



Young children's experience of a parent with bipolar disorder

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AUTHOR ACCEPTED MANUSCRIPT

Running head: *Young children's experience of a parent with bipolar disorder*

Title: Young children's experiences of living with a parent with bipolar disorder:
Understanding the child's perspective

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Abstract

Objectives

To explore the experiences of young children of living with a parent with bipolar disorder (BD), and how this impacts on their emotional wellbeing.

Design

Qualitative study using a computer assisted semi-structured interview, 'In My Shoes' (IMS). **Methods** Ten children aged between 4 and 10 years with a parent with BD identified via self-help groups were interviewed about their experience of family life. Thematic analysis was used following transcription.

Results

Four main themes emerging from thematic analysis were: perception of parents; knowledge and awareness of BD; managing family life with a 'bipolar' parent; and living in a family with BD. Four year old children could participate in the IMS interviews and discuss their parent's mood, behaviour and mental health. Children had candid and insightful discussions about their parent's BD including symptoms and parenting, and could reflect on how having a parent with BD affected them emotionally and practically. Older children were better able to articulate their parent's illness and its impact.

Conclusions

This exploratory study represents an important step in examining directly experiences of young children whose parents have BD. Using IMS, it was possible to gather insightful information from children to generate hypotheses and influence service development. Children of all ages had some knowledge and understanding of their parent's illness, describing both positive and negative experiences in the family. Further research to build understanding of children's perspectives and the support they feel they and their family would benefit from would enhance the development of appropriate services and interventions.

Practitioner Points:

Using age-appropriate tools, it is possible to elicit the views of young children about their parent's mental health and parenting.

Young children have insight into the impact of bipolar disorder in the family on themselves and family members.

Bipolar disorder (BD) has a worldwide prevalence of 1% to 4% (National Institute of Mental Health, 2011; Royal College of Psychiatrists, 2011). Evidence indicates BD runs in families (Hirshfeld-Becker et al., 2006; Mrazek & Agathen, 2002). Much research focuses on the impact on the child of having a parent with BD. The majority of these studies are quantitative and indicate that children of parents with BD are at increased risk of developing mood disorders, anxiety disorders, Attention Deficit Hyperactivity Disorder, disruptive disorders and co-morbidity (Birmaher et al., 2009; Chang, Steiner, & Ketter, 2003; Goldstein et al., 2010; Singh et al., 2007, Vandeleur et al., 2012, Wals et al., 2010). Increased rates of behaviours including aggression, rule breaking and attention problems have also been reported (Dienes, Chang, Blasey, Adleman, & Steiner., 2002; Giles, DeBello, Stanford, & Strakowski, 2007).

More recent research has explored children's psychological risk, (Peay, Rosenstein & Biesecker, 2014), psychosocial functioning and socio-emotional development. Studies have indicated that children of parents with BD may not function as well those of 'healthy' parents in areas including life satisfaction, recreation, work, school, and interpersonal relationships (eg., Bella et al., 2011). Research exploring potential predictors of BD report higher rates of depressive, anxiety and behavioural disorders in children of parents with BD. Studies highlight the importance of therapeutic targeting for these disorders in those at high genetic risk for BD (Nurnberger et al., 2011; Duffy et al., 2014, & Perich et al, 2015).

Although offering important insights relevant for service planning and prevention, research often overlooks children's experiences and views (Bee, Berzins, Calam, Pryjmachuk & Abel, 2013). Children are often not regarded as the primary source of knowledge on their experience; this is often filtered through their parents, distancing researchers from the child's world and denying children the opportunity to speak about situations concerning them (Oakley, 2000). Emerging qualitative research in mental health explores children's experiences of living with a parent with mental illness directly (Buckwalter, Kerfoot, & Stolley, 1988; Cogan, Riddell, & Mayes, 2005; Fjone, Ytterhus, & Almvik, 2009; Garley, Gallop, Johnston, & Pipitone, 1997; Handley, Farrell, Josephs, Hanke, & Hazelton, 2001; Maybery, Ling, Szakacs, & Reupert, 2005; Meadus, & Johnson, 2000; Mordoch, 2010; Mordoch & Hall, 2008; Ostman, 2008; Polkki, Ervast, & Huupponen, 2005; Riebschleger, 2004; Stallard, Norman, Huline-Dickens, Salter, & Cribb, 2004). These are largely retrospective interviews with

adolescents and adults. Findings suggest that many children and adolescents lack understanding about their parent's illness, experience a range of emotional and behavioural effects and need support to help cope with difficult situations.

Studies often include mixed parental conditions. Only four reported including parents with BD (Garley, Gallop, Johnston, & Pipitone, 1997; Meadus & Johnson, 2000; Mordoch, 2010, Mordoch & Hall, 2008). No studies have focussed explicitly on exploring the experiences of young children who have a parent with BD and how this might impact their emotional wellbeing. Only by researching this unique sample can we understand the way parents with BD are perceived by their children, given the often unpredictable nature of the illness.

We conducted a qualitative study to explore the experiences of young children living with parents experiencing BD, and how this might impact emotional wellbeing. Young children are under-represented in existing studies exploring children's experiences of parental mental illness, and were therefore the focus of study. Both positive and negative experiences were explored to highlight areas of resilience and difficulties children experienced. Children were also asked to comment on their support needs. The main research question was 'How do children with parents who have BD experience family life and how does this impact on their emotional wellbeing?'

Methods

Qualitative methodologies are effective in understanding phenomena from the research participant's perspective, and valuable when little research on a subject exists (Pope & Mayes, 1995, 2006). They encourage children to express their perceptions and provide an understanding of the context of their lives (Davis & Wright, 2008). The present research used 'In My Shoes' (IMS), a computer-assisted, semi-structured interview for communicating with children and vulnerable adults (Calam, Cox, Glasgow, Jimmieson, & Groth-Larsen, 2000). This modular interview has been designed to enable children to describe their emotions and experiences in different contexts, including the home, and with different people. Because the interview provides visual images and "scaffolding", it has been used successfully with children as young as four. IMS does not have a specific interview schedule, but provides visual and verbal prompts to the child to choose and label themselves and family members and the emotions they may have experienced. The interviewer asks the child to think of a time when they have felt a particular emotion and say who was with them. The child can add

thought and speech bubbles. The interviewer adds to the process by asking open questions and using reflections to enable the child to give their perspective on their experiences with particular people at particular times. Validity of the interview has been established (Bokstrom, Fangstrom, Lucas, Calam & Sarkardi, 2016). Using IMS and incorporating questions regarding experience and understanding of their parent's BD provided opportunities for the children to describe experiences in their own words.

Recruitment

Purposive sampling was used to recruit eight parents with BD via a UK user-led BD organisation via a research advert in a quarterly publication distributed to group members. Inclusion criteria for child participants were: being a child of a parent who has a diagnosis of BD; being between 4 and 12 years of age, and living with or regularly cared for by the parent with BD. Table 1 shows details of the sample demographic data.

Parents who self-reported BD who agreed to be interviewed were asked to consent to their children being interviewed. Six parents agreed, yielding 10 children overall. On receiving confirmation that the children met inclusion criteria, information packs were sent out containing information sheets and consent forms for both parents and children. Child assent and parental consent was required for participation.

Interviews

An initial meeting with parents prior to the interviews enabled the interviewer to establish whether the child knew their parent had BD and any terminology used by the family. This terminology was then used in the interview. All interviews took place in the family home. It was made clear in the information sheets and prior to interviews that if the parent did not feel comfortable, then there would be no specific questions about BD, only about family life, and children did not need to be aware of their parent's diagnosis to participate. Interviews were initially piloted on two children, with minor adjustments made to question wording. These interviews were subsequently included in analysis. All child participants were interviewed by the main researcher, a trained, registered IMS user. It was made clear before and during interviews that the child could withdraw at any time. Interviews lasted between 20 and 80 minutes depending on the child. Of the 10 children, eight were seen individually. Two younger children chose to be interviewed with an older sibling present. If the child made

reference to their parent's illness, this was followed up with bipolar-specific questions if the parent had consented. Two parents did not consent to this as they did not think their young children were aware of their illness. Parents completed a questionnaire providing socio-demographic information, diagnosis and management of their BD.

Analysis

Interviews were video recorded, digitally audio-recorded and transcribed verbatim. Identifiable information was removed from the transcripts. Data were analysed using thematic analysis (Braun & Clarke, 2006; Boyatzis, 1998). During analysis the research team looked for themes about the overall descriptions that children gave of what family life was like and how they experienced it. Data from the pilot cases were incorporated and analysed as a whole. Thematic analysis was used because it is a flexible analytic tool which can provide rich, detailed and often complex accounts of data (Braun & Clarke, 2006). The main researcher looked for emerging codes and themes in the data, under guidance from an experienced qualitative researcher. Themes were coded at the semantic level (Braun & Clarke, 2006), and it was a systematic and iterative process. The coding framework was continually refined until both researchers were satisfied that the themes were representative of the data. Themes were discussed regularly during research meetings every 2 to 3 weeks with the wider team, approximately 6 meetings. To ensure consistency a codebook was developed by the main researcher with descriptions of the themes. Two independent researchers were given transcript excerpts and asked to code these using the themes, to ensure reliability (Mays & Pope, 1995). To aid rigour of analysis, an audit trail documented decisions made during the analytic process, and a reflective journal was kept by the main researcher to document the researcher's influence on the research process as a whole and on construction of data.

Results

Three single parents and three two parent families consented; one father and five mothers with BD, all UK White British (North/Central England). Four of the six parents had been hospitalised previously. Five were prescribed and compliant with medication for BD at the time of interviews. Children consisted of nine boys and one girl, median age seven years (range 4 to 10 years). Seven children scored in the "normal" range on the Strengths and Difficulties Questionnaire. Three children scored in the "abnormal" range; of these two had diagnoses of Asperger's Syndrome

and Attention Deficit Hyperactivity Disorder. One child had been identified by services as having delay in emotional and social skills. There was greater than 70% agreement for all themes, the acceptable level of reliability in thematic analysis (Boyatzis, 1998). Four main themes emerged from the child interviews: perception of parents; knowledge and awareness of BD, managing family life with a “bipolar” parent; and living in a family with BD. These and their sub-themes are discussed in relation to children’s developmental stages, with quotations from children to demonstrate reliability.

Perception of Parents

Parent with “Bipolar”. All children were able to describe their parent and the symptoms of BD, whether they knew about the illness or not. As the focus of the interview was labelling emotions, discussing times they had felt emotions and who was with them, this enabled insightful discussions about their parent’s moods throughout the interview. Children of all ages used a variety of terms to describe their parent: depressed, sad, happy, giddy, irritable, angry, worried, stressed, “funny face” and “naughty”, for example:

Interviewer (Int): So Bipolar makes your mum irritable a bit, yep, are there any other things that it makes your mum?

Participant (P): Um happy, sad, erm, angry and lots of different emotions. (Alice, aged 10)

Int: Yeah so Bipolar makes your mum angry, how else does it affect your mum?

P: Erm stressed... makes her worried about things she shouldn’t be. Makes her worried about the future and not enjoy the present (Jake aged 9)

The terms “funny face” and “naughty” were used by one of the youngest children. Some children discussed reasons why they thought their parent was experiencing a particular mood. One younger child blamed himself for making his mother angry; another stated his mother’s mood was angry and sad for no reason “because she just cries for no reason, I don’t know, she just told that to me once.” (Harry, aged 6). Younger children attributed much of their parent’s mood and behavior to themselves, for example because they had been naughty, or gave no reason. Children of all ages could describe the frequency of their parent’s moods, often stating that their parent was more happy,

“normal” or “ok” than sad and angry. Only one child made reference to his father’s insight into his moods.

“Well when he’s erm sad and depressed he erm tells us but when he’s giddy I don’t think he can really tell. We can, but he can’t.” (Thomas, aged 9)

Although the interview prompted children of all ages to reflect on emotions and parent’s moods, younger children gave clearer descriptions of their parent’s behavior, for example angry parents shouting, over-reacting and telling their children off. One child referred to her mother being irritable and not liking people to go near her. Sad parents were described as tired, sleeping lots during the day, resting and generally not doing very much.

“It’s the same when she’s unwell . . . sleeps for the whole day and then she gets more sleep at night.” (Aaron, aged 5)

Another child compared his mother to others:

“...she’d tell off [brother’s name] but she wouldn’t entire entirely be too comforting to me, she’d still comfort, but not as much as maybe another mother would. I don’t mind that cos I don’t like too much comforting, it makes me feel uncomfortable.” (Jake, aged 9)

Only two siblings referred to their mother being in hospital because of being unwell; only one child reported that her mother took medication. This was surprising given the majority of parents had been in hospital and the children were aware of this at the time, and all but one took prescribed medication. One child’s perception of his mother and BD was expressed simply “It’s like being on the other side of the world with mummy.” (Connor, aged 6).

“Well” Parent. The children in two parent families often described their perception of the parent without bipolar and their role within the family. This enabled insight into family adjustment. One child described his father being different to his mother; “Erm freefalling. Dad’s not a care in the world he’s, he enjoys what’s happening now and doesn’t worry about the future which is what me and mummy do.” (Jake, aged 9). Having a supportive “well” parent appeared to have a “buffering” effect, enabling children to cope with the “bipolar” parent’s symptoms in more manageable ways. Having a consistent parent provided a sense of routine and predictability alongside an otherwise “unpredictable

illness". Often the "well" parent was more prominent in the child's life, looking after them, playing and disciplining them in the absence of their partner:

Int: How is it different since your mum got bipolar?

P: Erm daddy's normally erm with us looking after us by his self especially when she went in hospital. (Michael, aged 7)

Children's perceptions of fathers differed depending on their role in caring. Two siblings described a positive relationship and positive regard, for example "my daddy makes me happy, makes me laugh." (Daniel, aged 4). However, because the father took sole responsibility for disciplining the children, this elicited negative reactions from the children "When my daddy gets cross." This father at other times was also described as "angry and stressed", when supporting the family when his wife was unwell. The interviews highlighted how the descriptions of the "well" parent were affected by the severity of the "bipolar" parent's illness. When children gave descriptions which resembled manic or depressive episodes, the role of the "well" parent changed accordingly as they took charge of the family.

Knowledge and Awareness of BD

Communication about Illness. All of the children above 7 years discussed hearing about their parent's bipolar from their parent. Some children stated they could not remember and others made reference to being told, but then forgetting:

P: Err she's told me a tiny bit about it but I've forgotten.

Int: Aah right can you tell me a bit more about that?

P: Mmm I've forgotten most I've forgotten nearly all of it, I can't remember any anything else about it. (Michael, aged 7)

It was unclear whether "forgetting" reflected avoidance, perhaps not wanting to display their parent in a negative light and appear critical; or whether it was uncomfortable or upsetting to talk about. Another child discussed how his father only talked to him about his bipolar when he became worried that the child had bipolar too:

“Well erm he thought I had it. Cos I was getting more and more, I was having more and more things to do with Bipolar and he’s told me that I might have it. And that’s when he told me about what it does.” (Thomas, aged 9)

Some older children who were aware of their parents’ bipolar discussed explicit conversations with their parents about bipolar symptoms and how it affected them, for example whether they were feeling happy, angry or sad. Three parents had discussed it with their children. Others had asked their partner to discuss it with them. Some children found it helpful for their parents to discuss their symptoms, for example knowing their parent’s moods so they could be prepared. Only one child discussed not liking these bipolar-specific conversations; she did not like the way bipolar made her mother unwell and not able to do what she wanted. Two of the younger children who did not know about bipolar, but were aware that their parents were unwell, said that they had not had or heard conversations within the family about this. This did not appear to worry them and they did not express a desire to know more. Older children seemed more curious, and although some stated their knowledge and understanding was limited, their descriptions of bipolar symptoms suggested a more sophisticated level of awareness.

Description of Illness. Children’s knowledge and awareness of their parent’s BD appeared to reflect their age. Five of the older children (aged 7 to 10), knew that their parent had a mental illness called “bipolar”. Some of these children referred to it as simply “an illness”, “being ill” or “unwell” and only referred to it as “bipolar” when asked if they knew what the illness was called. One child referred to physical symptoms such as headaches and stomach aches her mother experienced, linking these to BD later in the interview. Four of the younger children (aged 4 to 6) did not know about their parent’s BD and so were not questioned directly, but described aspects of their parent and family life in ways which indicated bipolar symptoms. Uncertainty was common, knowing it was BD but being unsure about what it was; being unsure about the frequency of their parent’s symptoms; or knowing that their parent was “different” but not knowing how to explain it “Yeah it’s like a mental illness. Quite complicated to understand.” (Michael, aged 7). Another discussed her mother’s bipolar symptoms in the context of it not being their fault “Erm when my mum feels irritable, but I know it’s not her fault, she

she probably sat on the sofa cos she um I don't know if she thinks it's her fault but I don't think it is.” (Alice, aged 10).

Only one child stated explicitly that he did not want to talk about his mother's illness. The children showing awareness of BD differed in their knowledge about how long their parent had been diagnosed. Two children talked about how their parent had bipolar before they were born so they did not know any different. In one family the mother had been diagnosed when her children were young, and two siblings from this family were able to make comparisons between their mother before and after bipolar “... there wasn't a single problem with her. Erm basically she was just normal.” (Michael, aged 7)

Older siblings commented how it was more difficult for their younger siblings to understand because they were too young and it affected them differently because of their age. One of the children made reference to her age and adjustment to her mother's disorder “Mmm I've probably got used to it when I turned ten.” (Alice, aged 10).

Managing Family Life With a 'Bipolar' Parent

Emotional Effects on Child. Children described a variety of emotions experienced in family life; many were in direct response to their symptomatic parent. The two prominent emotions were “sad” and “anger”. Over half of the children expressed sadness that their parent was “ill” or “unwell” and described feeling upset:

Int: Your mum was saying that she was quite poorly a while ago. Can you remember what that was like?

P: Mmm yeah...Upsetting (James, aged 8)

Some children described feeling sad when their parent was in a particular mood, for example when their parent was angry, irritable or annoyed, and one of the youngest children said that his mum made him cry when she was sad. Some older children reflected on the impact of their parent's moods and how it affected them on a daily basis:

P: Well he gets all angry and sometimes he gets sad and doesn't do much, just sits and sleeps, or rests. He can't get to sleep but he rests.

Int: And how does that make everyone else in the house?

P: Well, it does make us a little bit um sad that he's not doing anything. (Thomas, aged 9)

Several older children discussed feeling angry at the parent for their moods (for example being angry or sad); generally younger children kept this to themselves. These children might express anger behaviorally (for example fighting and "being naughty"). One older child described his father laughing at him when he told him he felt angry, and the oldest child described feeling angry when her routine was disrupted because of her mother's illness "and if we plan to go a place and all of a sudden my mum gets stomach ache or irritable. I get quite angry cos we've already planned it and I've been looking forward to it." (Alice, aged 10)

Other emotions children expressed included feeling annoyed when the parent was "giddy", and scared when the parent was angry. When asked directly if they thought having a parent with BD affected them, one older child had difficulty describing what he meant:

Int: How do you think that affects you?

P: Erm, well of course it makes her angry more so, I don't get as much erm, of any, erm, err. I'm not sure I said that actually [laughs] really. I sort of know but. (Jake, aged 9)

The oldest child did not believe that her mother's illness had a big effect on her:

"Mmm I don't think it really affects me except that I don't really get to do much if she's feeling down. But if she's feeling happy then I get to do quite a lot and do lots of things when she takes me out." (Alice, aged 10)

'Independent' Child. Older children (aged 7 to 10) displayed a mature attitude when adjusting to family life. They discussed doing tasks independently in the absence of their parent when they were either in bed or not feeling well:

"I go I go downstairs, play for a little bit, decide when I have my breakfast, make the breakfast. If I want some more I just make as much as I like and when I've done that I normally wait until daddy's down, then most of the time playing." (Michael, aged 7)

Some children referred to looking after themselves and the oldest child referred to looking after her mum and helping her:

“Mmm erm I feel happy because I like helping her, so and I help her like make things and make my own tea, and if she wants something I'll go fetch from the shop, I'll go and fetch it.”(Alice, aged 10)

One child described himself as like his mother's carer, and others described helping out around the house to make their parent feel better

Sources of support. Children rarely discussed “support” and were unable to talk about what support they felt their family required, often stating they did not know or they did not need help. This might reflect their age, or inability to reflect about family issues as a whole; parental responses to accessing support; or to lack of understanding and knowledge about the types of formal support available and how they could meet the family's needs. However, almost all children discussed the importance of having other extended family members, specifically grandparents, who they saw frequently and the children valued. Children did not say whether they discussed their parent's illness with wider family. Visiting grandparents was seen a distraction and an opportunity for positive attention, for example being taken shopping or to nice places “And I'm having dinner at grandad's and I had a lolly, and there was an ice cream and I ate it all. And grandma was reading stories for me.” (Luke, aged 4).

Many children discussed their friends, saying they had lots of friends at school, and referred to best friends. Children described how friends made them happy and not lonely. With most children, the discussion of friends was not in the context of having a parent with bipolar, and they did not talk about whether they had told their friends about this, with the exception of the oldest child:

Int: Did you think it was important for them to know?

P: Yeah so they can like understand why I can't play. (Alice, aged 10)

Alice wanted friends to know so that she did not have to “bottle things up” when feeling upset. As the eldest child she showed maturity, understanding and could reflect on the impact of her mother's mood and behaviour. Finally, a major influence for some children was their pets. Pets were a

great source of amusement, love and played a key role in the interviews. Pets were frequently represented when the children described feeling happy. Children felt like they could talk to their pets and enjoyed playing with them.

Only one child discussed professional help that they had accessed as a result of having symptoms similar to his dad's BD:

P: Yeah they took me to um CAM things.

Int: Oh the CAMHS team? [child and adolescent mental health service] And what did they do?

P: Erm they talked me through what I my emotions and what I feel like when it happens, and I think we did it for over, about maybe 6 weeks or something.

Int: Did you see a psychologist or psychiatrist or something?

P: Erm I think he was I don't know really but they helped me with um problems and I don't go anymore.

Int: What sorts of problems?

P: How to not get angry and how to not get too giddy. I feel a lot better. (Thomas, aged 9)

This was also an exception; it was clear from questionnaire data that some other children were experiencing difficulties, but not all had received professional input.

Avoidance and Coping. Many children talked about their active avoidance of their parent when they were angry, sad or irritable:

"Erm it makes, if she is angry then I know to try and kind of avoid her slightly. Of course not entirely but just be wary that it's happening." (Jake, aged 9)

"Yeah I just get on with it and sometimes I just ignore her when she's acting funny" (Michael, aged 7)

Children described different forms of avoidance, perhaps going upstairs to their bedrooms to play, or visiting friends and relatives nearby. One child discussed how when angry, he actively went

off somewhere to be alone. Children discussed their hobbies, which they often used as a distraction when avoiding the parent. Children discussed school; half of them liked it and did very well, and the other half described feeling angry about going to school. Nevertheless school served an important function in providing routine, consistency and a chance to see friends.

Living in a Family with BD

Our interviews highlighted the importance of everyday family life in the context of BD, describing spending time together, arguments, and mundane activities. Children described both positive and negative experiences of living in their family, unrelated to having a parent who was unwell. Almost all children with siblings discussed fighting and rivalry. Many described fights, often in the context of breaking or stealing toys and revenge. Children discussed the punishments which followed, for example being told off, "smacked", or not being allowed to play on the computer or watch television. Some children described fighting with their brothers and how angry it made them; "Then I say stop it or I'll punch you with my knuckle. I start to get a bit violent." (Michael, aged 7)

Children gave a variety of responses about family life, for example stressful and challenging; happy; nice because of the people, house and garden; and good because friends and extended family lived close by. Only one child said he did not like living in his family, and two others struggled to say what was nice or the best thing about their families. The rest of the children spoke highly of their relationship with their parent(s). They discussed love and affection and despite arguments, most children stated that they mostly got on well with their parent(s) and were happy when they spent time together. One child expressed that there was nothing bad about his family. Children valued activities and days out with the whole family spending quality time together, for example going on holiday, to the park, to theme parks, and enjoying birthdays and Christmases:

Int: Do you ever spend time together altogether?

P: Yeah when we go out we have fun. (Aaron, aged 5)

Children also listed other things that made them happy, for example playing with their siblings and doing well at school. These findings suggest that during times of stability, families were able to function "normally" and spend time together. When the parent's symptoms were manageable, children could enjoy family life alongside BD.

Discussion

This study is the first to focus explicitly on the experiences of young children living with a parent with BD. Using age-appropriate methods, children as young as four years were enabled to describe their parent's mood and behaviour. Children had candid, insightful discussions about their parent's BD, showing knowledge of symptoms, and how it impacted on them both emotionally and practically. Children aged seven and above showed some knowledge, awareness and understanding of their parent's mental illness. As a small study of young children, our findings are tentative and hypothesis-generating.

In contrast to studies finding children have poor understanding parental illness, the children in our study appeared to have basic knowledge and awareness, particularly the older children. Elicitation of this information may have been due to the non-threatening 'side by side' nature of the computer-assisted interviews, which meant that children were able to discuss potentially sensitive and upsetting information whilst focussing on the screen. One study found similar results with children aged 6 to 11 regarding knowledge and awareness of parental mental illness (Fox, Buchanan-Barrow, & Barrett, 2010). Children's level of knowledge and awareness differed and was not always consistent with what the parent thought they knew.

The children in our study appeared to enjoy helping out their parents and being independent, unlike studies of the perception of child carers of mentally ill parents (Aldridge, 2006). Studies have reported 'parentification', which occurs when children are required to function as an adult when it is developmentally inappropriate for them to do so (Wells & Jones, 2000). These children are at an increased risk of developing a range of mental health difficulties as they get older and it can cause disruption to academic studies. (Hooper, DeCoster, White, & Voltz, 2011).

The literature also suggests that parents often feel guilty about their children having to grow up faster and take on 'adult roles'. Children in our study did not appear to perceive responsibility as a burden, appearing to derive pride and achievement from role reversal/parentification. Although this is not the norm in the literature, this may be a reflection of their younger ages and the lack of qualitative information available from this young age group. It is possible that parentification might become more of an issue as children get older when it could have more of an impact on school work and the time available to play and spend time with friends.

Jurkovic (1998) highlights two types of parentification: 'instrumental', involving the child completing physical tasks for the family or looking after a sick relative; and 'emotional', where the child provides parental support and acts as confidant or mediator between family members. Older children in our study certainly fitted the first type, helping out with practical tasks including housework, shopping and making their own meals. The children did not describe emotional parentification, which may occur more for adolescents as they become more emotionally mature and are able to provide support and advice in a way that younger children are unable to (Jurkovic, Thirkfield & Morrell, 2001).

Given that children often had additional responsibilities, what was evident was the importance of support for these children, whether from another parent, extended family members or friends. Pets were also important sources of fun and comfort. Having someone to talk to, support, distract and be consistent was valued. Although children described the emotional effects of having a parent with BD, many of them were functioning well in school. It is possible that children's functioning might be less affected by parental illness at these younger ages with increased impact in adolescence as social and academic demands increase, and children experience more consequences of their own problems, parent's mental illness, and subsequent life disruptions (Bella et al., 2011). Children of parents with BD have been observed to develop psychosocial competencies early in life, but lose them by early adolescence (Radke-Yarrow, Nottelmann, Martinez, Fox, & Belmont, 1992).

Benefits described by children accessing mental health services themselves suggests early intervention is valuable. Although the majority of children appeared to be doing well, some were struggling. Early identification of child difficulties and issues such as parentification, as well as access to support and treatment for both children and parents would be valuable. Although clinical implications we can draw are limited by our sample, there are pointers for intervention strategies. The findings are consistent with generic parental mental illness studies, indicating that interventions involving the whole family are effective in facilitating shared communication and problem-solving, with a collaborative emphasis and shared responsibility within the family. This would help children to understand their parent's problems, cope with difficult events and reduce distress caused by not understanding mental illness and develop effective coping strategies. This should help improve parental functioning and reduce distress highlighted by reports by parents with severe mental illness

(Dolman, Jones & Howard, 2013). Using age appropriate information, materials and language would also facilitate this and enable young children to develop an understanding of their parent's illness. Day (2008) recommended that children, particularly those who are socially excluded, require support and consideration in service development. It is crucial that young children's perspectives are understood and taken into account when developing appropriate services and interventions to support children and parents with mental illness, including BD.

Interviewing young children can often be difficult due to poor concentration, lack of understanding, difficulty expressing thoughts and feelings, anxiety about speaking to a stranger or making mistakes (Livingstone & Lemish, 2001). This can impact the amount and depth of information elicited and accuracy. In our study, children as young as four years old engaged in the interviews using IMS, retaining concentration and interest for twenty to thirty five minutes. Using technology and computer-based information can enhance communication and children's knowledge about parental mental health. Computer-assisted interviews such as IMS may be more effective than standard methods for interviewing children, such as 'write and draw' techniques (Backett-Milburn & McKie, 1999). This area needs further exploration.

Families recruited were skewed with regard to gender and ethnicity; recruitment via a user group may have influenced findings. The sample was based on parents who self-reported diagnoses; given the heterogeneity of BD and differences of opinion regarding this diagnosis, this should be noted. The researchers' clinical experience with mental illness and the use of the Internal States Scale (Bauer, 1991) suggested that self-report diagnoses were likely to be accurate. All parents reported being under the care of mental health services; the majority had experienced hospital admission in relation to diagnosis of BD. The majority of parents were educated to university degree level, which might influence the sophistication of the accounts the children gave. Other factors which could have influenced the results might be including children with difficulties with social and emotional understanding and interviewing children from the same family.

This research represents an important step forward in exploring the experiences of young children who have parents with BD. Children discussed "stresses" and "struggles" as well as positives of being a young child growing up in their family, albeit 'different' to the families of their

peers. Some children described experiencing negative emotions affiliated to their parent's behaviour when unwell and struggling with their own emotional and social development. Other children were doing well, and reported positive experiences related to parentification. These children described adapting to their context, some children learning about BD, accessing support from other family members and developing coping mechanisms, and some taking on additional responsibility and independence. Researching children's perspectives illuminates the voices of a previously neglected group, highlighting the importance of communication and understanding; only through their inclusion in this process can we identify children's difficulties and potential vulnerabilities and facilitate the development of intervention and support tailored to meet their unique needs.

Compliance with ethical standards

This work was undertaken when xx and xx were doctoral students, with research expenses provided by the Doctorate in Clinical Psychology at The University of xx. Ethical approval for this study was granted by The University of xx. xx is a developer of the In My Shoes computer assisted interview for children. She derives no financial benefit from it. There are no other conflicts of interest to declare.

References

- Aldridge, J. (2006). The experiences of children living with and caring for parents with mental illness. *Child Abuse Review, 15*(2), 79-88. doi:10.1002/car.904
- Backett-Milburn K, McKie L. (1999). A critical appraisal of the draw and write technique. *Health Education Research, 14*, 387-398. doi:10.1093/her/14.3.387
- doi:10.1080/09687590120083967
- Banks, P., Cogan, N., Deeley, S., Hill, M., Riddell, S., & Tisdall, K. (2002). Does the covert nature of caring prohibit the development of effective services for young carers? *Journal of Guidance and Counselling Psychology, 30*, 231-245. doi:10.1080/030698802100002281
- Bauer, M., Crits-Christoph, P., Ball, W., Dewees, E., McAllister, T., Alahi, P., Cacciola, J., & Whybrow, P. (1991). Independent assessment of manic and depressive symptoms by self-rating scale characteristics and implications for the study of mania. *Archives of General Psychiatry, 48*, 807-812. doi:10.1001/archpsyc.1991.01810330031005
- Bee P., Berzins, K., Calam, R., Pryjmachuk, S., & Abel, K. (2013). Defining Quality of Life in the Children of Parents with Severe Mental Illness: A Preliminary Stakeholder-Led Model. *PLoS ONE, 8*(9): e73739. doi:10.1371/journal.pone.0073739
- Bella, T., Goldstein, T., Axelson, D., Obreja, M., Monk, K., Hickey, M.B., Goldstein, B., Brent, D., Diler, R.S., Kupfer, D., Sakolsky, D., & Birmaher, B. (2011). Psychosocial functioning in offspring of parents with bipolar disorder. *Journal of Affective Disorders, 133*(1-2), 204-211. doi:10.1016/j.jad.2011.03.022
- Birmaher, B., Axelson, D., Monk, K., Kalas, C., Goldstein, B., Hickey, M.B., Obreja, M., Ehmann, M., Iyengar, S., Shamseddeen, W., Kupfer, D., & Brent, D. (2009). Lifetime psychiatric disorders in school-aged offspring of parents with bipolar disorder: the Pittsburgh Bipolar Offspring study. *Archives of General Psychiatry, 66*(3), 287-296. doi:10.1001/archgenpsychiatry.2008.546
- Bokstrom, P., Fangstrom, K, Lucas, M., Calam, R, Sarkardi, A. (2016). I felt a little bubbly in my tummy': Eliciting pre-schoolers' accounts of their health visit using a computer-assisted interview method. *Child: Care, Health and Development. 42*(1), 87-97. doi:10.1111/cch.12293
- Boyatzis, R.E. (1998). *Transforming Qualitative Information: Thematic Analysis and Code Development*. California: Sage.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research Psychology, 3*, 77-101. doi:10.1191/1478088706qp063oa

- Buckwalter, K.C., Kerfoot, K.M., & Stolley, J.M. (1988). Children of Affectively Ill Parents. *Journal of Psychosocial Nursing*, 26(10), 8-14.
- Calam, R.M., Cox, A.D., Glasgow, D.V., Jimmieson, P., & Groth-Larsen, S. (2000). Assessment and therapy with children: can computers help? *Clinical Child Psychology and Psychiatry*, 5(3), 329-343.
- Chang K, Steiner H, Ketter T. (2003). Studies of offspring of Parents with Bipolar Disorder. *American Journal of Medical Genetics Part C*, 123c:26-35. doi:10.1002/ajmg.c.20011
- Cogan, N., Riddell, S., & Mayes, G. (2005). Children living with an affectively ill parent: How do they cope? *Educational & Child Psychology*, 22 (4), 16-28.
- Cogan, N., Riddell, S., & Mayes, G. (2005). The understanding and experiences of children affected by parental mental health problems: a qualitative study. *Qualitative Research in Psychology*, 2, 47-66. doi:10.1191/1478088705qp024oa
- Davis, J., & Wright, J. (2008). Children's voices: A review of the literature pertinent to looked-after children's views of mental health services. *Child and Adolescent Mental Health*, 13(1), 26-31. doi:10.1111/j.1475-3588.2007.00458.x
- Day, C. (2008). Children's and young people's involvement and participation in mental health care. *Child and Adolescent Mental Health*, 13(1), 2-8. doi:10.1111/j.1475-3588.2007.00462.x
- Dienes, K.A., Chang, K.D., Blasey, C.M., Adleman, N.E., Steiner, H. (2002). Characterization of children of bipolar parents by parent report CBCL. *Journal of Psychiatric Research*, 36, 337-345. doi:10.1016/S0022-3956(02)00019-5
- Dolman, C., Jones, I., Howard, L.M. (2013). Pre-conception to parenting: a systematic review and meta-synthesis of the qualitative literature on motherhood for women with severe mental illness. *Archives of Women's Mental Health*, 16:173-196. doi:10.1007/s00737-013-0336-0
- Duffy, A., Horrocks, J., Doucette, S., Keown-Stoneman, C., McCloskey, S., & Grof, P. (2014). The developmental trajectory of bipolar disorder. *The British Journal of Psychiatry*, 204 (2), 122-128. doi:10.1192/bjp.bp.113.126706
- Fjone, H.H., Ytterhus, B., & Almvik, A. (2009). How children with parents suffering from mental health distress search for 'normality' and avoid stigma: To be or not to be ... is not the question. *Childhood*, 16, 461-477. doi:10.1177/0907568209343743
- Fox, C, Buchanan-Barrow, E, & Barrett, M. (2010). Children's conceptions of mental illness: A naive theory approach. *British Journal of Developmental Psychology*, 28, 603-625. doi:10.1348/026151009X461366

- Garley, D., Gallop, R., Johnston, N., & Pipitone, J. (1997). Children of the mentally ill: a qualitative focus group approach. *Journal of Psychiatric and Mental Health Nursing*, 4, 97-103. Doi:10.1046/j.1365-2850.1997.00036.x
- Giles, L., DelBello, M., Stanford, K., & Strakowski, S. (2007). Child behavior checklist profiles of children and adolescents with and at high risk for developing bipolar disorder. *Child Psychiatry & Human Development*, 38(1), 47-55. doi:10.1007/s10578-006-0041-6
- Goldstein, B.I., Shamseddeen, W., Axelson, D.A., Kalas, C., Monk, K., Brent, D.A., Kupfer, D.J., & Birmaher, B. (2010). Clinical, demographic, and familial correlates of bipolar spectrum disorders among offspring of parents with bipolar disorder. *Journal of American Academic Child and Adolescent Psychiatry*, 49(4), 388-396. doi:10.1016/j.jaac.2010.01.009
- Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A Research Note. *Journal of Child Psychology and Psychiatry*, 38, 581-586. doi:10.1111/j.1469-7610.1997.tb01545.x
- Handley, C., Farrell, G.A., Josephs, A., Hanke, A., & Hazelton, M. (2001). The Tasmanian children's project: The needs of children with a parent/carer with a mental illness. *Australian and New Zealand Journal of Mental Health Nursing*, 10, 221-228. doi:10.1046/j.1440-0979.2001.00214.x
- Hirshfeld-Becker, D.R., Biederman, J., Henin, A., Faraone, S.V., Cayton, G.A., & Rosenbaum, J.F. (2006). Laboratory-Observed Behavioral Disinhibition in the Young Offspring of Parents With Bipolar Disorder: A High-Risk Pilot Study. *American Journal of Psychiatry*, 163, 265-271. doi:10.1176/appi.ajp.163.2.265
- Hooper, L. M., DeCoster, J., White, N., & Voltz, M. L. (2011). Characterizing the magnitude of the relation between self-reported childhood parentification and adult psychopathology: A meta-analysis. *Journal of Clinical Psychology*, 67, 1-16.
- Jurkovic, G.J. (1998). 'Destructive Parentification in Families' in Luciana L'Abate ed., *Family Psychotherapy*, New York, 237-25.
- Jurkovic, G. J., Thirkfield, A., & Morrell, R. (2001). Parentification of adult children of divorce: A multidimensional analysis. *Journal of Youth and Adolescence*, 30, 245-257.
- Livingstone, S., and Lemish, D. (2001). Doing comparative research with children and young people. In S. Livingstone & M. Bovill (Eds.), *Children and Their Changing Media Environment: A European Comparative Study*, 31-50. Mahwah, NJ: Lawrence Erlbaum Associates.

- Maybery, D., 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 (AEJAMH)*, 4(2), 1-11. doi:10.5172/jamh.4.2.78
- Mays, N., & Pope, C. (1995). Qualitative research: rigour and qualitative research. *British Medical Journal*, 311, 109-112. doi:10.1136/bmj.311.6997.109
- Meadus, R.J., & Johnson, B. (2000). The experience of being an adolescent child of a parent who has a mood disorder. *Journal of Psychiatric and Mental Health Nursing*, 7, 383-390. doi:10.1046/j.1365-2850.2000.00319.x
- Metcalfe, A., Coad, J., Plumridge, G.M., Gill, P., Farndon, P. (2008). Family communication between children and their parents about inherited genetic conditions: a meta-synthesis of the research. *European Journal of Human Genetics*, 16, 1193–1200. doi:10.1038/ejhg.2008.84
- Mordoch, E. (2010). How Children Understand Parental Mental Illness: “You don’t get life insurance. What’s life insurance?” *Journal of Canadian Academic Child and Adolescent Psychiatry*, 19(1), 19-25.
- 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. doi:10.1177/1049732308320775
- Mrazek, D.A., & Agathen, J.M. (2002). Psychiatric disturbances in children of parents with bipolar disorder. *Journal of Psychiatric Practice*, 8(4), 196-204.
- Nurnberger, J.I., McInnis, M., & Reic, W. (2011). A High-Risk Study of Bipolar Disorder: Childhood Clinical Phenotypes as Precursors of Major Mood Disorders. *Arch Gen Psychiatry*, 68(10), 1012-1020. doi:10.1001/archgenpsychiatry.2011.126
- Oakley, M.W. (2000). Children and young people and care proceedings. In: Lewis, A., Lindsay, G., eds. *Researching children’s perspectives (pp.73)*. Buckingham: Open University Press.
- Ostman, M. (2008). Interviews with children of persons with a severe mental illness-Investigating their everyday situation. *Nordic Journal of Psychiatry*, 62(5), 354-359. doi:10.1080/08039480801960065
- Peay, H.L., Rosenstein, D. L. & Biesecker, B. B. (2014). Parenting with bipolar disorder: Coping with risk of mood disorders to children. *Social Science and Medicine* 104, 194-200. doi:10.1016/j.socscimed.2013.10.022
- Perich, T., Lau, P., Hadzi-Pavlovic, D., Roberts, G., Frankland, A., Wright, A., Green, M., Breakspear, M., Corry, J., Radlinska, B., McCormack, C., Joslyn, C., Levy, F., Lenroot, R., Nurnberger Jnr, J.I., &

- Mitchell, P.B. (2015). What clinical features precede the onset of bipolar disorder? *Journal of psychiatric research*, 62, 71–77. doi:10.1016/j.jpsychires.2015.01.017
- Perrin E.C., & Gerrity P.S. (1981). There's a Demon in Your Belly: Children's Understanding of Illness. *Pediatrics*, 67, 841-849.
- Polkki, P., Ervast, S.A., & Huupponen, M. (2005). Coping and Resilience of Children of a Mentally Ill Parent. *Social Work in Health Care*, 39(1), 151-163. doi:10.1300/J010v39n01_10
- Pope, C., & Mayes, N. (1995). Qualitative research: reaching the parts that other methods cannot reach: an introduction to qualitative methods in health and health services research. *British Medical Journal*, 311, 42-45. doi:10.1136/bmj.311.6996.42
- Pope, C., & Mays, N. (2006). *Qualitative research in health care*. 3rd ed. Oxford: Blackwell.
- Radke-Yarrow, M., Nottelmann, E., Martinez, P., Fox, M., & Belmont, B. (1992). Young children of affectively ill parents: a longitudinal study of psychosocial development. *Journal of American Academic Child & Adolescent Psychiatry*, 31, 68–77. doi:10.1097/00004583-199201000-00011
- Riebschleger, J. (2004). Good Days and Bad Days: The Experiences of Children of a Parent with a Psychiatric Disability. *Psychiatric Rehabilitation Journal*, 28(1), 25-31. doi:10.2975/28.2004.25.31
- Singh, M.K., DelBello, M.P., Stanford, K.E., Soutullo, C, McDonough-Ryan, P., McElroy, S.L., & Strakowski, S.M. (2007). Psychopathology in children of bipolar parents. *Journal of Affective Disorders*, 102(1-3), 131-6. doi:10.1016/j.jad.2007.01.004
- 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(1), 39-52. doi:10.1177/1359104504039767
- The National Institute of Mental Health (NIMH). (2011). *Bipolar Disorder Among Adults*. National Institutes of Health (NIH): U.S. Department of Health and Human Services.
- The Royal College of Psychiatrists. (2011). *Mental Health and Growing Up*. London: The Royal College of Psychiatrists.
- Vandeleur, C., Rothen, S., Gholam-Rezaee, M., Castelao, E., Vidal, S., Favre, S., Ferrero, F., Halfon, O., Fumeaux, P., Merikangas, K.R., Aubry, J-M., Burstein, M., & Priesig, M. (2012). Mental disorders in offspring of parents with bipolar and major depressive disorders. *Bipolar Disorders*, 14(6), 641–653. doi:10.1111/j.1399-5618.2012.01048.x
- Wahl, O.E. (2002). Children's Views of Mental Illness: A Review of the Literature. *Psychiatric Rehabilitation Skills*, 6(2), 134-158. doi:10.1080/10973430208408430

- Wals, M., Hillegers, M., Reichart, C., Ormel, J., Nolen, W., & Verhulst F. (2010). Prevalence of psychopathology in children of a bipolar parent. *Journal of American Academic Child & Adolescent Psychiatry*, 40(9), 1094-1102. doi:10.1097/00004583-200109000-00019
- Wellman, H.M., Gelman, S.A., Khun, D., & Siegler, R.S. (1998). Knowledge acquisition in foundational domains. In: (ed.), *Handbook of Child Psychology, Vol 2. Cognition, Perception and Language*. New York: Wiley, 523-573.
- Wells, M., & Jones, R. (2000). Childhood parentification and shame-proneness: A preliminary study. *American Journal of Family Therapy*, 28(1), 19-27.

| Parent | Age | Children at time of diagnosis | Ethnicity | Marital Status | No. of Children | Level of education | Currently employed (Y/N) | Child pseudonym, age, additional needs and SDQ overall stress score | | | Professional Agencies Involved (Y/N) | | Parental medication and mood state (ISS) |
|-------------|-----|-------------------------------|-----------|----------------|-----------------|-------------------------------|--------------------------|---|---|----------------|--------------------------------------|-----|--|
| | | | | | | | | | | | | | |
| 1 Mother | 39 | Yes | White | Married | 2 | University Degree, Mphil, MBA | Self-employed Part-time | Jake (age 9) | Asperger's Syndrome | 18 (High) | Children | Yes | Yes Euthymia |
| | | | | | | | | Participant | Yes | | | | |
| 2 Mother | 33 | Yes | White | Married | 3 | University Degree | No | Harry (age 6) | Delay in emotional and social skills | 31 (Very High) | Partner | No | Yes Depression |
| | | | | | | | | Michael (age 7) | None | 3 (Average) | Children | No | |
| | | | | | | | | Participant | Yes | | | | |
| 3 Mother | 41 | No | White | Single | 2 | University Degree | No | Connor (age 6) | None | 12 (Average) | Partner | No | Yes Depression |
| | | | | | | | | Daniel (age 4) | Hearing Impairment | 3 (Average) | Children | Yes | |
| | | | | | | | | Participant | Yes | | | | |
| 4 Mother | 50 | Yes | White | Single | 1 | GCSE's, CSE's or O-levels | No | Jordan (age 8) | ADHD, Poor communication & motor skills | 31 (Very high) | Children | Yes | No Euthymia |
| | | | | | | | | Participant | Yes | | | | |
| 5 Father | 35 | Yes | White | Married | 3 | University Degree | Yes | Not interviewed (age 4) | None | -- | Children | No | Yes Depression |
| | | | | | | | | Alice (age 10) | None | 2 (Average) | Participant | Yes | |
| 6 Mother | 36 | No | White | Separated | 1 | GCSE's, CSE's or O-levels | No | Thomas (aged 9) | None | 12 (Average) | Children | Yes | Yes Euthymia |
| | | | | | | | | Participant | Yes | | | | |
| | | | | | | | | Aaron (age 5) | None | 12 (Average) | Partner | Yes | |
| 7 Mother | 36 | No | White | Separated | 1 | GCSE's, CSE's or O-levels | No | Not interviewed (age 2) | None | -- | Children | No | Yes Euthymia |
| | | | | | | | | Luke (age 4) | None | 10 (Average) | Participant | Yes | |