Lives Unseen:

Unacknowledged Trauma of

Non-Disordered, Competent

Adult Children of Parents with a Severe Mental Illness

(ACOPSMI)

Suzette Misrachi

Submitted in partial fulfilment of the requirements of the

degree of Master of Advanced Social Work (Research)

August 2012

Department of Social Work Melbourne School of Health Sciences

Faculty of Medicine, Dentistry and Health Sciences

The University of Melbourne

Produced on archival quality paper

Abstract

This theoretical thesis attempts to make visible the needs of adult children of parents with a severe mental illness (ACOPSMI), a population which has attracted little scholarly attention to date. It employs a methodology in which established trauma and alternative grief theories are applied to existing multidiscipline, scholarly and lay ACOPSMI literature. The thesis attempts to broaden the definition of ACOPSMI to include non-disordered, competent individuals. It argues that the unique, trauma-based needs of ACOPSMI are not being adequately met within existing family-focused policies and practice, which focus on the needs of parents with an SMI to the potential detriment of their adult offspring. Limitations, implications, and recommendations of this research are outlined.

Declaration of Authorship

This is to certify that: (i) The thesis comprises only my original work towards the Masters degree except where indicated; (ii) Due acknowledgement has been made in the text to all other material used; (iii) The thesis is less than 50 000 words in length, exclusive of figures, references and appendices.

Signed:

Date: /   /

Acknowledgements

Gratitude goes to my supervisors Winsome Roberts, PhD (sociology), and Bridget Hamilton, PhD (nursing) for sharing their time and experiences. They provided an unwavering belief in the worthiness of my topic while encouraging the expansion of my ideas.

Special thanks go to Associate Professor Lynette Joubert who stepped in at short notice to become committee chair, and in that brief time contributed to the success of this project.

I thank my parents, Isaac and Malka, my siblings Avner, Shavtay and Joy. Each was such an immense source of inspiration during my struggle to engage with this complex topic.

Very special people assisted me in this thesis. I am grateful to each and every one of them. There is one person who applied an enormous amount of effort to help me complete this research. Without a doubt, my greatest debt is to my husband. Despite this topic being *not* one of your primary interests, every time I gave you something to read you always provided critical, useful feedback. You have an amazing "eye for detail" and were with me at every stage. I know it was hard for you at times. Indeed, I can neither match nor repay what you did for me throughout this process.

I thank my son, Reuben, for his reassuring insights, sense of humour and for his spontaneous meals which never went astray on nights when the thesis took over the household's main cook! I hope your international lifestyle since Amsterdam inspires you to continue seeking further safe journeys, not only throughout Europe and the Middle East – but throughout life.

It is amazing what can transpire even within fleeting moments or in snippets of conversations. There are international leaders in the field whom, although met only briefly at conferences, etc., conveyed a belief in the worthiness of my topic while giving me invaluable encouragement. This gave confidence and lasting influence to this research. They are: Martin Dorahy (New Zealand), Maggie Stroebe (The Netherlands), Mario Mikulincer

6

(Israel), Colin Murray Parkes (United Kingdom), Ken Doka (USA), Irwin Epstein (USA), and Warwick Middleton (Australia). Irrespective of their differing theoretical orientations and disciplines, what made each so special is who he or she is as a human being.

ACOPSMI with trauma histories will be the ultimate judges of this work. If not for the privilege of witnessing glimpses of their brave lives, I would not have been sufficiently moved to do this research. Their honesty made me determined to tell the world what happened to them, and gave me energy and a rich pathway to understanding their internal worlds which no book, article, or movie has ever done. To them, and to future ACOPSMI, I hope the words in this research offer some comfort.

Dedication

This thesis is dedicated to my ex-lecturer, Dr Elisabeth Bruce, who sadly died in 2008 leaving behind a young family. I remember being mesmerised by her remarkable quick mind and unshakeable devotion to the grief field, leading her to contribute to it with her invaluable "nonfinite" grief theory. In 1998 after examining my analysis of Sylvia Plath's suicide, Dr Bruce (or Liz as she preferred) urged me to become a practitioner and to continue my scholarly interest in the field. Without her contagious enthusiasm, I probably would not have been inspired to explore the mysteries of the loss, trauma and grief experiences of ACOPSMI. The magnitude of her loss brought home just how finite a physical death can be, and how "nonfinite" psychological gains and losses could feel. Thanks, Liz.

Table of Contents

List of Figures

Chapter 1

Glossary

ACOPSMI – refers to Adult Child of Parents with a Severe Mental Illness. They are individuals who grew up with one or more severely mentally ill parents.

A family-focused approach – refers to any intervention at policy or practice level that aims to facilitate recovery of mentally-ill family members, such as parents with an SMI. A family-focused approach is an intervention associated with communication, psycho-education, problem-solving skills training, including counselling families where a relative is mentally ill.

Children – refers to the offspring, including adult children, of parents.

Competent – refers to terminology used in empirical research regarding a subset of the larger ACOPSMI population (Ramsay, 1977, cited in Anthony, 1974; Bleuler, 1974; M. J. Brown, 1994; L. Fisher, Kokes, Cole, Perkins, & Wynne, 1987; Hansen, 2009; Rengstorff, 1992). In this thesis, it refers to ACOPSMI being both potentially affected by early life adversities (i.e., traumatised) yet socially competent.

COPMI – refers to Children of Parents with a Mental Illness. This acronym is used in describing a government initiative detailed in Chapter 4: Public Policy.

COPSMI – refers to Child of Parents with a Severe Mental Illness.

Psychiatric Diagnosis – refers to the attribution of a diagnosis made by a qualified medical practitioner or mental health specialist using either of two systems which classify mental disorders: (1) Chapter V of the *International Classification of Diseases* (ICD-10) (World Health Organization, 2011), and (2) the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (American Psychiatric Association, 2000). Both provide comparable standardised criteria for diagnosis (Jeffreys, Rogers, & Hirte, 2011). Based on an assessment, the practitioner decides if psychiatric diagnosis is warranted. The DSM raises various questions (Phillips, Frances, Cerullo, Chardavoyne, Decker, First et al., 2012) including the

subjective nature of practitioner decisions and the exclusion of a bio-psycho-social perspective (Read, van Os, Morrison & Ross, 2005).

Grief – refers to loss that produces psycho-emotional pain and unhappiness in individuals deprived of something needed, wanted or expected (Whitfield, 1987). Grief occurs as a reaction to loss (Doka & Martin, 2010) and is unique to the griever expressing the grief (Wortman & Silver, 1989).

Maltreatment – refers to child abuse and neglect (Szajnberg, Goldenberg, & Harari, 2010).

Non-disordered ACOPSMI – refers to ACOPSMI that do not have an SMI and are mentally well-enough to be understood by society as psychologically/mentally "competent" (Rengstorff, 1992). That is, such individuals may, in some cases, suffer from common mild mental health conditions brought on by a distressing upbringing, such as depression or anxiety, but not to the extent that it impinges on their capacity to be high functioning members of society. In this sense, they are understood as "non-disordered".

Parent – in this thesis refers to all primary caregivers, e.g., person rearing their biological child, orphanage carers, foster parents, stepparents, etc., who have a severe mental illness.

Parentification – refers to the expectation that children under age eighteen will assume caretaking responsibilities for parents or for various family members at the expense of their own developmental needs and pursuits (Boszormenyi-Nagy & Spark, 1973; Castro, Jones, & Mirsalimi, 2004; Earley & Cushway, 2002).

Policy – refers in this thesis to guidelines for action adopted by the state.

Practice – refers to any kind of practice involving ACOPSMI in a therapeutic capacity within Australia's public health system. This involves multidisciplinary workers of various disciplines who assist with a variety of problems with individuals regarding their mental

14

health. This may include grief counselling, family work, mental health or child protection work, generic counselling, family therapy, psychiatric care, social work, etc.

Practitioner – is short hand for any worker, including counsellors, mental health practitioners, child protection workers, or family-focused counsellors, etc., who come into contact with ACOPSMI in any kind of helping capacity within the Australian public health and welfare systems.

SMI – refers to severe mental illness. SMI is in common usage within the public health sector to usefully describe a mental health category. It originated from an abbreviation of the phrase, "severely mentally ill", and a phrase often used in clinical settings. For example, schizophrenia and affective disorders are usually included in the category of SMI (Schinnar, Rothbard, Kanter, & Adams, 1990). So is bipolar disorder (S. H. Jones, Tai, Evershed, Knowles, & Bentall, 2006) or severe personality disorder (Newman & Stevenson, 2005). There are ambiguities in some diagnoses of SMI (Read et al., 2005).

Trauma – refers to "a psychological experience in which inner representations of self and world are disrupted" (McCann & Pearlman, 1990, p.3).

Trauma-informed – refers to services that are "informed about, and sensitive to, trauma-related issues present in survivors" (Jennings, 2004, p.15).

Trauma response – refers to a normal reaction in the wake of severely distressing events (J. L. Herman, 1992a, 1992b; Lanius, Vermetten, & Pain, 2010).

15

Prologue

I came to this research question out of my own professional interests. This prologue gives a brief explanation of how the thesis topic arose.

As a mental health practitioner, I am responsible for delivering counselling to clients referred to me by doctors via Australia's universal health care system, Medicare (Department of Human Services, 2012). This is how I became increasingly aware of individuals, who although well integrated into society, disclosed painful and disturbing experiences and interactions with their parents since childhood. These experiences manifested in various ways, from school failure to conversion disorder. The parents of these clients had a diagnosis of a severe mental illness (e.g., borderline personality disorder, schizophrenia, bipolar disorder), or client-reported behaviours of their parents indicated something was wrong.

These referred individuals spoke of intrusive traumatic experiences, usually stemming from self-described childhood abuse and neglect, and often not previously shared. Although they or their family of origin had no involvement with wars or concentration camps, the clients would resort to using these two phenomena as metaphors to describe their internal experiences.

Nothing about these referred individuals would stick out in an ordinary crowd. They had professions, their own families, and were otherwise competent, even highly successful in some cases. It seemed that these referred individuals found in their professional work a sense of 'normalcy' inaccessible while growing up – a normalcy that made them feel somehow safe. Yet a common GP referral would indicate "generalised anxiety or depression" or "low self-esteem". Their sadness and trauma symptoms did not dissolve despite good jobs and their own families to go home to. It was not rare for me, knowing them intimately as a practitioner, to hear as from the depths of their hearts and minds a long-drawn breath before comments like, "I don't want to be afraid anymore".

Despite personal, social and educational achievements, it seemed that trauma symptoms were part of the lives of these individuals. They had rebuilt their existences as competent, non-disordered, useful citizens. But the impact of being raised by severely troubled parents contributed to their sense of desolation, vulnerability, detachment, physical and mental exhaustion – often involving deep shame and loneliness. It was also accompanied by physical symptoms, such as migraines, stomach ailments, body tensions and sleep issues.

Some sought counselling via government-run services but were turned away because they were deemed non-disordered and socially competent. It seemed that their abnormal upbringing was within the context of trauma. For some, events like "Father's Day" or "Mother's Day" became trauma triggers, with individuals either expressing sincere reluctance, or strong ambivalence to any contact with their parents. Others fantasised the physical death of their parents.

As somebody who diligently studied grief counselling models, what kept these individuals circling round and round on an endless treadmill of confusion and sadness, unable to step off, yet very capable of functioning socially in daily ordinary life, was baffling. Perhaps they were tackling something complex and unnamed in adulthood that was beyond their control during childhood? This piqued my interest. I wanted to know what was going on.

A call for a better understanding of these adult children of parents with a severe mental illness led me to participate in three international conferences (one on mental health and two on grief) as well as local professional workshops and presentations. Surprisingly, next to no attention was paid to the trauma or grief responses of this population – be they for children or adults. Indeed, there was generally inadequate information available on this population group at these events. This sounded alarm bells.

All too often, when I raised my (then) under-theorised concerns about the disenfranchised sadness these people seemed to be experiencing, I was met with agreeable nods by colleagues and supervisors. Most were either ready to embrace this group's

pathology or relieved that those individuals were able to survive as competent, non-disordered, useful people. Their reactions further stirred my interest in the needs of ACOPSMI.

In the medical environment of counselling theories and models I was situated in, how was I to conceptualise the needs of these ACOPSMI? On the one hand, they are competent and non-disordered. On the other, trauma features loomed large. I perceived a paradox – one with possibly disturbing implications.

Frustrated by the plight of these referred individuals and a lack of available information about their needs, I created "Surviving Parents With a Mental Illness" (Misrachi, 2008), a website based on my collective professional work and knowledge of loss and grief theories. Reader feedback added to the impetus for my research.

The findings of this research are of use to me in my own practice as I continually strive for excellence and ponder various lingering questions. At this point in time, I do not claim to hazard answers to all the key questions. I have simply arrived at the end of one part of a journey – that of a practitioner – only to begin the next part – formal research.

Chapter 1: Introduction

Adult children of parents with a severe mental illness (henceforth ACOPSMI) are individuals who were raised by one or more parents diagnosed with a severe 'low prevalence' mental disorder (e.g., schizophrenia, bipolar or severe personality disorder). Having grown up with one or more severely mentally ill parents, ACOPSMI face a set of threats and hardships. Estimates are high in numbers of such individuals; however, surprisingly when these children grow up very little is spoken about their lasting trauma responses into adulthood (Lanius, Vermetten, & Pain, 2010).

This thesis focuses on one idea: that the inclusion of trauma theory and research would better capture the unacknowledged trauma and grief responses of non-disordered, competent ACOPSMI.

1.1 Problem and hypothesis

Problem

The lasting impact of trauma on many ACOPSMI, resulting from early life experiences including abuse and neglect by their parents, is not addressed in policy and practice literature. Their lives remain unseen.

Hypothesis

Many people who were raised by parents with an SMI and were abused and neglected by them carry the effects of their trauma into adulthood – irrespective of life trajectory.

1.2 Aim and objectives

Aim

The aim of this thesis is to articulate and advocate for the needs of ACOPSMI by suggesting the inclusion of trauma knowledge in policy and practice.

Objectives

1. Test some of the contentions in existing literature against trauma theory, trauma studies and ACOPSMI experiential accounts.

2. Gauge how well the trauma-based needs of ACOPSMI are met through existing policy and practice.

3. Provide a theoretical basis for a more collective identity of ACOPSMI as a population group according to trauma science.

1.3 Scope

This thesis focuses on ACOPSMI born to one or more parent with SMI, and whose accounts of family life never indicated recovery or intermittent periods of health in these parents although that might have occurred. Space consideration does not permit a fuller discussion regarding parents with an SMI who may recover, those who may have become mentally ill when their offspring were older, or those who may have intermittent periods of health or episodic mental health problems.

For reasons of brevity, a number of related and tangential ACOPSMI issues were excluded from the thesis scope. There are groups of ACOPSMI who are not discussed in this thesis because their situations are characterised by comorbidity. Specifically, the lives of some ACOPSMI may involve drug and alcohol issues (Wilsnack, Vogeltanz, Klassen, & Harris, 1997); criminal activities (Widom, 1998); behavioural problems, such as aggression (Rees,

2010b); unemployment, poverty, homelessness (D. B. Herman, Susser, Struening, & Link, 1997); or emerging mental illness (Mattejat & Remschmidt, 2008; Mednick, Cudeck, Griffith, Talovic, & Schulsinger, 1984; Quinton & Rutter, 1985; Read et al., 2005). However, not every ACOPSMI is on such a negative life trajectory. These comorbid problems likely deserve a separate treatment outside the scope of this thesis.

It is acknowledged that the parents of ACOPSMI may be ACOPSMI themselves (Liotti, 1992), or, for example, have themselves experienced preventable childhood trauma leading to possible untreated psychosis and schizophrenia (Read et al., 2005). However, the purpose and thrust of this thesis is to assess how well the needs of competent, non-disordered ACOPSMI are, not those of their parents. This is because the needs of their parents are already captured elsewhere (Alakus, Conwell, Gilbert, Buist, & Castle, 2007; Howard & Underdown, 2011) as also demonstrated in current policy (see Chapter 4) and practice (see Chapter 5). The needs of parents with an SMI "dovetail with their children's needs but are not identical" (Hetherington, Baistow, Katz, Mesie, & Trowell, 2002, p.199) and may well be diametrically opposed (see Chapters 2 and 5).

It should be acknowledged that parents with an SMI may have been traumatised, potentially leading to the next generation developing major mental illnesses (Read et al., 2005). However, as this thesis sets out to argue, many traumatised individuals are capable of being socially well-camouflaged and not consumers of the mental health system. Fitting in to society does not eliminate the impact of early traumas suffered, including physical costs (Felitti et al., 1998).

In order to focus in on ACOPSMI experiences, problems arising from high prevalence disorders, including depression and anxiety in parents, although significant in the lives of affected parents and their children, are excluded.

This research answers an "interdependency question" (Stamm & Bieber, 1996, p.198): whether or not grief and trauma go together without necessarily asking how (detailed in Chapter 3). Similarly, this thesis advocates but does not attempt to operationalise trauma at policy or practice levels. For example, it does not explore *how* to treat ACOPSMI carrying

trauma-based needs, because ample trauma research and practice wisdom exists regarding this matter (Bloom, 2000e; Cloitre, Cohen, & Koenen, 2006; Courtois, 2010; Gold, 2000; Kezelman & Stavropoulos, 2012; Rothschild, 2000; Summerfield, 1995; van der Kolk & Saporta, 1991); it seeks only to identify the dimensions of its omission (Bickman & Rog, 2009).

ACOPSMI research participants use two survivor metaphors, "war" (e.g., Foster, 2006) and the "Holocaust" (e.g., Camden-Pratt, 2002, 2006). Despite the Holocaust metaphor being validated by some trauma researchers as being relevant to the ACOPSMI context (Paul Valent, personal communication, June 9, 2009), due to shortage of space, the "war" metaphor will be emphasised. But in certain instances, child Holocaust survivor studies will be utilized for specific points.

A chapter on the explicit investigation of grief of ACOPSMI is conspicuous for its absence. Any overlooking of the "context" of the grief of ACOPSMI, i.e., situations, circumstances, timing, psychosocial and socio-cultural factors, historical and psychological issues, and in particular the relationship between who is gone and who is left behind (Nader & Pynoos, 1993; Stamm, 1999) is intentional because "grief of ACOPSMI" deserves a separate treatment and cannot be accommodated within the space limits of this thesis. Consequently, cross-cultural grief (Klass & Goss, 1999) including cross-cultural trauma (Dansie, 2006; Drožđek & Wilson, 2007) where some individuals may also be ACOPSMI are excluded. A detailed analysis of the various contexts in which grief occurs (Dillenburger & Keenan, 2005; Horwitz & Wakefield, 2007; Moos, 1995) may also be missing.

This research is not suited to address many important questions, such as to what extent does resilience conceal trauma features and suffering (Schumn, Doane, & Hobfoll, 2012). Other issues, deserving of a separate treatment, are also not addressed such as ACOPSMI and their specific developmental needs across their lifespan (Nathiel, 2007); how gender issues interact, influencing policy (Dalton, Draper, Weeks, & Wiseman, 1996) and practice (Doka & Martin, 2010); and traumatised ACOPSMI who enter military service (Duckworth & Fellitti, 2012) with exposure to retraumatisation (P. C. Alexander, 2012).

22

The emotionally charged recovered-memory debate (Courtois, 2010) is not addressed. Survivors of sexual abuse (J. E. Davis, 2005) and others with the urge to deal with their traumatic memories have sometimes gone to the length of speaking out, of going public. ACOPSMI, to date, have not. Yet it is not the purpose of this thesis to explore the potentially important question why ACOPSMI have not come forward in an organised way.

1.4 Sensitivities

Throughout this thesis, child abuse by parents with SMI and other sensitive matters are raised, in an effort to confront the issues of importance to ACOPSMI.

The idea that many ACOPSMI are survivors of trauma at the hands of trusted parents is indeed a sensitive issue and therefore potentially controversial. Health workers, parents, policy-makers, educators, and advocates for both parents and children may all bring deeply felt perspectives to this topic. ACOPSMI themselves will hold diverse views about childhood and trauma. Some individuals may not wish to revisit their early childhood for a variety of conscious or unconscious reasons (Bleuler, 1974). It is not assumed all ACOPSMI are conscious of personal experiences of trauma requiring supportive treatment. For a range of reasons, some may be unable to articulate their traumatic family-of-origin "atmosphere" (Gold, 2000; Lifton, 1979) or trauma experiences (Duckworth & Follette, 2012; J. L. Herman, 1992a).

This thesis does not seek to blame parents as has sometimes been the case (Johnson, Renaud, Schmidt, & Stanek, 1998; Lukens & Thorning, 1998; Rubin, Cardenas, Warren, Pike, & Wambach, 1998). It recognizes mentally ill parents themselves may have been traumatized during their childhood (Read et al., 2005), thus seriously disrupting their capacity to consistently function interactively and adequately with their offspring (Liotti, 1992). Due to psychological incapacities, some parents cannot be called to account and may have been unable to adequately parent with consistency due to severity or chronicity of their mental illness (Centre for Parenting and Research NSW Department of Community Services, 2005).

Some parents with SMI may have invested considerable efforts into achieving "good enough" parenting (Winnicott, 1953) by providing a nurturing and stimulating environment for their children (Parrott, Jacobs, & Roberts, 2008). According to Bleuler (1974) large numbers of people with schizophrenia are recognised as good-enough parents. Thus, it is not assumed that mental illness disqualifies people from effective parenting.

Parent as "perpetrator" is an ugly thought and one which many understandably shy away from; it is a thorny and debated issue (Aldridge, 2006; Aldridge & Becker, 2003; Cousins, 2004; Donald & Jureidini, 2004 ; Obadina, 2010; Sahoo & Suar, 2010). Yet advocates in protective service settings assert, "the legal standard is what is in the best interests of the child, not the parent" (L. E. Walker & Shapiro, 2010, p.281). In addition, there are factors that portend mental health problems in later life (Beardsley, Versage, & Gladstone, 1998; Maybery, Reupert, Patrick, Goodyear, & Crase, 2005), including exposure to problematic parenting styles which, despite intervention efforts, cannot always change (Bleuler, 1974; Donald & Jureidini, 2004 ; Tunnard, 2004).

Ultimately, in the interests of children, evidence of trauma should not be downplayed. Whether the perpetrator is a perfect stranger or an imperfect parent does not reduce its impact; the *intention* to harm is less significant than the experience of harm (Dubowitz & Bennett, 2007; R. Gilbert et al., 2009). Declarations of "love" (Kahn, 2006; Rees, 2010b) cannot diminish trauma responses where it occurs or its adult sequelae (Massie & Szajnberg, 2006).

It is not uncommon for both parents to have an SMI where only one is being 'diagnosed' as mentally ill (Bleuler, 1974). Many parents struggling with mental health problems may come to the attention of protective services and not mental health services. Even mental health services often suspect that a parent may have an SMI but that same parent may not have been assessed or diagnosed (Jeffreys, et al., 2011).

Some individuals may identify their parent as disturbed due to the parent's parenting style or behaviours, and then go through a process of deciding in their own mind that their parent probably has a mental illness (Landerman, George, & Blazer, 1991; Neff, 1994; O. B.

24

Williams & Corrigan, 1992). Some offspring have long suspected their (undiagnosed) parent as having an SMI (e.g., Camden-Pratt, 2002; Nathiel, 2007; Secunda, 1997). This thesis attempts to respect their judgements, reflecting the primary focus on the experience of ACOPSMI.

This thesis adopts the same definition of competence as Rengstorff (1992) did, in relation to ACOPSMI, whose subjects were rated as "career competent based on the ability to maintain a professional position or [whether they] achieved upward mobility" (p.1). Because of this definition's emphasis on employment, professional position and social mobility, there are assumptions underlying what is deemed to be "competent" which some may possibly find offensive. Missing is competence outside these narrow categories, such as competence in the maternal and home environment, competence among the unemployed and lower socioeconomic groups, etc. However, leaving aside the stereotypical social norm of competence, gender bias, and other socioeconomic limitations of this definition, the term does capture and bring forward the important suggestion that ACOPSMI can be both powerfully affected by early life experiences (i.e., traumatised) and competent. It is precisely this simultaneous possibility which this thesis seeks to emphasise. In this way, the relevance of trauma experience to ACOPSMI – irrespective of life trajectory – is highlighted. Although existing first-person studies do not always describe participants as "competent, non-disordered", respondents in a considerable volume of such research are often deemed competent, therefore, judged as competent for the purpose of this theoretical work.

Unless otherwise stated, the acronym "ACOPSMI" as used in this thesis refers to competent, non-disordered individuals who grew up with parents with an SMI.

Although first-person literature use phrases such as "personal perspective" (Cowling, 2004a) or "narrative" (Foster, 2006), this thesis sometimes makes deliberate use of the possibly sensitive term "testimony", usually associated with the legal system (L. E. Walker & Shapiro, 2010) or with Holocaust survivors offering firsthand authentication of their experiences (Kestenberg & Kahn, 1998). This term is used because some ACOPSMI want to be understood as "survivors" (e.g., see Stevenson, 2002); some use the Holocaust as a metaphor for their experiences (e.g., Camden-Pratt, 2002, 2006); many ACOPSMI survived

25

injury, or (real or perceived) threats of death (as detailed in Chapter 2); and traumatised ACOPSMI share similarities with other trauma survivors (as elaborated in Chapter 3).

This research emphasises that ACOPSMI lives are unseen and that their trauma and grief remain unacknowledged in the literature. This may be interpreted as implying that the Australian government and other relevant parts of the public sector are neglecting their duties. The principal driving force behind government policies is to preserve the family unit via certain family orientated approaches. However well intended, such policies have the questionable result of policy-makers and practitioners considering parents with an SMI over and above their offspring (as outlined in Chapters 2, 3 and 5).

1.5 Rationale for studying competent, non-disordered ACOPSMI

There are a number of reasons to justify the selection of competent, non-disordered ACOPSMI. The reasons include a knowledge vacuum; warnings in the literature that competencies, skills and strengths are superficial concepts; the good social camouflage which this subgroup employs and which carries risks; and ACOPSMI functioning as role models.

A knowledge vacuum

There is little information on the needs of ACOPSMI as their needs are often acutely underestimated, both during their childhood (Stiffman, Chen, Elze, Dore, & Cheng, 1997; Sturges, 1977) and adulthood (Foster, 2006, 2010). Little attention is paid to their experiences unless they themselves are identified as disordered, diagnosed and treated (Foster, 2006; Slominski, 2010).

26

Literature warns that competencies, skills and strengths are superficial concepts

Even competent, well-functioning offspring, or "superkids", of disturbed parents remain at risk (C. Kauffman, Grunebaum, Cohler, & Gamer, 1979) because abuse and neglect during childhood leads to trauma responses (see Chapters 2 and 3). Competencies, skills and strengths which seemingly lead to adequate coping do not release individuals from painful traumatic experiences (J. E. Davis, 2005; Sturges, 1977). In Bleuler's (1974) 20-year study of 184 children born to 208 parents with schizophrenia, he states his dismay at:

> *"the fact that even normal offspring who are successful in life can never fully free themselves from the pressures imposed by memories of their [parents who had schizophrenia during] childhood" (Bleuler, 1974, p.106).*

Results of a longitudinal study from birth to age 30 of adults who were maltreated as children reported by Massie and Szajnberg (2006) indicate that strengths and competencies (also known as resilience)

> *"may be a superficial concept, for, in [their] series of cases, seemingly adequate coping in formerly mistreated children always came at the price of emotional vulnerability and compromised potential" (p.471).*

Anthony (1974), Kauffman, Grunebaum, Cohler and Gamer (1979), and Rengstorff (1992) all caution that individual successes do not mean freedom from pain – irrespective of occupation (i.e., socio-economic standing) or social achievements (i.e., having their own family and able to maintain loving relationships). Anthony (1974) warns consequences exist even for individuals appearing invulnerable as they inevitably end up paying a price. "Price" in this context emerges repeatedly in trauma literature and first-person research (e.g., see Bloom, 2002; Courtois, 2010; J. L. Herman, 1992a; Rengstorff, 1992).

Because this subgroup employs good social camouflage, which carries risks

The community of ACOPSMI include philosophers (Gaita, 1998), nurses (Blair & Cowling, 2004), psychologists, doctors (Nathiel, 2007), social workers (Burdekin, Guilfoyle, & Hall, 1993), authors and playwrights (Lachenmeyer, 2000), and physicists (Blizard, 2008). Who then would think these people are traumatic stress-carrying ACOPSMI?

There is also the risk of being misunderstood. For example, at policy level ACOPSMI who are socially competent and who choose not to be in a carer role for their parent may be at special risk of being seen as "uncaring". Society may disaffirm or invalidate their traumatic experiences which may be at the very core of their reasons – be it conscious or unconscious – for not assuming a carer role.

Since non-disordered, competent ACOPSMI are well-camouflaged, they may be viewed as "better off" than parents with an SMI or siblings by virtue of being competent and not disordered. This adds to their risk of their needs remaining invisible and therefore forgotten. Undetected trauma may stop or delay prevention of physical diseases and illnesses (Felitti et al., 1998).

Because competent, non-disordered ACOPSMI could function as role models

Just as career-competent and famous individuals have come forward, in Australia's *beyondblue* initiative (beyondblue, 2012), declaring they are or were depressed, ACOPSMI need a vehicle where they may feel safe to communicate their trauma-based needs and similarly be helped. Raising the public profile of ACOPSMI may "normalise" (P. Gilbert, 2011) their fundamental needs. Strengthening and uniting them as a population group may serve to reduce their sense of shame as a trauma-affected population because shame shapes people's lives (Dearing & Tangney, 2011).

1.6 Methodology

This research is a theoretical work as set out by Silverman (2005). That is, in planning and executing this research, a practical choice was made to use an existing theoretical corpus, in this case trauma theory, as the conceptual foundation. This is because firstly, studies indicate many ACOPSMI – irrespective of life trajectory – suffered abuse and neglect during childhood at the hands of their attachment figures and presumed protectors (Bleuler, 1974; Jeffreys, et al., 2011). Where that occurs, trauma experience and grief follow (Bloom, 2002). Secondly, the ACOPSMI field could potentially benefit from "theory-based development of intervention programs" (Siegenthaler, Munder, & Egger, 2011, p.9). Thirdly, empirical research is not appropriate to every topic (Punch, 1998; Silverman, 2010). Finally, trauma theory may have the power to address the broad audience addressed in this thesis – individuals, groups, society, and institutions – in a way that adds to the ACOPSMI literature.

Trauma theory may provide a reliable compass to guide stakeholders due to its vast, rigorous research corpus (Kezelman & Stavropoulos, 2012). For instance, trauma knowledge has the power to identify ACOPSMI losses (Bloom, 2000b), and so is posited to be a reliable theoretical construct relevant to the ACOPSMI context. The weight of this thesis is informed by rigorous trauma research (E. B. Carlson, 1996; Lerner, 1996). It adopts a "trauma-informed" approach in which interventions are responsive to trauma-related matters carried by individuals or groups deemed trauma survivors (Jennings, 2004).

A trauma-informed approach may offer an opportunity to better understand, and perhaps test whether trauma theory has the power to explain why the twin themes of "silence" (e.g., E. M. Brown, 1989; Foster, 2006; Goldman, 1996; Gopfert, Webster, & Seeman, 2004; Young, Bailey, & Rycroft, 2004), and "invisibility" (e.g., Fudge & Mason, 2004; S. Lancaster, 1999; Maybery & Reupert, 2006) persist in the literature about ACOPSMI during their childhood and adulthood.

This thesis is not a qualitative meta-synthesis. Such a study exploring the experiences of ACOPSMI already exists (Murphy, Peters, Jackson, & Wilkes, 2011). Rather, it supplements exploratory research with an explanatory theory.

Since there is very little empirical research on competent, non-disordered ACOPSMI, and very few that feature randomised controlled trials (Fraser, E. L. James, K. Anderson, Lloyd, & Judd, 2006), an alternative source of literature was used to build a theoretical case for including trauma responses in discussions of ACOPSMI. This thesis considers already gathered evidence to theorize and illuminate what may have been overlooked at policy and practice intervention levels: a trauma-informed view of ACOPSMI and their needs.

The following describes how the methodological framework used for this research was constructed. It outlines a sample of key sources of literature underpinning this thesis – how they were derived, organised, and determined to be eligible.

Collection

To ensure relevant knowledge on ACOPSMI was not overlooked, the search for empirical evidence was ongoing through the study. Moreover, researchers have a tendency to deny trauma (Armstrong, 1996). This alerted the researcher to the possibility that articles found about ACOPSMI might not be adequately trauma-informed, or that they conceal, misinterpret, or inadequately address the specific needs of ACOPSMI.

Eight (scholarly and lay) sources of material were identified (see figure 1.1) and relied on for this thesis.
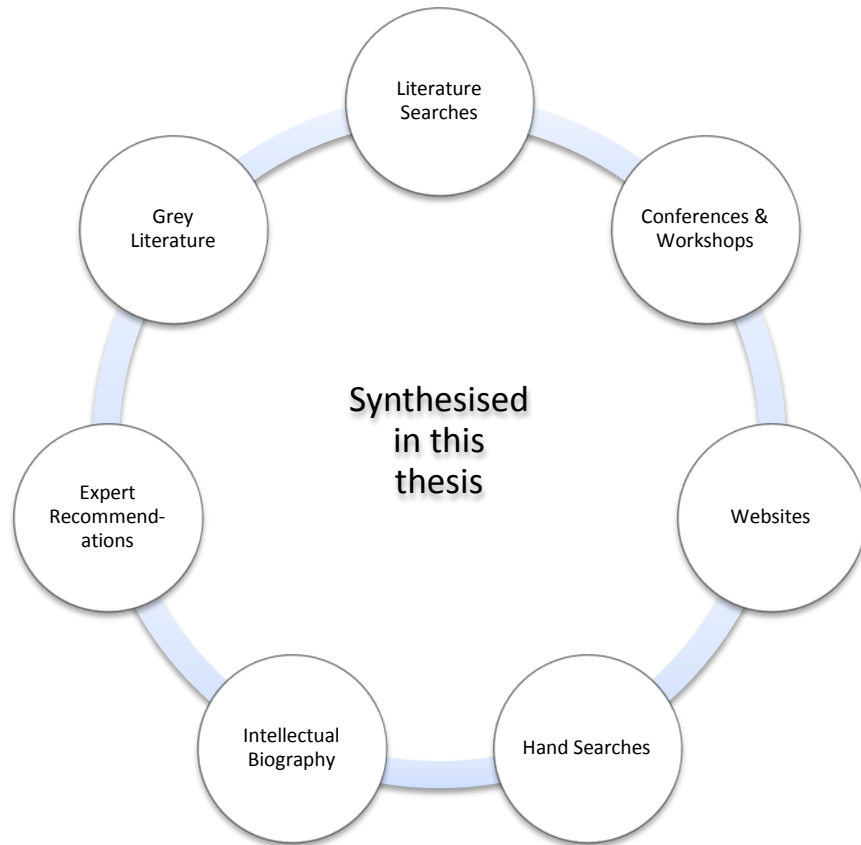
Figure 1.1: Literature sources

Combining sources allowed for linking and collating diverse literature:

1. *A library search* was conducted. Academic databases were employed using an extensive search strategy (see Appendix A) with no limitations placed on year of publication. Email alerts (set up early in the literature search) were automatically performed by CSA Illumina database PsycARTICLES. Nine alerts were set up using a variety of search queries (saved in an earlier Alert Profile – see Appendix B). Up to 250 newly retrieved references within each set were received at any given

time with new, useful content matching any combination of the search queries. Each set was sifted for relevant material.

2. *Conferences and workshops* led to, among other resources, Vicki Cowling's books: one written on (adult) children, parents and service providers (Cowling, 1999), and another on personal and clinical perspectives (Cowling, 2004a). The former provided website links to relevant government policies. The latter recognises competent, non-disordered ACOPSMI via testimonies (e.g., Blair & Cowling, 2004).

3. *Websites* provided up-to-date newsletters and information on research projects. For example, the *Australian Child and Adolescent Trauma, Loss and Grief Network* (ACATLGN) created by the Australian National University; and Children Of Parents with a Mental Illness (COPMI) (Australian Infant Child Adolescent and Family Mental Health [AICAFMHA], 2012).

4. *Hand searches* were heavily depended on for difficult-to-locate material – particularly for experiential research and material on counselling of ACOPSMI. Typically, a hand search initiated a chain, i.e., one resource led to the next. References were hand searched, checked for recent citations, and key articles located and analysed. For example, literature that framed the counselling needs of ACOPSMI was rare. A handful of peer-reviewed articles on the counselling of ACOPSMI were located after a considerable degree of hand searching and serendipitously found. For instance, Young, Bailey and Rycroft's (2004) article was inadvertently found in the reference list of policy guidelines for psychiatrists. This cycle of material collection was often repeated until saturation point, i.e., until important references started showing up repetitively

5. *Intellectual biography.* Previously completed tertiary studies by the author made it easier to decipher and analyse (unspecified and unattributed) counselling models which were employed in literature on counselling of ACOPSMI.

32

6. *Recommendations by experts* working within the trauma and grief fields recommended Freyd (1996) and Bloom (2002).

7. *Grey literature*, i.e., writing and electronic sources outside of academic publications, offered extra insights, e.g., an ABC Radio National transcript of an interview with ACOPSMI philosopher and academic Raymond Gaita (Koval, 2011). A *New York Times* obituary (Vitello, 2011) of key scientist Robert Ader led to studies making important links between stress and illness.

8. *Personal communications* with leaders in the field led to validation or confirmation of theoretical and conceptual points raised in the thesis. Such sources were used sparingly and only when experiential accounts in the literature either appeared absent or insufficient.

Identification

Where possible peer-reviewed publications were sought, and in fact made up the vast majority of materials.

Once the initial search (search queries, search strategies, and multiple search categories are detailed in Appendix A and B) was completed, literature sources were identified as opportunities for to address the research question to ensure the thesis aim and objectives were met**.**

Existing research literature is referenced throughout this thesis rather than in a separate review at the beginning or discussion at the end (Wolcott, 1990).

Literature sources excluded

Sources were excluded from consideration early in the process if they were not within the scope of this research (details given in Section 1.4); did not embrace specific subject areas; and did not fit this research purpose.

Studies not focusing on adults were excluded. The exception was those child studies relevant to the ACOPSMI context. For instance, because as children many ACOPSMI were raised under difficult and painful circumstances (Bleuler, 1974), it was important to verify such knowledge with up-to-date research (Jeffreys, et al., 2011).

In general, given that a Masters thesis must be written to a word limit, the breadth of literature found required parsimony in selection of sources.

Specific selection criteria for subject areas

To ensure relevance, selected materials were grouped according to subject areas. Those subject areas include ACOPSMI, trauma, policy and practice, the details of which are listed below:

ACOPSMI

There was little information to choose from on ACOPSMI. Most was found in the literature under 'Family and/or Mental Illnesses' (Hatfield, 1983, 1987). Since no trauma counselling approach has been designed specifically for this population, material on competent, non-disordered ACOPSMI was selected according to degree to which testimonies or case studies revealed trauma experiences.

Trauma

Trauma literature was selected to demonstrate knowledge gaps found in government policies and in the literature on counselling of ACOPSMI, and in terms of what could best be used to address this thesis' goals and objectives.

Policy

Policy literature was selected according to which policies acknowledged the population group studied and whether individual policies were trauma-related and applied across the lifespan of ACOPSMI.

Practice

Grief theory literature was chosen according to those specific conventional grief models employed within key articles on the counselling of ACOPSMI which implicitly address their grief responses. Some alternative grief models that accommodated trauma characteristics are also included.

Interdisciplinary enquiry

At the time of writing, no research could be found that explicitly addressed the trauma responses of ACOPSMI. A range of concepts and multiple sources/types of evidence were reviewed to construct a framework for understanding the ACOPSMI context in relation to their early childhood experiences. To avoid limiting an enquiry to one single discipline, it was decided that an interdisciplinary enquiry was appropriate (Ahearn, 2000). This ensured that mapping impacts on lives of the population studied – from multiple standpoints – increased credibility and validity (L. Cohen, Manion, & Morrison, 2007). As such, literature arising from a range of disciplines was considered including psychiatry, psychology, anthropology, philosophy, social work, and education. Other disciplines within the field of trauma, such as psychological literature on incest (Courtois, 2010), or bio-scientific literature addressing the neurobiology of abuse and neglect (McCrory et al., 2011), were also employed.

Literature types

Literature was drawn from five multidisciplinary literature types.

Theories – relating to trauma, attachment, loss and grief were relied upon for this project. They are described and interpreted in specific chapters according to a specific purpose, e.g., parents with an SMI, attachment theory, and the impact of parentification addressed in Chapter 2.

Experiential accounts – because this project is not empirical research, accounts made in personal histories, empirical first-person case studies or narratives were more heavily relied upon. Such literature provided a suitable substitute for readily available and reliable qualitative data on the trauma experiences of ACOPSMI. Experiential accounts are not set in any particular chapter but rather used in much the same way as would occur in empirical research.

Policies – policy documents that address intervention programs pertinent to this population, discussed in Chapter 4, were selected on the basis of whether they were: (1) pertinent to ACOPSMI as a population group; (2) provided insights into the extent to which policies are trauma-informed; (3) allowed for a lifespan or 'cradle-to-grave' approach for this population; (4) confirmed warnings given by previous trauma researchers or policy makers; or (5) revealed the impact policies may have on future ACOPSMI

Practice literature – the very little literature available on the counselling of ACOPSMI was used in Chapter 5.

Empirical studies – rigorous qualitative or quantitative trauma studies were examined in this thesis. While grief theories were included, grief studies were omitted. Grief, loss and trauma are connected concepts (Brom & Kleber, 2000). Despite this integration being critical for ACOPSMI, the coupling of grief and trauma is not clear cut (Brom & Kleber, 2000; J. A. Cohen, Mannarino, Greenberg, Padlo, & Shipley, 2002; Kleber, Brom, & Defares, 1992). Psychiatry and psychology do not always connect grief and trauma as concepts (Brom &

Kleber, 2000). Neither does social work (Bland, 1998; Goldsworthy, 2005). The general literature on grief is inconsistent regarding grief as a concept (Brom & Kleber, 2000). The very few empirical investigations into grief are found to be unreliable. For example, the stage model of grief investigated by Maciejewski, Zhang, Block and Prigerson (2007) was found to have serious methodological flaws, lack of reliable measures, biases within methods used, and containing interpretations and conclusions threatening to misguide professionals and others (Bonanno & Boerner, 2007; Silver & Wortman, 2007; Weiner, 2007; Wortman & Silver, 1989).

In contrast to grief studies, trauma studies were vast and found to be more reliable. For example, the United States longitudinal Adverse Childhood Experiences (ACE) Study (Felitti et al., 1998) involved questionnaires, standardized medical evaluations, and categorisation of adverse childhood experiences which were compared to measures of adult risk behaviour, health status, and disease. Statistical procedures were used to control for effects of diverse demographic factors covering 9,508 subjects. This study establishes the relationship between adverse experience during childhood (i.e., adults with specific trauma histories relating to abuse and neglect) and subsequent negative physical ill health during adulthood.

Additional Considerations

The following do not represent selection criteria, but rather a number of additional considerations pertaining to the materials collected, filtered and used in this thesis.

Consistency: If findings were consistent across studies and disciplines then the source was used. For instance Bleuler's (1974) descriptions of ACOPSMI and their childhood maltreatments matched Nathiel's (2007) descriptions.

Current and up-to-date: For example, state-of-the-research studies were considered in this thesis, including, from trauma Kezelman and Stavropoulos (2012), or from bio-sciences, McCrory and colleagues (2011).

Methodological rigour and data quality: Especially valuable were findings that came from longitudinal studies with a substantial sample size (e.g., Bleuler, 1974; Felitti & Anda, 2010; Felitti, et al., 1998; Szajnberg, et al., 2010).

Studies that map out clear links between early abuse and physical health across the lifespan are relevant to traumatised ACOPSMI. Warnings about trauma impacting on the physical body are heeded in this thesis essentially via Felitti and colleagues' (1998) longitudinal research. They reconceptualise the interrelationship between adult ill-health and childhood trauma, and confirm the importance of being trauma-informed (Jennings, 2004).

Obsolescence: If studies were practical then data obsolescence was not a factor. For instance, physical manifestations of trauma described in 1922 by Canavan and Clark match trauma features described by Lanius and colleagues (2010). Indeed, some of the research employed reaches back decades. This may be justified by Roberts' (1996) methodological rules concerning the notion of data obsolescence, in which data remains vibrant and alive and could "speak to the question [it is] immutable against the passage of time" (p.49).This rule was borrowed from an unrelated study – secondary analysis in qualitative methodologies in music education research – which nonetheless forcefully generalises the notion that obsolescence is not a factor in whether research is useful. Robert's (1996) rule was applied in this thesis and influences its search scope. For example, early trauma research by Freud (1917/1957) and Bowlby (1951) remain relevant, as does Bleuler's (1974) longitudinal study on competent, non-disordered ACOPSMI. Due to the paucity of ACOPSMI literature, it is not unusual for current studies to use older sources; for example, Murphy and colleagues' (2011) qualitative meta-synthesis of ACOPSMI uses older material (e.g., E. M. Brown, 1989).

38

Sample size: Sample size varies enormously among studies selected given the restricted number of literature on the target group. For instance, Dunn's (1993) study had 9 participants whereas, Felitti and colleagues' (1998) questionnaire about adverse childhood experiences was completed by 9,508 adult respondents.

Seminality: For example, attachment theory (Bowlby, 1969) which has been widely cited and applied to this day.

Relevance: Applicability to the research question was most important. Sources that presented a clear case for acknowledging the trauma responses of ACOPSMI (e.g., Lanius, et al., 2010) and the grief that follows (Bloom, 2000b, 2002) were difficult to locate and therefore highly prized – irrespective of discipline, sample size, year of publication, or whether they directly addressed the topic of this research.

Since the ACOPSMI literature is not well integrated or systematic, an established analysis of research, as found in sexual abuse literature (J. E. Davis, 2005), inspired the idea of grouping the comparatively meagre ACOPSMI literature into three distinct "Waves" for ease of understanding as the following illustrates.

Three "Waves" of ACOPSMI Literature

First Wave literature essentially asks 'what's wrong'? It is concerned with the problem-saturated view of ACOPSMI arising from the medical model (Reupert & Maybery, 2007). This view arose during the 1920s and is based on a deficit-risk construct within research on psychiatric pathology (Kinsella, Anderson, & Anderson, 1996).

First Wave literature provides useful evidence which suggest ACOPSMI are a traumatised population (see Chapter 2). For example, children in Mordoch and Hall's (2008) study felt a need to stay connected to their parent to preserve some semblance of attachment. However, they also needed to "create safe distances between themselves and

39

their parents" (p.1127), sometimes involving "physically or mentally leaving the scene" (p.1133). Such dissociative trauma responses (defined in Chapter 3), are a natural trauma coping mechanism for children (Bacciagaluppi, 2011; Putnam, 1997) and adults (Kezelman & Stavropoulos, 2012) when matters become overwhelming. First Wave literature reads such responses as an immediate sign that something is wrong. For example, Maybery, Ling, Szakacs, and Reupert (2005) view children "withdrawing [from their parent as a potential] risk for later maladjustment" (p.5). This may be taken as evidence suggesting ACOPSMI are a traumatised population.

Second Wave asks 'what's right'? It moves the focus towards investigating coping strengths. Solidifying in the 1970s, this view favours theories of protective factors, strengths, skills, resilience, competencies in the face of adversity and outcome-based expectations (Focht-Birkerts & Beardslee, 2000; Garmezy, 1974; Marsh & Lefley, 1996). Such views are noted as a "serendipitous discovery" (Foster, 2006, p.26), as it provides partial relief from problem-saturated First Wave literature. However, those arguing for expansion of this risk-resilience framework (Gladstone, Boydell, & McKeever, 2006) are challenged by studies wanting to go beyond asking 'what's right' through to questioning any over-reliance on a coping-strengths framework (Anthony, 1974; L. Fisher, et al., 1987; Gladstone, et al., 2006; Massie & Szajnberg, 2006).

Although potentially important, Second Wave may obscure trauma responses. It may not be as valuable in revealing gaps and areas demanding attention from a trauma perspective. This is because of its limited power in conceptualising ACOPSMI as a traumatised group. Its preoccupation with competencies and strengths put ACOPSMI (particularly competent, non-disordered individuals) at risk of their trauma being covered up or minimised due to strong emphasis on skills development. Second Wave is sampled but not considered as relevant for this thesis.

Third Wave literature responds to the question 'what happened'? It is made up of research that gives direct voice to ACOPSMI as an underrepresented group. In offering their accounts, it enriches the ACOPSMI field of study by uncovering first-hand – and perhaps for the first time – the question of 'what happened' directly from survivors able and willing to

tell their stories. Drawing on input from other disciplines such as sociology (e.g., see Camden-Pratt, 2002), this shift made a big splash in the 1980s.

Survivor autobiographies have high value for research (Bertrand, 2000). Literature investigating survivors of other traumatised groups, such as refugees (Ahearn, 2000), child Holocaust survivors (Fohn & Heenen-Wolff, 2011), war survivors (Suleiman, 2006), or sexual abuse survivors (Davis, 2005), clarify the important role of autobiographies. Competent, non-disordered ACOPSMI are more likely to be the ones willing and able to contribute to Third Wave literature by writing autobiographical accounts.

Subjective lived experiences are important testimonies fulfilling a need similar to those of other survivors while also being instructive (e.g., see M. Cohen, Brom, & Dasberg, 2001; Frankl, 1984; Sagi-Schwartz, Koren-Karie, & Joels, 2003; Solkoff, 1981; Suleiman, 2006). Testimonies are also more cogent with this author's practice experience (see Prologue), therefore more compelling.

Deep pain is not easy to share. But compelled to write their testimonies, Third Wave contributors give oxygen to the ACOPSMI context. To be believed with honesty and integrity is for all survivors a mark of progress from debilitating trauma and towards recovery and healing of long-simmering hurt (Cloitre, et al., 2006; Courtois, 2004, 2010; Courtois & Ford, 2009b). The appearance of Third Wave literature therefore supports ACOPSMI "moral safety" (Bloom, 2000e, p.8).

The subjective views of ACOPSMI are valid (Kinsella, et al., 1996) so they should be taken as able to speak authoritatively about their plight. Yet few studies seek the opinions or investigate the needs of ACOPSMI (Knutsson-Medin, Edlund, & Ramklint, 2007). The profile of Third Wave literature in this thesis is therefore elevated.

The input of academics who are also ACOPSMI (e.g., M. J. Brown, 1994; Camden-Pratt, 2002; R. R. Lancaster, 1993; Rengstorff, 1992) is of great relevance because the body of Third Wave empirical research produced by them is critical to advancing knowledge in this field.

According to Gladstone and colleagues (2011), three common themes emerge in the literature regarding the offspring of parents with an SMI: (1) their coping, (2) their understanding of mental illness, and (3) how parental mental illness impacts on their lives. The most scholarly interest lies in the first two themes. The third theme – *how* the lives of ACOPSMI are impacted on (as illustrated retrospectively in Third Wave literature) does not appear as popular within the ACOPSMI literature.

Although Bleuler (1974) believed his sample of 184 subjects too small to allow for general and valid conclusions, most studies from Third Wave literature have even smaller samples, ranging from 9 to 21 subjects. Nevertheless, experiential literature employs qualitative in-depth methods to analyse rich, first-person accounts. Findings and concepts from Third Wave literature offer important material on the interior lives of ACOPSMI. These serve as indicators for future data collection and are relied upon in this thesis because of the way they uniquely describe personal trauma responses in raw detail.

Various first-person research and case studies were employed in this thesis – too numerous to list here. Camden-Pratt's (2002) research was particularly rich and heavily relied upon in this thesis. It most directly describes trauma responses and trauma-based grief pertaining to being raised by parents with an SMI. Her feminist, cross-disciplinary research is informed by the use of critical autobiography. As Foster (2006) rightly points out, because Camden-Pratt's findings are presented in the form of a conversational-styled written play, summarising them is challenging. In essence, it is a study of the experiences of 12 adult daughters of mothers with (unspecified) severe mental illnesses. Similar to Foster (2006), it is informed by the researcher's own adult child experiences and concerned with multiple meanings of language and its power to enact. Stories were gathered using a combination of standard and radical methods: (1) notions of narrative and re-storying experiences, (2) postmodern and post structural theoretical and critical perspectives, (3) focus groups, (4) individual interviews, (5) a grounded theory approach and content analysis (used to analyse verbal data), and (6) creative arts involving paintings and collages.

Foster (2006) considers Camden-Pratt's (2002) research as lacking in contribution towards wider understanding and development of the field, and therefore a weakness.

42

However, the profound sincerity with which trauma and grief responses are portrayed by Camden-Pratt's (2002) research participants deemed her research to be special for this thesis. It offered a crystal clear picture of the depth and breadth of trauma and grief responses in the lives of this population group. Unlike other experiential literature, Camden-Pratt's research offers this thesis an unvarnished sketch of the internal reality of ACOPSMI. This is because her subjects are willing to give an honest exposition of their trauma and grief by crossing the thickest taboo line, i.e., vocalising their wish for the physical death of their tormentors, their parents (commensurate with this author's practice experiences – see Prologue). Based on her (2002) doctoral thesis, Camden-Pratt published *"Out of the shadows: Daughters growing up with a 'mad' mother"* (2006). In her advanced review of the book, Professor Louise Newman highlights this publication as a "searingly honest [and] brave account [of] harm done in the past by failing to respond to their [ACOPSMI] needs" (no page number available).

Categorising the existing ACOPSMI literature into three Waves provided this thesis with (1) historical understandings of ACOPSMI; (2) the question each Wave was pursuing; (3) pivotal shifts in overall thinking about this population; (4) their potential needs; and (5) the degree of support each Wave offered ACOPSMI.

Compatibility of child protection services literature and mental health services literature

Identification and classification of material was further refined according to whether the main researchers supplying data relevant to ACOPSMI approached the topic from a child protection perspective or a psychiatry perspective, i.e. mental health services. This ensured clarity of orientation. However, a psychiatric perspective can be compatible with a child protection perspective, as the following describes.

43

Both Bleuler (1974) and Jeffreys, et al., (2011) contribute towards an important discussion. Their research may function to help unify an important logic: child maltreatment by parents with an SMI potentially causes trauma, which in turn has consequences such as later adult physical diseases (Felitti, et al., 1998). The impact of early life trauma on health and disease carries socioeconomic consequences and is a "hidden epidemic" (Lanius, et al., 2010).

The language of the day used by Bleuler (1974), e.g., "schizophrenic parents", may offend some. Nevertheless, although written decades ago, Bleuler's (1974) landmark 20-year intergenerational family study of 184 children (143 attaining maturity by investigation's end) is extensively detailed. His study, which examined the impact on the offspring of parents with schizophrenia, remains "immutable against the passage of time" (Robert, 1996, p.49), and speaks to questions posed throughout this thesis.

Likewise, findings from Jeffreys, Rogers and Hirte's (2011) research was also rigorous and of high relevance throughout this research. Their study, entitled "Keeping the child in mind: Child protection practice and parental mental health", focuses on prevalence of parental mental health disorders in the context of child protection. The authors first collected and analysed data relating to all substantiated cases of child abuse and neglect (during 2007-2008 from Families South Australia, Department for Families and Communities statutory child protection agency administrative data system). The second stage involved a random sample of 30 cases drawn from the original substantiated cases where parental emotional and mental health was assessed as problematic. Thematic responses were then derived from in-depth interviews with individual caseworkers and used to conduct three focus groups (two with Anti-Poverty Services and one with Families SA Psychological Services).

Jeffreys and colleagues (2011) aimed to "increase knowledge and understanding of the prevalence and nature of parental mental health difficulties associated with protective concerns for children and young people and the service responses required by these families" (p.15). Their research applies to the future generation of ACOPSMI by substantiating that (1) child neglect and emotional abuse by parents is most common and a

44

significant reason for reporting children to child protection services; (2) many mentally-ill parents come to the attention of child protection agencies rather than adult mental health services; (3) despite lack of epidemiologic data, shortage and difficulties of reliable measures, estimations of prevalence of parents with an SMI is probably higher than what is reported and therefore likely to reflect higher numbers of traumatised children; (4) not addressing mental illness type in protective services constitutes a protective concern as it interferes with understanding prevalence of parents with an SMI at different stages of child protection processes; (5) knowledge of parental mental illness type and its impact is limited among child protection workers; (6) some parents with SMI are over-represented in child protection services, e.g., borderline personality sufferers are 'high risk' parents, exposing their children to trauma and adversity; (7) many parents with SMI parentify their children; and (8) adult mental-health services need to become more child-sensitive (interpreted by Jeffreys and colleagues as more "family-centred"), with new evidence provided to inform and overcome tensions and boundaries to facilitate partnerships at the intersection of child protection and mental health services.

Synthesis

This conceptual analysis brings together various bodies of literature with the intention of suggesting that trauma theory can add to perceptions of ACOPSMI as an understudied group. This synthesis aims to see what one body of literature can add to the other, including any similarities or differences between each which may assist this thesis' aim. The intention is also to look for conceptual gaps, weaknesses, problems or biases in existing literature that may overlook the lives and unacknowledged trauma of ACOPSMI in the spirit of trauma research (Armstrong, 1996).

In the process of reviewing the literature, trauma themes distilled from trauma studies were filtered according to the aim and objectives of this research. Connections were then made between themes emerging in trauma theory and knowledge gained about ACOPSMI in

Third Wave literature. These were then purposefully connected to the lives of ACOPSMI, and then slotted into logical sequence inside respective chapters.
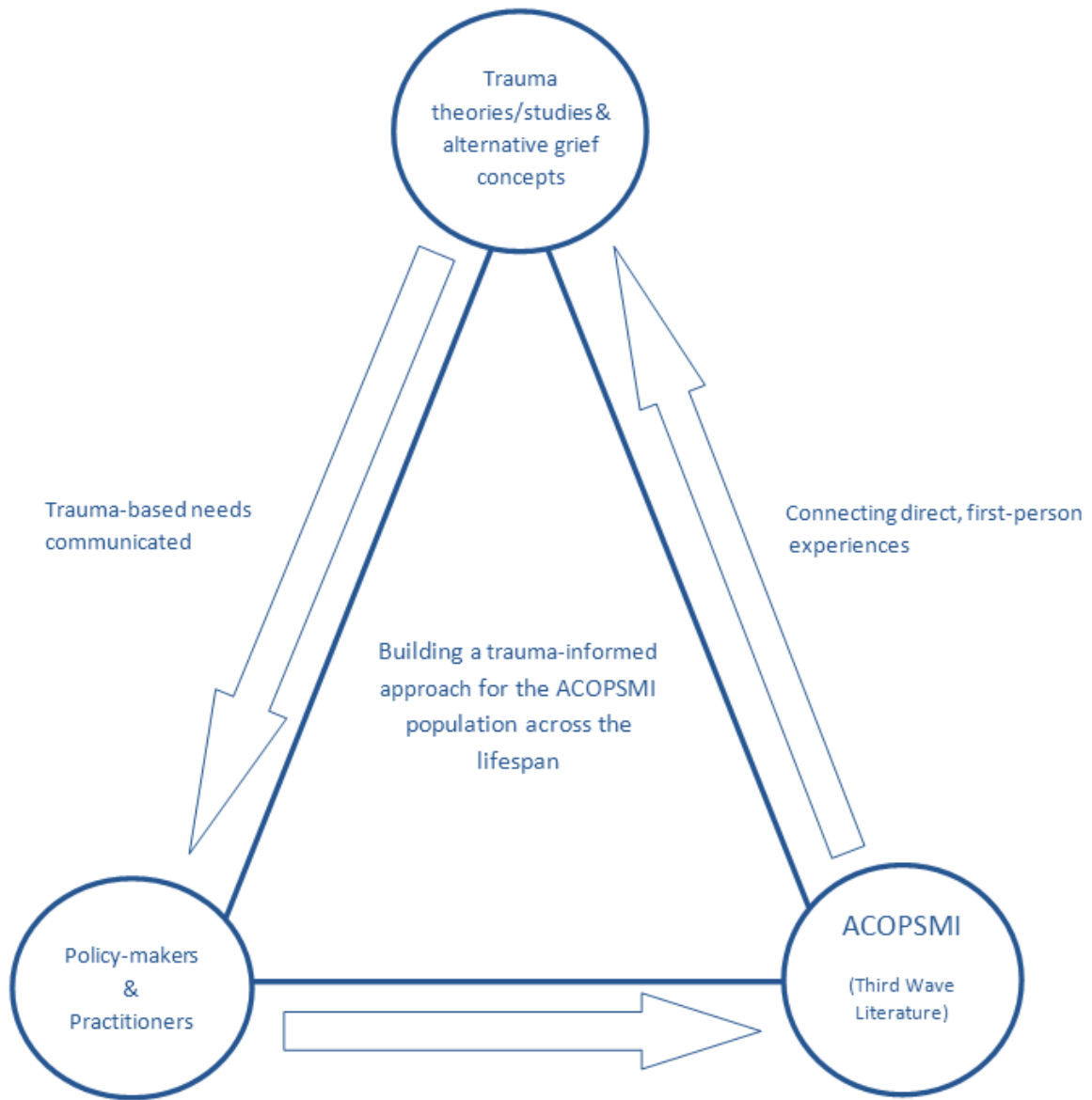
Patterns were sometimes derived intuitively then demonstrated more formally by collecting and analyzing sources to suggest how the main elements of trauma theory translated into specific examples found in experiential accounts. For instance, trauma theory and studies specifically suggest that the impact of trauma takes many decades to surface (e.g., Felitti, et al., 1998). Experiential accounts relay this very message (e.g., Camden-Pratt, 2002). This ongoing process of induction (from specific examples) moved to deduction where large ideas were conveyed into the body of the thesis, such as "time delay of trauma awareness" which is developed in Chapter 3. Connecting experiential accounts to theory in this way was an integral method for this thesis. Forming these connections between trauma theory and ACOPSMI narratives revealed gaps in policies.

Insights derived from trauma and attachment theories and Third Wave literature determined the task, direction, and flavour of each chapter. A trauma-informed approach directed the overall structure of this thesis, involving implications and other matters (discussed in Chapter 6) to be stratified across three levels – individual ACOPSMI (micro), family (meso), and national policies (macro).

Trauma is not something new. Yet it appears new because few have applied trauma theory as a method to the ACOPSMI context at policy and practice levels. This thesis compares literature on trauma of other survivor groups against the body of thought found in Third Wave literature, suggesting there is room to improve on how ACOPSMI are perceived or "seen".

The purpose of this theoretical thesis, according to thesis aim and objectives, is depicted in figure 1.2. It sums up the flow of knowledge of this research.

Figure 1.2: Knowledge flow

Trauma
theories/studies&
alternative grief
concepts

Trauma-based needs
communicated

Connecting direct, first-person
experiences

Building a trauma-informed
approach for the ACOPSMI
population across the
lifespan

Policy-makers
&
Practitioners

ACOPSMI

(Third Wave
Literature)

1.7 Overview of thesis

Chapter 1 presents the problem and hypothesis. Key terms are defined and sensitivities acknowledged. Justifications for using trauma theory as a methodological approach are given. The rationale for studying competent, non-disordered ACOPSMI is put forward. The thesis aim, objectives and scope are outlined, including details regarding methods used, such as collection, identification and selection criteria of literature sources in subject areas with described samples. The idea of dividing the ACOPSMI literature into three "Waves" is introduced. Additional considerations are put forward, such as the different perspectives represented, i.e., psychiatric vs. child protection in the literature on this population group. A synthesis and a brief overview are then offered.

The aim of *Chapter 2* is to show why it is important to recognise and address the needs of all ACOPSMI – including non-disordered competent individuals. Twin themes appearing in the literature on this population group, "invisibility and silence", are explored via three questions: (1) *Why identify ACOPSMI?* (2) *How are ACOPSMI perceived?* and (3) *What may be their needs as adults?*

Because trauma and grief responses have important implications for ACOPSMI, *Chapter 3* justifies the use of a trauma-informed perspective. Central to the critique of policy and practice which follow in later chapters, key trauma constructs, principles, alternative concepts, additional trauma features, and the notion of ACOPSMI as a 'collective identity' are defined. The neurobiological trauma framework is augmented by existentialism as an alternative theoretical framework suitable for thinking about the lives of ACOPSMI. Greater profile than what is available in existing literature is given to trauma. Although trauma theories directly relate to practice, surprisingly it is equally relevant if not perhaps more urgent at policy level – the subject of the next chapter.

Chapter 4 investigates the extent to which Australian national and Victorian state government mental health policies address the trauma-based needs of this population across the lifespan. Using major government policy documents, reviews, journals, and

government websites against a brief historical background, this chapter reviews policy implications for this population. Organisations and initiatives that offer alternate support for ACOPSMI are listed. The chapter aims to demonstrate how silence and invisibility of ACOPSMI operate at official levels.

Chapter 5 looks at how counselling practice of ACOPSMI does take place but 'behind the scenes', according to government-driven, family-focused counselling approaches. It examines how the literature frames the counselling of ACOPSMI in terms of models used and what is missing – trauma.

Chapter 6 contains a discussion that summarizes and highlights findings, including the limitations of this theoretical study. Implications and recommendations for this research are stratified across three levels – individual ACOPSMI (micro), family (meso), and national policies (macro).

Chapter 2: About ACOPSMI

There is a need to better understand adult children of parents with a severe mental illness (ACOPSMI), and to explore whether counselling practice and government policy should specially consider this population. This chapter attempts to answer these questions: (1) why identify ACOPSMI?, (2) how are ACOPSMI perceived?, and (3) what may be their needs?

2.1 Why identify ACOPSMI?

ACOPSMI are likely to represent a substantial portion of Australia's population. In the following section, the extent of life impacts for the population of ACOPSMI is detailed. The features of ACOPSMI and their experiences are specified including: extent of the ACOPSMI population, underestimation of population, legacy of trauma, suicidality, parentification, intergenerational relevance, and economic imperatives relevant to policies and to society as a whole.

Extent of the ACOPSMI population

Estimating ACOPSMI numbers is a difficult exercise given that much of the reported data concerns mentally ill parents rather than the children themselves – an indirect measure at best. Additionally, definitions of illness severity and reporting rates of SMI among parents appear to vary from region to region and from study to study (Owen, 2008).

Maybery, Reupert, Patrick, Goodyear and Crase (2009) collected data from 701 community participants, via the 1997 Australian Bureau of Statistics Victorian Mental Health Branch service, with the aim of estimating the numbers of Australian and Victorian families

and children living in families where a parent has had a mental illness. They estimate that nationally 1.3% of all children lived in families where parental mental illness was severe and chronic. However, when not constrained by recognised levels of severity of mental illness, a different picture emerged:

"23.3% of all children in Australia have a parent with a non-substance mental illness, 20.4% of mental health service users have dependent children and 14.4% of the community study participants report having at least one parent with a mental illness" (p.22).

In Jeffreys and colleagues (2011) study, parental mental illness is a concern in 10-42% of child protection cases across Europe, the UK, Canada, the US, and Australia. In Western Australia, parents were experiencing psychiatric illness in 28% of cases where children were on care and protection orders (Farate 2001, cited in Jeffreys, et al., 2011). This same percentage was found in a recent audit of adult mental health services of parents of dependent children in the Northern Sydney Central Coast (Owen, 2008). "Parental mental illness was a contributing factor in 31% of cases where children first entered out of home care in Victoria" (Victorian Department of Human Services 2003, cited in Jeffreys, et al., p.10). This same figure emerged in cases of parental psychiatric illness at a home visiting service in Midland and Albany, Western Australia (Owen, 2008).

Jeffreys and colleagues (2011) note that estimates of numbers of children from parents with an SMI may be ill defined and underestimated due to shortage of reliable epidemiological data and measures. They further note that such parents come to the attention of child protection services, *not* mental health services, where data about parenting status is inconsistently collected – some centres collect information while others do not.

Looking outside Australia, the number of children and adolescents in households with mentally ill parents appear to be considerable in the UK (Creswell & Brereton, 2000; Gopfert

& Webster, 1996), Canada (Mordoch & Hall, 2002), the US (Kessler et al., 2005) and Sweden (Oppenheimer, 1979 cited in Östman & Afzelius, 2011; Östman & Eidevall, 2005; Östman & Hansson, 2002). Worldwide, millions of young people are exposed to parental mental health problems at any given time (Creswell & Brereton, 2000).

Underestimation of ACOPSMI population

After SMI patients were moved from institutions to community living under a policy of deinstitutionalization, the number of children born to people with SMI increased (Risley-Curtiss, Stromwall, Hunt, & Teska, 2004; Tunnard, 2004) to come in line with the general population by the late 20th century (Devlin & O'Brien, 1999; Fadden, Bebbington, & Kuipers, 1987; Judge, 1994; H. Kaplan & Sadock, 1988; Nicholson & Blanch, 1994).

Mental health service personnel who typically deal with SMI adult patients may unknowingly come into contact with those who are parents (Jeffreys, et al., 2011). Their lack of training in child protection matters (Owen, 2008) may have the effect of underreporting numbers of parents with an SMI as workers do not always ask SMI patients about their parenting status (Burdekin, et al., 1993). They may not consider this important. Information regarding parenting status of people attending mental health services is not systematically or routinely collected (Cowling, McGorry, & Hay, 1995; DeChillo, Matorin, & Hallahan, 1987; Howe, Batchelor, & Bochynska, 2009; Maybery & Reupert, 2009; Nicholson, Geller, Fisher, & Dian, 1993; Oates, 1997; Zielinski, 2009). Although adult mental health services recommend that clients are assessed at intake for parenthood status (Maybery, Ling, et al., 2005), the mere identification of SMI individuals who are also parents is rare within Australia, the UK, Europe or North America (Alakus, 2000; Jeffreys, et al., 2011; Maybery & Reupert, 2006, 2009; Nicholson, Biebel, Hinden, Henry, & Stier, 2001).

There is a discrepancy between estimations of numbers of parents with an SMI by research and those made by case workers in mental health services. For instance, Jeffreys

52

and colleagues (2011) observe "there is probably a larger group of parents who either do not meet clinical (DSM-IV) criteria (e.g., those with 'borderline traits'), or who have not come to the attention of mental health services, but who still have significant difficulties and problems in parenting" (p. 7). Yet 78.6% of case worker assessments report they "did not assess parents as having chronic or severe problems in either their emotional or mental health" (p.41).

Other concerns may compound accuracy of reported numbers of parents with an SMI and their offspring. For example, mentally ill parents, even if aware of their parenting struggles and shortcomings, are reluctant to seek help (Cowling, 1996) because they fear intervention or loss of their parenting role to welfare organisations or others (Buist, 1998; SANE Australia, 2012). They may also fear that their parentification of their children may not continue. Moreover, disclosure is less likely when victims are related to their assailants (Arata, 1998). Ford (2009) states underreporting of protective issues occurs whenever there is some form of dependency or fear of retribution, stigmatization, further victimization, or reduced support (even if support is minimal). The notion of not reporting abuse and neglect has also been addressed by other scholars (Freyd, 1996).

Fears perpetuate underreporting and underreporting conceals needs. ACOPSMI may fear emotionally falling apart (Acierno, Kilpatrick, & Resnick, 1999), or have a mixture of fears, such as fears that disclosure may break up the family (McNally, 2007) mixed with fears of retribution by their parents. As one ACOPSMI respondent states, he was too "afraid to speak up for fear of anger and more abuse at the hand of the abuser [and] no one ever asked and I could not be the one to give away my mother or the love of my family" (Gushurst, 2003, p.935).

The problem of mental health services underreporting may go beyond the need for greater data collection; qualitative data may need to be rich enough to serve policy and practice to identify and help the offspring of parents with an SMI.

Legacy of trauma

This section briefly addresses the range of effects trauma can have on ACOPSMI. The topic of trauma is considered in greater detail in Chapter 3.

The effects of trauma can impact on mind or body. As a result of abuse and neglect, some individuals may sadly become mentally ill (Mattejat & Remschmidt, 2008; Mednick, et al., 1984) because traumatic relationships and serious mental disorders sometimes go hand in hand (Allen, 2001). But, as identified in the introductory chapter, many ACOPSMI survive *without* mental illnesses. Trauma research also indicates "the body keeps the score" (van der Kolk, 1994) on a physical level (Ogden, Minton, & Pain, 2006). Yet bodily responses caused by traumatic experiences, such as chronic diseases, e.g., lung disease, heart disease, cancer, stroke, diabetes, skeletal fractures, and liver disease (Felitti, et al., 1998), are seldom tracked to their antecedents (J.L. Herman, 1992a).

Clearly, child abuse and neglect can have a devastating impact (Cummins, Scott, & Scales, 2012) which does not stop at childhood but continues across the lifespan (Lanius, et al., 2010). This impact often continues beyond 50 years, partially due to extension into adulthood of coping strategies developed in childhood for self-protection (Felitti, et al., 1998).

The 1993 National Inquiry into the Human Rights of People with Mental Illness (Burdekin, et al., 1993; hereafter also referred to as the Burdekin Report) reports ACOPSMI "live their lives acceptably to society" (p.498). Society may wonder what is the problem since "[a]fter all, they survived, didn't they?" (Bloom, 2002, p.8). Authors such as Burdekin, et al., (1993) may be referring to competencies (Anthony, 1974; Garmezy, 1974) like resilience (Focht-Birkerts & Beardslee, 2000; Marsh & Lefley, 1996). But these are separate issues relating to psychological functioning – not psychological survival.

The legacy of trauma can facilitate a chameleon-like effect in the daily lives of ACOPSMI (described in Chapters 1 and 3). Research on ACOPSMI reflects just how possible it is to

socially function as a citizen and still be trauma-affected (e.g., see testimonies in Nathiel, 2007; Camden-Pratt, 2002).

Suicidality

Felitti, et al., (1998) suggests that adults who suffered early childhood adversity are at greater risk of death or physical injuries than the general population.

There appears to be a relationship between childhood abuse, household dysfunction, and adult suicide. Adults exposed to four or more adverse experiences in childhood were twelve times more likely to have attempted suicide than those who had no adverse experiences in childhood (Felitti, et al., 1998). Gilbert and colleagues (2009) conducted a meta-analysis of retrospective studies, in which participants' recollections of past traumatic events were recorded. They showed that consequences of child maltreatment in high-income countries show a strong association between child abuse and neglect and attempted suicide in adults. Many other studies point to similar connections between child maltreatment and risk of death via suicide attempts among youth and adults (Felitti, et al., 1998; Kinsella, et al., 1996; Lamont, 2010; Rossow & Lauritzen, 2001).

The above paints a grim picture and supports the view that traumatized children who survived into adulthood and function well socially may not necessarily come away unscathed.

Parentification

Conceptualised by Boszormenyi-Nagy and Spark (1973), "parentification" is a process in which, at the expense of their own developmental needs, children (younger than age eighteen), are expected to look after the very adults who are meant to take care of them.

55

Parentified individuals attend to physical and/or logistic necessities of their parents during childhood, involving inappropriate, high-level, adult responsibilities coupled with unrealistic expectations by younger children looking to older siblings (not their parents) for their needs to be met (Jeffreys, et al., 2011). The ACOPSMI literature reveals that many ACOPSMI were parentified (e.g., Bleuler, 1974; Dunn, 1993; Foster, 2006).

Despite the lack of empirical research on parentification (McMahon & Luthar, 2007), the weight of evidence appears to lean towards general agreement that when ACOPSMI were children they neglected their own needs as a result of parentification (Burdekin, et al., 1993; Jeffreys, et al., 2011; Jurkovic, 1997; Sivec, Waehler, Materson, & Pearson, 2007). A parentified child learns to "react by sacrificing his or her own needs for comfort and guidance and care for logistical, emotional, and self-esteem needs of the parents" (Chase, Deming, & Wells, 1998, p.105). To view oneself "as a person" (Shengold, 1999, p.110) may therefore be difficult for parentified ACOPSMI familiar with putting their own needs aside as children. ACOPSMI report that:

> *"as children, they felt they must be 'good', healthy and strong because the family already had many problems" (Sivec, et al., 2007, p.579).*

Contrary to previous findings (Aldridge, 2006; Shifren & Kachorek, 2003), Sahoo and Suar (2010) reveal that young carers report being mentally affected, expressing more needs and pressures than non-carers, with more negative than positive consequences. This finding is consistent with other research (e.g., see Jurkovic, 1997). Foster (2006) and Cousins (2004) note that some parentified ACOPSMI may have become 'martyred' to their parents' poor mental health while being raised by them. This type of upbringing is understood by E.M. Brown (1989) as "premature pressure" (p. 128) to assume grown-up emotional tasks. One ACOPSMI articulates this as:

> *"I grew up long before 'childhood' ended" (Camden-Pratt, 2002, p.94).*

Mentally ill parents can parentify their children (Huntsman, 2008; Jeffreys, et al., 2011). They do this by informally and persuasively recruiting them as a "need satisfying object" (Mudaly & Goddard, 2001, p.228) to fulfil their own perceived needs for care (Valleau, Raymond, & Horton, 1995). Children (irrespective of age) in this situation often have no voice or choice but to comply. This is because children must sacrifice and respond in socially desirable ways if they are to receive social approval from important adults (Sahoo & Suar, 2010).

Children who grow up with non-disordered parents and who are not parentified take for granted that they will receive attention from and have an emotional connection to their parents (C. Lewis, Bornstein, & Lamb, 2011; P. K. Smith, Cowie, & Blades, 2011). Parentified children, however, cannot take for granted but can only maintain hope of such attention from and connection to their parents (Jurkovic, Jessee, & Goglia, 1991), which sadly may not eventuate (Donald & Jureidini, 2004; Jeffreys, et al., 2011).

According to Bowlby (1977), care-giving constantly directed away from child to parent has the child growing up and inevitably associating care-giving (not care-receiving) with what a child-parent relationship is meant to feel like. It thus primes children for compulsive care-giving patterns of relating in adulthood. Bowlby (1977) states:

> *"the person showing [these patterns] may engage in many close relationships but always in the role of giving care, never that of receiving it [and] the person who develops in this way has found that the only affectional bond available is one in which he must always be the care-giver" (p. 207).*

A parentified individual risks losing "any ability to express need or ask for care, yet retains a pervasive, unsatisfied neediness and longing for care" (West & Keller, 1991, p.431).

Parentified individuals socially morph into false selves in the service of parents (R. A. Jones & Wells, 1996). Parentification is a hidden form of abuse and exploitation, and therefore traumatic as it represents "role corruption" (Garber, 2011).

Intergenerational Relevance

Early abuse can impact on personal distress and interpersonal relationships across generations (J. L. Davis & Petretic-Jackson, 2000). As far back as 1923, Canavan and Clark (1923) warned against focusing solely on the needs of one generation (parents) and ignoring the needs of the next generation (offspring).

The intergenerational transmission of childhood losses, trauma and grief often occurs with low awareness (Dixon, Browne, & Hamilton-Giachritsis, 2005; Dixon, Hamilton-Giachritsis, & Browne, 2005). For example, vulnerabilities such as shame can be perpetuated within families and transmitted unknowingly across generations (Furukawa & Hunt, 2011; Teyber, McClure, & Weathers, 2011).

Societal beliefs regarding the virtues of caring for parents with an SMI and social representations of the family unit (see Chapters 4 and 5) may be overlooking the emotionally loaded collective memory of past conflicts often passed on across generations, as in cases of war (Suleiman, 2006).

Most ACOPSMI do not want their legacies repeated (see for example, Camden-Pratt, 2002, 2006; Foster, 2006).

Economic Imperatives

To the extent that ACOPSMI potentially represent a physical and mental health resource burden due to early trauma, their plight must also be seen in economic terms. Not recognising the situation of ACOPSMI could be expensive for society. The large visible cost in terms of money spent is measurable according to mental health service budgets, medical expenses, and societal expenditures (e.g., see Bromfield, Holzer, & Lamont, 2011; Read et al., 2005). Yet the arguably larger invisible cost in terms of its emotional and psychological

toll on survivors is in many respects immeasurable (Cook, Blaustein, Spinazzola, & van der Kolk, 2003).

The economic effect of trauma may be seen in the context of government budgets and in the private sector, for example contributing to workplace absenteeism (Casey, Greenberg, Nicassio, Harpin, & Hubbard, 2008; Truchon et al., 2012). Living in tighter times means governments seek fiscally advantageous solutions. For example, in the counselling context, some may believe group work is more economical than one-to-one work (e.g., Ehly & Dustin, 1989). Due to resource restrictions, governments may perceive they cannot offer cradle-to-grave mental health support (Adams & Grieder, 2005; Miller-Perrin & Perrin, 2007). Resource allocation is often either crisis driven or associated with recovery needs of people who have become physically (Felitti, et al., 1998) or mentally ill (Maybery & Reupert, 2008). Yet, internationally, the impact of early life trauma is fast becoming an epidemiological mental-health headache (Lanius, et al., 2010).

The traumatic effects experienced by ACOPSMI are not confined to the personal but, in economic terms at least, impact on the larger public and private spheres.

Perhaps there is a need to consider more closely ACOPSMI in order to identify their needs, in order to make a more effective preventative response for economic reasons.

2.2 How are ACOPSMI perceived?

This section examines how ACOPSMI are perceived by their parents, and by researchers and policy makers. Research conclusions often lead to policy decisions; therefore how researchers view their target population may have policy effects on that population down the line.

ACOPSMI are often perceived by their parents according to those parents' needs. One study by Mowbray, Bybee, Oyserman, MacFarlane and Bowersox (2006) show parents with

an SMI viewing their adult offspring in positive terms if they are living in close proximity and have achieved a high level of education. But this study leaves out a trauma perspective. Living in close proximity may be more reflective of insecure mental representations of attachment to their parents and fear of intimacy (discussed later in this chapter), or a trauma response, such as traumatic bonding (detailed in Chapters 3). Preserving appearances of normality while disguising problems is common in all abusive families (J. L. Herman, 1992a); perhaps educational achievement may not be a reliable indicator of positive outcome for ACOPSMI carrying abuse histories.

Parents with an SMI cannot reliably report on the experiences of their offspring "because of their greater investment in the tie" (Birditt, Rott, & Fingerman, 2009, p.769). Such parental respondents "often answer questions in a way that portrays [themselves as parents] in a positive light" (Centre for Parenting and Research NSW Department of Community Services, 2005).

Using mentally ill parents as informants about children's needs is also problematic since they often deny or not recognise they have problems (Maybery & Reupert, 2006; Stallard, Norman, Huline-Dickens, Salter, & Cribb, 2004; Sturges, 1977). Using parents' views to research ACOPSMI may therefore be risky.

Researchers and policy makers often see ACOPSMI in binary ways. For example, they are either consumers (i.e., mentally ill themselves) or carers (of their parents) (Goodwin & Happell, 2007; Lammers & Happell, 2004) or potentially both.

Although there is a dearth of quantitative evidence relating to the experience of those offspring who do not themselves develop a disorder (Hansen, 2009), qualitative research portrays this population – irrespective of chronological age **–** in dichotomise terms. In childhood, they are either "good" or "bad" in terms of behaviour (a point argued in Chapter 4 regarding public policy). In adulthood, they are either on "good" or "bad" trajectories (e.g., criminal activities; see section 1.3). Viewing the ACOPSMI context in such black and white terms overlooks the far greyer areas of their unmet needs and trauma responses.

The gradual influx of Third Wave literature may be useful in reducing any dichotomized or skewed perception of ACOPSMI by adding first-person views to the mix. The increasing chorus of ACOPSMI voices heard through Third Wave literature may be a powerful self representation of their plight – particularly from ACOPSMI who are academics. Yet limits to these voices are reflected in the few studies exploring their needs (Knutsson-Medin, et al., 2007). ACOPSMI themselves not 'seeing' self as having needs, or their parents as problematic or abusive. There may be various trauma-based reasons some of which are: inadequate appreciation of the connectedness between their parents' mental illness and their own physical health in terms of stresses growing up and being dependent on their parent (Prince et al., 2007); perceived family preservation needs (Ford, 2009); misconstrued loyalties mixed with trauma (Ford, 2009; J. L. Herman, 1992a); self-imposed isolation "from a sense of humiliation or shame about their situation" (Dunn, 1993, p.186); and deep shame-by-association due to having a parent who may be stigmatized (G. Kauffman, 1989; H. B. Lewis, 1990; Nathanson, 1992).

Trauma research helps explain why socially competent ACOPSMI carrying childhood trauma manage to socially succeed like other survivors (J.L. Herman, 1992a, 1992b), such as child Holocaust survivors (M. Cohen, et al., 2001). However, "a later crisis or loss in adult life may unmask an underlying vulnerability that has been lurking beneath the apparently normal surface of their lives for years" (Bloom, 2002, p.7).

Ultimately, the question of "for who is the research valid and in whose interest is this claim to truth being made" (Winter, 2000, p.10) needs to be asked if trauma-based needs of the ACOPSMI population are to be met.

2.3 What might be their needs as adults?

The lives of many ACOPSMI were interrupted by the impact of early abuse and neglect. When they were children, ACOPSMI may have required professional intervention for their trauma-based needs (Riley et al., 2008), or counselling in adulthood (Cloitre, et al., 2006).

In this section the needs of ACOPSMI are explored with reference to attachment theory. Key issues include their need for human connection; how earlier parenting capacity and style of their parents may have influenced their needs; what might be their needs; and what happens if their needs remain unaddressed.

Assessing needs of traumatized individuals involves attachment theory (Bowlby, 1969, 1973, 1980), which is integral to the ACOPSMI need for human connection, and how parents' earlier parenting capacity influences current ACOPSMI needs.

The ACOPSMI need for human connection

"Attachment theory", created by psychologist, psychiatrist and psychoanalyst Bowlby (1969, 1973, 1977, 1980, 1983, 1985, 1988a, 1988b, 1999), offers a conceptual framework for identifying potential needs for all humans, and by extension ACOPSMI. The value of attachment as a construct goes beyond infants (J. G. Bremner & Wachs, 2010), to young adults (Bartholomew & Horowitz, 1991), and into old age (Cicirelli, 2010; Consedine & Magai, 2003).

While Bowlby (1969, 1973, 1977, 1980) illuminated the human experiences of attachment and loss, it was Ainsworth (Ainsworth, Blehar, Waters, & Wall, 1978) who first described children's relationship attachment styles. A variety of attachment styles have since been catalogued (Buchheim & Mergenthaler, 2000; Cassidy & Shaver, 2008).

The word "attachment" is synonymous with "relationship" because the foundational human connection begins when mother and infant have matching inner states or "affect attunement" (Stern, 1985). Babies are crucially dependent on this affect attunement. If this attunement is sufficiently successful, then it can lead to a "secure attachment" (Bowlby, 1969, 1973). This delicate, intimate, reciprocal relationship with parent is, for humans, a matter of life or death.

Simply put, secure attachment is generally associated with positive affect. According to studies, secure attachment is a key lifelong feature of relationships (Lyons-Ruth, Yellin, Melnick, & Atwood, 2005; Main & Hesse, 1990). By contrast, insecure attachment, in which infants do not get responsive, nurturing, consistent care, is generally associated with negative emotions (Mikulincer, 2008; Shaver & Mikulincer, 2006).

The notion of attachment appears simple and straightforward because usually parents cater to their offspring's needs instinctively, protecting and nurturing them (Shear et al., 2007) – yet it is also immensely profound. For example, in a study of 100 adolescents in South India by Azam and Kumar (2009), rejecting-style parenting led to increased likelihood of insecure attachment emerging than for adolescents of non-rejecting and accepting parents.

Evidence indicates that the legacy of trauma for many suffering adults, such as ACOPSMI, had their origins in childhood (van der Kolk, Roth, Pelcovitz & Mandel, 1994 cited in Blaustein & Kinniburgh, 2010; Cummins, et al., 2012) when frightening things happened at the hands of children's parental figures "with no buffer to protect" (Blaustein & Kinniburgh, 2010, p.4).

Parental mental illness can profoundly disrupt the fragile matching inner state and the developing relationship that ensues (Paul, 2010). Twin studies show how adversities resulting from an environment containing a parent with a mental illness can interact with other factors including traumatic attachment (E. Walker, Cudeck, Mednick, & Schulsinger, 1981).

More research is needed into the association between mentally ill parental attachments and the well-being of their offspring (Jeske, Bullinger, & Wiegand-Grefe, 2011). However, attachment theory and research does serve as a reliable bridge between infancy and adulthood (Tyano, Keren, Herrman, & Cox, 2010). As one ACOPSMI encapsulates:

> *"I wonder at our places of connection and disconnection" (Camden-Pratt, 2002, p.75).*

The unique pattern of early attachment (Ainsworth, et al., 1978) may be a significant factor for ACOPSMI. For instance, "ambivalent attachment", in which caregivers respond inconsistently and haphazardly – sometimes the child's needs are attended to, sometimes not – is associated with shame, including lack of self-confidence and high levels of sadness (Bartholomew & Horowitz, 1991; Massie & Szajnberg, 2006). Lack of early fulfilled needs is described by this ACOPSMI:

> "I've had to generate my own fuel [and] I've never felt I've had anybody behind me. I feel like I started with an empty tank" (Nathiel, 2007, p.173).

Rejection of the infant's overtures can lead to disruptions to their instinctive mental representations of self and others (Bretherton & Munholland, 2008). This mental representation or "working model" (Bowlby, 1973, p.236) helps infants understand and predict their environment for the sake of survival. It is the cornerstone of attachment theory. In the ACOPSMI context, such internal working models may translate into fear of intimacy:

> "Bottom line, I feared intimacy would lead to death [and] if I let someone in I might actually be killed – it wasn't that I just might die – I might be killed" (Camden, Pratt, 2002, p. 315).

The world and its inhabitants can no longer be reliable if parents are perceived as frightening, unreliable, hostile, dangerous or rejecting, as originally articulated by Bowlby (1969, 1973; 1977; 1980, 1988a) and other researchers (e.g., Reder & Duncan, 2001) including practitioners. For example, Secunda (1997) describes the terror of parents, as reported by her participants, as:

> "[t]he moment a parent leaves the real world and enters the world of madness, the child must enter that world as well because of his or her utter dependency on the parent" (p.43).

Attachment and fear are interrelated concepts. Parents with an SMI who may be "animated by unseen demons, reflecting back to the child not warmth or welcome but,

64

rather, emotional deadness or diabolical harshness" (Bloom, 2002, p.46) may be exerting a powerful influence upon the lives of their offspring who are witness to that. As one ACOPSMI testifies, "I have no positive memories of my mother from my childhood or indeed teenage years. Rather I remember how scared I was of her when she would come home" (Camden-Pratt, 2002, p.106). Some ACOPSMI may have a sense of fear mixed with abandonment and loss, as articulated by Nathiel's (2007) respondent: "I grew up not knowing if I was going to be here next week" (p.172).

Most children self-assign responsibility to themselves for events they are not responsible for (Gholson & Rosenthal, 1984) and frequently respond to even relatively minor threats by investing in their attachment relationships (Bowlby, 1988a). This implies that attachment needs may keep children – even after entering adulthood – in the position of *needing to* look after their parent (a point addressed in Chapters 3, 4 and 5).

Parenting capacity and style

Capacity and style of parenting by parents with an SMI may influence the brain development of their offspring – particularly if there is early stress, abuse and neglect associated with childhood trauma and adversity (Belsky & De Haan, 2011; De Bellis, 2010; Keverne, 2005; Teicher et al., 2010).

The following section attempts to address (1) parenting capacity, (2) type, severity, and chronicity of mental illness in parents, and (3) whether diagnosis or parenting style predicts parenting performance in relation to early childhood trauma and adversity.

Parenting capacity can be understood via Hetherington and colleagues' (2002) assertion that a parent should "respond, putting the child's needs first ahead of his or her own and whose view of the world is based on reality with appropriate concern – an adult capable of fun, enjoyment, content with themselves most of the time" (p.189). Donald and Jureidini

65

(2004) encapsulate this as "the parents' ability to empathically understand and give priority to their child's needs" (p.5).

Of the few scholars examining ACOPSMI needs, the tendency is to focus on parenting capacity and mental illness type. Focusing on parents with schizophrenia (Duncan & Browning, 2009) or psychosis (Dunn, 1993), while worthwhile, is also problematic for a range of scientific, social, historical, economic and political reasons (Cooksey & Brown, 1998; Faust & Miner, 1986; Parker, Georgaca, Harper, McLaughlin, & Stowell-Smith, 1995; Pilgrim, 2009; Pilgrim & Rogers, 2009; Prichard, 2006; Wakefield, 1992).

Diagnosis itself may not be a predictor of parenting performance but rather of parenting style (Jeffreys, et al., 2011). This may be a subtle but important difference whenever assessing the needs of ACOPSMI. For instance, bipolar disorder produces an inconsistent parenting style, making matters more difficult for children to understand or predict (Hansen, 2009; Mowbray, et al., 2006). Parents suffering from psychosis may unavoidably produce "terrorising attacks" (Anthony, 1986, p.326). This may erode trust in the individual towards their parent because of confusion (Dunn, 1993), as encapsulated by the following ACOPSMI:

> "Safety, security, trust were shattered [and] I was screaming for help but didn't know how or what for" (Marsh, 1994, p.123).

Parents can compromise the promotion of attachment security and healthy child development by either punishing or erratically reinforcing their children's natural attachment behaviours. Research confirms that parenting styles (associated with mental illness type) have a direct relationship with early childhood trauma and adversity. For example, Jeffreys and colleagues (2011) note "depression and borderline personality disorder were the most compromising of parenting capacity" (p.38), demonstrating that "[p]arents with borderline personality are 'high risk' parents [and] likely to be over-represented in child protection services" (p.44). This is confirmed by Newman and Stevenson (2005).

It is worth noting that some researchers believe that severity and chronicity of psychiatric symptoms are more important than diagnosis of SMI regarding parenting capacity (Mowbray, Oyserman, Bybee, & MacFarlane, 2002). Irrespective of mental-illness type and other elements, most mentally ill parents have a lack of motivation and an inability to engage (Bleuler, 1974; Jeffreys, et al., 2011; Sturges, 1977).

What happens if their needs are not addressed?

Needs are important. If they go unmet, trauma research warns that individuals engage in self-defeating behaviours, face poor health consequences, have poor life trajectories, and can even lead to suicide (Drake, Raucusin, & Murphy, 1990; Felitti, et al., 1998; Kinsella, et al., 1996; Mattejat & Remschmidt, 2008).

Yet some minimise the needs of children who would grow up to become ACOPSMI. They believe, with the exception of more serious cases involving child protection services, that their needs are simple and straightforward. For example, Aldridge (2006) believes the needs of children are "often relatively modest, even when parents have severe and enduring mental health problems" (p.86), and "[s]ometimes all that's needed is just a five-minute phone call" (p.87). Such views risk overlooking unfulfilled attachment needs causing insecurely attached offspring, still under the control of their parent, to persistently invest in the very person rejecting their attachment overtures (Bowlby, 1988a).

There appears to be no specific listing of what the trauma-induced needs of ACOPSMI might be. A new frontier for acknowledging and attending to their needs awaits detailed exploration. However, a variety of scholars address the needs of adults who were exposed to early childhood adversities (see for example, Courtois, 2010; Donald & Jureidini, 2004 ; Gold, 2000).

Bloom's (2000c) list of twelve needs in people who were abused during childhood may apply to many ACOPSMI carrying trauma histories. This is because of its pragmatic approach

without compromising complexity. Distilled and adapted for brevity, ACOPSMI may need to (1) recognise their (trauma-based) problems; (2) experience their grief; (3) give up formerly reliable coping skills; (4) allow themselves to attach to new, more functional attachments; (5) quit attachments that were highly pathological, dysfunctional, or toxic (including to parents); (6) give up fantasies of restoration or rescue that never comes, e.g., that amends will be made, loveless parents will turn into loving ones, innocence will be retrieved or other fantasies of restoration; (7) work with nonverbal self-expressions (e.g., story-telling, ritual, enactments, art and music) to help integrate the verbal with the nonverbal aspects of trauma safely; (8) develop social supports; (9) create meaning as trauma survivors; (10) work out historical reasons for such abuse and neglect in terms of its intergenerational component, including how it was precipitated and perpetuated; (11) become involved in the process of emancipation via the grief process; and (12) transform the pain into something of personal value and of value to others.

It would be important to note that the needs of ACOPSMI may not be straightforward. For instance, losses may include estrangement (e.g., Lachenmeyer, 2000) which might come with its own set of needs (Agllias, 2011; Dattilio & Nichols, 2011; Garber, 2011).

Needs should not be confused with pathology. Although some consider that a relationship exists between trauma narratives and trauma pathology (Amir, Stafford, Freshman, & Foa, 1998), narratives coming from ACOPSMI clearly spell out trauma (see for example, Camden-Pratt, 2002; Nathiel, 2007; Slominski, 2010). This does not necessarily lead to trauma pathology but often leads to needs (Bloom, 2002).

The phenomena of trauma and grief in ACOPSMI are addressed in the next chapter, where it may become clearer that meeting the above needs is likely to go beyond "just a five-minute phone call" (Aldridge, 2006, p.87).

Chapter 3: Trauma

This chapter builds a case for utilising concepts of trauma to better inform interventions for ACOPSMI. It aims to strengthen the conceptual understanding of this population and provide a logical foundation for critiquing contemporary policy (in Chapter 4), and practice (in Chapter 5).

Trauma and its common features are examined as are specific characteristics relating to trauma's universal pathways. Additional features of the effects of trauma include: time delay of trauma awareness and the ACOPSMI need for psychological distance from their parents. A justification is given for the use of a trauma-informed perspective in the population studied. Other elements involved in trauma are offered, including shame, and how professional achievements potentially conceal trauma's effects. The potential 'collective identity' of ACOPSMI is briefly explored before examining some grief principles and concepts that may apply to them. The neurobiological trauma framework addressed in this chapter (see 3.2) is augmented by existentialism as an alternative theoretical framework suitable for thinking about the lives of ACOPSMI.

3.1 What is trauma?

This section discusses the definition of trauma and some of the common characteristics and effects of trauma. It is beyond the scope of this chapter to cover the extensive trauma literature which began in 1889 with Janet and continues to this day (e.g., Dorahy, van der Hart, & Middleton, 2010).

The definitions of trauma vary (Courtois, 2010). Terr (1991) proposes two primary forms of trauma: type I and type II. Type I results from sudden, one-off occurrences, e.g., earthquake, bushfire, car accident. Such events are unanticipated, causing acute stress reactions, and are usually resolvable with supportive emotional processing over time. Type

II is not one-off but a phenomenon made up of repetitive, prolonged, cumulative exposure to multiple traumatic stressors, usually of an interpersonal nature and in a range of situations and roles with intermittent escalations. Type II trauma results from the actions of people, not natural disasters. Embedded in abuse histories, it often involves abandonment or harm by primary caregivers and presents a persistent, long-term challenge to adult health, involving various chronic physical diseases (detailed in Chapter 2) which can lead to early death (Felitti & Anda, 2010; Felitti, et al., 1998; Scott-Storey, 2011).

Other interchangeable terms for type II trauma may include "sequential traumatisation", coined by Keilson (1979, translated from the German and cited in van Ijzendoorn, Bakermans-Kranenburg, & Sagi-Schwartz, 2003); combined or cumulative trauma understood as "poly-victimization" (Finkelhor, Ormrod, & Turner, 2007); and "complex trauma" (Cook, et al., 2003). For ease of reading in this thesis, the term "trauma" hereafter refers to type II trauma or its equivalents.

Because trauma for ACOPSMI often relates to interpersonal abuse (J.L. Herman, 1992a) by parents, as detailed in Chapter 2, type II trauma, as defined by Terr (1991), has been chosen for this thesis.

According to Ford (2009), type II trauma is "more prevalent than typically recognised (i.e., affecting as many as one in seven to one in ten children)" (p.18). Such harm occurs at developmentally vulnerable points in a survivor's life, particularly during their childhood when they needed to trust their parents for survival (Courtois & Ford, 2009b; Freyd, 1996).

Although some of the effects of childhood trauma in adulthood are treatable and preventable (Read et al., 2005), the younger the survivor, the greater the potential for trauma's harmful effects (Kestenberg & Kahn, 1998). Type II trauma may take a long time to heal, as encapsulated by one ACOPSMI:

> *"I've still got frustrations and angry moments about not having had a mother and a normal childhood and not being able to play [so] healing is still going on. It's not over yet" (Camden-Pratt, 2002, p.330).*

70

Although many adults suffer early childhood maltreatment (Reder & Duncan, 2001), within the ACOPSMI context, harm by a parent with an SMI is often unintentional (R. Gilbert, et al., 2009). Astrachan and colleagues' (2010) understanding of the impact of trauma may therefore apply to the ACOPSMI context:

> *"the psychological effects of early life trauma require attention not only to what happened to the survivor but also to what did not happen. Early life trauma involves prolonged, recurring abuse, which is generally coupled with neglect" (p.295).*

This description complements Glaser's (2011) notion of emotional abuse and neglect, and Gilbert and colleagues' (2009) notion of maltreatment:

> *"[a]ny act of commission or omission by a parent or other caregiver that results in harm, potential for harm, or threat of harm to a child [including] [f]ailure to meet a child's basic physical, emotional, medical/dental, or educational needs; failure to provide adequate nutrition, hygiene, or shelter; or failure to ensure a child's safety" (p.69).*

Trauma's universal path

The complexity of trauma effects lies in its chronicity, origins, impact and occurrence with or without internal and external resources, within different contexts according to culture, community and family, and at various developmental stages (Blaustein & Kinniburgh, 2010). It occurs in different situations, circumstances, and frequencies (Lanius, et al., 2010). Although the long-term impact of trauma is rarely direct or linear (Starr, MacLean, & Keating, 1991), the effects of type II trauma do not discriminate according to specific trauma experienced. This is because the effects of trauma impact on victims in similar ways – even if not linear – across the board. As Brom and Kleber (2000) observe, trauma experiences are:

> *"normal responses to severely distressing events [which] follow a universal path" (p.48).*

71

It is appropriate to borrow trauma concepts across disparate groups to develop insights into trauma-based needs of adults surviving childhood trauma experiences – irrespective of context or history. This is not radical but anticipated by trauma literature (Brom & Kleber, 2000; E. B. Carlson, 1996; Danieli, Brom, & Sills, 2005; Duckworth & Follette, 2012; J. L. Herman, 1992a, 1992b; Kleber, et al., 1992; Kleber, Figley, & Gersons, 1995; Valent, 1998).

Investigations of adults who as children survived childhood trauma relate to stresses associated with sexual abuse (Courtois, 2010; J. E. Davis, 2005; Freyd, 1996; Warner, 2009) or the Holocaust (Durst, 2003; Sagi-Schwartz, et al., 2003; Witztum & Malkinson, 2009) may offer precedents for studying childhood trauma across the lifespan in similar but understudied populations, such as ACOPSMI. For example, in writing about incest, Courtois (2010) notes how "lack of empathy in the context of abuse is itself trauma inducing" (p.250-251). ACOPSMI may have witnessed overwhelming experiences devoid of empathy:

> *"The mad things that I was in, witnessed and participated in indirectly had such potency – such power" (Camden-Pratt, 2002, p.318-319).*

Trauma theorist and psychiatrist J.L. Herman (1992a) unifies divergent bodies of studies and experiential accounts. Her clinical work and two decades of research from her earlier studies on incest and borderline personality disordered people illustrate how cross-group comparisons are not only possible but necessary to deepen understanding of trauma's impact. J.L. Herman (1992b) also draws similarities between combat veterans, victims of political terror, domestic violence, survivors of concentration camps and sexual abuse reflected via case vignettes. J.L. Herman's (1992a) case studies illustrate how trauma goes undetected in the lives of traumatised adults. Survivors' endure traumatic events and "suffer predictable psychological harm" (p.3). J.L. Herman (1992b) states:

"prolonged, repeated trauma can occur only where the victim is in a state of captivity, unable to flee, and under the control of the perpetrator. Examples of such conditions include prisons, concentration camps, and slave labor camps. Such conditions also exist in some religious cults, in brothels and other institutions of organized sexual exploitation, and in some families. Captivity, which brings the victim into prolonged contact with the perpetrator, creates a special type of relationship, one of coercive control. This is equally true whether the victim is rendered captive primarily by physical force (as in the case of prisoners and hostages), or by a combination of physical, economic, social, and psychological means (as in the case of religious cult members, battered women, and abused children)" (p.377-388).

For some ACOPSMI with type II trauma histories, the tormenting presence of their parent may not have lost its power since their childhood. Psychiatrist Shengold (1989, 1999), discusses parallels between treatment meted out to inmates of concentration camps and that of child maltreatment in the context of childhood parental absence, neglect and abuse. Shengold (1999) observes how:

"every child is so dependent that tyranny and oppression by a sadistic parent are easily possible. Much can be learned from the experiences of those who have survived the concentration camp that is applicable to the child victims of abuse by parents and parent substitutes" (p.97-98).

Persecution is a common metaphor seen peppered throughout Third Wave literature. For instance, M. Walker (1992) views parents of ACOPSMI as equivalent to 'persecutors' because:

"The very people who should protect them are their persecutors. There is nobody to turn to [and their] pain gives us only a hint of the magnitude of the suffering" (p. 62).

73

As discussed in Chapter 2, assessing the needs of ACOPSMI with trauma histories involves attachment theory (Bowlby, 1969, 1973,1980), which is integral to the ACOPSMI need for human connection, as encapsulated by Shengold (1999):

"The child who was once abused must learn both to remember and to love" (p.109).

A trauma-informed approach may enable prediction of future problems or hazards, such as parentified ACOPSMI readily slipping into the role of carer for parents. As carriers of untreated type II trauma, they may have little conscious choice at their disposal (discussed in Chapters 4 and 5). For instance, Shengold (1989) addresses early emotional abuse as causing abused adults to go to great lengths to preserve "the delusion of good parents" (p.26).

In a similar vein, J.L. Herman (1992b) discusses "hostages, who come to view their captors as their saviors and to fear and hate their rescuers" (p.384). In the ACOPSMI context, such "rescuers" may be child protection workers, a relative or neighbour. One ACOPSMI described loyalty to their parent with an SMI as "hellish at times" (Dunn, 1993, p.182). Rather than fleeing, ACOPSMI loyal to their parents may remain as "captives" unable to leave (J.L. Herman, 1992b). This may be because people with insecure attachments frequently respond to even relatively minor threats by investing in the very relationship that generates threats in the first place (Bowlby, 1988a).

When ACOPSMI reflect back to their childhood and remember their parent's psychological decay, it "can feel as though they've been hit by a sledge-hammer" (Secunda, 1997, p.48). This may be because their early emotional experiences with their attachment figure may be "comparable to or even greater than the stress of divorce and death" (Sturges, 1977, p.90). It would therefore be important to know more about the features of such traumatic stresses.

Common characteristics of the effects of trauma

The list of conventional trauma features recognised in other parallel trauma groups is exhaustive (see for example, Courtois & Ford, 2009b; Horowitz, Wilner, & Alvarez, 1979; Loewenstein & Welzant, 2010). However, universally recognised trauma features potentially applicable to the ACOPSMI context are: dissociation, intrusions, flashbacks and triggers, traumatic stress, traumatic bonding, and avoidance of remembering maltreatments.

Dissociation

Dissociation, a term arising from psychoanalytic theory in the early 1900s, is an integral part of trauma literature, and means separating oneself psychologically, emotionally or physically from the traumatic event or events. It occurs without awareness or control and is defined by Kezelman and Stavropoulos (2012) as:

> *"the act of disconnection from immediate experience [which] operates on a continuum from mild to severe. Because serving a protective function as a defence against overwhelming threat, it is commonly present to varying degrees as a dimension of trauma" (p.97).*

Dissociation can include not always feeling completely present in one's body or surroundings, or sometimes losing track of time (J. L. Herman, 1992a; Vermetten, Dorahy, & Spiegel, 2007). Individuals do this by disengaging from their immediate surroundings (Dell & O'Neil, 2009; Dorahy & Huntjens, 2007). As one ACOPSMI puts it:

> *"I have to pat myself all over and check myself to see if I'm still in my body" (Secunda, 1997, p.48).*

Behaviours can include denial and avoidance (Courtois, 2010). *"Denial* can be not so much a blatant disregard for what is [but rather] a feverish attempt *not to reexperience what was*" (Secunda, 1997, p.51; italics in original).

Putnam (1997) notes that dissociation functions as a primary coping mechanism for children trapped in inescapable distress. The experience of traumatic loss in infancy and early childhood often sits alongside specific trauma-anchored experiences fostered in the child by frightening or frightened caregiving (Newman & Stevenson, 2005). As children, ACOPSMI often had no choice when entering their parent's mental state:

> *"But unlike the parent, the child has not lost touch with reality, and cannot escape it; rather, the child absorbs it with punishing acuity" (Secunda, 1997, p.43).*

Children can engage with play while simultaneously dissociating (Bacciagaluppi, 2011; Chae, Goodman, Eisen, & Qin, 2011). Adults can dissociate in complex or more extreme ways as detailed in Middleton and Butler's (1998) research through to more simple levels manifested as "day-dreaming and mild trancing" (Kezelman & Stavropoulos, 2012, p.132). In attempting to control their trauma some ACOPSMI may disengage using dissociation as a trauma-response strategy. One ACOPSMI demonstrates this in terms of:

> *"believing things are going to be there when I need them - people, other supports. I detach from things before they get out of hand [it is] automatic shutdown"(Nathiel, 2007, p.171).*

Dissociation is reframed from the pathological tone of psychoanalytic theory to be seen in trauma theory as initially a functional strategy. This functional strategy can persist long after it ceases to be of any functional use. When it does continue unnecessarily, it can be treated by a trauma-informed practitioner (Courtois & Ford, 2009).

Intrusions (or flashbacks) and triggers

Victims of trauma re-experience traumatic events in multisensory ways. Intrusions (or flashbacks) are defined as "[i]ntrusive and disturbing memories in the form of images and/or sensory inputs which are indicators of unprocessed traumatic experience" (Kezelman & Stavropoulos, 2012, p.176). Triggers are activated on a physiological level. They engage on cue according to a perceived threat. Even when no threat is apparent, triggers can be set off. Formed by habit, triggers become devices alerting the traumatised to self-protect (Ogden, et al., 2006). Intrusions and triggers occur when a "surge of emotions and images [emerge] that directly or indirectly imply the reexperiencing of the event" (Kleber, et al., 1992, p.22).

> *"The fear just put me down into my little child. I felt the little victim very much. That was the hardest thing to give up... it'll probably take me a few years to integrate those experiences" (Camden-Pratt, 2002, p.329).*

When trauma memories trick the brain via such intrusions, the person thinks they are back with the original trauma. Trauma-informed counselling helps individuals detect triggers causing flashbacks and to remember without reacting or reliving trauma (Cloitre, et al., 2006; Ford, 2009; Gold, 2000). One of Camden-Pratt's (2002) ACOPSMI respondents demonstrates this when she was able to remember without reliving her trauma:

> *"I can feel fear and not lose myself" (p.329).*

Although triggers occur without the person experiencing the trigger realizing it, any damage they might cause can only be known in retrospect. That is, it might be only acknowledgeable once the triggered behaviour or thought subsides, and the traumatised person is able to reflect back on it. Processing a trigger may be enabled by another person who either witnessed the trigger or hears of the triggering experience as narrated retrospectively by the individual (Cloitre, et al., 2006).

77

Traumatic stress

A traumatic stressor is "non-normative, exceed[ing] the individual's perceived ability to meet its demands, and disrupts the individual's frame of reference [and] psychological needs" (McCann & Pearlman, 1990, p.10). ACOPSMI may say:

"I feel like I'm coming apart" (Secunda, 1997, p.48).

In its diagnostic description of traumatic stress, the DSM-IV-TR (American Psychiatric Association, 2000) includes subjective elements such as "intense, overwhelming, and intolerable reactions of fear, helplessness, or horror feelings" (p.424). In relation to this, a treating psychiatrist describes such childhood exposures by ACOPSMI as living "in a nightmare world you can't get away from" (Secunda, 1997, p.42). Traumatic stress reactions are natural behaviours to unnatural, unexpected events (Courtois, 2010). Fear and horror can be seen in one ACOPSMI describing her parent's "grotesque deformity, a rapid dissolve from Jekyll to Hyde" (Secunda, 1997, p.49). According to Secunda (1997), ACOPSMI "feel enormous helplessness" (p.43). Her direct descriptions reveal reactions of intense fear and overwhelming horror described by one ACOPSMI who recalls a parent's behaviour as "toppled from gracious benevolence to howling madness – "totally crazed" (p.48). Another ACOPSMI faced their parent's "deathlike trances" (p.47).

Traumatic bonding and avoidance of remembering maltreatment

The notion of traumatic bonding is derived from trauma, exploitation and victimization literature describing puzzling emotional and attachment features between abuser and the abused (Courtois, 2010). It is a relationship between two people, with intense feelings of attachment to each other, involving cognitive distortions and behaviours that serve to maintain and reinforce the dysfunctional bond. Typically one has more power than the other, (such as between adult and child). The concept of traumatic bonding is applicable in

cases of maltreatment more broadly. It goes beyond the emotional tie to behavioural strategies of both perpetrator and victim, involving cognitive distortions which reinforce the emotional connection however unintentional (deYoung & Lowry, 1992).

Traumatic bonding is identifiable within the context of threat and violence in a range of victimizations (e.g., hostages, cults, incest) and in all forms of family abuse – particularly if any attachment is at risk and when substantial duration is involved. Traumatic bonding may be confusing because it may include "loving attention as reinforcement of the bonding, as part of or interspersed with the abusive and fear-inducing acts" (Courtois, 2010, p.67). Traumatic bonding is a destructive process and ought not to be confused with love (J. L. Herman, 1992a; Kahn, 2006; Rees, 2010b). It may be an important trauma concept for ACOPSMI for the following reasons.

Since traumatic bonding is about the inherently unequal power between those in need (offspring) and those fulfilling attachment needs (parents), this power differential (Davis, 2005) may reinforce and generate various forms of abuse resulting in type II trauma. This is because parents have greater authority and power over their child's high dependency and attachment needs which can continue into adulthood (J. L. Herman, 1992b; Warner, 2009). The close proximity that parentification of children, i.e., young carers of parents with an SMI, affords may facilitate or promote traumatic bonding, as maltreatment can occur irrespective of any *intent* to harm (deYoung & Lowry, 1992; R. Gilbert, et al., 2009). Because acts of omission are typically found in ACOPSMI histories of child maltreatment (Myers et al., 2002), and deliberate negligence is uncommon (Dubowitz & Bennett, 2007), tracking traumatic bonding may be challenging.

This trauma concept may have value in explaining some of the confusion around ACOPSMI carrying type II trauma yet taking on carer roles for their parents who may be the cause, albeit unintentionally, of their early childhood maltreatment (a point argued in Chapter 4).

Dissociation may lead many traumatised individuals to become used to not remembering maltreatment (Freyd, 1996). For ACOPSMI, this may reinforce the traumatic

79

bonding process. For example, over half of Brown's (1994) ACOPSMI subjects forgot or chose to block out memories of emotionally painful events which occurred during their childhood. They did this to protect themselves. One individual states "I think a lot of weird incidents occurred, and I just choose not to remember them" (p.182). Adult attachment research is powerful enough to predict avoidance of memories of maltreatment (P. C. Alexander, 1993, 2012).

Additional features of the effects of trauma

Two additional features distilled from experiential accounts, attachment theory and trauma research may apply to ACOPSMI: (1) time delay of trauma awareness; and (2) a need for psychological and emotional distance from their parents.

The above two characteristics require an appreciation of attachment theory (Bowlby, 1988a; 1988b) – a theoretical concept discussed in Chapter 2. Results from longitudinal studies and clinical observations by Szajnberg and colleagues (2010) reveal that early adverse experiences are a most profound form of trauma, representing "attacks by someone from whom the dependent child expects protection and caring" (p. 33). That is, their primary attachment figures. Additionally, the offspring of parents with an SMI, whether children or adults, may find it necessary to remain unaware in pursuit of more pressing emotional, psychological and physical survival needs (whether real or symbolic) from their attachment figure such as food, love and shelter (Freyd, 1996, 2009).

Time delay of trauma awareness

Like a 'time-bomb', cumulative trauma reactions are delayed for reasons only trauma research may have the capacity to explain. Results from longitudinal studies and clinical

observations confirm that trauma takes a long time to surface and is then carried forth across the lifespan (Felitti & Anda, 2010; Szajnberg, et al., 2010). Slominski's (2010) longitudinal study reveals "even at age 40, experiences with parental mental illness during childhood can play a salient role in the lives of offspring" (p.138).

Developmentally there is a cognitive time lag in engaging with the emotional demands of grief as a result of trauma-based losses during childhood (Berrick & Gilbert, 1991). Therefore, as with child Holocaust survivors (Fohn & Heenen-Wolff, 2011), researching ACOPSMI retrospectively (as opposed to researching young children) may be a more fruitful pathway to understanding age-specific needs for this population. As one ACOPSMI observes:

> "All the post stress stuff has come out in the last few years. I mean I never experienced that as a child" (Camden-Pratt, 2002, p.329).

ACOPSMI may only be capable of becoming aware of their childhood losses once they enter adulthood. ACOPSMI are often mature adults before seeking counselling (Stevenson, 2002). Loss that comes about when an attachment figure is physically present but psychologically and emotionally absent may explain delayed trauma and grief:

> "I didn't start even consciously acknowledging that my mother was different until I was in my forties. When it's deep and you hold it and you keep it down, it stays in there" (Camden-Pratt, 2006, Dedication page).

Two other factors may contribute to time delay in trauma awareness by ACOPSMI: unspoken pressures from parents with an SMI in parentification cases (detailed in Chapter 2), and government-approved, family-focused interventions where the needs of parents with an SMI are given priority over the needs of their traumatised offspring (Goodwin & Happell, 2007).

A need for psychological and emotional distance from their parents with an SMI

Psychological distance is not the same as spatial distance. During their childhood, ACOPSMI may have preferred to keep a safe distance from their parent as encapsulated by Jeffreys and colleagues' (2011) research:

> "[i]f mum's not having a good day they'll tend to give her a wide berth, they'll interact, but distantly" (p.26).

This "wide berth" may begin spatially in the physical sense, but may then progress to the psychological. For example, individuals, regardless of age, have been observed to express relief when their parent physically dies (Camden-Pratt, 2002).

As confirmed in Anthony (1974, 1986), Anthony and Cohler's (1987) research, and in findings from Bleuler's (1974) 20-year intergenerational study, this "wide berth" may be more than just about physical distance. It may act as a psychological distancing device that provides psychological and emotional safety. That is, a mechanism that defends ACOPSMI against their experiences of their parent's behaviours. It may occur to preserve their mental health by preventing further distress. Such a strategy could be likened to dissociation (described earlier) – a coping mechanism persisting until something better can replace it. The risk of the offspring remaining emotionally and psychologically attached to families where parents are abusive is asserted by Gold's (2000) trauma research.

Bleuler (1974), Anthony (1974, 1986), and Anthony and Cohler's (1987) research also confirm that those offspring who do maintain a safe psychological and emotional distance from abusive parents fare better in life than those who do not. Such findings remain valid some four decades later. They uncannily concur with current research. New Australian national guidelines on treatment of trauma state that client psychological and emotional safety must, above all, occur "to the fullest extent possible" (Kezelman & Stavropoulos, 2012, p.41).

82

A separate and authentic sense of self in adulthood (Karpel, 1976 cited in Chase, et al., 1998) directly links to fundamental developmental human needs (Chenoweth, 1994). If ACOPSMI are not able to maintain psychological distance from their parents, then this may reflect difficulties in the separation-individuation process which often continues even when individuals no longer live in a dysfunctional parental household (Kins, Soenens, & Beyers, 2011).

This aforementioned need for psychological distance may begin with spatial distancing or a physical "wide berth" (Jeffreys, et al., 2011, p.26) before being transformed into a need to psychologically separate, cut off (Briere, 1992) or "amputate" – a notion communicated within bereavement (Parkes, 1975) and Third Wave literature. For example, E.M. Brown (1989) refers to having a need to "psychologically amputate parts of yourself to survive" (p.18).

Various ACOPSMI research participants report cutting off from their parents (Kinsella, et al., 1996). As Camden-Pratt's (2006) research respondent states "I learned to cut off to survive" (p.88). Camden-Pratt (2002) describes this challenge to both cut off and maintain normality for psychological survival:

> *"the individual knows she does not belong [and that this feeling] necessitates an amputation of daily lived experience if belonging is to be bestowed by those considered 'normal' (p.150-151).*

According to M. Walker (1992):

> *"final acceptance of losses [for abused individuals] is often marked by psychological and physical separation [i.e. cutting off] from their abuser. If this is a parent, separation is not straightforward because home is not a safe spring-board into an adult world or a secure base to retreat to if difficulties arise" (p.194).*

Cutting off to survive may well be a normal reaction to an abnormal situation (Courtois, 2010). But it may occur at the risk of being misunderstood. For example, the need to cut off

83

can lead some practitioners to erroneously believe that it is a dissociative symptom (an earlier described trauma concept) expressed by the individual (ACOPMI) that is problematic. However, the need to cut off may be more concrete; that is, a need to simply cut off from the very person causing the pain (parent). Simply put, cutting off may be emblematic of what lies underneath – a straightforward need to self-protect by moving away from that which brings harm (J.L. Herman, 1992a).

In sum, the features and characteristics of trauma are vast and rich in their implications for the ACOPSMI population. ACOPSMI not mentally ill may become physically ill if they do not receive trauma-informed acknowledgement and treatment for the impact of type II trauma. Borrowing trauma concepts from across disparate groups – irrespective of context or history – is legitimate. Such divergent bodies of studies greatly assist the critical development of insights into trauma-based needs of ACOPSMI. Common trauma features and characteristics of other groups opens the gate towards a much richer interogation of the needs of this understudied population. However, there are additional reasons for using a trauma-informed approach for ACOPSMI.

3.2 Why use a trauma-informed perspective for ACOPSMI?

ACOPSMI have not been adequately considered in light of a trauma-informed perspective. Yet it can be demonstrated that use of a trauma-informed approach for ACOPSMI is not only important historically but also scientifically. Neuroscientific research supports Third Wave literature. ACOPSMI use of "war" as metaphor to describe their internal experiences has been given substance by recent neuroscientific findings showing similarities in the physical impact of war combatants and survivors of abuse and neglect. This has strong implications for policy and practice as the following section explains.

Many ACOPSMI have type II trauma histories (as evident in the ACOPSMI stories introduced in Chapter 2). Empirical studies are replete with descriptive evidence of trauma

84

for this population. For example, children and adolescents of mentally-ill parents experience trauma and grief effects that often manifest as "fear, loneliness, loss and sorrow" (Trondsen, 2012, p.174). Citing 12 authors from six different countries, Bleuler (1974) observed:

> *"Many children of [parents with schizophrenia] have atrocious childhoods [and] suffer at the hands of their psychotic parents [with] ample evidence of the wretched conditions [and] the horror and misery they have experienced in childhood" (p. 105-106).*

As far back as 1923, a trauma perspective is supported historically. Using the language of the day, Canavan and Clark described children of parents with an SMI as "seclusive", "feebleminded" or with "nervous hearts" (p.141). Research on trauma symptomatology shows how withdrawal (i.e. being "seclusive"), lack of confidence and self-esteem (i.e. being "feebleminded"), and having problems with the heart's condition (i.e. "nervous hearts") are indeed trauma features (J. L. Herman, 1992a; Lanius, et al., 2010).

Perhaps the internalized trauma legacy of competent, non-disordered ACOPSMI may be of less interest to scholars. However, as substantiated by research, ACOPSMI continue to be affected – despite outwardly normal disposition and successful working lives.

Traumatised individuals are capable of appearing functional (J.L. Herman, 1992a). And a diagnosis is not always a prerequisite for trauma as a result of abuse and neglect (Bleuler, 1974). Nevertheless, Rutter and Quinton's (1984) seminal study of 137 families over four years (where parents with an SMI were engaged in psychiatric treatment) report a third of children experienced no emotional or behavioural problems, one third experienced some transient psychiatric issues, while another third experienced more long-term, serious adjustment issues. Their study focused on *outward signs* of problems – not inward signs of traumatic stress, which according to J.L. Herman (1992a) are rarely traced to their origins. There is epidemological evidence that shows a link between early adversity and tendencies towards later poor physical health (Felitti, et al., 1998) due to the disruptive impacts of prolonged toxic stress (Shonkoff & Garner, 2012).

85

Nevertheless, to the best knowledge of this author, using trauma as a way of understanding ACOPSMI has not been tested. Trauma as a theme is rarely found in the ACOPSMI literature. It is not mentioned in Bleuler's (1974) study of 184 children of subjects diagnosed with schizophrenia, nor in Jeffreys and colleagues' (2011) research on prevalence of parental mental health disorders in the context of child protection. Its absence is also noticeable in international studies (e.g., Oskouie, Zeighami, & Joolaee, 2011).

Despite Brown's (1994) aim to "increase the psychological community's awareness of the plight of offspring of [parents with schizophrenia]" (p.8), trauma is not mentioned in this qualitative study exploring and describing the lived experiences of 21 ACOPSMI. Yet their family-of-origin home environments are described by M.J. Brown (1994) as chaotic with an atmosphere filled with domestic disruptions, abuse, neglect, and social isolation. Furthermore, M.J. Brown (1994) suggests ACOPSMI experiences can be understood as normal reactions to clearly abnormal situations – which in effect is the universal understanding of what trauma is (e.g., see Courtois, 2010).

Murphy, Peters, Jackson and Wilkes (2011) carried out a qualitative meta-synthesis on the experiences of adult children of parents with a mental illness. These experiences were collated into 26 themes, again trauma is an absent theme despite trauma descriptions, e.g., "emotional blocking" (p.3438), found in several of the studies in the meta-synthesis.

Neuroscientific research supports a trauma perspective for diverse populations exposed to the effects of trauma. For example, McCrory, et al., (2011) investigated the brain activity of two groups: children who had been exposed to documented violence at home, and studies of psychiatrically healthy soldiers exposed to combat. They did this by reviewing files from previous scientific research on maltreated children, and by using functional magnetic resonance imaging (fMRI, a procedure detecting blood flow changes to measure brain activity) studies of prolonged experience of stress and exposure to environmental threat of these two groups. They observed that the brain's response to angry faces in individuals who were abused as children were similar to the response in the brains of psychiatrically healthy soldiers exposed to combat. They concluded that children exposed to family violence (with

normative levels of anxiety) become increasingly vigilant to possible sources of threat, as do soldiers in combat.

McCrory and colleagues' (2011) findings give substance to experiential accounts of ACOPSMI who use "war" as metaphor to describe their internal experiences. For example, Nathiel (2007) refers to storytelling as "pieces of history emerging as "old shrapnel" (p. xvi), Foster (2006) writes "even now it's a battle sometimes" (p.18). One of Nathiel's (2007) respondents articulates (in their own idiosyncratic verbal style) their anguish involving a sense of being "killed" by a parent with SMI:

> *"you killed me each time you denied my pain each tear you did not see was one of millions of deaths my many deaths at your hands....i died before your eyes it was as if you did not see me at all" (p.175).*

In summary, a trauma-informed perspective adds to any practice, policy, theoretical or research approach used for traumatised populations (Kezelman & Stavropoulos, 2012). Importantly, a trauma-informed approach may help prevent denial of trauma as a phenomenon among researchers themselves, and overcome tricky emotional and ethical aspects of conducting research involving populations carrying trauma histories (Armstrong, 1996).

Shame and trauma

Lives are powerfully shaped by trauma, especially when mixed with shame. Foster (2006) refers to shame as a "long-suppressed" feeling (p.34). Shame is defined by Morrison (2011) as:

> *"a painful burden that permeates the whole body and envelops one's complete sense of self". It is, perhaps, the most agonizing of human emotions in that it reduces us each in stature, size, and self-esteem, such that we wish to disappear, to sink into the ground" (p.23).*

Humiliation and shame emerged in Dunn's (1993) study on ACOPSMI. And 48% of Brown's (1994) ACOPSMI subjects spoke of "shame/embarrassment" (p. 167). Bleuler (1974) observed shame among the 143 ACOPSMI respondents in his longitudinal research:

> "All too often [ACOPSMI] remain silent about their sufferings, and can seldom be motivated to discuss them. Even after they are grown, they much prefer to keep to themselves all the horrors of the past. Somehow they consider it a disgrace to have suffered so much misery at the hands of their own parents" (p.104-105).

Shame is a very important emotional component of the trauma response and may inhibit treatment-seeking behaviour (Bratton, 2010).

Professional achievements potentially conceal trauma's effects

Coping via professional achievements conceals rather than reveals trauma-based needs. Morrison (2011) observes the concealment of shame as human nature, with individuals going:

> "to great extremes to overcome those shortcomings that lead to shame. If we can't hide, we attempt to change the very attributes that have caused this distress" (p.23).

What better way to change the very attributes that have caused this distress than to create an identity that speaks of order rather than chaos – a familiar home-of-origin atmosphere for adult child abuse survivors (M. J. Brown, 1994; Gold, 2000). ACOPSMI readily create identities as professionals, such as doctors (Nathiel, 2007), physicists (Blizard, 2008), researchers (Foster, 2010), and social workers (Burdekin, et al., 1993). A professional identity can serve to conceal pain by facilitating avoidance rather than processing the pain itself via trauma-informed care (Kezelman & Stavropoulos, 2012). Reports one ACOPSMI:

"College enabled me to have a new identity, where I would not be constantly reminded of my depressing family" (Marsh, Appleby, Dickens, Owens, & Young, 1993, p.28)

ACOPSMI might not be able to "step out" of their trauma via professional careers (Rengstorff, 1992) without trauma-informed support (Jennings, 2004). However, ACOPSMI and former Western Australia director of social work told the Burdekin Report (1993):

"[a]s an adult, you remain damaged and stay voiceless, or you step out of it and find a route through" (p. 505).

According to trauma research and practice (Cloitre, et al., 2006; J. L. Herman, 1992a; Lanius, et al., 2010), an authentic self without trauma-informed support appears seemingly near impossible. To "step out" of trauma may not be straightforward (Kezelman & Stavropoulos, 2012).

Trauma research consistently affirms the impact of abuse by a parent – despite occurrences decades earlier – and sees accounts of coping as superficial (Anthony, 1974; Felitti & Anda, 2010; Massie & Szajnberg, 2006; Szajnberg, et al., 2010). Such scholars argue today as they did in the 1970s (e.g., Sturges, 1977), against practitioners emphasising protective factors in the offspring of parents with an SMI because a coping bias is artificial and risks overlooking the emotional component of losses during childhood. M.J. Brown (1994) provides substantial detail on the private yet inhibited sense of loss and grief of ACOPSMI using words, such as "intense" "enduring" "lifelong", and crying "a lot" – despite outward coping via successful careers.

Kauffman, and colleagues' (1979) follow-up study on competent children of psychotic mothers whom they call "superkids" reveal such individuals have needs. Recovery from trauma of emotional abuse (present in all forms of abuse) "is a complex therapeutic task, often extending over years" (Rees, 2010b, p.1) as Felitti (2010) points out:

"Traumatic events of the earliest years of infancy and childhood are not lost but, like a child's footprints in wet cement, are often preserved lifelong. Time does not heal the wounds that occur in those earliest years; time conceals them. They are not lost; they are embodied" (p.xiii).

Competent psychological functioning on its own may therefore serve to conceal rather than reveal or ameliorate trauma's impact leading to physical illnesses (Anda et al., 2006). This in itself underscores the strong justification for ACOPSMI joining other groups requiring trauma-informed approaches (Kezelman & Stavropoulos, 2012).

Elderly ACOPSMI may also be carrying untreated trauma (Woods & Clare, 2008). Szajnberg and colleagues (2010), reviewing the effects of early experiences of trauma in adult life in two major longitudinal studies, report on long-term outcomes and their implications. They state people:

"abused by their parents continue to re-experience forms of suffering... predominately internally, even after those children have grown up and are liberated from abuse"(p.33).

Without trauma-informed interventions (Kezelman & Stavropoulos, 2012), the internal effects of shame may persist. A proper understanding of the role shame has in trauma and recovery would be important in understanding why there is power in keeping trauma a secret (Furukawa & Hunt, 2011).

ACOPSMI as a collective identity

The growing research interest and public awareness of trauma derived from war-time experiences (Dorahy, et al., 2010) may facilitate the acknowledgement of ACOPSMI as a population group according to trauma science, not social standing. Scientific connections between war combatants and trauma caused by early abuse and neglect (detailed in

90

Chapter 1) suggest ACOPSMI may have a legitimate case for being assisted as a collective identity.

War combatants are understood more clearly as a group exposed to trauma; this contrasts with undefined groups of individuals, such as some ACOPSMI who, as children, were also exposed to life threatening experiences. However, unlike war veterans, ACOPSMI do not have public rituals to commemorate their endured traumas. First-hand exposure to injury and death in battle is acknowledged by both the military and the public, and is commemorated via elaborate ceremonies, returned soldiers' parades, awards and documentation. Such ceremonies and rituals also have the function of facilitating grieving (Boss, 1999). As Courtois (2010) notes, incest survivors have "no certification process to mark their ending or a mourning ritual that marks finality and allows a goodbye" (p.256). Neither do ACOPSMI because they are unseen entities (see Chapter 2) with no established "collective identity" (J. C. Alexander, Eyerman, Giesen, Smelser, & Sztompka, 2004).

In sum, using trauma as a way of understanding ACOPSMI has not been tested. A trauma perspective is supported historically, neuroscientifically, and by accounts found in Third Wave literature. A move towards a collective identity for the ACOPMI population that takes into account a lifespan perspective is proposed. Trauma as a theme is rarely found in the ACOPSMI literature. Yet the impact of trauma cannot be ignored or downplayed. Trauma, shame, and professional achievements can serve to conceal. But such concealment may be short lived because where there is trauma there is grief, as the following section explores.

3.3 What grief concepts might be relevant to ACOPSMI with trauma histories?

During childhood many ACOPSMI had "parents who were physically present, but the nature of their parenting was so abusive and/or neglectful that their losses are not even seen as losses at all, but a way of life" (Bloom, 2002, p.5; Secunda, 1997). As one ACOPSMI

91

states, "I lost a mother. If I ever even had her" (Nathiel, 2007, p.171). Such losses can lead to experiences of grief. Massie and Szajnberg (2006) describe how maltreatment "endures in the psyche as an inchoate sadness" (p.471) during adulthood – long after abuse stops. One respondent encapsulates such sadness as: "[m]y life is a longing" (p. 471).

Grief is not necessarily a 'symptom' signalling something is wrong which requires 'fixing' (Lindemann, 1944). Grief is active (Attig, 1991), normal, healthy, and a necessary process (Kleber, et al., 1992) for recovery (Tyano, et al., 2010; Worden, 2002, 2009). The experience of grief is natural to both humans and animals (Bekoff, 2009; Bradshaw, 2004) and human grief has been documented in ancient texts (Trebolle Barrera, 1998). Essentially, loss is a universal concept (Murray, 2001). When people experience grief, in bereavement terms, they experience trauma (Worden, 2002). And when people experience trauma-based losses associated with abuse and neglect they also experience grief (Bloom, 2000a, 2000b, 2002).

Although the grief of ACOPSMI can be natural and active, its uniqueness has not been adequately documented (a point argued in Chapter 5), and might not be as straightforward as might be hoped for by some.

The following section explains grief concepts involving a non-physical death, i.e., grief that is about a "psychological death" (L. Kaplan, J., 1995); a catalyst for growth post trauma (Konrad, 2006; Tedeschi & Calhoun, 2004); "ambiguous" loss (Boss, 1991, 1999; Patrick-Ott & Ladd, 2010); "chronic" grief responses (Olshansky, 1962); and "nonfinite" loss and grief (Bruce & Schultz, 2001). This section also discusses grief that is hidden due to being "disenfranchised" (Doka, 1989). Fragmented or seemingly disjointed storytelling of grief and loss experiences when narrated by the trauma survivor will also be addressed (J.L. Herman, 1992a).

Psychological death

"Psychological death", coined by L. Kaplan (1995), is where a person is simultaneously physically present and psychologically absent. Freud (1917/1957) first recognised grief as a regular reaction to various losses, including "loss of liberty, an ideal, and so on" (p.243). Others followed suit: Bowlby (1951) addressed loss of parent due to being psychologically and emotionally unavailable, referring to a need to differentiate between various "death" types (Bowlby, 1980); Birtchnell (1970) wrote "[i]t is important to differentiate between parent death and parent loss from other causes and quite unhelpful to deliberately confound them" (p.572); Miller (1996) states the "principal component of this sense of loss is unutterable feelings of grief for the parent who is there but not there" (p.633); and Cicchetti and Toth (1995) discuss a mentally-ill parent's "psychological unavailability" (p.280).

Importantly, Bowlby (1980) notes, loss can be due to "death or desertion" (p. 180). One ACOPSMI describes this as:

> *"I feel like I didn't have a mom. I didn't have a mom to go to when I was a kid, and I don't do it now. She was there, but she wasn't there. There's just that emptiness" (Nathiel, 2007, p.172).*

Following the *physical death* of a loved one, most adults know why they are grieving (Bonanno et al., 2002) – it is not necessarily so with *psychological death*. One ACOPSMI likened the psychological death of his SMI father "to a living death" (Marsh, et al., 1993, p.27). After a loved one's *physical* death, most grievers return to pre-event (i.e., pre-loss) levels (Bonanno, 2009). This might not occur for ACOPSMI. L. Kaplan (1995) describes the difference between a physical and a psychological death as:

> *"When someone dies, you eventually say, "They're gone and they're never coming back". But when someone is suffering from severe mental illness, they're in an altered state of*

93

consciousness. A person is unrecognizable and frightening because they're beyond the border between being dead and being alive. [Yet] They look human" (cited in Secunda, 1997, p.45).

One ACOPSMI interviewed by Young and colleagues' (2004) is able to compare grief associated with a physical death to lack of clarity associated with a psychological death:

"there's no change."You're stuck in this powerless pain. It's part of the same pain, that loss, that painful loss, it's just that it's happened over 20 years; you just go along with it. There's no beginning or end or middle part" (p.189).

ACOPSMI may also experience a double death of their parent; as one ACOPSMI encapsulates "I had lost her twice; she died when I was five and she died when I was thirty" (M.J. Brown, 1994, p.166).

Posttraumatic Growth (PTG) after a physical death of a parent with an SMI

Whenever addressing grief principles relevant to ACOPSMI, it may be necessary to remember that many ACOPSMI are likely to be carriers of early trauma histories (see Chapter 2). The concept of Posttraumatic growth (PTG) may apply to the grief experience of ACOPSMI.

PTG is defined as progress within an array of unexpected positive transformations emerging from struggles with trauma, loss or tragedy (Konrad, 2006; Tedeschi & Calhoun, 2004). Stress, burden, and sorrow are not surprising responses for individuals whose parents have physically died (Corr & Pacholski, 1987). What may be largely unforeseen are individuals articulating how they felt transformed positively as a result of the physical death of their tormentors: the parents whom they consider the source of their trauma and

94

adversity. Such trauma reactions may sit uncomfortably within the public's psyche. However, as Bettelheim (1984, p.166) points out:

> "what cannot be talked about can also not be put to rest; and if it is not, the wounds continue to fester from generation to generation" (cited in Danieli, et al., 2005, p. 663-664).

Although taboo, "[a] loss could be appraised as positive – an end to extreme suffering" (Doka & Martin, 2010 , p.60). One Camden-Pratt (2006) respondent clearly reflects PTG:

> "When I was 25 and my mother died my life actually started. I saw that as a major mental healing for me" (p.183).

PTG may even occur for young children, as another Camden-Pratt (2006) participant articulated feelings of relief as a child once her mother died:

> "Oh the relief was really enormous – it was so big that I didn't want to admit it". But I was very relieved (p.198).

Such relief directly connects with personal liberation (whether fantasy or reality) via their parents' biological death, which may connect with Bloom's (2002) notion of a need for "emancipation" (p.30) from maltreatment even as an adult:

> "What a relief she's dead! You know it sounds so horrible and yet I was so relieved to know she was no longer around to abuse me" (Camden-Pratt, 2006, p. 198).

The ever present yearning for a parent who is psychologically absent, a common theme in the literature (Holley & Holley, 1997), ought not to be confused with 'love', particularly when protector and abuser are one (Kahn, 2006). Parents with an SMI are not necessarily a neutral absence. An absent parent can be "a frightening presence" (Sinason, 1992 cited in Bruce, 2007, p.7).

Such yearning should also not be confused with the longing for a parental relationship if the parent is experienced as "both there and not there, alive in body but dead in spirit" (Bloom, 2002, p.46). Yet some believe otherwise. For example, Bland (1998) states severely distressed family members, such as some ACOPSMI, experience grief "as normal responses to the emergence of mental illness in a loved family member" (p.27-28). This assumption contradicts Third Wave literature: "I shed the majority of my tears through my life living with her" (Camden-Pratt, 2006, p.198).

Bloom (2002) refers to death as metaphor for people with early trauma histories. Among the 7,000 patients in her trauma research, "death" is viewed as experiences of "the 'little deaths' – of hope, of innocence, of love and of joy" (p.1). ACOPSMI grief is perhaps not about loss of their parent's sanity.

Ambiguity

Boss' (1991, 1999) concept of ambiguous loss is a standard theory for understanding the impact of situations that contain uncertainty and vagueness – for example, where the presence or absence of a family member is subject to ambiguity, such as never-met family members lost in the Holocaust (Davidson, 1980; Solkoff, 1981; Witztum & Malkinson, 2009). This type of unseen loss is nevertheless felt because it impacts on individuals, groups, communities, and nations (Kleber, et al., 1995; Suleiman, 2006).

Boss (1991, 1999) distinguishes between two types of ambiguous loss situations: (1) when a family member is physically absent (e.g., kidnappings), and (2) when the loss is emotional or cognitive (e.g., chronic mental illness) resulting in psychological absence despite physical presence. In the ACOPSMI context, the parent with an SMI is often absent yet present. One ACOPSMI articulates ambiguity as follows:

> *"I love my mother. She is my mother but I don't feel any connection with her. I don't even necessarily feel a fondness for her which I hate" (Camden-Pratt, 2002, p.115).*

96

This comment suggests the ambiguity of having a parent to whom one is meant to connect, yet that emotional connection is absent due to the parents' psychological absence.

Chronic grief

Since trauma is lifelong (Lanius, et al., 2010), reminders of losses unexpectedly reoccurring (Bloom, 2000b) are likely to be accompanied by chronic sorrow (M. L. Burke, Hainsworth, Eakes, & Lindgren, 1992). The concept of grief with no psychological endpoint would therefore be relevant to ACOPSMI, as encapsulated in the following words:

> *"It's like being in a funeral all the time… that grief never stops. It never quits. I really wish I could get rid of the sadness. It permeates everything" (R. R. Lancaster, 1993, p.91).*

Since most Third Wave literature views grief of ACOPSMI as chronic, the concept of "chronic sorrow" (Olshansky, 1962) merits particular attention.

The notion of "chronic sorrow", formulated by Olshansky (1962), is "a permanent and reoccurring experience of pervasive sadness and loss which underlies the life experience and which recurs over time" (Masterson, 2010, p.2). The term, "chronic sorrow" is used in the ACOPSMI literature although sometimes without attribution to Olshansky (1962). Most of M.J. Brown's (1994) ACOPSMI subjects reported "chronic sadness about [their] losses" (p.164). Grief that never ends is also a characteristic attributed to ACOPSMI by The British Columbia (Canada) Ministry of Children and Family Development (Gryba, 2002).

Nonfinite loss

The chronicity of sorrow suffered by ACOPSMI is suggestive of "nonfinite loss and grief" (Bruce & Schultz, 2001) in which unanticipated grief never ends. When somebody loved dies the grief process usually has some kind of endpoint where the intensity of grief subsides (Bonanno, 2009). With nonfinite grief, the grieving process is fundamentally continuous. The magnitude of the loss is often unrecognised and unacknowledged by both the griever and those around them. This facilitates an ongoing sense of powerlessness and hopelessness regarding losses – including loss of one's hopes or ideals associated with what should, could, or might have been. For example, few people would think that they will lose their pregnancy or their child will have a disability. Likewise, few people anticipate their parent will have an SMI, will abuse, neglect, or obstruct (irrespective of intentionality) their basic needs. Nobody anticipates their parent will parentify them.

Loss of something that should have been implies continuous grief (Bruce & Schultz, 2001) and a disconnection between what is deemed a "normal" human experience within mainstream society. ACOPSMI may consequently be living with a great many uncertainties, as recounted in experiential accounts (e.g., see Camden-Pratt, 2002; Nathiel, 2007). This may affect cohesion when narrating their lived experience.

Tolerating the telling of fragmented stories

When ACOPSMI talk about their losses, what they say may not fit snugly into conventional thinking. To the listener, their story may appear fragmented because the impact of trauma on consciousness can reduce the ability to communicate (Sklarew, 2010). The more complex the trauma, the greater the fragmentation (Chae, et al., 2011).

This may cause inhibitions in ACOPSMI when communicating their narratives. One ACOPSMI describes their ability to communicate their abstract loss "like someone who

98

masters a foreign language" (Camden-Pratt, 2002, p.315). J.L. Herman (1992a) discusses the highly emotionally charged and disjointed telling of stories by traumatised people:

> *"which undermines their credibility and thereby serves the twin imperatives of truth-telling and secrecy" (p.1).*

Hidden sorrow

Disenfranchised grief (Doka, 1989) is defined as grief which "cannot be openly acknowledged, socially validated, or publicly mourned" (p.xv). ACOPSMI losses are about hidden sorrow because their grief has not been acknowledged and no ritual allows them to publically mourn. ACOPSMI loss cannot be 'buried' in the earth and there is no death certificate issued. Instead, for the many ACOPSMI with early trauma, losses are hidden invisible to the outside world. They can also be hidden in their internal world:

> *"[t]he biggest negative, I would say, was she wasn't able to be my mother. I didn't really have a mother. That's the hardest thing to grieve over… invisible illness" (Nathiel, 2007, p.172).*

Lack of sympathy

Type I trauma may typically elicit sympathy because of the suddenness of events which bring it about, e.g., a tsunami. Society may be more able to sympathise with an individual's grief if his or her parent were to physically die suddenly and unexpectedly (Lehman, Wortman, & Williams, 1987). Type II trauma is by definition not sudden but subtle, operating in pervasive (yet invasive) ways (Courtois, 2010). Nobody anticipates experiencing their parent's psychological death – especially if their parent is physically alive, fit and well, and not partaking in life-threatening occupations or recreational pursuits. In such a situation, any thought of psychological death of their parent becomes a remote possibility because they are physically present and healthy. Society may be less able to sympathise with individuals with type II trauma because it is insidious, i.e., it creeps up slowly in the

lives of its sufferers. Both type I and type II traumas are unanticipated. However, what is unexpected is the lack of sympathy that ACOPSMI experience which may disenfranchise their grief further. Their grief, generated by type II trauma, may remain unseen because of the lack of sympathy from society. As one of Dunn's (1993) respondents notes retrospectively:

> "we were really abused. . . I remember the bruises, and no one ever noticed that. . . I had this dream that I was going to jump out the window and break my leg just so they could see what was going on. So many people didn't see, so many people that should've seen" (p.180).

Ultimately, ACOPSMI are "illegitimate mourners" (author's own term). Like those of other survivors of abuse and neglect, "losses they experience are usually not considered appropriate causes for grief" (Bloom, 2002, p.8) – especially since some wish for the physical death of their parent (Camden-Pratt, 2002).

In writing about physical death, Worden (2002) acknowledges that grief can be prolonged and intensely painful, resulting in emotional distress. However, the distress may be even greater when grief is unacknowledged by self or others. Without social permission to grieve, the ACOPSMI ability to do so may contribute to "Loss of the Ability to Complete Mourning" (Bloom, 2000b, p.2). ACOPSMI with early trauma histories have many grief-like demands which include willingness "to tolerate the grief associated with all of the lost opportunities that will never be restored" (Bloom, 2002, p.18).

Missing grief of ACOPSMI relevant to early trauma histories

Surprisingly, a grief perspective is largely missing from the literature about ACOPSMI. A thorough search failed to produce any empirical research dedicated to their grief which takes into account the relationship between losses endured during their childhood as a

100

result of type II trauma, and the grief which follows. Grief of ACOPSMI does not appear as a separately studied phenomenon. Yet in 2007 the majority of phone calls to GriefLine (Australia's not-for-profit organisation providing anonymous service to people experiencing grief) came from ACOPSMI (Cini, 2008).

While the Burdekin (1993) report devotes one page to acknowledging losses for ACOPSMI, current Australian policies devote none. However, The British Columbia (Canada) Ministry of Children and Family Development (Gryba, 2002, p. 150-156) lists several characteristic losses for ACOPSMI: arrested or sabotaged development; isolation; deferred dreams; unfinished family business; dual identities; and a search for meaning. They suggest ACOPSMI losses extend beyond loss of a normal parent to loss of a normal childhood; lost opportunities in all areas of life; and lost personal potential. Such complex losses involve diminishing inner confidence, self esteem and self worth through self-questioning and self-monitoring, and a "fear of failure" (p.150). Importantly, they articulate the physical impact of loss involving grief for ACOPSMI, stating grief of unfinished family business is "a more debilitating condition, causing greater suffering than chronic physical pain" (p.151-152). For many ACOPSMI, their life *began* with loss because certain things others take for granted were often lacking. Losses associated with type II trauma may therefore require particular grief concepts and principles.

The overlap between grief and trauma concepts is rare and unclear (Brom & Kleber, 2000). There are implications if trauma knowledge and alternative grief theories are overlooked in attempting to understanding the ACOPSMI population. According to Abramovitch (2000), whenever individuals are unable to process their grief, it is not only disenfranchising but the "inability to work through such 'hidden losses' may lead to [further] silent traumas" (p.263). To enable ACOPSMI to begin dealing with their grief, trauma-based ideas suitable to the ACOPSMI grief situation require some articulation.

In brief, grief of ACOPSMI has its etiological roots in trauma resulting from the actions of their parents as opposed to a natural disaster. Consequently, their grief may be hidden, witnessed by outsiders in fragmented ways, not clear-cut yet ongoing. With no psychological endpoint it risks not fitting into standard expectations within mainstream

101

society. Grief of ACOPSMI is not the usual type of grief one finds after the physical death of a loved one. Its unique expression may even be considered taboo. With the legitimate grief of ACOPSMI remaining unacknowledged, the danger of further disenfranchising their grief process may remain.

3.4 What theoretical trauma framework may apply to ACOPSMI?

There are approximately seven major psychological trauma models: (1) psychoanalytical, (2) neurobiological (briefly addressed in Chapters 1 and 2), (3) existential, (4) cognitive (5) cognitive behavioural, (6) narrative, and (7) ecological (for a full summary and review of all the available trauma models see Courtois, 2010; Ford, 2009, 2010; Lanius, et al., 2010). These trauma models are typically influenced by psychoanalytic (A. Freud, 1981; S. Freud, 1917, 1957); rational emotive–behavioural (Ellis, 2001); cognitive (Beck, 1976); family (Minuchin, 1988); and behavioural (Marks, 1987) frameworks. The scope of this thesis does not permit a full discussion of these various theoretical frameworks potentially suited to the trauma experiences of ACOPSMI.

This section addresses the more interpretative and meaning-making aspects of trauma experience relating to existentialism (Leys, 2000) as another suitable trauma framework for thinking about ACOPSMI. This is because central themes interwoven into existential frameworks, such as death, freedom, isolation, meaninglessness (Lifton, 1967; Yalom, 1980), meaning-making, and the will to live (Kahana, Kahana, Harel, & Rosner, 1988; Wilson, Harel, & Kahana, 1988) are commonly found in ACOPSMI testimonies within Third Wave literature. The British Columbia (Canada) Ministry of Children and Family Development also describes ACOPSMI as having a need to search for meaning (Gryba, 2002).

Existential frameworks essentially emerged from testimonies of Holocaust survivors seeking meaning in life (e.g., see Bettelheim, 1986; Frankl, 1984). Some ACOPSMI want to be known as survivors (a view introduced in Chapter 1), and may also be seeking meaning in

life post trauma. Recovery and the importance of developing testimonies of trauma and grief for the sake of recovery are espoused by various narrative scholars (Cloitre, et al., 2006; Hall, 2001; Neimeyer, 2001; Suleiman, 2006; White, 2004, 2005). As J.L. Herman (1992a) observes: "In the telling, the trauma story becomes a testimony" (p. 181). And testimonies by ACOPSMI respondents are often existential in character:

> "I have trouble with death, dying, and suffering. It just brings up all the losses" (Nathiel, 2007, p.172).

One ACOPSMI describes their isolation as:

> "an overwhelming sense of loneliness and hopelessness" (Secunda, 1997, p.6)

The existential theme of freedom is reported by this ACOPSMI who felt his needs were ignored:

> "The upshot is [my SMI mother's] freedom is protected. Mine isn't" (Secunda, 1997, p.61).

In needing to wear clothing cast-down by others throughout her life while growing up, one ACOPSMI experienced this as a symbolic existential challenge:

> "you have to put an immense amount of existential effort into overcoming the fact that you don't have anything that everybody else takes for granted" (Camden-Pratt, 2006, p.55).

Recovery from losses incurred during childhood is often reliant on the sense of an internal witness (Laub & Auerhahn, 1993). J.L. Herman (1992a) observes in her trauma research that the final stage of trauma recovery becomes emblemised by the words "I know I have myself" (p.202). But one ACOPSMI articulates not even having that:

> "to be robbed of myself is the most devastating" (Nathiel, 2007, p.170).

103

Various theoretical frameworks potentially suited to the trauma experiences of ACOPSMI are too numerous to include in this thesis. However, a neurobiological framework (demonstrated earlier in the thesis) and an existential theoretical framework employed in this chapter illustrate how trauma knowledge can be applied to ACOPSMI with type II trauma histories. The more interpretative and meaning-making aspects of trauma experience relating to existentialism, commonly found in ACOPSMI testimonies within Third Wave literature, may be of relevance. It reflects links between ACOPSMI, science and experiential accounts, indicating a potential need for a trauma-informed perspective.

In order to provide a logical foundation to better inform interventions at policy and practice levels, this chapter has built a case for the necessity of utilising trauma-informed concepts derived from trauma and grief literature. Policy and practice that overlook, deny, or go against signposts and warnings by trauma research may be ineffective and may cause iatrogenic damage (Caplan & Caplan, 2001). Denial of type II trauma risks perpetuating, rather than preventing, the impact of trauma, which often carries economic and social implications (Cummins, et al., 2012). The next chapter illustrates how the impact of trauma and its effects in ACOPSMI is overlooked at policy level.

Chapter 4: Public Policy

This thesis concerns itself with an adult population group. However, Australian and Victorian state-level policies do not directly address needs of ACOPSMI. Existing policies focus on young children who are in the care of parents with mental illness. So policies reviewed here mainly relate to current day children who will grow up to be ACOPSMI.

This chapter begins with a review of government policies for current and future ACOPSMI in light of trauma literature. Trauma theory and studies (detailed in previous chapters) provide a context for the broader question: how "trauma-friendly" are Australia's government policies towards people raised by parents with an SMI? A handful of potentially helpful Australian organisations and initiatives that offer support, however indirectly, to ACOPSMI are described. This is followed by a brief background to policies for Australia's future ACOPSMI, including peer-support programs and "family-focused" interventions. In the final section, a more critical approach is taken towards policies and family-focused interventions. The issue of stigma versus shame is addressed, and the chapter concludes with a section on the advantages for policy-makers in taking a trauma-informed approach.

4.1 Policies for current ACOPSMI (survivors over the age 18 years)

The limited array of policies indirectly relating to this population requires attention. Their genesis is in the consumer and carer movement which began in the US in the 1970s (Thomson, 1973 cited in Cowling, Edan, Cuff, Armitage, & Herszberg, 2006) and continues to influence Australia's policies. The Burdekin report (1993) raised the profile of mental health consumers and their carers. These two groups continue to exert influence over policy via their recommendations at national and state levels where policies are implemented across mental health services (Cowling, et al., 2006).

Two policies that can be said to relate, albeit indirectly to ACOPSMI are, on an Australia-wide level, the *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health, 2000* (Commonwealth Department of Health and Aged Care, 2000) (hereafter referred to as the 2000 Action Plan); and, on a state level, Victoria's 2009-19 Mental Health Reform Strategy and implementation plan, *Because Mental Health Matters* (Department of Human Services, 2009) (hereafter referred to as the 2009-19 Strategy).

The 2000 Action Plan

The 2000 Action Plan is a joint Commonwealth, state and territory initiative. It aims to "[r]educe the incidence and prevalence of mental health problems and mental disorders associated with adverse life events affecting individuals" (Department of Human Services, 2009, p.38). It seeks to do this by providing education, prevention and early intervention activities for traumatised individuals belonging to identified groups. Using a population-health approach (Raphael, 2000), the government collected feedback (via systematic reviews and evidence derived from a broad range of sources) for consideration by the *National Mental Health Promotion and Prevention Working Party* from which the 2000 Action Plan was derived. The 2000 Action Plan identifies groups of traumatised people from diverse cultural and linguistic backgrounds (with assistance programs for survivors of torture and trauma), Aboriginal peoples and Torres Strait Islanders. Other priority groups experiencing adverse life events within families, communities, rural and remote communities include consumers and carers. Individuals ranging from perinatal through to older adults are also recognised – especially if they experience "bereavement, physical illness, unemployment, divorce and separation, trauma and violence" (p.12). This policy has not specifically included ACOPSMI in its list.

The 2000 Action Plan implements action on the basis of evidence of identified at risk groups. It appears as if a 'chicken-egg' situation exists that might lock out many ACOPSMI trauma survivors from this policy. Nevertheless, there is evidence that could be taken to

argue for the eligibility under this 2000 Action Plan which includes evidence that (1) ACOPSMI are an identified group (see Chapter 1); (2) many experienced type II trauma (e.g., see Third Wave literature; Bleuler's (1974) longitudinal study; see also Chapters 2 and 3); (3) trauma knowledge is applicable across a broad range of groups – irrespective of content and history – and therefore includes ACOPSMI (see Chapter 3); and (4) bio-scientific comparisons exists regarding traumatised ACOPSMI and traumatised war combatants (see Chapter 3).

The 2009-19 Strategy

The 2009-19 Strategy is designed "to ensure all Victorians have the opportunities they need to maintain good mental health" (p.19). It is based on prevention, early intervention, recovery and social inclusion. It offers *all* Victorians individual choices regarding two identified types of support: "client-centred" (p.17, Summary section) or "family focused" (p.10, Summary section).

Unlike the 2000 Action Plan, it does not specify which groups are helped. Its Summary (p.7) stipulates that health is addressed "at every stage of life [which] should be promoted and protected as seriously as physical health". This Strategy's scope logically (albeit indirectly) includes ACOPSMI. Its declaration "[p]eople of all ages are able to access early and effective advice, treatment and care for the mental health problems that affect them – without having to be acutely unwell or in crisis", is philosophically inclusive of traumatized yet socially competent, non-disordered ACOPSMI.

In addition to government policies that may have some bearing on ACOPSMI, it is worth mentioning a handful of potentially helpful organisations and initiatives that offer, however indirectly, support to ACOPSMI. The first two organisations offer research-based advice to policy-makers. None specifically identify ACOPSMI as a distinct population.

Adults Surviving Child Abuse (ASCA)

Adults Surviving Child Abuse (ASCA) (2012) is an Australian national charity and key Australian organisation supporting adults surviving child abuse and childhood trauma. They aim to increase community awareness about the impact and needs of adults surviving child abuse via professional education and training. ASCA also provide workshops offering tools for positive change for adults recovering from child abuse. Survivors are given information about child abuse and its impacts, and how they may relate to feelings, reactions, and behaviours in the present.

ASCA also deliver and broker their expertise in sustainable services while advocating nationally for the needs of trauma survivors to be better met via a trauma-informed approach to care. ASCA has a lifespan and intergenerational interest in advancing the health and wellbeing of people and communities affected by child abuse. Under the leadership of the Mental Health Coordinating Council (MHCC), ASCA seeks to improve the mental health and wellbeing of people with trauma histories. It does this by advocating for a national agenda for trauma-informed care and practice across: public; private; community health; mental health; primary care; and human services sectors at state and national levels. This includes recognition of the needs of adults with a lived experience of complex trauma secondary to child abuse in all its forms – including the witnessing of family violence in childhood and of other adverse childhood events. ASCA note on their website that: "more than 2 million adult survivors of childhood trauma live in Australia (with real figures est. 4-5 million) and over 8 million Australian community members are directly affected".

Recently, ASCA joined the Australian government's reform process to improve practice in human service settings. The Australian Government Department of Health and Ageing funded ASCA to create the first *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery* (Kezelman & Stavropoulos, 2012). These Guidelines, based on research conducted by ASCA, fill an important knowledge gap in policy and practice. They aim to provide new ways of conceptualising and responding sensitively to the needs of adults burdened with type II trauma – including their recovery and that of their

offspring. These government-funded Guidelines adopt a lifespan approach – whenever individuals with unresolved trauma present.

ASCA is likely the most useful organisation for ACOPSMI. Their recent *Practice Guidelines* (Kezelman & Stavropoulos, 2012) offer most hope for this population because ACOPSMI do not have to be carers or diagnosed with a mental illness before being noticed. ASCA also facilitate survivor connections to help adults, like ACOPSMI, survive child abuse, overcome isolation and the loneliness that often accompany individuals with child abuse histories.

The Australian Centre for Posttraumatic Mental Health (ACPMH)

Australian Centre for Posttraumatic Mental Health (The Australian Centre for Posttraumatic Mental Health, 2012) undertakes trauma-related research (as displayed via their website resource, *TraumaNew*s). They provide services and information regarding traumatic stress to help organisations and health professionals who work with people affected by traumatic events. They offer policy advice involving prevention, early recognition, assessment, treatment, and compensation. This includes needs assessments, research and validation for policy development based on evidence-based principles. They also draft policy papers, review new proposals, and evaluate existing policies. ACPMH note on their website that: "Up to 65 per cent of Australians are likely to experience or witness an event [type I or type II traumas] which threatens their life or safety".

The Australian Trauma and Grief Network (TGN).

Another initiative that also deals with trauma-related research is the *Australian Trauma and Grief Network* (TGN). While not specifically mentioning the ACOPSMI population, this Network brings together families, members of the community and professionals to share experiences and resources on the care of children and adolescents affected by the impact of trauma, loss and grief (Australian Child & Adolescent Trauma Loss & Grief Network, 2012).

beyondblue

beyondblue (2012) is a national initiative begun in 2000 (Jorm, Christensen, & Griffiths, 2006). It is a state and territory governmental, not-for-profit organization addressing children and adults with depression, anxiety and related disorders. Its priority areas are: community awareness and destigmatization; applied research; primary care training and support; prevention and early intervention (from perinatal onwards); consumer and carer advocacy; depression-related research; and a youth program (12 to 25 year olds) to help family and friends identify early warning signs or behaviours and promote help-seeking behaviour.

Children Of Mentally Ill Consumers (COMIC)

COMIC (Children Of Mentally Ill Consumers, 2012) is a non-governmental organisation formed in 2000 under the auspices of the Mental Illness Fellowship of South Australia. It is staffed by ACOPSMI who do this work out of their own personal experience, which they draw on to inform their activities. This organisation also has members with expertise in the field who share a common perception of past failures by mental health services in acknowledging them as children with unique needs. Their organization strives to raise awareness about the needs of children of mentally ill parents via, for example, a resource website. However, they do not focus on themselves as adults or as a separate group with potential trauma-based needs. Instead, they lobby and advocate for the rights of children. Yet the problem of remaining voiceless as children (Cousins, 2004; Mordoch & Hall, 2002) applies to adults (M. J. Brown, 1994; Camden-Pratt, 2002; Foster, 2006).

To sum up, some organisations may be helpful for ACOPSMI, but government policies (under mental health strategies) that may be taken to apply – however indirectly – to them do not appear to adequately recognise them or serve their trauma-based support needs.

4.2 Policies for future ACOPSMI (survivors under age 18 years)

This section offers a historical snapshot of the policy landscape for "future ACOPSMI", who are children and adolescents being raised by parents with an SMI and who will enter adulthood as ACOPSMI. It outlines current policies created to address these children. It then attempts to clarify the policy context in which these individuals are situated, including information regarding government-run peer-support programs. A background to "family-focused" interventions is then sketched out as family-focused approaches influence policy (including practice, discussed in Chapter 5).

Background

The invisibility and silence of the offspring of parents with an SMI have been of major concern for many scholars since the 1920s (Canavan & Clark, 1923), during the 1970s (Sturges, 1977), through to the 1990s (M. J. Brown, 1994; Cowling, 1999), and more recently (Camden-Pratt, 2002; Foster, 2006; Mordoch & Hall, 2002).

Between 1993 and 1997, two projects designed to make future ACOPSMI more visible were created by Cowling (and reported in her 1999 book) were pivotal at policy and service levels. *Research Project – Children of Parents Experiencing Major Mental Illness* and the *Southern Partnership Project – 'Listen to the Children': A Community Development Project* were aimed at professionals managing and delivering services to families. The projects aimed to lift public awareness of the needs of children being raised by parents with an SMI via the media and further contacts between researchers and policy planners. Both projects confirm Sturges' (1977) and Burdekin's (1993) findings on the basic need to also be cognizant of children whenever supporting mentally ill parents.

Descriptive accounts of support and service needs of mentally ill parents and their children via, for example, children and adolescent programs (Cowling, 1996), ultimately led

to government-funded early intervention programs (i.e., COPMI and FaPMI, described later in this chapter).

Sturges (1977) and Cowling (1996b) wanted to inform others about these children's needs and how they were affected by growing up with mentally ill parents. Sturges's audiences were practitioners working within therapeutic settings such as hospitals, whereas Cowling's audiences were essentially policy makers. Although it was known that children suffered under the care of parents with an SMI, it was when Cowling (1996b) communicated this to policy makers that Cowling's work began on a national scale.

Conclusions emerging from Cowling's two projects influenced current policy structures within agencies and organizational practice. They mirror some recommendations germinating from Sturges' (1977) practice research. These reverberate within today's policy guidelines on children and adolescents. Sturges' (1977) research spelt out why these children have particular needs. Her critical suggestions including "listening to their experiences and emotions" (p.90) are partially echoed today (see for example, Steer, Reupert, & Maybery, 2011). However, the purpose of listening to their experiences and emotions may be different today. For example, it has been suggested that childcare workers become trained in early signs of pathology (Sims et al., 2012).

It is worth noting that the recent 2012 Cummins Inquiry includes parental mental health problems among its list of significant risk factors for child abuse and neglect (see p.xxxii).

Policies

The identification of children's needs is a policy focus of protective services and quite separate from adult mental health policies (Cummins, et al., 2012). The following three policies frame institutional thinking on Australia's future ACOPSMI. They come from adult mental health services – not child protective services.

1. *National Principles and Actions for Services and People Working with Children of Parents with a Mental Illness* (2004) (Australian Infant Child Adolescent and Family Mental Health, 2004). (Henceforth the 2004 Principles)

2. *National Children of Parents with a Mental Illness (COPMI) Initiative* (Australian Infant Child Adolescent and Family Mental Health [AICAFMHA], 2012). (Henceforth 2002 COPMI Initiative and 2010-12 COPMI Initiative).

3. State of Victoria, *Families where a Parent has a Mental Illness Strategy* (FaPMI Strategy). (Victorian Government Department of Human Services, 2007). (Henceforth FaPMI).

The 2004 Principles details national, discipline-specific practice standards for the mental health workforce (building on 2002 National Practice Standards for the Mental Health Workforce). It came out of a need to implement the 2000 Action Plan (detailed earlier).

Prior to the above policies emerging, the *National Mental Health Promotion and Prevention Working Party* in 1999 released the *Mental Health Promotion and Prevention National Action Plan*. This plan took on board Cowling's 1993-1997 work (Cowling, 1994), and finally, at policy level, recognised that Australia's children of parents with a mental illness had particular needs. Even though long overdue, this was a major development serving the interests of children.

Following a national study commissioned by the *Australian Infant, Child, Adolescent and Family Mental Health Association* (AICAFMHA) of responses to the needs of children and their mentally ill parents, the *Children of the Parents Affected by a Mental Illness Scoping Project* was commenced in 2001 (Australian Infant Child Adolescent and Family Mental Health Association, 2001). This project successfully convinced the Commonwealth to fund a nationwide initiative to develop practice principles and guidelines for workers and services. National funding for the 2002 COPMI Initiative was allocated. The *2010-2012 COPMI Initiative* is an extension of the *2002 COPMI Initiative*.

The 2004 Principles heralded the recognition that children of parents with a mental illness had needs as previously expressed by Canavan and Clark (1923), Sturges (1977), Burdekin (1993), and Cowling (1996, 1999). This recognition complements the more recent 2012 Report of the *Protecting Victoria's Vulnerable Children Inquiry* (Cummins, et al., 2012) in which key evidence on the needs of the children of parents with an SMI is offered with the purpose of meeting "the needs, improve the lives and secure the rights of Victoria's vulnerable children and young people" (p. xxiii, Volume 1). Formerly neglected by policy, these children and adolescents are now part of Australia's policy agenda, offering some optimism for this population.

The 2002 COPMI Initiative does not go on to address the *adult* needs of this population. However, it (indirectly) honours them because it signals that: (1) ACOPSMI do exist; (2) trauma-based needs may exist in this population due to respite options offered; (3) prevention is necessary; and (4) the needs and competencies of this group embody a wide range (Reupert & Maybery, 2011; Steer, et al., 2011).

The more recent *2010-2012 COPMI Initiative* aims to promote better mental health outcomes for children and adolescents of mentally-ill parents more generally, because it does not specify severity, chronicity, or type of parental mental illness. Instead, it provides information for family members where a parent has a mental illness, offered nationally via a website, the media, research, educators, service organisations, consumers, carers and interested others. A recently opened clearinghouse aims to develop a national evidence base in the COPMI field by promoting and coordinating the sharing of theory and practice in research and project evaluations.

The FaPMI strategy, established in 2007, builds on the developmental work in the COPMI domain complementing the national *COPMI Initiative*. It represents a second stage of service development as it builds on what was learnt from pilot projects jointly funded by the Victorian state government through the Mental Health Branch, *Victorian Health Promotion Foundation* (VicHealth) and *beyondblue.* Victoria's FaPMI objectives were distilled from the 2004 Principle guidelines and complement the ethos of 2002 COPMI.

Peer-support

Cumulative evidence endorses psycho-education for children about their parents' mental illness, and is provided within peer-support group interventions for children (Gladstone, et al., 2011). Peer-support programs aim to reduce isolation. They essentially focus on education about mental illness, give young people an opportunity to share their experiences, develop a plan in the event their mentally ill relative becomes unwell, offer coping skills, and provide respite for young carers.

Peer-support programs typically acknowledge the range of needs and competencies among children (Reupert & Maybery, 2011; Steer, et al., 2011). They do not refer to type II trauma.

Although there are no peer-support programs for adults in Australia, there was restricted funding for limited programs for children age 8 to 18 living in urban areas (Reupert et al., 2009). These programs were time-limited to trialling and evaluating models of best practice to improve support and activities for the children and adolescents. Within the state of Victoria there were two peer-support groups: *Paying Attention To Self* (PATS), for children aged between 12 –18 years (Hargreaves, Bond, O'Brien, Forer, & Davies, 2008); and *Children and Mentally Ill Parents* (VicCHAMPS), a school holiday and after-school activity programs which were operating in Melbourne and northeast Victoria for 8 –12 year-olds (Goodyear, Cuff, Maybery, & Reupert, 2009). Nevertheless, there may be other peer-support programs under the COPMI initiative operating outside the state of Victoria, e.g., the eight-week *Offspring* group in Adelaide for young people who have a carer or sibling with a diagnosed mental illness – not specifically those who have a parent with an SMI.

"Family-focused" interventions – what are they and who are they for?

Family-focused interventions are an extension of deinstitutionalisation policies of mental health services. Deinstitutionalisation began over fifty years ago (Ohaeri, 2003).

115

Historically, family-focused approaches began after research findings revealed that family involvement led to better treatment outcomes for individuals with schizophrenia, improved compliance (Pitschel-Walz, Leucht, Bauml, Kissling, & Engel, 2001), and reductions in relapse and readmissions (Pilling et al., 2002; Resnick, Ros'enheck, & Lehman, 2004). This seemed to have caused a rush of psycho-educational, family-focused interventions targeting families where a family member had schizophrenia (Pitschel-Walz, et al., 2001). Ultimately, family-focused interventions resulted in a high dependency by adult mental health services on informal care given by family members (Bittman, 2007). The definition of "relatives" has fast expanded to include as many family members as possible, such as siblings, spouses, and offspring, without concern for who these "relatives" are in terms of their human connection or attachment.

A family-focused philosophy continues on with the current 2009-19 Strategy offering Victorians family-focused approaches (see Summary p.10).

Although family-focused approaches are also seen at practice levels (as addressed in Chapter 5), at policy level Australia's family-focused interventions provide facilitation of crisis or care plans associated with recovery of parents with a mental illness (Reupert, Green, & Maybery, 2008). This includes psycho-education, communication and problem-solving skills training for all family members (Glynn, Cohen, Dixon, & Niv, 2006).

As an iteration of the family-focused agenda, FaPMI provides for the "capacity of specialist mental health services" (p.12) via training, education and support for both clinical and family-focused services. It also addresses (unspecified) health and schooling needs striding both mainstream (child, family, youth and education) and specialist (mental health) services by connecting individuals to appropriate supports. Consistent with a "family-focused" ethos, FaPMI categories include parents, their offspring, infants, children, young people, and others, such as partners, siblings, grandparents and those in their caring role (see p. 11-12). According to the FaPMI strategy:

"A family focused approach considers the needs of all family members. To meet the needs of all family members, mental health services would need to work in partnership with other services that may provide further support and care to the family and document the chosen strategies within their care plan" (p.4).

Whether a family-focused approach considers the needs of all family members may need to be carefully assessed. Adult mental health services might not always be able to work in partnership with other services, such as child protection services. Support and care for other family members, such as offspring, might therefore not be as straightforward as FaPMI outlines. The following gives a closer scrutiny to current policies and their strategies to address the needs of the ACOPSMI population.

4.3 A closer scrutiny of current policies

The following section seeks to identify the dimensions of policy-makers' omission of trauma knowledge by examining current policies for current and future ACOPSMI. It attempts to more closely scrutinise the government's "partnership" program, family-focused policy interventions and other issues, such as the risk for this population of continuing their invisibility in the name of avoiding stigma. It also addresses the relevance of trauma knowledge in policies regarding ACOPSMI.

Scrutiny of policies for adults

There has only been sporadic recognition of ACOPSMI by isolated enquiries and writers (e.g., Burdekin, et al., 1993; Cowling, 2004a). Today's policies for this population stop at age 18 years. Scholars like Foster (2006) urge stakeholders: "Notice the adult children" (p.250). Research tirelessly echoes this same message (Bleuler, 1974; M. J. Brown, 1994; Burdekin,

et al., 1993; Canavan & Clark, 1923). However, they are only noticed in limited situations. For example, research on the grief of ACOPSMI, the individuals closest to the epicentres of chaotic family life, remains elusive unless they are carers (Pakenham, Bursnall, Chiu, Cannon, & Okochi, 2006; Saunders, 2003). Research on the trauma of ACOPSMI, meanwhile, is often done on risk of mental illness and its intergenerational transmission (Read et al., 2005). Both trauma and grief are overlooked in competent, non-disordered ACOPSMI who, although unlikely to engage with government mental health services, *are* likely to be (physically) impacted (Felitti et al., 1998).

ACOPSMI are locked out of policies because the focus of concern on deinstitutionalised individuals with SMI including those who are also parents, remains. The *Not for Service* (Mental Health Council of Australia, 2005) report addresses the experiences of injustice in Australia's mental health care. This report is based on consultations with the *Mental Health Council of Australia*, the *Brain and Mind Research Institute*, the *Human Rights and Equal Opportunity Commission*, and national data (collected between 2003 and 2005) from consumers, health professionals, non-government organisations and private health care providers. Its goal is "to determine the key concerns of those who have recently sought primary care or specialist mental health services" (p.11). Unless ACOPSMI are consumers (i.e., have a diagnosed mental illness) or carers (caring for somebody mentally ill), then their own needs or experiences of injustices would not be addressed in this report. The report suggests that the process of deinstitutionalisation has been unaccompanied by corresponding supports for those adults who grew up and may still be living with their mentally ill parents.

Partnerships

Family-focused research aims to change whole systems with the purpose of promoting and making family members partners as part of their parent's treatment team – with the unwell parent's consent (Glynn, et al., 2006). As a family member, this often translates into

118

ACOPSMI supporting their parent with an SMI by devoting time to their parent's well being. For instance, ACOPSMI may become part of the development of services in their role as carer by joining family advocacy groups (e.g., World Fellowship for Schizophrenia and Allied Disorders, 2012). This new development may have led the Australian government to essentially view relatives, like ACOPSMI, as potential "partners" within Australia's "partnership project" (Mental Health Council of Australia & Carers Association of Australia (MHCA & CAA), 2000). Such partnerships are an extension of the family-focused philosophy of having family members in key roles of caring for SMI individuals – that is, helping the Australian government manage their parents' mental illness post-deinstitutionalization. How did this evolve?

Evidence indicates that involving families in the treatment of SMI individuals benefits individuals with SMI (McFarlane, Dixon, Lukens, & Lucksted, 2003; Pharoah, Mari, Rathbone, & Wong, 2006). This made various government departments eager to enlist family engagement within adult mental health services. Australia's *National Action Plan* on *Mental Health 2006-2011* (Council of Australian Governments, 2006), *Because Mental Health Matters*, and state-level mental health policies, such as the Victorian Mental Health Reform Strategy (Department of Human Services, 2009) all promote family engagement.

Carers are recognised by government-run agencies as "central to the smooth delivery of care and treatment" of mentally ill people. The *Victorian Government Department of Human Services* (Goodwin & Happell, 2007, p.607) now offer family members, like ACOPSMI carers, the title "partner" (Victorian Government Department of Human Services, 2002, p.39) to improve the health and wellbeing of their parents. In return for this assigned title, ACOPSMI carers are "required to take 'greater responsibilities'" (Victorian Government Department of Human Services, 2005, p.7).

Arno, Levine, and Memmott (1999) highlight the economic value of informal caregiving in the era of community based care, and informal care-giving. The partnership project compliments the philosophy of economic rationalism which "influences what goes on the general policy agenda and the form it takes, as well as what doesn't get on the agenda" (Dalton, et al., 1996, p.109-110).

119

"Partnership" may be a euphemistic term representing a false partnership because the implications for what this may mean for ACOPSMI carers remains unclear within government-run mental health institutions. Moreover, engaging in family-focused approaches that involve ACOPSMI as carers of their parents within a "partnership" arrangement may go against the idea that traumatised people prefer to disengage and avoid reminders of their unprocessed trauma (Combs & DePrince, 2010) as articulated by this ACOPSMI:

> *"I didn't even look at anything to do with her [parent with SMI], just escaped!" (Camden-Pratt, 2006, p.113).*

Furthermore, those suffering the effects of type II trauma and who do not "escape" may remain for the sake of survival. Shengold (1999) observes "the need to assume that one's parents are benevolent is the chief reason for denying the reality of the abuse" (p.105). Policies that comply and support the needs of the mentally unwell parent over and above the needs of their 'mentally available' offspring may be overlooking how type II trauma plays out. It is perhaps unsurprising that uptake of family-focused interventions is minimal (Fadden, 1997; O'Hanlon & MacRae, 2009).

Unchecked by a trauma-informed approach, denial may continue as a mental coping strategy for decades (Felitti, et al., 1998). To remain as carers, the offspring may need to continue denying maltreatment (such trauma features as denial are addressed in Chapter 3). Denial may include that of various daily distresses. Camden-Pratt (2002) reports that her ACOPSMI respondents were:

> *"haunted by [their mentally ill parent's] deep deep distress" (p.75) and "when [the parent] arrived so did chaos" (p.306).*

The title "partner" suggests mutual benefits of care and respect, but research reveals otherwise:

First, research, government practice guidelines, and current adult mental health policies aim to support the needs of one sub-group (parents) over and above the needs of other sub-groups (ACOPSMI) within the same family unit. As demonstrated earlier, studies reveal a "higher priority placed on the rights of the consumer" (Goodwin & Happell, 2006, p.140), e.g., parents with an SMI.

Second, assumptions of mutual benefits of care and respect are based on research derived from a biased sample involving one base-line subset (parents), and essentially one category of SMI – schizophrenia (as detailed in 4.2). The same research findings have been generalised to include all SMI categories, whereas research regarding other categories of parents with an SMI do not reveal mutual benefits of care and respect for other family members (see for example, Jeffreys et al., 2011).

Third, Gold's (2000) trauma research – available at the time of the writing of this "partnership" policy – confirms whole-family involvement with adult survivors of maltreatment does not promote mutual benefits of care and respect. This indicates that policies which conceptualise such family members in "partnership" terms are inappropriate. Other studies, meta-analyses, and practice guidelines associated with type II trauma research spanning several decades (see trauma references provided by Kezelman & Stavropoulos, 2012) – available during formulation of the "partnership" policy – were not consulted.

There are other limitations, such as conflicting agendas between consumers, that is between parents with an SMI and their offspring carers (Goodwin & Happell, 2006, 2007); an unsatisfactory working relationship between families and service providers (O'Hanlon & MacRae, 2009); and family members dissatisfied with mental health services (Department of Human Services, 2004; Drapalski et al., 2008).

Keen to bring family members like ACOPSMI to engage with parents with an SMI, the state government of Victoria funded an investigation into barriers to participation of families. Findings reveal that family engagement "remains more an aspiration rather than a reality" (O'Hanlon & MacRae, 2009, p.6).

121

When current ACOPSMI were children there were no policies in place to support them. Now as adults, ACOPSMI are still not receiving government support.

Scrutiny of policies for children

The following section highlights four areas that may need to be looked at more closely in terms of care of Australia's future ACOPSMI: peer-support programs; the division of the two areas of services understood as two silos (adult mental health and child protection services); the dichotomised way in which children and adolescents are conceptualised; and the greater opportunities for parentification via greater exposure to needy parents.

Peer-support programs

Previous FaPMI programs within Victoria were preoccupied with giving information to the future ACOPSMI regarding their parent with an SMI – not psycho-education on self-awareness of *their own needs* as children of such parents. The focus on children putting effort into understanding parental mental illness may be at the cost of minimising or not understanding their own important needs. This imbalance may represent a policy and service limitation. Life after type II trauma implies a need for self-care for children (Blaustein & Kinniburgh, 2010) and adults (Rosenbloom, Williams, & Watkins, 2010). This is ignored in FaPMI as interventions and approaches within adult mental health services are quintessentially "family-focused".

Overall, peer-support programs were considered inadequate and ineffective (Fraser, et al., 2006a; Huntsman, 2008; Reupert, et al., 2009; Steer, et al., 2011) because they (1) occurred unsystematically; (2) relied heavily on a range of insufficiently trained individuals, including volunteers, with coordinators being confronted by organisational barriers (Owen, 2008); (3) were not based on sound theoretical grounds; (4) were not rigorously evaluated

122

using standardized evaluation strategies; (5) were unclear with regards to entry and exclusion protocols to programs and how children's strengths and vulnerabilities are matched; (6) grouped children regardless of their parents' diagnoses; and (7) only partially screened or assessed peer-support programs by poorly trained program coordinators' use of self-constructed questionnaires (Steer, et al., 2011).

Services are divided into two silos

Child protection services are separate from adult mental health services. But partnerships have been suggested at their intersection (Cummins, et al., 2012; Jeffreys, et al., 2011; Owen, 2008). For the benefit of children, child and adult services need to complement each other to ensure the protection and care of children at risk of, or who already experience, abuse or neglect (Gopfert, et al., 2004). Although research by Jeffreys and colleagues' (2011) suggest adult services should be challenged to become more child-sensitive, within the ACOPSMI literature, there is conflict over who should be the client – parent or child (Cousins, 2004).

The two silos (child protection and adult mental health services) are insufficiently coordinated. For example, program coordinators of FaPMI (Families where a Parent has a Mental Illness Strategy) cite "parental mental illness" as the main reason for referral and program selection for children (Steers, et al., 2011, p.510) – not abuse and neglect by mentally ill parents as reported by child protection services (Jeffreys, et al., 2011). In this way, FaPMI programs risk overlooking the trauma-based needs of referred children and adolescents. In other words, many children of parents with an SMI grow up without screening for or identification of type II trauma. Once 'graduating' from COPMI and FaPMI programs, young individuals may be unprepared for adulthood – a period when the ticking 'time bomb' for trauma symptoms is more likely to require counselling (Kezelman & Stavropoulos, 2012).

Part of the Cummins report (2012) expresses a need to go towards case management in an attempt to make more coherent linkages between parental mental illness (within adult mental health services) and their offspring (within child protection services). Ideally adult and children's services need to work together to address issues of maltreatment in families where there are parents with SMI. Descriptions of domestic disruptions and maltreatment in First and Third Wave literature (detailed in Chapters 1 and 2) clearly spell out the need for policy-makers to pay more attention to child protection issues. This call has not yet been directly tagged or in any way woven into adult mental health services.

The boundary between child protection and adult mental health services may benefit from becoming more porous. If trauma knowledge could seep through this boundary it may reduce the silo effect currently operating. Because trauma knowledge is client-focused, it may unite rather than create divisions across institutions responsible for the ACOPSMI population. For example, trauma knowledge may offer a more sensitive gateway towards overcoming various divisions, obstacles and barriers as known to occur between adult mental health and child protection services (e.g., see Darlington, Feeney, & Rixon, 2005; Owen, 2008), including preventative strategies (Read et al., 2005). Better interagency and inter-service collaboration between these two silos may occur if the universal language, knowledge, and scientific research of trauma are adopted because of the focus on information and related issues pertaining to survivors (Jennings, 2004).

Future ACOPSMI conceptualised in dichotomized terms

Consistent with Sturges' (1977) directive, "[a]ssess those who need additional help" (p.91), Burdekin (1993) advocates for "assistance for children who need intervention for their own psychological, emotional or behavioural difficulties" (p.500-501) – a sentiment documented in the 2010-2012 COPMI policy. Yet most FaPMI programs "exclude children with behavioural and/or emotional difficulties" (Reupert, et al., 2009, p.6). This overlooks the fact that traumatised children exhibit difficult behaviours (P. Fisher, A. & Gunnar, 2010).

124

Such ancillary indications of trauma are ignored by policy and the individuals concerned punished via deliberate rejection and without support by the very programs meant to service their needs.

Government-run, peer-support programs may have been rejecting competent, non-disordered children who may have type II trauma histories. These children may have been functioning normally, for example engaging with play activities even though they may be simultaneously dissociating without others noticing (Bacciagaluppi, 2011; Chae, et al., 2011). Yet program coordinators may deem them to be problematic if, on other occasions, their need to act-out or express internal traumas relating to distressing events is read as "misbehaviour". Bleuler (1974, p.105) clearly encapsulates the two extremes: Good children may "become shy, retiring, [and] sensitive", and bad children are "either provocative [or] aggressive". At the core of both types of behaviours is fear, an integral component of type II trauma: "[i]n small children, especially, fear is at the very surface, particularly bodily manifestations of fear". But the bodily manifestations of fear in children perceived as remarkably quiet may not be visible to an untrained eye. This is because sensory and somatic experiences of trauma are hidden (Ogden, et al., 2006).

Steer and colleagues' (2011) Australian study of 20 current program coordinators responsible for 19 peer-support intervention programs found distressed children are excluded because of certain acting-out behaviours. They note:

> *Exclusion criteria were also applied, resulting in an otherwise eligible child being disqualified from the program. Exclusion criteria included significant emotional or behavioural problems (e.g., aggression)"* (p.508).

Socially competent or "good" children, although not rejected by these programs, are accepted potentially for the wrong reasons, i.e., not for their potential trauma-based needs, but whether their threshold for distress is high enough to not erupt into "bad" behaviours. Mental health nurse Blair (in Cowling, 2004a) gives an account of difficulties in environments disadvantaging individuals such as herself; well-camouflaged, "good",

125

socially-functioning (child or adult) individuals. She reports "outward appearances don't necessarily speak of the turmoil that can lie beneath an apparently successful surface" (p.85-86).

Both "good" and "bad" children risk falling through policy nets because their need for trauma-informed interventions (e.g., Kezelman & Stavropoulos, 2012; Raine et al., 2003) are overlooked. Assessing risk of trauma cannot be left to non-professionals or to the observer's discomfort caused by the subjects' outward behaviours. Otherwise, eligible children may be excluded from peer-support programs on the basis of externalised trauma symptoms. Rejecting children with needs contradicts the purpose of FaPMI and COPMI policies and contravenes the *United Nations Convention on the Rights of the Child* (United Nations General Assembly, 1989).

Greater opportunities for parentification via greater exposure to needy parents

The institution that bears primary responsibility for the care and quality of the next generation is the family (Bronfenbrenner, 1977a, 1977b). But when the family is dysfunctional or toxic, then that responsibility falls on government policies not children (Burdekin, et al., 1993).

Although one of FaPMI's (Families where a Parent has a Mental Illness 2007 Strategy) strengths is its recognition that parents and children have different (unspecified) needs and should be supported by different services, the needs of the offspring – irrespective of chronological age – are still not provided for in policy. For example, as an initial step to accessing the PATS program (Hargreaves et al., 2005), adolescents were offered individual counselling and the family linked into support services. But this program is no longer operating.

Furthermore, it seems reasonable to offer respite from caring for parents with an SMI, or from being in a stressful home-environment associated with parental mental illness. The

PATS program, while making a broad reference to "respite that meets [adolescents'] specific needs" (Hargreaves, et al., 2008, p.15), did not clearly define precisely what the needs of such children or adolescents might be. Interventions focusing on young carer support programs alleviate "caring responsibilities by the child for an ill parent" (Huntsman, 2008, p.24). The term "respite" may need to find a basis in the more rich descriptions of trauma-based needs (see Chapters 2 and 3).

Young caregivers appear to be an important target for service and policy planning (Ireland & Pakenham, 2010). For example, one key FaPMI activity aspires to "address the needs of children and young people in their caring role for a parent with a mental illness" (p.12) with programs in place to support child carers (see p.10). The focus here is clearly on *their carer role,* not first and foremost on their developmental needs outside this role. The developmental needs of such children were outlined decades ago by Sturges (1977) and echoed in current research (Cummins, et al., 2012).

The more socially acceptable term "young carer" (FaPMI, p.10) is euphemistic because it overlooks their plight as individuals with lost childhoods while concealing the reality of what it means to be parentified (Jurkovic, 1997). They are "burdened children" (Chase, 1999). Some researchers have identified the role of young carers as an exploitative one, and urge that "kids need somebody that's there for them emotionally now" (Jeffreys, et al., 2011, p.31). But to this day, the offspring of parents with an SMI are mainly viewed by policy as resources, i.e., relatives potentially able to work as carers – including very young children.

Some play down or minimize the impact of parentification, or claim that children are acting out of choice (e.g., Aldridge & Becker, 2003). However, children may not be able to decide, not only because of their powerful attachment and dependency needs (P. C. Alexander, 1993; Bowlby, 1973; J. G. Bremner & Wachs, 2010; Bureau, Martin, & Lyons-Ruth, 2010; V. Carlson, Cichetti, Barnett, & Brownwald, 1989; Cassidy & Shaver, 2008), but also for developmental reasons (Ward & Glaser, 2010) and due to the way trauma often works (detailed in Chapter 3). For example, according to J.L. Herman (1992b), experiences of interpersonal trauma occur "where the victim is in a state of captivity" (p.377). Most children are unable to leave their parent due to attachment needs (described in Chapter 2).

But in cases of individuals with type II histories, they may have a need to continue to remain "in a state of captivity", i.e., under the control of their parent because of the way trauma and early attachment operates (detailed in Chapter 2). Research by Wuest, Malcolm and Merritt-Gray (2010) illuminates how survivors of child maltreatment could become caregivers for their abusers. This 'state of captivity' may continue into adulthood because, as Rees (2010b) points out, "[e]arly foundations run deep" (p.1).

Parentification processes need to be stressed. Inappropriate titles such as "Children Who Care" (Aldridge & Becker, 1993) implicitly send a powerful message that children who are not carers for their parent do not care and by association are uncaring people. It also clouds their own legitimate need for receiving care themselves. Parentified respondents in Dunn's (1993) research retrospectively articulate a need for acknowledgement of demands that were placed on them during their childhood via the parentification process.

Unfortunately, parentification is a sacrifice normalised by some who believe caring for needy parents is good for children (e.g., Aldridge, 2006). Unquestioned acceptance of children and adolescents caring for parents with an SMI may not be in the best interest of the child (Gopfert, et al., 2004).

Huntsman's (2008) review of consequences and effectiveness of (national and state) policy interventions for children mentions parentification (see p.iii) as does Jeffreys and colleagues' (2011) research. Evaluations and reviews that take a closer look at 2002 COPMI (Fraser, E.L. James, K Anderson, Lloyd, & Judd, 2006; Hargreaves, et al., 2005) and FaPMI (Fernbacher, Goodyear, & Farhall, 2009; Steer, et al., 2011), while useful, may not go far enough because type II trauma, attachment and parentification issues are omitted.

Traumatic childhood experiences and the unmet needs within one's own life may make caregiving at any age an emotionally impossible task (Bleuler, 1978), with serious physical, psychological, and later occupational and economic status implications (Grant, 1999; Grunfeld et al., 2004; Vitaliano, 1997; Vitaliano, Zhang, & Skanlan, 2003). Yet the offspring are not only viewed favourably by their own needy parents, who to varying degrees succeeded in parentifying their offspring during their childhood years (see Chapter 2), but

128

also by agencies who hold few objections to parentification (Aldridge & Becker, 1993 ; Aldridge & Becker, 2003; Keith & Morris, 1995). Such agencies may try to get young children to help service their mentally ill parents while overlooking parentification issues as demonstrated in the following paragraph.

In her advice to adult mental health and project workers in children's services, Aldridge (2006, p.81-82) sees nothing wrong with children of parents with an SMI taking on adult duties. She claims children may act in carer roles akin to (1) professional nurses "overseeing the safe and regular administration of prescription drugs"; (2) professional social workers engaging in "crucial preventive interventions such as, critical crisis support; (3) psychologists "monitoring and assessing parents' emotional health and wellbeing"; (4) professional clinicians or psychiatrists handling mentally ill parents' "sudden downturns in their mental health, for example during episodes of self harming or psychosis"; and (5) pastoral carers by emotionally "being there".

Aldridge (2006) claims, based on interviews with children, parents, and key workers, that "no evidence was found of physical harm or neglect of children by parents" (p.82). Yet such interview-based assertions may be unsupportable because parents are viewed as unreliable reporters (a point argued earlier), and children are not psychologically or emotionally capable of reporting abuse and neglect meted out to them by their parents due to attachment needs (detailed in Chapters 2 and 3). Neither can they prevent maltreatment because they can only identify factors that can cause an event rather than those that prevent it (Schultz & Mendelson, 1975). Additionally, workers in this field may not be adequately trained (Owen, 2008). Harm done by emotional abuse is complex, and is considered the most damaging of all abuse types because it is not easily detected (Rees, 2010a, 2010b). Nevertheless, parentification termed by Aldridge as "role adaptation" (p.82) is even viewed as a natural consequence since it "undoubtedly occurs when children care" (p.82).

Parentification also means this group of children would be too busy caring for their parents to process their own trauma, preventing them from doing what trauma research strongly recommends – "stop the self-sacrifice" (Courtois, 2010, p.256; J.L. Herman, 1992a).

It is claimed that "most programs for FaPMI in Australia today are directed primarily at the child, and less so at the family as a unit" (Reupert & Maybery, 2010, p.12). This claim does not match policy documents. For example, FaPMI states children "should be consulted and respected for their understanding of their parents' health status and needs" (p.12). The wording clearly reflects a focus on health status needs of parent not child, and puts the child in a "consultant" role regarding their parents' needs.

Parentification issues have not received sufficient attention in policies and, unscreened, may potentially lead to iatrogenic damage (Caplan & Caplan, 2001). Ignoring parentification may obscure rather than illuminate future problems or hazards. On an optimistic note, a Parentification Inventory is now available to assess roles, responsibilities and processes that undergird parentification processes within a family-focus milieu (Hooper, Doehler, Wallace, & Hannah, 2011).

Family-focused policy interventions examined

There are benefits and limitations to family-focused approaches and interventions. In the context of a child-centred approach to early intervention (Jeffreys, et al., 2011), there may be some merit in working within a family-focused framework. For example, family-focused approaches intervene in neonatal care for pregnant SMI women (Nguyen et al., 2012), or for infants, toddlers and preschoolers of parents suffering from an SMI (Kowalenko et al., 2012).

Working with the family may also protect the child by extending networks and providing child care and other activities outside the family. For example, family-focused approaches offer opportunities to shift the focus from the parent to other family members, as noted in Huntsman's (2008) report.

Family-focused policies may also apply in the case of other family members where, for instance, a young adult develops an SMI and the parents and or siblings are the carers

(Judge, 1994; Kinsella, et al., 1996). In such cases, there may be genuine scope for family-focused interventions and family partnerships (e.g., see Riebschleger, 1991). Young and colleagues (2004) refer to this context where non-disordered competent siblings are carers for their mentally-ill sibling.

While a family-focused approach may be a useful framework from which to support families and address issues arising from parental mental illness (Foster, O'Brien, & Korhonen, 2012), focusing on parents with an SMI may not be enough because "the best interests of the [young] child must be paramount" (Gopfert, et al., 2004, p.xv). The interests of that same child during their adulthood would be a separate yet important matter.

Family-focused policies emphasis that "regular family contact will create a better context for offering families evidence based interventions than one in which contact is infrequent and limited to crisis" (O'Hanlon & McRay, 2009, p.8). "Evidence" spoken of here is selective. The findings relate essentially to the treatment of individuals with schizophrenia.

Not defining what the relationship is among family members, e.g., in attachment terms, may risk perpetuating crisis. This is because in practice, identifying the circumstances and context of needs is crucial (Broder & Hood, 1983) for survivors needing to process their trauma experiences (Rosenbloom, et al., 2010). Family-focused approaches may threaten this process due to a lack of clarity – whose needs are being met among which family members?

To this day, the apparent loyalty to parents in policy extends to the presumption that the needs of children with mentally ill parents will be met if parents are given parenting skills under the rubric of family support (Steer, et al., 2011). Yet research questions the parenting capacity of parents with an SMI despite parenting and family support (Cousins, 2004; Donald & Jureidini, 2004 ; Jeffreys, et al., 2011). It also questions practitioner capacity (Devlin & O'Brien, 1999; Jeffreys, et al., 2011; O'Brien, Brady, Anand, & Gillies, 2011; Owen, 2008) because clinicians have difficulties articulating theoretical frameworks for parenting programmes they themselves design, and employ simplistic evaluation strategies (Reupert

& Maybery, 2011). Judge (1994) observes "[s]ervice providers too often assume that education and support offered to parents will "trickle down" to other family members" (p.174).

Family-focused approaches may be limited in families where there was early maltreatment (Cummins, et al., 2012). While placing greater priority on the needs of parents with an SMI, policy-makers may be ignoring: (i) reasons why crises emerge from within such families, such as a parent's mental illness type potentially perpetuating and exacerbating the original crisis (Shelton & Harold, 2008); (ii) serious family conflicts and stress generated by unwell parents (L. Burke, 2003; Goodman & Gotlib, 1999) and negative parenting practices (Lovejoy, Graczyk, O'Hare, & Neuman, 2000); (iii) the overdependence on family potentially leading to family burden of care and stress (Fadden, et al., 1987; Ohaeri, 2003; Pakenham, et al., 2006; Sahoo & Suar, 2010; Shifren & Kachorek, 2003; Vitaliano, 1997; Vitaliano, et al., 2003); (iv) conflicts in agenda between ACOPSMI as carers and their mentally ill parents as consumers (Goodwin & Happell, 2007; Lammers & Happell, 2004); (v) conflict in needs between parents and their offspring (Goodwin & Happell, 2006); and (vi) other customized interventions that may better address trauma and grief reactions (Cloitre, et al., 2006; Jordan & Neimeyer, 2003).

For many ACOPSMI, the motivation and experiences of connection or non-connection with their mentally ill parent is complicated by their mentally ill parent potentially representing "the scene" of their experiences of trauma (Gold, 2000). Thus, as carers they remain within the haunting presence of their past as represented by the very people they are encouraged to care for. One of Dunn's (1993) ACOPSMI research participants communicates this inner tension between the potential effects of early trauma and dysfunctional dependency needs reflective of ambivalence and guilt:

> "As long as I can stand it, I think it's good for her. It's not good for me – it's pretty bad, actually-sometimes intolerable, and I have to leave" (p.182).

132

Reform takes time. The policy of deinstitutionalisation meant parents with an SMI were sent home, without adequate support, to parent their (often mentally intact) children. Instead, their children parented them (via "parentification" processes). Within current policy literature, the impact of parentification across the lifespan of the ACOPSMI population may need to be made more visible. What is visible and what remains invisible in the population studied are important, as the next section demonstrates.

In the name of avoiding stigma

This section offers a trauma perspective on what the phrase 'at risk' may be taken to mean. Here, it is understood as being at risk of not having needs seen and met.

Meeting the needs of the ACOPSMI population may sometimes be side-stepped due to fear of stigma. Yet the 1993 Burdekin Report states that (irrespective of chronological age) the "lives of thousands of children are being permanently damaged as a result [of having parents with an SMI]" (see p.504, "Adults Whose Parents Were Affected by Mental Illness"). This has been confirmed in more recent research (Cummins, et al., 2012; Jeffreys, et al., 2011). Nevertheless, Tanner (2000) suggests policy avoid the social identity of "child of adult with mental illness" (p.293). Steer and colleagues (2011) concur with Tanner, justified by the importance of "sensitive assessment or screening processes that are supportive and confidential and do not presuppose that such children are at risk or are otherwise negatively impacted" (p.511). They argue that "identifying children 'at risk' could be a violation of children's privacy, with subsequent labelling becoming a potentially stigmatising issue" (p.510-511).

Curiously, Steer and colleagues (2011) do not argue that these children may be at risk of abuse, neglect, trauma, and parentification. Not identifying them due to privacy violation concerns may violate their right to safety (Cummins, et al., 2012; Jeffreys, et al., 2011; United Nations General Assembly, 1989), and their right to having their needs known and

133

met (see Chapter 2). Shying from identifying this population may not be advisable also for the following reasons:

First, there is evidence showing children want friends and others to talk to about their lives (Maybery, et al., 2005). Second, adults do not fear stigma because some openly declare their identity (see Third Wave scholars noted in Chapter 1). Third, fears of stigma link to feelings of shame (Dearing & Tangney, 2011) and shame "must be accessed in order to transform it" (Greenberg & Iwakabe, 2011, p.72). Fourth, worry over stigma pales in significance when one considers the impact of trauma as a hidden epidemic (Lanius, et al., 2010; a point addressed in Chapters 2 and 3). Fifth, maltreatment is equally a public as it is a private affair because of associated socioeconomic costs (a point detailed in Chapter 2). Sixth, when individuals are isolated and disenfranchised, the social phenomena of stigma may persist if the shame experienced by these individuals is kept secret. Recovery from trauma requires dealing with any felt shame by the individuals (Furukawa & Hunt, 2011). Scholars from Third Wave literature such as Brown (1994); other scholars (e.g., Freyd, 2009; Freyd, Klest, & Allard, 2005) urge policies to more vigorously and assertively reduce levels of secrecy and denial of abuse and neglect.

Fear of others identifying who these children are may inadvertently contribute to rather than avoid stigma, resulting in a deepening of the silence and invisibility of this population. Stigma may have more to do with society's collective sense of shame projected onto the individual, rather than shame itself which may belong to the individual. The difference between shame (an individual experience) and stigma (a social experience) can be observed in Furukawa and Hunt's (2011) work involving therapy with refugees and other immigrants' experience of personal shame in the new society they are settling in. In many respects, it could be argued that future ACOPSMI are also 'settling in' a new social environment – one outside the chaotic atmosphere they are likely to be familiar with in their home-of-origin (e.g., Camden-Pratt, 2002).

Evidence shows that helping traumatised individuals realise they are not alone and their reactions to trauma not unique is helpful; it diminishes their feeling of hopelessness and trauma symptoms, and gives them a sense of control over their lives (Furukawa & Hunt,

2011; Layne, Pynoos, & Cardenas, 2001). Trauma research can provide a better understanding of obscure or difficult to articulate early childhood traumas (Lifton, 1979) including the role shame has in trauma and recovery needs (J. L. Herman, 2011). The 2010-12 COPMI policy regarding stigma may inadvertently obstruct trauma awareness and recovery (Kezelman & Stavropoulos, 2012), including prevention strategies (Raine et al., 2003; Read et al., 2005).

The need for policy to acknowledge the role of childhood trauma in service delivery and in prevention programs for children is well established. Read and colleagues (2005) suggest policy-makers should create "guidelines for how and when to ask about trauma in general, including child abuse" (p.345). Raising the ACOPSMI public profile, as has occurred with other "hidden" traumatised groups (e.g., M. Cohen, et al., 2001; Scott, 2011), may help overcome intrapersonal loss, the acquisition of any stigmatised identity, and trauma's impact in a non-shaming way (Dearing & Tangney, 2011). This implies a need for a broad educational approach in raising the public profile of this population group. Giving hope and dignity to the many well-camouflaged, traumatised individuals – who from outward appearances live an ordinary existence – is relevant. Such a policy approach may also lessen any fears, guilt, shame or stigma.

Taking advantage of trauma knowledge

In Australia the present policy landscape is not yet taking advantage of a trauma-informed approach because very little trauma knowledge has percolated through to policy.

There is evidence to show the benefits of using a trauma-informed approach in policies (Jennings, 2004). Trauma experiences are challenging. But when traumatised individuals and their practitioners have access to evidence-based information about trauma then this may militate against the impact of trauma, lessening the emotional and psychological intensity of their suffering (Courtois & Ford, 2009).

Lack of acknowledgment of ACOPSMI by policy does not necessarily mean lack of an identity as a population which can be established via a trauma-informed approach. Trauma models express "the collective stories in the individual-level interpretations" (J. E. Davis, 2005, p.135). Although ACOPSMI do not have a trauma model yet, they do have stories of their lived experiences (seen in Third Wave literature).

Trauma is a lifespan issue but current policies for ACOPSMI are not yet lifespan friendly. The point at which policies adopt a lifespan approach is when they look to the offspring to act as carers for their parents. The 2004 Principles while advocating for a lifespan approach, avoid direct mention of the adults integral to this population. The FaPMI Initiative has no provision for adult offspring not mentally ill or engaged as carers. Moreover, the 2002 and 2010-2012 COPMI initiatives only privilege the first-quarter of the ACOPSMI lifespan (i.e., 0-18 years). There were also difficulties including certain age groups, e.g., five to seven year olds (Huntsman, 2008). While current ACOPSMI are ignored, the attention to the needs of future ACOPSMI, i.e., children and adolescents, is still patchy in policy.

For ACOPSMI there has been a policy lag because naturally the focus has been on children (COPSMI). It may now be time to look at the natural sequel to the focus on children especially in circumstances where there was no child focus for current ACOPSMI. It can be surmised that there is quite a large population that did not have support during their childhood, and many ACOPSMI may want more support now than what is currently offered (Knutsson-Medin, et al., 2007).

Trauma research can directly inform policy. But, policy is currently not always informed by trauma research. J.L. Herman (1992a) argues trauma and recovery need to be connected within the social and political sphere, implying preconditions for enhanced trauma recovery environments (e.g., see Raine et al., 2003). Trauma researchers De Prince and Freyd (2002) urge all to "consider the individual who experienced the trauma, the event itself, the sociopolitical context, and the community response" (p.80). This directly connects with a trauma-informed approach (Jennings, 2004).

In effect, trauma knowledge offers a unique unifying framework for policies seeking to reduce the economic burden while increasing health outcomes of populations confronted by adversity (Shonkoff, Richter, van der Gaag, & Bhutta, 2012). Understanding trauma may be well worth the effort for policy-makers interested in making a difference by investing in the ACOPSMI population.

Currently, there are public health implications associated with childhood maltreatment that extend well into adulthood. The interrelationship between adult ill-health and childhood trauma, as mapped-out by trauma science, show links between childhood maltreatment and poor adult physical health continuing for decades (Felitti, et al., 1998; Kezelman & Stavropoulos, 2012; Lanius, et al., 2010).

Since people traumatised in childhood make up a neglected population (De Young, Kenardy, & Cobham, 2011), a movement is underfoot to shift policy thinking more towards current advances in emerging evidence-based interventions. This promises better outcomes via a better scientific understanding of the antecedents and causal pathways of diseases in adulthood that begin in childhood (Shonkoff, 2010). Trauma science invites a new era for policy. It potentially offers policy-makers better return on policy spending via more effective prevention and intervention because it is now understood that "young children do not simply follow fixed genetic trajectories, environments do matter" (Shonkoff & Levitt, 2010, p.689).

It took 76 years after Canavan and Clark's (1923) research and more than 17 years after Burdekin (1993) before Australia began acknowledging and serving the needs of children of parents with an SMI. Children often become adults. How long will it take to complete the lifespan picture by including ACOPSMI, many of whom carry type II trauma histories?

Recognition of the need to adopt trauma-informed interventions has just begun in Australia with the Government Department of Health and Ageing funding the new Practice Guidelines on trauma-informed care and services (Kezelman & Stavropoulos, 2012). However, until these new Practice Guidelines filter down from policy to implementation on

the ground, standard counselling for ACOPSMI according to a family-focused philosophy continues to dominate practice – the topic of the next chapter.

Chapter 5: Practice

As the previous chapter illustrated, policy is capable of influencing many areas. One area is counselling (Meadows & Singh, 2001), as the following family-focused policy suggests:

> *"Services that are offering assessment, treatment, rehabilitation and support to these families need to embed family focused practice in their core service delivery" (FaPMI, 2007, p.18).*

Those ACOPSMI unable to afford private care are more likely to turn to government-run support services as depicted in the above family-focused statement. Private health insurance may not be affordable for the many ACOPSMI potentially seeking relief from the effects of type II trauma, and current Medicare rebates for counselling via Australia's universal health care system are restricted to a set number of sessions (Department of Human Services, 2012). Many ACOPSMI may be seeking the free counselling available to them as unspecified "relatives" or "family members" within family-focused practice interventions.

This chapter begins with an exploration of the standard counselling practices for ACOPSMI and their implications. It examines whether family-focused interventions recognise individuals carrying type II trauma histories, and the extent to which such practice interventions suit their counselling needs as children of the mentally ill. Next, how the literature frames the counselling of ACOPSMI is discussed in terms of normative family values such as "love" and "closeness". The mismatch of theory to practice in family-focused counselling interventions is then briefly examined. Ultimately, the chapter shows that when the elements that make up family-focused practice are dissected, all may not be in the best interest of ACOPSMI carrying type II trauma histories.

5.1 Family-focused practice as a government-approved counselling approach

Various studies identify the need for counselling of ACOPSMI (Camden-Pratt, 2002; Dunn, 1993; Foster, 2006; R. R. Lancaster, 1993; Stevenson, 2002). According to M.J. Brown's (1994, p.259) qualitative study, the effects on ACOPSMI who had parents with schizophrenia include a need for "participation in psychotherapy" to address various issues including: "chronic sorrow", "loss and grief", "lost potential", and "self esteem". Maybery, Ling, Szakacs and Reupert's (2005) survey-based study reveals that young children and adolescents of mentally ill parents also have a need to receive counselling.

Despite the evidence-based need for counselling of ACOPSMI, according to A.S. Williams (1998) there is almost no literature addressing treatment specifically for individuals raised by mentally ill parents. Nevertheless, counselling of ACOPSMI does take place albeit 'behind the scenes'. That is, there seems to be standard counselling practices for ACOPSMI located within government-driven services delivered by institutions, organisations and agencies.

Family-focused practice refers to any type of work involving practitioners who treat mentally-ill individuals with the participation of family members of the afflicted person. Family-focused practitioners may typically extend counselling services to family members of the SMI individual, and this may include ACOPSMI. Practitioners are guided by advice on how to go about counselling family members from a variety of disciplines, e.g., social work (Bland, 1998); psychology (Young, et al., 2004); and psychiatry (F. E. Miller, 1996; Solomon & Draine, 1996). Advice about therapeutic interventions for families and relatives of the mentally ill essentially comes from non-practitioner academics, e.g., Bland (1998) and F.E. Miller (1996), or from those in managerial roles, e.g., Young (in Young, et al., 2004) who, at the time of writing was in the role of community program manager.

In a typical family-focused therapy session the counsellor may meet with the mentally-ill individual together with their immediate family members. The mentally-ill person is the focus of concern. All other family members – including ACOPSMI – are to respond to the

needs of that parent with an SMI as directed by the practitioner. The practitioner has little choice but to follow family-focused principles as directed by policy (see Chapter 4). That is, the particular needs of other family members present may not be emphasised or acknowledged.

The Australian government funds family-focused research (Maybery & Reupert, 2009; McGorry, 2004; Reupert & Maybery, 2011; Tanaghow, 2005). Such research is capable of influencing the counselling of ACOPSMI. Standard counselling of ACOPSMI is premised on family-focused principles as directed by policy. The few articles on the counselling of ACOPSMI were collectively found under a family-focused umbrella. For example, Young, et al. (2004) was found in the Chief Psychiatrist's Guideline (Tanaghow, 2005) on working with families and carers.

Implications

The following addresses various implications for ACOPSMI who have type II trauma histories and who may be exposed to policy-driven, family-focused counselling approaches.

In writing about counselling practice more broadly, Egan (2007) observes that the cultural, historical and political context in which evidence is embedded matters. The premise that because family-focused approaches are evidence-based they are therefore effective for *all* relatives (O'Hanlon & MacRae, 2009) may be false. Although clinical practices should be evidence-based (L'Abate, 2008), it may be useful to ask for whom are the practices intended and for whose benefit is the evidence collected (Wampold, 2003)? Within the family-focused milieu, the purpose is clearly for parents with an SMI. Counselling of ACOPSMI may be serving a "political purpose" of reducing demands for services or supports (Bickman & Rog, 2009, p.32).

Family-focused approaches favour broad family involvement for the care of the mentally ill as "the preferred 'gateway'" (O'Hanlon & MacRae, 2009, p.49). This may be problematic. For example, the strong focus on needs of parents with an SMI over and above the children

had Jeffreys and colleagues (2011) write "an adult-centric view can dominate" (p.38) because children's needs are missing. Others agree (Mauritz & van Meijel, 2009). However, family-focused counselling approaches may not be adult-centric but rather "parent-centric" (author's own term) because "family" readily becomes code for "parents". The term "family" is deceptive because it promises counselling for *all* yet this is not necessarily the case.

The existing literature explicitly gives parents priority. Scholarship in this field is essentially dedicated to parents whether they are mentally-ill or not. For example, in practice terms it covers the specific grief of parents with mentally ill children (Boursnell, 2007; Donald & Jureidini, 2004 ; Godress, Ozgul, Owen, & Foley-Evans, 2005; Osborne & Coyle, 2002), their caregiving burden (Ghosh & Greenberg, 2012; Möller-Leimkühler & Wiesheu, 2012), and their stories (Johansson, Anderzen-Carlsson, Åhlin, Andershed, & Sköndal, 2012; LeCroy, 2011). It looks at the lived experiences of parents with a mental illness (Boursnell, 2007; O'Dowd, 2003) and their specific grief (Mauritz & van Meijel, 2009).

The family-focused practice philosophy has perhaps unintentionally disowned its responsibility for the well-being of *all* family members (Cousins, 2004). For example, this approach may overlook the parent-adult-child tie influencing each other within the family context (Spitze, Ward, Deane, & Zhuo, 2012). It also overlooks that many ACOPSMI carry type II trauma histories. Family-focused practices do not assess for family conflict and stress generated by parents' mental illness (L. Burke, 2003; Goodman & Gotlib, 1999), or any suspected history of interpersonal violence, evidence of trauma, or of parental capacity prior to engaging individuals like ACOPSMI in family-focused counselling (Donald & Jureidini, 2004).

Standard family-focused counselling practice may not be designed for ACOPSMI. Some scholars understand parental mental illness as essentially a matter which involves the whole family (Baulderstone, Morgan, & Fudge, 2012; Cowling & McGorry, 2012; Maybery, Goodyear, Reupert, & Harkness, 2012) but this may be due to the developmental attachment needs of infants, toddlers and preschoolers (Kowalenko, et al., 2012).

142

With all the best of intentions, family-focused approaches are invested in sustaining the continuity of the parent-child connection. However, in cases where traumatic bonding may have occurred, that investment might not be appropriate. For example, family-focused practitioners aiming to sustain a parent-child connection may overlook the mind shutting down among the traumatised to protect against further trauma intrusions (J. D. Bremner, Vermetten, & Lanius, 2010; Lanius, et al., 2010; LaPrairie, Heim, & Nemeroff, 2010). More concretely put, family-focused practitioners may suggest to ACOPSMI that they assist their parent with an SMI in a way that may cross a protective psychological boundary. For example, approving or encouraging ACOPSMI to live in physical proximity to the parent with an SMI (potentially creating care opportunities) is understood as a positive psychosocial outcome (Mowbray, et al., 2006).

It has been known for decades that the offspring of parents with an SMI are the most vulnerable and most affected family members where family mental illness is a concern (Cummins, et al., 2012; Lidz, Fleck, Alanen, & Cornelison, 1963). But ACOPSMI are not identified in family-focused approaches as a group. Yet adults exposed to traumatic experiences during childhood require support and protection of their mental and emotional health (Cloitre, et al., 2006; Gold, 2000; Kezelman & Stavropoulos, 2012; Miller, 2005; Shengold, 1999).

Family-focused counselling approaches use terms such as "family" or "relatives" in the counselling literature. These function to describe *all* family members including the individual diagnosed with a mental illness (O'Hanlon & MacRae, 2009). Such terms lack precision regarding what the relationship is to the mentally ill person. A lack of interest in family members other than those who are mentally-ill shows a disregard for the interpersonal nature inherent in type II trauma within the ACOPSMI context (detailed in Chapters 2 and 3). Recognising ACOPSMI and their type II trauma is important because "[a]buse is about relationships. So is recovery" (Rees, 2010b, p.1). In not identifying who ACOPSMI are and their intimate relationship to their parent while growing up, family-focused practitioners may fail to protect them from further interpersonal abuse (J.L. Herman, 1992a).

143

Interpersonal abuse can be subtle. For example, early emotional abuse is detrimental yet difficult to pinpoint (Rees, 2010a). According to J.L. Herman (1992a), Saber (2000) and Rees (2010a, 2010b), lack of comprehension of emotional abuse is due to inadequate attention to chronicity of such abuse or understanding its contextual symptoms. Some trauma practitioners detail the impact of emotional abuse on adult survivors of early maltreatment (e.g., Miller, 2005; Shengold, 1989, 1999). For example, one ACOPSMI describes his experience of emotional abuse by his SMI father as "words that bite deep even a decade later" (Lachenmeyer, 2000, p.145). Family-focused counselling does not explore such issues as emotional abuse. For instance, no details are provided regarding why emotional support was sought when "[f]amilies wanted help with a relative's behaviour" (O'Hanlon & McRay, 2009, p.14). Could this be a request for help regarding unmet psychological and emotional needs?

As Berrick and Gilbert (1991) observe: "To be empowered, individuals need to experience control and to have a realistic sense that they can change their environment" (p.121). ACOPSMI seeking support may feel stuck in an environment that gives preferential treatment to the very people who may have meted out maltreatment to them while they were growing up. Counselling may not be a family matter for ACOPSMI who survived abuse and neglect within their family-of-origin (Gold, 2000; Shengold, 1989), and adulthood does not guarantee trauma recovery without trauma-informed counselling services (e.g., Cloitre, et al., 2006; Jennings, 2004).

Family-focused counselling approaches that ignore type II trauma may obstruct or act as a deterrent for ACOPSMI seeking counselling. They may inadvertently encourage a climate of closed-off support because the family-focused philosophy aims to help the parent's own emotional needs (O'Hanlon & MacRae, 2009; Riebschleger, 2005). This may inhibit ACOPSMI from speaking openly about a parent's past maltreatment (e.g., see Camden-Pratt, 2002, 2006).

144

A partial "death"?

On another theme, some ACOPSMI may not consider themselves as being part of a "family" in the usual sense of the word. For example, Shengold (1999) notes the long, painful therapeutic process that his adult patients go through with existential questions on life without a mother or father. On the other hand, there are some family-focused practitioners that may be tempted to persuade the offspring of parents with an SMI to experience their parents as having only a "partial" psychological death, or a "sometimes" death. That is, that their parent is sometimes (in some reduced degree, with intermittent episodes) "alive" and present. Miller (1996), for instance, instructs workers who are grief counselling family members, like ACOPSMI, to "embrace the idea that all mentally ill persons still have a healthy aspect, or partial self" (p.636). This may be inappropriate.

Evidence shows that many ACOPSMI traumatized by their parents' behaviours due to a SMI are reluctant to experience their parent as having any "partial" self, i.e., any partial psychological death (e.g., see Camden-Pratt, 2002; Dunn, 1993; Nathiel, 2007) . Practitioners not respecting such lived experiences of ACOPSMI may go against an emerging culture of trauma-informed care in which the organizing principle of trustworthiness, empowerment, safety and choice are diligently followed (Fallot & Harris, 2009).

Individuals exposed to trauma have the need to process their traumatic events (van Wesel, Boeije, Alisic, & Drost, 2011). Such knowledge has led to a movement towards advocating that people, like many ACOPSMI, who survived childhood trauma do indeed need trauma-informed counselling (Kezelman & Stavropoulos, 2012; Little & Akin-Little, 2011). However, some practitioners may remain unaware of the impact type II trauma can have on survivors of parents with an SMI. Other supportive family members or carers may not be enough in mediating the effects of trauma. For example, in an article by Cowling, et al., (2006) one parent caring for their mentally ill spouse wrote about their child:

145

"the worst moment for us was when we realised our 7-year-old daughter was suffering emotional injury and herself needed counselling" (p.416).

From a trauma-informed perspective, it would have been the 'best moment', as it allows the child to receive much needed one-to-one attention for her emotional and psychological well-being (Maybery, Ling, et al., 2005). As Parkes, Stevenson-Hinde and Marris (1991) note:

"… all unintelligible events are disturbing, but unintelligible events which also disrupt our purposes and attachments are doubly threatening" (p.82).

The threat of losing a parent to a psychological death is complex due to trauma intermingling with attachment needs across a person's lifespan (as discussed in Chapters 2 and 3). Such losses are likely to require resources and attention that go beyond that which family-focused approaches are presently able to offer.

Trauma influencing grief: Implications and lessons

To the best knowledge of this author, the trauma and grief of ACOPSMI have no discourse and thereby no opportunity for any normalization process. If grief and trauma are indeed companions (Brom & Kleber, 2000) and trauma is lifelong (Lanius, et al., 2010), then the lifelong nature of trauma is likely to influence grief into becoming lifelong. This would have strong implications for the counselling of ACOPSMI. Family-focused practice literature appears to address just grief while ignoring the trauma component (e.g., Bland, 1998; F. E. Miller, 1996; Solomon & Draine, 1996; Young, et al., 2004). However, where there is trauma there is grief (Brom & Kleber, 2000; see also Chapter 3).

Unfortunately, family-focused counselling literature does not identify or consider grief and trauma as co-existing elements. For instance, according to F.E. Miller (1996, p.635), who

writes on grief therapy for relatives of persons with an SMI, a "sense of alienation" and "chronic sorrow" cannot co-exist. Secunda (2000) is another example; "people sought help [to] "resolve" their traumatic childhoods [and] their ambivalent or nonexistent connections to their parents. [But] These are not "grief" issues; they are identity issues" (p.223-224). Yet she refers to their traumatic life.

A dual (trauma and grief) approach may prevent inappropriate assumptions, such as assuming the offspring grieve for the parents they once knew (Robinson, Rodgers, & Butterworth, 2008): As one ACOPSMI states: "It's like [my parent] was born with an illness" (Nathiel, 2007, p.172).

Although grief and trauma are intertwined, trauma may need to be acknowledged first and foremost because trauma and losses during childhood may impact on a person's capacity to grieve (see Chapter 3). Unless trauma is identified, the grief of ACOPSMI may not be able to unfold as a natural process and risks remaining disenfranchised (Doka & Martin, 2010).

Donald and Jureidini (2004) assert that assessing for trauma should occur prior to commencement of *any* counselling. They believe the enduring nature of interpersonal trauma stemming from childhood maltreatment should remain central across all ages because "the extent of the psychological harm accompanying abuse is not always readily apparent" (p.5). Furthermore, for grief to unfold, trauma may need to be treated first because trauma features, e.g., nightmares, flashbacks, fears of death, inhibit, mask and delay the grief process (Brom & Kleber, 2000; Lindy, Green, Grace, & Titcheneer, 1983).

However, scholarship on grief covers family members more generally (McGregor, 1994; Wasow, 1995). The lived experiences of young children of parents with an SMI and their particular grief remain largely unknown (Mordoch & Hall, 2002). See for example, the recent qualitative study on outcomes of parental mental illness on children by Oskouie, Zeighami and Joolaee (2011).

This situation does not differ for the adults. Literature on ACOPSMI hardly names 'grief' or 'trauma' as words. Scholars writing in Third Wave literature use euphemisms for "grief" which only hint at the concept, such as E.M. Brown (1989) referring to "alone mood" (p.1); or "come to terms with internal stuff" (p.124). Foster (2006), Secunda (1997, 2000), Nathiel (2007), E.M. Brown (1989), M.J. Brown (1994), and Camden-Pratt (2002, 2006) use "grief" as a noun to form part of a list of words referring to various emotions ACOPSMI experience. A qualitative meta-synthesis of adult children of parents with a mental illness by Murphy and colleagues (2011) mentions the word grief without elaboration under their heading "Adult children's emotional reflections" (p.3437).

Grief-laden titles implicit of grief have theories and studies missing. For instance, grief does not feature in M. Walker's (1992) *A Catalogue of Loss* (p.61) in which adult reflections of their childhood experiences of abuse are observed. Neither does it appear in Secunda's (1997) index or contents – despite a chapter titled: *Shattered Families* (p.17). R.R. Lancaster's (1993) retrospective phenomenological study of adult perceptions on growing up with a mentally ill parent has one paragraph devoted to "grief". The study offers ten pages of references – none on grief.

Trauma as a theme is also noticeably absent as reflected in the way titles are phrased. For example, some titles of articles on the counselling of ACOPSMI appear as if context is included. The phrase "contextual analysis" in Young and colleagues' (2004) counselling article on family grief has the critical context of trauma missing. Furthermore, the ubiquitous term "family" does not give adequate context on who is grieving and why. This would render any "contextual analysis" about ACOPSMI void. Context is important whenever addressing sadness and sorrow (Horwitz & Wakefield, 2007).

Nevertheless, the literature on counselling of ACOPSMI indicates that ACOPSMI as relatives of the mentally ill are mourners (e.g., F.E. Miller, 1996). Why they are mourning is unexplored. Losses need to be identified in order to be mourned (Doka & Martin, 2010; Rando, 1993). Additionally, individuals who have type II trauma histories have cumulative losses (a point addressed in Chapter 3). Since losses suggest grief, overlooking losses of ACOPSMI with type II trauma histories may be detrimental to their grief process. This is

because there is a need to "identify what [grieving people] must do to mourn in ways that are consistent with who they are and what they need" (Doka & Martin, 2010 , p.xviii). Who ACOPSMI are, and the origins of their grief – type II trauma caused by key attachment figures on whom they depended on for survival (as detailed in Chapters 2 and 3) – remains unacknowledged in the literature on the counselling of ACOPSMI.

Counselling can become a place of change and restitution (Gatti, 2011). Laying a foundation for restitution for ACOPSMI as legitimate family members may need to begin with family-focused practitioners becoming trauma-informed and sensitive to potential trauma-related needs (Jennings, 2004) which include: understanding their type II trauma; their need for psychological distance from parents with an SMI; and trauma-sensitive principles, such as using a dual grief and trauma approach (addressed in Chapter 3). In doing so they may frame the counselling of ACOPSMI more appropriately.

5.2 How the literature frames the counselling of ACOPSMI

The needs of individual ACOPSMI are likely to be framed according to structured family-focused interventions aimed at reducing relapse and re-admission rates of their parents (Fadden, 1997; Kavanagh et al., 1993; Magliano, Fiorillo, Malangone, De Rosa, & Maj, 2006). It is claimed that family-focused interventions may benefit some family members in terms of reducing burden and distress (Cuijpers, 1999). However, counselling for ACOPSMI may need to be framed according to their potential type II trauma histories.

Family-focused counselling approaches may build a series of expectations and assumptions which may act as filters through which ACOPSMI are understood. Such filters may serve to make sense of what is expected, i.e., according to current policy directives. Choice of counselling models used for ACOPSMI, as family members of the mentally ill, then becomes part of this filter because practice models influence the direction in which counselling proceeds (Egan, 2007). In this sense, contrary to reducing burden and stress,

149

family-focused interventions may in effect increase them because they are not framed by trauma understandings (Cloitre, et al., 2006). Instead, they are framed by family-focused values. This implies that certain expectations and assumptions, according to a family-focused philosophy, are relied upon as the following attempts to explain.

Proximity

Family-focused counselling literature favours normative family values. Historically, European society confirmed and protected its identity by using family values via the idea of "home" (S. Smith, R, Hamon, Ingoldsby, & Miller, 2009). Ringmar (2005) argues it is not what a home is per se but what it does. As children, many ACOPSMI grew up in a family home characterised by chaos (M. J. Brown, 1994; Gold, 2000), and with abnormalities associated with maltreatment, threats of death, and unpredictable terror (detailed in Chapter 2). For many ACOPSMI, "home" may equate with trauma because of the atmosphere of fear and danger (Abosh & Collins, 1996; Belsky, 2005; Camden-Pratt, 2002; Shengold, 2006). This may disqualify the normative notion of "home" as a place of safety and protection (J.L. Herman, 1992a).

Nevertheless, certain normative family values may seep into interpretation of research regarding ACOPSMI, which in turn guides family-focused practice. For instance, research by Mowbray and colleagues (2006) on the psychosocial outcomes of adult children of mothers with depression and bipolar disorder interpret ACOPSMI not "fleeing the family [but instead living] in proximity to their [SMI] mothers" (p.105) as a positive outcome. This interpretation may fit the normative model of family members remaining physically close but may not fit trauma research that spells out a paramount need for psychological distance. The traumatised often prefer to "flee" or escape to safety (Bloom, 2002; Ford, 2009; J. L. Herman, 1992a). Such escape can be a good strategy (Anthony, 1987; Anthony & Cohler, 1987) – at least in the interim until psychological safety is reached (Kezelman, & Stavropoulos, 2012).

ACOPSMI outwardly demonstrating the family value of living in proximity to parents with an SMI may appear as a positive outcome, but this may be a result of insecure attachments (e.g., Ainsworth, et al., 1978; Horowitz et al., 1984). For instance, traumatised individuals experiencing "omnipotent responsibility guilt" (Weiss, Sampson, & O'Connor, 1995), in which an over-exaggerated sense of responsibility for the well-being of others is felt, may be indelibly marked by trauma. Research by Wuest, Malcolm and Merritt-Gray (2010) illuminates how survivors of child maltreatment could become caregivers for their abusers. They reveal how an obligation to care in the context of past abuse is often characterised by a sense of never being good enough, degradation and unpredictability – themes found in the ACOPSMI literature (detailed in Chapters 2 and 3) and in trauma counselling literature (Cloitre, et al., 2006).

Guilt

Summerfield (1995) suggests mental health practitioners have power over influencing the delicate counselling process. But if practitioners are influenced by a family-focused philosophy rather than a trauma-informed philosophy, then their capacity to empower ACOPSMI may be limited. For example, Bland (1998) does not include trauma knowledge when writing about grief and guilt for family members. Adopting family-focused values that aim to unite ACOPSMI and their parent may induce in ACOPSMI "separation guilt" (Friedman, 1985; Weiss, et al., 1995). This is "characterized by the belief that one is harming one's parents" by virtue of separating or being different from what is expected (Weiss, et al., 1995). This is similar to survivor guilt because, as with other type II trauma groups such as childhood sexual abuse (Easton, Coohey, O'leary, Zhang, & Hua, 2011), incest (Courtois, 2010) or Holocaust survivors (Durst, 2003; Kestenberg & Kahn, 1998; Solkoff, 1981), survivor guilt can keep individuals with type II trauma from achieving their potential (Bloom, 2002).

The pervasive sense of guilt – as if the parent's needs were their responsibility or obligation – may be at risk of being misunderstood for "closeness" by family-focused

151

researchers and practitioners unfamiliar with trauma science. It may also be misunderstood for "love".

Love

The most common family value embodied within family-focused counselling is the assumption that ACOPSMI love their parents despite the impact an SMI can have. Sugar-coated love references are sprinkled throughout the literature on the counselling of ACOPSMI. For example, Bland (1998), in an attempt to guide social work practice to understand grief and guilt in family responses to mental illness, asserts that grief of all relatives occurs as "normal responses to the emergence of mental illness in a loved family member" (p.27-28). Other disciplines, for example, psychology, also adopt this sentiment without defining the relationship, e.g., "they care for their loved ones with the illness" (Hansen, 2009, p.5). Since the family member's relationship is unspecified, we must therefore assume *all* family members. This automatically includes ACOPSMI. In the ACOPSMI context this assumption may be inaccurate. As Secunda (1997) notes:

> "Some of these kids, when they grow up, tell me, "It's better to have no mother than a crazy mother" (p.43).

The family-focused assumption of love being present between child and parent is perhaps the most misleading and problematic notion because "love" can create a weakening of the ACOPSMI situation. This is because most anticipate the family value of love between child and parent. However, this anticipation may prevent attendance to their "real victimization" (Davis, 2005, p.5). That is, prevent their needs being met as individuals who suffered hardships due to their parent being unavailable psychologically to protect and nurture them in ways that promoted well being.

152

Family-focused counselling literature uses conventional grief models which assume loss of a "loved one" (see Chapter 3). Yet trauma research concludes that what survivors of childhood abuse actually grieve for is an irreplaceable stolen childhood (Bloom, 2000a, 2000b, 2000c). The lack of careful definition of specific features and context of grief is what complicates and trivializes it (Doka, 1989).

Practitioners working with this population are already inadequately trained (a point raised in Chapter 4). Family-focused practitioners who are inadequately trauma-informed and who also adopt normative family-focused assumptions and values (e.g., love or close geographic proximity between adult-child and parent) may not be counselling optimally. Society "insists that children are to be valued, loved, cherished and protected from harm" (Bloom, 2002, p.4). But to the unsuspecting eye, traumatic bonding for example, may appear like family love as it often includes "loving attention as reinforcement of the bonding [which is] interspersed with the abusive and fear-inducing acts" (Courtois, 2010, p.67).

Family-focused values resting on assumptions of love (e.g., Bland, 1998) or geographic closeness (e.g., Mowbray, et al., 2006) may also lead to iatrogenic damage (Caplan & Caplan, 2001). As Kahn (2006) notes: "When a parent or caregiver whose charge it is to love and protect is also a perpetrator of abuse, love and abuse become acceptable partners" (p.1).

Rejection

While some ACOPSMI may love their parents with an SMI (Marsh & Lefley, 1996), still others disengage, become distanced, alienated, or reject their parents. For example, Lachenmeyer (2000) writes to his father "I can't live in your world; you can't live in mine" (p.146). Evidence for such rejection can be quite subtle, such as their refusal to engage in research involving their mentally ill parents (Solomon & Draine, 1996), or failure of ACOPSMI to engage in treatment designed to support their parent (O'Hanlon & MacRae, 2009). It can also be more direct, such as when ACOPSMI, in striving towards emancipation,

commit the taboo of celebrating their parents' physical death – as seen for example in Camden-Pratt's (2002, 2006) respondents. Trauma reactions, no matter how unusual, are normal responses to abnormal circumstances (J.L. Herman, 1992a). It would therefore seem important to be trauma-informed whenever framing the counselling needs of ACOPSMI.

The ACOPSMI counselling literature is dotted with what Caplan and Caplan (2001) describe as "Enthusiastic Plan[s]" (p.55) – that is plans framed with good intentions which potentially lead to iatrogenic damage if context (addressed in Chapters 2 and 3) is not taken into account. For example, Bland's (1998) plan to "build realistic expectations [to] support the family's hopefulness that the person with the illness will make a full recovery" (p.33) is incongruent when placed against testimonies from Nathiel's (2007) ACOPSMI respondent: "I lost a mother. If I ever even had her" (p.171).

Expectations of the scholarly community, keen on family-focused counselling approaches, may be at odds with trauma research. It makes intuitive sense that family-focused approaches would need to take type II trauma information into account whenever framing the counselling of ACOPSMI, and whenever deciding which counselling intervention best accommodates their predicament.

5.3 Counselling strategies employed in family-focused practice

According to Egan (2007):

> "Counseling provides an opportunity for helping clients embark on the prevention path" (p.10), and the nature and goals of helping depends on "picking the best fit strategies" (p.xvi).

In light of trauma knowledge (discussed in Chapter 3), this section attempts to examine family-focused counselling interventions as applicable to ACOPSMI as family members of

the mentally ill. It argues that guidance given to practitioners on counselling family members, such as ACOPSMI, has not included strategies or theories that accommodate the typical ACOPSMI context.

Family-focused practitioners and choice of counselling models

Therapeutic approaches vary as do the professionals who utilise them (Egan, 2007). However, family-focused practitioners irrespective of their discipline or theoretical orientation are united by a family-focused philosophy (outlined in Chapter 4), not by a designated "family-focused" counselling model.

Family-focused approaches use step-by-step intervention guidelines, sometimes including reproducible handouts and forms (Miklowitz, 2008), and do not represent any theoretical counselling model (Leff, 2005). Family-focused practitioners therefore choose which counselling models to employ from the array available within therapy literature. They can also be guided by scholars who come from various disciplines: social work (e.g., Bland, 1998), psychology (e.g., Young, in Young, et al., 2004), and psychiatry (e.g., F. E. Miller, 1996; Solomon & Draine, 1996). They guide family-focused practitioners on how to conduct family-focused counselling using their preferred counselling models. There are no articles specifically tailored to address the counselling of ACOPSMI. However, family-focused articles addressing the counselling of "family members" (e.g., Solomon, & Draine, 1996) or "relatives" (e.g., Miller, 1996) of SMI individuals can be taken to include ACOPSMI.

Kleber and colleagues (1992) note that whenever establishing needs within any counselling process, therapists "must have a theoretical model" (p. 10). Apart from scant reference to Doka's (1989) disenfranchised grief (found in Bland, 1998; Young, et al., 2004) or Boss's (1991) ambiguous grief (found in Young et al., 2004), articles guiding family-focused practitioners depend on theoretical grief models pertaining to a physical death. This may not fit the ACOPSMI context involving a psychological death. It may benefit

155

practitioners to become aware of non-physical death grief models because many ACOPSMI experience the psychological death of their parents (as noted in Chapter 3).

In stark contrast to grief studies on bereavement through a physical death (Parkes & Prigerson, 2010), grief as a result of a psychological death does not appear as a separately studied phenomenon. Yet losses as a result of a *non-physical death* require more grief-recovery tasks – twelve (Bloom, 2002) – than that following a physical-death – four (Worden, 2002). Moreover, ACOPSMI lose their parents twice – psychologically, then physically (M. J. Brown, 1994). Family-focused counselling articles do not attempt to identify or address this "double death" (author's term).

It appears from the ACOPSMI literature that initial steps towards unpacking ACOPSMI and grief present two challenges. In addition to the aforementioned normative grief of the kind resulting from a physical death (Hall, 2001), there is also the power differential operating between those 'in need' (offspring) and those 'providing needs' (parent) (deYoung & Lowry, 1992; J. L. Herman, 1992a; Warner, 2009) which demand attention. This is because loss and grief of ACOPSMI may have to do with quality of attachment to their parent (Bowlby, 1969, 1999). These two challenges are ignored as the following demonstrates.

The Final Report: Protecting Australia's Children Research Audit (McDonald, Higgins, Valentine, & Lamont, 2011) mentions that "for many, the trauma of maltreatment is compounded by experiences such as the [physical] death of a parent" (p.38). The physical death of a parent with an SMI may not necessarily "compound", i.e., increase or worsen their situation, because the physical death of parents with SMI are sometimes welcomed with relief by both children and adults. For some ACOPSMI, the physical death of their parent may represent the end of a destructive power struggle between them and their parent which may have resulted in their disempowerment (see for example, Camden-Pratt, 2002, 2006). This represents posttraumatic growth (PTG) as detailed in Chapter 3. Ignoring trauma knowledge may overlook the parent's psychological death considered "more excruciating to a child than a parent's physical death" (L. Kaplan, 1995 cited in Secunda, 1997, p.45).

Attachment theory and trauma research would therefore need to play a key role within any intervention involving ACOPSMI (as detailed in Chapters 2 and 3). For example, attachment organisation or style may serve to inform the counsellor as to which therapeutic modalities are likely to be effective when attending to the needs of ACOPSMI (Cicchetti & Toth, 1995) and which counselling models are likely to not be trauma-informed (Jennings, 2004; Kezelman & Stavropoulos, 2012).

Family-focused counselling articles do not seek to use, extend, or enhance existing trauma knowledge. Trauma-informed counselling recommendations, such as the need to integrate painful experiences of trauma (Cloitre, et al., 2006; Courtois & Ford, 2009; Gold, 2000) might not be compatible with trauma-avoidant family-focused counselling approaches. Contrary to family-focused practitioners, trauma-informed practitioners working with ACOPSMI may: show empathy for how trauma interrupted their life (Cloitre, et al., 2006); recognise the relationship between somatic complaints and negative emotion, which often helps counsellors comprehend a possible link between the physical body and sadness (Yoshino et al., 2010); attend to potential trauma features of ACOPSMI (see Chapter 3); suggest psychological distance between abuser and the abused (Anthony, 1986, 1987; Anthony & Cohler, 1987; Bleuler, 1974).

A theoretical basis for any intervention involving ACOPSMI is considered important by various scholars in the ACOPSMI field. For example, in examining intervention programs for children of parents with a mental illness Fraser and colleagues (2006a) observe that few outline their theoretical basis for interventions. They conclude practitioners should use recognised theories whenever developing interventions for future ACOPSMI. To this end, they recommend selecting intervention components used across other areas of the public health spectrum. ACOPSMI have strong affinities with other populations of adult survivors of childhood maltreatment. Family-focused counselling could take advantage of interventions typically used in such groups (discussed in Chapter 3).

However, typical counselling models described in family-focused articles that guide practitioners on how to counsel ACOPSMI appear to be transposing conventional grief counselling models onto ACOPSMI without being trauma-informed. This may be problematic

because traditional grief theories mostly adopt a physical death perspective where loss is absolute. That is, the dead person cannot be brought back to physical life, whereas not all parents with an SMI can be presumed to be physically dead.

A misunderstood grief

Grief of ACOPSMI is at risk of being misunderstood in a family-focused counselling setting. ACOPSMI losses are not straightforward yet in the ACOPSMI literature, 'grief' as a word is absent, and not finetuned enough. It has also become blunted by a certain lack of precision in various family-focused counselling articles (e.g., F.E. Miller, 1996). This is problematic as grief should be defined and used with extreme caution and always strictly within context (Doka & Martin, 2010).

Some scholars postulate that grief need not have any sequence (Ramsay, 1977, cited in Kleber, et al., 1992p.114). Kubler-Ross' (1969, 1974) predictable, lock-step "stages" model, in which grief unfolds via a five-stage process (denial, anger, bargaining, depression, and acceptance), remains appealing as a grief model – even though Kubler-Ross meant it for the dying not the bereaved. The idea of people travelling through "stages" is no longer well-regarded among scholars. It is contradicted in various studies (Bonanno, 2004; Wortman & Silver, 1989), criticised for its prescriptive style (Corr, 1993), expectations of passivity (Worden, 1991), and lack of scientific rigour (Neimeyer, 2001; Friedman & James, 2009). Nevertheless, in examining grief among family members of individuals with serious and persistent mental illness, Solomon and Draine (1996) anticipate that such family members, and by implication ACOPSMI, will demonstrate arrival at a prescribed "stage" of their grief. This may reflect insufficient reference to trauma theory.

The duration of grief for ACOPSMI may be unique. It might be better understood in the context of type II trauma. In a paper exploring the analytical encounter with adults who suffered early trauma, abandonment and neglect, Waldron (2010) describes early trauma as

158

those parts of a person that have been 'frozen' during adulthood due to the impact of early trauma. Since the grief of ACOPSMI is often inextricably tied to type II trauma, it may therefore not decline over time without trauma-informed support – but may remain 'frozen'.

Much can be learnt from Third Wave literature. One ACOPSMI describes their grief as "being in a funeral all the time" (Lancaster, 1993, p.91), another stating "[t]he long term effect is a sadness and a longing for a mother" (Nathiel, 2007, p.172). Reference to "mother" in this instance connects to attachment theory whereby degrees of reliability to that attachment figure often carries implications beyond childhood – into adulthood. As M.J. Brown (1994) points out, the "validation of [ACOPSMI] perceptions that this is a psychologically detrimental experience" (p.10) is essential.

Misinterpretations of grief alter the path of grief (Weiner & Roth, 2006). Lafond (2000, cited in Young, 2004) notes the danger of seeing grief only in its component parts (e.g., anger) warning that if grief goes unnamed, it risks being dismissed, minimized, or pathologised. Young and colleagues (2004) report how "[g]rief symptoms in [non-mentally ill] family members may be misinterpreted as personality deficits and even as causes of the mental health crisis itself" (p.188). This relates to Horwitz and Wakefield's (2007) research in which the loss of sadness is examined from a psychiatric perspective. They argue that psychiatry has transformed normal sorrow into depressive disorders. As M. Cook, third-generation ACOPSMI and convenor of *Children of Mentally Ill Consumers* (COMIC, 2012), reports: "I have come to understand that I am not so much depressed but grieving" (personal communication, April 24 2009).

For practitioners untrained in trauma, it may not be readily apparent why ACOPSMI may often feel sad as a result of a traumatic upbringing. Murphy and colleagues (2011) emphasize the need to avoid incorrect treatments or diagnoses in the ACOPSMI population because adult children in studies included in their metasynthesis "highlighted their experiences of grief, worry and a need to heal wounds [not] depressive episodes" (p.3439). The reference to "wounds" is suggestive of trauma (e.g., see Courtois, 2010).

159

A denial of trauma

Practitioners and researchers would be well served to recall that grief and trauma can coexist. However, Murphy and colleagues (2011) state that because participants reported creativity, personal growth, and resilience, such positive elements could not co-exist alongside the effects of trauma. They state that this "therefore, creat[ed] some debate with the automatic correlation of parental mental illness and trauma" (p.3439). This may overlook the point that being creative is no accurate reflection of internal wounds (as pertaining to type II trauma), and that personal growth could manifest as PTG (posttraumatic growth) as seen in Camden-Pratt's (2002) research. Furthermore, concepts considered favourable within Second Wave literature such as strengths, competencies, and resilience do not cancel out the effects of trauma (a point argued in Chapters 1 and 3). In her study of adults reflecting back on childhood abuse experiences, Walker (1992) observes: "denial is often a successful means of transcending sensible debate. In cases of abuse, there is a constant challenge to reason, since we would prefer to think of some of the facts of abuse as being impossible" (p.113).

Connecting a recognised theory appropriately to practice

The connection between trauma theory and counselling practice has not been adequately made in the counselling literature on ACOPSMI. Fraser and colleagues' (2006) recommendation that practitioners use a *recognised* theory whenever developing interventions may have gone unheeded. Grief theories chosen in proposed family-focused counselling are not readily recognised. For example, Miller (1996), Bland (1998), and Young and colleagues (2004) employ Continuing Bonds (Klass, Silverman, & Nickman, 1996) by deliberately encouraging memories to prompt individuals to engage with their grief, for example via photographs (Young, et al., 2004). Yet none name or give attribution to Klass and colleagues (1996) who developed this theory. Not identifying key authors in the grief counselling field might make it challenging (for the uninitiated in grief theory) whenever

160

testing a counselling model for appropriateness of fit. Connecting theory to practice is important yet challenging (Kane & Trochim, 2009).

Family-focused practitioners that use conventional death-related grief theories in the counselling of family members, like ACOPSMI, would typically assume their client will perform according to expectations inherent in the practitioner's selected theory. ACOPSMI may, unknowingly, be at risk of being misunderstood because they are likely to be assessed according to a set of theoretical expectations inappropriate to their situation. For example, in writing about studies of grief and bereavement in adult life, Parkes and Prigerson (2010) state that in the context of grief, the term mentally ill "would only be justified if the symptoms were so lasting, severe, and disabling" *(p.5)*. They are referring to bereavement as a result of a physical death. In the context of ACOPSMI carrying type II trauma, grief as a result of childhood losses and deprivations is likely to be "*lasting*" because trauma is long-lasting (Lanius, et al., 2010). It is likely to be "*severe*" because their grief connects with earlier attachment figures. And ACOPSMI are likely to have "*disabling*" occasions during their life as even competent, non-disordered ACOPSMI carrying type II trauma have "*disabling*" moments (Koval, 2011).

Being raised by parents with an SMI meant circumstances were not normal (detailed in Chapter 2). As one ACOPSMI recalls:

> "weirdness was routine. I had to be taught that the whole world isn't insane" (Secunda, 1997, p.44).

It may be unfair on ACOPSMI to have a grief "test" applied to them using conventional grief theories in their counselling. This is because, by definition, ACOPSMI did not have what may be considered traditional or normal circumstances.

Can ACOPSMI take refuge in family-focused counselling approaches?

ACOPSMI may be at risk of failure in meeting unrealistic expectations of the scholarly community who attempt to address their counselling needs via inappropriate counselling theories within a family-focused approach.

Perhaps denying the existence of trauma within the ACOPSMI population can be anticipated because denying trauma is a typical tendency for scholars researching traumatised populations (Armstrong, 1996). Within this reality, the trauma-based counselling needs of ACOPSMI have not yet materialised in the counselling literature. Consequently, their grief has not been normalised, socially accepted, or acknowledged (Doka & Martin, 2010).

Bowlby is reported to have said "the true test of theory is its applicability to alleviating the distress of our clients" (cited in Sable, Sable, 2000, p.xviii). Using traditional grief theories in the ACOPSMI context may not alleviate the distress of ACOPSMI. They may lead practitioners, and more importantly ACOPSMI, astray. As Anthony's (1986) trauma research indicates, it is both good and necessary for ACOPSMI to withdraw and dissociate. Therefore, according to trauma research, ACOPSMI would show a measure of strength if, when overtaxed by circumstances beyond their control, they could "withdraw from an intolerable reality into protective fantasy" (p.327). Within conventional grief counselling models employed by family-focused practitioners, ACOPSMI cannot withdraw because they are expected to do a "task" (Worden, 1991, 2002) as anticipated by Miller (1996), Young et al., (2004), and Bland (1998); demonstrate arrival at a prescribed "stage" (Kübler-Ross, 1969, 1974) as anticipated by Solomon and Draine (1996); or continue a parental "bond" (Klass, et al., 1996) as anticipated by Young and colleagues (2004).

All sources of family-focused counselling guidelines have a focus on grief – not trauma. None introduce trauma as a clinical concept, employ trauma models or trauma theories to their proposed counselling. For instance, they do not tackle the question of ACOPSMI losses being about a "psychological death" (L. Kaplan, J., 1995) because none appear to have learnt

162

from first-person narratives. Family-focused counselling articles by Miller (1996), Young et al., (2004), Bland (1998), and Solomon and Draine (1996) were written when experiential accounts by ACOPSMI were already published. Ample qualitative studies, autobiographies and testimonies from ACOPSMI articulate their type II trauma. They include strong trauma features such as shock, horror and fear (E. M. Brown, 1989; Nathiel, 2007; Rengstorff, 1992), which are likely to produce a unique mix of various grief responses (outlined in Chapter 3).

The counselling of ACOPSMI is more likely to be a trauma-recovery matter as opposed to a family-focused matter. Trauma recovery by ACOPSMI seems to have been hijacked by family-focused approaches which ignore trauma knowledge while framing their counselling needs according to inappropriate intervention models. An over-focus on parents with an SMI may be at the expense of their surviving adult children and their recovery needs.

In sum, ACOPSMI cannot take refuge in family-focused approaches which dominate core service deliveries by organisations and agencies within the counselling arena. Government-driven, family-focused approaches are aligned with some problematic expectations, assumptions, theoretical constructs and ideologies which may cause iatrogenic damage (Caplan & Caplan, 2001).

Chapter 6: Horizons

It can be difficult to predict what lies ahead for individuals growing up exposed to parental maltreatment – particularly if in adulthood they live, on the surface, according to society's expectations. Various forms of literature and concepts presented herein point to consequences for type II trauma in the ACOPSMI population continuing unnamed and unquestioned. This final chapter discusses implications and recommendations for researchers, policy makers and practitioners, including limitations of this study. Final words suggest complacency is not in society's best interest.

6.1 Discussion

The impetus for this study began with this researcher's private practice experience of competent, non-disordered ACOPSMI, who despite professional achievements and connection to their own current families nevertheless experienced distress left over from adversities suffered during childhood (see Prologue). The title of this research suggests an inherent paradox: the possibility of ACOPSMI being traumatised yet competent, productive people. This point, first emerging in Bleuler's (1974) work, continues to reverberate today in Third Wave literature.

ACOPSMI are a large and somewhat amorphous group, of whom one must take care when and how to generalise. Broadly speaking, ACOPSMI are a heterogeneous group often united by type II trauma. They are likely to be a larger-than-evident group due to substantial underreporting.

Since ACOPSMI are likely to constitute a substantial slice of Australia's population and since early trauma is a "hidden epidemic" (Lanius, et al., 2010), society can ill afford to continue disregarding the needs of this population across the lifespan. Felitti and colleagues'

(1998) pioneering work and other scientific evidence (listed in this research) suggest the magnitude of the problem demands recognition. Trauma awareness needs to be at the helm in policy and practice. But unfortunately, ACOPSMI do not live in a trauma-informed world because currently their trauma is unacknowledged.

Established trauma and alternative grief theories are applicable to ACOPSMI with type II trauma histories, enabling the aim and objectives of this study to be met. These theories also pave the way for testing future assumptions in policy and practice, as illustrated in certain idealised notions of family relationships generated by normative family-focused values. Ultimately, connections between trauma theory and ACOPSMI narratives provide a logical foundation for critiquing policy's lack of a lifetime perspective and for scrutinising use of inappropriate counselling models in practice.

The concept of trauma acts as a versatile "glue" that can unite the thinking of scholars in various spheres even when the word "trauma" or "grief" is absent. For instance, concerns expressed today (e.g., Jeffreys, et al., 2011) and as far back as the early 1920s (Canavan & Clark, 1923) do not mention the word "trauma" or "grief", and present day trauma research does not mention ACOPSMI (e.g., Kezelman & Stavropoulos, 2012). This research gives a new twist by deliberately using trauma and grief as key concepts when reviving concerns regarding this population.

There is more common ground between child-protection and mental health services than may have at first been thought. Literatures from both vantage points acknowledge the suffering of the offspring of parents with an SMI. Recall that Bleuler's (1974) longitudinal psychiatric perspective interestingly does not contradict Jeffreys and colleagues' (2011) child protection perspective. Neither does it contradict testimonies in experiential accounts including first-person research authored by academics who are ACOPSMI (Camden-Pratt, 2002; Foster, 2006).

Decision-makers in the policy sector need to rethink the purpose of current policy efforts. Many ACOPSMI already suffer a psychological penalty due to losses during their childhood, traumatic attachment issues, and a family-of-origin atmosphere involving

165

dysfunctional parenting styles. Yet policy-makers and scholars seem prepared to sacrifice the needs of the offspring for the needs of parents with SMI.

Policy is the 'engine room' determining society's future. Policy-makers and scholars need to be mindful of fundamental issues and processes involving the ACOPSMI population. But the following obstacles persist.

The current focus is on detection rather than prevention of mental illness within this population. Moreover, there is a dichotomised approach towards individuals whose unprocessed trauma might manifest as "good" or "bad" behaviours. Additionally, the lack of connection between adult and child services hardly enables the needs of ACOPSMI to be met.

There are less obvious obstacles, as well. Euphemisms conceal parentification matters. "Partnership" programs are carer recruitment-efforts that overlook ACOPSMI who were parentified (Mental Health Council of Australia & Carers Association of Australia (MHCA & CAA), 2000). Phrases like "children who care" (Aldridge & Becker, 1993) or "young carers" (Aldridge & Becker, 2003) overlook parentification processes that compound the effects of type II trauma.

The three restrictive views or categories of ACOPSMI (mentally ill, carer, or mentally ill *and* carer) represent another obstacle. Third Wave literature demonstrates that not all ACOPSMI are mentally ill or carers, and that they can be simultaneously traumatised and career (or otherwise socially) competent. Restrictive and simplistic views of ACOPSMI ultimately deny that bodily responses caused by traumatic experiences continue for decades across the lifespan (Lanius, et al., 2010). This means avoidable physical chronic illnesses, such as lung disease, heart disease, cancer, stroke, diabetes, skeletal fractures, and liver disease (Felitti, et al., 1998) will continue if not tracked to their origins (J.L. Herman, 1992a).

The little literature there is on grief counselling of ACOPSMI, important as it is, omits trauma knowledge. Limited sources within the literature on ACOPSMI suggest the need to

look to other therapeutic fields for direction. This is a 'blessing in disguise' as it allows for the notion of a trauma-informed approach (Jennings, 2004).

To many readers it seems preposterous to use literature on sexual abuse, war combatants, or child Holocaust survivors to visualise the unacknowledged trauma of ACOPSMI. It may surprise that fighting the enemy during wartime impacts on combatants just as struggling to have dependency needs met by maltreating parents (with or without an SMI) impacts on the offspring. Nevertheless, brain imaging studies do show similarities between these two groups (McCrory, et al., 2011). Yet in the eyes of most, "parent" is not interchangeable with "enemy". In terms of attachment theory, this implies that for ACOPSMI with type II trauma histories the "enemy" is indeed within. Unlike in war, "the enemy" is not an external party but is symbolically and internally cultivated via dysfunctional and toxic attachments. It should come as no surprise then that testimonies in Third Wave literature are peppered with metaphors of "war".

Trauma's vast research facilitates and unites rich understandings, such as time delay of trauma awareness and the need for psychological distance from parents unites with experiential accounts in Third Wave literature. Common features of the effects of trauma justify inclusion of a trauma-informed perspective for the population studied. It conceptually guides use of grief principles and strengthens the logical foundation for critiquing policy and practice on how well their needs are met.

6.2 Limitations of the study

There are several limitations to this study. In summary they are as follows.

This thesis is not empirical research. Not all research topics are suited to an empirical approach. Sensitivities underlying this topic (detailed in Chapter 1) suggest a theoretical piece may have been an appropriate start towards better trauma-awareness for the

population studied. Conducting theoretical research means that application of theories into practice can be later tested in the 'real world' via follow-up empirical research.

Samples of first-person narratives that form the bulk of Third Wave literature were meagre, difficult to obtain, and cannot act as a substitute for large-scale empirical research. However, the researcher believes that the project design has the potential power to educate all parties involved in the importance of being trauma-informed whenever addressing the ACOPSMI population at policy and practice levels.

This research seeks only to identify the dimensions of the omission of trauma-informed care of ACOPSMI. Within the word limit of a Master's thesis it cannot explore *how* to address type II histories of ACOPSMI.

This study does not pretend to address or represent the needs and issues of all ACOPSMI. It is a single, non-representative study, and the experience of competent, non-disordered ACOPSMI may not be immediately generalisable or transferable to those on negative life trajectories (e.g., drug and alcohol addicted). The lack of literature within the ACOPSMI sphere of study further limits inferences that can be made to the larger ACOPSMI population. However, trauma knowledge is applicable across a broad range of groups – irrespective of history. This includes individuals on various life trajectories, as the defining features of trauma are universally recognised among divergent bodies of studies.

Due to limited space and time for enquiry, no chapter dedicated to grief is included. However, the potential for trauma knowledge to influence the type of grief models employed is glimpsed in Chapters 3 and 5.

6.3 Implications

The following highlights implications across three levels – practice (micro), family (meso), and national policies (macro). It begins with broader implications for any future research endeavours targeting the ACOPSMI population.

Implications for future research

Researchers studying the ACOPSMI population need to bear in mind that many individual ACOPSMI carry type II trauma histories. Importantly, they need to heed warnings from existing trauma studies that the impact of trauma is distinctly a separate matter from outward displays of competencies (e.g., Massie & Szajnberg, 2006). Well camouflaged, socially competent, non-disordered ACOPSMI are not exempt from the impact of (untreated) trauma, which can manifest physically for at least 50 years (Felitti et al., 1998). If ACOPSMI do not receive trauma awareness, for instance, via psycho-education early enough they can become physically sick. This situation may contribute to the rise in demand for hospital beds and lengthier stays in care. On the other hand, trauma awareness-raising opportunities as found in *beyondblue* (beyondblue, 2012) for the ACOPSMI population are publically unavailable.

Given the time delay of trauma awareness, research into this population may best focus on retrospective accounts given by older adults. Retrospective accounts from competent, non-disordered ACOPSMI are likely to be useful for research into programs designed to meet the future needs of this population from infancy to old age.

There is a need to pay careful attention to Third Wave literature because of the illustrative power of the testimonies found therein. For example, many adults reflecting back on their whole life experience demonstrate how they could not have visited certain thoughts and feelings due to trauma and dependency needs.

Exploring the unique grief of ACOPSMI and its impact, with a view to improve practice, is highly recommended. It is critical to design a trauma-informed study with adequate power to map out the grief of ACOPSMI amidst their functioning. Further theory-driven and trauma-informed studies in the ACOPSMI field may also provide a useful launch pad for better interventions.

Implications for practice (micro)

In order to prevent iatrogenic damage (Caplan & Caplan, 2001), practitioners should keep in mind a number of discrete implications whenever attending to the needs of their ACOPSMI clientele, as listed below.

❖ Trauma responses are normal in individuals who experienced an abnormal upbringing (not withstanding other factors, such as culture). Testimonies from ACOPSMI who are also academics doing important empirical research within Third Wave literature underscore trauma as a normal response to abnormal circumstances.

❖ One can be traumatised and not be mentally ill. No matter how highly functioning ACOPSMI are on the outside, there is a part of them which experiences intense personal suffering.

❖ Grief associated with loss is natural and expected during life. But interpersonal trauma visited by parents upon their offspring is unnatural and unexpected, therefore abnormal.

❖ Born into adversity, many ACOPSMI began life with loss. Those not born into adversity also suffer loss. Grief of ACOPSMI is not straightforward. It is deeply disenfranchised. ACOPSMI are often not grieving for "loved" parents but for their own lost, interrupted, or eroded childhood.

❖ Grief intersects and interacts with trauma in potentially powerful ways, as demonstrated via the PTG concept, i.e., post-traumatic growth as a trauma reaction by ACOPSMI after their parents' physical death. Trauma is a normal reaction so is grief. Normalising grief and trauma reactions of ACOPSMI (even if social taboo lines are crossed) validates ACOPSMI on two levels: (1) as traumatised children, when matters were outside their control due to dependency needs; and (2) as disenfranchised trauma-carrying adults.

❖ ACOPSMI with type II trauma histories suffer the same internal demands as other groups carrying such histories, so practice models for ACOPSMI should be trauma-informed.

❖ Practitioners need to screen for (1) mental illness type, severity and chronicity of their clients' parents; (2) type II trauma history carried by individual ACOPSMI, including type of early abuse and neglect; and (3) signs of disenfranchised grief requiring supportive facilitation. Specific counselling approaches, whether for children or adults, require development.

❖ It is problematic if ACOPSMI living in proximity to parents with an SMI is automatically interpreted as a positive psychosocial outcome (Mowbray, et al., 2006) and by default an outward impression of love. Such interpretations obstruct (1) openness and frankness about interpersonal trauma and attachment needs (Courtois & Ford, 2009; Freyd, 1996); (2) recognition of the power of guilt (described in Chapter 5); (3) validation of shame as a more important mechanism shaping the lives of trauma survivors than stigma (Dearing & Tangney, 2011).

❖ ACOPSMI need psychological distance from their parent before trauma awareness can safely surface. Consequently, counselling is typically sought in later adulthood – not only because it takes a longer time before ACOPSMI feel psychologically safer – but also it is when existential questions are likely to emerge in life.

Implications for families where there is a parent with an SMI (meso)

Family-focused approaches are not in the best interest of ACOPSMI with type II trauma histories. Focusing on the family is important in neonatal care and in cases of young children (COPSMI), but not as important or advisable in the case of adults (ACOPSMI). In adulthood, family of origin per se is not as relevant as *origin* of maltreatment, i.e. in attachment terms. Not defining what the relationships are among family members risks overlooking type II trauma. The unquestioned assumption that all ACOPSMI love their parents – by virtue of being a family member – has led the literature into overlooking the relevance of the *origins* of their abuse and neglect. Relevance of early traumatic attachments needs to be acknowledged. Family-focused interventions therefore need to be approached with extreme caution and always with a trauma-informed stance.

Family-focused counselling approaches do not protect or guard ACOPSMI from the effects of type II trauma. Because they do not provide sanctuary, they are inherently self-limiting for them. Yet they nonetheless dominate core service deliveries.

Policy-makers, practitioners, organisations, agencies and service providers contribute to iatrogenic damage if they obligingly and uncritically abide – knowingly or unknowingly – by the government's family-focused philosophy.

The latest neurobiological trauma research is not a threat but an opportunity to constructively interrupt family-focused approaches. Such approaches currently have the effect of narrowing discussions of policy and practice initiatives and recommendations, as if only certain family members (namely, parents with SMI) are struggling.

Implications for policy (macro)

It is indelicate to overlook trauma in this population. Policy and practice intent on clinging to the comfort and familiarity of normative family values are overlooking

testimonies collectively found within Third Wave literature that read as accounts of lost innocence, of trauma, and of the self.

Trauma-based needs of ACOPSMI include the need for psychological distance from parents. This is unrecognised in policies involving the ACOPSMI population. FaPMI programs offer respite to children. But the various forms psychological distance can take (illustrated in Chapter 3) require further trauma-informed acknowledgement and development – beyond a need for respite.

The uneven distribution of resources channelled into research favours the well-being of parents with SMI at the cost of that of their offspring. Australian policies need to be more equitable in the distribution of scarce resources by including *all* immediate family members affected by parents with an SMI – irrespective of chronological age.

Unfulfilled attachment needs keep offspring "captive" (J.L. Herman, 1992b) to parents with an SMI, psychologically *needing to* care for their parent. They remain attached without free choice. Survivors of child maltreatment often become caregivers for their abusers (Wuest, et al., 2010).

Publically available psycho-education for current and future ACOPSMI is necessary. Given that policies aim to be preventative, prevention of adult physical diseases in particular calls to attention the responsibility and role policy has in providing free education around self-care. There is a time delay before trauma survivors can safely become aware of their experiences. This time delay needs to be appropriately circumvented via education as it impacts in physical health terms (Felitti, et al., 1998).

Type II trauma is a personal and a public health hazard (J. E. Davis, 2005). To prevent health problems from occurring or intensifying as a consequence of early trauma, policy-makers and practitioners are obliged to do a great deal more for the ACOPSMI population and, by implication, for society.

6.4 Future preventive actions

The following points provide a brief outline on forward actions that can be made for ACOPSMI.

❖ It would be relevant for practitioners and policy makers to assist current and future ACOPSMI to maintain psychological distance between them and their parents. This needs to be appropriate to chronological age, developmental stage of need, and tailored to individual circumstances and context.

❖ A trauma-focussed approach need not be confined to indigenous or culturally and linguistically diverse communities (CALD), including refugees. It is important to include the ACOPSMI population among the list of traumatised groups in the 2000 Action Plan – their needs are just as great as those of anybody exposed to type II trauma.

❖ Incorporating a more trauma-informed approach in COPMI and FaPMI initiatives and programs is useful.

❖ The joining of two silos, adult mental-health and child protection services, could be enabled using a trauma-informed approach as "the glue".

❖ Developing a universal set of trauma-informed practice principles as part of a standard approach tailored to the ACOPSMI context to meet the needs of this population across the lifespan is critical.

❖ Adopting a communication model specifically for the ACOPSMI population similar to that established by the *Australian Trauma and Grief Network* (TGN) for type I trauma (e.g., from floods or bushfire events) is important.

❖ Provide psycho-education and support pathways to greater type II trauma awareness on all levels (micro, meso and macro). This may prevent the effects of

174

trauma escalating into negative outcomes and taking hold of an already difficult life to which many ACOPSMI were exposed during the first part of their life.

6.5 Final words

Embedded in the title of this thesis are the questions of whether the lives of competent, non-disordered ACOPSMI remain 'unseen', and whether it can be assumed that their trauma and grief remains unacknowledged. It is unlikely that the experiences of children who grew up with parents with an SMI will have their trauma-based needs recognised. Trauma-based policy and practice have benefited other groups but are yet to be applied to the ACOPSMI population.

Despite the new trauma-informed Practice Guidelines (Kezelman & Stavropoulos, 2012) and research on other trauma-affected populations offering guidance in the interim, some pessimism remains. Due to the very real obstacles operating systemically on a large scale in policy and practice, the trauma-based needs and subsequent grief processes that occur are not recognised in ACOPSMI. Due to the way trauma behaves, ACOPSMI need respectful external acknowledgement. Until then, the twin themes of "silence" and "invisibility" are destined to continue in the ACOPSMI population. Powerful barriers against accessing trauma-informed awareness by all stakeholders persist. Does this mean that the unseen and delayed impact of type II trauma on many ACOPSMI is destined to contribute to society's ever-rising levels of avoidable health problems and disease?

In the final analysis, there is some hope on the horizon. There is a promising yet underdeveloped interface among three worlds: (1) adult mental health policies, (2) trauma knowledge inclusive of experiential accounts (from Third Wave literature), and (3) child protection policies. These three worlds will benefit from more permeable boundaries. Trauma science and Third Wave literature provides the evidence, child-protection has the

will power, and policy is strategically positioned to serve as front-line guardians for the healthier development of survivors of parents with an SMI.

The reader is invited to look beneath the surface of even the most functioning ACOPSMI across their lifespan. The more clearly their inner lives are "seen", the more likely ACOPSMI themselves will recognise – without shame – that their early suffering was beyond their control and that their needs are legitimate.

List of References

Abosh, B., & Collins, A. (Eds.). (1996). *Mental illness in the family: Issues and trends.* Toronto: University of Toronto Press.

Abramovitch, H., Hanoch. (2000). "Good death" and "bad death": Therapeutic implications of cultural conceptions of death and bereavement. In R. Malkinson, S. S. Rubin & E. Witztum (Eds.), *Traumatic and nontraumatic loss and bereavement: Clinical theory and practice* (pp. 255-272). Madison: Psychosocial Press/International Universities Press.

Acierno, R., Kilpatrick, D. G., & Resnick, H. S. (1999). PTSD in adults relative to criminal victimization: Prevalence, risk factor and comorbidity. In P. A. Saigh & J. G. Bremner (Eds.), *Posttraumatic stress disorder in adults* (pp. 44-68). Boston: MA: Allyn and Bacon.

Adams, N., & Grieder, D., M. (2005). *Treatment planning for person-centered care: The road to mental health and addiction recovery. Mapping the journey for individuals, families, and providers.* Burlington: MA: Elsevier Academic Press.

Adults surviving child abuse. (2012). ASCA home page. Retrieved July 2, 2012, from http://www.asca.org.au/displaycommon.cfm?an=1&subarticlenbr=74

Agllias, K. (2011). No longer on speaking terms: The losses associated with family estrangement at the end of life. *Families in Society - The Journal of Contemporary Social Services, 92*(1), 107-113.

Ahearn, F., L. (Ed.). (2000). *Psychosocial wellness of refugees: Issues in qualitative and quantitative research*. New York: Berghahn Books.

Ainsworth, M., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale: N.J.: Lawrence Erlbaum.

Alakus, C. (2000). Children of adult consumers of mental health services: Towards principles of practice. *Australian Social Work, 53*(3), 45-53.

Alakus, C., Conwell, R., Gilbert, M., Buist, A., & Castle, D. (2007). The needs of parents with a menal illness who have young children: An Australian perspective on service delivery options. [Article]. *International Journal of Social Psychiatry, 53*(4), 333-339.

Aldridge, J. (2006). The experiences of children living with and caring for parents with mental illness. *Child Abuse Review, 15*, 79-88.

Aldridge, J., & Becker, S. (1993). *Children who care: Inside the world of young carers*. Loughborough: Department of Social Sciences, Loughborough University in association with Nottinghamshire Association of Voluntary Organisations.

Aldridge, J., & Becker, S. (2003). *Children caring for parents with mental illness: Perspectives of young carers, parents and professionals*. Bristol Policy, c2003.

Alexander, J. C., Eyerman, R., Giesen, B., Smelser, N. J., & Sztompka, P. (2004). *Cultural trauma and collective identity*. Berkeley, Calif University of California Press.

Alexander, P. C. (1993). The differential effects of abuse characteristics and attachment in the prediction of long-term effects of sexual abuse. *Journal of Interpersonal Violence, 8*(3), 346 - 362.

177

Alexander, P. C. (2012). Retraumatization and revictimization. An attachment perspective. In M. P. Duckworth & V. M. Follette (Eds.), *Retraumatization: assessment, treatment, and prevention* (pp. 191-220). New York: Routledge.

Allen, J. G. (2001). *Traumatic relationships and serious mental disorders.* Chichester, England: Wiley Sons.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th Text Revision ed.). Washington, DC: Author.

Amir, N., Stafford, J., Freshman, M. S., & Foa, E. B. (1998). Relationship between trauma narratives and trauma pathology. *Journal of Traumatic Stress, 11*, 385-392.

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., et al. (2006). The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clincial Neuroscience, 256*, 174-186.

Anthony, E. (1974). The syndrome of the psychologically invulnerable child. In E. J. Anthony & C. Koupernick (Eds.), *The child in his family: Children at psychiatric risk*. New York: Wiley.

Anthony, E. (1986). Terrorizing attacks on children by psychotic parents. *Journal of the American Academy of Child Psychiatry, 25*(3), 326-335.

Anthony, E. (1987). Children at high risk for psychosis growing up successfully. In E. J. Anthony & B. J. Cohler (Eds.), *The invulnerable child* (pp. 147-184). New York: Guilford.

Anthony, E., & Cohler, B. (1987). *The invulnerable child*. New York: Guildford Press.

Arata, C. M. (1998). To tell or not to tell: Current functioning of child sexual abuse survivors who disclosed their victimization. *Child Maltreatment, 3*(1), 63-71.

Armstrong, J., G. (1996). Emotional issues and ethical aspects of trauma research. In E. B. Carlson (Ed.), *Trauma research methodology* (pp. 175-187). Brooklandville, MD: The Sidran Press.

Arno, P. S., Levine, C., & Memmott, M., M. (1999). The economic value of informal caregiving. *Health Affairs, 18*(2), 182-188.

Astrachan, T., Bernardes, C., & Herman, J. (2010). Part 6 synopsis. In R. A. Lanius, E. Vermetten & C. Pain (Eds.), *The impact of early life trauma on health and disease: The hidden epidemic* (pp. 295-299). Cambridge: Cambridge University Press.

Attig, T. (1991). The importance of conceiving of grief as an active process. *Death Studies, 15*, 358-393.

Australian Child & Adolescent Trauma Loss & Grief Network. (2012). The Australian child & adolescent trauma, loss & grief network. Retrieved July 2, 2012, from http://www.earlytraumagrief.anu.edu.au/about_the_network/about_trauma_loss_grief/

Australian Infant Child Adolescent and Family Mental Health. (2004). *National principles and actions for services and people working with children of parents with a mental illness*. Stepney: Australian Infant Child Adolescent and Family Mental Health.

Australian Infant Child Adolescent and Family Mental Health [AICAFMHA]. (2012). Children of Parents with a Mental Illness and their Families (COPMI). Retrieved July 2, 2012, from http://www.copmi.net.au/about-us.html

178

Australian Infant Child Adolescent and Family Mental Health Association. (2001). Children of parents affected by a mental illness scoping project. Retrieved July 2, 2012, from http://www.aicafmha.net.au/projects/scoping/file/intro.htm

Azam, A., & Kumar, G. V. (2009). The relationship between perceived parental acceptance-rejection and the emotional health problems of adolescents in South India. *Journal of Psychosocial Research, 4*(1), 109-119.

Bacciagaluppi, M. (2011). The study of psychic trauma. *The Journal of The American Academy of Psychoanalysis And Dynamic Psychiatry, 39*(3), 525-538.

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61*(2), 226-244.

Baulderstone, M. J., Morgan, B. S., & Fudge, E. A. (2012). Supporting families of parents with mental illness in general practice. *Medical Journal Australia*(16 April Supplement), 11-13.

Beardsley, W. R., Versage, E., & Gladstone, T. (1998). Children of affectively ill parents: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 37* (11), 1134-1141.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: Penguin Books.

Bekoff, M. (2009). Animal emotions, wild justice and why they matter: Grieving magpies, a pissy baboon, and empathic elephants. *Emotion, Space and Society, 2*(2), 82-85.

Belsky, J. (2005). The developmental and evolutionary psychology of intergenerational transmission of attachment. In C. S. Carter, L. Ahnert, K. E. Grossmann, S. B. Hrdy, M. E. Lamb, S. W. Porges & N. Sachser (Eds.), *Attachment and bonding: A new synthesis* (pp. 167-198). Cambridge: MA: MIT Press.

Belsky, J., & De Haan, M. (2011). Annual research review: Parenting and children's brain development -- the end of the beginning. *Journal of Child Psychology and Psychiatry, 52*(4), 409-428.

Berrick, J. D., & Gilbert, N. (1991). *With the best of intentions: The child sexual abuse prevention movement*. New York: The Guilford Press.

Bertrand, D. (2000). The autobiographical method of investigating the psychosocial wellness of refugees. In F. Ahearn, L. (Ed.), *Psychosocial wellness of refugees: Issues in qualitative and quantitative research* (pp. 88-102). New York: Berghahn Books.

Bettelheim, B. (1986). *The informed heart*. Ringwood: Harmondsworth

beyondblue. (2012). *beyondblue*. Retrieved July 2, 2012, from http://www.beyondblue.org.au/index.aspx?

Bickman, L., & Rog, J. D. (Eds.). (2009). *Handbook of applied social research methods* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Birditt, K. S., Rott, L. M., & Fingerman, K. L. (2009). "If you can't say something nice, don't say anything at all": Coping with interpersonal tensions in the parent-child relationship during adulthood. *Journal of Family Psychology, 23*(6), 769-778.

Birtchnell, J. (1970). Psychiatric sequelae of childhood bereavement. *The British Journal of Psychiatry, 116*, 572-573.

Bittman, M., Hill, T., & Thomson, C. (2007). The impact of caring on informal carers' employment, income and earnings: A longitudinal approach. *Australian Journal of Social Issues, 42*(2), 255-272.

Blair, K., & Cowling, V. (2004). In a daughter's voice: A mental health nurse's experiences of being the daughter of a mother with schizophrenia. In V. Cowling (Ed.), *Children of parents with mental illness 2: Personal and clinical perspectives* (pp. 85-98). Camberwell, Victoria, Australia: ACER Press.

Bland, R. (1998). Understanding grief and guilt as common themes in family responses to mental illness: Implications for social work practice. *Australian Social Work, 51*(4), 27-34.

Blaustein, M. E., & Kinniburgh, K. M. (2010). *Treating traumatic stress in children and adolescents: How to foster resilience through attachment, self-regulation, and competency*. New York: Guilford Press.

Bleuler, M. (1974). The offspring of schizophrenics. *Schizophrenia Bulletin, 1*(8), 93-107.

Blizard, R. A. (2008). The role of double binds, reality-testing and chronic relational trauma in the genesis and treatment of borderline personality disorder. In A. Moskowitz, I. Schafer & M. J. Dorahy (Eds.), *Psychosis Trauma and Dissociation: Emerging Perspectives on Severe Psychopathology* (pp. 295-306). Hoboken, NJ: John Wiley & Sons, Ltd.

Bloom, S., L. (2000a). The grief that dare not speak its name Part I: Dealing with the ravages of childhood abuse. *Psychotherapy Review, 2*(9), 408-410.

Bloom, S., L. (2000b). The grief that dare not speak its name. Part II: Dealing with the ravages of childhood abuse. *Psychotherapy Review, 2*(10), 469-472.

Bloom, S., L. (2000c). The grief that dare not speak its name. Part III: Dealing with the ravages of childhood abuse. *Psychotherapy Review, 2*(12), 516-519.

Bloom, S., L. (2000e, July 1, 2012). Creating sanctuary: Healing from systematic abuses of power. *Therapeutic Communities: The International Journal for Therapeutic and Supportive Organisations*. Retrieved 22nd August, 2012, from http://www.sanctuaryweb.com/PDFs_new/Bloom%20Creating%20Sanctuary%20Healing%20From%20Systemic.pdf

Bloom, S., L. (2002). Beyond the beveled mirror: Mourning and recovery from childhood maltreatment. In J. Kauffman (Ed.), *Loss of the assumptive world*. New York: Brunner-Routledge.

Bonanno, G., A. (2004). Loss, trauma, and human resilience. *Amerian Psychologist, 59*, 20-28.

Bonanno, G., A. (2009). *The other side of sadness: What the new science of bereavement tells us about life after loss*. New York: Basic Books.

Bonanno, G., A., & Boerner, K. (2007). Letters June 27. *JAMA, 297*(24), 2693.

Bonanno, G., A., Wortman, C. B., Lehman, D. R., Tweed, R. G., Haring, M., Sonnega, J., et al. (2002). Resilience to loss and chronic grief: A prospective study from preloss to 18-months postloss. *Journal of Personality and Social Psychology, 83*(5), 1150-1164.

Boss, P. (1991). Ambiguous loss. In F. Walsh & M. McGoldrick (Eds.), *Living beyond loss*. New York: Norton.

Boss, P. (1999). *Ambiguous Loss: Learning to live with unresolved grief.* Cambridge, MA: Harvard University Press.

Boszormenyi-Nagy, I., & Spark, G., M. (1973). *Invisible loyalties: Reciprocity in intergenerational family therapy.* Hagerstown, MD: Harper & Row.

180

Boursnell, M. (2007). The silent parent: Developing knowledge about the experiences of parents with mental illness. *Child Care in Practice, 13*(3), 251-260.

Bowlby, J. (1951). *Maternal care and mental health, WHO Monogram. No.2*. Geneva: World Health Organization.

Bowlby, J. (1969). *Attachment and Loss: Vol.1. Attachment*. New York: Basic Books.

Bowlby, J. (1973). *Separation: Anxiety & anger. Attachment and loss.* London: Hogarth Press.

Bowlby, J. (1977). The making and breaking of affectional bonds.1: Aetiology and psychopathology in the light of attachment theory. College of Psychiatrists, 19 November 1976 version of the Fiftieth Maudsley Lecture, delivered before the Royal psychopathology in the light of attachment theory. An expanded. *British Journal of Psychiatry, 130*, 201-210.

Bowlby, J. (1980). *Attachment and loss: Vol. 3. Loss: Sadness and depression*. New York: Basic Books.

Bowlby, J. (1983). *Loss: Sadness & Depression. Attachment and Loss.* London: Hogarth Press.

Bowlby, J. (1985). *Attachment and loss: Vol. 3. Loss: Sadness and depression*. Middlesex: England: Pelican Books.

Bowlby, J. (1988a). *A secure base*. London: Routledge.

Bowlby, J. (1988b). Developmental psychiatry comes of age. *American Journal of Psychiatry, 145*(1-10).

Bowlby, J. (1999). *Attachment: Attachment and Loss.* New York: Basic Books.

Bradshaw, I. G. A. (2004). Not by bread alone: Symbolic loss, trauma, and recovery in elephant communities. *Society & Animals, 12*(2), 143-158.

Bratton, K. L. (2010). Shame, guilt, anger, and seeking psychological treatment among a trauma exposed population. Unpublished doctoral dissertation. The University of Montana.

Bremner, J. D., Vermetten, E., & Lanius, R., A. (2010). Long-lasting effects of childhood abuse on neurobiology. In R. A. Lanius, E. Vermetten & C. Pain (Eds.), *The impact of early life trauma on health and disease: The hidden epidemic* (pp. 166-177). Cambridge: Cambridge University Press.

Bremner, J. G., & Wachs, D. T. (Eds.). (2010). *The Wiley-Blackwell handbook of infant development*. Chichester, West Sussex: Wiley-Blackwell.

Bretherton, I., & Munholland, K. A. (2008). Internal working models in attachment relationships: Elaborating a central construct in attachment theory. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research and intervention* (pp. 102-128). New York: Guildford.

Briere, N. J. (1992). *Child abuse trauma: Theory and treatment of the lasting effects*. London: Sage Publications.

Broder, E. A., & Hood, E. (1983). A guide to the assessment of child and family. In P. D. Steinhauer & Q. Rae-Grant (Eds.), *Psychological problems of the child in the family* (pp. 25-55). New York: Basic Books.

Brom, D., & Kleber, R. J. (2000). On coping with trauma and coping with grief: Similarities and differences. In R. Malkinson, S. S. Rubin & E. Witztum (Eds.), *Traumatic and nontraumatic loss and bereavement: clinical theory and practice*. Madison, CT: Psychosocial Press.

Bromfield, L., Holzer, P., & Lamont, A. (2011). The economic costs of child abuse and neglect. *Resource Sheet, Australian Institute of Family Studies, National Child Protection Clearing House.*(April), 1-6.

Bronfenbrenner, U. (1977a). Doing your own thing--our undoing. *Child Psychiatry and Human Development, 8*(1), 3-10.

Bronfenbrenner, U. (1977b). Toward an experimental ecology of human development. [Article]. *American Psychologist, 32*, 513-531.

Brown, E. M. (1989). *My parent's keeper: Adult children of the emotionally disturbed* Oakland, CA: New Harbinger Publications.

Brown, M. J. (1994). Silent suffering: An exploration of the experience and psychological effects of growing up with a schizophrenic parent. Unpublished doctoral dissertation. Saybrook Institute.

Bruce, E. J. (2007). *Extraordinary parenting: A manual for parents of children aged 0-12 with chronic physical or medical conditions*. Victoria, Australia: Emotional Health Centre.

Bruce, E. J., & Schultz, C. L. (2001). *Nonfinite loss and grief: A psychoeducational approach*. Baltimore: Brooks Publishing.

Buchheim, A., & Mergenthaler, E. (2000). The relationship among attachment representation, emotion-abstraction patterns, and narrative style: A computer-based text analysis of the Adult Attachment Interview. *Psychotherapy Research 10*(4), 390-407.

Buist, A. (1998). Mentally ill families: When are the children unsafe? *Australian Family Physician, 27*, 261-265.

Burdekin, B., Guilfoyle, M., & Hall, D. (1993). *National inquiry into human rights and mental illness*. Canberra: Australian Government Publishing Service.

Bureau, J.-F., Martin, J., & Lyons-Ruth, K. (2010). The effects of life trauma: Mental and physical health. Attachment dysregulation as hidden trauma in infancy: early stress, maternal buffering and psychiatric morbidity in young adulthood. In R. A. Lanius, E. Vermetten & C. Pain (Eds.), *The impact of early life trauma on health and disease. The hidden epidemic* (pp. 48-56). Cambridge: Cambridge University Press.

Burke, L. (2003). The impact of maternal depression on familial relationships. *International Review of Psychiatry, 15*(3), 243-255.

Burke, M. L., Hainsworth, M. A., Eakes, G. C., & Lindgren, C. L. (1992). Current knowledge and research on chronic sorrow: A foundation for inquiry. *Death Studies, 16*, 231-245.

Camden-Pratt, C. E. (2002). *Daughters of Persephone: Legacies of maternal "madness"*. University of Western Sydney, Sydney.

Camden-Pratt, C. E. (2006). *Out of the shadows: Daughters growing up with a 'mad' mother*. Sydney: Finch Publishing.

Canavan, M. M., & Clark, R. (1923). The mental health of 463 children from dementia-praecox stock. *Mental Hygiene, 7*, 137-148.

Caplan, R, B, & Caplan, G. (2001). *Helping the helpers not to harm: Iatrogenic damage and community mental health*. New York: Brunner-Routledge.

Carlson, E. B. (Ed.). (1996). *Trauma research methodology*. Brooklandville, MD: The Sidran Press.

Carlson, V., Cichetti, D., Barnett, D., & Brownwald, K. G. (1989). Finding order in disorganisation: Lessons from research on maltreated infants' attachments to their care givers. In D. Cicchetti & V. Carlson (Eds.), *Child Maltreatment: Theory and research on the causes and consequences of child abuse and neglect.* Cambridge: Cambridge University Press.

Casey, C. Y., Greenberg, M. A., Nicassio, P. M., Harpin, R. E., & Hubbard, D. (2008). Transition from acute to chronic pain and disability: A model including cognitive, affective, and trauma factors. *PAIN, 134* (1-2), 69-79.

Cassidy, J., & Shaver, P. R. (Eds.). (2008). *Handbook of attachment: Theory, research, and clinical applications* (2nd ed.). New York: The Guildford Press.

Castro, D. M., Jones, R. A., & Mirsalimi, H. (2004). Parentification and the impostor phenomenon: An empirical investigation. *American Journal of Family Therapy, 32*(3), 205-216.

Centre for Parenting and Research NSW Department of Community Services. (2005). Assessment of parenting capacity. Literature review. Retrieved 22nd August, 2012, from http://www.community.nsw.gov.au

Chae, Y., Goodman, G. S., Eisen, M. L., & Qin, J. (2011). Event memory and suggestibility in abused and neglected children: Trauma-related psychopathology and cognitive functioning. *Journal of Experimental Child Psychology, 110*(4), 520-538.

Chase, N., D (Ed.). (1999). *Burdened children: Theory, research and treatment of parentification* California: Thousand Oaks.

Chase, N., D, Deming, M., P, & Wells, M., C. (1998). Parentification, parental alcoholism, and academic status among young adults. *American Journal of Family Therapy, 26*(2), 105-114.

Chenoweth, B. (1994). The adolescent with a mentally ill parent: Effects and special needs. *Annals AUSAP 3*, 255-259.

Children Of Mentally Ill Consumers. (2012). COMIC (Children of Mentally Ill Consumers). Retrieved July 2, 2012, from http://www.howstat.com/comic/Home.asp

Cicchetti, D., & Toth, S., L. (1995). Child matreatment and attachment organisation. In S. Goldberg, R. Muir & J. Kerr (Eds.), *Attachment theory: Social, developmental, and clinical perspectives* (pp. 279-308). Hillsdale: NJ: The Analytic Press.

Cicirelli, V. G. (2010). Attachment relationships in old age. *Journal of Social and Personal Relationships, 27*(2), 191-199.

Cini, C. (2008). Grief-Line: A unique response to grief counselling in contemporary society. *8th International Conference on Grief and Bereavement in Contemporary Society*. Melbourne: Australian Centre for Grief and Bereavement. Retrieved 17th May, 2011, from http://www.grief.org.au/

Cloitre, M., Cohen, L. R., & Koenen, K. C. (2006). *Treating survivors of childhood abuse: Psychotherapy for the interrupted life*. New York: Guilford Press.

Cohen, J. A., Mannarino, A. P., Greenberg, T., Padlo, S., & Shipley, C. (2002). Childhood traumatic grief: Concepts and controversies. *Trauma Violence Abuse, 3*, 307-321.

Cohen, L., Manion, L., & Morrison, K. (2007). *Research methods in education* (Fifth ed.). New York: Routledge.

Cohen, M., Brom, D., & Dasberg, H. (2001). Child survivors of the Holocaust: Symptoms and coping after fifty years. *The Israel Journal of Psychiatry and Related Sciences, 38*(1), 3 -12.

Combs, M., D., & DePrince, A., P. (2010). Memory and trauma: Examining disruptions in implicit, explicit and autobiographical memory. In R. A. Lanius, E. Vermetten & C. Pain (Eds.), *The impact of early life trauma on health and disease: The hidden epidemic.* (pp. 217-224). Cambridge: Cambridge University Press.

Commonwealth Department of Health and Aged Care. (2000). *National action plan for promotion, prevention and early intervention for mental health*. Canberra: Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care.

Consedine, N. S., & Magai, C. (2003). Attachment and emotion experience in later life: The view from emotions theory. *Attachment & Human Development, 5*(2), 165-187.

Cook, A., Blaustein, M., Spinazzola, J., & van der Kolk, B. (2003). Complex trauma in children and adolescents. Retrieved 22nd August, 2012, from http://www.nctsnet.org/nctsn_assets/pdfs/edu_materials/ComplexTrauma_All.pdf

Cooksey, E. C., & Brown, P. (1998). Spinning on its axes: DSM and the social construction of psychiatric diagnosis. *International Journal of Health Services, 28*(3), 525-554.

Corr, C. A. (1993). Coping with dying: Lessons that we should and should not learn from the work of Elisabeth Kubler-Ross. *Death Studies, 17*, 69-83.

Corr, C. A., & Pacholski, R. A. (Eds.). (1987). *Death: Completion and discovery*. Lakewood, OH: Association for Death Education and Counseling.

Council of Australian Governments. (2006). *National action plan on mental health 2006-2011*. Canberra: Council of Australian Governments (COAG).

Courtois, C. A. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, Research, Practice, Training, 41*(4), 412-425.

Courtois, C. A. (2010). *Healing the incest wound: Adult survivors in therapy* (2nd ed.). New York: W.W. Norton & Company.

Courtois, C. A., & Ford, J. D. (Eds.). (2009). *Treating complex traumatic stress disorders: An evidence-based guide*. New York: Guilford Press.

Cousins, C. (2004). When is it serious enough? The protection of children of parents with a mental health problem, tough decisions and avoiding a 'martyred' child. *Australian e-Journal for the Advancement of Mental Health (AeJAMH), 3*(2), 1-8. Retrieved July 2, 2012, from http://www.auseinet.com/journal/vol3iss2/cousins.pdf

Cowling, V. (1994). *Children of parents experiencing major mental illness: What services are there? What do families want?* Surviving Metal Illness: Families, Consumers and the Mental Health System. Paper presented at the 4th Annual Mental Health Services Conference of Australia and New Zealand.

Cowling, V. (1996). Meeting the support needs of families with dependent children where the parent has a mental illness. *Family Matters, 45*, 22-25.

Cowling, V. (Ed.). (1999). *Children of parents with mental illness / written by children, parents and service providers.* Camberwell, Victoria, Australia: ACER Press.

Cowling, V. (Ed.). (2004a). *Children of parents with mental illness 2: Personal and clinical perspectives.* Camberwell, Victoria, Australia: ACER Press.

Cowling, V., Edan, V., Cuff, R., Armitage, P., & Herszberg, D. (2006). Mental health consumer and carer participation in professional education: 'Getting there together' for children of parents with mental illness and their families. *Australian Social Work, 59*(4), 406-421.

Cowling, V., & McGorry, P. D. (2012). Parental mental illness is a family matter. *Medical Journal Australia, April 16*(Supplement), 5-5.

Cowling, V., McGorry, P. D., & Hay, D. A. (1995). Children of parents with psychotic Disorders. *Medical Journal Australia, 163*, 119-120.

Creswell, C., & Brereton, J. (2000). Community mental health services and the children of service users. *Clinical Psychology Forum*(144), 4-6.

Cuijpers, P. (1999). The effects of family interventions on relatives' burden: A meta-analysis. *Journal of Mental Health, 8*(3), 275-285.

Cummins, P. D., Scott, D., & Scales, B. (2012). *Report of the protecting Victoria's vulnerable children inquiry [electronic resource] / the Hon. Philip Cummins (Chair), Prof. Dorothy Scott, Mr Bill Scales*: Melbourne, State Government of Victoria, Department of Premier and Cabinet, 2012.

Dalton, T., Draper, M., Weeks, W., & Wiseman, J. (Eds.). (1996). *Making social policy in Australia: An introduction*. St Leonards, Sydney: Allen & Unwin.

Danieli, Y., Brom, D., & Sills, J. (Eds.). (2005). *The trauma of terrorism: Sharing knowledge and shared care, an international handbook*. New York: The Hawthorn Maltreatment & Trauma Press.

Dansie, R. (2006). Cultural perspective of healing trauma. In A. Hosin (Ed.), *Responses to traumatized children* (pp. 162- 185).

Darlington, Y., Feeney, J. A., & Rixon, K. (2005). Interagency collaboration between child protection and mental health services: Practices, attitudes and barriers. *Child Abuse & Neglect, 29*, 1085-1098.

Dattilio, F. M., & Nichols, M. P. (2011). Reuniting estranged family members: A cognitive-behavioral-systemic perspective. *American Journal of Family Therapy, 39*(2), 88-99.

Davis, J. E. (2005). *Accounts of innocence: Sexual abuse, trauma, and the self*. Chicago: The University of Chicago Press.

Davis, J. L., & Petretic-Jackson, P. A. (2000). The impact of child sexual abuse on adult interpersonal functioning: A review and synthesis of the empirical literature. *Aggression and Violent Behavior, 5*(3), 291-328.

De Bellis, M. D. (2010). The neurobiology of child neglect. In R. A. Lanius, E. Vermetten & C. Pain (Eds.), *The impact of early life trauma on health and disease: The hidden epidemic* (pp. 123-132). Cambridge: Cambridge University Press.

De Prince, A. P., & Freyd, J. J. (2002). The harm of trauma. Pathological fear, shattered assumptions or betrayal? In Kauffman, J. (Ed.), *Loss of the assumptive world: A theory of traumatic loss* (pp. 71-82). New York: Brunner-Routledge.

De Young, A. C., Kenardy, J. A., & Cobham, V. E. (2011). Trauma in early childhood: A neglected population. *Clinical Child and Family Psychology Review, 14*(3), 231-250.

Dearing, R. L., & Tangney, J. P. (Eds.). (2011). *Shame in the therapy hour* (1st ed.). Washington, DC: American Psychological Association.

DeChillo, N., Matorin, S., & Hallahan, C. (1987). Children of psychiatric patients: Rarely seen or heard. *Health and Social Work, Fall*, 296-302.

Dell, P. F., & O'Neil, J. A. (Eds.). (2009). *Dissociation and the dissociative disorders: DSM-V and beyond*. New York: Routledge.

Department of Human Services. (2004). *Survey of consumer and carer experience of Victorian Public Area Mental Health Services (2003-2004)*.

Department of Human Services. (2009). *Because mental health matters: Victorian mental health reform strategy 2009-19*. Melbourne: Mental Health and Drugs Division, Department of Human Services.

Department of Human Services. (2012). Medicare. Retrieved July 2, 2012, from http://www.humanservices.gov.au/customer/information/welcome-medicare-customers-website?utm_id=9

Devlin, J., M., & O'Brien, L., M. (1999). Children of parents with mental illness: An overview from a nursing perspective. *Australian and New Zealand Journal of Mental Health Nursing, 9*, 19-29.

deYoung, M., & Lowry, J. A. (1992). Traumatic bonding: Clinical implications in incest. *Child Welfare, 71*(2), 165-175.

Dillenburger, K., & Keenan, M. (2005). Bereavement: A D.I.S.C. analysis. *Behavior & Social Issues, 14*(2), 92-112.

Dixon, L., Browne, K. D., & Hamilton-Giachritsis, C. (2005). Risk factors of parents abused as children: A mediational analysis of the intergenerational continuity of child maltreatment (Part I). *Journal of Child Psychology and Psychiatry, and Allied Disciplines, 46*(1), 47-57.

Dixon, L., Hamilton-Giachritsis, C., & Browne, K. D. (2005). Attributions and behaviours of parents abused as children: A mediational analysis of the intergenerational continuity of child maltreatment (Part II). *Journal of Child Psychology and Psychiatry, and Allied Disciplines, 46*(1), 58-68.

Doka, K. J. (1989). *Disenfranchised grief: Recognising hidden sorrow.* Lexington, MA: Lexington Press.

Doka, K. J., & Martin, T. L. (2010). *Grieving beyond gender: Understanding the ways men and women mourn.* New York: Routledge.

Donald, T., & Jureidini, J. (2004). Parenting capacity. *Child Abuse Review, 13*(1), 5-17.

Dorahy, M., J, & Huntjens, R., J.C. (2007). Memory and attentional processes in dissociative identity disorder: A review of the empirical literature. In E. Vermetten, M. J. Dorahy & D. Spiegel (Eds.), *Traumatic dissociation: Neurobiology and treatment* (pp. 82-103). Washington, DC: American Psychiatric Pub.

Dorahy, M., J, van der Hart, O., & Middleton, W. (2010). The history of early life trauma and abuse from the 1850s to the current time: How the past influences the present. In R. A. Lanius, E. Vermetten & C. Pain (Eds.), *The impact of early life trauma on health and disease: The hidden epidemic.* (pp. 3-12). Cambridge: Cambridge University Press.

Drake, R. E., Raucusin, R. J., & Murphy, T. A. (1990). Suicide among adolescents with mentally ill parents. *Hospital and Community Psychiatry, 41*(8), 921-922.

Drapalski, A., Marshall, T., Seybolt, D., Medoff, D., Peer, J., Leith, J., et al. (2008). Unmet needs of families of adults with mental illness and preferences regarding family services. *Psychiatric Services, 59*, 665-662.

Drožđek, B., & Wilson, J. P. (Eds.). (2007). *Voices of trauma: Treating psychological trauma across cultures*. New York: Springer.

Dubowitz, H., & Bennett, S. (2007). Seminar: Physical abuse and neglect of children. *The Lancet, 369*, 1891-1899.

Duckworth, M. P., & Follette, V. M. (Eds.). (2012). *Retraumatization: Assessment, treatment, and prevention*. New York: Routledge.

Duncan, G., & Browning, J. (2009). Adult Attachment in Children Raised by Parents with Schizophrenia *Journal of Adult Development, 16*(2), 76-86. Retrieved July 2, 2012, from http://www.springerlink.com/content/bt4387l771q80873/

Dunn, B. (1993). Growing up with a psychotic mother: A retrospective study. *American Journal of Orthopsychiatry, 63*(2), 177-189.

Durst, N. (2003). Child-survivors of the Holocaust: Age-specific traumatisation and the consequences for therapy. *American Journal of Psychotherapy, 57*(4), 499-518.

Earley, L., & Cushway, D. J. (2002). The parentified child. *Clinical Child Psychology & Psychiatry, 7*(2), 163.

Easton, S., Coohey, C., O'leary, P., Zhang, Y., & Hua, L. (2011). The effect of childhood sexual abuse on psychosexual functioning during adulthood. *Journal of Family Violence, 26*(1), 41-50.

Egan, G. (2007). *The skilled helper: A problem-management and opportunity-development approach to helping* (9th ed.). Belmont: CA: Brooks/Cole, Cengage Learning.

Ehly, S., & Dustin, R. (1989). *Individual and group counseling in schools*. New York: Guilford.

Ellis, A. (2001). *Overcoming destructive beliefs, feelings, and behaviors: New directions for rational emotive behavior therapy*. New York: Prometheus Book.

Fadden, G. (1997). Implementation of family interventions in routine clinical practice following staff training programs: A major cause for concern. *Journal of Mental Health, 6*(6), 599-612.

Fadden, G., Bebbington, P., & Kuipers, L. (1987). The burden of care: The impact of functional psychiatric illness on the patient's family. *British Journal of Psychiatry, 150*, 285-292.

Fallot, R., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. Retrieved July 2, 2012, from http://www.annafoundation.org/CCTICSELFASSPP.pdf

Faust, D., & Miner, R. A. (1986). The empiricist and his new clothes: DSM-III in perspective. *The American Journal Of Psychiatry, 143*(8), 962-967.

Felitti, V. J. (2010). Forward. In R. A. Lanius, E. Vermetten & C. Pain (Eds.), *The impact of early life trauma on health and disease: The hidden epidemic* (pp. xiii-xv). Cambridge: Cambridge University Press.

Felitti, V. J., & Anda, R. F. (2010). The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders and sexual behavior: Implications for healthcare. In R. A. Lanius, E. Vermetten & C. Pain (Eds.), *The impact of early life trauma on health and disease: The hidden epidemic* (pp. 77-87). Cambridge: Cambridge University Press.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., & Edwards, V. (1998). Relationship of childhood abuse and household dysfunction to many of the leading

causes of death in adults: The adverse childhood experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), 245-258.

Fernbacher, S., Goodyear, M., & Farhall, J. (2009). Taking a closer look: A cross-sector audit of families where a parent has a mental illness. *Australian e-Journal for the Advancement of Mental Health, 8*(3), 242–249. Retrieved July 1, 2012, from *http://amh.e-contentmanagement.com/archives/vol/8/issue/3/article/3474/taking-a-closer-look*

Finkelhor, D., Ormrod, R. K., & Turner, H. A. (2007). Poly-victimization: A neglected component in child victimization. *Child Abuse and Neglect, 31*, 7-26.

Fisher, L., Kokes, R. F., Cole, R. E., Perkins, P. M., & Wynne, L. C. (1987). Competent children at risk: A study of well-functioning offspring of disturbed parents. In E. J. Anthony & B. Cohler (Eds.), *The Invulnerable Child* (pp. 211-228). New York: Guildford Press.

Fisher, P., A., & Gunnar, M. (2010). Early life stress as a risk factor for disease in adulthood. In R. A. Lanius, E. Vermetten & C. Pain (Eds.), *The impact of early life trauma on health and disease: The hidden epidemic* (pp. 133-141). Cambridge: Cambridge University Press.

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*(4), 417-434.

Fohn, A., & Heenen-Wolff, S. (2011). The destiny of an unacknowledged trauma: The deferred retroactive effect of après-coup in the hidden Jewish children of wartime Belgium. *The International Journal Of Psycho-Analysis, 92*(1), 5-20.

Ford, J. D. (2009). *Posttraumatic stress disorder: Scientific and professional dimensions*. London: Academic.

Ford, J. D. (2010). Complex adult sequelae of early life exposure to psychological trauma. In R. A. Lanius, E. Vermetten & C. Pain (Eds.), *The impact of early life trauma on health and disease: The hidden epidemic*. Cambridge: Cambridge University Press.

Foster, K. N. (2006). *A narrative inquiry into the experiences of adult children of parents with serious mental illness.* Unpublished doctoral dissertation . Griffith University, Queensland, Australia.

Foster, K. N. (2010). 'You'd think this roller coaster was never going to stop': Experiences of adult children of parents with serious mental illness. *Journal of Clinical Nursing, 19*(21-22), 3143-3151.

Foster, K. N., O'Brien, L., & Korhonen, T. (2012). Developing resilient children and families when parents have mental illness: A family-focused approach. *International Journal of Mental Health Nursing, 21*(1), 3-11.

Frankl, V. (1984). *Man's search for meaning (Revised and Updated ed.).* New York: Washington Square Press.

Fraser, C., James, E. L., Anderson, K., Lloyd, D., & Judd, F. (2006). Intervention programs for children of parents with a mental illness: A critical review. *The International Journal of Mental Health Promotion, 8*(1), 9-20.

Freud, A. (1981). A psychoanalyst's view of sexual abuse by parents. In P. B. Mrazek & C. H. Kempe (Eds.). New York: Pergamon Press.

Freud, S. (1957). Mourning and melancholia (1917), standard edition, (vol XIV) (Sigmund, Trans.). In J. Strachey (Ed.), *The standard edition of the complete psychological works*

of Sigmund Freud (Vol. 4, pp. pp. 237-260). New York: Basic Books. (Original work published in 1917).

Freyd, J. J. (1996). *Betrayal trauma: The logic of forgetting childhood abuse*. Cambridge, MA: Harvard University Press.

Freyd, J. J. (2009). What is a Betrayal Trauma? What is Betrayal Trauma Theory? Retrieved July 2, 2012, from http://dynamic.uoregon.edu/~jjf/defineBT.html

Freyd, J. J., Klest, B., & Allard, C., B. (2005). Betrayal trauma: Relationship to physical health, psychological distress, and a written disclosure intervention. *Journal Of Trauma & Dissociation: The Official Journal Of The International Society For The Study Of Dissociation (ISSD), 6*(3), 83-104.

Friedman, M. (1985). Survivor guilt in the pathogenesis of anorexia nervosa. *Psychiatry, 48*, 25-39.

Friedman, R., & James, J. (2009). The myth of the stages of dying, death and grief. *TAPS Magazine, 15*(1). Retrieved July 12, 2011, from http://www.taps.org/magazine/article.aspx?id=6918

Fudge, E., & Mason, P. (2004). Consulting with young people about guidelines relating to parental mental illness. *Australian e-Journal for the Advancement of Mental Health (AeJAMH), 3*(2), 50-58. Retrieved July 2, 2012, from http://*www.auseinet.com/journal/vol3iss2/fudgemason.pdf*

Furukawa, E., & Hunt, D. J. (2011). Therapy with refugees and other immigrants experiencing shame: A multicultural perspective. In R. L. Dearing & J. P. Tangney (Eds.), *Shame in the therapy hour* (1st ed., pp. 195-215). Washington, DC: American Psychological Association.

Gaita, R. (1998). *Romulus, my father*. Melbourne: Text Publishing.

Garber, B. D. (2011). Parental alienation and the dynamics of the enmeshed parent–child dyad: Adultification, parentification, and infantilization. *Family Court Review, 49*(2), 322-335.

Garmezy, N. (1974). Children at risk: The search for the antecedents of schizophrenia. Part 1. Conceptual models and research methods. *Schizohrenia Bulletin, 8*, 14-90.

Gatti, P. (2011). The locked box in the attic: Ghosts and memories. *Journal of Child Psychotherapy, 37*(2), 147-162.

Gholson, B., & Rosenthal, T. C. (Eds.). (1984). *Application of cognitive developmental theory*. New York: Academic Press.

Ghosh, S., & Greenberg, J. S. (2012). Gender difference in caregiving experience and the importance of social participation and marital satisfaction among aging mothers and fathers of adults with schizophrenia. *Social Work in Mental Health, 10*(2), 146-168.

Gilbert, P. (2011). Shame in psychotherapy and the role of compassion focused therapy. In R. L. Dearing & J. P. Tangney (Eds.), *Shame in the therapy hour* (1st ed., pp. 325-354). Washington, DC: American Psychological Association.

Gilbert, R., Spatz Widom, C., Browne, K., Fergusson, D., Webb, E., & Janson, J. (2009). Burden and consequences of child maltreatment in high-income countries. *Lancet, 373*, 68-81.

Gladstone, B. M., Boydell, K., & McKeever, P. (2006). Recasting research into children's experience of parental mental illness: Beyond risk and resilience. *Social Science & Medicine, 62*(10), 2540-2550.

Gladstone, B. M., Boydell, K. M., Seeman, M. V., & McKeever, P. D. (2011). Children's experiences of parental mental illness: a literature review. *Early Intervention In Psychiatry, 5*(4), 271-289.

Glaser, D. (2011). How to deal with emotional abuse and neglect: Further development of a conceptual framework (FRAMEA). *Child Abuse & Neglect: The International Journal, 35*(10), 866-875.

Glynn, S. M., Cohen, A. N., Dixon, L. B., & Niv, N. (2006). The potential impact of the recovery movement on family interventions for schizophrenia: opportunities and obstacles. *Schizophrenia Bulletin, 32*(3), 451-463.

Godress, J., Ozgul, S., Owen, C., & Foley-Evans, L. (2005). Grief experiences of parents whose children suffer from mental illness. *Australian Journal of Psychiatry, 39*, 88-94.

Gold, S. N. (2000). *Not trauma alone: Therapy for child abuse survivors in family and social context*. Philadelphia: Brunner-Routledge.

Goldman, L. (1996). *Breaking the silence: A guide to help children with complicated grief - suicide, homicide, AIDS, violence, and abuse*. New York: Braun-Brumfeld.

Goldsworthy, K. K. (2005). Grief and loss theory in social work practice: All changes involve loss, just as all losses require change. *Australian Social Work, 58*(2), 167-178.

Goodman, S. H., & Gotlib, I. H. (1999). Risk for psychopathology in the children of depressed mothers: A developmental model for understanding mechanisms of transmission. *Psychological Review, 106*(3), 458-490.

Goodwin, V., & Happell, B. (2006). Conflicting agendas between consumers and carers: The perspectives of carers and nurses. *International Journal of Mental Health Nursing, 15*, 135-143.

Goodwin, V., & Happell, B. (2007). Consumer and carer participation in mental health care: The carer's perspective: Part 1 - the importance of respect and collaboration. *Issues in Mental Health Nursing, 28*, 607-623.

Goodyear, M., Cuff, R., Maybery, M., & Reupert, A. (2009). VicCHAMPS: A peer support program for children of parents with a mental illness. *Australian e-Journal for the Advancement of Mental Health (AeJAMH), 8*(3), 296 - 304. Retrieved July 2, 2012, from http://amh.e-contentmanagement.com/archives/vol/8/issue/3/article/3479/champs

Gopfert, M., & Webster, J. (1996). *Parental Psychiatric Disorder: Distressed Parents and Their Families*. Cambridge: Cambridge University Press.

Gopfert, M., Webster, J., & Seeman, M. V. (Eds.). (2004). *Parental psychiatric disorder: Distressed parents and their families* (2nd ed.). New York: Cambridge University Press.

Grant, I. (1999). Caregiving may be hazardous to your health. *Psychosomaic Medicine, 61*, 420-423.

Greenberg, L, S, & Iwakabe, S. (2011). Emotion-focused therapy and shame. In R. L. Dearing & J. P. Tangney (Eds.), *Shame in the therapy hour* (1st ed., pp. 69-90). Washington, DC: American Psychological Association.

Grunfeld, E., Coyle, D., Whelan, T., Clinch, J., Reyno, L., Earle, C. C., et al. (2004). Family caregiver burden: Results of a longitudinal study of breast cancer patients and their principal caregivers. *Canadian Medical Association Journal, 170*(12), 1795-1801.

Gryba, H. (2002). Experiences of adult children whose parent(s) had a mental illness: The legacy. In, Supporting families with parental mental illness: A Community education and development workshop: Training tool for communities to organize services to support families. Retrieved March 17, 2009, from http://www.mcf.gov.bc.ca/mental_health/mh_publications/supporting_families1.pdf

Gushurst, C. A. (2003). Child abuse: Behavioral aspects and other associated problems. *Pediatric Clinics of North America, 50*(4), 919-938.

Hall, C. (2001). Reconstructing meaning in the wake of loss: Creating "meaningfull" ritual. *Grief Matters, Summer*, 51-53.

Hansen, D. P. (2009). *Young's Schemas in adult non-disordered offspring of a bipolar or schizophrenic parent.* Unpublished doctoral dissertation, University of South Australia, South Australia.

Hargreaves, J., Bond, L., O'Brien, M., Forer, D., & Davies, L. (2008). The PATS peer support program: Prevention/intervention for adolescents who have a parent with mental illness. *Youth Studies Australia, 27*, 43-51.

Hargreaves, J., O'Brien, M., Bond, L., Forer, D., Basile, A., Davies, L., et al. (2005). Paying Attention to Self (PATS): An evaluation of the PATS program for young people living with a parent affected by mental illness. Retrieved July 2, 2012, from www.rch.org.au/pats

Hatfield, A. B. (1983). What families want of family therapy. In W. R. McFarlane (Ed.), *Family therapy in schizophrenia*. New York: Guilford Press.

Hatfield, A. B. (1987). Coping and adaptation: A conceptual framework for understanding families. In A. Hatfield & H. Lefley (Eds.), *Families of the mentally ill: Coping and adaptation* (pp. 60-84). London: Cassell.

Herman, D. B., Susser, E. S., Struening, E. L., & Link, B. L. (1997). Adverse childhood experiences: Are they risk factors for adult homelessness? *American Journal of Public Health, 87*(2), 249-255.

Herman, J. L. (1992a). *Trauma and recovery: The aftermath of violence-from domestic to political terror* (2nd ed.). New York: Basic Books.

Herman, J. L. (1992b). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress, 5*(3), 377-391.

Herman, J. L. (2011). Posttraumatic stress disorder as a shame disorder. In R. L. Dearing & J. P. Tangney (Eds.), *Shame in the therapy hour* (1st ed., pp. 261-275). Washington, DC: American Psychological Association.

Hetherington, R., Baistow, K., Katz, I., Mesie, J., & Trowell, J. (2002). *The welfare of children with mentally ill parents: Learning from inter-country comparisons*. New York: John Wiley & Sons.

Holley, T. E., & Holley, J. (1997). *My mother's keeper: A daughter's memoir of growing up in the shadow of schizophrenia*. New York: W. Morrow & Company Inc.

Hooper, L. M., Doehler, K., Wallace, S. A., & Hannah, N. J. (2011). The Parentification Inventory: Development, validation, and cross-validation. *The American Journal of Family Therapy, 39*(3), 226-241.

Horowitz, M. J., Weiss, D., Kaltreider, N., Krupnick, Wilner, N., Marmar, C., et al. (1984). Reactions to the death of a parent: Results from patients and field subjects. *Journal of Nervous and Mental Disease, 172*, 383-392.

Horowitz, M. J., Wilner, N., & Alvarez, W. (1979). Impact of Event Scale: A measure of subjective stress. *Psychosomatic Medicine, 41*, 209-218.

Horwitz, A. V., & Wakefield, J. C. (2007). *The loss of sadness: How psychiatry transformed normal sorrow into depressive disorder*. Oxford: Oxford University Press.

Howard, L. M., & Underdown, H. (2011). The needs of mentally ill parents: A review of the literature. *Psychiatrische Praxis, 38*(1), 8-15.

Howe, D., Batchelor, S., & Bochynska, K. (2009). Estimating consumer parenhood within mental health services: A census approach. *Australian e-Journal for the Advancement of Mental Health (AeJAMH), 8*(3), 1-10. doi: 10.5172/jamh.8.3.231

Huntsman, L. (2008). *Parents with mental health issues: Consequences for children and effectiveness of interventions designed to assist children and their families* Retrieved July 2, 2012, from http://www.community.nsw.gov.au/docswr/_assets/main/documents/research_parentalmentalhealth.pdf

Ireland, M., & Pakenham, K. (2010). Youth adjustment to parental illness or disability: The role of illness characteristics, caregiving, and attachment. *Psychology Health and Medicine, 15*(6), 632-645.

Jeffreys, H., Rogers, N., & Hirte, C. (2011). *Keeping the child in mind: Child protection practice and parental mental health*. Retrieved July 2, 2012, from http://www.dfc.sa.gov.au/pub/LinkClick.aspx?fileticket=ec1nlu8xxAo%3d&tabid=811.

Jennings, A. (2004). *Models for developing trauma-informed behavioral health systems and trauma-specific services.* Report produced by the National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for State Mental Health Planning (NTAC) United States.

Jeske, J., Bullinger, M., & Wiegand-Grefe, S. (2011). Do attachment patterns of parents with a mental illness have an impact upon how they view the quality of life of their children? *Vulnerable Children & Youth Studies, 6*(1), 39-50.

Johansson, A., Anderzen-Carlsson, A., Åhlin, A., Andershed, B., & Sköndal, E. (2012). Fathers' everyday experiences of having an adult child who suffers from long-term mental illness. *Issues in Mental Health Nursing, 33*(2), 109-117.

Johnson, H., C., Renaud, E. F., Schmidt, D. T., & Stanek, E. J. (1998). Social workers' view of parents of children with mental and emotional disabilities. *Families in Society, 79*(2), 173-187.

Jones, R. A., & Wells, M. (1996). An empirical study of parentification and personality. *The American Journal of Family Therapy, 24*(2), 145-152.

Jones, S. H., Tai, S., Evershed, K., Knowles, R., & Bentall, R. (2006). Early detection of bipolar disorder: a pilot familial high-risk study of parents with bipolar disorder and their adolescent children. *Bipolar Disorders, 8*(4), 362-372.

Jordan, J. R., & Neimeyer, R. A. (2003). Does grief counselling work? *Death Studies, 27*, 765-786.

Jorm, A. F., Christensen, H., & Griffiths, K. M. (2006). Changes in depression awareness and attitudes in Australia: The impact of beyondblue, the national depression initiative. *Australian & New Zealand Journal of Psychiatry, 40*(1), 42-46.

Judge, K. (1994). Serving children, siblings and spouses: Understanding the needs of other family members. In H. P. Lefley & M. Wasow (Eds.), *Helping families cope with mental illness* (pp. 161-194). Newark, NJ: Harwood Academic.

Jurkovic, G. (1997). *Lost childhoods: The plight of the parentified child*. New York: Brunner-Mazel.

Jurkovic, G., Jessee, E. H., & Goglia, L. R. (1991). Treatment of parental children and their families: Conceptual and technical issues. *American Journal of Family Therapy, 19*(4), 302-314.

Kahana, E., Kahana, B., Harel, Z., & Rosner, T. (1988). Coping with extreme trauma. In J. P. Wilson, Z. Harel & B. Kahana (Eds.), *Human adaptation to extreme stress: From the Holocaust to Vietnam* (pp. 55-79). New York: Plenum.

Kahn, L. (2006). The understanding and treatment of Betrayal Trauma as a traumatic experience of love. *Journal of Trauma Practice, Vol.5*(3). doi:10.1300/J189v05n03_04

Kane, M., & Trochim, W. M. (2009). Concept mapping for applied social research. In L. Bickman & J. D. Rog (Eds.), *Handbook of applied social research methods* (2nd ed., pp. 435-474). Thousand Oaks, CA: Sage Publications.

Kaplan, H., & Sadock, B. (1988). *Synopsis of psychiatry: Behavioral sciences, clinical psychiatry*. Baltimore: William & Wilkins.

Kaplan, L., J. (1995). *No voice is ever wholly lost*. New York: Simon & Schuster.

Kauffman, C., Grunebaum, H., Cohler, B., & Gamer, E. (1979). Superkids: Competent children of psychotic mothers. *American Journal of Psychiatry, 136*, 1398-1402.

Kauffman, G. (1989). *The psychology of shame: Theory and treatment of shame-based syndromes*. New York: Springer.

Kavanagh, D. J., Clark, D., Piatkowska, O., O'Halloran, P., Manicavasagar, V., Rosen, A., et al. (1993). Application of cognitive-behavioural family intervention for schizophrenia in multidisciplinary teams: What can the matter be? *Australian Psychologist, 28*(3), 181-188.

Keith, L., & Morris, J. (1995). Easy targets: A disability rights perspective on the 'children as carers' debate. *Critical Social Policy, 15*(44/45 no.2/3), 36-57.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry, 62*(6), 593-602.

Kestenberg, J, S, & Kahn, C. (Eds.). (1998). *Children surviving persecution: An international study of trauma and healing*. Westport, CT: Praeger.

Keverne, E. B. (2005). Neurobiological and molecular approaches to attachment and bonding. In C. S. Carter, L. Ahnert, K. E. Grossmann, S. B. Hrdy, M. E. Lamb, S. W. Porges & N. Sachser (Eds.), *Attachment and bonding: a new synthesis.* (pp. 101-117). Cambridge, MA: The MIT Press.

Kezelman, C. A., & Stavropoulos, P. A. (2012). *Adults surviving child abuse 2012 practice guidelines for treatment of complex trauma and trauma informed care and service delivery.* [To appear.] Sydney: Adults Surviving Child Abuse (ASCA).

Kins, E., Soenens, B., & Beyers, W. (2011). "Why do they have to grow up so fast?": Parental separation anxiety and emerging adults' pathology of separation and individuation. *Journal of Clinical Psychology, 67*(7), 647-664.

Kinsella, K. B., Anderson, R. A., & Anderson, W. T. (1996). Coping skills, strengths, and needs as perceived by adult offspring and siblings of people with mental illness: A retrospective study. *Psychiatric Rehabilitation Journal, 20*(2), 24-32.

Klass, D., & Goss, R. (1999). Spiritual bonds to the dead in cross-cultural and historical perspective: Comparative religion and modern grief. *Death Studies, 23*(6), 547-567.

Klass, D., Silverman, P., & Nickman, S. (Eds.). (1996). *Continuing bonds: New understandings of grief*. Washington DC: Taylor and Francis.

Kleber, R. J., Brom, D., & Defares, P., B. (1992). *Coping with trauma: Theory, prevention and treatment*. Lisse, Netherlands: Swets & Zeitlinger.

Kleber, R. J., Figley, C., R, & Gersons, B., P.R (Eds.). (1995). *Beyond trauma: Cultural and societal dynamics*. New York: Plenum Press.

Knutsson-Medin, L., Edlund, B., & Ramklint, M. (2007). Experiences in a group of grown-up children of mentally ill parents. *Journal of Psychiatric and Mental Health Nursing, 14*(8), 744-752.

Konrad, S. C. (2006). Posttraumatic growth in mothers of children with acquired disabilities. *Journal of Loss and Trauma, 11*(1), 101-113.

Koval, R. (Writer). (2011). Raimond Gaita speaks about After Romulus [Radio]. In A. Radio (Producer), *The Book Show*. Australia: Radio National

Kowalenko, N. M., Mares, S. P., Newman, L. K., Williams, A. E. S., Powrie, R. M., & van Doesum, K. T. M. (2012). Family matters: Infants, toddlers and preschoolers of parents affected by mental illness. *Medical Journal Australia*(Supplement 1), 14-17.

Kübler-Ross, E. (1969). *On death and dying*. New York: Macmillan.

Kübler-Ross, E. (1974). *Death: The final stage of growth.* New York: Simon & Schuster/Touchstone.

L'Abate, L. (Ed.). (2008). *Toward a science of clinical psychology: Laboratory evaluations and interventions*. New York: Nova Science.

Lachenmeyer, N. (2000). *The outsider: A journey into my father's struggle with madness*. New York: Broadway Books.

Lammers, J., & Happell, B. (2004). Mental health reforms and their impact on consumer and carer participation: A perspective from Victoria, Australia. *Issues in Mental Health Nursing, 25*, 261-276.

Lamont, A. (2010). Resource sheet: Effects of child abuse and neglect for adult survivors. *National Child Protection Clearinghouse at the Australian Institute of Family Studies*(April), 1-7.

Lancaster, R. R. (1993). Growing up with a mentally ill parent: A phenomenological study of adult perceptions. Unpublished doctoral dissertation. University of Texas.

Lancaster, S. (1999). Being there: How parental mental illness can affect children. In V. Cowling (Ed.), *Children of parents with mental illness* (pp. 14-33). Melbourne: The Australian Council for Educational Research Ltd.

Landerman, R., George, L. K., & Blazer, D. G. (1991). Adult vulnerability for psychiatric disorders: Interactive effects of negative childhood experiences and recent stress. *Journal of Nervous and Mental Disease, 179*, 656-653.

Lanius, R. A., Vermetten, E., & Pain, C. (Eds.). (2010). *The impact of early life trauma on health and disease: The hidden epidemic*. Cambridge: Cambridge University Press.

LaPrairie, J., L., Heim, C., M., & Nemeroff, C., B. (2010). The neuroendocrine effects of early life trauma. In R. A. Lanius, E. Vermetten & C. Pain (Eds.), *The impact of early life trauma on health and disease: The hidden epidemic* (pp. 157-165). Cambridge: Cambridge University Press.

Laub, D., & Auerhahn, N. C. (1993). Knowing and not knowing massive psychic trauma: Forms of traumatic memory. *Int J. Psycho-Anal 74*, 287-302.

Layne, C. M., Pynoos, R. S., & Cardenas, J. (2001). Wounded adolescence: School-based group psychotherapy for adolescents who sustained or witnessed violent injury. In M. Shafii & S. L. Shafii (Eds.), *School Violence: Assessment, Management, Prevention* (pp. 163-186). Washington, DC: American Psychiatric Press.

LeCroy, C. W. (2011). *Parenting mentally ill children: Faith, caring, support, and surviving the system*. Santa Barbara, CA: Praeger.

Leff, J. (2005). *Advanced family work for schizophrenia: An evidence-based approach*. Glasgow: Bell & Bain Limited.

Lehman, D. R., Wortman, C. B., & Williams, A. F. (1987). Long-term effects of losing a spouse or child in a motor vehicle crash. *Journal of Personality and Social Psychology, 52*, 218-231.

Lerner, F. (1996). Searching the traumatic stress literature. In E. B. Carlson (Ed.), *Trauma research methodology* (pp. 1-21). Brooklandville, MD: The Sidran Press.

Lewis, C., Bornstein, M. H., & Lamb, M. E. (2011). The role of parent-child relationships in child development. In M. H. Bornstein & M. E. Lamb (Eds.), *Developmental science: An advanced textbook* (6th ed., pp. 469-517). New York: Psychology Press.

Lewis, H. B. (1990). Shame, repression, field dependence, and psychopathology. In J. Singer, L. (Ed.), *Repression and dissociation: Implications for personality theory, psychopathology, and health* (pp. 233-257). Chicago: University of Chicago Press.

Leys, R. (2000). *Trauma: A genealogy.* Chicago: University of Chicago Press.

Lidz, T., Fleck, S., Alanen, Y. O., & Cornelison, A. (1963). Schizophrenic patients and their siblings. *Psychiatry, 26*, 1-18.

Lifton, R. (1967). *Death in life: The survivors of Hiroshima*. London: Weidenfeld and Nicholson.

Lifton, R. (1979). *The broken connection*. New York: Simon and Schuster.

Lindemann, E. (1944). Symptomatology and management of acute grief. *American Journal of Psychiatry Research, 101*, 141-148.

Lindy, J. D., Green, B. L., Grace, M., & Titcheneer, J. (1983). Psychotherapy with survivors of the Beverly Hills supper club fire. *American Journal of Psychiaty, 4*, 593-610.

Liotti, G. (1992). Disorganized/disoriented attachment in the etiology of the dissociative disorders. *Dissociation, 5*(4), 196-204.

Little, S. G., & Akin-Little, A. (2011). Responses to childhood trauma: An international perspective. *School Psychology International, 32*(5), 441-447.

Loewenstein, R., J., & Welzant, V. (2010). Pragmatic approaches to stage-oriented treatment for early life trauma-related complex post-traumatic stress and dissociative disorders. In R. A. Lanius, E. Vermetten & C. Pain (Eds.), *The impact of early life*

trauma on health and disease: The hidden epidemic (pp. 257-267). Cambridge: Cambridge University Press.

Lovejoy, M. C., Graczyk, P. A., O'Hare, E., & Neuman, G. (2000). Maternal depression and parenting behavior: A meta-analytic review. *Clinical Psychology Review, 20*(5), 561-592.

Lukens, E., & Thorning, H. (1998). Psychoeducation and severe mental illness: Implications for social work practice and research. In J. Williams & K. Ell (Eds.), *Breakthrough in mental health research* (pp. 256-286). New York: NASW Press.

Lyons-Ruth, K., Yellin, C., Melnick, S., & Atwood, G. (2005). Expanding the concept of unresolved mental states: Hostile/helpless states of mind on the Adult Attachment Interview are associated with disrupted mother-infant communication and infant disorganization. *Developmental and Psychopathology, 17*(1), 1-23.

Maciejewski, P. K., Zhang, B., Block, S. D., & Prigerson, H. G. (2007). An empirical examination of the stage theory of grief. *JAMA, 297*, 716-723.

Magliano, L., Fiorillo, A., Malangone, C., De Rosa, C., & Maj, M. (2006). Implementing psychoeducational interventions in Italy for patients with schizophrenia and their families. *Psychiatric Services, 57*(2), 266-269.

Main, M., & Hesse, E. (1990). Parent's unresolved traumatic experiences are related to infant disorganized attachment status: Is frightened and/or frightening parental behavior the linking mechanism? In M. Greenberg, D. Cicchetti & M. Cummings (Eds.), *Attachment in the preschool years* (pp. 161-182). Chicago: University of Chicago Press.

Marks, I. M. (1987). *Fears, phobias, and rituals: Panic, anxiety, and their disorders*. New York: Oxford University Press.

Marsh, D. T. (1994). The Psychodynamic model and services for families: Issues and strategies. In H. Lefley, P. & M. Wasow (Eds.), *Helping families cope with mental illness* (pp. 105-128). Baltimore: Harwood Academic.

Marsh, D. T., Appleby, N. F., Dickens, R. M., Owens, M., & Young, N. O. (1993). Anguished voices: Impact of mental illness on siblings and children. *Innovations & Research, 2*(2), 25-34.

Marsh, D. T., & Lefley, H. P. (1996). The family experience of mental illness: Evidence for resilience. *Psychiatric Rehabilitation Journal, 20*(2), 3.

Massie, H., & Szajnberg, N. (2006). My life is a longing: Child abuse and its adult sequelae. Results of the Brody longitudinal study from birth to age 30. *International Journal of Psychoanalysis, 87*, 471-496.

Masterson, M., K. (2010). *Chronic sorrow in mothers of adult children with cerebral palsy: An exploratory study.* Unpublished doctoral dissertation. Kansas State University, Manhattan, Kansas.

Mattejat, F., & Remschmidt, H. (2008). The children of mentally ill parents. *Deutsches Ärzteblatt International, 105*(23), 413-418.

Mauritz, M., & van Meijel, B. (2009). Loss and grief in patients with schizophrenia: On living in another world. *Archives of Psychiatric Nursing, 23*(3), 251-260.

Maybery, D. J., Goodyear, M. J., Reupert, A. E., & Harkness, M. K. (2012). Goal setting within family care planning: Families with complex needs. *Medical Journal Australia* (Supplement 1), 37-39.

Maybery, D. J., Ling, L., Szakacs, E., & Reupert, A. (2005). Children of a parent with a mental illness: Perspectives on need. *Australian e-Journal for the Advancement of Mental Health, 4*(2), 78-88. Retrieved July 2, 2012, from http://amh.e-contentmanagement.com/archives/vol/4/issue/2/article/3357/children-of-a-parent-with-a-mental-illness

Maybery, D. J., & Reupert, A. (2006). Workforce capacity to respond to children whose parents have a mental illness. *Australian and New Zealand Journal of Psychiatry, 40*(8), 657-664.

Maybery, D. J., & Reupert, A. (2008). The importance of being child and family focused. COPMI GEMS: Children Of Parents with a Mental Illness Gateway to Evidence that Matters. *COPMI GEMS Children of Parents with a Mental Illness Gateway to Evidence that Matters,* (July 2008). Retrieved July 2, 2012, from http://www.copmi.net.au

Maybery, D. J., & Reupert, A. (2009). Parental mental illness: A review of barriers and issues for working with families and children. *Journal of Psychiatric and Mental Health Nursing, 16*, 784-791.

Maybery, D. J., Reupert, A., Patrick, K., Goodyear, M., & Crase, L. (2005). *VicHealth Research Report on children at risk in families affected by parental mental illness.* Melbourne: Victorian Health Promotion Foundation.

Maybery, D. J., Reupert, A. E., Patrick, K., Goodyear, M., & Crase, L. (2009). Prevalence of parental mental illness in Australian families. *Psychiatric Bulletin, 33*(1), 22-25.

McCann, I. L., & Pearlman, L. A. (1990). *Psychological trauma and the adult survivor: Theory, therapy, and transformation*. New York: Brunner-Mazel.

McCrory, E. J., De Brito, S. A., Sebastian, C. L., Mechelli, A., Bird, G., Kelly, P. A., et al. (2011). Heightened neural reactivity to threat in child victims of family violence. *Current Biology, 21*(23), 947-948.

McDonald, M., Higgins, D., Valentine, K., & Lamont, A. (2011). *Final report protecting Australia's children research audit (1995-2010)*. Retrieved July 2, 2012, from http://www.aifs.gov.au/nch/pubs/reports/audit/2011/audit2011.pdf

McFarlane, W. R., Dixon, L., Lukens, E., & Lucksted, A. (2003). Family psychoeducation and schizophrenia: A review of the literature. *Journal of Marital and Family Therapy, 29*(2), 223-245.

McGorry, P. (2004). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of schizophrenia and related disorders. *Australian and New Zealand Journal of Psychiatry, 39*, 1-30.

McGregor, P. (1994). Grief: The unrecognized parental response to mental illness in a child. *Social Work, 39* (2), 160-166.

McMahon, T. J., & Luthar, S. S. (2007). Defining characteristics and potential consequences of caretaking burden among children living in urban poverty. *American Journal of Orthopsychiatry, 77*(2), 267-281.

McNally, R. J. (2007). Betrayal trauma theory: A critical appraisal. *Memory (Hove, England), 15*(3), 280-294.

Meadows, G., & Singh, B. (Eds.). (2001). *Mental health in Australia: Collaborative community practice*. Oxford: Oxford University Press.

Mednick, S., Cudeck, J., Griffith, S., Talovic, S., & Schulsinger, F. (1984). The Danish high-risk project: Recent methods and findings. In N. F. Watt, E. J. Anthony, L. C. Wynne & J.

Rolf (Eds.), *Children at risk for schizophrenia: A longitudinal perspective*. Cambridge: Cambridge University Press.

Mental Health Council of Australia. (2005). Not for Service - Experiences of Injustice and despair in mental health care in Australia. Retrieved 17th May, 2012, from http://www.hreoc.gov.au/disability_rights/notforservice/index.html

Mental Health Council of Australia & Carers Association of Australia (MHCA & CAA). (2000). *Carers of people with mental illness project: Final report.* Canberra: Commonwealth Department of Health and Aged Care.

Middleton, W., & Butler, J. (1998). Dissociative identity disorder: An Australian series. *The Australian And New Zealand Journal Of Psychiatry, 32*(6), 794-804.

Miklowitz, D., Jay. (2008). *Bipolar disorder: A family-focused treatment approach* (2nd ed.). New York: Guilford Press.

Mikulincer, M. (2008). An attachment perspective on resilient and complicated grief reactions. *8th International Conference on Grief and Bereavement in Contemporary Society*. Melbourne: Australian Centre for Grief and Bereavement. Retrieved 17th May, 2011, from http://www.grief.org.au/

Miller-Perrin, C., L., & Perrin, R., D. (2007). *Child maltreatment* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Miller, A. (2005). *The body never Lies: The lingering effects of cruel parenting*. New York: W.W. Norton & Company.

Miller, F. E. (1996). Grief therapy for relatives of persons with serious mental illness. *Psychiatric Services, 47*(6), 633-637.

Minuchin, P. (1988). Relationships with the family: A systems perspective on development. In R. A. Hinde & J. Stevenson-Hinde (Eds.), *Relationships within families: Mutual influences,* (pp. 7-26). Oxford: Clarendon Press.

Misrachi, S. (2008). Surviving parents with mental illness. Retrieved 22nd August, 2012, from https://sites.google.com/site/workwithin/survivingparentswithmentalillness

Möller-Leimkühler, A. M., & Wiesheu, A. (2012). Caregiver burden in chronic mental illness: The role of patient and caregiver characteristics. *European Archives of Psychiatry and Clinical Neuroscience, 262*(2), 157-166.

Moos, N. L. (1995). An integrative model of grief. *Death Studies, 19*(4), 337-364.

Mordoch, E., & Hall, W. A. (2002). Children living with a parent who has a mental illness: A critical analysis of the literature and research implications. *Archives of Psychiatric Nursing, XVI*(5 October), 208-216.

Mordoch, E., & Hall, W. A. (2008). Children's perceptions of living with a parent with a mental illness: Finding the rhythm and maintaining the frame. *Qualitative Health Research, 18*(8), 1127-1144.

Morrison, A. P. (2011). The psychodynamics of shame. In R. L. Dearing & J. P. Tangney (Eds.), *Shame in the therapy hour* (1st ed., pp.23-44). Washington, DC: American Psychological Association.

Mowbray, C. T., Bybee, D., Oyserman, D., MacFarlane, P., & Bowersox, N. (2006). Psychosocial outcomes of adult children of parents with severe mental illness: Demographic and clinical history predictors. *National Association of Social Workers, 31*(2), 99-108. Retrieved July 2, 2012, from http://www.ncbi.nlm.nih.gov/pubmed/16776027

Mowbray, C. T., & Mowbray, O. P. (2006). Psychosocial outcomes of adult children of mothers with depression and bipolar disorder. *Journal of Emotional and Behavioral Disorders, 14*(3), 130-142.

Mowbray, C. T., Oyserman, D., Bybee, D., & MacFarlane, P. (2002). Parenting of mothers with a serious mental illness: Differential effects of diagnosis, clinical history, and other mental health variables. *Social Work Research, 26*(4), 225-240.

Mudaly, N., & Goddard, C. (2001). The child abuse victim as a hostage: Scorpion's story. *Child Abuse Review, 10*(6), 428-439.

Murphy, G., Peters, K., Jackson, D., & Wilkes, L. (2011). A qualitative meta-synthesis of adult children of parents with a mental illness. *Journal of Clinical Nursing, 20*(23/24), 3430-3442.

Murray, J. (2001). Loss as a universal concept: A review of the literature to identify common aspects of loss in diverse situations. *Journal of Loss and Trauma, 6*, 219-241.

Myers, J. E. B., Berliner, L., Briere, J., Hendrix, C. T., Reid, T., & Jenny, C. (Eds.). (2002). *The APSAC handbook on child maltreatment* (2nd ed.). Newbury Park, CA: Sage Publications.

Nader, K., & Pynoos, R. S. (1993). The children of Kuwait following the Gulf Crisis. In L. A. Lewis & N. A. Fox (Eds.), *Psychological effects of war and violence on children* (pp.181-195). Hillsdale, NJ: Laurence Erlbaum Publishers.

Nathanson, D. L. (1992). *Shame and pride: Affect, sex, and the birth of the self*. New York: Norton.

Nathiel, S. (2007). *Daughters of madness: Growing up and older with a mentally ill mother* Westport, CT: Praeger Publishers.

Neff, J. A. (1994). Adult children of alcoholic or mentally-ill parents: Alcohol consumption and psychological distress in a triethnic community study. *Addictive Behaviors, 19*(2), 185-197.

Neimeyer, R. A. (2001). *Meaning reconstruction and the meaning of loss*. Washington, DC: American Psychological Association.

Newman, L., & Stevenson, C. (2005). Parenting and borderline personality disorder: Ghosts in the nursery. *Clinical Child Psychology and Psychiatry, 10*(3), 385-394.

Nguyen, T. N., Faulkner, D., Frayne, J. S., Allen, S., Hauck, Y. L., Rock, D., et al. (2012). Obstetric and neonatal outcomes of pregnant women with severe mental illness at a specialist antenatal clinic. *MJA Open: The Medical Journal of Australia, Supplement 1*, 26-29.

Nicholson, J., Biebel, K., Hinden, B., Henry, A., & Stier, L. (2001). *Critical issues for parents with mental illness and their families.* Rockville, MD: Center for Mental Health Services/Substance Abuse and Mental Health Services Administration.

Nicholson, J., & Blanch, A. (1994). Rehabilitation for parenting roles for people with serious mental illness. *Psychosocial Rehabilitation Journal, 18*, 109-119.

Nicholson, J., Geller, J. L., Fisher, W. H., & Dian, G. L. (1993). State policies and programs that address the needs of mentally ill mothers in the public sector. *Hospital and Community Psychiatry, 44*, 484-489.

O'Brien, L., Brady, P., Anand, M., & Gillies, D. (2011). Children of parents with a mental illness visiting psychiatric facilities: Perceptions of staff. *International Journal of Mental Health Nursing, 20*(5), 358-363.

O'Dowd, G. (2003). Recognising the 'living' loss and grief experience of people with a mental illness and their carers: Personal reflections from a former mental health worker. *Grief Matters,* (Winter), 26-30.

O'Hanlon, B., & MacRae, M. (2009). *Relative invisibility: Identifying factors impacting on family engagement with a continuing care team*. Melbourne: Department of Human Services, Mental Health Research Fellowship, The Bouverie Centre & North West Area Mental Health Service.

Oates, M. (1997). Patients as parents: The risk to children. *British Journal of Psychiatry, 170*(32), 22-27.

Obadina, S. (2010). Parental mental illness: Effects on young carers. *British Journal of School Nursing, 5*(3), 135-139.

Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy*. New York: W.W. Norton.

Ohaeri, J. (2003). The burden of caregiving in families with a mental illness: A review of 2002. *Current Opinions in Psychiatry, 16*, 457-465.

Olshansky, S. (1962). Chronic sorrow: A response to having a mentally defective child. *Social Casework, 43*, 190-193.

Osborne, J., & Coyle, A. (2002). Can parental responses to adult children with schizophrenia be conceptualized in terms of loss and grief?: A case study analysis. *Counselling Psychology Quarterly, 15*(4), 307-323

Oskouie, F., Zeighami, R., & Joolaee, S. (2011). Outcomes of parental mental illness on children: A qualitative study from Iran. *Journal of Psychosocial Nursing & Mental Health Services, 49*(9), 32-40.

Östman, M., & Afzelius, M. (2011). Children's representatives in psychiatric services: What is the outcome? *International Journal of Social Psychiatry, 57*(2), 144-152.

Östman, M., & Eidevall, L. (2005). Illuminating patients with children up to 18 years of age: A one-day inventory study in a psychiatric service. *Nordic Journal of Psychiatry, 59*(5), 388-392.

Östman, M., & Hansson, L. (2002). Children in families with a severely mentally ill member: Prevalence and needs for support. *Social Psychiatry and Psychiatric Epidemiology, 37*, 244-255.

Owen, S. (2008). *Children of Parents with a Mental Illness: Systems Change in Australia Report B2*. Stepney: Australian Infant Child Adolescent and Family Mental Health Association.

Pakenham, K. I., Bursnall, S., Chiu, J., Cannon, T., & Okochi, M. (2006). The psychosocial impact of caregiving on young people who have a parent with an illness or disability: Comparisons between young caregivers and non-caregivers. *Rehabilitation Psychology, 51*(2), 113-126.

Parker, I., Georgaca, E., Harper, D., McLaughlin, T., & Stowell-Smith, M. (1995). *Deconstructing psychopathology*. London: Sage Publication

Parkes, C. M. (1975). What becomes of redundant world models? A contribution to the study of adaptation to change. *British Journal of Medical Psychology, 48*, 131-137.

Parkes, C. M., & Prigerson, H. G. (2010). *Bereavement: Studies of grief in adult life* (4th ed.). New York: NY: Routledge.

Parkes, C. M., Stevenson-Hinde, J., & Marris, P. (Eds.). (1991). *Attachment across the life cycle*. London: Routledge.

Parrott, L., Jacobs, G., & Roberts, D. (2008). Stress and resilience factors in parents with mental health problems and their children. Social Care Institute for Excellence. Retrieved July 2, 2012, from http://www.scie.org.uk/publications/briefings/briefing23/index.asp

Patrick-Ott, A., & Ladd, L. D. (2010). The blending of Boss's concept of ambiguous loss and Olshansky's concept of chronic sorrow: A case study of a family with a child who has significant disabilities. *Journal of Creativity in Mental Health, 5*(1), 73-86.

Paul, C. (2010). The symptomatology of a dysfunctional parent-infant relationship. In S. Tyano, M. Keren, H. Herrman & J. Cox (Eds.), *Parenthood and Mental Health: A bridge between infant and adult psychiatry* (pp. 415-428). Oxford: Wiley Blackwell.

Pharoah, F., Mari, J., Rathbone, J., & Wong, W. (2006). Family intervention for schizophrenia. *Cochrane Database of Systematic Reviews, 4*.

Pilgrim, D. (2009). Recovery from mental health problems: Scratching the surface without ethnography. *Journal of Social Work Practice, 23*(4), 475-487.

Pilgrim, D., & Rogers, A. (2009). Survival and its discontents: The case of British psychiatry. *Sociology of Health & Illness, 31*(7), 947-961.

Pilling, S., Bebbington, P., Kuipers, E., Garety, P., Geddes, J., & Orbach, G. (2002). Psychological treatments in schizophrenia: Meta-analysis of family intervention and cognitive behaviour therapy. *Psychological Medicine, 32*, 763-782.

Phillips, J., Frances, A., Cerullo, A. M., Chardavoyne, J., Decker, H. S., First, M. B., et al. (2012). The six most essential questions in psychiatric diagnosis: A pluralogue part 3: issues of utility and alternative approaches in psychiatric diagnosis. *Philosophy, Ethics & Humanities in Medicine, 7*(1), 9-23.

Pitschel-Walz, G., Leucht, S., Bauml, J., Kissling, W., & Engel, R. R. (2001). The effect of family interventions on relapse and rehospitalization in schizophrenia: A meta-analysis. *Schizophrenia Bulletin, 27*(1), 73-92.

Prichard, D. (2006). Deconstructing psychopathology: Contextualizing mental disorders in teaching psychosocial assessment. *Journal of Progressive Human Services, 17*(2), 5-26.

Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, R. M., et al. (2007). No health without mental health. *Global Mental Health, 370*(September 4), 859-877. doi:10.1016/S0140- 6736(07)61238-0

Punch, K. (1998). *Introduction to social research: Quantitative and qualitative approaches*. London: Sage.

Putnam, F. W. (1997). *Dissociation in children and adolescents: A developmental perspective*. New York: Guildford Press.

Quinton, D., & Rutter, M. (1985). Family pathology and child psychiatric disorder: A four year prospective study. In A. Nichol (Ed.), *Longitudinal studies in child psychology and psychiatry: Practical lessons from research experience*. Chichester: John Wiley and Sons.

Raine, A., Mellingen, K., Liu, J. H., Venables, P., & Mednick, S. A. (2003). Effects of environmental enrichment at ages 3-5 years on schizotypal personality and antisocial behavior at ages 17 and 23 years. *American Journal of Psychiatry, 160*(9), 1627-1635.

Rando, T. A. (1993). *The treatment of complicated mourning*. Champaign, IL: Research Press.

Raphael, B. (2000). *Grief and loss in Australian society. In A. Kellehear (Ed.), Death and Dying in Australia*. South Melbourne: Oxford University Press.

Read, J., van Os, J., Morrison, A. P., & Ross, C. A. (2005). Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica, 112*(5), 330-350.

Reder, P., & Duncan, S. (2001). Abusive relationships, care and control conflicts and insecure attachments. *Child Abuse Review, 10*, 411-427.

Rees, C. A. (2010a). Understanding emotional abuse. *British Medical Journal Archives of Disease in Childhood 95*(1), 59-67.

Rees, C. A. (2010b). All they need is love?: Helping children to recover from neglect and abuse. *British Medical Journal Archives of Disease in Childhood, September 22nd*, 1-8.

Rengstorff, B. M. (1992). Competent adult children of schizophrenic parents. Unpublished doctoral dissertation. Saybrook Graduate School and Research Center, San Francisco.

Resnick, S. G., Ros'enheck, R. A., & Lehman, A. F. (2004). An exploratory analysis of correlates of recovery. *Psychiatric Services, 55*(5), 540-547.

Reupert, A., Goodyear, M., Eddy, K., Alliston, C., Mason, P., Maybery, D, J, et al. (2009). Australian programs and workforce initiatives for children and their families where a parent has a mental illness. *Advances in Mental Health, 8*(3), 277-285.

Reupert, A., Green, K., & Maybery, D. J. (2008). Family care plans for families affected by parental mental illness. *Family Social Journal of Contemporary Social Science, 89*(1), 39-43.

Reupert, A., & Maybery, D., J. (2007). Families affected by parental mental illness: A multiperspective account of issues and interventions. *American Journal of Orthopsychiatry, 77*(3), 362-369.

Reupert, A., & Maybery, D. J. (2010). Families affected by parental mental illness: Australian programs, strategies and issues: The (missing) role of schools. *International Journal for School-Based Family Counseling, II*(August), 1-16.

Reupert, A., & Maybery, D. J. (2011). Programmes for parents with a mental illness. *Journal of Psychiatric and Mental Health Nursing, 18*(3), 257-264.

Riebschleger, J. (1991). Families of chronically mentally ill people: Siblings speak to social workers, *Health & Social Work, 16*(2), 94-103.

Riebschleger, J. (2005). Mental health professionals' contact with family members of people with psychiatric disabilities. *Families in Society, 86*(1), 9-16.

Riley, A., Valdez, C., Barrueco, S., Mills, C., Beardslee, W., Sandler, I., et al. (2008). Development of a family-based program to reduce risk and promote resilience among families affected by maternal depression: Theoretical basis and program description. *Clinical Child & Family Psychology Review, 11*(1/2), 12-29.

Ringmar, E. (2005). *Surviving capitalism: How we learned to live with the market and remained almost human*. London: Anthem Press.

Risley-Curtiss, C., Stromwall, L. K., Hunt, D. T., & Teska, J. (2004). Identifying and reducing barriers to reunification for seriously mentally ill parents involved in child welfare cases. *Families in Society: The Journal of Contemporary Human Services, 85*(1), 107-118.

Roberts, B. A. (1996). Qualitative methodologies in music education research conference II: Secondary analysis in qualitative research: Thoughts on data obsolescence. *Bulletin of the Council for Research in Music Education*(130), 44-51.

Robinson, E., Rodgers, B., & Butterworth, P. (2008). *Family relationships and mental illness: Impacts and service responses*. Retrieved July 2, 2012, from www.aifs.gov.au/afrc/pubs/resource/resource4.html

Rosenbloom, D., Williams, M. B., & Watkins, B. E. (2010). *Life after trauma: A workbook for healing* (2nd ed.). New York: Guildford Press.

Rossow, I., & Lauritzen, G. (2001). Shattered childhood: A key issue in suicidal behavior among drug addicts? *Addiction, 96*(2), 227-240.

Rothschild, B. (2000). *The body remembers: The psychology of trauma and trauma treatment.* New York: Norton.

Rubin, A., Cardenas, J., Warren, K., Pike, C. K., & Wambach, K. (1998). Outdated practitioner views about family culpability and severe mental disorders. *Social Work, 43*(5), 412-422.

Rutter, M., & Quinton, D. (1984). Parental psychiatric disorder: Effects on children. *Psychological Medicine*(14), 853-880.

Sable, P. (2000). *Attachment and adult psychotherapy*. Lanham, MD: Rowman & Littlefield.

Sagi-Schwartz, A., Koren-Karie, N., & Joels, T. (2003). Failed mourning in the adult attachment interview: The case of Holocaust child survivors. *Attachment & Human Development, 5*(4), 398-409.

Sahoo, R., & Suar, D. (2010). Influence of social environment on young carers, assistance and consequences of caregiving. *Psychological Studies - University of Calicut, 55*(4), 323-329.

SANE Australia. (2012). Parenting and mental illness: The school years. *SANE Research Bulletin,* (16). Retrieved August 30, 2012, from http://www.sane.org/information/research

Saunders, J. C. (2003). Families living with severe mental illness: A literature review. *Issues In Mental Health Nursing, 24*, 175-198.

Schinnar, A. P., Rothbard, A. B., Kanter, R., & Adams, K. (1990). Crossing state lines of chronic mental illness. *Hospital & Community Psychiatry, 41*(7), 756-760.

Schultz, T., & Mendelson, R. (1975). The use of covariation as a principle of causal analysis. *Child Development, 46*, 394-399.

Schumn, J., A, Doane, L., S, & Hobfoll, S., E. (2012). Conservation of resources theory: The central role of resource loss and gain in understanding retraumatization. In M. P. Duckworth & V. M. Follette (Eds.), *Retraumatization: Assessment, treatment, and prevention* (pp. 111-128). New York: Routledge.

Scott-Storey, K. (2011). Cumulative Abuse: Do things add up?: An evaluation of the conceptualization, operationalization, and methodological approaches in the study of the phenomenon of cumulative abuse. *Trauma, Violence & Abuse, 12*(3), 135-150.

Scott, D. (2011). Coming out: Intrapersonal loss in the acquisition of a stigmatised identity. In D. Harris (Ed.), *Counting our losses: Reflecting on change, loss, and transition in everyday life* (pp. 171-183). New York: Routledge.

Secunda, V. (1997). *When madness comes home: Help and hope for the children, siblings, and partners of the mentally ill*. New York: Hyperion.

203

Secunda, V. (2000). *Losing your parents finding yourself: The defining turning point of adult life*. New York: Hyperion.

Shaver, P., R., & Mikulincer, M. (2006). Attachment theory, individual psychodynamics, and relationship functioning. In A. L. Vangelisti & D. Perlman (Eds.), *The Cambridge handbook of personal relationships* (pp. 251-271). Cambridge: Cambridge University Press.

Shear, K., Monk, T., Houck, P., Melhem, N., Frank, E., Reynolds, C., et al. (2007). An attachment-based model of complicated grief including the role of avoidance. *European Archives of Psychiatry and Clinical Neuroscience, 257*(8), 453-461. doi: 10.1007/s00406-007-0745-z

Shelton, K. H., & Harold, G. T. (2008). Interparental conflict, negative parenting, and children's adjustment: Bridging links between parents' depression and children's psychological distress. *Journal of Family Psychology, 22*(5), 712-724.

Shengold, L. (1989). *Soul murder: The effects of childhood abuse and deprivation*. New Haven, CT: Yale University Press.

Shengold, L. (1999). *Soul murder revisited: Thoughts about therapy, hate, love, and memory*. New Haven, CT: Yale University Press.

Shengold, L. (2006). *Haunted by parents*. London: Yale University Press.

Shifren, K., & Kachorek, L. V. (2003). Does early caregiving matter?: The effects on young caregivers' adult mental health. *International Journal of Behavioral Development, 27*(4), 329-337.

Shonkoff, J. P. (2010). Building a new biodevelopmental framework to guide the future of early childhood policy. *Child Development, 81*(1), 357-367.

Shonkoff, J. P., & Garner, A. S. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics, 129*(1), 232-246.

Shonkoff, J. P., & Levitt, P. (2010). NeuroView: Neuroscience and the future of early childhood policy: Moving from why to what and how. *Neuron, 67*, 689-691.

Shonkoff, J. P., Richter, L., van der Gaag, J., & Bhutta, Z. A. (2012). An integrated scientific framework for child survival and early childhood development. *Pediatrics, 129*(2), e460-e472.

Siegenthaler, E., Munder, T., & Egger, M. (2011). Effect of preventive interventions in mentally ill parents on the mental health of the offspring: Systematic review and meta-analysis. *Journal of the American Academy of Child & Adolescent Psychiatry*, *51*(1), 8-17.

Silver, R. C., & Wortman, C. B. (2007). Letters, June 27. *JAMA, 297*(24), 2692.

Silverman, D. (2005). *Doing qualitative research* (2nd ed.). London: Sage Publications.

Silverman, D. (2010). *Doing qualitative research: A practical handbook* (3rd ed.). London: Sage.

Sims, M., Davis, E., Davies, B., Nicholson, J., Harrison, L., Herrman, H., et al. (2012). Mental health promotion in childcare centres: Childcare educators' understanding of child and parental mental health. *Advances in Mental Health, 10*(2), 138-148.

Sivec, H., J., Waehler, C., A., Materson, P., J., & Pearson, B., L. (2007). Hearing the silent need: Assessing children who have a parent with a serious mental illness. In S. Smith, R. & L. Handler (Eds.), *The clinical assessment of children and adolescents: A practitioners handbook* (pp. 575-593). Mahwah, NJ: Lawrence Erlbaum Associates.

Sklarew, M. (2010). Crossing boundaries: Memory and trauma. *Studies in American Jewish Literature, 29*, 102-113.

Slominski, L. J. (2010). *The effects of parental mental illness on children: Pathways to risk to resilience from infancy to adulthood.* Unpublished doctoral dissertation. University of Michigan, Michigan.

Smith, P. K., Cowie, H., & Blades, M. (Eds.). (2011). *Understanding children's development* (5th ed.). Hoboken, NJ: John Wiley & Sons.

Smith, S., R, Hamon, R., R, Ingoldsby, B., B, & Miller, J. E. (2009). *Exploring family theories*. New York: Oxford University Press.

Solkoff, N. (1981). Children of survivors of the Nazi Holocaust: A critical review of the literature. *American Journal of Orthopsychiatry, 51*, 29-42.

Solomon, P., & Draine, J. (1996). Examination of grief among family members of individuals with serious and persistent mental illness. *Psychiatric Quarterly, 67*, 221-234.

Spitze, G., Ward, R., Deane, G., & Zhuo, Y. (2012). Cross-sibling effects in parent-adult child exchanges of socioemotional support. *Research on Aging, 34*(2), 197-221.

Stallard, P., Norman, P., Huline-Dickens, S., Salter, E., & Cribb, J. (2004). The effects of parental mental illness upon children: A descriptive study of the views of parents and children. *Clinical Child Psychology and Psychiatry, 9*, 39-52.

Stamm, B. H. (1999). Empirical perspectives on contextualizing death and trauma. In C. R. Figley (Ed.), *Traumatology of grieving: Conceptual, theoretical, and treatment foundations* (pp. 23-36). Philadelphia: Brunner-Mazel.

Stamm, B. H., & Bieber, S. L. (1996). Data analysis: Matching your question of interest to your analysis. In E. B. Carlson (Ed.), *Trauma research methodology* (pp. 188-205). Brooklandville, MD: The Sidran Press.

Starr, R., H., MacLean, D., J., & Keating, D., P. (1991). Life-span developmental outcomes of child maltreatment. In H. R. Starr & A. D. Wolfe (Eds.), *The effects of child abuse and neglect: Issues and research* (pp. 1-32). London: Guilford Press.

Steer, S., Reupert, A., & Maybery, D., J. (2011). Programs for children of parents who have a mental Illness: Referral and assessment practices: "One size fits all"? *Australian Social Work, 64*(4), 502-514.

Stern, D. M. (1985). *The interpersonal world of the infant*. New York: Basic

Stevenson, T. (2002). The adult experience of growing up with a seriously mentally ill parent(s). Unpublished master's thesis. Curtin University of Technology, W.A., Australia.

Stiffman, A., R., Chen, Y.-W., Elze, D., Dore, P., & Cheng, L.-C. (1997). Adolescents' and providers' perspectives on the need for and use of mental health services. *Journal of Adolescent Health, 21*, 335-342.

Sturges, J. S. (1977). Talking with children about mental illness in the family. *Health and Social Work, 2*(3), 88-109.

Suleiman, S. R. (2006). *Crises of memory and the Second World War*. Cambridge, MA: Harvard University Press.

Summerfield, D. (1995). Addressing human response to war and atrocity: Major challenges in research and practices and the limitations of western psychiatric models. *Development in Practice, 5*(4), 352-356.

Szajnberg, N., Goldenberg, A., & Harari, U. (2010). Early trauma, later outcome: Results from a longitudinal studies and clinical observations. In R. A. Lanius, E. Vermetten & C. Pain (Eds.), *The impact of early life trauma on health and disease: The hidden epidemic.* (pp. 33-42). Cambridge: Cambridge University Press.

Tanaghow, A. (2005). *Working together with families and carers: Chief Psychiatrist's Guideline*. Retrieved July 2, 2012, from http://www.health.vic.gov.au/mentalhealth/cpg/families.pdf

Tanner, D. (2000). Crossing bridges over troubled waters?: Working with children of parents experiencing mental distress. *Social Work Education, 19*(3), 287-297.

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Enquiry, 15*(1), 1-18.

Teicher, M., H., Rabi, K., Sheu, Y.S., Seraphin, S., B., Andersen, S., L., Anderson, C., M., et al. (2010). Neurobiology of childhood trauma and adversity. In R. A. Lanius, E. Vermetten & C. Pain (Eds.), *The impact of early life trauma on health and disease: The hidden epidemic* (pp. 112-122). Cambridge: Cambridge University Press.

Terr, L. C. (1991). Childhood traumas: An outline and overview. *The American Journal of Psychiatry, 148*(1), 10-20.

Teyber, E., McClure, F. H., & Weathers, R. (2011). Shame in families: Transmission across generations. In R. L. Dearing & J. P. Tangney (Eds.), *Shame in the therapy hour* (pp. 137-166). Washington, DC: American Psychological Association.

The Australian Centre for Posttraumatic Mental Health. (2012). ACPMH home page. Retrieved July 2, 2012, from http://www.acpmh.unimelb.edu.au/

Trebolle Barrera, J. C. (1998). *The Jewish Bible and the Christian Bible: An introduction to the history of the Bible*. New York: Brill.

Trondsen, M. V. (2012). Living with a mentally ill parent: Exploring adolescents' experiences and perspectives. *Qualitative Health Research, 22*(2), 174-188.

Truchon, M., Schmouth, M.E., Cote, D., Fillion, L., Rossignol, M., & Durand, M.J. (2012). Absenteeism Screening Questionnaire (ASQ): A new tool for predicting long-term absenteeism among workers with low back pain. *Journal of Occupational Rehabilitation, 22*(1), 27.

Tunnard, J. (2004). Parental mental health problems: Messages from research, policy and practice (Research Review: Research in Practice, No. 7). *The British Journal of Social Work, 35*(5), 769-770.

Tyano, S., Keren, M., Herrman, H., & Cox, J. (2010). *Parenthood and mental health: A bridge between infant and adult psychiatry*. Oxford: Wiley-Blackwell.

United Nations General Assembly. (1989). United Nations Convention on the Rights of the Child. Retrieved July 2, 2012, from http://www2.ohchr.org/english/law/crc.htm

Valent, P. (1998). Child survivors: A review. In J. Kestenberg, S & C. Kahn (Eds.), *Children surviving persecution: An international study of trauma and healing* (pp. 109 -123). Westport, CT: Praeger.

Valleau, P. M., Raymond, M. B., & Horton, C. B. (1995). Parentification and caretaker syndrome: An empirical investigation. *Family Therapy, 22*, 157-164.

van der Kolk, B. A. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry, 1*, 253-265.

van der Kolk, B. A., & Saporta, J. (1991). The biological mechanisms and treatment of intrusion and numbing. *Anxiety Research, 4*, 199-212.

van Ijzendoorn, M. H., Bakermans-Kranenburg, M. J., & Sagi-Schwartz, A. (2003). Are children of Holocaust survivors less well-adapted? A meta-analytic investigation of secondary traumatization. *Journal of Traumatic Stress, 16*(5), 459-469.

van Wesel, F., Boeije, H., Alisic, E., & Drost, S. (2011). I'll be working my way back: A qualitative synthesis on the trauma experience of children. *Psychological Trauma: Theory, Research, Practice, and Policy*, Oct 24, 2011. doi: 10.1037/a0025766

Vermetten, E., Dorahy, M. J., & Spiegel, D. (Eds.). (2007). *Traumatic dissociation: Neurobiology and treatment*. Washington, DC: American Psychiatric Publishing.

Victorian Government Department of Human Services. (2002). *New directions for Victorian mental health services*. Retrieved July 2, 2012, from http://www.health.vic.gov.au/mentalhealth/archive/services/new_directions.pdf

Victorian Government Department of Human Services. (2005). *Information for families and carers of people with a mental illness*. Melbourne: Metropolitan Health and Aged Care Services Division.

Victorian Government Department of Human Services. (2007). *Families where a parent has a mental illness: A service development strategy*. Melbourne: Victorian Government Department of Human Services.

Vitaliano, P. P. (1997). Physiological and physical concomitants to caregiving: Introduction to a special issue. *Annals of Behavior and Medicine, 19*, 75-77.

Vitaliano, P. P., Zhang, J., & Skanlan, J. M. (2003). Is caregiving hazardous to one's physical health?: A meta-analysis. *Psychological Bulletin, 129*(6), 945-972.

Vitello, P. (2011). Robert Ader, who linked stress and illness, dies at 79. *The New York Times, December, 25*. Retrieved July 2, 2012, from http://www.nytimes.com/2011/12/26/science/robert-ader-who-linked-stress-and-illness-dies-at-79.html?_r=2

Wakefield, J. C. (1992). The concept of mental disorder: On the boundary between biological facts and social values. *American Psychologist, 47*(3), 373-388.

Waldron, S. (2010). A curious metaphor: Engaging with trauma: An analytical perspective. *The Journal Of Analytical Psychology, 55*(1), 74-90.

Walker, E., Cudeck, R., Mednick, S. A., & Schulsinger, F. (1981). Effects of parental absence and institutionalization on the development of clinical symptoms in high-risk children. *Acta Psychiatrica Scandinavica, 63*, 95-109.

Walker, L. E., & Shapiro, D. L. (2010). Parental alienation disorder: Why label children with a mental diagnosis? *Journal of Child Custody, 7*(4), 266-286.

Walker, M. (1992). *Surviving secrets: The experience of abuse for the child, the adult and the helper.* Buckingham, UK: Open University Press.

Wampold, B. E. (2003). Bashing positivism and revering a medical model under the guise of evidence. *Counseling Psychologist, 31*(5), 539-545.

Ward, H., & Glaser, D. (2010). The developmental needs of children: Implications for assessment. In J. Horwath (Ed.), *The child's world: The comprehensive guide to assessing children in need* (2nd ed., pp. 160-173). London: Jessica Kingsley.

Warner, S. (2009). *Understanding the effects of child sexual abuse: Feminist revolutions in theory, research and practice*. London: Routledge.

Wasow, M. (1995). *The skipping stone: Ripple effects of mental illness on the family*. Palo Alto, CA: Science & Behavior Books.

Weiner, J. S. (2007). Letters June 27. *JAMA, 297*(24), 2692-2693.

Weiner, J. S., & Roth, J. (2006). Avoiding iatrogenic harm to patient and family while discussing goals of care near the end of life. *Journal of Palliative Medicine, 9*, 451-463.

Weiss, J., Sampson, H., & O'Connor, L. (1995). How psychotherapy works: The research findings of the San Francisco Psychotherapy Research Group. *4*. Retrieved July 2, 2012, from http://www.behavior.net/orgs/sfprg/research.html

West, M. L., & Keller, A. E. (1991). Parentification of the child: A case study of Bowlby's compulsive care-giving attachment pattern. *American Journal Of Psychotherapy, 45*(3), 425-431.

White, M. (2004). Working with people who are suffering the consequences of multiple trauma: A narrative perspective. *The International Journal of Narrative Therapy and Community Work, 1*, 45-76.

White, M. (2005). Children, trauma and subordinate storyline development. *The International Journal of Narrative Therapy and Community Work*(3 & 4), 120-121.

Whitfield, C. L. (1987). *Healing the child within: Discovery and recovery for adult children of dysfunctional families*. Pompano Beach, FL: Health Communications.

Widom, C. S. (1998). Child victims: Searching for opportunities to break the cycle of violence. *Applied & Preventive Psychology, 7*, 225-234.

Williams, A. S. (1998). A group for the adult daughters of mentally ill mothers: Looking backwards and forwards. *British Journal of Medical Psychology, 71*, 73-83.

Williams, O. B., & Corrigan, P. W. (1992). The differential effects of parental alcoholism and mental illness on their adult children. *Journal of Clinical Psychology, 48*(3), 406-414.

Wilsnack, S. C., Vogeltanz, N. D., Klassen, A. D., & Harris, T. R. (1997). Childhood sexual abuse and women's substance abuse: National survey findings. *Journal of Studies on Alcohol, 58*, 264-271.

Wilson, J. P., Harel, Z., & Kahana, B. (Eds.). (1988). *Human adaptation to extreme stress: From the Holocaust to Vietnam*. New York: Plenum Press.

Winnicott, D. W. (1953). Transitional objects and transitional phenomena. *International Journal of Psychoanalysis, 34,*, 89-97.

Winter. (2000). A comparative discussion of the notion of 'validity' in qualitative and quantitative research. *The Qualitative Report, 4*(3/4). Retrieved July 2, 2012, from http://www.nova.edu/ssss/QR/QR4-3/winter.html

Witztum, E., & Malkinson, R. (2009). Examining traumatic grief and loss among Holocaust survivors. *Journal of Loss and Trauma, 14*(2), 129-143.

Wolcott, H. (1990). *Writing up qualitative research*. Newbury Park, CA: Sage.

Woods, B., & Clare, L. (Eds.). (2008). *Handbook of the clinical psychology of ageing*. Chichester, UK: John Wiley & Sons.

Worden, J. W. (1991). *Grief counselling and grief therapy: A handbook for the Mental Health Practitioner* (2nd ed.). London: Routledge.

Worden, J. W. (2002). *Grief counseling and grief therapy: A handbook for the mental health practitioner* (3rd ed.). New York: Springer.

Worden, J. W. (2009). *Grief counseling and grief therapy: A handbook for the mental health practitioner* (4th ed.). New York: Springer.

World Fellowship for Schizophrenia and Allied Disorders. (2012). *FPC goals and principles*. Retrieved July 2, 2012, from http://www.world-schizophrenia.org/activities/fpc/principles.html

World Health Organization. (2011). International Classification of Diseases, 10th Revision, 2007 (ICD-10). 2010. Retrieved 28th August, 2012, from http://www.who.int/classifications/icd/ICD10Volume2_en_2010.pdf

Wortman, C. B., & Silver, R. C. (1989). The myths of coping with loss. *Journal of Consulting and Clinical Psychology, 57*(3), 349-357.

Wuest, J., Malcolm, J., & Merritt-Gray, M. (2010). Daughters' obligation to care in the context of past abuse. *Health Care for Women International, 31*(12), 1047-1067.

Yalom, I. D. (1980). *Existential psychotherapy*. New York: Basic Books.

Yoshino, A., Okamoto, Y., Onoda, K., Yoshimura, S., Kunisato, Y., Demoto, Y., et al. (2010). Sadness enhances the experience of pain via neural activation in the anterior cingulate cortex and amygdala: An fMRI study. *Neuroimage*(April 15), 1194-1201.

Young, J., Bailey, G., & Rycroft, P. (2004). Family grief and mental health: A systemic, contextual and compassionate analysis. *Australian and New Zealand Journal of Family Therapy, 25*(4), 188-197.

Zielinski, D. S. (2009). Child maltreatment and adult socioeconomic well-being. *Child Abuse and Neglect, 33*(10), 666-678.

Appendices

Appendix A: SEARCH STRATEGY

Search details for: **Lives Unseen: Unacknowledged Trauma of Child-Survivors of Parents with a Severe Mental Illness How Well are Their Needs Captured?**

Grief of psychological parental absence

Grief OR Loss OR trauma OR sadness
AND
"parental mental illness" or "adults with mentally ill parents" or "adults of the mentally ill" or "parental mental illness and adults"
AND

S1	**S2** (terms to be further explored)	**S3**	**S 4**	**S5**	
Grief Loss Trauma Sadness Bereavement Disenfranchised grief Grief and Betrayal Trauma and Betrayal	ACOPSMI (or ACOPMI) **"parental mental illness"** **"adults with mentally ill parents"** **"adults of the mentally ill"** **COPSMI (or ACOPSMI)** **"Children of parents with mental illness"** **"adults of ill parents"** **"psychological parental absence"** **"Mentally ill parent*"** (For international literature) search: 'psychiatric disability' and 'psychiatric disorder'.	Adult children Adults*	High achievers University educated		

211

Databases (ongoing consultations including "alerts"):

Psychology
Advance Search (Synonyms Page)
Psycinfo
Psychology & Behavioural Sciences Collection EBSCO

Medical
Medline/Pubmed
Cinahl
Scopus (includes embase records)

Multidisciplinary
Web of Science
Scopus
Expanded Academic
Academic Search Premier
Google Scholar

Extra search terms
"parental mental illness" or "adults with mentally ill parents" or "adults of the mentally ill" or "parental mental illness and adults"

Fields for Detailed Exploration

Children Of Parents with a Mental Illness (COPMI), Children Of Parents with a Severe Mental Illness (COPSMI), and Adult Children Of

Parents with a Severe Mental Illness (ACOPSMI) Literature

Grief theories

General Psychological-Trauma Literature

Appendix B: SEARCH QUERIES

CSA Illumina database PsycARTICLES – Nine Alerts and their Search Queries

<u>Alert #1:</u>

Search Query: (grief or loss or sadness) and (parental mental health) or (parental mental illness) and not (death or (drugs and alcohol) or suicide)

<u>Alert #2:</u>

Search Query: (Grief or Loss) and (Parental Mental Illness) or (Parental Mental Health)

<u>Alert #3:</u>

Search Query: (grief or loss or trauma) or (sadness or bereavement or disenfranchised) or grief

<u>Alert #4:</u>

Search Query: (copmi or acopmi or (parental mental illness) or (adults with mentally ill parent*) or (adults of the mentally ill) or (children of parent* with mental illness) and (adults of ill parent*) or (mentally ill parent*)

<u>Alert #5:</u>

Search Query: (copmi or acopmi or (parental mental illness) or (adults with mentally ill parent*) or (adults of the mentally ill) or (children of parent* with mental illness) and (adults of ill parent*) or (mentally ill parent*)

<u>Alert #6:</u>

Search Query: adult children

Alert #7:

Search Query: (grief or loss or trauma) or (sadness or bereavement or disenfranchised) or grief) (copmi or acopmi or (parental mental illness) or (adults with mentally ill parent*) or (adults of the mentally ill) or (children of parent* with mental illness) and (adults of ill parent*) or (mentally ill parent*) (adult children)

Alert #8:

Search Query: (grief or loss or sadness) and (parental mental health) or (parental mental illness) and not (physical death or drugs and alcohol) or (suicide) or (psychological death)

Alert #9:

Search Query: (grief or loss or trauma) or (sadness or bereavement or disenfranchised) or grief) and (copmi or acopmi or (parental mental illness) or (adults with mentally ill parent*) or (adults of the mentally ill) or (children of parent* with mental illness) and (adults of ill parent*) or (mentally ill parent*) and (adult children).