Bridges to the Future</strong></th>
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<td><strong>Goals</strong>: to provide closure for the group member; to share realistic wishes and dreams for the future. <strong>Activities</strong>: revisit some of what they’ve learned &amp; write a collective letter to incoming participants; facilitators write a personal ‘graduation’ letter to each child, which is to be optimistic, hopeful, but uniquely tailored to the individual, includes memories of something shared during the group sessions.</td>
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