The Qualitative Report

Volume 19 | Number 15 Article 1

4-14-2014

Growing Up with a Mother with Depression: An Interpretative Phenomenological Analysis

Hanna Van Parys
University of Leuven, hanna.vanparys@ugent.be

Jonathan A. Smith
Birkbeck University of London

Peter Rober
University of Leuven

Growing Up with a Mother with Depression: An Interpretative Phenomenological Analysis

Abstract

The aim of this study was to explore the childhood experience of living with a parent with depression from a retrospective point of view. Five women between 39 and 47 years of age, who grew up with a mother with depression, were interviewed about their current perspectives on their childhood experiences. Interviews were semi-structured and the data were analyzed using interpretative phenomenological analysis. Data analysis led to a narrative organized in two parts. The first part (retrospective understanding of childhood experiences) reports on feelings of desolation contrasted to exceptional support, context-related dwelling on own experiences, and growing into a caring role as a way to keep standing. The second part (towards an integration of childhood experiences in adult realities) evidences ongoing processes of growing understanding of the situation at home, coping with own vulnerabilities, making the difference in their current family life and finding balance in the continued bond with the parents. This retrospective investigation of adults' perspectives on their childhood experiences gave access to aspects of their experience that remain underexposed in research based on data from children and adolescents.

Keywords

Children, Caregivers/Caregiving, Depression, Interpretative Phenomenological Analysis (IPA), Parent-Child Relationships, Qualitative Research

The Qualitative Report 2014 Volume 19, Article 29, 1-18
http://www.nova.edu/ssss/QR/QR19/van_parys29.pdf

Growing Up with a Mother with Depression: An Interpretative Phenomenological Analysis

Hanna Van Parys
University of Leuven, Leuven, Belgium
Jonathan A. Smith
Birkbeck University of London, London, United Kingdom
Peter Rober
University of Leuven, Leuven, Belgium

The aim of this study was to explore the childhood experience of living with a parent with depression from a retrospective point of view. Five women between 39 and 47 years of age, who grew up with a mother with depression, were interviewed about their current perspectives on their childhood experiences. Interviews were semi-structured and the data were analyzed using interpretative phenomenological analysis. Data analysis led to a narrative organized in two parts. The first part (retrospective understanding of childhood experiences) reports on feelings of desolation contrasted to exceptional support, context-related dwelling on own experiences, and growing into a caring role as a way to keep standing. The second part (towards an integration of childhood experiences in adult realities) evidences ongoing processes of growing understanding of the situation at home, coping with own vulnerabilities, making the difference in their current family life and finding balance in the continued bond with the parents. This retrospective investigation of adults' perspectives on their childhood experiences gave access to aspects of their experience that remain underexposed in research based on data from children and adolescents.
Keywords: Children, Caregivers/Caregiving, Depression, Interpretative Phenomenological Analysis (IPA), Parent-Child Relationships, Qualitative Research

Introduction

In the past 2 decades, a growing number of studies focused on the influence of parental mental illness on general family functioning (e.g., Dickstein et al., 1998; Foster et al., 2008) and on children's well-being in particular (e.g., Cummings, Keller, & Davies, 2005; Goodman et al., 2010). The main aim of this type of research is predicting and explaining relations between parental mental illness and psychopathology in the child and later in life (e.g., Forbes et al., 2006; Peisah, Brodaty, Luscombe, & Anstey, 2004; Whiffen, Kerr, & Kallos-Lilly, 2005). In this research, children tend to be pictured as passive receivers of adverse outcomes to their parent's condition. Lacking a circular conceptualization of family dynamics, research on children of parents with depression, for instance, often unilaterally stresses the diminishing parenting capacities and the negative impact of depression on the parent-child interaction (e.g., Hammen, 1997).

While some studies examined stress and coping in relation to parental depression (e.g., Compas, Langrock, Keller, Merchant, & Copeland, 2002) or children's behavioral and emotional responses to low parental mood (Solantaus-Simula, Punamaki, & Beardslee, 2002a, 2002b), only a few studies have explored children's experiences of parental depression in the family (Earley & Cushway, 2002; Goodman, Tully, Connell, Hartman, & Huh, 2011; Mordoch

& Hall, 2008). One important theme that emerges in these studies is the child's meaning making. As the parental depression itself is often one of the subjects that is not under discussion in the family, children express their need for more information about the parent's illness (Meadus & Johnson, 2000; Stallard, Norman, Huline-Dickens, Salter, & Cribb, 2004). However, while children need information to give meaning to what is happening around them, there is also a danger in receiving too much information as this might burden the child (Stallard et al., 2004).

Apart from enabling an understanding of the parent's behavior, making sense of the parental depression and their own experiences is also related to coping with this parental condition (Aldrigde & Becker, 2003; Meadus & Johnson, 2000). The child's experience of coping with the parent's depression is investigated by Mordoch and Hall (2008). In a qualitative study, they describe how children and adolescents try to find a daily rhythm by first monitoring the parent's behaviors and moods, and then adjusting their own behaviors in response to their observations. At the same time, children and adolescents try to create an appropriate distance towards the parents to avoid being engulfed by the parental mental illness. In this long-term process children and adolescents preserved themselves partly by building their own identity and differentiating from their parents (Mordoch & Hall, 2008). Related to that, Kaimal and Beardslee (2010), in a study about the way emerging adults perceive parental depression, reveal five general perspectives: resistance and negativity (clustered as "self-oriented" perspectives), acceptance and compassion (clustered as "other-oriented" perspectives) and ambivalence. Furthermore, the transition paths between these perspectives are analyzed at the ages of 17, 18, and 19 years, revealing both changing and stable patterns (Kaimal & Beardslee, 2010).

A third theme that is critical in studies on the children's and adolescents' experiences of parental depression is sensitivity and caregiving. For a child, one particular way to go about adversity at home is active involvement in the family or in the parent's emotional life. Children might feel the vulnerabilities in their parent and try to act in a way that they cause the least trouble or actively contribute to the family (Earley & Cushway, 2002). This family process is referred to as parentification (Chase 1999; Jurkovic, 1997; Peris, Goecke-Morey, Cummings, & Emery, 2008). Parental mental illness is considered one of the contexts in which parentification occurs (Aldridge, 2006; Champion et al., 2009). Children of parents with depression are sensitive for behavioral signs of their parent and cues in the conversation with their parent that inform them about their parent's well-being or distress (e.g., Pölkki, Ervast, & Huupponen, 2004; Van Parys & Rober, 2013). Along with this sensitivity, children worry a lot about their parent's emotional well-being and they experience increased responsibility for their families (Knutsson-Medin, Edlund, & Ramklint, 2007; Van Parys & Rober, 2013). For instance, children "try to be there for the parent" when he or she is in a state of emotional despair (Aldridge, 2006). Using thematic analysis, Van Parys and Rober (2013) construct a general framework of 14 children's experiences of parental depression and their own caregiving in the family. The theme "trying to comfort the parent" was selected for a microanalysis, illustrating processes of overt negotiating of caretaking between parent and child as well as dynamics of the child hiding or denying his worries as an answer to parental distress (Van Parys & Rober, 2013).

In a meta-analysis of the experiences of young carers, Rose and Cohen (2010) report that children try to integrate caring into their emerging identity. Children might be prone to a carer identity as "their exploration of alternative identities [is] limited" (Rose & Cohen, 2010, p. 484). Lastly, there seems to be some kind of secrecy in the family with regard to this caring role (Aldridge & Becker, 2003; Rose & Cohen, 2010). Pölkki et al. (2004) suggest that especially younger children do not talk about their caretaking actions. In general, Focht-Birkerts and Beardslee (2000) state that for both parents and children, the most difficult thing to talk about is the distress children experience about having a parent with a mental illness.

The Current Study

In family therapy practice, family therapists encounter numerous difficulties in trying to reach children of parents who are stressed or who suffer from mental illness. They often find themselves wondering: "what is going through the child's mind?" or "how does this child experience the situation at home?," and most of all, "how can we be of help to children and to their families?" In addition, the research review reveals that it can be hard for children to express their perspectives on their parent's depression (e.g., Focht-Birkerts & Beardslee, 2000), partly related to a secrecy in the family with regard to children's caring roles (Aldridge & Becker, 2003; Pölkki et al., 2004; Rose & Cohen, 2010). What can be talked about differs in terms of the developmental stage of the child and the stage in the family life cycle (McGoldrick, Carter, & Garcia-Preto, 2011). Presumably, some experiences may be hard to talk about in childhood, but as the child grows older and has more psychological distance from his/her family of origin and from the parent with depression, the child might be able to articulate aspects of his/her experiences that could not be talked about when he/she was younger (McAdams, 2006).

Starting from the difficulty to reach these children in the context of family therapy, the current study is set up in order to explore the child's experience from a retrospective point of view. According to Arnett (2006), the role of self-understanding becomes salient in emerging adulthood. Through ongoing processes of self-reflection, learning and understanding, grown-up children may become able to make more sense of their childhood experiences and the way they grew up in their family (Kaimal & Beardslee, 2010). While there are some studies approaching the experience of children of parents with depression by obtaining data from children and adolescents (e.g., Aldridge, 2006; Kaimal & Beardslee, 2010; Mordoch & Hall, 2008; Van Parys & Rober, 2013), research about an adult's reflections on growing up with a parent with depression is scarcely represented in the field of family studies. Three studies focus on childhood experiences with regard to parental mental illness from a retrospective point of view. Firstly, Knutsson-Medin et al. (2007) explore experiences in 36 grown-up children of mentally ill parents through open-ended questionnaires. In addition to experiences of contact with psychiatric services, grown-up children also report on their experiences of worry and an increased responsibility for their families at that time (Knutsson-Medin et al., 2007). Secondly, in an analogous study, Dunn (1993) reports on adults' retrospective accounts on their childhood experiences growing up with a psychotic mother, bringing feelings of neglect and isolation as well as their own excessive caretaking to the fore. Thirdly, Pölkki et al. (2004) combine two perspectives on childhood experiences with parental depression, namely interviews with children aged 9-11 years old and retrospective narratives of grown-up children of parents with a mental illness. In contrast with the grown-up children, the younger children do not talk about their caretaking actions, nor do they express their experiences and emotions (Pölkki et al., 2004).

Unlike Knutsson-Medin et al. (2007) and Pölkki et al. (2004), who analyzed written answers to one or more open-ended retrospective questions, we used interviews giving access to more in-depth personal accounts of the participants' experiences. For the current study we interviewed adult women (39-47 years old) who identified themselves as having been raised by a parent with depression, about their childhood experiences. We used Interpretative Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009) as a method for qualitative data analysis because of the focus on the lived experience and on how participants made sense of their experiences both as a child and now. Moreover, the experience of family relations is considered as a research area that is suitable for IPA (e.g., Harris, Pistrang, & Barker, 2006; Smith, 1999). Even though the participants were talking about a long distant past, they

described their childhood experiences in a particularly vivid way. The content of both childhood and adulthood experiences were considered in this study. In contrast to narrative analysis the focus was not on the way the life story was told. We aimed at including a small number of participants in order to be able to look for patterns across cases. Data analysis was done case by case as this allowed us to hold on to the unique aspects of each person's experiences (idiographic focus), before moving on to more general conclusions. The principle research question in this investigation was *How do adults retrospectively make sense of their childhood experiences of parental depression?* In the second part of the interview, we addressed the way the reported childhood experiences—if still meaningful at present—were integrated in the participants' current lives. In sum, our findings reflect both retrospective meaning making of childhood experiences, and ongoing meaning making processes in adulthood, including the way participants sculpt their current family relationships.

The current study is part of a larger doctoral project about children's experiences of parentification in families with a parent with depression. The third author served as the supervisor for the first author; his research projects are focused on family therapy processes, the therapist's inner conversation, and selective disclosure in families in different contexts, including the context of parental mental illness. The second author is the developer of IPA and promoted the rigorous application of IPA to this research subject. He served as a co-supervisor for the first author.

Methods

Participants

In accordance with the requirement of the adopted analytic approach (IPA) that samples should be small enough to enable an idiographic analysis, in-depth interviews with five women who grew up in a family affected by maternal depression were analyzed. Participants were approached via several channels (e.g., advertisement on university websites and in a woman's magazine, email via personal network, circulation research flyer on workshops). Sixteen people filled out a demographic questionnaire including open questions about their childhood experiences of growing up with a parent with depression. Only two of the respondents were men. Furthermore, all of the respondents reported on a mother who was hospitalized for depression. As IPA requires homogeneity in the sample (Smith et al., 2009), we decided to include women whose mothers had been diagnosed. The participants for this study represent a reasonably homogeneous sample in that they were all European, White, middle class women living in the Flemish part of Belgium and aged between 39 and 47. In each case, the participant's mother was hospitalized for depression several times before the participant turned 18. All participants were married and had children between 12 and 27 years old. Seven women were interviewed by the first author. However, one interview was analyzed as a preliminary case study and another one did not meet the IPA criteria for rich interview data. Therefore, the remaining five interviews form the basis for this IPA study. The names of the participants have been changed to protect confidentiality. To reconstruct information on the parents' diagnosis, we used self-reports of the participants. Demographic information is provided in Table 1. Local ethical approval from University of Leuven had been secured for the study and the appropriate informed consent forms were administered. Participants were informed about the details of the study by means of e-mails sent by the first author.

Table 1: Demographic Information

	Age	**Siblings Female (F)/ Male (M)**	**Position in child row**	**Diagnoses mother**	**Number of hospitalize-tions mother**	**Length of hospitalizations**	**Current marital status of participant**	**Children in nuclear family Female (F)/ Male (M)**
Mary	46	F (45), F (passed away at age 43)	oldest	depression borderline schizophrenia	3 (two times when pp was age 5-8 and once when pp was age 29)	not specified, children were hospitalized at a preventorium during the first two hospitalizations	Married	F (18), M (20), F (20), F (22)
Amy	47	M (44), F (42)	oldest	depression anxiety	2 (once when pp was age 5 and once when pp was age 15)	each hospitalization had a duration of several weeks, first time pp stayed with family, second time she ran the family	Married	F (18)
Sofie	39	M (34), F (31), M (29), M (27)	oldest	chronic depression	Regularly starting age 12	first hospitalization had a duration of a year, after that regular hospitalizations with a duration of 3 to 4 months.	Married	F (15), F (12)
Jane	47	M (46), F (45)	oldest	depression	2 (once when pp was age 11 and once when pp was age 18)	first hospitalization had a duration of three months, second hospitalization had a duration of a couple of months	Remarried	three children from first marriage: M (27), M (26), M (passed away at age 23)
Brenda	44	M (58), M (51), F (48)	youngest	depression	2 (once when pp was age 16, and once when pp was age 20)	not specified	Married	F (18), F (16)

Procedure

Participants were invited to an interview about their childhood experiences, growing up in a family in which one of the parents was depressed. All interviews were audio recorded. Interviews lasted between 70 and 90 minutes and were semi-structured. The first part consisted of questions about childhood experiences starting from descriptive narratives about that period in their lives (e.g., “Can you describe an ordinary day at home?”). In the second part of the interview the meaning of these recounted childhood experiences with regard to their current lives (for instance in relationships with parents, partner, and children) was asked about. These open questions aimed at exploring both past and current experiences with regard to the mother’s depression. By means of probes, the participants’ experiential accounts were facilitated (Smith et al., 2009).

Analysis

IPA involves a detailed step-by-step analysis of each case before turning to the level of comparison across cases. First, reading through the transcript, descriptive, linguistic, and conceptual notes were made in order to obtain familiarity with the case and enhance interpretation of the data (Smith et al., 2009). For example, the use of particular metaphors (e.g., children having a "referee position" at home) and possible meanings of this metaphor were discussed in a linguistic note. The next stage consisted of a first coding based on the annotated transcript. In this first coding we looked for patterns and connections across the data. In this analytical process a shift is made from making rich interpretative notes about the data in the commenting stage, to reducing the detail while maintaining complexity. An example of a code in this stage is "being away as relief." Subsequently, the codes were clustered into themes and subthemes according to conceptual similarities and differences. Finally a table of themes and subthemes holding information about key phrases and locations in the transcript was made for each case. The five tables of themes can be found in the Appendix. Based on the different tables of themes, a group analysis across the five cases was conducted (see Table 2). This group analysis resulted in an overall narrative account supported by verbatim extracts from each participant.

The first two transcripts were translated from Dutch to English by the first author, in order to give the second author the opportunity to check on the analytic work in detail. Other transcripts were not translated due to time constraints. However, all analyses have been conducted in English and relevant quotes have been translated as well. Each case was carefully reviewed by the second author. The first group table of themes was challenged by the second author and then revised to represent the connections between the themes more clearly. For instance, the first group table of themes included the general descriptive category, "feeling desolate as a child," but this was challenged by the second author. After discussion the code name was changed to "feelings of desolation" as this better reflected the "momentary" state of these feelings. The first author took a reflexive stance and discussed with the second and the third author both her "research identity" (Daly, 2007) and possible ways in which personal experiences might color the analysis. In three different meetings the first author's personal meanings attached to family members suffering from depression were interrogated in order to get a clearer view on the way the first author looked for themes and patterns in the data. This way we made sure that these personal meanings did not interfere with the systematic analysis of the material.

Findings

In Table 2 we provide an overview of the themes. Following that, in Part One we discuss the meanings participants now give to their childhood experiences of growing up with a mother with depression. In the first part we describe three themes that form a retrospective understanding of the participant's experiences as a child: feelings of desolation contrasted to exceptional support, context-related dwelling on own experiences, and growing into a caring role as a way to keep standing. Although some participants spoke about their parents in general, most of them deliberately addressed their mother—the parent who went through one or more episodes of depression—in their accounts. Occasionally, the relationship with the father was discussed. In Part Two, we document how a growing understanding of the situation at home, alongside coping with one's own vulnerability, trying to make the difference in their current family life, and finding balance in the continued bond with their parents form an integrated current reality.

Table 2: Overview of the Themes

Part One: Retrospective Understanding of Childhood Experiences
Feelings of desolation contrasted with exceptional support
Context-related dwelling on own experiences
Growing into caring role as a way to keep standing
Part Two: Towards an Integration of Childhood Experiences in Adult Realities
Growing understanding of the situation at home
Coping with own vulnerability
Trying to make a difference in current family life
Trying to find a balance in continued bond with parents

Part One: Retrospective Understanding of Childhood Experiences

In the interviews, people mentioned past feelings of desolation in the context of their family homes and more specifically in the relation with their mother. However, these feelings of desolation were contrasted with more exceptional experiences of being supported by another adult caregiver, such as a grandmother or a teacher. The participants reported that they, as children, most often did not realize and did not linger on these feelings of desolation. At the same time, sharing their own experiences/emotions with others in their environment was limited. Starting from the vulnerability they sensed in their parent and the need they felt in their family, some participants reported on taking a caretaking role in the family. For some, this caretaker position also served as a way to keep standing themselves. Instead of dwelling on their experiences, they preferred to focus on action and helping out in the family, as this allowed both the family and themselves to keep standing.

Feelings of desolation contrasted with exceptional support

Two participants recalled feelings of loneliness in their childhood. Having missed an emotional bond with their mother was seen as a very important component of their experience. Sofie, for instance, said, “Thinking about it now, it probably has been the most central thing in my life: as a child I never had love and affection.” She considered this perceived lack of maternal warmth as having been more crucial to her later functioning than other aspects of her mother’s illness, such as her repeated suicidal attempts. In this retrospective account, Sofie compared what her mother had been to her and what she *could have been* to her. It is only “thinking about it now” that she realizes this experienced lack of love and affection.

Another participant, Jane, recounted how she felt a certain distance with her mother. When her mother came back home after a hospitalization, it was as if she could not reach her: “She was weird, not really weird, but she wasn’t there like for the full 100%.” As a child she perceived her mother as not fully present, which in turn constrained the experience of emotional contact with her mother.

In Mary’s story, a similar experience of missing maternal warmth is connected with her position in the family. Being in the middle of her parents’ constant fights, she often felt the need to choose sides. Mary, regularly finding herself in her father’s camp, consequently had to deal with the reproach from her mother. These tensions in the intramarital as well as in the parent-child relationship “overshadowed” the experienced bond with her mother. She did not recall feeling nurtured by her mother. Rather she had recollections of enduring alertness and being vigilant to family tensions. Thus, in addition to the fact that Mary missed something in the bond with her mother, she also had to deal with mother’s negative emotions towards her.

The theme, feelings of desolation, is furthermore related to an experienced lack of information. Not being informed about the parent's illness and the uncertainty about what was going on in the family seemed to be among the heaviest burdens for the child. Related to this lack of information, some participants recalled how they, as a child, felt little consideration from their parents. Mary spoke with great emotion when she recounted how she regretted that she and her sisters never got an explanation for what was going on at home: "In all those years, neither when we were little, we have never been told [what was going on with our mother][1]. Never. We were not allowed to know." Mary felt like she did not matter to her parents as a result of not being allowed to know.

Like Mary, Jane felt it was unfair that she and her siblings were not acknowledged in their need for an explanation of what happened at home. Especially at moments that were fearful and distressing for Jane (e.g., a confrontation with other patients in the psychiatric hospital where her mother resided), an appropriate explanation would have been helpful: "I was frightened, really like (takes a deep breath) but yes. You don't, you don't get any explanation." When she talked about this memory, Jane seemed to live it in the moment, giving us a clue about the fairly low degree to which these past experiences have been processed, and storied in a narrative.

Each of the women participating in this study reported on the lack of support they had felt as a child. Amy, for instance, felt no support within her context. As a consequence she mostly kept her worries for herself: "I bottled up a lot of stuff, like they say." However, the participants mentioned that there were a few people they could turn to, some of whom still play an important role in their lives. Sofie, for instance, grew up with her maternal grandmother for the first 3 years of her life and she considered her as a lifelong lasting attachment figure. Her experience of missing her mother's emotional care was contrasted with the connection she felt with her grandmother: "She would also not hug me, but I knew she loved me." In addition, when she grew up, her class teacher became a great support for Sofie (see theme of context-related dwelling on own experiences). The significance of an adult they could rely on was further supported by Jane who considered good family support offered by a person the children felt connected to, as a highly protective factor.

Context-related dwelling on own experience

The feelings that were discussed in the previous theme, seemed to be realized on a limited basis. Taking a meta-perspective on their childhood experiences, participants recalled how they did not pay great attention to their own experiences with regard to the situation at home, nor did they share their feelings with others. Sofie recalled how she could remain standing by not recognizing these feelings herself or showing them to the outside world: "I've certainly found that my home was not like my girlfriend's home or like someone else's. But I have not given in to it. And I think that perhaps has saved my life." Even though Sofie seemed to have a notion of the difference between her family and other families, she preferred not to go into that too deeply. This "not dwelling," in her opinion, added to her ability to overcome the difficulties at home. It helped her to remain standing as she learned that acting in a crisis rather than dwelling on it could be successful in terms of family well-being (see Growing into caring role as a way to keep standing).

Similarly, Brenda recalled a painful memory involving missing parental support when she went to the official presentation of the diplomas at her school: "Well, at that moment you choke up, but it's like that." Related to the first theme, Brenda felt desolate at that time.

[1] In quotations, words inserted for clarity are represented in paired square brackets [ ].

However, the quick acquiescence of "it's like that" suggests that both then and at the moment of the interview, she preferred to not go into it too deeply.

Furthermore, the process of realizing what actually happened in the family and what it meant to the child seemed to depend on the person's context. When in another context, for instance in conversation with her class teacher, Sofie could focus on her own experiences to a certain extent, and realize that the situation at home was "not normal." Some understanding of her family situation started to emerge in the context of a relationship with her class teacher "who listened":

> "And then I thought 'what I encounter is not normal, because other children don't come across that, you know.' But from the moment I went back home with my bike and put the key in the door, I was like, 'yeah it's like that.' That was my world, you know."

It seemed that Sofie could not give in to this idea of her home situation being "not normal," as at the moment she arrived home she felt compelled to state that "this is my world," and to take up her role as a family caregiver. In conclusion, this theme shows the complex dialectic of knowing and not knowing, being aware and preferring not to be aware in order to keep standing. The issue of children focusing on active caring roles in the family is further elucidated in the next section.

Growing into caring role as a way to keep standing

Several participants reported on a range of caretaking activities in their family. The starting point was an urgent need in the family. Sofie described how she as a person changed through the challenging family situation: "you grow in it huh. And indeed I am uh, my character has changed a lot: I've started to be independent, right at the age of 12, just like that." Her mother's sequential suicidal attempts required her to be independent, rather than relying on her mother. At the same time she gradually adopted a caring role.

"Growing into a caring role" might refer to a learning process as well as to a process of accommodating to the situation at home. With regard to the former, Amy, for instance, developed more skills to act as a family caregiver over the years: "The moment you get a little older, you are able to do more in the family and in the household." In addition, the meaning of "one grows into it" was related to a sense of getting used to it. Furthermore, the caring role might refer to a general position in the family as well as to a specific role in relation to the parent who suffered from depression.

Taking care of the household, in some cases was seen as an obvious arrangement by the participant and her family members. Jane put forward that at that time she did not see any harm in taking on this responsibility. In retrospect however, the lack of acknowledgement for this caregiving was sometimes raised. As part of their initiative to temporarily "run the family," some participants felt responsible for their younger siblings and also took care of them. Amy, for instance, said,

> "Probably that has always been a part of me: being a serious girl and feeling responsible for my brother and sister. Because at a certain moment, my mother didn't get up anymore in the morning, then I set my alarm and woke my brother and sister and prepared breakfast. My father was already off for work at that time."

This feeling of responsibility was elicited in a family situation with both mother and father being "absent" in some way. Apart from running the family in general, taking responsibility for mother's well-being was part of the participants' daily childhood realities. For instance, Sofie recalled her mother's suicidal attempts as an appeal to save her:

> "And then I was so young and I panicked and wept and yelled at her and shook her. But I did go downstairs, I immediately went to the phone, called the family doctor, he said 'call 999.' I did all those things, all fairly quick and fairly strong, and I succeeded. I must say, I was really panicking but I have succeeded. Whatever I did, I always succeeded."

Sofie presented herself as showing a calm and purposeful sense of agency. She repeated the words "I succeeded" several times, reflecting her feeling of pride about what she realized and the way she kept standing.

Previous to this "dealing with the situation," an overwhelming fear and panic was mentioned. Other participants expressed similar fears that seemed to be at the base of their caretaking in the family. An alternative reaction to this fear included being careful in their expressions and behaviors in order not to distress their mothers or to avoid fights between the parents. When attempts to take away the fear by supporting the parent did not result in reassurance, the child was usually left with a feeling of confusion. In an attempt to help her mother, Amy recounted trying to cheer her up, for instance by buying her a gift:

> "So I bought a necklace with my pocket money. And (tearful) as a child you think: she will be glad. But when I handed her the gift, she started crying very hard. And as a child you don't understand. You give her a gift, she must be glad though?"

Amy talked about an incomprehensible experience of "failure" in trying to help her mother. She was not able to understand her mother's emotional reaction at all and felt angry about it. For Amy, the relationship with her mother was very confusing and burdensome. With respect to her tasks in the household, Amy felt much more comfortable, stating that she "grew into" her caring role.

Part Two: Towards an Integration of Childhood Experiences in Adult Realities

The second part of the results section consists of participants' reflections on the ways their meaning making had evolved over the years. It became clear how they had continuously tried to make more sense of the situation and had tried to find ways to come to terms with it. Some participants linked their parent's depression to their own sense of vulnerability today. A consciousness about their own vulnerabilities paired with a strong wish to be good parents who treated their children differently from the ways they were raised emerged from the interviews. Furthermore, their current relationships with their parents revolved around finding a balance between their own resources and strengths on the one hand, and their loyalty to their parents on the other hand.

Growing understanding of the situation at home

Over time as they moved into adulthood, these children who had a mother with depression have tried to get a grip on what was really going on at home. Little by little—often through conversations with their partners, friends, and therapists—they started to realize what

happened in the past and have given it some meaning. For instance, Mary reflected on a distancing movement that coincided with her awareness of the problems at home: “The older I got, the more I took a distance from home. I knew: something’s wrong here.” However, Mary also recounted how in spite of greater clarity and manageability, she never came to know the “true story” about what happened in the past. Thus, while understanding sets one more at ease, restlessness is maintained in case that “truth” is never completely found.

On her road to creating a sense of integration, Amy went through several depressive episodes herself. In a way, these episodes helped her to get a better understanding of what it is like to be depressed. This comprehension of her mother’s depression gave Amy the chance to give new meaning to her confusing experiences as a child: “I expected a reaction from my mother that she couldn’t give at that moment.” Here Amy was able to alternate between her own perspective (“I expected a reaction from my mother…”) and her mother’s point of view (“…that she couldn’t give at that moment”). Taking a meta-perspective on her past experiences enabled her to finally get a grip on them.

Coping with own vulnerability

As adults, the participants struggled with and tried to cope with their own vulnerabilities, including their vulnerability for depression. Amy conveyed how she believed that she formed an over-developed feeling of responsibility from her childhood experience. However, she cherishes this part of her personality as well and does not want to change this personality trait entirely:

> “I don’t want to lose these specific parts of myself. I think there are enough tough people in the world, so… But I have to, for myself I need to limit this, I have to learn not to adapt myself to everybody.”

Coping with vulnerabilities implies that they try to find a balance between acknowledging and accepting certain aspects of their personality and trying to modify these aspects in their current lives.

Furthermore, some participants expressed experiencing difficulty in sharing feelings or worries with others. One reason for this was the fear of being misunderstood or even not believed. In addition, some participants as children learned to cope with worries on their own, and they did this coping at least in part by not dwelling on their experiences. As an adult, Sofie still found it difficult to reflect on her experiences and to share them with others:

> “I always want to solve everything myself and every time I believe that it will be alright. That's what I do. I will not dwell on it and I think 'I'm going to act like that and like that and if I'm not going into it too much it will be fine.’”

Similarly, Amy found it hard to confide in people when it came to dealing with her own worries. She preferred to silence them instead. Amy related this to the fact that “I never learned to do that; I am very open and talkative--I cannot confide in people when it comes to my own problems. I’m not used to that.”

In contrast to Amy, Jane, who also experienced difficulty in asking others for help, discovered how to confide in others over the years. However, Jane reported on the effort it had taken her to reach that point.

Trying to make a difference in current family life

One of the domains in which people were willing to differentiate from their family of origin was their current family lives. In carrying out their parenting roles, the participants had an explicit wish to be different from their own mothers. First, there was a tendency to spare their own offspring from the harsh experiences they had gone through as children. Mary's narrative centered around the wish to avoid what she has been through: "I would never, ever let my children down. Not one of the four. This is what they [my parents] did to me."

Amy wants to be a "good mother" even though she sometimes feels vulnerable herself. Among other things she tries to silence her own worries not to burden her daughter. Experiencing depressive episodes herself, she wanted to explain this condition to her daughter in an appropriate way. For instance, she would try to temper the information, protecting her daughter against statements that she herself had to hear from her mother:

> "Well, I always try to…I never said those things to my daughter, things that I did hear when I was little. Things like 'it doesn't matter anymore, I want to make an end of it all.'"

Besides, Amy also paid attention to her daughter's experiences, asking her regularly how she felt about her mother's illness. Brenda said she was aiming for a corrective experience in the upbringing of her two teenage daughters: "I think that's because I missed that part. That I now try to be there for my children." It made her feel proud to find that her daughters appreciate her help and are doing well at school and in other domains of their lives.

Trying to find a balance in continued bond with parents

In the current relationship with their parents, the participants reported that they balance maintaining the bond with their parents and protecting and/or screening themselves. Amy, for instance, could clearly delineate how she at times felt like she had to protect herself when her mother had been "too negative" during a visit:

> "Because at times, when I don't feel very well myself, I'd rather not go there, because she can suck out all my energy in only half an hour's time. Then I leave the parental home and I feel the need to just drive the car for a while, listen to some cheerful music and talk to myself. Because that is, you're still related through a blood-tie after all."

By visiting her parents she tries to help her father who, in her opinion, suffered from her mother's depression the most. She then tried to bring in something positive. However, she also wanted to protect herself from being brought down by her mother. There is an ongoing process of constantly balancing her parent's and her own need for closeness with her strengths and resources.

When it came to her needs in the relation with her parents, Sofie stated that she still cannot call on her parents. Her daughter struggles with a serious learning disability and she said, "I cope with it well. But yet I cannot talk about it at home." At the parental home, her mother would only comment or change the subject rather than really listen to her.

Amy's own experiences with depression stimulated a new understanding for her mother as well as increased anger towards her. There seemed to be an inner conflict between anger towards her mother and understanding for her: "Why can't she fight her depression like I do?"

is alternated with "I know it's not fair to think that." Furthermore, she stressed the fact that her mother has good moments as well.

Jane was feeling some indignation about her mother's passivity and she tried to incite her mother to take some action such as taking the bus on her own or going to see another psychiatrist. According to Jane, her own personal growth has also been a benefit to her mother. In conclusion, although blame, anger, and disappointment constituted a substantial part of their experience in the current relationship with the parents, the participants reported on new, positive, and reciprocal bonds with their parents as well.

Discussion

The participants' accounts in this IPA study link and integrate both childhood and adulthood experiences. From a retrospective point of view the participants now report on feelings of desolation and experiences of growing into a caring role in their families of origin. As opposed to the initial coping process of "not dwelling on own experience," the participants in later life realized more about what happened in their childhood and also tried to come to terms with it. Coming to terms also seemed to promote an ongoing process of coping with their own vulnerabilities. In their current family lives they try to make a difference, primarily by giving their children what they have missed as a child. With regard to the ongoing relationship with their own parents, new positions are sought in order to find a balance between maintaining the bond with the parents while remaining standing themselves. In this discussion we reconsider the findings of the IPA study in light of the existing literature and clarify its meaning for the clinical field. Furthermore, we elaborate on how a retrospective point of view might have facilitated the reflection on certain experiences.

Retrospective Meaning Making of Childhood Experiences

This in-depth qualitative analysis presents a new perspective on the experiences of children growing up with a mother with depression. First, we consider the findings of Part One: Retrospective Understanding of Childhood Experiences. When it comes to feelings of desolation, resonance is found with previous research findings concerning unavailability of a parent (Meadus & Johnson, 2000) and negative emotions such as feelings of abandonment, loneliness, and insecurity (Dunn, 1993; Knutsson-Medin et al., 2007). Conversely, the importance of having a support figure is stressed. In dialogue with this support figure, the children sometimes focused more on their own experiences and were able to make more sense of the situation at home.

The second theme, context-related dwelling on own experience, sheds new light on the clinical observation that children often remain silent in burdensome family situations. The child's dwelling on her own experiences is limited, as well as the family communication about the child's experiences (Focht-Birkerts & Beardslee, 2000; Van Parys & Rober, 2013). In their experiential accounts, the participants in this study presented silence in the family as a perceived lack of consideration from their parents on the one hand and a way for them to deal with otherwise painful experiences on the other hand. Furthermore, the child's not dwelling fits in the overall goal of helping the family to survive, rather than being brought down by negative emotions. Focht-Birkerts and Beardslee (2000) proposed that by helping children to express their affect, the creation of a meaning system for individual resiliency is promoted and the risk for negative child outcomes can be diminished (Focht-Birkerts & Beardslee, 2000). Our analysis suggests that we should nuance this and also consider the reasons why children do not speak about their experiences.

With regard to the third theme, growing into caring role as a way to keep standing, it seems that our findings connect well with the parentification literature emphasizing that children in stressed family situations often take on a caring role towards the parents or towards the (younger) siblings (e.g., Champion et al., 2009; Chase, 1999). Our study highlights that for the participants, taking on caring roles in their family of origin was evident. Whether these children had the impression that they could contribute, and that they had some grip on the situation, seemed to be crucial in their sense of well-being. In accordance with Göpfert, Webster, and Seeman (2004), we have found some evidence for children taking care of their parent as a way of dealing with negative emotions such as fear and worry for the parent.

Part Two of the findings reflects the integration of childhood experiences in their current lives. In this respect the themes, context-related dwelling on own experience (Part One) and growing understanding of the situation at home (Part Two), can be contrasted. The participants seemed to have made a shift from paying little attention to their own experiences to a more conscious coping with past (and current) sadness and feelings of loss and disappointment. Some participants linked their history to their current personality and their own vulnerabilities (i.e., they tentatively related their childhood tendency to not dwell on their own experiences to an ongoing habit of not sharing difficulties with others). Furthermore, the participants recounted how carrying out a parenting role is based on a corrective family script (see Byng-Hall, 1995, 2002, 2008) as they wanted to protect their children from adverse family experiences they had as children. According to Dunn (1993) setting "realistic yet caring boundaries with the mentally ill parent" (p. 188) can be a goal in individual therapy with grown-up children of mentally ill parents. It seems that some of our participants were facing the same challenge in the current bond with their parents, even apart from therapy.

Retrospective Nature of the Study

The retrospective nature of our study might have facilitated the emerging of new meanings about "feelings of desolation" and "not dwelling on own experience." It seems that the retrospective distance opened space for the participants to dwell on some of their painful childhood experiences in a way that was not possible when they were still children living with their mother with depression. In that respect, our results might come across as predominantly negative. A similar "negative" discourse was found by Dunn (1993) who reported on adult reflections on their childhood growing up with a psychotic mother. We suppose that the participants have succeeded in processing and coping with these experiences to a certain extent, and that they in their current lives took some distance from these past experiences. Consequently, it might be easier for people to report on adverse childhood experiences at some point later in life, for instance in the context of a research interview. In other words, these children seem to have grown up into adults who felt able to reinterpret the past through a different lens.

Comparing our findings with the results of Mordoch and Hall (2008) who interviewed children about their perceptions of living with a parent with mental illness, it becomes clear that these aspects of our participants' experiences were not represented in their study. Mordoch and Hall (2008) described the process of finding a way to cope with the parent's illness as "finding a rhythm" including aspects of monitoring the parent, adjusting their own behavior to what they felt was needed in the family, and finding an appropriate distance between themselves and their parent. There was no reflection on feelings of desolation in this current perspective on experiences. In a previous study with minor children interviewed in a family conversation together with their parent who was hospitalized for depression, the children reported on feelings of distress (Van Parys & Rober, 2013). However, at an interactional level,

it seemed that these feelings of distress received only limited "dialogical" space (Van Parys & Rober, 2013).

Limitations and Suggestions for Future Research

Dangers of using retrospective methods formulated by Earley and Cushway (2002) include forgetting, defensiveness, and social desirability. Rather than considering these data as a "deformation" of reality, we perceive them as an additional perspective that adds to a better understanding of children growing up with a parent with depression. However, it should be noted that the social discourse, including the specific historical time period in which the mothers of these participants were hospitalized for depression, has not been taken into account in the analysis of the data. For instance, the way psychiatric hospitals were perceived and the taboo that was placed on mental illness in the family 30 to 40 years ago, might not be comparable to the current situations of families facing parental mental illness. In that respect, the transferability of these findings is somewhat limited (Kvale & Brinkman, 2009).

A specific feature of the study is that it sketches how, in adult life, an integration of childhood experiences takes place. Throughout their lives, the participants continually tried to understand their childhood experiences better, in light of new life experiences. A suggestion for future research would be to investigate how the participants' accounts in the context of an interview serve a narrative function of finding a more coherent story about the self. In addition to the current IPA study a narrative analysis of these data could serve this purpose (Crossley, 2007; Riessman, 2008).

Conclusion and Clinical Implications

In summary, the findings of the present study offered a new perspective on children's experiences of parental depression as well as on the ongoing evolution of coming to terms with childhood experiences. This retrospective investigation with adults talking about their childhood experiences gave access to aspects of their experience that remained underexplored in research based on data from children and adolescents. For instance, it was found that negative emotions including feelings of desolation were recognized in retrospect. Secondly, the participants were able to reflect on the process of "growing into a caring role" in retrospect. Thirdly, the participants helped us to understand how their tendency to not dwell on their experiences as a child might become apparent in family conversations in which the child presents oneself as "doing fine." As a result, the current study may inform clinical practice with families coping with parental depression and in particular help us to understand children's silences in family therapy. It is important for family therapists to understand the child's silence as a protective coping mechanism and to handle this coping strategy with care. By first accepting the child's silence, the therapist can then make some space for reflecting on the meaning of this silence through a subtle and careful dialogue with the family members. The child's silence can be addressed as a way of caring for the family members. Eventually, it could also be discussed how the child possibly *can* be burdened by his/her perceived caretaking responsibilities (related to his/her loneliness in this position). On a societal level, the research findings support the recent efforts to organize meetings for children of parents with a psychiatric illness. In these support groups children might find a protective context in which they are helped to make sense of the situation at home and in which they are able to dwell on their own experiences to a certain extent.

References

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

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

Arnett, J. J. (2006). The psychology of emerging adulthood: What is known, and what remains to be known. In J. J. Arnett & J. A. Tanner (Eds.), *Emerging adults in America: Coming of age in the 21st Century* (pp. 303-330). Washington, DC: American Psychological Association.

Byng-Hall, J. (1995). *Rewriting family scripts: Improvisation and systems change.* London, UK: Guilford Press.

Byng-Hall, J. (2002). Relieving parentified children's burdens in families with insecure attachment patterns. *Family Process, 41,* 375-388.

Byng-Hall, J. (2008). The significance of children fulfilling parental roles: Implications for family therapy. *The Association for Family Therapy and Systemic Practice, 30,* 147-162.

Champion, J. E., Jaser, S. S., Reeslund, K. L., Simmons, L., Potts, J. E., Shears, A. R., & Compas, B. E. (2009). Caretaking behaviors by adolescent children of mothers with and without a history of depression. *Journal of Family Psychology, 23,* 156-166.

Chase, N. (1999). Parentification: An overview of theory, research, and societal issues. In N. D. Chase (Ed.), *Burdened children, theory, research, and treatment of parentification* (pp. 3-33). London, UK: Sage.

Compas, B. E., Langrock, A. M., Keller, G., Merchant, M. J., & Copeland, M. A. (2002). Children coping with parental depression processes of adaptation to family stress. In S. H. Goodman & I. H. Gotlib (Eds.), *Children of depressed parents: Mechanisms of risk and implications for treatment* (pp. 227-252). Washington, DC: American Psychological Association.

Crossley, M. L. (2007). Narrative analysis. In E. Lyons & A. Coyle (Eds.), *Analysing qualitative data in psychology* (pp. 131-144). London, UK: Sage.

Cummings, E. M., Keller, P. S., & Davies, P. T. (2005). Towards a family process model of maternal and paternal depressive symptoms: Exploring multiple relations with child and family functioning. *Journal of Child Psychology and Psychiatry, 46,* 479-489.

Daly, K. J. (2007). *Qualitative methods for family studies and human development.* London, UK: Sage.

Dickstein, S., Seifer, R., Heyden, L. D., Schiller, M., Sameroff, A. J., Keitner, G., Miller, I., Rasmussen, S., Matzko, M., & Magee, K. D. (1998). Levels of family assessment: II. Impact of maternal psychopathology on family functioning. *Journal of Family Psychology, 12,* 23-40.

Dunn, B. (1993). Growing up with a psychotic mother: A retrospective study. *American Journal of Orthopsychiatry, 63,* 177-189.

Earley, L., & Cushway, D. (2002). The parentified child. *Clinical Child Psychology and Psychiatry, 7,* 163-178.

Focht-Birkerts, L., & Beardslee, W. R. (2000). A child's experience of parental depression: Encouraging relational resilience in families with affective illness. *Family Process, 39,* 417-434.

Forbes, E. E., Shaw, D. S., Fox, N. A., Cohn, J. F., Silk, J. S., & Kovacs, M. (2006). Maternal depression, child frontal asymmetry, and child affective behaviour as factors in child behaviour problems. *Journal of Child Psychology and Psychiatry, 47,* 79-87.

Foster, C. E.,Webster, M. D., Weissman, M. M., Pilowky, D. J., Wickramaratne, P. J., Rush, J., …, King, C. A. (2008). Course and severity of maternal depression: Associations with family functioning and child adjustment. *Journal of Youth and Adolescence, 37*,

Goodman, S. H., Rouse, M. H., Connell, A. M., Broth, M. R., Hall, C. M., & Heyward, D. (2010). Maternal depression and child psychopathology: A meta-analytic review. *Clinical Child and Family Psychology Review, 4,* 1-27.

Goodman, S. H., Tully, E., Connell, A. M., Hartman, C. L., & Huh, M. (2011). Measuring children's perceptions of their mother's depression: The children's perceptions of others' depression scale – Mother Version. *Journal of Family Psychology, 25,* 163-173. doi: 10.1037/a0023082

Göpfert, M., Webster, J., & Seeman, M. V. (2004). *Parental psychiatric disorder: Distressed parents and their families* (2nd ed.). Cambridge, UK: Cambridge University Press.

Hammen, C. (1997). Children of depressed parents. The stress context. In S. A. Wolchik & I. N. Sandler (Eds.), *Handbook of children's coping: Linking theory and interaction* (pp. 131-157). New York, NY: Plenum Press.

Harris, T. J. R., Pistrang, N., & Barker, C. (2006). Couples' experiences of the support process in depression: A phenomenological analysis. *Psychology and Psychotherapy: Theory, Research and Practice, 79,* 1-21.

Kaimal, G., & Beardslee, W. R. (2010). Emerging adulthood and the perception of parental depression. *Qualitative Health Research, 21,* 1213-1228.

Knutsson-Medin, L., Edlund, B., & Ramklint, M. (2007). Experiences in a group of grown-up children of mentally ill parents. *Journal of Psychiatric and Mental Health Nursing, 14,* 744-752.

Kvale, S., & Brinkmann, S. (2009). *Interviews, learning the craft of qualitative research interviewing* (2nd ed.). CA: Sage.

McAdams, D. P. (2006). The problem of narrative coherence. *Journal of Constructivist Psychology, 19,* 109-125.

McGoldrick, M., Carter, B., & Garcia-Preto, N. (Eds.). (2011). *The expanded family life cycle: Individual, family, and social perspectives* (4th ed.). Boston, MA: Allyn & Bacon.

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.

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,* 1127-1144.

Peisah, C., Brodaty, H., Luscombe, G., & Anstey, K. J. (2004). Children of a cohort of depressed patients 25 years later: Psychopathology and relationships. *Journal of Affective Disorders, 82,* 385-394.

Peris, T. A., Goecke-Morey, M. C., Cummings, E. M., & Emery, R. E. (2008). Marital conflict and support seeking by parents in adolescence: Empirical support for the parentification construct. *Journal of Family Psychology, 22,* 633-642.

Pölkki, P., Ervast, S.-A., & Huupponen, M. (2004). Coping and resilience of children of a mentally ill parent. *Social Work in Health Care, 39,* 151-163.

Riessman, C. K. (2008). *Narrative methods for the human sciences*. London, UK: Sage.

Rose, H. D., & Cohen, K. (2010). The experiences of young careers: A meta-synthesis of qualitative findings. *Journal of Youth Studies, 13,* 473-487.

Smith, J. A. (1999). Towards a relational self: Social engagement during pregnancy and psychological preparation for motherhood. *British Journal of Social Psychology, 38,* 409-426.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London, UK: Sage.

Solantaus-Simula, T., Punamäki, R.-L., & Beardslee, W. R. (2002a). Children's responses to low parental mood. I: Balancing between active empathy, over involvement, indifference, and avoidance. *Journal of American Academy of Child & Adolescent Psychiatry*, *41*, 278-286.

Solantaus-Simula, T., Punamäki, R.-L., & Beardslee, W. R. (2002b). Children's responses to low parental mood. II: Associations with family perceptions of parenting styles and child distress. *Journal of American Academy of Child & Adolescent Psychiatry*, *41*, 287-295.

Stallard, S., Norman, P., Huline-Dickens, S., Salter, E., & Cribb, J. (2004). The effects of parental mental illness on children: A descriptive study of the views of parents and children. *Clinical Child Psychology and Psychiatry*, *9*, 39-52.

Van Parys, H., & Rober, P. (2013). Trying to comfort the parent: A qualitative study of children dealing with parental depression, *Journal of Marital and Family Therapy*. 39, 330-345.

Whiffen, V. E., Kerr, M. A., Kallos-Lilly, V. (2005). Maternal depression, adult attachment, and children's emotional distress. *Family Process*, *44*, 93-103.

Author Note

Hanna Van Parys, PhD, is research assistant at the Department of Experimental-Clinical and Health Psychology, Ghent University and family therapist at the University Hospital Ghent, Belgium.

Jonathan A. Smith is professor of psychology at Birkbeck University of London. During the past 20 years he has developed Interpretative Phenomenological Analysis (IPA) as a particular experiential qualitative approach in psychology and its application to a range of areas in health, social and clinical psychology.

Peter Rober, PhD, is family therapist in Context (UPC KU Leuven) and full professor at the Institute for Family and Sexuality Studies, University of Leuven, Belgium. His research interests include family therapy processes, the therapist's inner conversation, and selective disclosure in families in the context of parental mental illness, adoption and third party reproduction.

Correspondence can be made to Hanna Van Parys, Department of Experimental-Clinical and Health Psychology Ghent University, Henri Dunantlaan 2, B-9000 Ghent, Belgium. E-mail: hanna.vanparys@ugent.be

Article Citation

Van Parys, H., Smith, J. A., & Rober, P. (2014). Growing up with a mother with depression: An interpretative phenomenological analysis. *The Qualitative Report*, *19*(29), 1-18. Retrieved from http://www.nova.edu/ssss/QR/QR19/van_parys29.pdf