Experiences of adults who as children lived with a parent experiencing mental illness in a small-scale society: A Qualitative study

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Abstract
Introduction: An estimated 23% of children worldwide live with a parent experiencing mental illness. These children are exposed to emotional and psychosocial challenges. Little is known about these children when living in small-scale societies.

Aim: To explore how adults, who as children lived with parents experiencing mental illness in a small-scale society, recalled their childhood life.

Method: Individual interviews with 11 adults were analysed using content analysis.
INTRODUCTION

An estimated 23% of children worldwide live in households where one parent is experiencing mental illness (Maybery & Reupert, 2009). Evidence tells us that these children often are carrying a burden in the family and often attend to parental more than to own well-being (Aldridge & Becker, 2003; Bee, Berzins, Calam, Pryjmachuk, & Abel, 2013; Grove, Reupert, & Maybery, 2015). Little is however reported about these experiences when growing up in a small-scale society. This study concerns experiences of Faroese adults who as children were living with a parent experiencing mental illness.

BACKGROUND

Research elicits both negative and positive effects of living in childhood with a parent experiencing mental illness, documenting the children to be threatened by behaviour, emotional and psychosocial problems (Bee et al., 2013; Goodman et al., 2011; Maybery & Reupert, 2009; Somers, 2007). In contrast, research has documented that some children are resilient (Aldridge & Becker, 2003; Beardslee & Podorefsky, 1988; Foster, O’Brien, & Korhonen, 2012; Gladstone, Boydell, & McKeever, 2006) with strengths and resources to manage family ups and downs (Drost, van der Krieke, Sytema, & Schippers, 2016; Dunn, 1993; Petrowski & Stein, 2016).

Childhood living conditions likewise have impact on these children. In a qualitative interview study with a group of these children, Skerfving (2015) interpreted research data in four childhood scenarios: the well-organized childhood with only emotional burden for the child; the complicated childhood when the child is either too involved or too lonely because of internal family conflicts; the problematic childhood when parental mental illness is not the only problem, drinking, sibling problems and economic problems add to the burden; and finally, the exposed childhood where parents are unable to care for the child. Lack of talking about the parents’ mental illness is also well documented. Both family and children may want to keep the mental illness a secret (Dam & Hall, 2016; Grove et al., 2015). However, the secrecy might further feelings of stigma, shame, self-blaming and problems with self-identity (Dam & Hall, 2016; Murphy, Peters, Wilkes, & Jackson, 2016; Tanner, 2000). The above-mentioned research as well as other studies (Bee et al., 2013; Foster, 2010; Grove et al., 2015) document that life for children living with a parent experiencing mental illness is well investigated in larger societies. The matter though is not explored in small-scale societies. The only research found documented that mothers experiencing mental illness and living in a small faraway village were uncertain as parents; they felt condemned by the village inhabitants and forgotten by the healthcare professionals (Cremers, Cogan, & Twamley, 2014).

Results: Living as a child with a parent experiencing mental illness in a small-scale society was described as “living in a paradox” which emerged from three categories: “intergenerational help and caring,” “barriers understanding parental illness” and “everybody knows everybody”. The children received little or no support from family members, nor from health and education professionals.

Discussion: In a small-scale society, stigma surrounding mental illness is notable. Families often attempt to conceal mental illness from outsiders with negative or adverse effects on children.

Implications for practice: Mental healthcare professionals need to consider the needs of children who have parents experiencing mental illness. It is imperative for the well-being of the patients’ children to support them in understanding what is happening, turn gossiping in a positive direction and address stigma in the communities.

KEYWORDS

caring, children, gossiping, parental mental illness, small-scale society, stigma
3 | METHOD

3.1 | Setting

The setting is Faroe Islands, a country consisting of 18 islands and situated in the North Atlantic, 602 km west of Norway and 310 km north of Scotland. Faroe Islands is politically connected to Denmark, and its capital is Torshavn. The Faroese people (<50,000) live in communities spread over 16 of the 18 islands, and they all speak Faroese as well as Danish. Life in small-scale societies is characterized by close and often helpful relationships. The close-knit conditions, however, contribute to lack of anonymity. Life and attitudes are well known and monitored by the society. Therefore, people who behave differently are easily subject to gossip and prejudice (Joensen & Hall, 2015).

3.2 | Design

The research was designed as a qualitative semistructured interview study (Kvale & Brinkmann, 2009). It took place in a nursing care paradigm assuming that when one in the family is experiencing mental illness, not only the individual but also family, friends and significant others are involved (Barker, 2001). In this paradigm, caring is described to be primary (Benner & Wrubel, 1989; Eriksson, 2006) and a craft in mental healthcare nursing (Barker, 2000, 2008). The role of mental healthcare professionals then is to help patients experiencing mental illness and their families towards recovery thus feeling well, safe and secure.

3.3 | Participants

Participants were recruited through emails and contacts within the mental healthcare system, voluntary sectors and mass media using convenience and snowball sampling (Polit & Beck, 2010). Inclusion criteria were adult children ≥18 years who were brought up in Faroe Islands and as children lived with at least one parent experiencing severe mental illness. Of the 14 participants contacted, three dropped out without reason. Eleven participants, eight women and three men, aged 18 till 49 years, were recruited. The average age was 34 years, and the group included two pairs of siblings who were interviewed separately. Five participants had a parent diagnosed with bipolar disorder, and six had a parent with a diagnosis of schizophrenia. Of the total eleven participants, 10 had a mother and one a father experiencing mental illness. The participants were living in towns and villages located on large and small islands in the Faroe Islands.

3.4 | Data collection

Individual interviews with the participants were performed once by the first author, an experienced nurse educator and doctoral student with experience of interviewing; it took place from July to August 2016 in the participant's or the interviewer's home depending on the participant's wish. An interview guide based on themes from a previous review guided the interviews. A videorecorded pilot test of the interviewer's efficacy of the interview process (Uhrenfeldt, Paterson, & Hall, 2007) resulted in remarks about pauses and hesitation, body gestures and the tone of voice. The interviews with the participants were audiorecorded and lasted from 25 to 90 min with an average length of 60 min. Repeat interviews and field notes were not carried out. The first question asked to the participants was "please tell me about your childhood". The participants then were asked questions about family, support and experiences from their daily life. All through the interviews, the interviewer tried to be sensitive, listening, show awareness and consider the remarks from the pilot study. At the end of the interviews, the participants were offered, but declined to get, the transcripts to be returned for comments.

3.5 | Data analysis

The interviews were transcribed verbatim to Faroese by the two Faroese authors. The transcripts were read several times to obtain a sense of the whole. As one of the authors did not understand Faroese, seven of the interviews were translated to Danish and analysed by the authors who were all females. Data and findings from the other four interviews were analysed by the Faroese authors and discussed among all authors. The text was interpreted following Graneheim and Lundman's (2004) suggestion for manifest and latent content analysis. Together, the authors

TABLE 1  Example of content analysis from meaning units to category

<table>
<thead>
<tr>
<th>Meaning units</th>
<th>Codes</th>
<th>Subcategories</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>My grandmother and aunt stepped in every time, all these years...I do not know where. I had been today if they had not been there,</td>
<td>Surrogate parents</td>
<td>Child and family support and care</td>
<td>Intergenerational relationships</td>
</tr>
<tr>
<td>Because my mother did not manage to be &quot;mum&quot; for several long periods of time (P4)</td>
<td>Practical care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I used to sit for hours listening to her.</td>
<td>Adult responsibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Everything she said was so depressing, everything was black talk, it was awful and hard to hear, but I couldn't leave here, I had to stay. (P2)</td>
<td>The children loved their parents and wanted to help and to protect them</td>
<td>Seeing and listening to parental emotional expression</td>
<td></td>
</tr>
<tr>
<td>Loyalty to their parents</td>
<td>The children felt responsible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of adult responsibility</td>
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divided the text to a large number of codes, described them in a coding tree and grouped them to subcategories and categories. This procedure was representing a manifest content analysis. Finally, categories and subcategories were linked in an overarching theme which was understood as the latent content analysis. An example of the analysis procedure is seen in Table 1. The data analysis did not have a linear fashion; it was a going back and forth between different abstraction levels all the time discussing, interpreting and finally reaching consensus among the researchers.

3.6 | Ethical considerations

The study was performed according to Ethical Guidelines for Nursing Research in the Nordic countries (Northern Nurses Federation 2003) and got ethical approval from the Faroese human ethics committee. Participants were given written and verbal information about the aim of the study, anonymity and the right to withdraw from the study. The authors were aware of special ethical problems about keeping confidentiality in doing qualitative research in a small community (Damianakis & Woodford, 2012), and all through the research process, anonymity was ensured. Furthermore, participants were informed that they could withdraw without causing them negative consequences. In case, the participants were emotionally affected by talking about their experiences, and they were offered follow-up interview as support. None of the participants made use of this offer.

3.7 | Reflexivity and rigour

All through the research process, we discussed and reflected on the meaning of our preconceptions for study trustworthiness. Following Kvale and Brinkmann (2009) notion that findings of a qualitative study are the responsibility of the researchers, we chose not to return the interpreted findings to the participants for commenting. We also reflected on the ethical challenge interviewing in a small-scale society (Damianakis & Woodford, 2012). However, none of the participants had any relationship to the interviewer prior to the study.

In qualitative studies, validity and credibility concern openness, coherence and accuracy in reasoning of analysis and findings (Elo et al., 2014; Graneheim & Lundman, 2004). We strived for transparency through ensuring consistency between research questions, method, findings and conclusion. We analysed the data individually and together, trying accurately to capture the essence of the study. Also, we illustrated the procedure in tables, and we described the research procedure in detail, in order for the readers to clearly follow analysis, findings and research conclusions. In reporting the study, we mutually discussed logic and structure of the findings and the whole content.

4 | FINDINGS

The overarching theme was identified as living in a paradox. The word paradox is originally Greek and refers to something that is unreasonable and evidently contradictory but anyway connected. The theme grew out of the data analysis showing the adult children’s recollections. The childhood of these Faroese children was filled with contradictions. On one side, a close and loving extended family life, on the other side, lack of awareness or insight into what was happening, lack of family openness and burdensome caring and coping. Not only did the children have to cope with complex family matters, they also had to accept cultural prejudices. Lack of anonymity in the small-scale society exposed the mentally ill parents to pettiness and prejudice.

The overarching theme living in a paradox is further refined in three categories, “intergenerational help and caring,” “barriers understanding parental illness” and “everybody knows everybody” (Table 2).

4.1 | Intergenerational relationships

The category intergenerational relationships refers to the adult children’s recollections of family support and care and to own feelings and actions related to the parent’s illness.

4.1.1 | Child and family support and care

The participants recalled that during childhood they received support and care from the other parent and from grandparents, aunts

<table>
<thead>
<tr>
<th>Categories</th>
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<tr>
<td>Overarching theme: Living as child with a parent experiencing mental illness in the small-scale society, is living in a paradox</td>
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<tr>
<td>Intergenerational relationships</td>
<td>• Child and family support and care</td>
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<td>• Seeing and listening to parental emotional expression</td>
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<td>• Participants feelings’</td>
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<td>• A balancing act</td>
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<td>Barriers understanding parental illness</td>
<td>• Parental absence and hospitalization as barriers</td>
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<td>• Staff as barrier</td>
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<td>• Taboo as barrier</td>
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<td>Everybody knows everybody</td>
<td>• Close relationships</td>
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<td>• Feeling different and less worthy</td>
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<td>• Lack of close relations</td>
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| TABLE 2 | Overarching theme, categories and subcategories |
and uncles. The family members took care of chores such as cooking, washing and cleaning. Some took care of the children, acting as surrogate parents. The participants stated that this was an indispensable support.

My grandmother and aunt stepped in every time, all these years ... I do not know where I had been today if they had not been there, because my mother did not manage to be "mum" for several long periods of time. 

(P4)

Some children though had no relatives or family who could take care of the chores. These children were acting as surrogate parents. They took care of chores in the home, went shopping and helped with practical matters. Those who had younger siblings had to take care of them too.

Me and my little sister walked around alone in town...nobody helped us ... I took care of my sister and made sure she was not hungry. 

(P6)

4.1.2 | Seeing and listening to parental emotional expressions

The children loved their parents, were loyal to them and wanted to protect and help them; they knew that they were sick and vulnerable, and they felt obliged to be with them, listen to them and help them when needed.

I used to sit for hours listening to her. Everything she said was so depressing, everything was black talk, it was awful and hard to hear, but I couldn't leave her, I had to stay. 

(P2)

They remembered helping their parents to get up in the morning, ensuring that they took their pills. They were feeling sorry for their sick and tired parent, and they also recalled how young and alone they were.

I used to take off her quilt in the morning to get her up and take care of me. She had to take her medicine, but she didn't. Sometimes she made my lunch box. She had no energy to take care of me. 

(P7)

It was really hard to see my mother being so ill. It was really hard for her, it was not her fault that she was sick. Nobody talked to me about it, and nobody understood her. 

(P2)

She was lying in the bed crying and sad. I was alone at home, when she attempted suicide. Nobody took care of me, and I was only six years old, I was totally lonely... 

(P3)

4.1.3 | Participants' feelings

Caring for the parent experiencing mental illness was a heavy burden. Often the children felt sorry for their parents whom they really loved. Also, it was hard to be left with their own thoughts and feelings. Nobody talked to them about the real matter, and this could often make them feel sad and lonely.

I was often very sad because it was so difficult, I thought a lot about it, you know, because he (father) told me, that he was seeing weird things. 

(P1)

The children had to put aside their own life, especially when the parents had bad days. Then, it happened that they stayed home from school to take care of the family. Also, already in early life, they were fearful of the effect of the mental illness on their parent and on family life.

I had to call for the ambulance, because I was afraid of what could happen if she couldn't breathe, I didn't know what to do, I was only seven at that time. 

(P3)

4.1.4 | A balancing act

Generally, the young children were attentive and vigilant to the parents' symptoms when alone to help and control. However, as one participant stated: "It was a balancing act ... I had to adapt, adapt, adapt ..." (P3) Sometimes they lost their patience, they could rebel, be disobedient and yell.

I said many bad things to my mother, I did not obey her and yelled at her if I could not get my will. 

(P9)

4.2 | Barriers to understanding parental illness

The category barriers to understanding parental illness refer to data that concerned the consequences of the parent's absence and hospitalization, the children's relationships to hospital staff and family and societal taboos.

4.2.1 | Parental absence and hospitalization as barriers

The participants reminisced that as children they were unaware of their parents' illness. The ignorance was a barrier to understanding, much because the parent for months was absent, and also because their visits at the hospital were rare. The ignorance, not knowing, not understanding and not being close, resulted in many deep feelings such as grief, bereavement, loss, sadness, anxiety and uncertainty. The participants recalled having difficult relationships with
the parents when visiting them. The consequences were unrealistic ideas about their parents’ illness. It could be hard to imagine that the parent would ever get well and come home.

She didn’t recognize me, she was kind of absent. ... she looked like my mother, but she did not act like my mother ... I was afraid that she would never get well again. (P8)

My mother was in the hospital for a very long time, often up to several months. I thought that she was critically ill and would never get home again ... she stared in an absent way. Still, it was awesome to get at hug and a kiss from her. (P6)

4.2.2 | Staff as a barrier

The participants talked about needing explanations for dealing with issues such as challenging behaviours of the ill parent or why the parent had attempted suicide; they really missed someone who listened to the difficulties and chaos they were facing. Many recalled being well greeted but otherwise ignored when visiting their parents thus feeling afraid and insecure.

The staff did other things, and they were not staying by us. They showed us her room, but they did not see and talk to me as the child to a sick mother. (P8)

I was not allowed to be in the corridor, I had to dwell in my mother’s room...The walls were made of concrete and the room seemed so cold. (P4)

My mother was admitted to hospital after she attempted suicide, but nobody talked to me about it. (P3)

To visit mum in the hospital was like coming to an office. It was as a nonexistent relationship, you know. Hello, Goodbye, You must go in that direction. (P4)

4.2.3 | Taboo as a barrier

Taboo as barrier refers to memories that many of the adult children recalled, such as lack of openness in the family, at school and in the society at large regarding their parent’s mental illness. It was as if mental illness was not allowed to be talked about, it was a taboo, or as an “infected tumour never to heal” (P9). The mental illness was to be kept a private business; it was a concealed secret, and this affected the children socially. Some were hiding the parental mental illness because of self-defence, shame and embarrassment.

It was not an issue to invite friends home ... I think it was because of self-protection. I did not want to show others how ill she was. (P2)

Some participants recalled telling special classmates about their parent’s illness. These friends listened, they were sympathetic and understanding, which was a huge relief for them.

I remember how relieved I was after telling my friends about the situation at home. I got peace in mind. (P5)

In spite of these disclosures, the adult children experienced discrimination and taboo at school about their parents’ mental illness. This was a burden because they badly needed to talk about their life.

The teachers did not talk to me, not at all. It would have been much easier if they talked to me instead of hiding it. (P1)

4.3 | Everybody knows everybody

The category everybody knows everybody refers to our reading of the data collated that it was almost impossible to live an anonymous life. The lack of anonymity meant that the children knew the parents of their friends, and the pals and their parents knew about the mentally ill parent. The children experienced close relationships with some, but they also recalled that people ignored them or talked in a derogatory manner about their parent. This made them feel different, sad and lonely.

4.3.1 | Close relationships

The adult children recalled that some people understood their particular family situation. This led to trusting and close relationships with friends. Such friends acted as buffers that made life easier. The children felt less shy, experienced being equal, recognized and accepted in spite knowing that people talked about their family.

I had very good friends and I was not shy with them because of my situation. Their home was not perfect, I thought that we were on an equal foot. They were a great support. (P11)

4.3.2 | Feeling different and less worthy

Already early in life, some participants were reminded of the difference between their parents who were experiencing mental illness and the parents of others who did not have a mental health diagnosis; they recalled feeling exposed, being constantly reminded of their parental difference and feeling less worthy than their pals. Such perceptions became visible, for example when comparing their homes with the others’ home. One participant stated:

My bedroom was not like the others. Some had a football star or a singer on their wall. I had nothing, my room was ugly. (P6)
4.3.3  |  Lack of close relationships

Feelings of lacking close relationships were reinforced by being ignored, bullied and laughed at. "I was bullied, the others laughed at me" (P6). Kept in the adult children's mind was that others ignored them and distanced themselves from them. Such matters led to feelings of sadness, loneliness and a wish to get away from everything. The quotes below tell about these recollections.

*My mother went around the city and behaved embarrassing. Others teased me and said "I saw your mother with a whip... it has always been terrible.*  
*(P9)*

*One girl told me that her mother had heard in the knitting club that my mother was crazy. I was so very sorry to hear that.*  
*(P11)*

*When I met someone, they ignored me; they went over to the other side of the road.*  
*(P8)*

*I was totally alone. I felt that they treated me like a leper. I did not want to stay in the village any longer.*  
*(P8)*

5  |  DISCUSSION

Eleven Faroese adult children of parents experiencing a severe mental illness were identified. The findings of the study suggest that these children are living a paradoxical life balancing between close family caring and supporting, concealing the illness because of gossiping and being bullied and societal prejudice against people experiencing mental health illnesses. It appeared that in the small-scale society, prejudice was having a profound effect on children; they perceived being exposed and desolated because of lack of anonymity. People were talking, and children were afraid that people would talk badly about them and their parents; they knew that people were talking or "gossiping" about them.

Generally, gossiping has a negative sound, emphasized by the definition: gossip is to exchange evaluative information about absent third parties (Foster, 2004). In scientific literature, especially in the field of social psychology, however, gossiping has several motives; it is both a positive and a negative phenomenon, in societies as well as among people of all ages and status. The beneficial part of gossiping is that it contributes to group norms, restricting people in a group to be self-serving (Beersma & Van Kleef, 2011). In that sense, gossiping serves as a functional social activity, it is a common conversational behaviour that is contributing to alignments, cultural learning, group acceptance and status enhancement (Dunbar, 2004; McAndrew, Warne, Fallon, & Moran, 2012; Parker & O’Reilly, 2012). Gossiping allows people to protect their group norms and have fun together (Beersma & Van Kleef, 2012). In a small-scale society, it is easy to suggest that gossiping is a frequent phenomenon with good intentions. Gossiping is part of the culture. Seen in this perspective, we argue that parents experiencing a mental health illness do not fit into the socially accepted group norms, they demonstrate "norm-violating behaviour" (Beersma & Van Kleef, 2012: 2656). Gossiping about families with a member experiencing mental illness, for example as mentioned above in the knitting club (a phenomenon most popular among Faroese women) might be group protecting and not caused by malice. However, gossiping as a cultural phenomenon might as well have negative intentions. This might be one reason for our study finding that the children were distancing from friends and concealing family matters. They experienced the gossiping as malicious and hurtful. Understanding the double meaning of gossiping might be of value or even change attitudes among mental healthcare professionals in a small-scale society when considering family health and well-being.

Another prominent finding was that caring, seeing and listening to parental emotional expressions were everyday matters for most of these children. As documented previously (e.g., McAndrew et al., 2012), our findings show that the children as well as their close relatives, such as the other parent, grandparents, aunts and uncles, were indispensable carers when a parent was experiencing mental illness. Old and young family members stood up and helped. From a caring theory perspective (Benner & Wrubel, 1989), the family helped because they were concerned, the family and the well-being of the family mattered to them. Benner and Wrubel (1989:119) state that, when people are concerned and things matter, it is because "we are involved in a world whose meanings for us are shaped by our concern". In this study, this "world" was a small-scale society filled with kind people who cared for each other but who also had prejudice over mental illness.

In small village life, communities may be close and with limited privacy; it is therefore understandable that a family with a member experiencing mental illness wants to conceal the illness. The family tries to protect the ill member because they love them. As mental illness is often unpredictable (Dam & Hall, 2016; Keen & Lakeman, 2008), and as shown in this study, not talked about, but concealed, the children of these families experience adverse outcomes.

The findings from the study relating to concealing, suffering, feeling lonely and taking care of chores in the family do not differ much from what is documented in previous studies about these children living in larger societies (e.g., Murphy et al. 2016; Somers, 2007). Likewise, previous studies document that children of parents experiencing a mental health illness might be responsible, resilient and caring. Foster (2010) for example found that adult children thought they matured fast. They balanced their everyday to perceive control and prevent awful things from happening (see Drost et al., 2016; Petersowski & Stein, 2016).

Our study was undertaken in a caring context, and in a caring theory perspective (Eriksson, 1997, 2006), to be suffering, as some of these children were, is to be in a state of being that might be unendurable. The unendurable suffering "can make deep wounds in a human being. The suffering person ... needs care that makes the suffering endurable." (Eriksson, 1997:73) Not only close friends and family members but also mental healthcare providers are able to help the suffering individual (as in this study the child of a parent experiencing mental illness) to develop resilience and better coping mechanisms.
The “craft of caring” (Barker, 2008) thus is to help the children understand the meaning of suffering and care and to give them courage to perceive and talk about the paradoxes of sadness, loneliness, love and care that makes “the deep wound” in the child. Caring also offers them support to prevent their caring responsibilities from becoming over burdensome. Our study shows that the staff failed in doing so. We interpreted this as a barrier towards an understanding of what happened. Psychiatric staff members were nice and polite, but, seen from the children’s perspective, they did not identify the needs of the children of patients hospitalized because of a mental illness.

According to Barker’s Tidal model of mental health recovery (Brookes, 2006), mental health nursing is a three-dimensional (consisting of self, others and the world) person-to-person encounter with a social mandate to care for the sick and to promote health and alleviate family suffering. Thus, we argue that mental healthcare nurses have to be open, attentive and listening not only to the mentally ill family member but also to the dynamics in the family with special attentiveness to young children.

6 | LIMITATIONS

To our knowledge, this is the first study, which exclusively is centring on adult children’s perspective of living in a small-scale society with a parent experiencing mental illness. Thus, the study adds new aspects (e.g., the meaning of gossiping) of this well-documented phenomenon from larger societies.

A limitation to consider is the retrospection of the study. The average age of the participants was 34 years. Reminiscing childhood experiences might be coloured by time passed and life experiences to follow after childhood. Some matters might be forgotten, others intensified, and other participants might have given different accounts of their childhood experiences. Additional limitations were that we interviewed the participants only once and that the fathers were poorly represented. Repeated interviews might have given deeper insight of childhood life, and findings might have been different if the participants’ mothers and fathers were more evenly represented.

In spite of these limitations, we consider the study a contribution to the child perspective of what constitutes living with a parent experiencing mental illness in a small-scale society.

7 | IMPLICATIONS

The needs of children and families should be considered when considering and planning nursing care interventions. We recommend that mental healthcare nurses spend extra time with children of patients who are experiencing a mental illness, knowing that this means a burden for the children. The children need to be recognized and met through appropriate and effective health and social care interventions (also see Foster et al., 2016); they need to be seen, heard and listened to: they are feeling desolated because they love their parent, the well-being of the parent matters for them and they do not always understand what caused the illness. It is a matter of being a “valued other” with whom the children dare share their deepest fears and secrets, thus getting alongside the child, encouraging and trying to demystify their suffering and what caused it (Keen & Lakeman, 2008). Including the children in the care, the mental healthcare nurse might limber up the prejudice of mental health and turn the societal talking and gossiping that we found prominent in the small-scale society, in a positive direction.

8 | CONCLUSION

In a small-scale society, childhood with a parent experiencing mental illness is not always easy because everybody knows everybody. Even though family members and close friends act as valuable supports, these children suffer under lack of anonymity, gossiping and social prejudice against people with a mental health issue. There is a need to raise awareness of mental health issues and children’s caring responsibilities in policy and practice. Mental health care would benefit if policymakers, managers and educators in such societies acknowledge the need for reflection about the meaning of prejudice and gossiping for health and well-being of patients and their children. Further research is likewise needed about childhood effect of adult life of these children when living in the small-scale society.

9 | RELEVANCE STATEMENT

Childhood with a parent experiencing severe mental illness in a small-scale society is a paradox. On one side everybody knows everybody, on the other side ignorance of what is happening, lack of openness and burdensome caring and coping. There is family support, though at the same time gossiping, concealing, taboos and prejudice regarding mental illness.

Children of parents experiencing mental illness need to be supported by mental healthcare professionals, and the professionals should pay attention to the importance of gossiping and turn it in a positive direction for the benefit of the children and their families.

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