Childhood experiences pursue adulthood for better and worse: a qualitative study of adults' experiences after growing up with a severely mentally ill parent in a small-scale society

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Abstract
Background: Growing up with a severely mentally ill parent can impact on subsequent adult life, and it can be extra challenging in a society with a small population, known as a small-scale society. Life in a small-scale society is characterised by multiple close relationships, lack of anonymity and a conservative attitude towards normal behaviour.
Aims: To look at the impact of growing up with a mentally ill parent on adult life in a small-scale society.
Methods: Data from semistructured interviews with 11 adult children of severely mentally ill parents were reanalysed and subjected to secondary analysis.
Results: The additional analysis resulted in four central themes: 'becoming open and courageous', 'seeking and giving help', 'feeling uncertain and different' and 'being resilient and sensitive'. These were conflated into an overarching theme: 'childhood experiences track into adulthood for better and worse'. The themes elucidate a diverse big picture and encompass positive and challenging features of adult life in a small-scale society.
Conclusions: The study ends with recommendations for the early establishment of collaboration and family-focused interventions with mentally ill parents and their children.

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Introduction

One in five children worldwide lives in a family in which at least one parent has a mental condition (Foster et al., 2012). Childhood with these parents can be burdened by the parental illness; a burden that is not always lifted in adult life (Bauer et al., 2015; O'Connell, 2008). Research indicates that 25–50% of such children are at higher risk of developing mental health problems during their lifetime than children of parents who are not diagnosed with mental illness (Lynne and Tuason, 2015; Murphy et al., 2011; Slominski et al., 2011). In this study, we investigated Faroese adult children's experiences. We wanted to know how, in their adult life, they manage the influence of their childhood with a parent with severe mental illness.

Background

Research has demonstrated that growing up with a mentally ill parent is both different and difficult for children (Dam and Hall, 2016; Dam et al., 2018; Gladstone et al., 2011; Simpson-Adkins and Daiches, 2018). Painful experiences linger in the adult children, resulting in ambivalent, strained and confusing relationships (Foster, 2010; Murphy et al., 2011; O'Connell, 2008). In a meta-synthesis aimed at investigating adult life with a severely mentally ill parent, Källquist and Salzman-Erikson (2019) documented that feelings, thoughts, relationships, personal growth, health and wellbeing were affected. The findings of this meta-synthesis underline what was previously reported; adverse emotions during childhood, such as fear of mentally ill parents hurting themselves and mistrust related to their unpredictable behaviour, remain in adult life (Mechling, 2016; Murphy et al., 2015). Likewise, adverse childhood experiences have been shown to limit the children's emotional literacy and, even in adulthood, threaten their sense of self (Stein, 2013). Furthermore, adult children have been documented to feel invisible to health and social service providers (Maunu and Stein, 2010). A tendency to conceal the mental illness socially adds to long-standing feelings of shame and embarrassment (Källquist and Salzmann-Erikson, 2019; Murphy et al., 2017). All the same, adult children have reported that, on parents' good days, their childhood was filled with hope, joy and care. At those times, life encompassed learning, maturing and self-enriching, thereby adding to coping, resilience and psychosocial wellbeing in adulthood (Bauer et al., 2015; Mechling, 2016; Murphy et al., 2015).

In summary, research has documented that adult children's experiences have been well investigated in larger societies (Ali et al., 2012; Murphy et al., 2018; Nilsson et al., 2015; Patrick et al., 2019). Research about such life in small communities is now required, and will undoubtedly generate new knowledge (Damianakis and Woodford, 2012). Literature searches in relevant databases produced no studies of this kind of childhood in small-scale societies. We hypothesised that these children's lives, due to the close relationships and lack of anonymity often prevalent in a small-scale society, might be different from those of children living in larger societies (Burton, 1967; Simmel, 1992). The aim of this study was

therefore to investigate the impact of growing up with a mentally ill parent on adult life in a small-scale society.

The Faroe Islands small-scale society

The setting for this study is the Faroe Islands, a country with a small population (about 52,000 inhabitants in 2019), therefore known as a small-scale society. The Faroese people live in villages and towns spread over 16 of the country's 18 islands. The official language is Faroese, with Danish also spoken.

Life in small-scale societies such as the Faroe Islands is characterised by multiple close and often cooperative relationships between inhabitants, although the myriad relationships among families, friends and neighbours often means a lack of anonymity (Burton, 1967; Tönnies, 2001). The inhabitants are defined by their relationship to one another (Burton, 1967), which might lead to social control, pettiness or prejudice (Simmel, 1992). People who behave differently, as might be the case with those with mental illness, easily therefore become subject to gossip and prejudice, which can have an impact on their children.

Methods

Design

The study has a qualitative design as the focal point of the study is lived experiences (Vallgårda and Kock, 2008) and builds on data originally collected to investigate experiences of being the child of a parent with severe mental illness (Dam et al., 2018). The rich quantity of data about adult life prompted us to pursue a secondary analysis of these data (Heaton, 2008). The original study took place in a cross-disciplinary paradigm, assuming that if one member of the family has severe mental illness, the whole family and significant others are affected (Barker, 2001). In this paradigm, the role of mental healthcare professionals, such as nurses, social workers and psychologists, is to help patients and their families manage a life with disease and threatened wellbeing.

Table 1. Demographic characteristics of the sample.

Sex	Age Year	Place of residence	Parent/diagnosis	Siblings	Civil status
Female	18	Town	Mother/schizophrenia		Single/not a parent
Female	21	Town	Mother/schizophrenia		In a relationship/not a parent
Female	23	Village	Father/schizophrenia		Single/parent
Male	25	Village	Mother/schizophrenia		Single/not a parent
Female	29	Village	Mother/bipolar disorder		Married/parent
Male	34	Town	Mother/bipolar disorder	X	Single/parent
Female	35	Village	Mother/schizophrenia	X	Single/not a parent
Female	40	Village	Mother/bipolar disorder		Married/parent
Female	47	Village	Mother/schizophrenia	X	In a relationship/parent
Male	49	Town	Mother/bipolar disorder	X	Married/parent
Female	51	Town	Mother/bipolar disorder		Married/parent

Participants

The participants were recruited through convenience sampling (Polit and Beck, 2010) using oral, written, radio and snowball approaches. Eleven participants – eight women and three men – were recruited from villages and towns throughout the country. The average age of the participants was 34 years. The participants included two pairs of siblings, who were interviewed separately. For demographic data, see Table 1. None of the participants was known to the interviewer prior to the study.

Data collection

Data were collected through semistructured interviews, with each participant interviewed once. The interviews took place in the participant's or the interviewer's home between July and August 2016. All interviews were conducted by the first-named author, who is a woman, was born and brought up in the Faroe Islands and, at that time, was a doctoral student in nursing and health sciences. Only the interviewer and the participant were present during interviews. An interview guide, containing questions about caring, concealing and coping, helped govern the data collection. Repeated interviews were not conducted and no field notes were taken. Prior to the interviews, a video-recorded pilot test (Uhrenfeldt et al., 2007) was undertaken with the first-named author, resulting in comments about pauses, body gestures and tone of voice. The interviews were audio-recorded and lasted 25–90 minutes (average 60 minutes). The participants were asked to talk freely about their childhood. Encouraged by the interviewer's request 'please tell more', they also talked about how their childhood had affected them in adult life and how they were living their life at present. In all interviews, the interviewer was sensitively aware and listening. Post interview, all participants declined an offer to read the transcript and any subsequent findings.

Data analysis

Data analysis was inspired by the five-step hermeneutical analysis (Table 2) of Kvale and Brinkmann (2015). For this secondary analysis, data concerning adulthood were extracted from the original data and compiled into a data subset relating to the participants' adult life.

Table 2. Description of the five-step hermeneutical analysis process according to Kvale and Brinkmann (2008).

Analysis – step 1
Interview text read several times to get a synthesis of the content
Analysis – step 2
Identification of natural meaning units expressed by the participants
Analysis – step 3
Identification of central themes
Analysis – step 4
Questions about the meaning units in relation to the purpose of the study
Analysis – step 5
Identification of an overarching descriptive theme

Table 3. Examples of natural meaning units, the central themes and the overarching theme.

Identification of positive and negative natural meaning units expressed by the participants	Central themes	Overarching theme
'I told my aunt, "Don't keep believing she's not sick . . . we have to realise that she's very ill . . . that she has a serious mental illness".' (p. 8)	Becoming open and courageous	Childhood experiences track into adulthood for better or worse
'I started reading everything I could get hold of, e.g. on Google and in different magazines. . . . I had to understand, you know.' (p. 9)		
'I've joined a self-help group. It should be a basic offer all through life because . . . you know . . . you have to deal with this all through life.' (p. 10)	Seeking and giving help	
'My focus is children, and especially children who have parents with mental illness. I want to fight for them . . . so I've gone into education in that area.' (p. 7)		
'I've missed a lot, I haven't experienced the same as others, I feel outside, you see. I can't join in when they talk about their childhood.' (p. 11)	Uncertainty and being different	
'My children should not experience the same thing as I have . . . not at all. . . . I want to be a good mother. Sometimes it's not easy because I'm unsure about a normal upbringing.' (p. 7)		
'I had to move far away . . . and it was a release because it's mission impossible to save her [the mother].' (p. 8)		
'I can sense it immediately if the atmosphere between people is tense, and I can hold out long after others break down. I don't break down, but I don't know if that's a strength, maybe not.' (p. 5)	Resilience and sensitivity	

In the first analysis of data, the authors read this subset several times to get a synthesis of the content. Positive and negative natural meaning units derived from the data were then identified to build central themes. This took place in a reflective and discussion-based process in which we asked questions about the meaning units in relation to the purpose of the study and condensed the meaning units into four central themes. Finally, these central themes were conflated into an overarching theme, thus providing a new synthesis of the data content. The relationship between natural meaning units, central themes and the overarching theme is shown in Table 3.

Ethical considerations

The original study followed the Ethical Guidelines for Nursing Research in the Nordic Countries (Northern Nurses' Federation, 2003) and was approved by the Faroese Human Ethics Committee. The participants were given written and verbal information about the study and informed of their right to withdraw without negative consequences. We were

aware of the special ethical problems regarding anonymisation in qualitative research in small-scale societies (Damianakis and Woodford, 2012) and sought to ensure confidentiality throughout the research process. The anonymity of the participants was ensured by using contact persons for distribution of the information sheet and letting the participants reply directly to the interviewer. An ethical challenge concerns missing consent from the participants about reuse, although we considered the new data question asked as closely linked to the original question. The analysis was an expansion of the first study and was performed by the same researchers. We agree with Bishop (2009) and Long-Sutehall et al. (2010) that renewed consent would have been difficult to obtain because of the elusiveness of the participants.

Results

The overarching theme was identified as 'childhood experiences track into adulthood for better or worse'. Four central themes – 'becoming open and courageous', 'seeking and giving help', 'feeling uncertain and different' and 'being resilient and sensitive' – are elaborated on in the following. These themes encompass both positive and challenging features of these children's adult lives.

Becoming open and courageous

Becoming open and courageous relates to the participants' ongoing need, even as adults, to understand better their parent's behaviour when they were children, their curiosity about and actions to accept what happened and the meaning of being mentally ill. One participant stated: '*I wanted to understand what had happened, and I went to the hospital and asked to see his [the father's] medical records*'. (p. 2). *Another participant said that when he got older, he sought out literature about mental illness: 'I started reading everything I could get hold of, e.g. on Google and in different magazines. I had to understand.'* (p. 9).

During childhood, parental mental illness was a concealed secret. Becoming courageous meant asking questions. As one participant stated: '*When I was around 20, I became courageous enough to ask him [the father] what had happened at that time and what went wrong with mum.*' (p. 7).

Openness helped members of the extended family accept the seriousness of the illness: '*I told my aunt, "Don't keep believing she's not sick ... we have to realise that she's very ill ... that she has a serious mental illness".*' (p. 8).

During their childhood, taboo and ignorance of mental illness were barriers to these children understanding the parents' unpredictable illness. Having grown up, some of the adult children broke the taboo. One of them said: '*Now I'm not afraid to talk about childhood and mental illness; on the contrary, I often bring up the subject.*' (p. 11).

It actually seemed to be imperative, as adults, to talk about what, as children, was a secret.

Seeking and giving help

Seeking and giving help relates to some participants' need for help and other participants' commitment to helping others. Several of the adult children had taken care of their parents during their childhood. Some of them had experienced this as a heavy burden; they were left

with a responsibility that made them sad. The need to seek external help was therefore prominent among several of the participants.

'*I have a very good friend I can talk to. She listens to my frustrations and thoughts ... I honestly don't know what I would do without her.*' (p. 7).

Some participants preferred to share their thoughts with people in similar situations and therefore joined a self-help group.

'*I've joined a self-help group. It should be a basic offer all through life because ... you know ... you have to deal with this all through life.*' (p. 10).

One participant got regular professional help: '*I've realised that I have to talk to a psychologist to cope with everyday life... so I talk to him almost once a month.*' (p. 9).

Other participants realised that they needed psychological help throughout their lives to deal with the childhood scars: '*I'm afraid I will have to seek professional help for the rest of my life to cope with everyday life.*' (p. 8).

A fear of becoming mentally ill themselves was a persistent concern: '*I'm afraid I've inherited my mum's disease, so life can be hard at times and I need help to deal with it.*' (p. 9).

Alongside the need to seek help, childhood experiences had inspired others to give help; they wanted to make a difference for vulnerable families. Some had chosen to study in the healthcare or education sectors. Others talked about how they collaborated with healthcare professionals.

'*I've been quite engaged in recent years ... actually, I'm very patient when mum is affected. ... Together with the hospital staff, I try to get her onto a positive course.*' (p. 4).

Yet others, mostly women, wanted to work with children. They were hoping to prevent others going through the same early-age experiences.

'*My focus is children, and especially children who have parents with mental illness. I want to fight for them and support and help them. ... I've therefore taken up education in that area.*' (p. 5).

The desire to seek and give help, and to participate in preventive activities, seemed to strengthen their lives and break down taboos.

Feeling uncertain and different

Feeling uncertain and different relates to thoughts and emotions concerned with not being good enough. These emotions seemed to be linked to childhood experiences in which they were repeatedly reminded of being very different from their peers. Some participants who had children of their own also expressed feelings of not being good enough as a parent. They reflected on the meaning of being brought up by a parent without a normal childhood.

'*My children should not experience the same thing as I have ... not at all. ... I want to be a good mother. Sometimes it's not easy because I'm unsure about a normal upbringing.*' (p. 7).

As children, the participants had often been parenting their mentally ill parents, seeing and listening to their unpredictable emotional outbursts; they had been helping their parents with chores and medicine. Often they had felt isolated, alone and different from friends who did

not have a mentally ill parent to care for. The uncertainty that they expressed as adults seemed to be linked to these lifelong feelings of being different. Others did not understand their strange and incomprehensible childhood experiences: '*I've missed a lot, I haven't experienced the same as others, I feel outside. You see, I can't join in when they talk about their childhood.*' (p. 11).

Some of the participants wondered whether their feelings were signs of mental illness. It seemed crucial for them to distinguish between normal and less normal behaviour, and ambivalent feelings of this nature were exhausting.

> '*I didn't have a normal childhood . . . my childhood was different from others. . . . I therefore have to learn what's normal and what's not normal. I spend a lot of energy on being normal.*' (p. 9).

Being resilient and sensitive

Being resilient and sensitive relates to reflections among some participants about being strong and at the same time sensitive and vulnerable; they easily sensed tense tones and dynamics among people, including in their families.

> '*I can immediately sense it if the atmosphere between people is tense, and I can hold out long after others break down. I don't break down, but I don't know if that's a strength, maybe not.*' (p. 5).

For these people, sensing tense situations could create a desire to distance themselves. Although running away contributed to loss of social relationships with colleagues and significant others, it reinforced the feeling of being different and lonely: '*I know it's not appropriate to escape from the situation because then I'm also fleeing from others. . . and I become lonely.*' (p. 11).

Being resilient also relates to having recovered from unpleasant childhood experiences. Then, there was an acceptance of the parent's mental illness; it was there to be. However, living close to mentally ill parents was too strenuous, so it was necessary to set boundaries, establish distance to the parents and live a life of one's own: '*I had to move far away. . . and it was a release, because it's mission impossible to save her [the mother].*' (p. 8). Some participants had moved abroad. Although this decision was necessary for living a normal life, the consequence was loss of culture, family and friends: '*I have to visit the islands at least once a year. I miss the nature, the food and speaking Faroese.*' (p. 8).

Some participants still lived close to their parents; for example, in the same village or in close proximity. To protect themselves, they had learned to set boundaries for their mentally ill parent.

> It's been hard setting boundaries, like. . . you know. . . she [the mother] mustn't visit me now and I mustn't do this or that. . . it's been a big job. I've found out that I'm self-regulating in relation to her, and that's just so good.' (p. 4).

Discussion

Data from 11 adults who grew up with a severely mentally ill parent in a small-scale society were analysed to provide knowledge about their adult life. One finding was that the feeling of being different persisted in adulthood, and this feeling created uncertainty in everyday life. Similar feelings were documented in previous studies concerning adult life

after a childhood with severe illness or a troublesome family life (Gjelsvik et al., 2014; Murphy et al., 2015). In a small-scale society where everybody knows everybody else and mental illness is concealed, it is no wonder that children of a mentally ill parent feel different and uncertain. In the context of illness, there will always be uncertainty (Barley and Stewart, 2006). In a small-scale society, the uncertainty might be a reaction to the parent's mental illness, it might be linked to childhood experiences of not being heard, understood or taken seriously, and it might come from societal gossip and family concealment of the illness, all prevalent during childhood in a small-scale society (Dam et al., 2018).

We found that the participants of this study demonstrated courage; in seeking help for themselves, in using their experiences to be concerned, and in helping others in similar situations. And they worked with their childhood experiences. Furthermore, they volunteered for this study, which was courageous. Courage involves strategies that help individuals towards wellbeing (Woodard and Pury, 2007). The philosopher McIntyre (1984) considers courage 'not simply as a quality of individuals, but as the quality necessary to sustain a household and a community' (p. 122). McIntyre sees courage as a virtue because individuals with courage risk harm, threat and danger to themselves.

> *If someone says that he cares for some individual, community or cause, but is unwilling to risk harm or danger on his, her or its own behalf, he puts in question the genuineness of his care and concern.* (McIntyre, 1984: 192).

Our findings about courage, care and concern among adult children of parents with a mental illness also concur with previous studies (Jönsson et al., 2011; Murphy et al., 2015). Seen in a caring theory context, Benner and Wrubel (1989) argue that human beings are concerned because things matter to them: '. . . where there is concern, anything that touches on that concern has salience for the person' (Benner and Wrubel, 1989: 87).

Another finding was that some participants were extremely sensitive to tone and atmosphere among people. Their parents' behaviour, due to mental illness, forced the participants, even as small children, to be vigilant towards the tone and atmosphere at home. When parents had bad days, the tone and atmosphere in the family were unpleasant. Van Manen (2002) stresses that atmosphere, or mood, belongs to all aspects of human existence; it is through tone and atmosphere that human beings experience the world. This was definitely the case for our study participants. Several were hypersensitive, which seemed both good and bad for them. The study shows that the participants experienced an unpleasant tone in situations when colleagues, family or friends used a high, sharp and non-relaxed tone. In those cases, some participants distanced themselves from the situation or from colleagues, family and friends. The tone then was more than the tone of the spoken word; the attributes of the tone were an invitation or a barrier to creating relationships; this contributed to feelings of belonging or loneliness. We argue, like Van Manen (2002), that family members and healthcare providers would benefit from seeing how voice tone and atmosphere contribute to a general sense of wellbeing. A sensitive mental healthcare worker is able to foster a pleasant atmosphere, knowing that this triggers feelings of wellbeing.

The findings of this study relating to resilience are in line with previous research (e.g. Power et al., 2016). Resilience relates to an inner enabling force to live a capable life under daring circumstances (Patterson, 2002). Childhood caregiving to parents with severe mental illness might provide skills, ability and maturity at an early age. Our findings show that some

of the adult children were able to set boundaries by balancing between closeness to and distance from their severely mentally ill parent. As adults, they went on supporting their parent with practical tasks; they cooperated with health professionals and ensured that their parent received the right treatment. In doing this, they refrained from too much engagement and were able to distance themselves when sensing an excessively onerous burden. Our findings are thus analogous to previous findings (Foster, 2010) that resilience grows out of attempts to achieve equilibrium in life.

The findings also show that uncertainty among some participants led to feelings of low self-esteem, expressed as not being good enough. Uncertainty among this group of participants was previously documented (Murphy et al., 2015). We would argue, with reference to Woodard and Pury (2007), that uncertainty is a prerequisite to courage. In a seminal article, Shelp (1984) described courage as a neglected virtue in the patient–physician relationship, compared to moral virtues such as competence, compliance, compassion and gratitude. It might be that courage, and its close link to uncertainty, is still neglected in healthcare contexts. Verbalising one's uncertainty, as seen in this study, points to being courageous. Likewise, courage is described as a unifying phenomenon that is key for helping patients face vulnerability, suffering and uncertainty, and key for confidence in oneself in arguing for professional care (Thorup et al., 2012). Ostensibly, adult children of severely mentally ill parents need caring and encouragement in their efforts to live a good life despite the unpleasant memories of their childhood. Furthermore, mentally ill patients and their families need support; for example, through the provision of family-focused interventions (Foster et al., 2016). Barker (2006), in his tidal model, originally developed to guide psychiatric and mental health nursing, and with clear tones of interdisciplinary collaboration, emphasises that what is of central importance for understanding an individual's needs is '. . . collaborative working, developing a therapeutic relationship through discreet methods of active empowerment . . .' (Barker, 2006: 697). By following Barker's notions about collaboration and therapeutic relationships in mental healthcare provision, adults who as children lived with severely mentally ill parents would hopefully achieve greater self-care capacity and resilience, and thereby be better able to cope with stressful situations in adulthood.

Study limitations

In this study, secondary analysis of previous data was applied to make further use of the original datasets. This approach has both methodological and ethical limitations. One methodological limitation is missing findings (Heaton, 2008). Our findings thus have to be considered with caution. There might be issues of importance for adult life in a small-scale society other than those stated in this study. Another limitation was that mentally ill fathers were poorly represented. The findings might have differed if the parents had been evenly represented in respect of gender. In spite of these limitations, the study adds to adult children's perspectives of adult life after a childhood with a severely mentally ill parent in a small-scale society.

Conclusions

To be an adult child of parents experiencing severe mental illness in a small-scale society is not always easy because childhood experiences track into adulthood. In adulthood, these

children are very sensitive to tone and atmosphere among people, and they might be uncertain and need help throughout their lives. By contrast, childhood adversity may contribute to resilience and courage in adult life. Some might be good at setting boundaries and avoiding unnecessary challenges, thus achieving equilibrium and wellbeing in daily life. Mental healthcare will benefit if policy-makers, managers and educators collaborate on key principles of family-focused practices and there is collaboration between family members and healthcare services. Furthermore, the absence of anonymity is an opportunity in terms of establishing interventions with these families. Such actions would result in resilience and courage to work for a good adult life.

Key points for policy, practice and/or research

- For better and worse, childhood experiences track into adult children of parents with a severe mental illness living in a small-scale society.
- Adult children may be sensitive and resilient, caring and cared for, close to or distant from their mentally ill parent. Or adult children want to talk about mental illness to understand better their parent's often unpredictable behaviour.
- Collaboration between policy-makers, managers, educators and researchers about principles of family-focused practice is needed; this will benefit adult children of mentally ill parents.
- In a rural, remote or any 'small-scale' society where everybody knows everybody else, mental healthcare professionals have to consider, and act on, the impact of mental illness on patients' adult children and, if possible, include adult children in their care planning.
- There is a need for future research on what is important for social and healthcare providers in small-scale societies in respect of family-focused care in psychiatric and mental health services.

Declaration of conflicting interests

The authors declared no potential conflict of interest with respect to the research, authorship and/or publication of this article.

Ethics

The original study was approved by the General Board for Research of the Faroe Islands, (www.dat.fo), J.nr 16/00020-1316/00020-13.

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