ORIGINAL ARTICLE

Navigating peer relationships: What do friendships look like for children whose parents have mental illnesses?

Ebenezer Cudjoe[1,3] ⓘ | **Marcus Y. L. Chiu**[2] ⓘ | **Cherry H. L. Tam**[3] ⓘ

[1]Department of Psychosocial and Psychoanalytic Studies, University of Essex, Colchester, United Kingdom

[2]Visiting Professor, School of Health & Wellbeing, University of Bolton, UK

[3]Department of Social and Behavioural Sciences, City University of Hong Kong, Kowloon Tong, Hong Kong

Correspondence
Ebenezer Cudjoe, Department of Psychosocial and Psychoanalytic Studies, University of Essex, Wivenhoe Park, CO4 3SQ, Colchester, United Kingdom.
Email: e.cudjoe@essex.ac.uk

Abstract

Peer support programmes among children whose parents have mental illnesses have rarely focused on how these children relate with peers in the general population. Therefore, this phenomenological study in Ghana involved interviews with 13 children (ages 10 to 17) living with parental mental illness to learn about their peer relationships. Data were analysed to identify the phenomenon's essential features and constituents. The study finds that peer relations entail secrecy, peer victimisation and abuse. To these children, keeping secrets about parental mental illness ensures they have 'normal' peer relationships like others, as troubled peer relationships can develop when peers are informed about the parents' mental illness. Name-calling, teasing and withdrawal persists when peers are aware of one's parental mental illness. Although the children perceive that they may find comfort in children who are in a similar situation, the pros and cons of developing peer support out of these in-groups have to be verified rather than assumed. It is recommended that helping professionals educate school children and address myths they have about mental illness and its impact on their relationships.

KEYWORDS
children, parental mental illness, peer abuse, peer relationships, peer victimisation

Key Practitioner Messages
- Interventions should include peers who do not have parents with mental illness as participants.
- Some children with parental mental illness may experience psychological difficulties due to stigma from peers. Social workers should identify these children and provide counselling support.
- Schools should introduce mental health literacy curriculum to address norms and values around mental illness that perpetuate stigma.

INTRODUCTION

Children whose parents have mental illnesses risk several negative outcomes like poor school performance and/or attendance, problem-behaviour, experience isolation and can even develop mental illness themselves (Hosman et al., 2009; van Santvoort et al., 2014). In response to the children's challenges, substantial work has been done to develop interventions based on psychoeducation to improve their outcomes. One of such is peer support interventions often targeting children from seven to 18 years where peers who are in a similar situation come together to learn about parental mental illness, adaptive coping and learn ways to access relevant supports from social and healthcare services (Reupert

et al., 2013). Indeed, peer support programmes in many countries, such as one in Australia (Foster et al., 2014, 2016), have shown promising results like improvement with connection outside the family, reducing isolation and increasing hope. However, the international literature on these interventions suggest that many occur in controlled settings in the form of RCTs (Fraser & Pakenham, 2008; van Santvoort et al., 2014), so, it is difficult to tell whether the changes are transferred to real-life contexts. A similar trend is found in interventions where evaluation is conducted at the end of the programme, again, making it unclear how outcomes are transferred to real life. More so, in Ghana where this study was conducted, there are no available interventions on this population to be evaluated and no study exists about their peer relations with the general population. Therefore, we investigate what it is like for children whose parents have mental illnesses to relate with their peers, particularly, peers from the general population.

Peer relationships among children whose parents have mental illnesses

Peer support programmes for children whose parents have mental illnesses are being developed internationally and there are examples in countries like the USA, UK, Australia, Germany, Canada and the Netherlands (Reupert et al., 2013). In Canada, Gladstone et al. (2014) analysed interactions in a peer support programme involving children from seven to 13 years where they were given a programme manual to learn from and perform some activities. A key element in the manual was providing children with information about how to engage or initiate conversations about the parent's mental illness. Especially during symptomatic episodes, children may not know how to react or respond to the parent. But peer supports can offer children diverse ways to talk about parental mental illness or engage with the parent. For instance, children learn to use other *appealing* terms instead of medical terms, like referring to bipolar depression as 'manic happiness', when referring to the parent's condition (Gladstone et al., 2014).

Peer support programmes have been used to address some of these myths about mental illness (Reupert et al., 2013). Some of these myths include the idea that mental illness can be caught like a cold or that children are to blame for their parent's mental illness. One programme in Australia for children eight to 11 years sought a general goal to improve children's mental health knowledge (Grove et al., 2015). The programme enabled children to learn that mental illness cannot be seen, is not always bad and that it is not their fault that the parent has the condition. Children who participated in such programmes are encouraged to be more open to talk to others about mental illness and acknowledge the importance of seeing their parents as unique from others (Grove et al., 2015).

Such programmes are unavailable in Ghana owing in part to a lack of awareness into the children's issues and the limited resources dedicated to mental health. Also, Cudjoe and Chiu (2021) mentioned that mental health nurses in Ghana rarely collect parenting information from patients, so it is difficult to reach these children and provide them with relevant intervention. Unlike the other countries that are well-advanced into developing interventions for these children, awareness to their concerns in Ghana is relatively low. Overall, peer support programmes show promising outcomes for children whose parents have mental illnesses. They report improved understanding of parental mental illness, awareness of social supports and professional services, increased chances that they seek supports, learned adaptive coping methods and are less likely to be isolated (Goodyear et al., 2009; Parkinson et al., 2021). It is recommended that research in Ghana adapts some of these interventions and evaluates outcomes.

However, there is much more to do for these children than offer interventions that are often focused on peers in a similar situation without much understanding into how the children relate with peers who do not have a parent with mental illness. Besides, it is more likely that in the school, neighbourhoods and other places where the children frequent, they are going to interact more with peers who do not have a parent with mental illness than those with parental mental illness. It is even possible that many of these children have no interaction with peers who are in a similar situation in their day-to-day activities. Therefore, it is important that research looks beyond the focus of such interventions and considers how children whose parents have mental illnesses interact with peers in natural settings. Additionally, in Ghana where peer interventions are non-existent, it may be particularly useful to explore the children's experiences of peer relations in a natural context. In this phenomenological study, we address this issue among children 10 to 17 years. It is hoped that this study can offer practical recommendations based on peer interactions so that professional supports can be provided for these children often burdened by the emotional and physical demands of having a parent with mental illness.

METHOD

Study design

This study was influenced by Edmund Husserl's transcendental phenomenology, particularly his concept of the *natural attitude*. The natural attitude consists of naiveté of experience or common-sense everyday reality which we live by, one

which is accepted straightforward without question (Christensen et al., 2017). It is natural because we are unaware of this attitude; it is an unreflective moment of time (Luft, 1998). Because we are already part of the external world, there is the tendency to take things for granted. This *taken-for-grantedness* seems to be a key feature of peer relations among children whose parents have mental illnesses. There has been so much focus on relations among peers who are in a similar situation, forgetting what it is like for the children with peers in the community. Questioning the natural attitude addresses taken-for-grantedness such as these (Dahlberg & Dahlberg, 2020).

Eligibility criteria and recruitment

Children from 10 to 17 years who have a parent with mental illness took part in this study. It is assumed that these children spend more of their daytime at school than at home with family. As a result of this, they are better positioned to talk about what it is like to relate with peers at school and their neighbourhood in the context of parental mental illness. The children were expected to have at least one of their parents receiving psychiatric treatments or mental health services from out-patient facilities. Children whose parents had ended their treatments, at most six months into the interview, were also eligible.

The children were selected by contacting two outpatient psychiatric units in Ghana. Letters were given to the nurses in charge of the psychiatric units to request for information on patients who had children from 10 to 17 years to take part in the study. Unfortunately, none of the psychiatric units had information about whether some of their mental health patients had children. Sadly, this is not surprising as literature continues to lament the lack of documentation on the parental status of psychiatric patients receiving services (Campbell & Poon, 2020; Strand & Rudolfsson, 2020). The nurses were asked to find out if the patient had children from 10 to 17 years. The psychiatric units together provided a list of 19 families with parental mental illness whose children could be potential participants. Of the 19 families approached, three did not qualify as they did not have a parent with mental illness but they were young adults with mental illness in the family. So, 16 families were contacted to ask about their children's availability for interviews. Eleven families agreed to have their children take part in the study. The others refused participation due to lack of time and scepticism about what the data was being used for. Thirteen children, ages 10 to 17 from 11 families with parental mental illness participated in the interviews.

Ethical considerations

Ethical clearance for the study was received from the Research Ethics Committee of City University of Hong Kong before data collection. Consent was sought from either their parents or close relatives before involving the child. Some of the parents were not capable of providing parental consent for the following reasons: hospitalisation, severe mental illness and presenting symptomatic episodes regularly. For such children in this situation, the parent without mental illness, close relatives or family friends gave consent. The children were also given the opportunity to give their assent before participating in the study. So, although parents or guardians had to give consent before contacting the children, the final decision to participate in the study rested on the child participant.

An informed consent form and an assent form were given to parents/guardians and children, respectively, which they had to sign before taking part in the study. The form for the children was written in a way that people from 10 to 17 years can easily comprehend. The researcher had meetings with the parents and children to explain the form and other associated obligations and rights pertaining to the study. For example, both children and parents were assured that the audio-recordings will be deleted within four weeks once they were transcribed. All the children agreed to conditions of the study like having the interview recorded, understanding that the interview could take 60 minutes, that they could refuse to answer any question, withdraw from the study and ask that their interview be deleted from the study. As part of agreeing to the interviews, the children were asked that there will be no parent/guardian present at the interview. It was hoped that, by interviewing the child alone, they may be more forthcoming with their narrations. Throughout the interviews, a mental health nurse accompanied the researcher to ensure that children who required immediate support received attention. The children were asked to choose pseudonyms they preferred to be used in reporting the data. No identifying information has been included in the analysis.

Participants

Thirteen children (10 to 17 years) living with a parent with mental illness participated in this study to explore what they think about interactions with peers in settings which they frequent. As seen from Table 1, all the children were active in

T A B L E 1 Details of interview participants

Pseudonym	Age	Year in school	Parent's diagnosis	Number of hospitalisations	Length of hospitalisations
Rosemary (F)	10	Primary	Mother with schizophrenia	Once	Five months; she ran away from the hospital on the fourth month but returned
Eric (M)	12	Primary	Mother with psychosis	Three times	Two months, one month, few days
Naomi (F)	13	Junior high	Mother with depression	Several times	Not specified
Dan (M)	13	Junior high	Mother with depression	Not specified	Not specified
Ajoa (F)	11	Primary	Mother with schizophrenia	Once	Three weeks
Rose (F)	13	Junior high	Mother with depression	Several times	Not specified
Paul (M)	14	Junior high	Mother with depression	Four times	Four months
Abigail (F)	10	Primary	Mother with psychosis	Several times	Not specified
Ama (F)	15	Junior high	Mother with depression	Not specified	Not specified
Ben (F)	12	Junior high	Mother with anxiety disorders	Once	One week
Ogla (F)	17	High school	Father with schizophrenia	Six times	Not specified
Vera (F)	12	Junior high	Mother with anxiety disorders	None	None
Ajoa (F)	11	Primary	Mother with schizophrenia	Once	Three weeks

school at three levels: primary, junior and secondary school. Parental diagnosis included schizophrenia, psychosis, anxiety disorders and depression. Except for one child, all other children had the mother with mental illness. Many of the children had parents with experiences of hospitalisation.

Data collection: Phenomenological interviewing

The interview started by focusing on narratives situated within the naiveté of experience, that is, the *taken-for-grantedness*, without much analysis on thoughts. Questions like "tell me about what a day with a friend is like" and "what do you usually talk about with friends at school?" were asked. These were to yield descriptive responses on ordinary, day-to-day activities. The next stage of the interview was to apprehend the phenomenon, which is a more critical approach (Bevan, 2014). Because a phenomenon like peer relations for these children can show itself in different ways, several forms of probing were used to know more about the nature of the phenomenon. A question like "so what do you think about when friends use your parent's mental illness to tease you?" was asked at this stage. Follow-up questions like these centred on eliciting detailed responses to know about the essential features of peer relations. The final process of interviewing was to clarify the phenomenon through imaginative variation. Responses from the children were used as a point of departure to ask imaginative questions. For example, imaginative questions like how do they see themselves in a world where all other children do not have a parent with mental illness were asked. Zahavi (2018, p. 45) states that by imagining a phenomenon being different from what it is 'we can slowly strip away its accidental properties, and thereby reach certain properties or features that cannot be changed without the object of investigation thereby also ceasing to be the kind of object it is'. The use of imaginative variation clarified the children's perspectives on peer relations that if those properties were changed it will cease to be the phenomenon being described.

 The interviews lasted from 30 to 70 minutes. All interviews were conducted in the Fante (local) language at the homes of the participants. The children were interviewed alone without the presence of parents or guardian.

Data analysis

The interviews were recorded and transcribed for analysis. The overall goal of data analysis was to identify the essence of peer relations for children whose parents have mental illnesses. After reading through the transcripts several times for familiarisation, stories were written for each participant to maintain key aspects of their narration. With the phenomenon in focus, questions were asked of the data from a reflexive stance. Attention was directed towards the meaning in the data so that meaning units were developed for each data (Dahlberg et al., 2008). After each interview had been finalised with meaning units, they were clustered. At this stage the essence of the phenomenon was developed by comparing the meaning clusters to each other. As part of data analysis, the participants' experiences were depersonalised by

removing demographic features and context from their experience (Larsen & Adu, 2022). The aim of this was to be able to grasp the essential features of the phenomenon. From the participants' naïve description of relations with peers, a new understanding of the phenomenon was formulated. Reference to 'naïve description' here does not refer to the children's experiences as unreliable or inaccurate per se. However, it is a phenomenological concept that shows how we can be uncritical or unreflective about the things around us due to our involvement in a pre-existing world.

FINDINGS

Results of the study are presented through a structure of meanings; the essential meanings are first presented before its constituents. Unlike the essential meanings that seek to attain the general form of the phenomenon, the constituents are shown in full details, depicting the nuances in the data.

The essence of the phenomenon 'peer relations for children whose parents have mental illnesses' entails secrecy, perceived and actual abuse and a search for 'similar others'. For the children, moving out of home to a space with peers maintains a distance from parental mental illness. It is the fact of keeping parental mental illness a secret that ensures that they continue to enjoy relationships with their peers. The children are aware that there is the potential of facing abuse from their peers should they know that they have a parent with mental illness. To continue having this space where parental mental illness is not referenced in a stigmatised way, the children keep silent about their parent's condition when interacting with their peers. Indeed, those children whose peers are aware about parental mental illness often feel uncomfortable around peers and sometimes are unable to join in play activities. The children feel they are better off sharing such information with peers who are in a similar situation than with others in the general population. The findings presented have been summarised in Figure 1 below for a more holistic understanding of the phenomenon.

The following further illuminates the meaning of the phenomenon: silence fostering happy relations with peers and peer victimisation and abuse.

Silence fostering happy relations with peers

As could be seen from Figure 1, children whose parents have mental illnesses commonly keep secrets about their parents' condition to enjoy relations with peers from the general population. The children are often socialised by their parents not to talk about their mental illness to other people. A child indicated this experience.

> I think it's *[mental illness]* not something they *[parents]* want you to tell others. Even me myself I'm not sure I will talk to someone about it. I think because people do not like it so just keep quiet. (Abigail)

This is further enforced by the societal stigma regarding people with mental illnesses: 'Someone will think she is mad when I am talking to her *[parent with mental illness]*' (Abena). Therefore, most of these children are not keen on
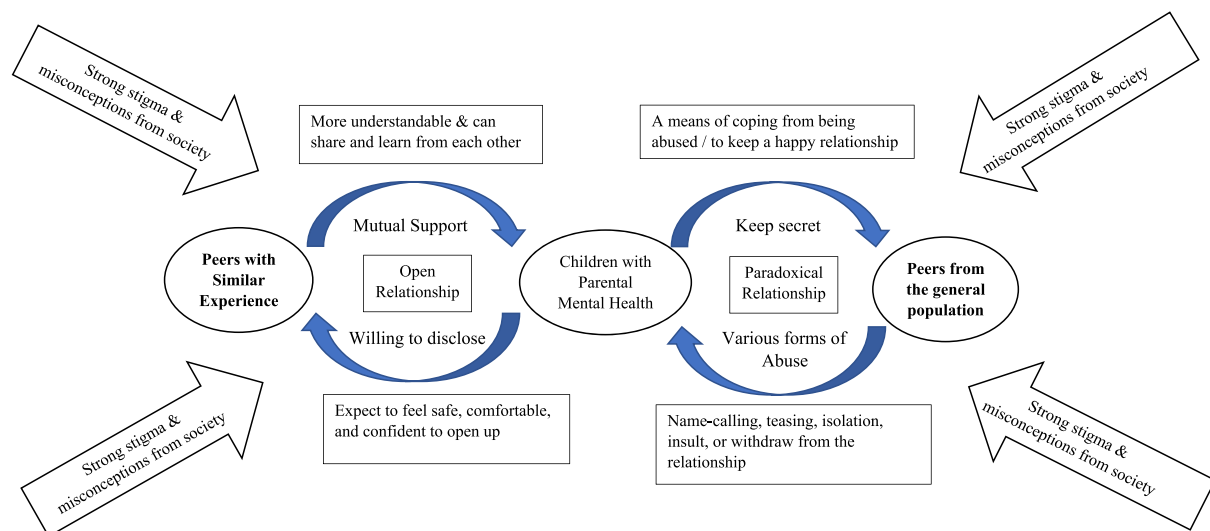

FIGURE 1 Peer relationships of children whose parents have mental illnesses

talking about parental mental illness with others. The children enjoyed relationships with peers. So, there is no need to mar the relationship by telling them about the parents' condition.

> There are friends there *[school]* who will make me happy. Even at home my mother *[parent with mental illness]* will not listen to me. (Dan)
>
> It is much better when with peers, when I come home he *[parent with mental illness]* has been insulting people. (Ogla)

The above quotes suggest that peers are an important part of the children's happiness when they leave home. However, the children commonly think that once their peers get to know about their parent's mental illness, they may cease to enjoy activities together. Therefore, it is important to keep silent about their parents' mental illness when around their peers to continue enjoying relationships with them.

> No need to tell my friends, I just play with them. We do not talk about our parents. (Paul)
>
> I do not tell them *[peers]* that she has mental illness. It is not good to let them know else they will always talk about it. Not comfortable. (Ama).

Peer victimisation and abuse

Peer relations for children whose parents have mental illnesses can be characterised by various forms of abuse including name-calling, teasing and withdrawal. This is the case when their peers become aware that the child has a parent with mental illness. The children usually become *victims of verbal assaults* through teasing and name-calling. There seems to be a burden on the children to be careful about how they communicate with their peers. For instance, some of the children described how in the classroom setting they need to be careful of the way they talk to peers because they had a parent with mental illness.

> If I do something in class and it hurts them *[peers]* they will bring in my parent and start insulting me using their condition. (Ajoa)
>
> I am very careful what I say to my friends, if not, and I hurt anyone's feelings, then they bring in my mother's condition to tease me. (Vera)

It seems to be a common occurrence among peer networks to engage in *name-calling*. There is always a chance that the child will be abused during interactions. It is a main reason why the children often think the best way is to keep parental mental illness to themselves. Some of the children reflected on the teasing and name-calling they encountered in the playground.

> When we are playing they always want me to take the role that makes my dress dirty because they have seen my mother wearing dirty clothes. (Abigail)
>
> They told me my mother is mad that is why I do not think and I just kick the ball anyhow. (Ben)

It is possible that *teasing and name-calling* is being perpetuated because their peers do not understand mental illness and also it becomes a handy reference for attack. For instance, the narration from this child shows how some peers can easily pick on these children by referring to the parent's symptoms.

> After school my friend just told the others that my father has been talking to himself like a crazy person, and they were all laughing. (Ogla)

What most of these peers know about mental illness comes from community perceptions, which is often negative. Therefore, there seems to be little concern about how they talk about mental illness or even what impact it can have on their fellow colleague.

Further, the children experience *isolation* among peers due to their association with parental mental illness. It appears that their peers withdraw from their company due to misconceptions surrounding mental illness. It is not uncommon for children to think that mental illness can be caught like a cold. Therefore, a way to not catch this cold is to stay away from people who are in contact with someone with mental illness. The fear of contagion also reinforces social stigma. This is how social exclusion occurs.

> They *[peers]* will say because my mother is ill they will not play with me. That they will be infected when they play with me. (Abena)
> When they *[peers]* are doing their things together they do not invite me to join. I do not like the way they see me. (Ama)

The children have to make a choice between relationships with their peers or being open about parental illness. It seems difficult to have both because letting others know about parental mental illness could contribute to their isolation from peers.

However, the children believe there is a chance for more positive relation with peers who are in a similar situation. These are people who have a shared experience of having a parent with mental illness so there is the assumption that they will be more understanding. In such relationships, children feel safe, comfortable and confident about opening up.

> Because they *[peers with parental mental illness]* have seen the situation and I am also aware so we all know what each other is going through. (Ben).
> For them I will take them *[peers with parental mental illness]* as my best friend… I will help them because I know how to deal with this. (Paul)

The children perceive they can have a more open relationship with peers who are in a similar situation where they can share and learn from each other's experiences. Of course, this is only a perception because they have actually not had this experience in real-life. The secrecy surrounding parental mental illness can make it challenging for these children to reach out to each other to offer emotional supports and comfort. But what this provides is the opportunity for positive relationships with peers which have been taken up in the way of peer support programmes.

Reflections

Studies on peer support programmes have been conducted in countries like the United States, the UK and Australia (Reupert et al., 2013). Yet, these peer programmes have often been limited to children in a similar situation. In Ghana, there are no programmes of this nature and research on these children's peer relations is lacking. This study addresses a gap internationally and in the local context by focusing more on peer relations with those in the general population and how stigma makes relationship building difficult for the children.

Research has shown that children living with parental mental illness can experience isolation, be secretive and keep family struggles to themselves (Mordoch, 2010; Grove et al., 2017). Peers are one of the key groups that children interact with, often at school or within their neighbourhood. However, having a parent with mental illness seems to prevent children from engaging in positive relationships with peers. Holding onto the family secret ensures that children continue to be part of peer relations that are healthy (as seen in Figure 1). On the surface, this might not be entirely problematic as it ensures that the space involving relations with peers is not interrupted with issues surrounding the parent's mental illness. In many situations, children want to keep their distance from parental mental illness to reflect on their lives (Kadish, 2015).

The study reveals two outcomes coming from peers' awareness of parental mental illness: the first is distancing themselves from the child and the other is perpetuating various forms of abuse and exclusion. These negative behaviours appear to justify why the children keep their secrets. Children whose parents have mental illnesses are victimised among their peers as a result of their association with parental mental illness. The affiliate stigma seems to come from public stigma towards people with mental illnesses, if they do not receive from proper sources the knowledge on mental illness (Chen et al., 2021; Reupert et al., 2021). Although peers may engage in such abusive behaviours due to their lack of understanding of mental illness, it has to do with broader societal views and attitudes that they have been socialised within. In general, peer relations can be essentially troubling for such children. These troubled relationships, if not addressed, can have adverse developmental outcomes on the children. There is substantial work to be done in terms of how healthy relationships with peers in the general population can be promoted and sustained.

Implications for practice

Interventions to address troubling peer relations could focus on different levels including the community, school and at the individual level. Strategies from the INSPIRE framework (WHO, 2019) could be used as a starting point to tackle peer victimisation and abuse against children whose parents have mental illnesses. Basic and secondary schools in Ghana do not provide much awareness into mental health literacy. Considering **implementation and enforcement of**

laws, schools should introduce regulations to prohibit bullying or ridiculing directed towards a child because they have a parent with mental illness. Mental health literacy should be part of the educational curriculum to change **norms and values** about people with mental illnesses and their family. School social workers, psychologists, mental health and other relevant professionals should make it their responsibility to promote mental health literacy in schools. A key focus of such education is to address myths and misconceptions surrounding mental illness as well as deal with peer victimisation and abuse. Part of the education in school could be about teaching students in general about how to respond sensitively to their peers who may be struggling at home due to parental mental illness. While peers can be a source of risk, they can be supportive to the children when provided with non-stigmatising information.

Addressing norms and values about people with mental illnesses should also extend to the communities where the children live. The stigmatising attitudes that peers demonstrate towards these children are often due to community socialisation. Therefore, social workers should engage in community visits to sensitise the general public with non-stigmatising information about mental illness. It is also important that these include home visits to the parent with mental illness and their children to provide **parent and caregiver support**. Some of these children may be unsure about appropriate words to use in talking to their peers about mental illness. Social workers can engage with the children and enable them to come up with appropriate vocabulary to talk about their parent's mental illness with peers in a way that they are not stigmatised.

Peer support from within and outside groups are equally important and non-exclusive. Peer group of 'sameness' provides a safe haven for children to talk about their anxieties, worries and troubles, which could be more easily understood within the group. However, not all children may want such peer group involvement. This is the reason why mental health literacy in schools and communities should be intensified. On the other hand, a carefully planned outsider group can instil proper knowledge on mental illness and ease social stigma on the children with parental mental illness. Group workers may start to ponder the use of mixed groups to impart further change on the friends of these children who are forming into a more trustful base of friendship.

Study limitations

This study followed ideas from Husserl's transcendental phenomenology which emphasises phenomenon's essence. Because the investigation was focused on the phenomenon, the analysis did not include personalised accounts as in idiographic analysis. Therefore, some aspects of analysis such as how experiences may differ in terms of age, gender or parent's diagnosis were not included.

CONCLUSION

Peer interventions should not only be limited to those who have a parent with mental illness but should extend to peers without a parent with mental illness. School-level and community education and interventions should be intensified because the stigma towards these children is often derived from community norms. School/community-level supports can better create a milieu for conducive care and inclusiveness for these children rather than rejection, discomfort and exclusion. Involving peers from the general population will further prevent other children from becoming stern stigmatisers when they grow up.

DECLARATION
The authors declare that this work is original and has not been submitted or published elsewhere.

CONFLICTS OF INTEREST STATEMENT
The authors declare that there are no conflicts of interest with the writing and development of the study.

ETHICS STATEMENT
The study has received ethical clearance from the Research Ethics Committee of City University of Hong Kong.

ORCID
Ebenezer Cudjoe https://orcid.org/0000-0002-9908-0834
Marcus Y. L. Chiu https://orcid.org/0000-0002-6676-8886
Cherry H. L. Tam https://orcid.org/0000-0002-6792-9725

REFERENCES

Bevan, M.T. (2014) A method of phenomenological interviewing. *Qualitative Health Research*, 24(1), 136–144. Available from: https://doi.org/10.1177/1049732313519710

Campbell, L. & Poon, A.W.C. (2020) Parenting Challenges for Persons with a Serious Mental Illness. In: Ow, R. & Poon, A.W.C. (Eds.) *Mental health and social work*. Springer, pp. 457–474.

Chen, L., Vivekananda, K., Guan, L. & Reupert, A. (2021) Parenting experiences of Chinese mothers living with a mental illness. *BMC Psychiatry*, 21(1), 1–11. Available from: https://doi.org/10.1186/s12888-021-03581-9

Christensen, M., Welch, A. & Barr, J. (2017) Husserlian descriptive phenomenology: A review of intentionality, reduction and the natural attitude. *Journal of Nursing Education and Practice*, 7(8), 113–118. Available from: https://doi.org/10.5430/jnep.v7n8p113

Cudjoe, E., & Chiu, Y.L.M. (2021). Kinship Care Support for Children Whose Parents Have Mental Illness in Ghana: Identifying a Culturally Informed Solution. In: Baikady, R. Sajid, S.M. Przeperski, J. Nadesan, V. Rezaul, I. & Gao, J. (Eds.) *The Palgrave Handbook of Global Social Problems Palgrave Macmillan*. https://doi.org/10.1007/978-3-030-68127-2_70-1

Dahlberg, H. & Dahlberg, K. (2020) Phenomenology of science and the art of radical questioning. *Qualitative Inquiry*, 26(7)), 889–896. Available from: https://doi.org/10.1177/1077800419897702

Dahlberg, K., Dahlberg, H. & Nyström, M. (2008) *Reflective lifeworld research*. Lund: Studentlitteratur.

Foster, K., Lewis, P. & McCloughen, A. (2014) Experiences of peer support for children and adolescents whose parents and siblings have mental illness. *Journal of Child and Adolescent Psychiatric Nursing*, 27(2), 61–67. Available from: https://doi.org/10.1111/jcap.12072

Foster, K., McPhee, I., Fethney, J. & McCloughen, A. (2016) Outcomes of the ON FIRE peer support programme for children and adolescents in families with mental health problems. *Child & Family Social Work*, 21(3), 295–306. Available from: https://doi.org/10.1111/cfs.12143

Fraser, E. & Pakenham, K.I. (2008) Evaluation of a resilience-based intervention for children of parents with mental illness. *Australian and New Zealand Journal of Psychiatry*, 42(12), 1041–1050. Available from: https://doi.org/10.1080/00048670802512065

Gladstone, B.M., McKeever, P., Seeman, M. & Boydell, K.M. (2014) Analysis of a support group for children of parents with mental illnesses: Managing stressful situations. *Qualitative Health Research*, 24(9), 1171–1182. Available from: https://doi.org/10.1177/1049732314528068

Goodyear, M., Cuff, R., Maybery, D. & Reupert, A. (2009) CHAMPS: A peer support program for children of parents with a mental illness. *Australian e-Journal for the Advancement of Mental Health*, 8(3), 296–304. Available from: https://doi.org/10.5172/jamh.8.3.296

Grove, C., Reupert, A. & Maybery, D. (2015) Gaining knowledge about parental mental illness: How does it empower children? *Child & Family Social Work*, 20(4), 377–386. Available from: https://doi.org/10.1111/cfs.12086

Grove, C., Riebschleger, J., Bosch, A., Cavanaugh, D. & van der Ende, P.C. (2017) Expert views of children's knowledge needs regarding parental mental illness. *Children and Youth Services Review*, 79, 249–255. Available from: https://doi.org/10.1016/j.childyouth.2017.06.026

Hosman, C.M.H., van Doesum, K.T.M. & van Santvoort, F. (2009) Prevention of emotional problems and psychiatric risks in children of parents with a mental illness in the Netherlands: I. the scientific basis to a comprehensive approach. *Australian e-Journal for the Advancement of Mental Health*, 8(3), 250–263. Available from: https://doi.org/10.5172/jamh.8.3.250

Kadish, Y. (2015) Five women's recollections and reflections on being raised by a mother with psychosis. *South Africa Journal of Psychology*, 45(4), 480–494. Available from: https://doi.org/10.1177/0081246315581565

Larsen, H.G. & Adu, P. (2022) *The theoretical framework in phenomenological research: Development and application*. Routledge.

Luft, S. (1998) Husserl's phenomenological discovery of the natural attitude. *Continental Philosophy Review*, 31(2), 153–170. Available from: https://doi.org/10.1023/A:1010034512821

Mordoch, E. (2010) How children understand parental mental illness:"you don't get life insurance. What's life insurance?". *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, 19(1), 19–25.

Parkinson, A., Keddell, E. & Walker, P. (2021) Exploring peer support as a strategy to reduce self-stigma for marginalised children of parents with mental illness (COPMI). *The British Journal of Social Work*, 51(3), 849–868. Available from: https://doi.org/10.1093/bjsw/bcaa161

Reupert, A., Gladstone, B., Helena Hine, R., Yates, S., McGaw, V., Charles, G., Drost, L. & Foster, K. (2021) Stigma in relation to families living with parental mental illness: An integrative review. *International Journal of Mental Health Nursing*, 30(1), 6–26. Available from: https://doi.org/10.1111/inm.12820

Reupert, A.E., Cuff, R., Drost, L., Foster, K., Van Doesum, K.T. & van Santvoort, F. (2013) Intervention programs for children whose parents have a mental illness: A review. *Medical Journal of Australia*, 199(3), S18–S22. Available from: https://doi.org/10.5694/mja11.11145

Strand, J. & Rudolfsson, L. (2020) Mental health Professionals' perceptions of parenting by service users with psychosis. *Community Mental Health Journal*, 56(6), 1014–1022. Available from: https://doi.org/10.1007/s10597-020-00548-0

van Santvoort, F., Hosman, C., Doesum, K. & Janssens, J. (2014) Children of mentally ill parents participating in preventive support groups: Parental diagnoses and child risk. *Journal of Child and Family Studies*, 23(1), 67–75. Available from: https://doi.org/10.1007/s10826-012-9686-x

World Health Organisation. (2019) *INSPIRE handbook: Actions for implementing the seven strategies for ending violence against children*. World Health Organisation.

Zahavi, D. (2018) *Phenomenology: The basics*. Routledge.