



2809443898

Processes of Resilience in Offspring of Parents With Depression

Emma Hartwell

D.Clin.Psy. thesis (Volume 1), 2007

University College London

UMI Number: U592869

All rights reserved

INFORMATION TO ALL USERS

The quality of this reproduction is dependent upon the quality of the copy submitted.

In the unlikely event that the author did not send a complete manuscript and there are missing pages, these will be noted. Also, if material had to be removed, a note will indicate the deletion.



UMI U592869

Published by ProQuest LLC 2013. Copyright in the Dissertation held by the Author.
Microform Edition © ProQuest LLC.

All rights reserved. This work is protected against
unauthorized copying under Title 17, United States Code.



ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106-1346

Overview

This thesis comprises three parts. Part one provides a review of the literature on the effects of growing up with a parent with depression and on resilience in offspring of depressed parents. Part two presents the qualitative empirical paper, which examined processes of resilience across the lifespan in adult offspring of depressed parents. Part three is a critical appraisal, which includes discussion of particular issues and challenges that arose regarding the design and implementation of the study and analysis of the data, and elaborates on the clinical implications of the findings.

Table of Contents

Acknowledgements	5
Part 1: Literature Review- Understanding Resilience in Offspring of Parents With Depression	6
Abstract.....	7
Introduction	8
Impact of Parental Depression.....	9
<i>Impact of Parental Depression in Childhood</i>	<i>9</i>
<i>Impact of Parental Depression in Adulthood.....</i>	<i>12</i>
<i>Explaining the Risk Associated with Parental Depression</i>	<i>14</i>
<i>Summary.....</i>	<i>16</i>
Resilience.....	17
<i>What Is Resilience?</i>	<i>17</i>
<i>Research on Resilience and Protective Factors.....</i>	<i>18</i>
<i>Summary.....</i>	<i>21</i>
Resilience in Offspring of Depressed Parents	21
<i>Identification of Studies.....</i>	<i>22</i>
<i>Coping in Offspring of Depressed Parents</i>	<i>23</i>
<i>Specific Factors Linked with Resilience.....</i>	<i>35</i>
<i>Preventive Interventions.....</i>	<i>40</i>
<i>Summary.....</i>	<i>45</i>
Conclusions	47
<i>Future Directions for Research.....</i>	<i>50</i>
<i>Clinical Implications</i>	<i>51</i>
References	53
Part 2: Empirical Paper - Processes of Resilience in Offspring of Parents With Depression.....	59
Abstract.....	60
Introduction	61
Method.....	65
<i>Ethical Approval</i>	<i>65</i>
<i>Participants</i>	<i>65</i>
<i>Researcher’s Perspective</i>	<i>68</i>
<i>Semi-structured Interview</i>	<i>70</i>
<i>Qualitative Data Analysis</i>	<i>71</i>
Results	73
<i>Domain 1: Context</i>	<i>73</i>
<i>Theme 1.1: Depression As Normality</i>	<i>74</i>
<i>Theme 1.2: Sensing But Not Understanding</i>	<i>74</i>
<i>Theme 1.3: Helplessness and Powerlessness</i>	<i>75</i>
<i>Theme 1.4: Own Problems and Vulnerabilities</i>	<i>76</i>
<i>Domain 2: Social.....</i>	<i>76</i>
<i>Theme 2.1: “A Fortress of Support”</i>	<i>76</i>
<i>Theme 2.2: Having a Normal Childhood.....</i>	<i>79</i>

<i>Domain 3: Family</i>	80
<i>Theme 3.1: Starting To Talk About It</i>	80
<i>Theme 3.2: Still a Good Parent</i>	81
<i>Theme 3.3: Having a Stable Parent Figure</i>	82
<i>Theme 3.4: Sharing the Burden With Siblings</i>	83
<i>Domain 4: Individual</i>	84
<i>Theme 4.1: Learning Strategies For Dealing With Parent</i>	84
<i>Theme 4.2: Separating Self From Parent</i>	85
<i>Theme 4.4: Becoming Self-Aware</i>	87
<i>Theme 4.5: Making Sense Of It</i>	88
Discussion.....	90
References	99

Part 3: Critical Appraisal	104
Introduction	105
Sample and Recruitment Issues.....	105
<i>Defining Resilience</i>	105
<i>Recruitment</i>	107
<i>Heterogeneity and Homogeneity of Sample</i>	109
Interviewing.....	110
Qualitative Data and Analysis	112
Clinical Implications of the Findings	114
References	117

Appendices

Appendix A - Ethics Committee Approval Letter.....	119
Appendix B - Participant Information Sheet	122
Appendix C - Informed Consent Form.....	125
Appendix D - Interview Schedule	127
Appendix E - Stage One of the Analysis.....	131
Appendix F - Stage Two of the Analysis	133
Appendix G - Stage Three of the Analysis.....	135
Appendix H - Example of Summary of Themes for Participants.....	140

Tables

Table 1 – <i>Summary of Studies</i>	24
Table 2 – <i>Participant Details</i>	69
Table 3 – <i>Domains and Themes</i>	74

Acknowledgements

I would like to thank all the people who took part in this study, for giving their time and sharing their stories with me; without their input and thoughtfulness this study would not have been possible. I would also like to thank my supervisor, Nancy Pistrang, who provided me with so many ideas and suggestions, and so much support and encouragement throughout the project. Finally, I would like to thank my family and friends for their love and support, and for putting up with me while I got this done! Particularly Mum, Dad, Cal and Mark, for their encouragement, proof-reading, cups of tea and pep talks.

Part 1: Literature Review

Understanding Resilience in Offspring of Parents With Depression

Abstract

The literature detailing the effects of growing up with a parent with depression is extensive, and there is a burgeoning body of literature delineating processes of resilience in at-risk children. Both of these fields are summarised here, before a more in-depth examination of studies which have brought these two areas together. Only a limited number of studies have explored resilience in offspring of depressed parents. These studies have focused on coping, on factors that aid resilience and on preventive interventions designed to promote resilience. Relevant factors have emerged from this review but less is understood about the processes that underlie resilience. Further research is needed to increase our understanding of both why and how some offspring of depressed parents show positive adaptation despite being at risk.

Introduction

People who grow up with a parent with depression have long been identified as being at higher risk of experiencing problems themselves. This risk encompasses not only a greater likelihood of experiencing depression but also other mental health problems and additional problems with areas such as social functioning and interpersonal interactions (Beardslee, Versage & Gladstone, 1998; Hammen, 2003). However, outcomes for offspring of depressed parents are by no means uniform, and there are many people who do not suffer any negative outcomes. Resilience – the process of positive adaptation despite experiencing significant adversity – is an area which is generating increasing interest amongst researchers (Cicchetti, 2003). Resilience is particularly relevant in considering how preventive interventions may be most effectively employed with at-risk populations. This paper addresses the question of what is known about processes of resilience in offspring of depressed parents, and therefore how resilience may be promoted for this group.

The first section sets the context with an overview of the current state of the field in parental depression risk research. As there are a number of thorough reviews available which provide an excellent summary of the research in this field (e.g. Downey & Coyne, 1990; Rutter, 1990; Beardslee, Versage & Gladstone, 1998), the aim of this section is to provide an overview of what is known about the impact of parental depression on offspring, both in childhood and adulthood, drawing on previous reviews and focusing on more recent, well-designed studies. Consideration will also be given to *how* this impact is proposed to occur: by what processes does having a depressed parent put individuals more at risk?

The second section will introduce the field of resilience as a theoretical base from which positive outcomes in offspring of depressed parents can be understood.

Consideration will be given to issues relevant to this field, particularly those relating to definitional difficulties, and a broad overview will be provided of the research which has identified factors and processes generally considered to be protective for those at risk.

The third, main, section will examine how these two fields have begun to be drawn together, providing a detailed literature review of research into resilience in the offspring of depressed parents.

Finally, the ways in which parental depression risk research and resilience research can be better integrated will be discussed. Consideration will be given to how the gaps in current knowledge about resilience in offspring of depressed parents can be addressed and suggestions for further research will be proposed.

Impact of Parental Depression

Impact of Parental Depression in Childhood

An early review of the literature on children of depressed parents (Downey & Coyne, 1990) concluded that these children are at risk for a wide range of problems in psychological functioning and for higher rates of psychiatric diagnoses, particularly affective disorders. Since that time much more work has been undertaken, which has generally added further support to this conclusion and has also begun to address some of the gaps highlighted by the authors of that review.

The rates of depression in offspring of depressed parents have been examined in a number of studies, and reports range from 20% to 45% for school age children and adolescents. The rates in the comparison offspring in these studies ranged from 4% to 24% (see review by Hammen, 2003). This fits with reported statistics for the general population: rates of episodes of depression in a community adolescent

sample in the USA were reported as 17.6% (Lewinsohn, 1988, cited in Beardslee, Keller, Lavori, Staley & Sacks, 1993), and in a community sample for the ages 15 to 54 years lifetime prevalence rates of depression were 17.1% (Kessler et al., 1994).

Thus, having a depressed parent may increase the risk of depression in children by up to threefold (Beardslee et al., 1993). Numerous studies have also found increased rates of other psychiatric disorders in children with affectively ill parents compared to those children whose parents are not ill (see review by Beardslee et al., 1998). Meta-analytic studies suggest that as many as 61% of offspring of parents with major depression will develop a psychiatric disorder during childhood or adolescence (Beardslee et al., 1998).

In addition to an increased likelihood of experiencing depression and other psychiatric illnesses, children of parents with an affective disorder are also more likely to experience other problems including emotional and behavioural disturbance, interpersonal difficulties, attachment difficulties, increased feelings of guilt, negative self-concept and negative attributional style (Pound, 1996; Beardslee et al., 1998).

Many of these studies have looked at children of parents selected from treatment clinics, and as such tend to include a subset of parents with more severe depression, or those who are more prone to seek help. However, the few studies which have looked at non-referred community samples show similar results to other studies in this area, giving a provisional indication that the findings are fairly robust and that effects on offspring are not limited to clinically identified populations but are also present in more representative samples (Beardslee et al., 1993; Lieb, Isensee, Hofler, Pfister & Wittchen, 2002). The validity of the findings is also supported by the fact that similar results have been found both in studies which use a “top-down” approach, looking at children of depressed parents, and in “bottom-up” studies which

look at rates of depression in parents of depressed and non-depressed children (Lieb et al., 2002).

In addition to higher prevalence rates, the episodes of depression experienced by offspring of depressed parents may be more severe than those of offspring whose parents are not depressed. Several longitudinal studies have found that the children of depressed parents had episodes of depression that were of earlier onset and longer duration, and also had a higher level of co-morbidity and greater reported impairment (Beardslee et al., 1993; Weissman et al., 2006; Hammen, Burge, Burney & Adrian, 1990).

Having a parent with bipolar disorder also has a negative effect for offspring; however, it is unclear whether the effects are the same as for offspring of parents with unipolar depression. Zahn-Waxler et al. (1988) looked at a small group of younger children of parents with bipolar disorder and found that, compared to a group of control children, at age 6 they were showing more problems in terms of both internalising and externalising disorders. However, for most of the children in the bipolar parent group there was a confounding factor of unipolar depression in their other parent. Another study showed some suggestion that children of mothers with unipolar depression fare slightly worse than those of mothers with bipolar disorder in terms prevalence and severity of mental health disorders at a younger age (Hammen et al., 1990). However this study used relatively small sample sizes and the cases of bipolar disorder were somewhat milder than the cases of unipolar depression, so it is questionable how meaningful this result is. Additionally, the authors note that a longer follow-up of the offspring may reveal more significant disorders in the bipolar group (Hammen et al., 1990).

Impact of Parental Depression in Adulthood

The research reported above has stemmed from an interest in the needs and experiences of children who are growing up with a parent with depression. However, until more recently, there has been less focus on these children once they have grown up and on the longer-term effects that their experiences may have on them, or indeed on the avoidance of any such longer-term effects. This has begun to be explored and, though there are some contradictory results, initial findings suggest that the effects of having a depressed parent are not limited to childhood. Beardslee et al. (1998), in their review, note that “longitudinal studies have shown that the disadvantages associated with growing up in a home with an affectively ill parent persist over time” (p.1135).

One group of researchers followed a cohort of offspring of depressed and nondepressed parents, and reported findings at 10 years and 20 years follow-up. In the results of the 10-year follow-up Weissman, Warner, Wickramaratne, Moreau and Olfson (1997) found that offspring of depressed parents had increased rates of major depressive disorder and of other disorders such as phobias, panic disorder and alcohol dependence, compared to offspring of parents who were not depressed. They also found that offspring of depressed parents had lower levels of general functioning in areas such as home, work and marriage than the control group at the 10-year follow-up. These findings were generally borne out by the 20-year follow-up study (Weissman et al., 2006). The results of this study indicated that offspring of depressed parents had approximately a threefold higher risk of having mood or anxiety disorders compared to the offspring of nondepressed parents. The highest incidences of specific disorders reported were of major depression and phobias. There was also a higher risk of substance dependence for offspring of depressed

parents, consistent with the findings from the 10-year follow-up. The decreased levels of general functioning in areas such as work and family life were also still evident at the 20-year follow-up.

Lieb et al. (2002) found fairly similar results in their study which used a large community sample of adolescents and young adults to examine rates of depression and other disorders in the participants and their parents. They reported an increased risk for depression, substance use and anxiety disorders in those participants who had one or both parents with depression. The results were similar whether the affected parent was male or female, and, perhaps surprisingly, there was little difference in risk between those with one or two affected parents. However, those with two affected parents showed a significantly earlier onset of depression (Lieb et al., 2002).

Contrary to the findings above, another recent study which looked at the offspring of a cohort of hospitalised depressed patients at a 25-year follow-up found that there was little difference between them and a control group in terms of levels of either overall psychiatric diagnosis or specifically of affective disorders (Peisah, Brodaty, Luscombe & Anstey, 2004). The only difference they did find was a trend towards children of depressed parents being at slightly higher risk of alcohol problems and anxiety disorders. The study additionally looked at relationships and found that while the participants seemed to have poorer relationships with their fathers if their mothers were depressed, their experiences had made them work harder on their own intimate relationships and they reported these as significantly more caring than the control group. The authors conclude that these adult children of depressed parents demonstrated “significant resilience” as shown by their similar levels of psychiatric problems and similar quality of intimate relationships to the control group (Peisah et al., 2004).

Explaining the Risk Associated with Parental Depression

The risk associated with parental depression is postulated to stem from a number of different factors, including genetic and biological influences, family factors and wider environmental or social factors (Beardslee et al., 1998; Dodge, 1990; Hammen, 2003).

Genetic influences. With respect to the genetic contribution, family studies, twin studies and adoption studies suggest that there is a degree of heritability involved in the transmission of depression; however these studies also highlight the importance of the role of the family environment (Beardslee et al., 1998). As Hammen (2003) concludes, “overall, the genetic effects appear to be significant but account for less variance than non-genetic factors” (p.54).

Environmental and social factors. There is an argument that the specific transmission of disorder from parent to child is less important for outcome than the influence of associated factors which are linked with depression. For example, early studies of children of parents with schizophrenia and depression showed similar outcomes for both, suggesting that it is not the diagnosis per se that is important, but rather the associated factors often linked with mental health problems, such as marital conflict or social deprivation, or the associated level of impairment (Downey & Coyne, 1990).

Hammen (2003) notes that stressful life events may be elevated in families where a parent is depressed, which may confer additional risk to the offspring. Depression is known to be associated with stressors such as low socio-economic status, loss of a parent, and lack of social support (Harris, Brown & Bifulco, 1987) and it may be these factors that lead to increased risk of difficulties for the offspring. Indeed, there is evidence that children with depressed parents who are also from

lower socio-economic groups are more severely affected (Grigoriu-Serbanescu et al., 1991).

Family factors. In terms of family factors which may increase risk, one aspect is the impact that depression may have on the ability to parent effectively. A number of studies have looked at the different ways in which depression may impact upon parenting skills and parent-child interaction, and various problems or impairments have been noted (Rutter, 1990). Solantaus-Simula, Punamaki and Beardslee (2002) note that there is evidence that “parental depression is mediated to children in coercive, impulsive parenting and reduced negotiations and warmth” (p.288). Depressed mothers of younger children may be less sensitive and responsive in their parenting skills which may impact upon the child’s attachment (Beardslee et al., 1998). An examination of interactions between depressed mothers and their infants showed that they spend more time in negative than positive behaviour states than do nondepressed mothers and infants, and they are more likely to be classified as intrusive or disengaged in their interactions. Additionally they exhibit less matching of behaviour states (Field, Healy, Goldstein & Gothertz, 1990).

Depression may also impact on a parent’s ability to manage their child’s social environment, thereby reducing opportunities to promote the child’s social development. Depressed parents may also be less available to their children and have less time to promote social competence through teaching and coaching (Dodge, 1990).

Rutter (1990) makes the important point that depression affects parenting in significantly different ways across individuals and thus the effects on children are unlikely to be homogenous. He notes that while irritability and hostility towards the child could be a feature of parental depression, children could also be used as a

comfort for their parents; however, both of these behaviours may impact on the development and well-being of the child.

Another family risk factor associated with depression is the occurrence of marital difficulties. Although research has found that marriage can serve a protective function for those vulnerable to depression, episodes of depression can impact upon the marital relationship and lead to marital conflict or higher levels of negative interactions. This in turn may decrease the ability of parents to provide sufficient support for their children (Beardslee et al., 1998). There is evidence that the combination of parental depression with divorce or separation of parents, or with family conflict, places children at higher risk (Beardslee et al., 1993; Rutter, 1990).

It has also been suggested that children of depressed parents may acquire negative cognitions about themselves due to experiences with their parent and observational learning of their parent's cognitions; these negative cognitions are then a vulnerability factor for later depression (Hammen, Burge & Stansbury, 1990).

An additional factor that may increase levels of risk is the severity and chronicity of the parent's depression. Poorer outcomes for children have been found to be associated with a higher number of episodes, longer duration, and higher severity of depression in their parent (Hammen et al., 1990; Rutter, 1990). Presence of psychopathology in the other parent may be an additional risk factor (Rutter, 1990). Evidence also suggests that the younger the child is at the onset of parental depression the higher their risk of experiencing psychopathology (Grigoriu-Serbanescu et al., 1991).

Summary

Overall, there is much evidence that growing up with a parent with depression can lead to difficulties for offspring across the lifespan. There is support

for a number of different routes through which this effect may occur. However, it is also clear that this effect is not universal, and these findings raise the question of what may lead to some offspring having more positive outcomes; this question is addressed in the next two sections.

Resilience

What Is Resilience?

The concept of resilience refers to positive adaptation in the face of life adversity (Cicchetti, 2003). Interest in this concept has grown over the last few decades and researchers have begun to examine why some people are able to function well despite being considered at risk.

Defining resilience has been an important part of initial work in this field and several important issues have been highlighted. Firstly, the idea of resilience as a trait or attribute possessed by an individual has been rejected by those working in the field who emphasise that resilience is rather a dynamic process (Luthar, Cicchetti, & Becker, 2000). The idea of resilience as an individual attribute is considered unhelpful because it fosters blame for those who are affected by risk, and it also fails to account for the many varying factors within the family or environment which impact upon adaptation (Luthar & Zelano, 2003). In line with the idea of resilience as a process rather than a trait, researchers have begun to try to identify a range of protective factors that play a part in promoting resilient adaptation.

Linked to this definitional issue is the acknowledgement that resilience is not a unitary concept, and must be considered in various domains, including academic functioning, social competence, psychological functioning, and behaviour. This has been cited as a criticism of resilience research (Tolan, 1996, cited in Luthar,

Cicchetti & Becker, 2000); however, an alternative view is that the concept of resilience does not require even functioning across domains, and that people can show a resilient profile in one domain and not others (Luthar, Cicchetti & Becker, 2000). Indeed, to expect resilience to generalise across all areas of life would be an unrealistic view of human development. It is, however, important that researchers ensure that they study resilience in domains related to the risk factor being investigated.

Another issue has been whether risk and protective factors should be universally defined or whether they are more usefully linked to the developmental level of the individual, to allow for consideration of the impact of cognitive and emotional capacities and other such developmental issues. The consensus has been that universally defined factors are less helpful (Radke-Yarrow & Sherman, 1990; Luthar, Cicchetti & Becker, 2000). Rutter (1987) commented early in the development of resilience research that “the search is not for broadly defined protective factors but, rather, for the developmental and situational mechanisms involved in protective processes” (p.317).

Research on Resilience and Protective Factors

The driving force behind much of the resilience research is the idea that identification of protective processes may lead to ways to intervene and improve outcomes for at-risk children. Investigation of resilience also promotes a focus on positives and strengths rather than on pathology which is often the focus in social sciences research, particularly when considering groups who are at risk.

Research into resilience has encompassed a wide range of risk factors that are known to predispose people to poorer outcomes and psychopathology – including socioeconomic disadvantage, maltreatment, catastrophic life events, and parental

mental illness – looking at how some people manage to thrive despite their high-risk experiences (Luthar et al., 2000).

Despite the suggestion noted above that research needs to extend beyond defining broad protective factors, much of the available research has focused on precisely this and a number of factors have been suggested to be significant in promoting resilience. It has been proposed that these factors fall into three main categories: attributes of the child, aspects of their families, and characteristics of the wider social environment (Luthar et al., 2000).

Luthar and Zelano (2003), in summing up findings from a number of studies on resilience in diverse at-risk groups, highlight a few key factors within these categories. Positive family functioning has repeatedly been found to be linked with benefits for offspring, and there is a key role for parenting in promoting resilience. Positive community functioning, such as high neighbourhood support and cohesion, can also be important, particularly for those at risk due to urban poverty. One key community protective factor seems to be the presence of social support from a warm, caring adult, such as a teacher, neighbour or other family member (Wolkow & Ferguson, 2001). Certain child attributes also have the potential to serve a protective function; for example, studies have identified high intelligence, internal locus of control, good coping skills and easygoing temperament as being linked with positive adaptation for children (Luthar & Zelano, 2003). Another child characteristic that may have an impact on resilience is the way a child cognitively and affectively responds to their situation. Rutter (1999) notes that “because people differ in how they view bad experiences they have had, it seems reasonable to suppose that individual differences in style of cognitive processing could be important in determining whether or not resilience develops” (p.134). However, on the whole,

environmental factors seem to exert a more powerful influence than do positive individual attributes. This may be partly due to the way that child attributes can be shaped by the environment, for example self-esteem can be altered by parental warmth (Luthar & Zelano, 2003).

There may be other factors which promote resilience by limiting the extent of risk experienced by a child. For example, some children may limit the extent to which they are exposed to psychosocial risks by fostering ties outside the home and associating more with external environments at the same time as detaching from their parents, if the home is a high risk environment (Rutter, 1999). Additionally resilience can be promoted if young people are able to avoid maladaptive coping strategies such as drug and alcohol use, or early marriage or pregnancy as a way to escape their family, as such strategies are likely to increase their risk for a negative outcome (Rutter, 1999).

It would be reasonable to expect that positive experiences should in some way promote resilience. However, Rutter (1999) notes that such experiences in themselves are unlikely to exert much effect, and that they are more likely to be protective when they directly counter or compensate for some risk factor, for example a close relationship with one parent may compensate for the negative effect of marital discord. These types of effects have been termed neutralising experiences.

Rutter (1999) discusses the importance of multiple risk and protective factors and how they may interact. He notes the cumulative effect of factors – single adverse experiences may not much increase the risk of psychopathology, but multiple adverse experiences will increase it many times over. Likewise, multiple protective factors are more likely to promote resilient adaptation. Rutter (1999) also discusses the idea of positive and negative chain reactions, whereby experience of success in

one area, such as school, may make it easier to approach new challenges and experience further success. Individual characteristics may well influence positive chain reactions as well, for example people with positive temperamental features are more likely to elicit warm responses from others, providing a further experience of success.

Summary

Resilience is a useful framework for thinking about positive outcomes in at-risk groups. There are a number of issues to be considered when interpreting findings in this field, particularly with respect to the definition of resilience. However, research has begun to identify factors and processes that contribute to positive adaptation for at-risk groups. Empirical work on resilience processes specific to offspring of depressed parents is reviewed in the next section.

Resilience in Offspring of Depressed Parents

Resilience in offspring of depressed parents has been a relatively neglected area, despite the fact that there are large numbers of people who grow up with a depressed parent and do not suffer any negative consequences (Hammen, 2003). Much of the research focus on offspring of depressed parents has been driven by ideas of risk and has employed quantitative methods to examine the outcomes for this group in comparison to offspring of non-depressed parents. Cogan, Riddell and Mayes (2005) note that “the disproportionate focus of previous work on risk rather than protective factors has tended to exaggerate the difficulties facing children” (p.17).

In terms of examining factors important for resilience in offspring of depressed parents, Hammen (2003) notes that there are two strategies to consider.

One is to focus on the influence of the absence of risk factors typically associated with parental depression, such as marital discord, negative mother-child interactions and family stress; low levels of these risk factors in the presence of parental depression may reduce the likelihood of maladaptive outcomes. The other strategy is to consider the presence of factors that may contribute directly to adaptive outcome, such as “intelligence, a positive self-concept, cognitive and behavioural coping skills, good school functioning, positive social relationships or friendships, or supportive adult relationships” (Hammen, 2003, p. 61).

Hammen (2003) has previously looked at the contribution of the mood disorders field to resilience research and her chapter provides a useful discussion of risk and protective factors and mechanisms. In her summary she examines several studies that have considered resilience or protective factors in this population; however, a more thorough review of the literature on factors and processes that may be relevant to resilient outcomes in offspring of depressed parents is needed. This section provides a detailed review of studies that have examined resilience in offspring of depressed parents.

Identification of Studies

A literature search was conducted using the electronic database PsychInfo. The database was searched for articles from 1982 to January 2007 using the following key terms: “parental depression” or “parental affective disorder” or “depressed parent” or “affectively ill parent” or “depressed mothers”, combined with, “resilience” or “resilient” or “protective factors” or “resources” or “competence” or “coping”. Additional articles were identified from reference lists of the selected articles. Only English-language papers published in peer-reviewed journals or book chapters were included.

Studies were included if they (a) focused on participants who were offspring of depressed parents, this included both child and adult offspring, and (b) examined factors or processes related to resilience, i.e. examining factors linked with positive outcomes or positive processes such as coping, or examining the reduction of risk factors. Studies which described intervention programmes for offspring of depressed parents were included if they explicitly examined the effect of specific processes proposed to foster resilience. Studies were excluded that examined resilience in broader groups of at-risk offspring, for example a study looking at resilience in socially disadvantaged children was excluded.

The studies clustered into three main groups: (1) studies focusing on coping in offspring of depressed parents; (2) studies examining the role of a range of specific factors in promoting resilience in offspring of depressed parents, including characteristics of the child, the family and the wider environment; and (3) studies evaluating preventive intervention programmes for families with a depressed parent. All of the studies focused on children or adolescents, covering an age range of 1 year to 22 years. Details of the studies are summarised in Table 1. The main findings from each group of studies are discussed below.

Coping in Offspring of Depressed Parents

Four studies looked at coping in offspring of depressed parents. Two of these studies were from the same research group and examined whether different styles of coping were correlated with levels of anxiety and depression symptoms in offspring. The other two studies examined differences in coping styles between offspring of depressed and non-depressed parents.

Table 1

Summary of studies

Authors (date)	N= (Control N=)	Design	Age of offspring	Parental status	Method	Measures ^(a)	Results
<i>Coping in offspring</i>							
Klimes-Dougan & Bolger (1998)	N = 124 (N = 55) Sibling pairs	Cross-sectional comparison between groups with depressed and non-depressed mothers	Younger sibling - mean age 13.92 years; Older sibling - mean age 17.69 years	Mothers with diagnosis of unipolar depression or bipolar illness (Schedule for Affective Disorders and Schizophrenia: Lifetime Version (SADS-L)). Control group - both parents without current or past psychiatric disorder	MANOVA on subscales of MACS, with maternal depression, sex of adolescent and sibling group as independent variables	Open-ended semistructured interview about awareness of depressed family members and ways of coping; Maternal Affective Coping Scale (MACS - child-report)	No difference between depressed and non-depressed groups for styles of coping. Females use more Social Support and Internalizing. Older sibling group used more Externalizing.
Langrock et al.	N = 101	Cross-sectional	Range 7-17	At least one parent with	Analysis of correlations	Responses to Stress	Parental withdrawal and parental intrusiveness

(2002)	comparison within group with depressed parent	years	DSM-IV diagnosis of Major Depressive Disorder or Dysthymia	between types of stress, types of coping/stress responses and symptoms of anxiety, depression and aggression	Questionnaire (parent report); CBCL (parent report) significantly correlated with child anxiety and depression and with all styles of coping. Secondary control coping negatively correlated with child anxiety and depression. Involuntary engagement stress response positively correlated with child anxiety and depression.
Jaser et al. (2005)	Cross-sectional comparison within group with depressed parent and between parent and adolescent ratings	Range 10-16 years	At least one parent with DSM-IV diagnosis of Major Depressive Disorder or Dysthymia	i) Analysis of correlations between adolescent report of types of stress, types of coping/stress responses and symptoms of anxiety, depression and aggression. ii) Analysis of correlations between parent and adolescent	Responses to Stress Questionnaire (parent report and adolescent self-report); CBCL (parent report) and YSR (adolescent self-report) i) Secondary control coping negatively correlated with adolescent anxiety and depression. Involuntary engagement and involuntary disengagement positively correlated with adolescent anxiety and depression. ii) Significant correlation between parent and adolescent ratings of stress, anxiety and depression, and all

ratings

types of coping except involuntary disengagement

Cogan, Riddell & Mayes (2005)	N = 20 (N = 20)	Cross-sectional comparison between groups with depressed and non-depressed parents	Range 12-17 years	ICD-10 diagnosis of affective illness. Control group - no family member with ICD-10 diagnosis of mental illness or in contact with CMHT.	Quantitative and qualitative analysis of difference in coping styles between 2 groups	Adolescent Coping Scale	Significant differences between 2 groups in 2 coping styles: affected group lower in reference to others and higher in non-productive coping styles.
-------------------------------	--------------------	--	-------------------	--	---	-------------------------	--

Factors in resilience

Beardslee & Podorefsky (1988)	N = 18	Longitudinal, 2.5 year follow-up	Range 14-22 years at follow-up	Parent with SADS diagnosis of affective disorder	Follow-up of group of identified offspring with good functioning to establish how many retained good functioning. Qualitative analysis of factors linked to continued positive functioning.	Diagnostic Interview for Children and Adolescents; Garmezy Child Interview; Rochester Adaptive Behavior Inventory (parent-	15 out of 18 offspring remained resilient. Factors identified by the offspring as helpful included involvement in other relationships, and understanding of their parent's illness and of themselves and avoidance of self-blame. Self-understanding and lack of self-blame were
-------------------------------	--------	----------------------------------	--------------------------------	--	---	--	--

<p>report); Interview examining behavioural functioning and self- understanding</p>	<p>absent in the 3 offspring who did not remain resilient.</p>
<p>Radke- Yarrow & Sherman (1990)</p>	<p>N = 25 (N = 18)</p> <p>Cross- sectional comparison between groups of offspring of depressed and non-depressed parents, and within group of offspring of depressed parents.</p> <p>Range 5-11 years for case analyses</p> <p>Mothers – unipolar or bipolar depression; Fathers – minor, major or bipolar depression or absent. (Control group - both parents with no history of psychiatric disorder)</p> <p>i) Between group analysis of coping in 2 groups of children. ii) Case analysis of 4 resilient children from at- risk group. iii) Analysis of whether protective factors identified discriminated between resilient and non-resilient children in sample of at-risk children.</p> <p>Child Assessment Schedule; Parent CBCL and Teacher CBCL.</p> <p>i) Significantly more diagnoses in at-risk group compared to control group (40% vs. 11%). ii) Protective factors: core of positive self- esteem (stemming from match between quality in child and need in parent), warm relationships with either mother or father despite difficulties, mastering academic and relational tasks of school. iii) Children with all protective factors were all resilient except 1; some children without all protective factors were still resilient.</p>

Conrad & Hammen (1993)	Unipolar N = 22, Bipolar N = 18, Medically ill N = 18, Control N = 38	Cross-sectional comparison between groups of offspring at different levels of risk. Additional 1 year follow-up.	Mean age 12.5 years	Mothers with SADS diagnosis of unipolar or bipolar depression, or chronic medical illness such as diabetes or arthritis, (Control group - no history of major psychiatric disorders)	Hierarchical multiple regression analyses for each resource/protective factor for each group, with children's diagnostic rating score as dependent variable.	Parent Perception Inventory; Social Adjustment Scale (mothers self-report); K-SADS; Piers-Harris Children's Self-Concept Scale; rating of academic functioning on a 5-point scale; CBCL (parent-report); child perception of social supports	<i>Resource factors for all groups:</i> child self-esteem, good academic performance, child social competence, positive perceptions of mother, number of children's friendships <i>Resource factors for maternal unipolar depression group only:</i> maternal social competence, healthy father at home, <i>Protective factor for maternal unipolar depression group only:</i> child social competence <i>Risk factor for maternal unipolar depression group only:</i> children's contact with an adult friend.
Garber & Little (1999)	N = 51 (N = 55)	Prospective longitudinal, with 2 year follow-up.	13 years	Mothers with DSM-III-R diagnoses of mood disorders (Control group - mothers with no identified -	High competence group initially identified and then reassessed 2 years later and 2 groups identified -	Longitudinal Interval Follow-up Evaluation for Children (K-LIFE);	Significant differences in commitment to achievement, positive coping styles and denial coping styles, child ratings of family

inventory; control, less maternal emotional involvement.
 Questionnaire assessing maternal warmth vs. hostility;
 Five-minute speech sample.

Preventive interventions ^(b)

Beardslee et al. (1997)	N = 37	Prospective longitudinal for family based intervention, 1.5 year follow-up	Range 8-15 years	Parent with affective illness	Between group analysis (ANOVA) of outcomes of different preventive intervention programmes (clinician-facilitated or lecture)	Semi-structured parent interview assessing perceived benefit of the intervention, parental concerns, changes in illness-related behaviour and attitudes	Participants in clinician-facilitated intervention reported greater benefit of intervention (e.g. increased understanding, greater helpfulness in addressing their concerns). Assessor ratings indicated greater increases in self-understanding and focus on children in the clinician-facilitated intervention.
Beardslee et al.	N = 12	Longitudinal. Follow-up for	Range 8-14	Parent with episode of	Qualitative analysis by	Semi-structured	Important themes are: Demystification of the

(1998)	3 years.	years	unipolar or bipolar disorder in past 12 months	clinicians of themes important for families in process of benefiting from intervention	parent interview	illness, modulation of shame and guilt, increase in the capacity for perspective taking, development of a hopeful perspective and belief in one's own competence.
Focht-Birkerts & Beardslee (2000)	N = 3	Prospective longitudinal for family based intervention, 6 year follow-up	Range 16-18 years at final follow-up	Qualitative examination of narrative data for shifts in affect	CBCL; GAS; SADS; Semi-structured child interview	All 3 participants developed increasing willingness to discuss their reactions to their parent's depression and showed increased "emotional fluidity" across follow-up.
Cicchetti, Toth & Rogosch (1999)	N = 108 (treatment N = 27; no treatment N = 36; Control N = 45)	Longitudinal. Random assignment to treatment or no treatment group, and comparison with control group. 36 month follow-up.	Mean age 20.40 months at baseline	Comparison of levels of secure and insecure attachment between groups at baseline and post-intervention. Intervention involved parent-toddler psychotherapy sessions for	Attachment Q-Set (AQS) mother report; Attachment Q-Scales	Higher levels of insecure attachment in offspring of depressed mothers compared to control group at baseline. At follow-up, decrease in insecure attachments in the treatment group, compared with increase in insecure attachment in the non-treatment group.

mother and offspring.

Clarke et al. (2001)	N = 45 (N = 49)	Randomised control trial, offspring allocated to cognitive therapy group or usual-care control.	Range 13-18 years	Parents with DSM-II-R diagnosis of major depression or dysthymia	Comparison of major depression between groups post-intervention and over 2 year follow-up. Intervention involved group CBT based on adolescent depression treatment programme.	CBCL (parent report); K-SADS-E; CES-D; Hamilton Depression Rating Scale; GAF.	Treatment group showed significantly lower cumulative major depression incidence compared to control group (9.3% vs 28.8%) at 1 year follow-up. These effects had diminished at 18 and 24 month follow-up.
----------------------	-----------------	---	-------------------	--	--	---	--

(a) Abbreviations of measures: CBCL = Child Behavior Checklist, YSR = Youth Self-Report, K-SADS = Kiddie – Schedule for Affective Disorders and Schizophrenia (K-SADS-E = Epidemiological Version), CGAS = Children’s Global Assessment Scale, GAS = Global Assessment Scale, SADS = Schedule for Affective Disorders and Schizophrenia, CES-D = Self-report depression scale, GAF = Global Assessment of Functioning.

(b) There are a number of studies from Beardslee’s research group, all evaluating the Preventive Intervention Project. A selection of these studies has been included here to highlight the main findings.

Langrock, Compas, Keller, Merchant and Copeland (2002) examined different coping responses in a group of children and adolescents of depressed parents, which they classified into primary control coping, where the individual attempts to take direct action to change the situation, secondary control coping, where the individual attempts to adapt to the situation, or disengagement coping, where the individual attempts to distance themselves from the situation. As well as examining voluntary coping responses they looked at involuntary stress responses which do not involve volitional effort. They found that secondary control coping (e.g. acceptance, cognitive restructuring, distraction) was associated with lower levels of symptoms of anxiety and depression. They also found that involuntary engagement responses to stress (e.g. emotional and physiological arousal, intrusive thoughts, rumination) were associated with higher levels of symptoms of anxiety and depression. The study relied on parental report of their children's styles of coping, and asked them to make judgements about the thought processes their children were engaging in (e.g. "she imagines something really fun or exciting happening in her life"). Given the deficits associated with depression it is questionable how reliable a source of information this may be.

In a second study from this research group, Jaser et al. (2005) attempted to address this problem by including adolescent reports and by correlating parent and adolescent reports of these factors. Analysis of the adolescent reports indicated the same associations as reported in the study above, with an additional significant association between involuntary disengagement responses to stress (e.g. emotional numbing, cognitive interference) and higher levels of symptoms of anxiety and depression. There were some differences between the parent and adolescent reports,

which highlights the need to use self-report of coping styles as these are often covert processes.

Cogan et al. (2005) used a combination of qualitative and quantitative methods to look at differences in coping styles between adolescent children of affectively ill and 'well' parents. They found that children of affectively ill parents were significantly more likely to use "non-productive" coping styles, such as avoidance strategies that did not lead to a solution to the problem, than the children of 'well' parents. They were also significantly less likely to use "reference to others" coping styles, which involved drawing on support of others such as friends or professionals in a bid to deal with family problems. There was no significant difference between the groups of children in terms of use of productive coping styles which involved attempting to solve the problem while remaining physically fit and socially connected. The authors highlighted the need for children to be provided with age-appropriate information about depression in order to prevent the tendency for children to blame themselves, as this may be a route to helping them cope better with their situation. Although these researchers stress the importance of moving away from focusing on the negative consequences facing offspring of depressed parents and highlight coping as a potential protective factor, they focus on the more negative style of coping utilised by this group in comparison to offspring of 'well' parents. The finding of no significant difference between the two groups in terms of productive coping styles was not explored further other than to note that this was the least common style in both groups, and there was no attempt to explicate the role that productive coping strategies may have in promoting resilience in these at-risk children.

Klimes-Dougan and Bolger (1998) recruited sibling pairs for their study and examined differences in coping styles between groups of offspring of depressed and non-depressed parents, as well as differences between siblings. They found no significant differences in the styles of coping used by the offspring of depressed and non-depressed mothers; both groups of offspring primarily used problem-focused approach strategies or sought social support. This is in contrast to the findings described by Cogan et al. (2005) that offspring of depressed parents were less likely to draw on social support. The differences in coping styles that Klimes-Dougan and Bolger (1998) did find were related to gender and age of the participants regardless of whether they had a depressed parent, and the authors highlight that there may be different coping challenges for children of depressed parents depending on their gender and developmental stage.

Specific Factors Linked with Resilience

Five studies examined the role of a range of specific factors in resilience; the scope of these studies was broader than those in the other groups and they covered a variety of different domains. The studies demonstrated associations between a number of factors and positive outcomes for offspring of depressed parents, including individual child factors, parent or family factors, and social factors. Although most of these studies were cross-sectional and did not demonstrate causal linkage, they did highlight factors which may potentially be significant in promoting resilient outcomes.

Beardslee and Podorefsky (1988) conducted a longitudinal study and identified a number of factors which they found characterised offspring who maintained good functioning and could therefore be described as resilient. These included involvement in relationships and activities outside the house, and an ability

to understand their parent's illness and not engage in self-blame. They found that this self-understanding and lack of self-blame were absent in those participants who had not maintained good functioning. The authors looked specifically at self-understanding as they had found from previous work with other groups that it was important in resilience. Additionally it is a factor which is potentially amenable to intervention. They identified three components of self-understanding that were present in the offspring they interviewed: awareness of the parent's illness, specific response to parental illness, and capacity to observe and reflect on the experience of parental illness and other matters. As part of this process of self-understanding the offspring had concluded that they were not the cause of their parent's difficulties and they highlighted this lack of self-blame as crucial to their ability to cope. In their description of the interviews, the authors also noted that relationships were crucial to all of the offspring, and that the majority of them reported turning to an identified other person in order to make sense of the experience of their parent's illness or to derive comfort, either an adult outside the family, a sibling, or a close friend. They also found that the majority of the offspring took a care-taking role in the family, but the authors did not discuss further the impact of this or its relevance to positive functioning and resilience.

Radke-Yarrow and Sherman (1990) compared a group of children who had either one or two parents with depression with a control group in which both parents had no history of psychiatric disorder. Unsurprisingly they found that the at-risk group had higher levels of psychiatric problems themselves; however, they also identified a sub-group who had avoided such problems. From this resilient subgroup they selected four children for an in-depth case analysis to identify processes by which resilience may be operating in these children. The authors did not indicate the

method of their case analysis, but concluded from it that all four children had a core of positive self-esteem, warm relationships with one or other of their parents, and were succeeding in school both academically and socially. The authors suggested that an important process for these children involved a match between a quality they possessed, such as gender or temperament, and a core need in one or both of the parents that it fulfilled. They proposed that this led the children to have a conception of themselves as having something good or special about them, enhancing their self-regard, which was carried into wider situations and environments, engendering further positive social interactions for the child. The authors also identified other positive characteristics in these children, such as above-average intelligence and social charm, which they suggested also contributed to the children's positive self-esteem and social experiences. They found that amongst the larger group only one child out of five who had all these factors of above-average intelligence, social engagingness and a special place in the family could not be described as resilient, whereas only four children out of 20 who did not have these factors could be labelled resilient. However, the authors also raised the warning that by having characteristics that meet their parent's need these children may be pushed into developmentally inappropriate demands and challenges and there may be further stresses which develop from this.

Conrad and Hammen (1993) focused on the difference between protective and resource factors in their study of children at-risk due to maternal depression. They defined protective factors as those that moderate against the effects of risk and which therefore have a greater effect for an at-risk group compared to a low-risk group. In contrast, resource factors were defined as those which are beneficial regardless of risk status. They also looked at whether protective and resource factors

generalised across different types of risk, comparing children of mothers with unipolar depression, bipolar disorder, and medical illness, with an additional low-risk control group. They included factors from each of the three domains of individual characteristics, family factors, and social supports in their exploration. They found that the variables they explored were primarily resource factors, being associated with lower diagnostic ratings regardless of risk status. These resource factors included positive self-concept, academic success, social competence, positive perceptions of the mother, maternal social competence, having a healthy father at home, and friendships. Only a few of the factors were found to be protective and even these showed only trends to significance so may not be robust findings; they included social competence for children of mothers with unipolar depression, and having mothers at home rather than externally employed for children of mothers with unipolar depression or medical illness. Somewhat surprisingly, contact with an adult friend was found to be a risk factor for children of mothers with unipolar depression. The authors speculated that this may be due to the increased likelihood of children having contact with other adults where there is worse family functioning. Although the factors studied were generally beneficial to all groups rather than just those at risk due to maternal depression and therefore classified as resource rather than protective factors this does not prevent them from being considered as potentially useful in promoting resilience.

Garber and Little (1999) undertook a prospective study to identify predictors of competence in children of depressed mothers. They followed a group of children who had been initially identified as competent based on high functioning and lack of psychopathology over two years and then identified within this group those children who remained continuously competent over this time and those whose competence

had decreased. They then compared these two subgroups on measures taken at the initial time point of various factors that they hypothesised may contribute to competence. They found that the children who had remained continuously competent had shown more commitment to achieving academically, and had coping styles which were characterised by more positive coping strategies and less denial. These children had also reported more positive family functioning in terms of high cohesion and low conflict, and rated their mothers as being more accepting. Additionally the children had rated higher levels of social support from their parents, relatives and close friends. The authors suggested that these personal and social resources may have better equipped the children to cope with the stressors of school during the time period of the study, and they found that commitment to achievement and positive family environments moderated the link between school-related stressors and competence. Interestingly, and perhaps surprisingly, the two groups did not differ in IQ or academic ability, both of which have been suggested as protective factors in other studies. They also showed no difference in terms of their actual or perceived social competence, their perceived self-worth or their attributional style which is also surprising given the links between both self-worth and attributional style and depression.

Brennan, LeBrocq and Hammen (2003) followed the work of Conrad and Hammen (1993) in looking at differentiating resource factors and protective factors in a larger sample where they focused specifically on parenting factors. They identified resilient adolescents from a group of offspring of depressed mothers, and compared the resilient and non-resilient offspring, along with offspring of non-depressed parents, on a variety of parent-child relationship variables. Similarly to Conrad and Hammen (1993) they found that a large number of the variables they

examined acted as resource factors, being related to positive outcome regardless of risk. However, they also found a number of protective factors, which showed more benefit for the at-risk group; these included high levels of perceived maternal warmth and acceptance and low levels of perceived maternal psychological control and overinvolvement, and low levels of perceived paternal psychological control. This finding that mother-child relationship factors seemed to be more significantly protective than father-child relationship factors for the offspring of depressed mothers was discussed by the authors who noted that missing data from fathers may explain this to some degree, and suggested that the protective role of fathers needs to be more fully examined.

Preventive Interventions

The majority of the research that has been done in evaluating preventive interventions for offspring of depressed parents has been carried out by Beardslee and his research group. There are a number of studies which examine the effectiveness of the Preventive Intervention Project which was started in the late 1980's in the USA as a family-based psychoeducational intervention for families in which one parent had an affective illness (Gladstone & Beardslee, 2000). A selected few of these will be reviewed here, highlighting the different aspects of the project and different areas of evaluation. Two other studies evaluating preventive interventions are reviewed in this section: one intervention based around parent-toddler interaction which aimed to increase attachment security, and another intervention based on a group cognitive therapy programme for at-risk adolescents.

Beardslee et al. (1997) described one evaluation of the Preventive Intervention Project, focusing on the outcomes of families who participated in the clinician-facilitated intervention compared to the lecture-based intervention. This

prospective longitudinal study followed a cohort of 37 families over 1.5 years. The content of the interventions used in this project was based on risk studies of children of affectively ill parents that identified resiliency-promoting characteristics and, as such, the study provides a further examination of the significance of these factors, which included encouraging relatedness to others, the capacity to function independently outside the home and self-understanding. Both forms of intervention focused on psychoeducation, providing information about affective illness. In the clinician-facilitated condition a family meeting was held where the family's experiences were linked with the information provided and discussion amongst the family was facilitated. In the lecture-based condition similar information was presented but only to the parents and there was no direct linking of the information to the families' individual experience. The study indicated that both interventions were beneficial, with greater changes in the parents' self-understanding and focus on children seen in the clinician-facilitated condition. The authors concluded that "the investigation demonstrates the value of cognitive, psychoeducational family-based interventions in decreasing the impact of parental affective illness on families" (Beardslee et al., 1997, p.514). However, the outcome measures were based primarily on parental report of benefit of the intervention, with additional assessor ratings of change in the parents. There was no assessment of direct change in the offspring of these families, making it difficult to draw conclusions about whether this intervention did actually increase their resilience by changing family factors.

Another of the Preventive Intervention Project studies used qualitative analysis to identify processes that were important to families in the effectiveness of the intervention (Beardslee et al., 1998). The authors discussed the importance of the process of moving from the cognitive material presented in the intervention towards

making links with the affective meaning for the family members, allowing families to develop self-understanding and shared meaning. The themes identified in the process of the intervention focused on the whole family, highlighting how increases in parental understanding may be important for children, as well as increases in their own understanding. This study was interesting as it was the only one found which looked more explicitly at processes involved in resilience. However, there were also problems with the study. It was not clear what form the qualitative analysis took and therefore how these processes were identified; the authors made reference to discussion amongst clinicians about the intervention cases but did not provide any detail about whether this was done systematically. The processes and themes appeared to be based upon clinician viewpoint rather than on direct assessment of the children themselves. There was also a primary focus on processes for the parents, such as increasing their capacity for perspective taking and increasing their belief in their own competence; although it is probable that these changes in parents impacted on the resilience of the children there was little consideration or discussion about these links.

The third study based on the Preventive Intervention Project did include child report outcomes, and focused on increasing communication within families about the effects of depression (Focht-Birkerts & Beardslee, 2000). This six year prospective longitudinal study examined narrative data from yearly interviews with three offspring following the initial family-based psychoeducational intervention aimed at increasing knowledge of and discussing experiences of affective illness, as described above. The aim was to focus on the way that affectively ill parents responded to the distress they caused in their children, and the impact this had on the emotional resilience of the children. The three children studied all showed increasing openness

to discussing their own emotional responses to their parents' depression over the period of follow-up, which the authors referred to as "emotional fluidity"; the authors saw this as an important characteristic of resilience. They concluded that if depressed parents were able to increase emotional fluidity in their children by encouraging them to elaborate on their negative affect through discussion then this encouraged relational resilience, and they suggested that a tendency for parents to constrict this affect was a risk factor. This expression of negative affect was seen as a way of allowing offspring to begin the separation process which is important in adolescence, but which may be more difficult in families with a depressed parent. Although this study described a clear rationale behind the intervention and provided some examples of the families describing increased communicativeness following the intervention, it is hard to separate the impact of the intervention from normal developmental and cognitive changes in the offspring which would increase their capacity to talk about the emotional impact of their parent's depression. It also seems likely that it was not just the elaboration of negative affect which was beneficial in this study. Other factors that were highlighted in the narratives were the provision of explanations about parental behaviour in terms of illness and the encouragement for offspring to identify and articulate symptoms of affective illness. Linked to this, the intervention and the research interviews with the offspring also encouraged the recognition in all three of them that they were not to blame for their parents' illness.

Cicchetti, Toth and Rogosch (1999) reported on an attachment-theory based preventive intervention which used toddler-parent psychotherapy to promote secure attachment in the offspring of depressed mothers. Depressed mothers and their toddlers were randomly assigned to a treatment group or control group, and an additional non-depressed control group was recruited. The study supported earlier

research in showing higher levels of insecure attachment in the offspring of depressed mothers as compared to the non-depressed control group at baseline. The intervention consisted of joint psychotherapy sessions for mother and toddler for a mean duration of 45 sessions aimed at assisting the mother in recognising her own attachment representations and how these were enacted with her infant and providing a corrective emotional experience. At follow-up the treatment group showed decreased levels of insecure attachment while the depressed control group showed increased levels of insecure attachment, suggesting that the intervention was effective in promoting secure attachment. Maternal depressive symptomatology at follow-up did not contribute to the differences in attachment stability and change, indicating that the intervention did have its effect on attachment directly, rather than via improving the mothers' mental health. However, the authors noted that the participants were deliberately selected from middle socioeconomic status, thus avoiding some of the associated risk factors often found in depressed mothers, and it is unclear whether the effectiveness of this intervention would generalise across a more representative sample. It would also be interesting to establish how long-lasting these effects on attachment security are, and how they correspond to later psychopathology in these children.

Clarke et al. (2001) described a group cognitive therapy intervention for adolescent offspring of depressed parents. This intervention was aimed at those offspring who reported levels of depressive symptomatology but did not reach criteria for a diagnosis of depression. The intervention was based on an adolescent depression treatment programme, teaching skills such as cognitive restructuring, with a particular focus on thoughts regarding the impact of their parent's depression. A significantly lower level of major depression diagnosis was found for the treatment

group compared to a control group at 1 year follow-up, suggesting that the intervention was effective in preventing depression in this at-risk group. However, this positive effect had decreased by 18 month and 2 year follow-up, suggesting that this intervention was not able to increase resilience in these offspring in the more long-term. The authors did not discuss explicitly how they considered that the intervention programme had its effect for these offspring, but it is possible that a cognitive therapy approach may be a way of reducing risk factors, such as the negative cognitions that offspring may learn from their parents through modelling or interactions.

Summary

The research to date on resilience in offspring of depressed parents has focused on three main areas: coping, specific factors and preventive intervention. Although the studies have utilised different approaches and methods and focused on different areas, there are some links and common themes.

With regards to coping in offspring of depressed parents, there is some support for the idea that certain styles of coping may be linked with better outcomes. There is also some suggestion that offspring of depressed parents differ from offspring of non-depressed parents in their styles of coping, although one study found no significant difference between the two groups. Utilising positive or productive coping styles may be a way of fostering resilience, and coping strategies such as cognitive restructuring and distraction that were found by Jaser et al. (2005) to be associated with better outcomes could potentially be taught to children at risk. All of the studies on coping styles employed a cross-sectional design, which prevents firm conclusions being drawn either about the direction of the relationship between styles of coping and positive adaptation in offspring or about the role of styles of

coping over different developmental periods. Prospective longitudinal designs employed in research looking at variables of coping in offspring of depressed parents will be an important next step.

The research into specific factors in resilience has identified a number of relevant factors, and the suggestion in the broader resilience literature that individual factors, parental or family factors, and social factors may all be important is supported here. In particular, self-esteem, social competence and social support seem to be themes that recur; however these findings are not completely consistent so some caution is needed. Although the factors identified in these studies seemed to be linked to better functioning in offspring, only one of the studies used a prospective longitudinal design; therefore it has not conclusively been demonstrated that these factors are protective. We cannot yet establish the direction of the links between the indices of good functioning and the variables under examination. Additionally, there is some cross-over in this research between factors being identified as potentially protective and those being used as measures of positive outcome: for example, school performance and social functioning are used in some studies as an indication of adaptive functioning, but are also cited in other studies as factors that increase resilience. Further prospective longitudinal research is needed to establish clearly the role of these different factors and the interplay between them.

The research into preventive interventions indicates their provisional value in increasing resilience in offspring of depressed parents. All the studies reviewed here reported some positive effect following the interventions. The longitudinal studies conducted by Beardslee's research group suggest that interventions aimed at parent-child interaction and family functioning are beneficial, and linked with more positive outcomes for the at-risk children. They suggest that increasing communication and

responsiveness between depressed parents and their offspring may be a useful route to promoting resilience. However, these studies are all based on the same project and cohort, and as such need to be interpreted with some caution. Overall, the findings are still limited and further research needs to examine the processes by which intervening in family relationships can be beneficial for outcomes in offspring. Within preventive intervention research there has been a focus on parent-child relationships, and only one of the studies reviewed here focused on individual factors rather than family factors. This may be because the parent-child relationship is seen as the most crucial factor in promoting resilience, or it may be that it is the area that is seen as most amenable to intervention, when compared with individual child factors or wider environmental factors. Van Doesum, Hosman and Riken-Walraven (2005) state that “the mother-child interaction is expected to be the most malleable... and therefore most sensitive to preventive intervention early in the child’s life” (p.167).

The research to date has begun to identify important aspects of resilience in offspring of depressed parents, but there is still much more to be done. Future directions for research are discussed in the final section.

Conclusions

There is ample evidence that having a parent with depression places offspring at increased risk throughout childhood and on into adulthood for a variety of psychiatric diagnoses and problems in a range of areas of functioning. But it is also clear that this risk is avoided by a significant number of offspring. In the literature on both risk and protective factors for offspring of depressed parents there is a focus on three areas: child characteristics, family and parental characteristics, and the broader

social environment. All three of these areas have an impact both on putting individuals at risk, and on promoting resilience, and there is also a cumulative effect of these risk and protective factors.

Although the present review has focused specifically on offspring who had depressed parents, it is hard to separate effects of parental depression from the effects of other risk factors. This is acknowledged in discussions about the mechanisms by which parental depression impacts upon children: it may be that depression is a marker for other risk factors that go alongside it, such as poverty and lack of social support. Thus, factors that are found to promote resilience may not be clear cut. Individual child characteristics such as self-esteem and social competence have been found by a number of studies to be linked with more positive outcomes. However, it may be that parenting factors have a strong influence on the development of both of these characteristics. A more in-depth exploration of the processes of resilience would be one way to establish why certain factors are important, and how they are linked with other factors. This is important when it comes to thinking about preventive interventions.

The preventive interventions for offspring of depressed parents which have been described to date have primarily focused on parent-child interactions and this has also been a focus in the literature on both risk and resilience. Because the majority of work in both these fields has focused on children and adolescents it is understandable that parenting has been at the forefront of exploration – the family is usually the most important context for children and it may be that intervening at the level of parenting is the easiest way to change a variety of both family and individual child factors. However, it is also important to consider resilience at later stages for these offspring, when factors other than the family context may need to become the

focus. The research has highlighted that there may be changes over time and developmental stage in both the expression of risk and the processes of resilience. It is likely that different processes aid resilience at different time points and further explication of these processes across the lifespan is needed.

This paper posed the question: what is known about processes of resilience in offspring of depressed parents? Although empirical studies on the subject are still few in number there is some evidence that specific factors may be protective against the effects of parental depression, and this has implications for possible routes for preventive intervention. Overall, the research to date has focused primarily on the presence of positive factors which may promote resilience, rather than the absence of risk factors, although some of these factors can be seen as the opposite side of the same coin: for example, the protective factor identified by Beardslee's group of good family communication probably also involves a reduction in the risk factor of family or marital discord. On the whole, despite the call for identification of the processes and mechanisms that underlie resilience (Rutter, 1987), there has been a focus on identifying specific factors associated with resilience. However, this can be seen as an important first step: once relevant factors are identified, a more in-depth consideration of how they exert their effect can be undertaken. There is some consensus across the range of studies about what the relevant factors are: these include productive coping, increased self-esteem, social competence, social support, good parent-child relationships, and self-understanding in children which includes an absence of self-blame. Further research is necessary to address some of the gaps in the current research, and also to start exploring the processes of resilience; consideration of the ways in which the current state of research may be taken forward is discussed below.

Future Directions for Research

Resilience across the lifespan. Within the field of parental depression risk research, longitudinal studies have been employed to explore a more developmental perspective. However, the focus in these studies has been on issues of diagnosis and symptomatology for offspring of depressed parents across the lifespan into adulthood. To date there has been no similar developmental consideration of those who are functioning well despite the risk of having a depressed parent. Some of the resilience literature has included a follow-up of offspring to adolescence but not beyond, and the studies reviewed here focus exclusively on childhood and adolescence. Luthar and Zelano (2003) highlight the importance of looking at risk modifiers that operate during adult years because resilience is not a static entity but a lifelong dynamic process. They suggest that trajectories can be altered significantly later in life, and factors of influence may include things such as career change, marriage or having children. Luthar et al. (2000) state that “resilience can be achieved at any point in the life cycle, and there is a need for additional work on at-risk individuals’ achievement of positive outcomes in later life” (p. 555-556). By focusing purely on childhood and adolescence the research into resilience in offspring of depressed parents may be missing important processes which become relevant for individuals later on in their development. For example, research examining resilience in older offspring could give consideration to the impact of moving out of home and away from the depressed parent, and other changes such as building new relationships, developing careers and experiencing different life events.

From factors to processes. Recently the focus of general resilience research has begun to move on from identifying factors which may be protective to looking at protective processes. Luthar et al. (2000) note that “rather than simply studying

which child, family, and environmental factors are involved in resilience, researchers are increasingly striving to understand *how* such factors may contribute to positive outcomes” (p. 544). The work of examining processes underlying particular relevant factors was started by Rutter in the late 1980’s and he highlighted the need for this to continue. However, despite some further research, Luthar (in press) notes that there has been relatively little progress and much more needs to be done. As described above, the literature on offspring of depressed parents has yet to move towards a deeper examination of processes underlying resilience. The focus on the process of resilience is important if research is to guide the development of preventive interventions. In order to help protect children from the risks associated with having a depressed parent we need to first understand what exactly it is about certain protective factors that confer an advantage. The current literature reviewed above identifies a number of factors proposed to be related to the positive adaptation of offspring in the face of parental depression, but it is important to disentangle exactly what it is about, for example, having good parent-child relationships, that is beneficial. Qualitative studies may be particularly valuable in extending this area of the research to look for mechanisms underlying resilience, as qualitative methods can address complex psychological processes (Willig, 2001). Luthar (in press) acknowledges that the generative and inductive nature and the focus on describing processes in qualitative research makes it an important tool for providing future directions for resilience research.

Clinical Implications

Depression is one of the most common mental health problems, affecting a significant number of both adults and children and, as such, is a significant public health concern. There is a lot of work focused on developing and improving ways of

treating depression; however, efforts focused on prevention of depression are also necessary. Depression has a kindling effect, meaning that people are more likely to experience another episode of depression once they have experienced one; therefore, preventive interventions are an important consideration as they may be more effective than treatment in the long term. Prevention efforts are often targeted at at-risk individuals to maximise effectiveness, and offspring of depressed parents are a group who are at particular risk, with higher rates of both depression and other problems. In order to intervene with this group it is important to learn from those individuals who do not succumb to the risk associated with having a depressed parent, and to understand how they manage to adapt well and have positive functioning. This necessitates a consideration both of factors which are linked with positive outcomes and the processes by which these factors have a positive effect. This understanding can then be used to inform the development of preventive interventions for this at-risk group, to promote resilience and lower the incidence of depression.

References

- Beardslee, W. R. & Podorefsky, D. (1988). Resilient adolescents whose parents have serious affective and other psychiatric disorders: Importance of self-understanding and relationships. *American Journal of Psychiatry*, *145*, 63-69.
- Beardslee, W. R., Keller, M., Lavori, P., Staley, J., & Sacks, N. (1993). The impact of parental affective disorder on depression in offspring: A longitudinal follow-up in a nonreferred sample. *Journal of the American Academy of Child and Adolescent Psychiatry*, *32*, 723-730.
- Beardslee, W. R., Salt, P., Versage, E. M., Gladstone, T. R. G., Wright, E. J., & Rothberg, P. C. (1997). Sustained change in parents receiving preventive interventions for families with depression. *American Journal of Psychiatry*, *154*, 510-515.
- Beardslee, W. R., Versage, E. M., & Gladstone, T. R. G. (1998). Children of affectively ill parents: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, *37*, 1134-1141.
- Beardslee, W. R., Swatling, S., Hoke, L., Rothberg, P. C., van de Velde, P., & Podorefsky, D. (1998). From cognitive information to shared meaning: Healing principles in prevention intervention. *Psychiatry*, *61*, 112-129.
- Brennan, P. A., Le-Broque, R., & Hammen, C. (2003). Maternal depression, parent-child relationships, and resilient outcomes in adolescence. *Journal of the American Academy of Child and Adolescent Psychiatry*, *42*, 1469-1477.
- Cicchetti, D., Toth, S. L., & Rogosch, F. (1999). The efficacy of toddler-parent psychotherapy to increase attachment security in offspring of depressed mothers. *Attachment and Human Development*, *1*, 34-66.

- Cicchetti, D. (2003). Foreword. In S.S. Luthar (Ed.), *Resilience and vulnerability: Adaptation in the context of childhood adversities* (pp. xix-xxvii). New York: Cambridge University Press.
- Clarke, G. N., Hornbrook, M., Lynch, F., Polen, M., Gale, J., Beardslee, W. R. et al. (2001). A randomized trial of a group cognitive intervention for preventing depression in adolescent offspring of depressed parents. *Archives of General Psychiatry*, 58, 1127-1134.
- Cogan, N., Riddell, S., & Mayes, G. (2005). Children living with an affectively ill parent: How do they cope? *Educational and Child Psychology*, 22, 16-28.
- Conrad, M. & Hammen, C. (1993). Protective and resource factors in high- and low-risk children: A comparison of children with unipolar, bipolar, medically ill, and normal mothers. *Development and Psychopathology*, 5, 593-607.
- Dodge, K. (1990). Developmental psychopathology in children of depressed mothers. *Developmental Psychology*, 26, 3-6.
- Downey, G. & Coyne, J. C. (1990). Children of depressed parents: An integrative review. *Psychological Bulletin*, 108, 50-76.
- Field, T., Healy, B., Goldstein, S., & Guthertz, M. (1990). Behavior-state matching and synchrony in mother-infant interactions of nondepressed versus depressed dyads. *Developmental Psychology*, 26, 7-14.
- Focht-Birkerts, L. & Beardslee, W. R. (2000). A child's experience of parental depression: Encouraging relational resilience in families with affective illness. *Family Process*, 39, 417-434.
- Garber, J. & Little, S. (1999). Predictors of competence among offspring of depressed mothers. *Journal of Adolescent Research*, 14, 44-71.

- Gladstone, T. R. G. & Beardslee, W. R. (2000). The prevention of depression in at-risk adolescents: Current and future directions. *Journal of Cognitive Psychotherapy, 14*, 9-23.
- Grigoriu-Serbanescu, M., Christodorescu, D., Mageureanu, S., Jipescu, I., Totoescu, A., Marinescu, E. et al. (1991). Adolescent offspring of endogenous unipolar depressive parents and of normal parents. *Journal of Affective Disorders, 21*, 185-198.
- Hammen, C., Burge, D., Burney, E., & Adrian, C. (1990). Longitudinal study of diagnoses in children of women with unipolar and bipolar affective disorder. *Archives of General Psychiatry, 47*, 1112-1117.
- Hammen, C., Burge, D., & Stansbury, K. (1990). Relationship of mother and child variables to child outcomes in a high-risk sample: A causal modeling analysis. *Developmental Psychology, 26*, 24-30.
- Hammen, C. (2003). Risk and protective factors for children of depressed parents. In S.S. Luthar (Ed.), *Resilience and vulnerability: Adaptation in the context of childhood adversities* (pp. 50-75). New York: Cambridge University Press.
- Harris, T., Brown, G. W., & Bifulco, A. (1987). Loss of parent in childhood and adult psychiatric disorder: The role of social class position and premarital pregnancy. *Psychological Medicine, 17*, 163-183.
- Jaser, S. S., Langrock, A. M., Keller, G., Merchant, M. J., Benson, M. A., Reeslund, K. et al. (2005). Coping with the stress of parental depression II: Adolescent and parent reports of coping and adjustment. *Journal of Clinical Child and Adolescent Psychology, 34*, 193-205.
- Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Eshleman, S., Wittchen, H. et al. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric

- disorders in the United States: Results from the national comorbidity survey. *Archives of General Psychiatry*, 51, 8-19.
- Klimes-Dougan, B. & Bolger, A. K. (1998). Coping with maternal depressed affect and depression: Adolescent children of depressed and well mothers. *Journal of Youth and Adolescence*, 27, 1-15.
- Langrock, A. M., Compas, B. E., Keller, G., Merchant, M. J., & Copeland, M. E. (2002). Coping with the stress of parental depression: Parents' reports of children's coping, emotional and behavioural problems. *Journal of Clinical Child and Adolescent Psychology*, 31, 312-324.
- Lewinsohn, P. M., Hops, H., Roberts, R. & Seeley, J. R. (1988). *Adolescent depression: prevalence and psychosocial aspects*. Paper presented at the Annual Meeting of the American Public Health Association. Boston, November 14.
- Lieb, R., Isensee, B., Hofler, M., Pfister, H., & Wittchen, H. (2002). Parental major depression and the risk of depression and other mental disorders in offspring: A prospective-longitudinal community study. *Archives of General Psychiatry*, 59, 365-374.
- Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development*, 71, 543-562.
- Luthar, S. S. & Zelano, L. B. (2003). Research on resilience: An integrative review. In S.S. Luthar (Ed.), *Resilience and vulnerability: Adaptation in the context of childhood adversity* (pp. 510-549). New York: Cambridge University Press.

- Luthar, S. S. (in press). Resilience in development: A synthesis of research across five decades. In D. Cicchetti & D.J. Cohen (Eds.), *Developmental Psychopathology: Risk, Disorder and Adaptation* (2nd ed.). New York: Wiley.
- Peisah, C., Brodaty, H., Luscombe, G., & Anstey, K. J. (2004). Children of a cohort of depressed patients 25 years later: Psychopathology and relationships. *Journal of Affective Disorders, 82*, 385-394.
- Pound, A. (1996). Parental affective disorder and childhood disturbance. In M. Gopfert, J. Webster, & M.V. Seeman (Eds.), *Parental psychiatric disorder: Distressed parents and their families* (pp. 201-218). Cambridge: Cambridge University Press.
- Radke-Yarrow, M. & Sherman, T. (1990). Hard growing: children who survive. In J. Rolf, A.S. Masten, D. Cicchetti, K.H. Nuechterlein, & S. Weintraub (Eds.), *Risk and protective factors in the development of psychopathology* (pp. 97-119). Cambridge: Cambridge University Press.
- Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry, 57*, 316-331.
- Rutter, M. (1990). Commentary: Some focus and process considerations regarding effects of parental depression on children. *Developmental Psychology, 26*, 60-67.
- Rutter, M. (1999). Resilience concepts and findings: implications for family therapy. *Journal of Family Therapy, 21*, 119-144.
- Solantaus-Simula, T., Punamaki, R.-L., & Beardslee, W. R. (2002). Children's responses to low parental mood. II: Associations with family perceptions of

- parenting styles and child distress. *Journal of the American Academy of Child and Adolescent Psychiatry*, 41, 287-295.
- Tolan, P. T. (1996). How resilient is the concept of resilience? *The Community Psychologist*, 29, 12-15.
- Van Doesum, K. T. M., Hosman, C. M. H., & Riken-Walraven, J. M. (2005). A model-based intervention for depressed mothers and their infants. *Infant Mental Health Journal*, 26, 157-176.
- Weissman, M. M., Warner, V., Wickramaratne, P., Moreau, D., & Olfson, M. (1997). Offspring of depressed parents: 10 years later. *Archives of General Psychiatry*, 54, 932-940.
- Weissman, M. M., Wickramaratne, P., Nomura, Y., Warner, V., Pilowski, D., & Verdeli, H. (2006). Offspring of depressed parents: 20 years later. *American Journal of Psychiatry*, 163, 1001-1008.
- Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham: Open University Press.
- Wolkow, K. E. & Ferguson, H. B. (2001). Community factors in the development of resiliency: considerations and future directions. *Community Mental Health Journal*, 37, 489-498.
- Zahn-Waxler, C., Mayfield, A., Radke-Yarrow, M., McKnew, D. H., Cytryn, L., & Davenport, Y. B. (1988). A follow-up investigation of offspring of parents with bipolar disorder. *American Journal of Psychiatry*, 145, 506-50

Part 2: Empirical Paper

Processes of Resilience in Offspring of Parents With Depression

Abstract

This qualitative study explored which processes were helpful to people in coping with growing up with a parent with depression. Participants were ten adults who had lived with a depressed parent as children and who were interviewed about their experiences. The interviews were analysed using Interpretative Phenomenological Analysis (IPA: Smith & Osborne, 2003). Analysis yielded 15 themes, which were organised into four domains: one described the context of living with a parent with depression, and the other three described processes of resilience at the social, family and individual level. Participants' accounts indicated a variety of processes that were useful; open communication and developing understanding were key ideas that linked a number of themes, and developmental considerations relevant to these were highlighted. The implications of the findings for preventive intervention programmes are discussed.

Introduction

Offspring of depressed parents are at increased risk of experiencing affective disorders and other mental health difficulties (Beardslee, Versage & Gladstone, 1998; Downey & Coyne, 1990). The rates of depression in offspring of depressed parents have been examined in a number of studies, and reports range from between 20% and 45% for school age children and adolescents (Hammen, 2003). In addition, children of parents with an affective disorder are also more likely to receive other psychiatric diagnoses and to experience other problems including emotional and behavioural disturbance, increased feelings of guilt, negative self-concept and problems in social and academic functioning (Beardslee et al., 1998; Downey & Coyne, 1990; Pound, 1996).

There are some indications that this risk continues into adulthood, although there has been less focus on examining the effects on offspring of depressed parents once they have grown up. The few studies which have followed offspring into adolescence and young adulthood have generally found similarly increased rates of depression and other disorders (Weissman, Warner, Wickramaratne, Moreau & Olfson, 1997; Weissman et al., 2006); although one study found little difference between offspring of depressed parents and a control group at a 25-year follow-up (Peisah, Brodaty, Luscombe & Anstey, 2004).

The research into risk for offspring of depressed parents has been extensive, but there has been much less focus on those who avoid this risk and do not suffer major negative consequences. Resilience, that is the positive adaptation in the face of life adversity (Cicchetti, 2003), has been a growing area of research. There are a wide range of risk factors that are known to predispose people to poorer outcomes and psychopathology – including socioeconomic disadvantage, maltreatment,

catastrophic life events, and parental mental illness – and studies have examined each of these, looking at how some people manage to thrive despite their high-risk experiences (Luthar, Cicchetti & Becker, 2000). Stemming from this research, a number of factors have been suggested to be significant in promoting resilience. It is proposed that these factors fall into three main categories: attributes of the child, aspects of their families, and characteristics of the wider social environments (Luthar et al., 2000).

There is a limited body of literature which has begun to examine resilience in offspring of depressed parents. The conclusions that can be drawn from the studies to date are tentative, but indicate that there are some specific factors which may be important in promoting resilience in offspring of depressed parents. Results from a number of studies suggest that offspring of depressed parents tend to use different styles of coping than those used by control groups (Cogan, Riddell & Mayes, 2005), and that using positive or productive coping strategies, such as distraction or cognitive restructuring, may be linked with better outcomes (Jaser et al., 2005).

Others studies have examined a range of specific factors which may be linked with resilience in offspring of depressed parents. The results are consistent with the wider resilience literature in identifying that a range of individual factors, family factors and social factors are important. Factors which were highlighted included involvement in social relationships, self-understanding which includes an absence of self-blame, positive self-esteem, good parent-child relationships including warmth and acceptance, and social competence (Beardslee & Podorefsky, 1988; Brennan, LeBrocq & Hammen, 2003; Conrad & Hammen, 1993; Garber & Little, 1999; Radke-Yarrow & Sherman, 1990).

A number of preventive interventions aiming to increase resilience in offspring of depressed parents have also been evaluated. These interventions have been primarily focused on parent-child relationships or family functioning and have been found to be effective, although a number of the evaluations have focused on changes in the parents rather than in the offspring themselves. In one project the aim was to increase discussion within families and to promote self-understanding (Beardslee et al., 1997). Another project aimed to decrease levels of insecure attachment in depressed mother-infant pairs (Cicchetti, Toth & Rogosch, 1999). The only project to focus on individuals rather than families used a cognitive therapy group to prevent offspring with below-clinical levels of depressive symptomatology from developing depression (Clarke et al., 2001).

While the literature has begun to identify factors that may play a part in promoting resilience there are a number of limitations of the studies to date. The majority of research into resilience has focused exclusively on children and there has been little work looking at resilience in later life following early adverse experiences such as parental depression. In addition, little attention has been paid to the perspective of the offspring themselves. One study interviewed children of depressed parents about their coping strategies (Cogan et al., 2005), but further explorations are still needed. Beardslee & Podorefsky (1988) note that “given the lack of standardized and validated measures of resiliency, investigation of a subject’s own perceptions of what enabled him or her to function effectively provides important information for understanding the psychological processes involved in such adaptive behaviour” (p.63).

There has been a call for a shift in focus in resilience research from identifying specific factors towards examining protective processes (Luthar, in

press). However, this endeavour is in the early stages, and the majority of research into resilience in offspring of depressed parents has looked at specific factors rather than processes. Luthar & Zelano (2003) in reviewing the current state of resilience research note that it is important for researchers to examine the precise mechanisms underlying protective factors. The benefit of examining processes is that it allows us to disentangle what particular aspects of certain factors or experiences are beneficial, and this knowledge can be utilised in preventive interventions. While it is helpful to know that having another non-depressed adult in the family is protective for offspring, it is even more useful to be able to disentangle what it is that underlies this benefit, for example, is it having emotional support, a role model or someone to shield them from the depressed parent that is valuable?

Given the current focus on the mechanisms of resilience, qualitative methods may be particularly valuable as they can address complex psychological processes (Willig, 2001). Rather than just identifying useful factors, they can examine in detail what participants felt that they got from these factors. Radke-Yarrow and Sherman (1990) in discussing methodological issues in resilience research raise the question of whether large-sample quantitative research or in-depth studies of individuals are more helpful. They conclude that “use of large-sample epidemiological studies clearly has been valuable for identifying factors that, in general, are predictive. Interest in mechanisms, however, forces another level of investigation, one that is sensitive to the individual” (p.99). Qualitative research methods are uniquely sensitive to the individual, stemming from a tradition of idiographic enquiry.

The aim of the present study was to obtain accounts from adult offspring about their experiences of growing up with a parent with depression and what things they felt were helpful to them. Interpretative Phenomenological Analysis (IPA:

Smith & Osborn, 2003) was utilised as a tool for accessing how participants understood their experiences, in order to explore what they felt the impact of growing up with a parent with depression was, and what processes they felt were important in helping them manage their experiences.

Method

Ethical Approval

The study was granted ethical approval by the UCL Research Ethics Committee (see Appendix A). All participants were provided with verbal and written information prior to taking part in the study, describing the process and aims of the study and outlining any ethical considerations (see Appendix B). Written consent was sought from the participants once they had been presented with all the relevant information (see Appendix C).

Participants

Participants were recruited primarily from the university community with the use of two sampling strategies. Firstly, posters were put up around the campus giving brief details about the project and asking people interested in participating to contact me to discuss the project further. Secondly, an email was sent out to people on my personal contact list and to trainee clinical psychologists at the university describing the project and asking people who might be interested in participating to contact to me. The email also requested that people forward the project details on to other people they knew who might be interested in participating.

Inclusion criteria were: (1) that participants were between the ages of 18-40, (2) that one or both of their parents had suffered from depression and been in contact with mental health services, and (3) that the depression had started in the

participant's childhood and that the parent had either multiple episodes or a chronic presentation. The cut-off age of 40 was chosen with the aim of increasing the homogeneity of the sample, by ensuring that the participants were all at a fairly similar life stage. It was thought that it was more likely that older participants might be dealing with different issues, such as the death of their parent, which would impact upon resilience. There were additional exclusion criteria, which aimed to ensure that the participants could be described as resilient. Given the high rates of depression and other disorders that have been reported in the offspring of depressed parents, it seemed appropriate for this study to define resilience as the absence of serious psychopathology, therefore criteria were: (1) that participants were not currently in contact with mental health services themselves, and (2) that participants had not had extensive previous contact with mental health services (e.g. in-patient care). Due to high rates of co-morbidity of other mental health disorders and of alcohol or substance misuse with depression, it was decided not to exclude participants whose parents also had co-morbid problems; however, co-morbidity was identified in the interviews, and issues related to this were considered in the analysis of the data. Details about parental depression were gathered solely from participants, and so accuracy of information about the parents' contact with mental health services could not be guaranteed. Due to this, and in order to obtain a sufficient sample size, two participants were included who reported that they were not aware that their parents had been in contact with mental health services, but they had received antidepressant medication from their GPs. Additionally, one participant was included despite being in current contact with mental health services; this decision was made as the participant was receiving psychotherapy in relation to a physical health problem and her score on the Beck Depression Inventory (BDI: Beck, Ward,

Mendelson, Mock & Erbaugh, 1961) was 12, which is in the minimal range, indicating that she was not currently experiencing significant symptoms of depression.

Twenty-one people expressed interest in the project; of these, twelve participated in an interview. Reasons for non-participation were varied and included people not re-establishing contact after being sent the information sheet, not being able to arrange interviews because people were too busy or had moved out of area, not meeting the inclusion and exclusion criteria, and non-attendance at interviews. Following the interviews, two of the participants were excluded from the data analysis. Both of these participants had had extensive contact with mental health services; one of them was attending ongoing counselling sessions and their BDI score indicated that they were currently experiencing depression, and the other had had extensive previous contact with mental health services which had included an in-patient admission.

The ten participants included in the study comprised nine women and one man. They ranged from 20-34 years old (mean = 26.4 years). Seven participants described themselves as White British, one as White Irish, one as Middle Eastern, and one as British Korean. Five were currently studying and, of these, four were studying psychology, one at undergraduate level, one at masters level, and two at doctoral level. The other student was studying law at undergraduate level. The other five were all currently employed; jobs included clinical psychologist, teacher, public relations, director of a charity and account manager. All of the employed participants had a degree level qualification or above. Five of the participants were single, and five were either married or living with their partner. Six had received some form of counselling or therapy previously. This ranged from one session of bereavement

counselling to two years of therapy. None of the participants showed significant current symptoms of depression as measured by the BDI. Participants' scores ranged from 0-12 (mean = 4.9); scores within the range of 0-13 are considered to be minimal, indicating an absence of current depression.

Three of the participants had a father who was depressed, six had a mother who was depressed, and for one participant both parents were depressed. Nine of the participants reported that their parent's main problem was depression, the other participant's parent had a diagnosis of bipolar disorder. Five of the participant's parents had co-morbid problems, including anxiety problems and alcohol misuse. For seven participants, their parent's depression had started prior to or at their birth, the rest started around the ages of six to eight. Three of the participants had experienced occasions where their parent was hospitalised due to their depression.

Table 2 presents details of individual participants and their parents in order to provide a context for the results. Some details have been omitted in order to protect confidentiality.

Researcher's Perspective

My interest in this research topic stemmed from my professional experience prior to clinical psychology training. I had previously worked in the psychological medicine department of a children's hospital where a service for children of parents with mental illness was being set up. I became interested in the impact of parental mental health problems on offspring from this point. My initial plan for researching this area was to evaluate the usefulness of support groups for people who grew up with a parent with depression, with the aim of exploring how these may promote resilience; however, I was unable to find any such groups in the

UK. As a result I decided to conduct a broader piece of exploratory work looking at processes underlying resilience.

Table 2

Participant Details

	Gen-der	Age	Affect-ed parent	Parental diagnoses	Co-morbid problems	Age of P at onset	Additional factors
P1	F	23	Dad	Depression	-	Age 8	-
P3	F	28	Dad	Depression	-	From birth	-
P4	F	27	Mum	Bipolar Disorder	-	From birth	2 periods of hospitalisation (age 5 and age 11)
P5	F	24	Dad	Depression	Alcohol abuse	Age 6	Parents divorced (age 6); Dad died (age 13)
P6	F	34	Mum	Depression	-	From birth	Parents divorced (age 3)
P7	F	23	Mum	Depression	Possible anxiety disorder	Age 7	Dad died (age 7)
P8	F	34	Mum and Dad	Mum – Depression; Dad – Depression	-	Mum – From birth; Dad – early teens	-
P9	F	20	Mum	Depression	OCD	From birth	Parents separated (age 9); Mum hospitalised on one occasion
P11	F	27	Mum	Depression	Panic attacks; Chronic Fatigue Syndrome (past 10 years)	From birth	Parents divorced (age 1); 2 periods of hospitalisation (birth and age 13)
P12	M	24	Mum	Depression	-	From birth	-

As a result of my initial interest in the utility of support groups, and also my training in psychology, I started with some pre-conceived ideas about what might be helpful, particularly with respect to the usefulness of talking and having support from others. I had also read literature suggesting certain factors that may be helpful in promoting resilience, both in this group and more generally. I made an effort to be aware of these assumptions and preconceptions that I held at the beginning of this project, and to put them aside whilst conducting the interviews and doing the analysis. I tried to maintain a neutral stance and to allow participants to explore what had been helpful or unhelpful for them, rather than searching for information that confirmed my beliefs.

Semi-structured Interview

A semi-structured interview was designed to elicit the participants' experiences of growing up with a parent with depression, and their perspective on what had been helpful to them or allowed them to cope with the experience (see Appendix D). The interview schedule was devised following guidelines from Smith and Osborn (2003) and was based on existing literature about offspring of depressed parents and about resilience. The interview covered a number of domains including: (1) the participants' memories of growing up with a parent with depression, (2) the participants' views on how their experiences affected them at the time and currently, and (3) the participants' views about what helped them to get through their experiences of growing up with a parent with depression, with a particular focus on what it was about those experiences or factors that was helpful.

Although the schedule provided a framework for the interviews, this was not followed rigidly, and the questions were adapted and developed according to responses elicited in each individual interview. As the research progressed the

overall schedule was shaped by feedback from the initial interviews to include areas that seemed to be significant. The aim of the interview was to allow flexibility and for the participants to be able to tell their story in the way that they found comfortable.

The interviews primarily took place at the university; however, a number of interviews were conducted at participants' homes at their request. All interviews were conducted by the researcher and lasted between 60-120 minutes. The interviews were audio taped with the participants' consent, and were then transcribed verbatim.

Qualitative Data Analysis

The interview transcripts were analysed using Interpretative Phenomenological Analysis (IPA: Smith & Osborn, 2003). IPA is an in-depth qualitative analysis method designed to "explore in detail how participants are making sense of their personal and social world" (Smith & Osborn, 2003, p. 51). IPA focuses on meaning, and particularly on how people think about things that happen to them, and as such is a suitable method for looking at individuals' perceptions of what helped them get through the experience of growing up with a parent with depression, and how these things helped.

The analysis followed the stages recommended by Smith and Osborn (2003), moving from the text gradually to higher levels of abstraction. In the first stage, for each individual interview the text was read and re-read and initial notes were made on the text, annotating anything that was interesting or significant (see Appendix E). In the second stage, emerging theme labels were developed by trying to capture the quality of text in concise phrases, and these were annotated in the other margin of the text (see Appendix F). The third stage comprised an initial clustering of the themes for each interview, looking at connections across themes that had emerged; these

were noted on a separate sheet of paper, with illustrative quotes for each theme also listed (see Appendix G). Once this had been done for each interview, the themes from each of the participants were compared and connections and patterns across the participants were identified. From this, a final table of themes was constructed, drawing out the themes that were most relevant to the research question and which were most illuminating in terms of processes of resilience. These were then organised into domains, and quotes from across the participants used to illustrate each theme within the domains.

A number of credibility checks were undertaken to ensure the validity of the findings, in line with recommendations suggested by Elliott, Fischer and Rennie (1999). A process of 'testimonial validity' was carried out; each participant was sent an initial summary of the themes identified from their interview (see Appendix H), and participants were then invited to provide feedback on the themes via either email or a face-to-face meeting. This procedure is an established method of increasing the validity of qualitative research (Barker, Pistrang & Elliott, 2002); it allows the participants to verify that the results are consistent with their understanding, and has the added advantage of enabling participants to add any further information that may have been missed initially. A process of consensus was also used in the in final stage of analysis: I had in-depth discussions with my supervisor in order to reach an agreement about the validity of the themes that were emerging (Barker & Pistrang, 2005). Additionally, a process of auditing was used to check the validity and credibility of the results (Smith, 2003); my supervisor looked at examples of the stages of analysis from transcripts to final themes.

Results

Participants highlighted a variety of ways in which growing up with a parent with depression had affected them, both in childhood and adulthood, and described a range of experiences which they felt had helped them to manage the difficulties associated with their experiences. The Interpretative Phenomenological Analysis yielded 15 key themes, which were organised into four broad domains (see Table 3). The first domain, 'context', provides background information about how participants' experiences affected them. The remaining three domains, which were informed by the literature on risk and resilience (e.g. Luthar et al., 2000), refer to: (1) processes relating to the wider social environment, (2) processes relating to the family environment and family relationships, and (3) processes relating to the individual.

Participants' accounts indicated some developmentally specific processes (i.e. helpful experiences in childhood versus adulthood) but there were also significant commonalities across the lifespan. Therefore, developmental issues have been woven throughout the domains and themes, and processes more prominent in childhood or in adulthood are noted. Each theme is described below, illustrated by quotations from the participants. The source of each quotation is indicated by the participant's identifying number. In quotations which have been edited for brevity, missing words are denoted by "...".

Domain 1: Context

The themes in this domain are provided as context for the themes on processes of resilience, and so will be discussed very briefly. They help to illuminate some of the processes which may be helpful, by drawing attention to what participants felt was most difficult about having a parent with depression.

Table 3

Domains and Themes

Domain	Theme
1. Context	1.1 Depression as normality 1.2 Sensing but not understanding 1.3 Helplessness and powerlessness 1.4 Own problems and vulnerabilities
2. Social	2.1 “A fortress of support” 2.2 Having a normal childhood
3. Family	3.1 Starting to talk about it 3.2 Still a good parent 3.3 Having a stable parent figure 3.4 Sharing the burden with siblings
4. Individual	4.1 Learning strategies for dealing with parent 4.2 Separating self from parent 4.3 Finding things to be good at 4.4 Becoming self-aware 4.5 Making sense of it

Theme 1.1: Depression As Normality

Some participants talked about how their parent’s depression just seemed like a part of normal life. They often did not question it when they were children because they felt that it was “just the way it was”, and some of them did not have a sense of whether it was different from how other people’s parents or childhoods were.

“I think when you’re 6 or 7, that’s just the way things are and you don’t really think about how unlucky your lot is...This is what it is, this is who Dad is, this is the way life is, and you get on with it.” (P5)

Theme 1.2: Sensing But Not Understanding

The majority of participants highlighted the lack of knowledge they had about their parent’s depression when they were children. Only one participant was directly

told about her parent's depression. However, despite not being told, the majority of participants sensed that things were not right and that there were problems but did not fully understand what these problems were.

"...there was a bit of a kind of skeletons in the closet that don't get opened and talked about to the kids. And I think we grew up kind of sensing that there was something wrong, but not ever having it really talked about." (P3)

"Even if you can't make sense of it you sort of notice it. You don't understand it, you don't make sense of it, but you, you pick up on it." (P7)

There was a sense that the participants' parents were attempting to protect them when they were younger. However, this was not always perceived as helpful by the participants, and one of them talked about the negative impact of not knowing.

"I think in some ways he tried to protect us too much, and I would have appreciated a bit more actual realistic information about it...the problem is that you imagine things that are much worse than they actually are don't you." (P4)

Theme 1.3: Helplessness and Powerlessness

The lack of control that some participants felt that they had as children in relation to their parent's mood was emphasised. The sense that there was nothing that they could do to help or change things led to strong feelings of helplessness and anxiety.

"When I was younger, I did feel pretty powerless, and that was, um, frustrating is probably the wrong word, um, anxiety-inducing. Because there was nothing I could do." (P1)

Other participants felt a sense of powerlessness because of their parent's unpredictability. They talked about not knowing what mood their parent would be in and not having consistent boundaries set by them, which meant that they did not have the control of knowing what response their behaviour would elicit.

"Because you'd do something one day and it would be fine and the next day you'd do it and, you know, she'd get really cross about it. And so there was this continual feeling like you were treading on eggshells." (P4)

Theme 1.4: Own Problems and Vulnerabilities

Some participants highlighted the impact that their parent's depression had had on their own emotional development and wellbeing. There was a range of severity in this; some had suffered from mental health problems themselves, such as depression or eating disorders, which they linked to their experiences with their parents.

“I guess we both kind of internalised it really, because I became bulimic and [sister] was really just so unhappy at school and became really aggressive” (P3)

Others talked about having problems in terms of their own emotional regulation or management, which they felt was either a result of modelling by their parents, or a consequence of how their parents had responded to their emotions when they were younger.

“...picking up on Mum's feeling that she's sort of, you know, quite worthless, or not very loveable...and I think I began to sort of feel similar things about myself.” (P8)

“Like I think I had a real problem, um, sort of after that whole experience, identifying any emotions that I had, just because I'd learnt to suppress them so well I couldn't put a name to anything, or ever say you know, that something had upset me.” (P9)

Domain 2: Social

The themes in this domain are related to processes which occurred as part of the participants' wider external environment. These included both relationships outside the family which provided support, and features of the social environment with which the participants were able to engage.

Theme 2.1: “A Fortress of Support”

The majority of participants highlighted the value of having people outside their family who they could turn to; these people were important in offering support

and being there for the participants to rely on. This seemed to be important across the lifespan. In childhood it was important for participants to feel that they had someone else who was always available to them, and it was described by one participant as like having “second families”. This knowledge that there would be other people around to support them regardless of what happened within their family seemed to contribute to a greater sense of safety.

“...it’s almost like building up a bit of a fortress of support around you, you know. When Dad was a bit rocky, if I had all these other, kind of, you know, bricks, to keep the foundations solid in a way.” (P3)

On a more practical level, it also seemed important for the participants to know that there were people outside the family who could care for them and meet their needs as children, so that they would be looked after when things were more difficult in their family.

“...she had a couple of very very very close friends, who we almost would consider to be like aunties and uncles...they used to look after us a lot.” (P6)

“...kind of having that other person...being able to rely on them and depend on them and know that probably, you know, my needs would be met and that they would care for me and everything would be ok if they were there.” (P3)

One participant noted that this external support was not permanently available to her as a child; however, she still recognised the value of the brief experiences of support from others that she had received. Having adult figures who showed an interest in her and would listen to her or be concerned about how she was getting on was beneficial, and this interest from others seemed to act as a substitute for the interest that she felt was missing from her parent.

“Mum actually had an affair when she was with my second step-father, and I developed a really close bond with this guy...And actually that was a real outlet at the time. It didn’t last very long but I found that really helpful, talking to an adult, and actually having an adult treat me like a person...I felt it was my first experience of anyone caring about how I felt.” (P11)

Another participant described how there was no external support available to her at all when she was a child and this had had a big impact on how her parent's depression affected her, and on the options that were available to her in terms of coping with it.

"I don't think there was an available emotional outlet that was safe...that person didn't exist in my life. So yeah, it was much more about escapism than anything." (P8)

Participants also talked about the importance of having other people who knew about the situation when they were younger and who could understand that things might be difficult. This particularly seemed to come up in childhood in relation to teachers.

Although participants didn't necessarily make use of these people to talk to, they still felt reassured by knowing that people were aware and cared about their situation.

"I did feel like I got on well with [teacher], and I think knowing, it was a bit more sort of that knowing that there was someone there who sort of cared about the situation. And I don't know if I ever did really talk to her about it, but I think I thought I could if I'd wanted to." (P5)

In relation to adulthood, participants talked about the importance of having friends to rely on and turn to when things were difficult. They also talked about having people who were able to help them and look out for them, and people that they could talk to in an honest way about how they were feeling. Again, participants referred to how having support from others was like having a second family. For some participants who experienced less external support when they were younger, friends seemed to play a major role in providing support and guidance in adulthood.

"Well I think the sort of friends that I've met here I've been able to be much more honest with...it's made it a lot easier to sort of talk about things in a much more useful way...Also, just sort of um, not being lonely...having kind of like a London family as opposed to my real family. But yeah, actually a sense that someone is there for you, with no real baggage attached, is quite nice." (P11)

Theme 2.2: Having a Normal Childhood

The majority of participants described the importance of being able to maintain a normal life despite everything that was going on with their parent's depression. This was a theme that came up in relation to childhood rather than adulthood, and participants described how it was useful to be able to do things that were part of being "normal kids". It seemed important that they were in an environment where they were able to connect with the wider world and engage in childhood pursuits.

"...it wasn't like I was deprived of any kind of childhood because of his depression...I still managed to do all the normal kids stuff." (P5)

However, for one participant, the insistence from others that she should have a normal childhood was something that she was less sure about. She felt that it was not necessarily helpful to ignore what was going on and to try to pretend that life was normal.

"I mean I think there's an argument for it both ways, there's definitely an argument for it in terms of you should continue to lead as normal a life as you can, and perhaps at such a young age you know, you shouldn't be deprived of your childhood experiences...On the other hand...it was like, no it's fine, everything's normal, go to the party. When it wasn't." (P7)

Participants described the importance of being able to escape and finding something that would take them away from their parent's depression. Having hobbies or having other places they could go to was a helpful distraction and a way of blocking thoughts about their parent's depression. It was also important for some participants just to be able to get away from the situation for periods of time and to be able to enjoy something else.

"I used to go into my room and read for hours...it was definitely a form of escapism I think...removing myself from the situation and just getting as far away as possible from it and the just doing something that occupied me...you don't have to think about it." (P4)

“So that was my theory in life, you know, play as much as possible. Enjoy everything as much as possible...So I was really just a kid, and I wanted to block that sad thing, part of my life as much as possible, and have those good bits as much as possible.” (P12)

Domain 3: Family

The themes in this domain are related to processes which occurred within the family. These primarily included family relationships, both with the depressed parent and with other members of the immediate family, but also processes that took place within the family environment, such as starting to talk about their parent's depression, which were helpful.

Theme 3.1: Starting To Talk About It

The importance of being able to talk about their parent's depression within the family was emphasised; it allowed participants to access more knowledge and was key in helping them to understand what was happening. For one participant the process of talking about her parent's depression started early on in childhood, and this openness was experienced as very helpful.

“Mum and Dad are very open, very aware, intelligent people so they weren't going to hide it from me or keep me in the dark. So they explained, um, what the problem was, and that he was suffering from depression.” (P1)

For other participants starting to talk about their parent's depression happened later on, in adolescence or adulthood. There was a shift towards knowing as they got older and as they discovered more information, or were told more and had more open conversations with their parents. Knowing more about what was going on and talking about it made it easier to cope. Participants also valued the increasing openness in their relationship with their parent.

“I think that because my Mum and I are really, we're very open about it now...I'm much more involved, then I don't feel upset about it.” (P6)

One participant also described wanting to talk about it more as she got older and as she became more interested in her mother's experience, and her mother responded well to this.

"My Mum did it [explained]...She would obviously say less, and more simple information when I was younger, but, uh, as I grew older she would speak to me about it more. And because I got more interested in it, she'd speak." (P9)

Theme 3.2: Still a Good Parent

The quality of the relationship with their depressed parent was something that seemed central in helping participants cope. Some participants talked about how their parent was still able to be a good parent despite their depression, and the importance of their parent still being able to meet their needs in both practical and emotional ways when they were younger.

"So I didn't feel like he was, um, an absent parent, he was still around and available and interested in me and what I was doing. So I didn't feel neglected." (P1)

"Yeah, I mean, my Mum, give credit to her, she was, I think she was um, no different to any other mother to the child...she was really really loving and caring..." (P12)

Another aspect of this that some participants emphasised was knowing that they were loved by their parent in spite of the depression, and being able to feel secure.

"If I was going to cite one thing which I think has meant that I'm alright it would be that. It would be that I always knew that I was sort of loved and all those things." (P5)

For some participants, another way in which their depressed parent managed to be a good parent was by protecting them from witnessing too much of their depression, either by keeping away from them when they were unwell or by trying to function as well as they could when they were with them.

"She tried everything she could to make us not suffer at all...she removed herself from the situation generally. Rather than us having to witness her being depressed essentially." (P6)

“...the actual sort of time we spent together was much less...I think that in the short time that she did see me she must have made a big effort to be kind of alright.” (P7)

Theme 3.3: Having a Stable Parent Figure

As well as the importance of their relationship with their depressed parent, participants also highlighted the importance of their relationship with another parent figure. They described the benefits of having a stable parent figure within the family that they could rely on to support them and look after them as a child, whether that was their other parent, or a substitute parent figure like a grandparent or older sibling. Participants stressed the benefit of knowing that this person was a constant in their lives.

“Mum’s always been very supportive, so that was another positive thing, that was like a light in the darkness.” (P1)

“So I guess, knowing that when we got in and my Gran was there, we weren’t, we weren’t on our own kind of kids. You know, we were there and she was going to look after us and everything was fine.” (P6)

As well as being someone they could rely on, having another parent figure meant that participants had someone who could be an active parent. It seemed important to have someone who would meet their needs as children and who would provide the boundaries and structure that they needed.

“I mean you need to have that as a child, you need to have the kind of structure and discipline and someone to ferry you around. And um, yeah, I think if both parents had been depressed or a bit emotionally absent or not able to do that, I would have suffered massively.” (P3)

Another role that the stable parent figure played was in protecting them from the worst of their parent’s depression and being a buffer. They talked about having someone who would keep them away from their depressed parent when things were difficult or provide them with somewhere else to be; this seemed to be important in

terms of having someone else who would take responsibility and provide a sense of safety. It also meant for some participants that they worried less about their parent.

“...he’d just go, oh well, you know, it’s alright, Mum’s just gone on holiday, you know...sort of managed to normalise the whole thing and kept it very upbeat and you know, didn’t go, oh my God, your Mother’s vanished.” (p4)

“But he would never let her get to us. He always sort of protected us from that side of her, when she was going crazy.” (P6)

The problems associated with the absence of a stable parent figure were highlighted by one participant. She described how it had impacted on the path that her life had taken in adolescence, and had led to her “going off the rails” for a while.

“...possibly if somebody had kind of come along and, and, I don’t know been a sort of very strong parent role to me saying look, you’re a mess, you will do this, and I’m in charge now, then maybe I could have gone down a different path, but there was nobody parenting me.” (P8)

Theme 3.4: Sharing the Burden With Siblings

Some participants talked about the important role that siblings played in helping them cope with having a parent with depression, both in childhood and adulthood. During childhood, siblings were helpful because it was someone to face things together with, and prevented participants from feeling they were doing it on their own. It was also helpful in terms of closeness and being able to look after each other.

“I just have no memory of really dealing with my Mum on my own, I always think about the two of us doing it together.” (P6)

“...me and my sister have got a really close relationship. And, um, or certainly did then. And we used to sort of talk quite a lot, um, and that, you know, we used to support each other I guess quite a lot at that time...I guess there was a sense of like being in it together.” (P11)

Other participants talked about their siblings being more helpful later in life; as they had grown up they had started to talk to their siblings more and make sense of their experiences together. Siblings were particularly valuable to talk to because they had

shared the same experience as participants and could understand what they were going through or what they were feeling. The benefit of this was similar to that described in childhood of having a sense that they did not have to cope alone.

“I suppose the relationship with my brother has changed enormously. And we’re very close now, and very supportive...he’ll have a hard time with it and we’ll talk, or I’ll have a hard time, and we’ll kind of be mutually supportive...So it’s just the sense that you’re not alone and you’re not, um, unique in the feeling the things that you feel.” (P8)

As well as providing a forum for talking and understanding in adulthood, participants also talked about the value of being able to share the burden of dealing with their depressed parent with their sibling, and of facing their parent together. This provided them with support in coping with difficult interactions.

“I’m going to be around and we’re going to make sure, we’ve spoken about it, and we’re going to do Dad together...cos it is hard spending a long time with him, you do come away feeling pretty drained and miserable, so now we kind of club together a bit more.” (P3)

Domain 4: Individual

The themes in this domain are concerned with processes that occurred in relation to the individual. Some of these were internal processes, such as making sense of it, while some were more relational, such as separating self from parent, but they were all processes that were driven by the individual rather than provided for them by their family or social environment.

Theme 4.1: Learning Strategies For Dealing With Parent

Participants discussed how it was useful for them to develop specific strategies for dealing with their parent when they were depressed. This theme appeared in accounts of both childhood and adulthood. Some participants learnt strategies early on and these had helped them cope when they were children. The types of strategies varied: for some it was learning ways to try and help their parent

feel better, for others it was more about keeping out of their parent's way and protecting themselves or trying not to escalate things.

“We learnt totally and utterly to judge her moods...because she did have this really violent streak when she was depressed...it was, it's a self-preservation thing because you know, she could do damage...we needed to know to keep away and to keep out of her way.” (P6)

“...whenever she was you know crying on her bed, and my Dad was all out, so empty house, just 2 of my brothers and myself, and we used to just, you know, go to her, and you know like, sing songs to her and trying to cheer her up. And I think in that way we sort of bonded.” (P12)

Participants had also learnt strategies more recently in adulthood. Many of these strategies seemed to be focused on helping or trying to help their parent to feel better. In some cases participants described the act of trying to help as being useful for themselves even if it was not successful. It gave them more of a sense of control and took away some of the sense of helplessness that they felt about not being able to do anything for their parent.

“...it's good to be proactive, or at least try to be, because I think there's nothing worse than feeling powerless about a situation.” (P1)

“I try to kind of focus on well-being stuff [for Mum]. So I suppose that for me is almost like something I can try to do for her. Because it does make you feel kind of helpless.” (P6)

Theme 4.2: Separating Self From Parent

Some participants talked about how it was helpful as they got older to separate themselves from their parent and to get some distance from the situation; this happened in adolescence and adulthood. This strategy seemed more useful for those participants who did not describe their parent as “still a good parent” despite their depression, and it may be that this was a more useful process for those participants who were not getting their needs met by their parent. Participants described how the process of separating allowed them to worry less about their parent and also was a way of breaking free and developing their own independence

away from their parent. For some participants it was also a useful way of limiting the negative impact that their parent was having on them.

“...now I have these barriers up towards her because I don’t want to be hurt by her so I’ve got all these barriers up. And like, as my, I think my main coping mechanism is just to keep a distance.” (P7)

“And also probably quite a big part of it was moving sort of, not just physically, but emotionally away from my Mother, and there was quite a long phase of time, um, when I completely sort of withdrew from the relationship.” (P11)

Theme 4.3: Finding Things To Be Good At

Finding something to be “good at” or excelling in a particular area seemed to be one way of participants boosting or protecting their self-esteem. This seemed to be particularly important in childhood, and doing well academically was common. For some participants, pursuing success in their school work was a way of getting attention and reinforcement and made them feel happier and more confident, and compensated for how things were at home.

“...even if I wasn’t getting that much reinforcement at home, maybe that helped that I was always doing well at school...” (P5)

“I didn’t like completely feel like a failure, because...when I was really young I was really good at school...So, so that obviously gave me confidence, and... And I was liked by my teachers and stuff so. So I was a successful kid in a way. And that obviously like gives you a bit of confidence and happiness.” (P9)

In adulthood, the process of finding something to be good was often linked to using the skills they had gained from their experiences of growing up with a parent with depression. Several participants reported being good at listening to people or understanding people, and being able to use this in their work, which was another way of building their self-esteem.

“...having kind of got that stuff, it gives you the opportunity to be so helpful and useful, and that’s probably where a lot of my self-esteem comes from as well, feeling that, you know, I have a purpose...and that, you know, that I can make a difference.” (P3)

“Which is absolutely perfect for my job because in the job that I...because I work with difficult children...so it’s ideal for that, because I don’t blame them for their behaviour, I can be totally calm with them, very patient and very tolerant...” (P4)

Theme 4.4: Becoming Self-Aware

Some participants highlighted the importance of becoming self-aware; it was important to make sense of their parent’s depression in terms of how it might have impacted on them. This came up particularly in relation to their own vulnerabilities; they discussed the benefit of being able to fit together their parent’s experiences with their own and to understand their own vulnerabilities and what made them who they are. This was a process that happened more in adulthood.

“But maybe it’s a good thing that I actually did get to see it, um, because maybe if I ever recognise any of those symptoms in myself, maybe I’ll be that little bit more aware of it...because it would have flagged my own vulnerabilities.” (P1)

“I’ve got a kind of whole formulation really, of why I’m at the point I am, and who I am, and why I had bulimia, and why I, you know, had these slight mood fluctuations, and why things are difficult for my family...I’ve developed a way of, yeah, making sense of it really and of it all fitting together.” (P3)

Some participants talked about how being self-aware meant that they could protect themselves and look after themselves better to ensure they avoided having mental health problems themselves.

“I now know myself pretty well, and I know I wouldn’t take street drugs because it would probably be the most stupid thing I could do...I know when I’m beginning to get a bit low, I know what I need to do to deal with that...” (P3)

“Since then...I’ve always tried to be very aware of how I am. And...I try not to put myself in situations that are going to be too much to deal with. Um, and if I do I kind of monitor fairly closely, so that as soon as I am feeling stressed out that’s when I try to change it...So I look after myself that way.” (P4)

Other participants talked about being influenced by their parents in terms of the way they behaved or responded to things, and how developing self-awareness meant that they could try to avoid this and could recognise the other options that were available to them.

“...when I’m feeling really stressed I tend to withdraw, I tend to sort of batten down the hatches and I’ll have to deal with this. And I’m aware that I do that, so I try not to do it, you know, totally.” (P8)

“I had this tendency that I wanted to express my emotions, but I was scared of it, and it was all like, go to the other extreme of denial. But at the same time, like, I want to be self-aware, so I try to express.” (P9)

Theme 4.5: Making Sense Of It

The majority of participants stressed the importance of making sense of their parent’s depression. This was something that mainly happened in adulthood and some participants talked about the move towards wanting to know more about it as they got older. They discussed the process of looking back as they got older and wanting to understand things in retrospect with the added benefit of adult knowledge.

“Because I suppose you begin to...want to learn more, well, not learn more but understand more. So you sort of find out more about depression.” (P6)

For some participants, understanding their parent’s depression was a route to coping better with it, accepting it, and forgiving their parent or moving away from blaming them.

“...at least when there was a diagnosis, it allowed me to, um, to be a bit more forgiving, a lot more forgiving about the whole thing, and to be able to take a step back and go, ok, I can deal with that now, because I know it’s not actually her, it’s the illness.” (P4)

Five of the participants were studying psychology, either at degree or postgraduate level, and for some of them this seemed to be linked to making more sense of their parent’s depression. The process of studying depression from an intellectual standpoint allowed them to reconcile their personal experiences.

“I think the more that you understand something, and the more you know about it intellectually and factually, the more you can kind of, come to terms with it...” (P1)

“...when I studied depression, and I looked at all those things, and it, they were all sort of categories, and all those things that didn't make sense, like depressed people not being logical, or blaming themselves too much, or being guilty, blah, blah, blah. I discovered that it was actually part of the disorder.” (P9)

One participant explicitly talked about how important they felt the process of “making sense” was in helping offspring of depressed parents cope.

“So you can't say whether someone with a parent with a mental health problem...will definitely be more miserable than a child without one, because everyone will have problems, and it's about the sense they make of them. And I happen to think that humans have the capability to cope with anything depending on what sense they make of it.” (P9)

For some participants an important aspect of making sense of their parent's depression was recognising that it wasn't their fault. This realisation that they weren't responsible was key, and this aspect of making sense seemed to be present earlier in childhood.

“...you're not kind of growing up feeling that it's something that you've done that's made your parent like this. You know I never thought that.” (P3)

“I never internalised it as being my fault. I realised I think that my actions impacted on him, but I don't think I ever felt that it was my fault that he was depressed...I did feel responsible for him, but it wasn't like, it was responsible for maintenance rather than aetiology I suppose.” (P5)

The recognition that they were not to blame was also something that came up as an important theme when participants were asked about advice or suggestions that they would give to someone who was growing up with a parent with depression.

“...I think it probably would be useful to say to somebody that it's nothing that you have done, and there probably isn't very much that you can do or have to do, that it's, that person has to work through it...Don't take the load on your own shoulders.” (P1)

“...the thing which has seemed in some ways the most important thing is the blame aspect of it. Or the, I suppose I would want people to sort of try and

internalise that it's not their fault and it can never be their fault as a child.”
(P5)

Discussion

This study aimed to explore processes of resilience in offspring of parents who had depression, by examining the perspectives of adult offspring on their experiences and the things that helped across the lifespan. Participants identified and discussed a range of processes which they felt had been useful, at the level of the individual, the family, and the broader social environment. The findings from this study are generally consistent with the previous literature on factors linked with resilience in offspring of depressed parents, and extend these by exploring the mechanisms by which these factors are helpful. This study also adds a developmental perspective to the literature, which has often been lacking; the results illustrate that some processes continued over time, while others were more important at particular life stages.

The themes generated from the data seemed to fit well into the domains of social, family and individual levels which have been used in previous literature. Although these domains have been used previously to discuss factors in both risk and resilience, they were developed here as part of the process of analysis rather than being used as a pre-determined framework; other domains were considered in the process of data analysis, specifically different developmental stages, but as there were some themes which crossed developmental categories the themes seemed to fit better into domains which focused on the level at which the processes occurred.

At the level of the social environment having an external network of support was crucial: participants described how this helped them to feel secure and cared for or provided an escape from their own families. This social support was important

across the lifespan; having supportive friends in adulthood that participants could rely on and talk to about their experiences was key. Some previous literature has noted the benefit of children having external support (e.g., Garber & Little, 1999). However, this is in contrast to findings by Conrad and Hammen (1993) that having an adult friend was a risk factor for children, although their explanation was that it may be a marker for worse parental functioning. Cogan et al. (2005) found that children of depressed parents were less likely to use coping styles which involved seeking external support. Thus it may be that having access to, or being able to use, external support in childhood as the participants in this study did is an important process in promoting resilience, and one that differentiates those offspring who do well from those who do not.

At the family level, participants highlighted the importance of the relationship with their depressed parent; those who felt secure in this relationship and who felt their parent's depression did not prevent them providing love and meeting their needs saw this as something that had been protective for them. This fits with Bowlby's (1998) emphasis on the importance of early interaction between parent and child in influencing the child's ideas about their acceptability and loveableness and impacting on later functioning. The importance of maternal warmth and acceptance as a protective factor has been reported previously (Brennan et al., 2003), and parenting ability has also been emphasised in preventive interventions which have largely focused on the parent-child relationship (e.g. Cicchetti et al., 1991).

Being able to talk within the family about their parent's depression was also essential for participants. They were generally not told about their parent's depression when they were younger, and starting to talk about it was an important process that occurred as they grew up, both with their parents and with siblings.

Researchers have previously argued that the provision of information to children may be important in helping them understand their parent's illness and therefore also in helping them to cope with it (Aldridge & Becker, 2003), and this open communication is one of the key principles behind the Preventive Intervention Project developed by Beardslee and his colleagues (Beardslee et al., 1997). Aldridge and Becker (2003) suggest that the provision of information should be the responsibility of professionals as it may be too difficult for parents to do. However, a number of participants discussed the reluctance they felt as children to discuss their parent's problems outside the family because it felt disloyal. Participants emphasised the value of being able to share the burden with siblings; they were crucial in providing support and a sense that participants were not isolated and that someone else could understand their experience. This is relevant in thinking about who children are likely to talk to about their parent's depression. It seems that it may be easier to talk to someone who has had a similar experience, and this may feel like less of a betrayal of the family.

At the individual level, participants described a number of different ways of coping with having a parent with depression. A key theme was the process of making sense of their parent's depression, and an important aspect of this was the recognition that they were not responsible for their parent's problems. The majority of participants talked about how important it was not to feel guilty; some of them had internalised from an early age that it wasn't their fault, while others seemed to understand it at a later stage. Beardslee and Podorefsky (1988) identified lack of self-blame as something evidenced by resilient children in their study, and the results of the present study further suggest that it may distinguish those who do well from those who do not. Participants also highlighted the developmental aspects of making

sense of their parent's depression: they wanted to understand more about it as they got older and this understanding allowed them to come to terms with it and in some cases to forgive their parent. It may be that 'making sense' happens in adolescence or early adulthood because it relies on the development of higher-order cognitive abilities. However, 'starting to talk', as discussed above, may also facilitate the process of making sense and it may be easier for offspring to make sense of things as they grow up if they are provided with information about their parent's depression from a young age.

Another key theme for participants at the individual level was the development of self-awareness; this process was linked to making sense, but had more emphasis on understanding how their parent's depression had influenced them in terms of the kind of person that they were. Participants felt that being self-aware meant that they could recognise their own vulnerabilities and protect themselves, actively avoiding things that might lead to difficulties for them, such as excessive stress or taking street drugs. One previous study also found that self-understanding was a key factor in a sample of resilient adolescents (Beardslee & Podorefsky, 1988). The development of reflective function, which is the ability to understand one's own and others' behaviour in mental state terms, is thought to be facilitated by responsive parenting and secure attachment (Fonagy & Target, 1997). Depressed parents have been described as being less responsive and therefore their offspring are likely to show impairment in the development of reflective function. This capacity is necessary for making sense of others' feelings and their impact on oneself, which is evidenced by participants here. As indicated earlier, it may be that the participants in the current study were generally securely attached and thus able to develop reflective function.

Some participants also emphasised the importance of creating some distance between themselves and their parent, both emotionally and physically. This is consistent with previous literature which suggested that resilient offspring were able to distinguish between themselves and their parents and to recognise that their life experiences would be different (Beardslee & Podorefsky, 1988). In the present study however, this was not a universal process: it seemed to be more useful for those who did not describe having a secure relationship with their parent. This highlights the need to consider processes of resilience in relation to individual circumstances.

There are a number of methodological issues to consider in interpreting the findings from this study. The aim was to select a sample of resilient offspring, and the criterion of an absence of mental health problems was used based on recommendations in the literature. However, it is debatable whether the absence of depression or other psychopathology in offspring of depressed parents is a true indication of resilience, and it is important to bear in mind the variety of ways in which having a depressed parent may influence offspring. Participants generally felt that their parent's difficulties had affected them to some degree, ranging from previous mental health problems to problems in dealing with stress or managing their emotions. However, participants did appear to be functioning well on the whole; they seemed to be socially successful and in fact described a positive impact in terms of their experiences with their parent making them more socially competent as they got older. They were also primarily from a university population and were all academically successful, and in this respect they were not a representative sample. It may be that the emphasis they placed on understanding is linked to their level of education. However, the sample was also heterogeneous in some ways: their depressed parents included fathers as well as mothers, with varying degrees of

severity and chronicity of depression, and co-morbid problems. Previous research has often focused exclusively on maternal depression (Hammen, 2003), although the themes that emerged in this study were similar across participants with depressed fathers and mothers.

This study relied on retrospective accounts from participants about the ways in which their experiences affected them and the things that were helpful at different points across their childhood and adolescence. The acceptance of retrospective accounts of childhood as accurate and reliable is something that has been debated within the research field, with concerns expressed about limitations in memory, as well as retrieval biases associated with mood states such as depression. However, a review of sources of error in retrospective reports of childhood experiences concludes that while there may be evidence for some reconstruction taking place in adults' retrospective accounts, there is also a reasonable level of accuracy, particularly regarding factual details for events which are "unique, consequential, and unexpected" (Brewin, Andrews & Gotlib, 1993, p.87).

Participants' accounts in the current study were detailed, and although they shed some light on the mechanisms of resilience, the underlying question of what enabled these individuals to engage in adaptive processes such as developing an understanding of their parent's depression still remains. The ability of this study to answer this question is limited and it is important to consider the extent to which self-report methods can access the kinds of subtle processes of resilience that the study addressed. It could be argued that people may not be fully conscious of, or able to reflect upon, their inner experience at this level.

Additional forms of credibility checks on the analysis of the data would have made the study stronger. A process of testimonial validity was utilised, where initial

results are shared with participants to check whether they are consistent with their understanding (Barker et al., 2002); however, there was a limited response from participants when they were asked for feedback on an initial list of themes from their interview. The three participants who did respond all felt that the themes were an accurate representation of their ideas, but it would have been useful to have further confirmation of this from other participants.

A variety of processes were identified by participants as being useful; however, ideas about open communication and developing understanding linked a number of these processes and seemed to be crucial in enabling participants to manage the difficulties associated with having a parent with depression. It would be useful for future research to look at some of these key processes in more depth. The development of self-understanding in offspring of depressed parents is something that could be examined further. Larger scale studies to test out associations between the processes described here and outcomes for offspring of depressed parents would also be useful.

The focus in this study was on offspring of parents who had been in touch with mental health services and received a diagnosis. However, previous research has indicated that current depressed mood and chronic stress contributes more to difficulties in children than does the parent's diagnosis itself (Hammen, Burge, Burney & Adrian, 1990), and there are many people who do not receive a diagnosis. Consideration of processes of resilience in offspring of parents who experience symptoms of depression but are not diagnosed would be useful, particularly as the processes of talking and making sense may be less readily available to this group.

Given the problems indicated above with relying solely on retrospective accounts, it would be helpful to extend this research by employing a longitudinal

design to explore processes of resilience with offspring of depressed parents across the lifespan, starting with interviews in childhood and following participants up in adulthood. Alternatively, the validity of retrospective accounts could be better established by including other informants as further sources of information. Studies could utilise sibling viewpoints to confirm reports from participants as these have been shown to be more accurate than those provided by parents, who tend to show a positive reporting bias regarding their children's experiences (Brewin et al., 1993).

Identifying processes of resilience is an important step in developing ways of promoting resilience and reducing the negative impact of parental depression on offspring. The implications of this study for informing preventive intervention work are interesting in that they diverge in some respects from previous work. The majority of preventive interventions to date for offspring of depressed parents have focused on parent-child relationships (e.g., Beardslee et al., 1997). However, a number of aspects of resilience at the individual level were highlighted here, which could be utilised for preventive intervention programmes, particularly for children whose parents are unwilling or unable to engage in family-based interventions. Providing offspring with the opportunity to talk and reflect on their experiences may help promote the development of an understanding of their parent's depression as well as self-understanding. It is important to bear in mind participants comments about talking feeling like a betrayal of the family, which suggests that children may need to be given explicit permission to talk. Offspring may find support groups helpful, where they could meet other people in similar situations and discuss their experiences. This is something that a few of the participants expressed interest in as they felt it would have been a way of normalising their experience when they were

growing up. Thus, peer support groups may be an avenue to consider for preventive interventions to promote resilience in offspring of depressed parents.

References

- Aldridge, J. & Becker, S. (2003). *Children caring for parents with mental illness: Perspectives of young carers, parents and professionals*. Bristol: The Policy Press.
- Barker, C., Pistrang, N., & Elliott, R. (2002). *Research methods in clinical psychology: An introduction for students and practitioners*. Chichester: John Wiley & Sons.
- Barker, C. & Pistrang, N. (2005). Quality criteria under methodological pluralism: Implications for conducting and evaluating research. *American Journal of Community Psychology*, 35, 201-212.
- Beardslee, W. R. & Podorefsky, D. (1988). Resilient adolescents whose parents have serious affective and other psychiatric disorders: Importance of self-understanding and relationships. *American Journal of Psychiatry*, 145, 63-69.
- Beardslee, W. R., Salt, P., Versage, E. M., Gladstone, T. R. G., Wright, E. J., & Rothberg, P. C. (1997). Sustained change in parents receiving preventive interventions for families with depression. *American Journal of Psychiatry*, 154, 510-515.
- Beardslee, W. R., Versage, E. M., & Gladstone, T. R. G. (1998). Children of affectively ill parents: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 1134-1141.
- Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, 4, 561-571.
- Bowlby, J. (1998). *Loss: Sadness and depression*. (vol. 3) London: Pimlico.

- Brennan, P. A., Le-Broque, R., & Hammen, C. (2003). Maternal depression, parent-child relationships, and resilient outcomes in adolescence. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42, 1469-1477.
- Brewin, C. R., Andrews, B., & Gotlib, I. H. (1993). Psychology and early experience: A reappraisal of retrospective reports. *Psychological Bulletin*, 113, 82-98.
- Cicchetti, D., Toth, S. L., & Rogosch, F. (1999). The efficacy of toddler-parent psychotherapy to increase attachment security in offspring of depressed mothers. *Attachment and Human Development*, 1, 34-66.
- Cicchetti, D. (2003). Foreword. In S.S. Luthar (Ed.), *Resilience and vulnerability: Adaptation in the context of childhood adversities* (pp. xix-xxvii). New York: Cambridge University Press.
- Clarke, G. N., Hornbrook, M., Lynch, F., Polen, M., Gale, J., Beardslee, W. R. et al. (2001). A randomized trial of a group cognitive intervention for preventing depression in adolescent offspring of depressed parents. *Archives of General Psychiatry*, 58, 1127-1134.
- Cogan, N., Riddell, S., & Mayes, G. (2005). Children living with an affectively ill parent: How do they cope? *Educational and Child Psychology*, 22, 16-28.
- Conrad, M. & Hammen, C. (1993). Protective and resource factors in high- and low-risk children: A comparison of children with unipolar, bipolar, medically ill, and normal mothers. *Development and Psychopathology*, 5, 593-607.
- Downey, G. & Coyne, J. C. (1990). Children of depressed parents: An integrative review. *Psychological Bulletin*, 108, 50-76.

- Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*, 215-229.
- Fonagy, P. & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology, 9*, 679-700.
- Garber, J. & Little, S. (1999). Predictors of competence among offspring of depressed mothers. *Journal of Adolescent Research, 14*, 44-71.
- Hammen, C., Burge, D., Burney, E., & Adrian, C. (1990). Longitudinal study of diagnoses in children of women with unipolar and bipolar affective disorder. *Archives of General Psychiatry, 47*, 1112-1117.
- Hammen, C. (2003). Risk and protective factors for children of depressed parents. In S.S. Luthar (Ed.), *Resilience and vulnerability: Adaptation in the context of childhood adversities* (pp. 50-75). New York: Cambridge University Press.
- Jaser, S. S., Langrock, A. M., Keller, G., Merchant, M. J., Benson, M. A., Reeslund, K. et al. (2005). Coping with the stress of parental depression II: Adolescent and parent reports of coping and adjustment. *Journal of Clinical Child and Adolescent Psychology, 34*, 193-205.
- Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development, 71*, 543-562.
- Luthar, S. S. & Zelano, L. B. (2003). Research on resilience: An integrative review. In S.S. Luthar (Ed.), *Resilience and vulnerability: Adaptation in the context of childhood adversity* (pp. 510-549). New York: Cambridge University Press.

- Luthar, S. S. (in press). Resilience in development: A synthesis of research across five decades. In D. Cicchetti & D.J. Cohen (Eds.), *Developmental Psychopathology: Risk, Disorder and Adaptation* (2nd ed.). New York: Wiley.
- Peisah, C., Brodaty, H., Luscombe, G., & Anstey, K. J. (2004). Children of a cohort of depressed patients 25 years later: Psychopathology and relationships. *Journal of Affective Disorders*, 82, 385-394.
- Pound, A. (1996). Parental affective disorder and childhood disturbance. In M. Gopfert, J. Webster, & M.V. Seeman (Eds.), *Parental psychiatric disorder: Distressed parents and their families* (pp. 201-218). Cambridge: Cambridge University Press.
- Radke-Yarrow, M. & Sherman, T. (1990). Hard growing: children who survive. In J. Rolf, A.S. Masten, D. Cicchetti, K.H. Nuechterlein, & S. Weintraub (Eds.), *Risk and protective factors in the development of psychopathology* (pp. 97-119). Cambridge: Cambridge University Press.
- Smith, J. A. (2003). Validity and qualitative psychology. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 232-235). London: Sage Publications Ltd.
- Smith, J. A. & Osborn, M. (2003). Interpretative phenomenological analysis. In J.A. Smith (Ed.), *Qualitative Psychology: A practical guide to research methods* (pp. 51-80). London: Sage Publications Ltd.
- Weissman, M. M., Warner, V., Wickramaratne, P., Moreau, D., & Olfson, M. (1997). Offspring of depressed parents: 10 years later. *Archives of General Psychiatry*, 54, 932-940.

- Weissman, M. M., Wickramaratne, P., Nomura, Y., Warner, V., Pilowski, D., & Verdeli, H. (2006). Offspring of depressed parents: 20 years later. *American Journal of Psychiatry*, *163*, 1001-1008.
- Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham: Open University Press.

Part 3: Critical Appraisal

Introduction

This paper is a reflection on the process of conducting the research study; it will include discussion of particular issues and challenges that arose regarding the design and implementation of the study and analysis of the data, and will elaborate on the clinical implications of the findings. The paper will cover four specific areas: (1) issues concerning the sample and recruitment, (2) the process of interviewing, (3) use of qualitative data and analysis, and (4) clinical implications of the study.

Sample and Recruitment Issues

There were a number of dilemmas which arose during the project, which were associated with the selection of an appropriate sample and recruiting participants. These will be discussed in turn, with consideration of how they may have impacted on the process of the research and on the results.

Defining Resilience

The aim of this study was to examine a group of 'resilient' offspring in order to access their perspectives on what things had helped them achieve resilience; however, it is difficult to select a resilient population or, indeed, to agree on what characterises resilience. The decision was taken to define resilience for this study as positive adaptation in the area of mental health, including only participants who were not currently experiencing mental health problems. The definition of resilience has been debated in the literature, but key researchers have recommended focusing on areas in which risk is significantly increased when studying a particular area of adversity (Luthar, Cicchetti & Becker, 2000). Thus, because parental depression confers a high risk for depression and other disorders, absence of mental health problems was deemed an appropriate indicator of resilience for this population.

However, it is debatable whether the absence of depression or other psychopathology in offspring of depressed parents is a true indication of resilience, and it is important to bear in mind the variety of ways in which having a depressed parent may influence offspring, aside from the issue of diagnosable disorders. As Radke-Yarrow and Sherman (1990) conclude, “there is a risk in the study of resilient or invulnerable children of failing to attend to the costs that these children are paying for their “successful” survival. Clearly a balance is needed in investigating the total functioning of children, noting their strengths and their weaknesses” (p.100).

The issue of whether or not participants in this study were resilient is debateable. They were not currently experiencing mental health problems, with the exception of one participant who reported that she had been experiencing depression in relation to physical health problems, although her score on the BDI was in the minimal range. Two participants were excluded from the study due to the presence of current mental health problems or severe previous problems; however, a number of the other participants who were included had previously experienced mental health problems, including depression and eating disorders. These participants were included because their previous problems seemed less severe, in that they did not result in inpatient treatment, and also because they appeared to be functioning better currently. This highlights the fact that the decisions made about how to conceptualise resilience for this study and who to include were necessarily subjective to some extent, because of the lack of a clear, overarching definition of resilience. An additional reason why participants who had previously experienced less severe mental health problems were not excluded was because resilience is conceptualised as a dynamic process and so can be achieved at any point across the lifespan, rather than being a static trait (Masten & Powell, 2003). In fact, for some participants in

this study it seemed that the process of experiencing mental health problems themselves and then making sense of this in light of their parent's depression was something that was useful and may have helped them to achieve resilience. However, it does appear that the participants were all affected to some degree by their parent's depression and so it cannot be truly said that they avoided all risk. The benefit of the use of qualitative methods meant that these more complex issues around the definition of resilience were not ignored; participants' strengths and weaknesses were explored through their own stories, and it was clear that there were varying levels of adaptation in different areas of their lives. One participant in particular commented that although she was managing life well, she was aware of a tendency to suppress her emotions because of a fear of being overwhelmed by them as her mother had.

Recruitment

In order to recruit a resilient sample, it was necessary to recruit via the community rather than through mental health services or settings. This made recruitment difficult as there was no identified population to draw on. One potential way around this would have been to identify offspring via their depressed parents, using records from GPs or mental health services, and then to contact them and have a screening process to identify those that met criteria for resilience. However, this would have been a much longer process and as I was looking to recruit adult offspring it may have been difficult to contact them through their parents as they would have been less likely to still be living with them. I decided that this was an unrealistic strategy for this study; instead I chose recruitment strategies that would reach a large number of people in the community, including use of posters and emails. This was more successful than may have been anticipated in attracting

enquiries, which was positive. However, as the posters were put up around the university premises, it meant that the participants in this study were primarily from a university population. There were a few other participants who were recruited via my email contact list, but they also had university level education. There was also a high proportion of psychologists in this sample, who were recruited via email or posters in the psychology department. It may have been that people who were studying psychology felt more comfortable about talking about their experiences of having a depressed parent, or were more interested in the idea of the study. The processes of resilience identified in this study may be heavily influenced by this, particularly given the emphasis on self-understanding and making sense which seemed to be linked to ideas about formulation that are very salient for psychologists. However, the same themes were found across the sample and so were also highlighted by those who were not psychologists.

There are other ways in which the research may have been influenced by the type of people who responded to the recruitment strategies. Although the majority of participants seemed to be functioning relatively well, I had concerns during the recruitment phase that people might contact me if they felt the need to discuss their experiences. Those who were relatively unaffected by their experiences may have been less likely to respond to the recruitment strategies if they were less inclined to need to talk about their experiences, thus it is possible that the study did not attract a more resilient population. It perhaps would have been helpful to address this by stating on the posters and emails that I wanted to interview people who felt that they had coped well with their experiences and who were willing to share their ideas about how they managed this.

Heterogeneity and Homogeneity of Sample

Another issue was trying to achieve an appropriate balance of heterogeneity and homogeneity using inclusion and exclusion criteria. One dilemma was in deciding how homogeneous to try and make the sample in terms of their parent's depression. There are a number of factors relevant to this, including severity and chronicity of the depression, diagnosis, and co-morbidity. Although only participants whose parents had experienced chronic or repeated episodes of depression were included, there was still a wide variety of experiences. One of the participants had a parent who had been given a diagnosis of bipolar disorder and, as such, her experiences were quite different in some respects from other participants. There were periods of depression which she was able to reflect upon, but it was difficult to separate the effects of depression from the effects of mania, and it is likely that there are different processes that are helpful in coping with a parent with mania compared to coping with a parent with depression. It was difficult to avoid these issues of different diagnoses or levels of severity in parents because the identification of the parents' problems was based entirely on information reported by the participants. Whilst some of them knew their parent's diagnosis, others were not aware of the specific diagnosis that their parent had been given, and their reports of the severity of their parent's problems were obviously subjective.

Another important issue acknowledged in the literature which was not fully addressed here was whether the effects on offspring arise specifically from their parent's depression, or whether it is associated factors that are more relevant, such as marital discord, parental stress or other co-morbid disorders (Rutter, 1990). In this study, some participants' parents had additional problems as well as depression, including alcohol abuse, bipolar disorder and anxiety. The issue of co-morbidity was

not fully addressed here; however, I decided that it was important not to exclude participants on this basis as co-morbidity is a common occurrence and so it is interesting to examine processes of resilience in these cases. One previous study indicated that current depressed mood and chronic stress contributed more to difficulties for children than did their parent's diagnosis itself (Hammen, Burge, Burney & Adrian, 1990). This argues for the fact that consideration needs to be given to children whose parents are experiencing difficulty with symptoms of depression and stress, regardless of psychiatric diagnosis.

Interviewing

Due to the types of recruitment strategy used, the people that I interviewed were very much self-selected. This may have impacted on the interviews in a number of ways. It may be that the people who responded to the posters or emails were those who were more affected by their experiences and felt the need to discuss them. The interview provided a space for people to talk at length about the impact of having a parent with depression and it may be that I was accessing those who still felt the need to process their experiences. This was highlighted by one potential participant who said that she thought it would really help her, although in fact she ended up choosing not to participate. In some cases, participants acknowledged that the interview provided a unique opportunity to talk about their experiences with their parent and how it had affected them, and it is possible that they were using the interview as a therapeutic space to consider these issues. The sensitive and emotionally charged nature of the topic meant that the boundaries between research and therapy were blurred, and this meant that I was required to use my clinical skills in the interviews,

in some cases containing people's distress and often allowing participants to continue talking about issues which felt important to them.

This highlights another issue with the interviews, which was the difficulty in sticking to the interview schedule. I experienced a tension in the interviews between wanting to follow up on what participants were talking about and being responsive to them, and trying to cover the material which was necessary in order to answer the research questions. I found that as the interviews progressed, I became less reliant on the schedule, and allowed participants more freedom in leading the interviews and discussing areas which they felt were important. However, I knew the interview schedule well and was able to hold in mind the topics that I needed to cover, and I also found it helpful to have a brief discussion with participants at the start of the interview about the areas that I was hoping to cover so that they were also tuned in to the areas that I wanted them to talk about.

The prevalence of psychologists in the sample may also have had an impact on the interviews. By the nature of their study or training, psychologists are likely to be more reflective and thoughtful about their experiences. This made the process of interviewing much easier in some senses. The participants who were psychologists seemed better able to answer the probing questions about *why* certain things had been helpful than other participants. This may have provided a biased reflection of what things were helpful; however, it may be that being thoughtful and reflective, and perhaps going into the field of psychology, could in itself be a process which promotes resilience. Certainly a couple of participants reflected on how useful their clinical psychology training had been in helping them process their experiences in a different way, and in giving them the skills to cope with their depressed parent.

These people may be part of a particularly resilient group, who have survived the risk

associated with having a depressed parent, and gone on to utilise their experiences in helping other people with mental health problems.

Qualitative Data and Analysis

A wealth of rich data was generated from the interviews, which was very useful in allowing detailed analysis, but also presented me with difficulties in terms of sticking to the focus of the research questions. My aim was to examine processes underlying resilience; however, the majority of participants talked in great detail about the ways in which their experiences with their parent had impacted upon them. I had included questions about this in the interview schedule as it seemed necessary to cover this background information before discussing what had been helpful. However, this meant that in the process of analysis many themes emerged which related to the experiences and impact of having a parent with depression rather than to resilience. It was necessary to put aside many of these themes in the final analysis, which I found difficult to do because I felt it was important to do justice to the participants in presenting their stories.

One problem with the qualitative data and analysis used here is the assumption that participants are able to adequately describe their experiences relating to processes of resilience. There are two different issues with this. One issue is that Interpretative Phenomenological Analysis (IPA: Smith & Osborn, 2003) assumes that participants are able to adequately capture and convey their experiences using language (Willig, 2001), which means that such a method may not be suitable for those who are unable to articulate their experiences. By virtue of recruiting primarily from a university population, participants in this study were well-educated and articulate. However, the processes of resilience that they described may differ

significantly from those of others in a broader population. It may be that the ability to articulate experiences is in itself a process which promotes resilience, given the emphasis by participants here on talking about and making sense of their experiences. The other issue relates to the ability of participants to reflect upon the subtle processes and mechanisms of resilience that this study was aiming to address. This study relied upon self-report, but it may be that some of the processes which are important occur at an unconscious level that participants are unable to access. This concern is supported by the difficulties some participants experienced in answering questions about why certain things were helpful, or what it was about certain situations or people that meant that they were able to manage better.

Despite problems with accessing details of participants' inner experiences using these methods, qualitative methods are probably the best way to try and achieve a deeper understanding of some of the processes of resilience. They allowed the provision of an initial detailed exploration of processes by understanding the views and perspective of a small number of participants (Smith, 2003). Although many of the themes described by this study are consonant with ideas already discussed in the literature, one thing that this study uniquely provides is the opportunity for offspring of depressed parents to have a voice and to tell their own stories. The use of IPA allows us to look at processes of resilience from the participants' viewpoints, focusing on what *they* felt was helpful, rather than making assumptions about their experiences.

A number of credibility checks were utilised during this study in order to try and ensure the validity of the results. The selection of these checks was guided by criteria suggested for ensuring quality of research when using qualitative methods (Barker & Pistrang, 2005; Elliott, Fischer & Rennie, 1999). I chose to employ

'testimonial validity' (which has also been termed respondent validation) as a key check in this study. The process of asking research participants to comment on the themes and interpretations of their interviews seemed like a useful way of making sure that the participants' voices were being heard through the study. However, the use of this credibility check had limited success. Only three of the participants responded to a document feeding back the initial themes from their interview. Of the three that did reply, two just confirmed that they were happy with the themes. The other participant went into some more detail about one theme and stressed its importance to her. It may be that this limited response was due to participants feeling unable to challenge the themes that I had proposed, due to the power balance inherent in conducting research (Barker & Pistrang, 2005). Another credibility check which I employed was the use of consensus, where the data is jointly analysed (Barker & Pistrang, 2005); my supervisor and I conducted the final stage of data analysis together, discussing which themes seemed to describe the data most accurately. This was a useful way of ensuring that my own ideas and pre-conceptions did not influence the final themes too strongly.

Clinical Implications of the Findings

The results of my study have a number of implications for the design of preventive interventions aimed at reducing the risk for offspring of depressed parents, and these are discussed in Part 2 of this thesis. I want to elaborate on one issue here, which is the idea that the provision of peer support groups may be useful. This seems to be something that has not been explored to date; there are a number of studies already exploring the benefit of preventive interventions aimed at improving parent-child relationships or family functioning (e.g., Beardslee et al., 1997;

Cicchetti, Toth & Rogosch, 1999), but less attention has been paid to the potential of preventive interventions for offspring as individuals. I had an initial interest in support groups when exploring ideas for this study. I was hoping to evaluate whether support groups were useful for offspring of depressed parents, and in what ways they might promote resilience. I tried a number of strategies for locating such groups, including conducting internet searches for both face-to-face support groups and on-line forums, and contacting a mailing list for researchers interested in self-help groups. I was unable to identify any groups for offspring of depressed parents in the UK, although such groups do exist in the USA. The results from this study suggest support groups may be useful in that participants highlighted the importance of talking about their parent's depression. However, they also discussed the concerns that they had when they were children about betraying the family by talking to other adults, such as teachers or doctors. Participants' comments about valuing their siblings because they felt that they understood their experiences indicates that offspring may find peer support groups helpful, where they could meet other people in similar situations and discuss their experiences. The proposed benefit of peer or mutual support groups is that the process of sharing experiences with others who are facing a similar stressor can lead to validation and a sense of belonging, and that the commonality of experience can help group members to gain understanding (Helgeson & Gottlieb, 2000). Gaining understanding is a process that my study found to be crucial for participants. Support groups may also contribute to the process of 'finding something to be good at' which was highlighted by participants; by helping others within the group, positive feelings about the self may be increased (Helgeson & Gottlieb, 2000). A number of participants in my study mentioned the idea of a support group as something that might have been helpful for them, both in

childhood and in adulthood. The reasons they gave for interest in this were that it would help to normalise their experiences, and that it would be interesting to talk to others who had similar experiences.

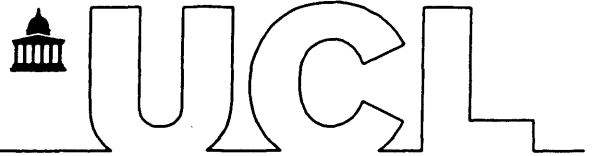
Preventive interventions for offspring of depressed parents have a crucial clinical role. The risk associated with parental depression is well documented, and interventions that aim to reduce that risk are not only of benefit to the individual, but also help to address the public health issue of the burden of treating depression. We can learn from those offspring who avoid this risk and show resilient adaptation in terms of their own mental health. There has been a lot of attention paid to children of parents with depression and preventive interventions have begun to be designed and trialled. However, adult offspring of depressed parents have been a relatively neglected group. This study has tried to begin to address this by focusing on processes of resilience across the lifespan, and considering how these processes may be promoted by preventive intervention programmes.

References

- Barker, C. & Pistrang, N. (2005). Quality criteria under methodological pluralism: Implications for conducting and evaluating research. *American Journal of Community Psychology, 35*, 201-212.
- Beardslee, W. R., Salt, P., Versage, E. M., Gladstone, T. R. G., Wright, E. J., & Rothberg, P. C. (1997). Sustained change in parents receiving preventive interventions for families with depression. *American Journal of Psychiatry, 154*, 510-515.
- Cicchetti, D., Toth, S. L., & Rogosch, F. (1999). The efficacy of toddler-parent psychotherapy to increase attachment security in offspring of depressed mothers. *Attachment and Human Development, 1*, 34-66.
- Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*, 215-229.
- Hammen, C., Burge, D., Burney, E., & Adrian, C. (1990). Longitudinal study of diagnoses in children of women with unipolar and bipolar affective disorder. *Archives of General Psychiatry, 47*, 1112-1117.
- Helgeson, V. S. & Gottlieb, B. H. (2000). Support Groups. In S. Cohen, I.G. Underwood, & B.H. Gottlieb (Eds.), *Social support measurement and intervention: A guide for health and social scientists* (pp. 221-245). Oxford: Oxford University Press.
- Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child Development, 71*, 543-562.

- Masten, A. S. & Powell, J. L. (2003). A resilience framework for research, policy, and practice. In S.S. Luthar (Ed.), *Resilience and vulnerability: Adaptation in the context of childhood adversities* (pp. 1-25). New York: Cambridge University Press.
- Radke-Yarrow, M. & Sherman, T. (1990). Hard growing: children who survive. In J. Rolf, A.S. Masten, D. Cicchetti, K.H. Nuechterlein, & S. Weintraub (Eds.), *Risk and protective factors in the development of psychopathology* (pp. 97-119). Cambridge: Cambridge University Press.
- Rutter, M. (1990). Commentary: Some focus and process considerations regarding effects of parental depression on children. *Developmental Psychology*, 26, 60-67.
- Smith, J. A. & Osborn, M. (2003). Interpretative phenomenological analysis. In J.A. Smith (Ed.), *Qualitative Psychology: A practical guide to research methods* (pp. 51-80). London: Sage Publications Ltd.
- Smith, J. A. (2003). Validity and qualitative psychology. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 232-235). London: Sage Publications Ltd.
- Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham: Open University Press.

Appendix A
Ethics Committee Approval Letter



Dr Nancy Pistrang
Sub-Department of Clinical Health Psychology
UCL
Gower Street

06 April 2006

Dear Dr Pistrang

Re: Notification of Ethical Approval

Re: Ethics Application: 0690/001: Growing up with a parent who had depression

I am pleased to confirm that following your satisfactory responses to the comments made by members of the committee, the above research has been given ethical approval for the duration of the project.

Approval is subject to the following conditions:

1. You must seek Chair's approval for proposed amendments to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form'.

The form identified above can be accessed by logging on to the ethics website homepage:

<http://www.grad.ucl.ac.uk/ethics/> and clicking on the button marked 'Key Responsibilities of the Researcher Following Approval'.

2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. Both non-serious and serious adverse events must be reported.

Reporting Non-Serious Adverse Events.

For non-serious adverse events you will need to inform the Ethics Committee Administrator within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair of the Ethics Committee will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

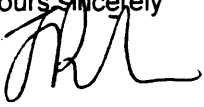
Reporting Serious Adverse Events

The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.

Letter to Dr Pistrang 21/3/2006

On completion of the research you must submit a brief report (a maximum of two sides of A4) of your findings/concluding comments to the Committee, which includes in particular issues relating to the ethical implications of the research.

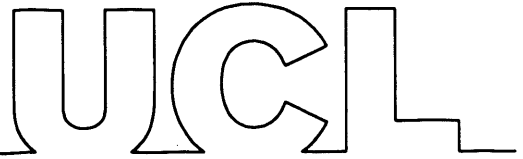
Yours sincerely

A handwritten signature in black ink, appearing to be 'J. Birch', written over the text 'Yours sincerely'.

Sir John Birch
Chair of the UCL Research Ethics Committee

Cc: Emma Hartwell, Sub-Department of Clinical Health Psychology, UCL

Appendix B
Participant Information Sheet



Version 3 – 01/09/06

Emma Hartwell
Trainee Clinical Psychologist

Dr Nancy Pistrang
Senior Lecturer in Clinical Psychology
n.pistrang@ucl.ac.uk

Growing up with a parent who had depression

Participant Information Sheet

You are being invited to take part in a research study. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the research about?

We are interested in the experiences of people who grew up with a parent who had depression. We would like to find out about their experiences and particularly about what sort of things helped them to get through those experiences. Resilience is the idea that some people do well despite difficult experiences, and this has been researched in relation to people who have a depressed parent. Although there has been quite a lot of research on resilience in children of depressed parents, no one has looked at it from the perspective of the individuals themselves.

Am I eligible to take part?

If you answer 'yes' to all of the questions below then you are eligible to take part in the study.

- Are you between the ages of 18-40?
- Did one or both of your parents suffer from depression?
- Did your parent's depression start before you were 16 years old?
- Did you live at home with your parent during the time they were depressed?
- Did your parent's depression last for longer than a year OR happen more than once?
- Did your parent receive help from mental health services for their depression?

What will I have to do if I take part?

If you agree to take part, we would like to meet with you for an interview. The interview will focus on what it was like for you growing up with a parent who had depression, how you feel it affected you, what things helped you to cope with the experience, and how these things helped. There aren't any right or wrong answers – we just want to hear about your opinions and experiences.

The interview will take no more than an hour and a half and will take place either at your home or at UCL, whichever you prefer. As a gesture of thanks for your participation in the interview we will give you £10.

After the interview, we will send you an initial summary of our findings and we will invite you to take part in a second interview. This will give you a chance to comment on the findings and to add any further comments about areas that we may have missed. The second interview will take no more than an hour. With your permission we will tape record both interviews, so that we have an accurate record of what was said.

Do I have to take part?

Taking part is voluntary. If you don't want to take part, you do not have to give a reason and no pressure will be put on you to change your mind. You can withdraw from the project at any time. If you choose not to participate, or to pull out during the interviews, this will not lead to any penalty or loss of benefits of any kind.

What are the risks and benefits of taking part?

We anticipate that you will find it interesting to talk about your experience of growing up with a parent with depression, the effect this had on you, and the things that have helped you with this. However, it is possible that during the interview you may feel uncomfortable about talking about some aspect of your experience, or distressed by some of the discussion. If this happens, you can tell us if you would like to stop the interview. We will also ask you throughout the interview how you are finding it, and if you are happy to continue or would like to stop. We hope that our research will provide a better understanding of what things are helpful to people growing up with a parent with a depression.

What happens to what I say?

All the information you give us will be confidential and used for the purposes of this study only. Only the researchers will have access to the information. The data will be collected and stored securely in accordance with the Data Protection Act 1998. Electronic data will be password protected, and paper files and audio tapes will be kept in a locked filing cabinet. The tapes will be transcribed and then erased. All identifying information will be removed from the interview transcripts so that you cannot be identified individually. Any reports or publications resulting from the study will not reveal the identity of anyone who took part. In accordance with normal scientific procedures the transcripts will be held for 5 years after publication and then destroyed.

What do I do now?

If you would like more information about this study or have any questions, or if you think you would like to participate in the study please contact Emma Hartwell (details below). Prior to taking part in the research, you will be given a copy of this information sheet to keep and a consent form to sign and keep. If you have concerns about this study at any point you should discuss these with one of the researchers, either Emma Hartwell (Trainee Clinical Psychologist, email: n.pistrang@ucl.ac.uk) or Nancy Pistrang (Senior Lecturer in Clinical Psychology, n.pistrang@ucl.ac.uk).

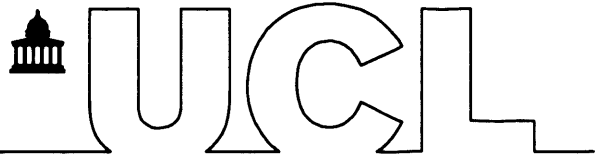
For your information:

The researchers have undergone satisfactory Criminal Records Bureau checks.

Thank you very much for considering taking part in this study.

THIS RESEARCH HAS BEEN APPROVED BY UNIVERSITY COLLEGE LONDON'S RESEARCH ETHICS COMMITTEE

Appendix C
Informed Consent Form



CONFIDENTIAL

Informed Consent Form

Growing up with a parent who had depression

**This form is to be completed independently by the participant.*

	Yes	No
I have read and understood the Participant Information Sheet. OR: I have had the Participant Information Sheet explained to me.		
I have had the opportunity to ask questions and discuss the study.		
I have had satisfactory answers to my questions.		
I have received enough information about the study.		
I understand that I can withdraw from the study at any time without penalty.		
I am aware of and consent to the tape recording of my discussion with the researcher.		
I agree with the publication of the results of this study in a research journal. I understand that I will not be identified in these publications.		
I give consent that I would like to take part in this research.		

Comment or Concerns During the Study

If you have any comments or concerns you should discuss these with one of the researchers; either Emma Hartwell (Trainee Clinical Psychologist, email:

or Nancy Pistrang (Senior Lecturer in Clinical Psychology, n.pistrang@ucl.ac.uk). If you wish to go further and complain about any aspect of the way you have been approached or treated during the course of the study, you should email the Chair of the UCL Committee for the Ethics of Non-NHS Human Research (gradschoolhead@ucl.ac.uk) or send a letter to: The Graduate School, North Cloisters, Wilkins Building, UCL, Gower Street, London WC1E 6BT who will take the complaint forward as necessary.

Signature of Participant: _____

Date: _____

Name in CAPITALS: _____

Signature of Researcher: _____

Date: _____

Name in CAPITALS: _____

Emma Hartwell

Nancy Pistrang
n.pistrang@ucl.ac.uk

Appendix D
Interview Schedule

Growing up with a parent who had depression

Interview schedule

Introduction

- **Information sheet and consent form**
- **Tape recording**
 - Test tapes with participant, start with saying “participant X, interview 1, on date”
 - Explain transcription, storage and wiping of tapes
- **Confidentiality**
 - Anonymity of data used in project
- **Aim of interview**
 - Explain areas I want to cover
 - More like conversation than interview
 - Aim is to get really good understanding of their story
 - No right or wrong answers

Background

- **Could you tell me a bit about your parent’s depression?**
 - How old were you when they first became depressed?
 - How long were they depressed for? / How many times did they have episodes of depression?
 - Did they experience any other mental or physical health problems?
 - Did they receive any help from mental health services?
 - Were they ever taken in to hospital because of their depression?
 - Who else was in your family at the time your parent was depressed?
 - When did you leave home or stop living with your depressed parent?

Impact of parental depression in childhood/adolescence

- **Could you describe what it was like growing up with your parent?**
 - How did the depression affect your parent?
 - How did it affect how they were with you?
 - What was your relationship with each of your parents like? (before depression and during depression)
 - Could you tell me a bit about what day to day life was like for you during the depression?
 - What were the most difficult things about their depression?
 - Were there any good things about their depression?
 - **[Ask these questions about childhood and adolescence separately if parent depressed throughout the time when the participant was growing up]**
- **How do you think having a parent with depression affected what you were like as a child?**
 - What effect did it have on the way that you felt?
 - Did it have an effect on the things did? (e.g. school, hobbies)
 - Did it have an effect on your relationships with other people (e.g. friends)

- **How did the other people in your family react to your parent's depression?**

Processes of resilience in childhood/adolescence

- **What helped you to get through your experiences of growing up with a parent with depression when you were younger?**
- **What was it about "X" that was helpful to you?**
 - [Explore potential mechanisms behind factors mentioned]
 - e.g. Why was having a relationship with another supportive adult important?
 - What did that relationship mean to you?
 - What did you get out of the relationship?
- **What other things helped you to get through your experiences?**
 - Did you have a good relationship with your other parent/another supportive adult?
 - Were there things about school that were helpful?
 - Did you have any hobbies or did you do any activities that helped?
 - Did you have friends who helped you through the experience?
 - Did anyone explain your parent's depression to you? Did you get information that made it easier to cope?
- **Were there any things that were unhelpful to you during your experiences?**

Impact of parental depression in adulthood

- **How do you think having a parent with depression affects what you are like now?**
 - How would you describe yourself as a person? What are the most important things about you?
 - How are you at coping with emotions? What do you do if you get very upset or sad?
 - Have you ever experienced any mental health problems yourself?

Processes of resilience in adulthood

- **Are there things that have happened in your adult life that have helped you cope with or come to terms with your experiences of growing up with a parent with depression?**
- **What was it about "X" that was helpful to you?**
 - [Explore potential mechanisms behind factors identified]
 - e.g. What is your relationship with your partner/your own children like?
 - How has it affected the way you think about your childhood experiences?
- **What other things helped you?**
 - Do you have a partner? Has that been helpful?
 - Do you have children of your own? Has that helped you?
 - Has your career or work helped you?

Ending

- **Based on your own experiences what would you tell someone now who was going through a similar experience?**

- **Are there other things that you think are important that I haven't asked about?**
- **Do you have any questions about the project?**
- **Thank them for participating, remind about process of transcribing, summary and possible second interview**
- **Ask them to complete questionnaires (demographic sheet and BDI)**
- **Participant payment form**

Appendix E
Stage One of the Analysis

IPA Analysis – First Stage

Extract from interview with P6 – Annotations on the text

I: And so, what do you think it was about having them around that was helpful?

P6: Well, I, I think there's two things. My, my Gran and Grandpa, as we call him, they, they offered completely different things. [I: hm] My Grandpa was a bit of a soft touch. He wasn't always there, and when he was he spoilt us. He always turned up with something nice, he always looked after us, he always went out to play with us. Um, so it, hence he sort of took us away from it I guess. And my Gran was more like the mother character. Just a very steady figure, who made us eat our veg, made us eat our greens. [I: hm] But then she was someone that we knew always that would be there for us. And I think we sort of relied on that, and we trusted that. But I also remember absolutely that [sister] and I did not go anywhere separately. [I: hm] So like if we went out to play, *we* went out to play. [I: yeah] And if we watched TV, *we* watched TV. But we also fought like cat and dog. But we were always fighting together, or going out together. We never, you know, it would be very, um, after school, it would be very unusual if she would then go outside and play with friends and I wouldn't. [I: right] We might have school friends over, but then if we were together, we were always just the two of us. And my Gran would sort of walk us to the shops, and take us out for periods, and sort of get us out of the house I guess. [I: yeah] We'd sort of wander round and then she'd buy us like a magazine or something like that. Um, but, but I think they offered... my Grandfather was the fun one, he like, he was the sort of happy, he was like the kind of quite rotund chap, and he was the one who would play with us and, and sort of make us our favourite tea. Whereas my Gran she was there more commonly, and she was just the, I guess she was the complete rock, that we both relied on.

Spoiling us

Taking us away from it

Reliable maternal figure
Making us eat properly

Someone always there

Bond with sister – sharing everything

Always together with sister

Getting out of the house – escaping

Someone to have fun with

Gran “complete rock” – someone to rely on

Appendix F
Stage Two of the Analysis

IPA Analysis – Second Stage

Extract from interview with P6 - Emerging theme labels

I: And so, what do you think it was about having them around that was helpful?

P6: Well, I, I think there's two things. My, my Gran and Grandpa, as we call him, they, they offered completely different things. [I: hm] My Grandpa was a bit of a soft touch. He wasn't always there, and when he was he spoilt us. He always turned up with something nice, he always looked after us, he always went out to play with us. Um, so it, hence he sort of took us away from it I guess. And my Gran was more like the mother character. Just a very steady figure, who made us eat our veg, made us eat our greens. [I: hm] But then she was someone that we knew always that would be there for us. And I think we sort of relied on that, and we trusted that. But I also remember absolutely that [sister] and I did not go anywhere separately. [I: hm] So like if we went out to play, we went out to play. [I: yeah] And if we watched TV, we watched TV. But we also fought like cat and dog. But we were always fighting together, or going out together. We never, you know, it would be very, um, after school, it would be very unusual if she would then go outside and play with friends and I wouldn't. [I: right] We might have school friends over, but then if we were together, we were always just the two of us. And my Gran would sort of walk us to the shops, and take us out for periods, and sort of get us out of the house I guess. [I: yeah] We'd sort of wander round and then she'd buy us like a magazine or something like that. Um, but, but I think they offered... my Grandfather was the fun one, he like, he was the sort of happy, he was like the kind of quite rotund chap, and he was the one who would play with us and, and sort of make us our favourite tea. Whereas my Gran she was there more commonly, and she was just the, I guess she was the complete rock, that we both relied on.

Escape of fun times

Someone to parent –
boundaries

Secure in having people to
rely on

Sharing things with sister

Sharing things with sister

Someone to rely on

Appendix G
Stage Three of the Analysis

IPA Analysis – Third Stage

Initial Themes for Participant 6

Living with a parent with depression

Mum absent or not coping

“she would just be, um, away from us...she would give us to my Grandparents a lot...my Mum wasn't able to cope so well” (p1)

“I remember things like, um, coming home from school, and being told that she wasn't there and she wasn't going to be back, because she wasn't feeling very well” (p4)

Mum unpredictable and scary

“she'd sort of just be in, in this kind of like mad rage. Um, which we'd walk into...we would come in and she'd be literally throwing stuff around the house...so I remember those kind of things because they were scary” (p5)

“you just never knew how my Mum was going to act, or going to react, or what we were going to find when we got home from school” (p16)

It was just the way it was

“I suppose we just, kind of, found it almost normal, you just kind of, it's just a part of life, because you don't really know anything different” (p5)

“I suppose, it almost, I mean it felt completely normal at the time that we'd spend, you know, say 3 weeks at somebody else's house” (p6)

Not understanding – depression not being talked about in childhood

“Because at the time we didn't know. It was just Mummy's not feeling very well. Mummy's very tired...I do remember when I was older wondering how my Gran who was at that point absolutely ancient as far as I was concerned could be less tired than my Mum” (p7)

“I don't remember talking to anyone really outside of it, of my house. I think that probably would have been, um, um, unloyal to my Mum” (p14)

“she would talk to us later, but nothing in detail, She would, she would generally say that her head wasn't feeling very good, um, that she felt tired again” (p22)

“I'm sure there was no information then. And certainly, I mean, my Gran wasn't ever going to tell us...I was just not, just not talked about at all” (p30)

Resilience processes

Support from others – reassurance of someone to rely on

“But then she was someone that we knew always that would be there for us. And I think we sort of relied on that, and we trusted that” (p8)

“Whereas my Gran, she was there more commonly, and she was just the, I guess she was the complete rock, that we both relied on” (p8)

“So I guess, knowing that when we got in and my Gran was there, we weren't, we weren't on our own kind of kinds. You know, we were there and she was going to look after us and we knew everything was fine” (p13)

“it's finding someone within your support network who you think you could trust” (p33)

Support from others – being provided with care

“she had a couple of very very very close friends, who we almost would consider to be like aunties and uncles...they used to look after us a lot” (p4)

“I can’t imagine how, what it would have been life if we hadn’t...Like we got home and she hadn’t been there, and no-one else was there, or if we’d got home and she hadn’t been able to look after us” (p8)

Support from others – people understanding

“they obviously knew what was going on...what they did do was, they would allow us, they would kind of give us special dispensation” (p21)

“these 2 teachers, who I didn’t really talk to, but they were understanding, and they were helpful” (p21)

Being protected from Mum – from her moods and from worrying

“She [Mum] tried everything she could to make us not suffer at all. And I think she knew that, when, I mean, you know, she removed herself from the situation generally. Rather than us having to witness her being depressed essentially” (p7)

“normally my Grandmother was there so, that was sort of, we were protected from it to an extent” (p7)

“I think it made us freer [having Gran there]. Because I mean, we would not want to, we would not want to leave her on her own” (p9)

“But he would never let her get to us. He always sort of protected us from that side of her, when she was going crazy” (p19)

Learning strategies for dealing with Mum

“We could usually sort of try to kind of, if, if she wasn’t very happy but she wasn’t in bed, you could usually sort of cheer her up, or seem to cheer her up. She seemed to respond well to us with music” (p14)

“We learnt totally and utterly to judge her moods...because she did have this really violent streak when she was depressed...it was, it’s a self-preservation thing because you know, she could do damage...we needed to know to keep away and to keep out of her way” (p22)

“You know you can, I can try and talk to her, and I can...you know I’ve learnt obviously ways of talking to her which will sort of have some result and will kind of, um, you know, bear fruit better than others” (p31)

Getting on with normal life

“still doing everything that we would normally do, but living in somebody else’s house...we used to play with their dolls instead of playing with our own toys, and I don’t know, I mean, that for me at the time felt normal” (p6)

“we also went round to other people’s houses a lot, and, and uh, we did have people over. I mean, we weren’t isolated kids by any stretch” (p6)

“I think it allowed us to probably be more kids. I think that basically my Grandmother being there all the time allowed us to have normal childhoods probably.” (p9)

Having the escape of fun times

“My Grandpa was a bit of a soft touch. He wasn’t always there, and when he was he spoiled us. He always turned up with something nice, he always looked after us, he

always went out to play with us. Um, so it, hence he sort of took us away from it I guess” (p8)

“I enjoyed spending time with him. And he, he was more like my Granddad in that, you know, he did fun stuff with us” (p18)

Someone to take the parent role – provide boundaries

“And my Gran was more like the mother character. Just a very steady figure, who made us eat our veg, made us eat our greens” (p8)

“our Mum wasn’t around as much, she was never at the school gates for example, whereas other mothers would be at the school gates. But our Gran generally was” (p9)

“And while she was always really really loving and caring...she was quite a strict woman, and we wouldn’t really mess around with her...We would be sort of quite good. We’d be, we’d do our homework if we had homework” (p13)

Bond with sister – relying on her

“I also remember that my sister and I did not go anywhere separately. So like if we went out to play, we went out to play...we were always just the two of us” (p8)

“even now, if there’s anything that happens between the two of us, like always the first...I mean, my partner teases me relentlessly about the fact that my sister will probably phone me 4 times a day” (p10)

“I think it makes me reliant on my sister emotionally, and her on me” (p26)

Sharing the load with sister – not having to deal with it alone

“as soon as we knew something was going to happen we would always grab each other and just, just go somewhere, or shut ourselves in a room together” (p10)

“I just have no memory of really dealing with my Mum on my own, I always think about the two of us doing it together” (p11)

“if my Mum was sort of needing to kind of talk, I would be the one that would listen...but when Mum was having a violent stage my sister was always the one to stand up to that. We did, we had different roles, yeah” (p11)

“we do try to kind of share the burden” (p28)

“sometime it can be quite good if my sister and I decide we’re going to go for a weekend together. And that can, that sort of, you know, we can do it together, and we can then go off into the kitchen and have a quick rant at each other and then go back” (p29)

Shared understanding with sister

“you know, when you’ve had a terrible conversation with your Mum for 2 hours, I’m not going to bore anyone else with it. You know, my sister is about the only person that’s going to listen, you know, while I rant on about how unbearable it is...No-one else is going to listen to that. So we do need each other I think from that point of view” (p27)

“it can obviously massively get you down, and so if you can talk about it to someone that that really really helps. And you know, it’s good for me to have my sister because she understands. She had the same, you know, same things” (p28)

Shift towards understanding and making sense

“that was when we kind of began to realise I suppose...I think we knew then, when she doesn't feel very well, it's not that she's being sick or she's got flu or anything else, it's that she, she's got depression” (p22)

“Because I suppose you begin to, you know, you want to learn more, well not learn more but understand more. So you sort of find out more about depression” (p23)

“definitely I would suggest people find out as much as they possibly could” (p32)

Separating from Mum

“And I'm going in there as me, and people were getting to know *me*...I was my own person probably for the first time...I wasn't having to worry about Mum” (p17)

“it was also a case of we were getting older and more involved in our own stuff” (p20)

“we both turned them [college places] down because they weren't far enough away. Uh, we wanted to just, we had to get away, and sort of break free of it” (p24)

More openness and talking

“it was much later, maybe when I was at University, where I actually you know would start then being open with her” (p23)

“I think we sort of take it much more in our stride. And um, we talk to my Mum about what she's taking and what she's doing, and what the doctor's saying” (p24)

“I think that because my Mum and I are really, we're very open about it now. And um, you know, I'm much more involved, then I don't feel upset about it” (p34)

Trying to help Mum – feeling less helpless

“I was suddenly finding all this stuff for my Mum. And actually started to become one of these kids who prints stuff off the internet and sends it to Mum to read. Try this, do this, join that. Talk to his person” (p25)

“The only thing I try to do now is I try to treat my Mum...I always try to think of holistic things that will make her feel better within herself” (p31)

“I try to kind of focus on well-being stuff. So I suppose that for me is almost like something that I can try to do for her. Because it does make you feel kind of helpless” (p31)

Channelling experience – shaping who I am

“So I think it makes, it makes me more aware. I knew straight away that something was happening with my little sister, and I guess that's because of my Mum” (p27)

“So I'm quite attuned to it. I can see people at work if they're sort of unhappy because maybe I'm just more attuned, attuned to it um, from that point of view” (p27)

Appendix H

Example of Summary of Themes for Participants

Initial Themes from Interview (P6)

Living with a parent with depression

Mum absent or not coping

When you were growing up your Mum would sometimes go away to stay with other people or give you to your Grandparents to look after because she wasn't able to cope.

Mum unpredictable and scary

When your Mum was depressed she would sometimes get into violent moods. You never knew how she was going to be and it was really scary for you when she was in a rage.

It was just the way it was

You weren't really aware of your childhood being different when you were growing up because it just felt normal to you and it was just how things were.

Not understanding – depression not being talked about in childhood

When you were younger no-one told you that your Mum was depressed – you were told that she wasn't feeling well or was tired. There wasn't any information around for you, and so it was hard to understand what was going on sometimes. You also felt that you shouldn't talk about it to others because it would be disloyal to your Mum.

“Resilience processes” – things that have helped

Support from others – reassurance of someone to rely on

There were lots of other people around when you were growing up, including your Grandparents and your Mum's friends. You knew that your Gran would always be there for you and she was the complete rock who you could rely on, and this sounds like it was reassuring.

Support from others – being provided with care

Your Grandparents and your Mum's friends were also involved in making sure you were provided with care and your needs were met as children.

Support from others – people understanding

There were teachers at your school who knew what was going on and made allowances for you when things were difficult.

Being protected from Mum – from her moods and from worrying

Other people protected you from your Mum, keeping you away from her when she being violent, and also protecting you from having to worry too much about it. Your Mum also tried to protect you by removing herself from the situation sometimes.

Learning strategies for dealing with Mum

You found different ways of dealing with your Mum as you were growing up, things like music to cheer her up and judging her mood and getting out of the way or calming her when she was in a rage. More recently you've learnt which are the best ways of talking to her.

Getting on with normal life

You were able to get on with a normal life most of the time when you were younger. Because your Gran and your Mum's friends were looking after you and your Mum you were freed up to be kids and they allowed you to get on with normal things, like playing.

Having the escape of fun times – taking us away from it

You had people around like your Grandpa who would “take you away from it” by providing you with fun and spoiling you. You also had a farm that you could escape to as a child to play.

Someone to take the parent role – provide boundaries

You had people around who helped with parenting you. Your Gran was a mother figure, who was quite strict with you, making sure that you ate properly, did your homework and didn't mess around. And later on your Stepdad would do things like look after you if you were sick.

Bond with sister – relying on her

You've always had a strong bond with your sister. When you were little you did everything together, and now you rely on each other emotionally and she's someone you trust and will turn to.

Sharing the load with sister – not having to deal with it alone

Having your sister around meant that you didn't have to deal with your Mum alone. You could face things together when you were younger and protect each other, and when you got older you started sharing the load – taking it in turns to talk to or look after your Mum.

Shared understanding with sister

Your sister was also the only other person that you felt shared your experience and therefore understood how things were. This means that you have someone to talk to who understands.

Shift towards understanding and making sense

As you got older you started to understand that your Mum had depression, and you wanted to find out more about it and try to make sense of what was happening for your Mum.

Separating from Mum

As you got older you started naturally separating from your Mum a bit, and becoming more involved with your own life and things that were happening to you, and less worried about your Mum. You also chose to go to Uni far away to break free a bit.

More openness and talking

More recently there has been much more openness about your Mum's depression and you've been able to talk to her about it more.

Trying to help Mum – feeling less helpless

You've started more recently to try and help your Mum too, suggesting things she can try or treating her to things that might make her feel better. It makes you feel less helpless to be able to try and do things to help.

Channelling experience – shaping who I am

You are quite aware of other people's emotions and when people are unhappy and you thought that this was something you've learnt from dealing with your Mum.