

LIVING IN A SHADOW: PSYCHOSOCIAL WELL-BEING OF EMERGING ADULTS  
WHO GREW UP WITH A DEPRESSED PARENT

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## **ABSTRACT**

**BRANDY M. MECHLING: Living in a Shadow: Psychosocial Well-being of Emerging Adults Who Grew up with a Depressed Parent**  
(Under the direction of Dr. Linda S. Beeber)

The purpose of this investigation was to utilize theoretical, methodological, and empirical approaches to address the lack of understanding of ambiguous loss and boundary ambiguity in emerging adults who grew up with depressed parents. Three papers framed by an exploration of the problem and conclusions examined the adequacy of two theories in explaining the phenomena associated with growing up with a parent with depression, the strengths and limitations of retrospective self-report as a method of data collection, and the results of an empirical study examining factors that might influence the psychosocial well-being of young or emerging adults who grew up with a depressed parent. Implications for nursing research and practice are also presented.

## **DEDICATION**

For Michael.

You were right here with me the whole way as you always will be a part of me.

We did it, my friend.

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As I reflect on the past five and a half years of my PhD studies, and all that it took to get to this point in my life, I have so many people to thank. First and foremost, I need to thank the Lord. I am so humbled and thankful for what the Lord has done with my life. True to his word, he gave me “double for my trouble” and created “beauty from ashes.” Thank you Lord Jesus, my father and savior for each blessing you have granted me. Also at the top of my list, I must express my love and thankfulness to my birth mother, Sharon Marie Pastorious. She gave me life and I was blessed to have her unconditional love and nurturance for the first eight years of my life and for that I am grateful. Even in that short time, she impressed upon me the value of spirituality, learning, and hard work. She taught me how to value my family and to always do what you can for others. To my adoptive parents, you are “Mom” and “Dad” to me. Although you did not raise me from birth or even from childhood, I have always been a “McCabe.” Both of you have been there for me; giving me love, support, and encouraging me to be all that I could be. Mom, I thank God every day for our relationship. He knew that I needed a strong, intelligent, professional woman who valued education to mentor and guide me. Mom and Dad, the two of you are just so special to me – it is difficult to put all of what I feel for you into words. For my in-laws, your prayers and support over the years have been so appreciated. I value our close relationship and thank God often for giving me such a wonderful family to marry into.

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## **CHAPTER 1**

### **INTRODUCTION**

Of all mental illness, depression has the highest prevalence. In any given year, 18.8 million American adults suffer from depression (National Institute of Mental Health [NIMH], 2009). An estimated 7.5 million people who are depressed are parents and more than 15 million children under the age of 18 are affected (National Research Council & Institute of Medicine, 2009). The World Health Organization (WHO, 2010) reports that the prevalence of depression, substance abuse, and suicidality in young adults is also increasing. They project that by 2020, depression will be a leading cause of disability in women and children worldwide (WHO, 2008).

Symptoms of depression can include a sad affect, changes in eating habits (either eating too much or not enough), altered sleep patterns (usually hypersomnia), lack of energy, loss of interest in activities that were once pleasurable, social isolation, and suicidal thoughts and at times, attempts (American Psychiatric Association, 2000). These symptoms can last for several weeks or in more severe cases, several years, and can be recurrent or occur as a single episode. Having a parent who is depressed can be very confusing and at times, an emotionally painful experience for the child, especially when the parent's mood state, affect, thought processes, and behavior fluctuate. Depression can alter the parent's relationships with their entire family, especially their children. Studies show that the parent often becomes withdrawn, disengaged, inconsistent, and overly critical of their children, yielding

communication difficulties and increased conflict in the relationship (Ahlstrom, Skarsatar, & Danielson, 2011; Campbell, Morgan-Lopez, Cox, & McLoyd, 2009; Hammen, Brennan, & Shih, 2004; Trondsen, 2011). These disruptions can lead to feelings of rejection, anger, and despair for children with lasting effects through adulthood, ultimately impairing psychosocial well-being (National Research Council & Institute of Medicine, 2009).

Children often struggle to understand their parent's mental illness and associated behaviors (Knutsson-Medin, Edlund, & Ramklint, 2007; Polkki et al., 2004; Trondsen, 2011; Riebschleger, 2004) and at times the parent that they once knew may not seem the same to them (Baik & Bowers, 2006; Beardslee & Podorefsky, 1988; Kaimal & Beardslee, 2010). The child who experiences this from day to day can suffer great adversity, including poorer quality parent-child relationships (Campbell et al., 2009; Hammen et al., 2004; D. R. Nelson, Hammen, Brennan, & Ullman, 2003), greater likelihood of having parents divorce or living in a one parent family (Fraser & Pakenham, 2009; Hammen et al., 2004; Mowbray, Bybee, Oyserman, MacFarlane, & Bowersox, 2006; Mowbray & Mowbray, 2006), and greater risk for experiencing abuse and neglect (Lu, Mueser, Rosenberg, & Jankowski, 2008; Mowbray & Mowbray, 2006).

Children of depressed parents tend to have higher rates of internalizing and externalizing symptoms (Hammen & Brennan, 2003; D. R. Nelson et al., 2003) and increased risk for mental illness such as: depression (Mowbray et al., 2006; Peisah, Brodaty, Luscombe, & Anstey, 2005; O'Connell, 2008; Ross & Wynne, 2010; Sarigiani, Heath, & Camarena, 2003; Timko et al., 2009; Weissman, Wickramaratne, Nomura, et al., 2006) anxiety (Ross & Wynne, 2010; Timko et al., 2009; Weissman et al., 2006), substance abuse disorders (Mowbray & Mowbray, 2006; Timko et al., 2009), as well as difficulties

establishing and maintaining personal relationships, especially in early adulthood (Knutsson-Medin et al., 2007; Lieb, Isensee, Hofler, Pfister, & Wittchen, 2002; Mowbray et al., 2006). For example, one study showed that 54% of youth (now ages 18 to 30) of parents with either depression or bipolar (manic depression) developed psychiatric problems in the course of their life, including mood (primarily depression) and anxiety disorders, substance abuse issues, and troubles with the legal system (Mowbray & Mowbray, 2006). In another 20 year longitudinal study of adults who grew up with a depressed parent, Weissman and colleagues (2006) discovered a threefold greater risk for mood (primarily depression) and anxiety disorders (primarily phobias), in their sample ( $N = 151$ ;  $M_{\text{age}} = 35$ ). The peak age of onset for major depression was 15 to 20 years of age.

### **Statement of the Problem**

For those who experience a depressed parent in the home during their upbringing, it has been difficult to decipher the most important elements in the experience that impact young adult outcomes. Emerging adults (ages 18 to 25) who encounter depression in a parent, are at increased risk for psychosocial problems as they transition into adult roles and relationships. Most studies have examined children (under the age of 18) of depressed parents. Few studies have investigated the memories of emerging adults who have a better capability to think abstractly and have had more time to reflect on their life experiences. They also tend to have greater social, emotional, and physical distance from their family due to their evolving independence. Much of the research on growing up with a depressed parent also lacks theoretical underpinnings. No studies have utilized a theory such as Pauline Boss's ambiguous loss theory to explain what children encounter or have compared the interplay of

*boundary ambiguity* and other factors that may influence outcomes as they transition into adulthood

### **Purpose**

The dissertation was organized into three publishable manuscripts:

Paper 1: “Emerging Adults with a Depressed Parent: The Explanatory Power of Two Loss Theories.”

The first manuscript compared two theories of loss: John Bowlby’s Attachment/Loss Theory and Pauline Boss’s Ambiguous Loss Theory. The purpose of this paper was to assess both theories in order to determine which has greater utility in explaining the emerging adult’s experience of growing up with a depressed parent.

Paper 2: “Issues in Using Retrospective Self-report with Emerging Adults who Faced Adverse Experiences in Childhood.”

The second manuscript examined the use of retrospective report and methodological issues associated with its use (e.g., accuracy, reliability, and validity). The purpose of this paper was to examine retrospective self-report in emerging adults who report childhood experiences with a depressed parent. Specific safeguards that need to be implemented to protect the accuracy, reliability, and validity and ensure optimal results are explicated.

Paper 3: “Living in a Shadow: Emerging Adults’ Perspectives of Parental Depression and Current Psychosocial Well-being.”

The third and last manuscript reported the results of the empirical study that examined boundary ambiguity and other factors that contribute to the psychosocial well-being of emerging adults who, while growing up, have experienced depression in a parent. These factors, consistent with the propositions of ambiguous loss theory, included: the length

and understanding of the parent's depression, caregiving involvement, stress, social support, hope, and boundary ambiguity. Therefore, the purpose of this study was to examine boundary ambiguity and other factors that contribute to the psychosocial well-being of emerging adults who, while growing up, have experienced depression in a parent.

A final chapter consisted of an overall discussion and conclusions regarding the entire dissertation. The purpose of this chapter was to integrate the findings from each of the three publishable manuscripts. In summary, the dissertation included theory, methodology, and an empirical study that examined boundary ambiguity and other factors that impact the psychosocial well-being of emerging adults who grew up with a depressed parent, with a final discussion of implications for nursing practice and research.

## **Background and Significance**

### **Emerging Adulthood**

Emerging adulthood (Arnett, 2000) is a proposed developmental stage that encompasses the period of development between the ages of 18 and 25. In comparison to an earlier term, "transitioning to adulthood," emerging adulthood specifies that this period of development is not only a transition, but a separate developmental stage all together (Arnett, 2000, 2007, 2010). During this time of life distinct developmental characteristics exist such as, continuing development of more refined abstract thinking and decision making abilities, independence from parents both physically and emotionally, solidifying sexual identity, and the ability to connect physical intimacy to emotional intimacy (Arnett, 2000, 2007, 2010). This is a stage in life where a young person experiences changes in family, friend, and romantic relationships and begins to establish adult roles (Arnett, 2007). It is also a time when there is an increase in mental health risks (Mowbray & Mowbray, 2006 ). National



studies have shown for example, that three quarters of mental illnesses are diagnosed by age 24 (Kessler, Berglund, & Demler, et al., 2005). It has also been found that for emerging adults, suicide is the second leading cause of death (American College Health Association, 2009). While there are several terms to describe young adults, the term “emerging adult” will be used throughout this dissertation.

Considerable evidence supports that having a depressed parent can adversely affect the development of children and that as they enter their own adulthood, they incur greater risk of mental illness themselves (Beardslee & Podorefsky, 1988; Lieb et al., 2002; Mowbray et al, 2006; Mowbray & Mowbray, 2006; Weissman et al., 2006). Thus, it is imperative that we have a better understanding of the interplay among developmental changes during emerging adulthood, the experience of growing up with a parent who suffers from depression, and increased risks for socialization difficulties, mental illness, and suicide. An additional factor that has not been explored is the perception of loss that these emerging adults likely experienced as a result of growing up in a household with a depressed parent.

### **Ambiguous Loss Theory**

One conceptualization of loss that may have great explanatory value is that of *ambiguous loss*. Ambiguous loss is defined as “a situation of unclear loss resulting from not knowing whether a loved one is dead or alive, absent or present” (Boss, 2004, p. 554). Unlike death which is a more definitive ending accompanied by rituals that yield some sense of closure and recognition from society, ambiguous loss lacks these qualities, may endure over a longer period of time, and causes feelings of confusion and uncertainty (Boss, 1999, 2004, 2009; Boss, Caron, Horbal, & Mortimer, 1990). Boss (1999) describes a variant of ambiguous loss, *ambiguous presence*, that exists when an individual is physically present,

but is psychologically absent or emotionally unavailable. Ambiguous loss situations of this type that have been studied include loved ones of those suffering from Alzheimer's disease, traumatic brain injury (TBI), and mental illness (autism and schizophrenia) (Boss, 2009). These qualities (physical presence but emotional unavailability) will define the type of ambiguous loss used in this dissertation work.

Ambiguous loss affects an individual physically, cognitively, behaviorally, and emotionally (Boss, 1999). Somatic symptoms such as sleeplessness, fatigue, headaches, or GI discomfort can ensue. Cognitively, manifestations can be worry, forgetfulness, dreaming of the loss, or having a preoccupation with the loss. Behaviors might be manifested by withdrawal, inactivity or hyperactivity, being hypervocal, or quiet. Emotional symptoms can include overwhelming sadness, loneliness, anger, irritability, or fear (Betz & Thorngren, 2006). Ambiguous loss creates stress within the individual and the family system, and can lead to difficulty identifying and utilizing effective coping strategies (Boss, 2004). Often this stress can progress and manifest in ways similar to anxiety, depression, or psychic numbing (Boss, 1999, 2009). Symptoms of ambiguous loss can be overlooked or misdiagnosed as depression or anxiety (Boss, 1999). However, ambiguous loss "is not an illness, but a situation of stress that is potentially debilitating" (Boss, 2004, p. 560).

As with any type of loss, change and a degree of upset are inevitable (Boss, 1992). Grieving a loss requires adjustment, redefining identity, and altering roles (Betz & Thorngren, 2006; Boss, 2009). To better explain what youth of depressed parents encounter, Ambiguous Loss Theory has a key concept of *boundary ambiguity*. Boundary ambiguity is defined as "a state in which family members are uncertain in their perceptions of who is in and out of the family and who is performing what roles and tasks within the system" (Boss,

Greenberg, & Pearce-McCall, 1990, p. 1). Behaviors associated with depression such as withdrawal, isolation, irritability, and being overly-critical can cause changes in the parent-youth relationship and create confusion for youth regarding their and parent's roles and responsibilities. "Parentification," was first described by Boszormenyi-Nagy & Spark in 1973 as a child fulfilling a parental role in the family system (in Barnett & Parker, 1998). Parentification occurring when a parent suffers from depression has been documented in the literature as these youth often adopt more of a parental role, while the parent takes on more of the youth's role (Fraser & Pakenham, 2009; Polkki, Ervast, & Huupponen, 2004). Boss and Greenberg (1984) described parentification and abandonment of parental responsibilities as "a change in family structure characterized by boundary ambiguity" (p. 6). They posit that parentification and lost parental responsibilities occur because family members are functioning in developmentally inappropriate roles. Lack of clarity regarding who should be doing what in the relationship, blurred boundaries, ignored parental roles, halted family decisions, undone tasks, and subsequent boundary ambiguity can negatively impact well-being (Boss, 2004). Long-term boundary ambiguity is particularly difficult for children to manage and the effects may carry into adulthood (Boss, 2002). Previous scholars have emphasized that boundary issues are more likely to occur during times of change in families, for example, when the emerging adult leaves for college (Boss & Greenberg, 1984).

Ambiguous Loss Theory has six propositions:

1. Higher boundary ambiguity in the family causes higher stress and greater individual and family dysfunction.<sup>1</sup>
2. Over a short period of time, boundary ambiguity may not cause dysfunction.

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<sup>1</sup> Boss and Greenberg (1984) consider "dysfunction" in the individual in terms of indicators such as, low self-esteem, somatization, and depression. For "dysfunction" in the family, indicators include conflict in the family environment (p. 10).

3. If boundary ambiguity is high and persists, family members become increasingly stressed and dysfunctional.
4. The value system of the family (i.e., religious beliefs, illness beliefs, beliefs over mastery vs. fatalism) influences the perception of boundary ambiguity.
5. The length of time boundary ambiguity can be tolerated is influenced by those values.
6. The family's perception of an event is influenced by the amount of perceived support available to assist the family and its members (Boss, Greenberg, et al., 1990).

Other theories, such as Bowlby's attachment/loss theory have been utilized to help explain adverse childhood experiences and the impact on adult outcomes. Studies using Bowlby's theory focused on the role of attachment in loss when a child experiences the death of a parent, loss of a parent who has a physically debilitating illness, losses associated with a parent suffering from cognitive and physical decline accompanying Huntington's disease, and loss through adverse childhood experiences such as abuse and neglect. While there might be potential parallels between the two theories in regards to what children encounter when their parent suffers from depression, it could be that Ambiguous Loss Theory has more explanatory power in emerging adult outcomes for individuals who grow up with a depressed parent.

Using retrospective reporting for adults who experienced adverse events as a child can create methodological issues. Veridicality or "the degree to which an experience, perception, or interpretation accurately represents reality," (Prescott et al., 2000) has been addressed frequently in stressful or adverse events research, including having a mentally ill

parent as a child. For example, it has been documented in the literature that the reliability of interview responses diminishes with the length of the recall period (Robinson & Clore, 2002). However, other scholars have argued that emerging adults are an excellent population for the use of retrospective self-report since memory clarity and accuracy is at its peak (Schilling, Aseltine, & Gore, 2007; Turner & Butler, 2003).

The loss endured by children of depressed parents is typically not recognized by others, but it is a loss that can impact their development, psychosocial functioning, and overall psychosocial well-being and the effects can endure throughout the lifespan. Pauline Boss's theory (Boss & Greenberg, 1984) has been utilized to explain the experiences and effects on family member's well-being for those patients suffering from a variety of illnesses, however empirical work with emerging adults who grow up with a mentally ill parent is non-existent. While we may not be able to stop mental illness in the parent, we can change how we intervene with the youth who may be affected. Boss's work on ambiguous loss shows a distinct, prescriptive therapeutic approach to individuals suffering an ambiguous loss. Using an alternative theoretical approach, if we could understand more about the experience and outcomes of these youth, then we could decrease the incidence of labeling their outcomes as pathological and implement innovative approaches into practice to assist youth of mentally ill parents to make healthy, effective transitions into adulthood. A National Institute of Health (NIH) - Healthy People 2020 goal is to equip vulnerable adolescents with services and skills needed to transition into an independent, self-sufficient adulthood (NIH, 2010). Findings from the three manuscripts constituting this dissertation will help professionals, including nurses, better understand what factors contribute to the psychosocial outcomes for this population. This knowledge gained could be important for developing or refining

interventions aimed at supporting youth who experience depression in a parent and improve outcomes.

### **Literature Review**

Studies have explored various risk and protective factors that might contribute to outcomes for emerging adults who grow up with a depressed parent in the home. These factors include but are not limited to: the age and developmental stage of the child when their parent's depression began, length and severity of parent's depression, degree of understanding that the child has about the parent's depression, parentification, and utilization of social support. The following literature review will discuss existing evidence regarding factors that can impact growing up with a depressed parent and emerging adult outcomes.

#### **Child's Age and Length and Severity of Parental Depressive Symptoms**

The age of the child when a parent's depressive symptoms begin, how long the symptoms last, and the severity of symptoms are all factors to consider regarding the impact of parental depression, although research findings remain unclear. Much research suggests that onset of parental depression before or immediately after the child's birth is most detrimental to the parent-child relationship and child outcomes throughout development and into early adulthood (Lieb et al., 2002; Lovejoy, Graczyk, O'Hare, & Neuman, 2000). However, in Mowbray and Mowbray's 2006 study of 61 adult children of affectively-ill mothers, nearly 60% of mother's suffered depressive symptoms before their child's birth, but no significant association was found with children's adult outcomes between them and the other 40% of mothers whose depressive symptoms began after their child's birth. Lieb et al. (2002) found in their longitudinal study ( $N = 2,427$ ; ages 14-25) that earlier onset of parental depression was associated with earlier onset, higher severity, increased impairment, and

higher reoccurrence of depressive disorders in their children. Then again, if the first onset of parental depression does not occur until during adolescence, it might be more challenging for the child to cope during a time when changes in parent's mood and behavior can cause more anger, confusion, and resentment (Campbell et al., 2009; Meadus & Johnson, 2000; Sarigiani et al., 2003; Smith, 2004). Most investigators agree that the onset of parental depression at any age can cause major stress to a child (Campbell et al., 2009; K. Foster, 2010; Meadus & Johnson, 2000; Polkki et al., 2004).

In one study examining adults who had grown up with a depressed parent, both younger age of parent's *hospitalization* ( $X^2 = 7.80$ ,  $df = 1$ ,  $p = .005$ ) and chronicity of parent's symptoms ( $X^2 = 15.44$ ,  $df = 4$ ,  $p = 0.004$ ) predicted psychological morbidity in adulthood ( $n = 94$ ) (Peisah et al., 2005). Depression is a complex illness in which symptoms can last for several weeks or in more severe cases, several years. It can be recurrent or occur as a single episode and symptoms can be mild to severe and erratic or unpredictable.

Hammen and Brennan (2003) examined the relationships between adolescent ( $N = 816$ ) outcomes and length and severity of maternal depression. Findings showed that both chronic/mild and brief/severe depressive symptoms in mothers were equally associated with adolescent depression. After controlling for severity, patterns of chronicity suggested that mild maternal depression would have to last 12 months or longer to pose an elevated risk for youth depression. Campbell et al. (2009) discovered that in situations of chronic (lengthier) maternal depression, both sub-clinical and severe symptoms were almost equally predictive of poor adolescent internalizing (e.g. withdrawal, depression, anxiety, or passivity) ( $p = .002$ ,  $R^2 = .010$ ;  $p = .002$ ,  $R^2 = .011$ ) and externalizing symptoms (e.g. aggressive or risk-taking) ( $p < .001$ ,  $R^2 = .017$ ;  $p < .001$ ,  $R^2 = .018$ ).

Timko, Sutkowi, Pavao, and Kimerling (2008) found that in comparison to adults who grew up with a non-depressed parent, those who experienced a parent with chronic, non-remittent depression showed higher and more severe rates of depression ( $F(3,317) = 5.03, p < .01$ ) over those whose parents had partially remitted depression ( $F(3,317) = 3.82, p < .05$ ). It might be that when there is at least some remission, these children experience a break with parental symptoms and are able to build some coping skills toward resiliency. But, if parental depression is chronic, this may be all that the child knows. It might be more confusing when a child has a parent who is not depressed for the first five or ten years of life, and then must encounter parental depression. Likewise, intermittent occurrence of parental depression can cause confusion. Since parental depression is often recurrent and chronic, the effects then accumulate and may impact the child the most during emerging adulthood (K. Foster, 2010; Lovejoy et al., 2000; Mowbray et al., 2006; Timko et al., 2008).

### **Child's Level of Understanding Regarding Parental Depressive Symptoms**

Often older children or adolescents are better able to understand what depression is and the symptoms exhibited by the parent (O'Connell, 2003). Still, having a parent who is mentally ill can be perplexing for a child of any age, particularly when the parent's mood, affect, thought processes, and behaviors fluctuate. Older adolescents and emerging adults often convey that they learned of their parent's depression over time or slowly realized how their parents and lives differed compared to their friends (Ahlstrom et al., 2011; Baik & Bowers, 2006; Riebschleger, 2004). Studies show that children of depressed parents voice discontent with family, friends, teachers, or mental health professionals, claiming that they do not receive adequate information regarding their parent's mental illness (Ahlstrom et al., 2011; K. Foster, 2010; Knutsson-Medin et al., 2007; Trondsen, 2011). Children of depressed



parents report wishing that mental health professionals would have taken the time to ask about their understanding of depression and explained more about the parent's illness to them. These children also desired regular follow-up with them by mental health professionals (K. Foster, 2010; Knutsson-Medin et al., 2007; Trondsen, 2011). Polkki et al. (2004) examined needs, coping, and resilience of children of depressed parents, and found that participants were never informed of their parent's diagnosis. Family members might try to hide or minimize the depression, perhaps in an attempt to shield the child. Unfortunately, at times children first learn of a parent's depression during a crisis period such as a suicide attempt and/or an acute psychiatric admission (Trondsen, 2011), in which the child is unprepared and likely even more frightened.

Children struggle to understand their parent's mental illness and associated behaviors and often indicate feeling confused about who their parent is to them now that the parent is depressed (Baik & Bowers, 2006; Kaimal & Beardslee, 2010; Knutsson-Medin et al., 2007; Meadus & Johnson, 2000; Polkki et al., 2004; Trondsen, 2011). For example, a participant in one qualitative study by Polkki et al. (2004) commented she had "lost her mother and received a sick relative instead" (p. 157). A parent battling depression might experience things like feelings of worthlessness, extensive guilt, overall negativity and isolative behavior. Psychology shows us that there is a tendency for children to internalize and self-blame with regard to family situations (e.g., illness, death, divorce, family discord) and having a parent with depression is no different. Children may have difficulty contributing mood, behavior, and relational changes with their parent to something external from themselves. In one study, when children of depressed parents ages 5 to 17 ( $N = 22$ ) were asked about perceptions of their parent's symptoms, 27% described "bad days" as occasions

when their parent was less attentive to their needs, while 82% described “good days” as occasions when their parent interacted more frequently with them (e.g., asking how their day was at school and showing them affection) (Riebschleger, 2004). In another qualitative study, a major theme for adult children ( $n = 10$ ) of parents with a depressive disorder (60% of sample) was “struggling to connect: we were super close and now we are not” (K. Foster, 2010). In a qualitative study examining young adult children ( $n = 8$ ) and disclosure of their mother’s depression, participants expressed having gone through their childhood seeking their mother’s love and approval until finally concluding that their mother “maybe just was not capable of such feelings” (Baik & Bowers, 2006, p. 2). Understanding depression and recognizing the signs can help the child separate themselves from the emotional experiences of the parent (K. Foster, 2010). For instance, realizing that the parent’s depression is not their fault, but rather a disease process, has been shown to be a protective factor (Fjone, Ytterhus, & Almvik, 2009; Fraser & Pakenham, 2009; Meadus & Johnson, 2000; Polkki et al., 2004).

### **Parentification and Young Caregiving when a Parent is Depressed**

Parentification often occurs in the parent-child relationship when a parent is depressed (Byng-Hall, 2008; K. Foster, 2010). The majority of these families are single parent households (primarily depressed mothers), are of low socio-economic status, and often lack social resources (Lovejoy et al., 2000; Mowbray & Mowbray, 2006; Riebschleger, 2004; Smith, 2004). Given these additional factors, it is understandable that these families often do not have the support needed for the depressed parent and responsibilities such as caregiving fall on the child.

Many times the caregiving duties accompanying parentification are in excess, are prolonged, interfere with children’s much needed socialization with peers, and go

unrecognized by both family and outsiders (Byng-Hall, 2008; Fraser & Pakenham, 2009; Polkki et al., 2004; Reupert & Maybery, 2007). In many cases the child cares for the parent(s), sibling(s), conducts household chores and completes other tasks usually handled by the parent (Fraser & Pakenham, 2009). Some children even manage the depressed parent's medication and emotional care and express worry over the parent potentially attempting suicide (Ahlstrom et al., 2011; Knutsson-Medin et al., 2007; Meadus & Johnson, 2000; O'Connell, 2008; Riebschleger, 2004; Trondsen, 2011). For many children, parental hospitalization is a negative experience, accompanied by feelings of criticism by mental health professionals for not preventing their parent's crisis (Knutsson-Medin et al., 2007). Other findings show that hospitalization is a positive experience for children of depressed parents since someone else was responsible for caregiving (Knutsson-Medin et al., 2007; O'Connell, 2008).

Still, there are some positive outcomes to caregiving, such as providing children with a constructive family role during times of stress, fostering empathy, and striving for excellence in school performance (Reupert & Maybery, 2007). Adult children who grew up caring for a depressed parent and the family have endorsed gains such as learning how to be responsible, effectively solve problems, and function independently (K. Foster, 2010). In another study where adult participants of depressed parents had engaged in child caregiving, high family mastery ( $p < .05$ ) was associated with endorsed quality of life ( $r = .31, p = .05$ ) (O'Connell, 2008).

It has been stated that for emerging adults who must care for a depressed parent, it is less likely that he or she will pursue his or her own educational or vocational goals (Ahlstrom et al., 2011; Mowbray et al., 2006). One investigator posited that unpredictable parental

moods and behaviors interfered with children's concentration and therefore, affected academic abilities (Trondsen, 2011). However, in one study, 94% of participants ( $N = 36$ ) who grew up and older with a depressed parent had completed high school and one-third obtained a college degree (Knutsson-Medin et al., 2007). Seventy-five percent of participants in O'Connell's 2008 study had completed at least some college education. In another study that examined psychosocial outcomes in adolescents of primarily depressed mothers ( $N = 166$ ), cluster analysis showed that 30.1% had the highest school competence score and GPA, and this same cluster showed the highest levels of social competency and lowest levels of depression and anxiety (Mowbray et al., 2004). O'Connell (2008) hypothesized that academic success was related to children studying excessively as a way of controlling an area in life, avoiding the depressed parent, or showing that they are different from their parent.

### **Social Support Available to the Family with a Depressed Parent**

Social support being available and utilized has been shown to contribute to emerging adult outcomes (Fraser & Pakenham, 2009; Mowbray & Mowbray, 2006). When a depressed parent cannot provide social interaction and emotional support, these needs can be met by others (Campbell et al., 2009; Kaimal & Beardslee, 2010; Reupert & Maybery, 2007), especially a non-depressed parent, if involved. For example, in a study of  $N = 126$  adult children (ages 18–21) most of whom had depressed mothers, the uncertainty or unpredictability in family life impacting the participant's experiences of anxiety and depression was buffered by paternal nurturance  $F(1, 5.5) = 7.7, p = .007, \eta^2 = .04$  (Ross & Wynne, 2010). Mowbray and Mowbray (2006) found that social support from family and friends during childhood was associated with higher life satisfaction in adult children of

parents with depression or bipolar disorder ( $N = 61$ ), ( $t(54) = 1.83, p < .05$ ). In a study investigating the relationship between resiliency factors and adjustment for children of mentally ill parents (primarily or 68% depression and bipolar disorder), the most significant predictor of life satisfaction for them as emerging adults was social connectedness ( $r = .54, p < .01$ ) (Fraser & Pakenham, 2009). Having one or more close peer relationships where the child can talk about their experience has frequently been cited as a protective factor (Baik & Bowers, 2006; Meadus & Johnson, 2000; Mowbray & Mowbray, 2006; Polkki et al., 2004).

Unfortunately, there are many barriers to socialization for children of depressed parents as they often encounter difficulties such as lacking in social competence, avoiding socialization, and overall poor social adjustment (Campbell et al., 2009; K. Foster, 2010; Mowbray et al., 2006; Reupert & Maybery, 2007; Timko et al., 2009). Studies show that as children of depressed parents age and function as adults, they face difficulty establishing trust and forming friendships (Baik & Bowers, 2006; Mowbray et al., 2006; O'Connell, 2008). One reason this might occur is the stigma that is attached to having a parent with a mental illness. For example, often parental depressive symptoms (isolation, irritability, fatigue, and lack of attention to self-care and the home) can cause fear of embarrassment and prevent the child from inviting over friends (Trondsen, 2011). Children of depressed parents may hesitate to even disclose their parent's depression and what they are dealing with at home to peers. In fact, many times they are taught not to talk about it (O'Connell, 2008; Polkki et al., 2004). Or as Ahlstrom et al. (2011) as well as Fijone et al. (2009) found, adult children reported that out of loyalty and respect for their parent, they did not talk about the depression outside of the home.

## **Summary and Conclusions**

In summary, depression in a parent can cause certain changes in the parent-child relationship which can facilitate enduring effects that could impact psychosocial well-being during the important developmental stage emerging adulthood. There is a gap in the literature as to what theory best explains the experience and later outcomes in emerging adulthood regarding adverse life events such as growing up with a depressed parent. There is also question as to what methods might best extract the reports of emerging adults who have experienced depression in their parent while growing up. Comparing the strengths of available theories and identifying safeguards when using the methodology retrospective self-report led to a theoretically-driven, scientifically sound study of factors impacting an emerging adult's psychosocial well-being after having grown up with a depressed parent. The results of this study are presented in Chapter 4.

## **CHAPTER 2**

### **PAPER 1: EMERGING ADULTS WITH A DEPRESSED PARENT: THE EXPLANATORY POWER OF TWO THEORIES OF LOSS**

#### **Introduction**

In any given year in the United States, 18.8 million individuals suffer from depression (National Institute of Mental Health, 2009). It has been estimated that over 7.5 million people who are depressed are parents and more than 15 million children under the age of 18 are affected (National Research Council & Institute of Medicine, 2009). Depressed parents often struggle to parent effectively. Disengagement, unpredictability, low warmth, and criticism of children can lead to the child's avoidance of the parent, poor social adjustment, and low self-esteem, all of which promote stress for the child (Brennan, Broque, & Hammen, 2003; Easterbrooks, Bieseckner, & Lyons-Ruth, 2000; C. E. Foster et al., 2008; Lovejoy, Graczyk, O'Hare, & Neuman, 2000; D. R. Nelson et al., 2003; Sarigiani, Heath, & Camarena, 2003).

Emerging adulthood (Arnett, 2000) is a developmental stage that includes individuals between the ages of 18 and 25. This stage poses high-risk for mental illness, substance abuse issues, and suicide (Arnett, 2000, 2010). For an emerging adult who grew up with a depressed parent, navigating this developmental stage can be more difficult than for others who grew up with a non-depressed parent. Depression in a parent can be experienced as a form of loss for the child that shapes development and causes cumulative effects into emerging adulthood.

Loss can result from the actual death of a parent (normative) as well as an event, object, experience, role or relationship (non-normative; Rando, 1993). Symptoms of depression include low energy, irritability, difficulty concentrating, excessive guilt, and withdrawal from family and friends (American Psychiatric Association, 2000). Whereas the actual death of a parent has been well documented to increase risks for mental health problems for children, a child of a depressed parent may experience a non-normative ambiguous loss, or “a situation of unclear loss resulting from not knowing whether a loved one is dead or alive, absent or present” (Boss, 2004, p. 554). Or, it could be that such a loss might disrupt attachment (Bowlby, 1980, 1988) and affect psychosocial well-being enduring into emerging adulthood.

Coping is the effort to regulate thoughts, emotions, behaviors, and the environment in response to a stressful experience (Walter & McCoyd, 2009). Researchers have identified three categories of coping strategies: primary control/engagement (problem-solving and emotional regulation), secondary control/engagement (positive thinking, acceptance, and distraction), and disengagement (denial, avoidance, and wishful thinking). Primary control coping involves direct action to change a stressful experience or one’s emotions about that experience. Secondary control coping entails adaptation to the stressful experience by managing attention and thoughts. Disengagement coping includes distancing oneself physically, cognitively, or emotionally from the stressful experience (Langrock, Compas, Keller, Merchant, & Copeland, 2002). Effective coping with the stress associated with growing up with a depressed parent can foster psycho-social well-being and more positive outcomes into adulthood (Fjone, Ytterhus, & Almvik, 2009).



The purpose of this paper is to compare two theories, attachment/loss theory and ambiguous loss theory, examining each for its explanatory power in understanding the loss a child experiences, children's coping, and the impact on their developmental trajectory into emerging adulthood, when his or her parent is depressed. Bowlby (1969) considered that the "attachment figure" was usually the mother, but could be either parent, or another caregiver. For this paper, parents (e.g., birth, step, adoptive or custodial mother or father since infancy) are the focus and the term 'parent' will be used. The term "child" refers to any age along the development trajectory between infancy and age 18. This paper will first address two key factors of timing of parental depression (in terms of the age of the child and duration of parent's symptoms), parent-child role and relationship changes, and factors affecting the child's coping capacity that affect the well-being of emerging adults whose parents were depressed in the family home during their upbringing. A comparison between Bowlby and Boss's theories will focus on the utility to explain the loss encountered by children of depressed parents. Finally, gaps in the literature and implications for future nursing research and practice will be addressed.

### **Key Factors that Affect Well-Being of Children of Depressed Parents**

#### **Timing of the Parent's Depressive Symptoms**

Two key aspects regarding the timing of parental depression include: the age of the child in which the symptoms begin and the duration, which may or may not span over different stages of the child's development. Early onset of maternal depressive symptoms (before or directly after the child's birth) is often viewed as the most detrimental to parenting and child outcomes throughout the development trajectory (Easterbrooks et al., 2000; Lieb, Isensee, Hofler, Pfister, & Wittchen, 2002). Hammen and Brennan (2003) found that only

one exposure to maternal depression at any time during the first 10 years of a child's life was equally predictive of depression as an adolescent. However, some evidence supports that adolescence is the most detrimental period, when parental depression may have been chronic, exposing the adolescent for a longer period of time. (Campbell, Morgan-Lopez, Cox, & McLoyd, 2009; Meadus & Johnson, 2000; Mowbray & Mowbray, 2006; Sarigiani et al., 2003). Or if the first onset, it might be more challenging for the adolescent during a time when inconsistent parenting can be more difficult to cope with, causing more confusion, anger, and resentment (Campbell et al., 2009; Smith, 2004). Other scholars argue that since parental depression is often recurrent and chronic, the effects then accumulate and impact the child the most during the transition to adulthood (K. Foster, 2010; Lovejoy et al., 2000; Mowbray, Bybee, Oyserman, MacFarlane, & Bowersox, 2006). The emerging adult needs to separate from parents while maintaining positive family bonds and then build their own relationships with significant others to adjust (Arseth, Kroger, & Martinussen, 2009). The child of a depressed parent is making a critical transition into adult roles likely with less parental role-modeling, guidance, and support (Baik & Bowers, 2006; K. Foster, 2010; Knutsson-Medin, Edlund, & Ramklint, 2007; Polkki, Ervast, & Huupponen, 2004). A summary of how parental depressive symptoms affect the major needs and outcomes at each stage of child development, and how attachment and ambiguous loss theories explain these changes, are presented in Table 2.1.

### **Parent Depressive Symptoms and Changes in Roles and Relationships**

When a parent suffers from depression, there can be dramatic shifts in family roles and relationships. "Parentification" was first defined by Boszormenyi-Nagy and Spark (1973) as a "problematic family dynamic in which the role of parent and child are reversed"

Table 2.1

*Child Development & Parents' Depressive Symptoms: Outcomes for Children as Explained by Bowlby and Boss*

Child Development	Parental Depressive Symptoms	Attachment Theory & Child Outcomes	Ambiguous Loss & Child Outcomes
<i>Infancy</i> – Major needs include parental responsiveness, reciprocity.	Emotional withdrawal, less responsive in parenting	<p>Primitive ability to cope can become overwhelmed.</p> <p>Can develop mistrust of others.</p> <p>Initial attachment pattern developed determines pattern for future relationships (secure or insecure/: avoidant, ambivalent, or disorganized).</p>	Does not examine changes over the developmental trajectory.
<p><i>Toddlerhood</i> – Major needs include consistent parental responses, structure, feeling safe to explore.</p> <p>Exploration builds social skills, mastery, and autonomy.</p>	Emotional dysregulation, inconsistent parenting behaviors, tend to provide less structure in the home	<p>Affects self-regulation and coping:</p> <ul style="list-style-type: none"> <li>Increased emotional lability,</li> <li>Increased frustration</li> <li>Increased impulsivity</li> <li>Decreased reflective ability</li> </ul> <p>Lack of structure often causes:</p> <ul style="list-style-type: none"> <li>Feelings of mistrust, insecurity,</li> <li>barriers to exploration</li> </ul>	Inconsistent mood states and parenting likely yield uncertainty for children, not knowing what behaviors to expect from the parent from day to day.

Table 2.1 (cont.)

Child Development	Parental Depressive Symptoms	Attachment Theory & Child Outcomes	Ambiguous Loss & Child Outcomes
<i>Young childhood</i> -Usually start preschool, kindergarten, where increasingly exposed to social situations with peers.	Isolation, diminished social interactions with child, family, and friends	<p>Less astute to how behavior affects thoughts, feelings for self, others</p> <p>Less sense-making of self and relationships</p> <p>Uncertainty of parents' positive feelings toward them</p>	<p>Boundary ambiguity can come from inside and outside of the family system.</p> <p>Boundary issues are more likely to occur during times of change in families.</p> <p>Starting school may be a time when children begin to realize that their depressed parent and the family dynamic is different from peers.</p>
<i>Middle childhood</i> - Major needs include acceptance and inclusion in the group.	Negative views of self and others, more critical appraisals of children	<p>Adopt more critical appraisals: Increased negative self-image Decreased social skills</p> <p>Stigma may invite ridicule or exclusion from the peer group.</p>	Stigma associated with having a parent who is depressed is likely more noticed; negatively affecting self-image, acceptance.

Table 2.1 (cont.)

Child Development	Parental Depressive Symptoms	Attachment Theory & Child Outcomes	Ambiguous Loss & Child Outcomes
<i>Adolescence</i> - Major needs include developing cooperation, self-confidence, and self-reliance.	Isolation, withdrawal contributes to less parental involvement and social role-modeling. Low self-esteem often role-modeled	Doubt others and themselves Less comfortable with being alone Less confident in problem-solving More afraid to ask for help	Common time when the child discloses that their parent is depressed and the experience.  Steady increase in care responsibilities, increasing boundary ambiguity. Many care responsibilities an adolescent cannot master, diminishing self-esteem.
<i>Emerging Adult</i> - Major needs include separation from parents, while keeping a bond.  Building intimate relationships and achieving mastery in relationship, college, work roles, and parenting own children.	Parent may depend on child for support	Adult Attachment Patterns: Secure-autonomous, Insecure-dismissing, or Insecure-preoccupied.  Less capacity for expressing intimacy  More emotional, behavioral difficulties  Difficulty forming, maintaining, and relinquishing relationships  Occupational troubles  Problems effectively parenting	Extending beyond emerging adulthood, boundary ambiguity in the parent-child relationship could have very similar cumulative effects.

(Castro, Jones, & Mirsalimi, 2004, p. 205). Studies show that depressed parents are often unavailable to perform parental tasks (Ahlstrom, Skarsater, & Danielson, 2011; K. Foster, 2010; Meadus & Johnson, 2000). Polkki et al. (2004) found that 88% of adolescents took on the parent's everyday chores and 61% assumed caring for siblings. Children may take on the responsibility of physically caring for their depressed parent as the parent may struggle with the basics of self-care (Fraser & Pakenham, 2009). Some children discuss growing up emotionally supporting their parent (Ahlstrom et al., 2011; Byng-Hall, 2008; K. Foster, 2010; Knutsson-Medin et al., 2007), a form of parentification that has been called, "emotional role-reversal" (Boszormenyi-Nagy & Sparks, 1973). When in such a role, a child provides rather than receives nurturance and often places the depressed parent's needs before his or her own and these experiences can negatively impact long-term emotional well-being (Katz, Petracca, & Rabinowitz, 2009; see Table 2.1).

How other family members react to the parent can strongly influence how a child experiences having a depressed parent (Knutsson-Medin et al., 2007). Societal misinformation and stigma often surround mental illness as evidenced by the shame and secrecy that surrounds these families. Sometimes parents and relatives may not tell children the truth about the depression (Fjone et al., 2009). Parental symptoms are minimized, excuses are made for behavior, and suicide attempts are hidden (O'Connell, 2008). Children may be asked to lie to others about their depressed parent's whereabouts when he or she is undergoing acute psychiatric treatment (Polkki et al., 2004). Communication among families where a parent is depressed is often strained and family cohesion is usually low (D. R. Nelson et al., 2003; Peisah, Brodaty, Luscombe, & Anstey, 2005; Reupert & Maybery, 2007; Sarigiani et al., 2003).

## **Parent Depressive Symptoms and Factors Affecting Children's Coping Capacity**

Various factors have been suggested that can affect a child's coping with a depressed parent. Studies show that children of depressed parents have difficulty coping and experience increased internalizing (e.g., withdrawal, depression, anxiety, or passivity) and externalizing (e.g., aggressive or risk-taking) symptoms (Campbell et al. 2009; C. E. Foster et al., 2008; Mowbray et al., 2006; D. R. Nelson et al., 2003), which can further add strain to the parent-child relationship. However, if the relationship with the parent prior to the onset of depression was positive (e.g., warm, nurturing, consistent), studies suggest that children cope more easily (Brennan et al., 2003). If the depressed parent, or a non-depressed parent if present, role-modeled and taught adaptive coping, these skills can buffer the experience of parental depression for the child (Walter & McCoyd, 2009). For example, children of depressed parents who use primary control coping strategies (problem-solving and effectively regulating and expressing emotions) or secondary coping strategies (positive thinking, acceptance, and distraction) tend to have less internalizing and externalizing problems than those who use disengagement coping strategies (denial, avoidance, and wishful thinking) (Jaser et al., 2005; Langrock et al., 2002).

Children often struggle to understand their parent's illness, affecting their ability to cope. Older children are usually better equipped to understand a parent's mental illness. In some studies (Baik & Bowers, 2006; Knutsson-Medin et al., 2007; Meadus & Johnson, 2000; O'Connell, 2003) participants spoke of not knowing until they were older what depression was and what their parent was dealing with. Sometimes children view parent's depressive symptoms as a weakness (Polkki et al., 2004) or blame themselves for what is happening, causing feelings of shame and guilt (Ahlstrom et al., 2011; Baik & Bowers, 2006; Mowbray

& Mowbray, 2006). Research on resiliency shows that understanding that parental depressive symptoms are associated with a mental illness increases children's psychological well-being (Fjone et al., 2009; Fraser & Pakenham, 2009; Meadus & Johnson, 2000; Polkki et al., 2004). If a child is able to understand a parent's mental illness this way, self-blame is reduced and independence from the parent's illness is maintained (Fraser & Pakenham, 2009).

Mastery is "a personal resource which influences the perceptions and coping abilities given a certain situation" and incorporates the personal belief that the situation is within one's control (Turner & Butler, 2003, p. 91). Individuals necessitate a sense of mastery, especially in relationships. There has been evidence suggesting that when children face parental depression, their mastery skills are diminished or helplessness prevails (Byng-Hall, 2008; Turner & Butler, 2003). Meanwhile, achieving understanding of depression (Baik & Bowers, 2006) and feeling confident as a caregiver (Fraser & Pakenham, 2009) can give the child a sense of mastery in their relationship with their parent and improve their coping. For example, Fraser and Pakenham (2009) found that for children of mentally-ill parents ( $N = 44$ , ages 12 to 17), confident caregiving was positively related to primary coping strategies such as problem-solving and effectively regulating emotions ( $r = .32, p = .05$ ) and life satisfaction was positively related to secondary coping strategies such as acceptance and positive thinking ( $r = .33, p = .05$ ). Still, while being in the caregiver role might be empowering for the child (Hooper, 2007), it is often more devastating to their self-esteem when unable to fully master such adult-like roles (Ahlstrom et al., 2011; Byng-Hall, 2008). The child might also meet needs for mastery in peer relationships, academics, or sports (O'Connell, 2003; D. R. Nelson et al., 2003; Polkki et al., 2004).



Social support can alter the loss experience for children of depressed parents. Studies show that children of depressed parents have socialization difficulties, such as social avoidance, poor social competence, and less social adjustment (Campbell et al., 2009; K. Foster, 2010; Mowbray et al., 2006; Reupert & Maybery, 2007). Research indicates that when a depressed parent is unable to provide social interaction and emotional support, these needs can be met by others (Campbell et al., 2009; Reupert & Maybery, 2007). It has been shown that having friends to talk to is an effective coping strategy for children of depressed parents (Baik & Bowers, 2006; K. Foster, 2010; Meadus & Johnson, 2000; Mowbray & Mowbray, 2006; Polkki et al., 2004).

In closing, the more effectively children cope with depression in their parent, the less likely the burden of loss and difficulties in emerging adulthood (Baik & Bowers, 2006). The next two sections will offer an overview of both theories and a comparison of how each explains the experience and outcomes for children growing up with a depressed parent in terms of timing in child development, changes in parent-child roles and relationships, and aspects impacting children's coping capacity.

### **Comparison of the Theories of Bowlby and Boss**

#### **Bowlby's Attachment/Loss Theory**

Attachment (Bowlby, 1969) is an enduring emotional tie to a significant person characterized by the tendency to seek and maintain closeness, particularly in times of stress. Bowlby (1965, 1969, 1973, 1979, 1980, 1988) examined the loss and coping response of a young child in situations of major maternal separation, (i.e. being physically apart for a significant period of time), the loss of bonds, and the reunion that took place afterwards. In 1980, Bowlby found that the child would attempt to maintain physical proximity to the

attachment figure and did so in four phases, comprising Bowlby's loss of bonds theory. The first phase is *numbness* which is signified by shock. The second phase is *protest* where the child experiences anxiety and anger as he/she searches for the parent to re-establish physical proximity. Third, is the *disorganization and despair phase* where the child begins to comprehend the loss and its finality and likely feels withdrawn and depressed. Still, he/she has not given up the hope of achieving physical proximity, giving way to eventual hopelessness. The final stage is the *reorganization phase* where the goal shifts from achieving physical proximity to finding security via psychological proximity in the new situation. The child now focuses on other aspects of life resulting in re-evaluation and re-integration. Bowlby's theory explains how a child understands the loss and revises his/her sense of self and environment without the parent (Thompson, 2010). Coping with a temporary loss (separation) is often manifested as anxiety, whereas prolonged parental separations are stressful and at times devastating, since there is little to no preparation (Bowlby 1965, 1980). Still, separation entails more than just the physical absence of that parent (Ainsworth, Blehar, Waters, & Wall, 1978). Goals of attachment include maintaining proximity to the attachment figure, but also communication with that person (McLeod, 2007).

Mary Ainsworth collaborated with Bowlby (1969) and operationalized attachment, facilitating the concept of a "secure base" and how maternal sensitivity to infant behaviors forms attachment patterns. Ainsworth (1978, 1985) examined child attachment behavior in response to *rejection and separation*. Parental behaviors like focused attention, guidance, and nurturance promote a healthy parent-child relationship. If the child views the parent as unresponsive (rejection) or inaccessible (separation), the child experiences loss. Repeated

fear of the parent's inaccessibility or unresponsiveness promotes increased anxiety, especially during earlier stages of development (Ainsworth et al., 1978).

Maternal *deprivation* refers to both the failure to attach and the separation and loss of the attachment figure (McLeod, 2007). A child is deprived if the parent is removed from the child *or* the parent cannot provide the care and love necessary for normal growth and development. Per Bowlby (1965), an infant and young child should experience a relationship with his or her mother that is warm, intimate, and continuous. Ainsworth and colleagues (1978) inferred that children of depressed mothers encounter deprivation since that mother is physically present, but emotionally unavailable (Barnett & Parker, 1998). The underlying assumption of maternal deprivation is that repetitive disruptions of attachment could cause long-lasting cognitive, emotional, and social problems (e.g., impaired intellect, delinquency, aggression, depression, and other forms of psychopathy, and lack of caring and concern for others) (McLeod, 2007).

An infant's attachment system is aligned with their parent's caregiving system. Each attachment style is a strategic behavioral attempt by the child to maintain proximity or closeness to their parent, especially when experiencing distress and despite the parent's caregiving behaviors (whether warm and nurturing or cold and rejecting) (Howe, 2011). Attachments are classified as secure, insecure (with two sub-types, including anxious avoidant and anxious ambivalent), or disorganized (Ainsworth et al., 1978). A child who is securely attached is comfortable and less apprehensive, sensing that when scared or hurt the parent will be present and take care of the child. When a parent is typically unresponsive to their child's needs the result is usually an *anxious-avoidant* attachment. The parent tends to be annoyed or agitated when the child presents in distress. In these cases, the child's

responses to the parent are diminished, he or she exhibits a restricted range of emotion, or over-regulates emotions as to not arouse a negative reaction from the parent. Children whose parents are inconsistent in their responses tend to have *anxious-ambivalent* attachment styles. Those children either under- regulate their emotions or feel the need to heighten their emotions to elicit a response from their parent. A *disorganized* attachment style develops when affective states are regularly mismatched between the parent and child. The child shifts between approaching the parent for comfort and avoiding them. He or she shows a lack of coherence in attachment behavior, seeming dazed, frozen, or fearful of the parent (Ainsworth et al., 1978; Easterbrooks et al., 2000; Field, 2006). Whatever the behavior the child exhibits, it does not bring them proximity or comfort from their parent. When the parent is absent or threatening absence as in unresponsive or unpredictable attachment relationships, Bowlby (1976, 1980, & 1988) and Ainsworth (1985) noted that the emotions of the child are anger, anxiety, sadness, and depression.

Ainsworth and Bowlby's collaborations further enhanced a central proposition of attachment theory; that characteristics of future relationships are significantly influenced by the relationship the child had with his or her parent. Bowlby (1969) explained this through the "internal working model," or the cognitive framework that assists one in understanding self, others, and the relationships between the two. Individuals develop this cognitive model to help them make sense of their world. Making sense or the meaning that we assign to experiences is based on what one thought and felt in the past and biases one's appraisal of future attachment-related experiences. This meaning influences what an individual thinks, feels, says, and does or assists an individual to negotiate his or her world, particularly in relationships with self and others (Howe, 2011). The internal working model has three key

features: 1) it impacts how an individual views themselves 2) it creates the degree of viewing others as trustworthy, and 3) it influences interactions with others (Bowlby, 1969). It contains beliefs and expectations regarding one's worthiness of love and acceptance, their and other's behaviors, and the emotional availability of others which guides behavior in important relationships (Howe, 2011). At about age three, the internal working model becomes ingrained into one's personality (Bowlby, 1980; McLeod, 2007) and is pertinent when considering how the emerging adult views his or her self-worth and behaves in relationships.

### **Bowlby and the impact of timing of parental depression on child development.**

While Bowlby (1965) argued that the most vulnerable time for a child in regards to attachment needs is during infancy and toddlerhood, he emphasized that this vulnerability extends into early childhood. Bowlby (1965) also stressed how the complex relationship with the mother underlies an individual's character development and degree of mental health throughout the lifetime. When examining parental depressive symptoms and how attachment/ loss theory and ambiguous loss theory might explain the impact for children, cumulative effects for the emerging adult are noted (Refer to Table 2.1). George, Kaplan, and Main (1984) operationalized these cumulative effects in the Adult Attachment Interview (AAI). The AAI was designed to evaluate the subjective meaning an adult assigns to relationships with parents (Bosquet & Egeland, 2001). Each adult attachment type corresponds to an attachment style from infancy. Securely attached adults value their relationships with parents, describe any diverse childhood experiences coherently, and view the attachment experience as an important part of personal growth. When faced with a stressor or loss, high self-esteem assists them to cope more efficiently (Howe, 2011). Adults

with a dismissing attachment deny, devalue, and have difficulty recalling past attachment experiences, or over idealize past experiences with his/her parent. Those who exhibit confusion, anger, or passivity or endorse negative memories are said to have a preoccupied attachment and may also report patterns of parentification. Adults who faced parental mental illness or losses as a child tend to have unresolved-disorganized attachments. Those with this attachment style often report trauma or shows signs of irrational thinking (Bowlby, 1973; Arseth et al., 2009). Bowlby (1979) also identified another anxious type attachment style labeled “compulsive caregiving,” which has received less attention in the literature. This attachment style is said to result from the parent reversing the normal parent-child relationship structure and pressuring the child to be an attachment figure to them instead.

**Bowlby and changes in parent-child roles and relationships.** Some investigators later examining parentification used Bowlby’s attachment theory as a foundation (Alexander, 2003; Hooper, 2007; Katz et al., 2009). For example, when piloting the *Relationship with Parents Scale*, a 42-item retrospective self-report measure of childhood parent-child relationships, Alexander (2003) found that among college students (emerging adults) who grew up with a mentally ill or chemically dependent parent, parent-child role-reversal predicted unresolved attachments. Barnett and Parker (1998) declared that role-reversal was a form of parentification that had potential to negatively impact the adult child’s children as well, continuing a parenting trend through one generation to the next.

Bowlby (1988) discussed how research utilizing his theory tended to blame the mother for attachment issues and child psychopathology. Bowlby (1980) noted that the parent-child relationship is affected by other members of the household such as the father and siblings. Having an alternate caregiver can assist a child to cope with loss. When a parent is

compromised by depression, disrupted attachments extending into adulthood might be buffered by a nurturing, secure relationship with another adult (Bowlby, 1980; Reupert & Maybery, 2007).

**Bowlby and aspects affecting the child's coping capacity.** Attachment patterns are viewed as a child's way of coping with impaired parenting. Bowlby (1980) proposed that attachment history in childhood is also indicative of how a person later copes with loss and suggested that the child who had a stronger attachment with their parent struggled more in coping with loss than those who did not have a strong attachment. However, Bowlby (1988) later declared that an individual who has experienced increased stress and poor attachment with a parent tends to have more difficulty handling other losses and adversities when compared to those who have a secure attachment. Researchers like Weiss (2001) and Stroebe (2002) also began to connect attachment styles with coping abilities in situations of loss. For example, those with a secure attachment cope with loss more easily than those with any other type of attachment (Stroebe, 2002). This may be related to how these people have an internal working model that reinforces that they are lovable and loved, are competent, and in turn are more at ease with expressing needs to be comforted (Howe, 2011).

Two main predictors of insecure attachment include a parent's emotional unavailability and psychological insensitivity (Bowlby, 1973; Ainsworth et al., 1978) which are common symptoms of parental depression. Children with an avoidant attachment evade the depressed parent's withdrawn or insensitive, behavior because it causes the child stress (Bowlby, 1988). In loss situations, individuals with an avoidant attachment often delay or inhibit their grief (Stroebe 2002). Their internal working model conveys that they are unlovable, but their perception is that they are self-reliant. So, they minimize their needs for

support and in fear of unavailability or rejection, tend to avoid seeking comfort for their grief (Howe, 2011). Children with an ambivalent attachment exhibit attention-seeking behaviors to get their needs met and these behaviors are magnified in situations of parental separation, emotional unavailability, or insensitivity. They have an internal working model of low self-worth, are very dependent, and anticipate that others are unreliable (Howe, 2011). Children who cannot organize an attachment strategy (disorganized attachments) usually have experienced a parent that was emotionally distant, confusing, unpredictable, or dangerous (parents with addiction, psychosis, or depression) and worries others will behave this way. Their internal working model regards the self as frightened, alone, and “bad,” and they tend to struggle the most with a loss (Stroebe, 2002).

When a child exposed to parental depression develops an insecure attachment, and functions in the parentified role, some researchers posit that the internal working model might be the mechanism in which positive or negative outcomes occur for them as an emerging adult (Hooper, 2007). For example, Katz et al. (2009) found a strong association between parental depression, attachment anxiety and parentification (emotional role reversal type) in the parent-child relationship, and then utilization of excessive reassurance seeking and depressive symptoms as that child became an emerging adult. The investigators argued that the depressed parent’s inconsistent behaviors (e.g., intermittent closeness) fostered the child’s negative internal working model of the self as unworthy. Fearing abandonment and having an anxious attachment strategy, to cope the emerging adult relied on the tendency to seek constant approval in relationships (Katz et al., 2009). Meanwhile, it has been proposed that some parentified children of depressed parents are able to draw on feelings of significant contribution and accomplishment from caregiving. This way of making meaning from the



experience promotes a more positive internal working model for viewing the self, others, and relationships (Hooper, 2007).

Bowlby (1980) stated that a child's age and degree of understanding of a loss (including when a parent is mentally ill) has ramifications for future psychosocial outcomes, addressing how mental health professionals working with children of "psychopathic parents" (Bowlby, 1965) should talk about the parent's mental state with children and then "wean them away from parents who are psychologically unfit and bad influences" (p. 148). He stated that the mental health professional must help the child to "consider the problem and understand its meaning" (p. 148). Bowlby (1980) mentions intelligence as a possible resiliency factor for children that suffer the loss of a parent. To Bowlby, rather than relating children's understanding and intelligence as components of mastery, mastery relates to maintaining affectional bonds or "seeking proximity" to the parent when faced with a stressful situation. Bowlby (1979) depicted the individual with a compulsive caregiving pattern as someone who can only retain an affectional bond through serving as the caregiver in that parent-child relationship. Others suggested that to avoid helplessness, the child serves in that caregiver role to maintain proximity or closeness to the parent (Barnett & Parker, 1998). Or, some research suggests that children ascertain a level of mastery as a caregiver to their depressed parent (Fraser & Pakenham, 2009; Hooper, 2007).

In empirical work utilizing attachment theory to view children of depressed parents, no studies were found that addressed understanding of parent's depressive symptoms, degree of intelligence, or relationships between the two with regards to mastery. In addition, while studies using the theory to examine children of depressed parents have found contributions of social support to children's well-being (Murray, Halligan, Adams, Patterson, & Goodyer,

2006; O'Connell, 2008), social support was not a focus by Bowlby. (For more detail, refer to Table 2.1.)

### **Boss's Ambiguous Loss Theory**

Pauline Boss (1984) proposed a theory of ambiguous loss, or “an incomplete, uncertain loss of a loved one where ambiguity interferes with meaning making, causing lack of resolution” (Boss, 1999, p. 3). There are two types of ambiguous loss. The first type helps explain the experience for people who have a loved one that is physically absent, but psychologically present (e.g. missing persons). For this paper, ambiguous loss will refer to the second type which helps explain what people encounter when a loved one is physically present, but psychologically absent. Situations that have been studied pertaining to this type of ambiguous loss are Alzheimer's disease (Blieszner, Roberto, Wilcox, Barham, & Winston, 2007; Boss, Caron, Horbal, & Mortimer, 1990), traumatic brain injury, (Landau & Hissett, 2008), autism (O'Brien, 2007), schizophrenia (Kristoffersen & Mustard, 2000), and military reservists returning home post-deployment (Faber, Willerton, Clymer, MacDermid, & Weiss, 2008).

Central to ambiguous loss theory is that the loss is characterized as “unclear, unresolved (complicated), and confuses relationships and inhibits closure” (Boss, 2009, p. 1). *Boundary ambiguity* follows and is defined as “a state in which family members are uncertain in their perceptions of who is in and out of the family and performing what roles and tasks within the system” (Boss, Greenberg, et al., 1990, p. 1). The uncertainty of the loved one's status and whether he or she will ever reunite with the family as they once were endures. One proposition in the theory is that higher boundary ambiguity in the family causes higher stress and greater dysfunction within the individual and family, often leading to

difficulty identifying and utilizing effective coping strategies (Boss, 2004). Short-term, boundary ambiguity may not cause dysfunction, but when persistent, family members become increasingly stressed and often manifest symptoms similar to anxiety, depression, or psychic numbing (Boss, Caron, et al., 1990; Boss, 1999, 2009).

**Boss and the impact of timing of parental depression on child development.**

Ambiguous loss theory does not examine coping and outcomes along the developmental trajectory. Boss and others using her theory have emphasized that boundary issues are more likely to occur during times of change in families. Boss and Greenberg (1984) described parentification as “a change in family structure characterized by boundary ambiguity” (p. 6). They posit that parentification and abandonment of parental responsibilities occur because family members function in developmentally inappropriate roles. Table 2.1 summarizes the impact of ambiguous loss related to parental depression on the child at different stages of development.

**Boss and changes in parent-child roles and relationships.** A primary focus of Boss’s theory are the changes that occur in family roles and relationships. Boss (1999) argued that a closer relationship between an individual and their psychologically absent loved one poses more difficulty in coping. The rationale may pertain to a deeper struggle with the confusion and uncertainty that occurs due to the ill loved one’s changed demeanor and behavior. Loved ones have often described how the person they once knew, was someone much different as symptoms of the illness began to manifest (Blieszner et al., 2007; Faber et al., 2008; Landau & Hissett, 2008; O’Brien, 2007). Researchers using the theory often focus on the unpredictable behaviors related to the illness and how uncertainty of what to expect from the ill loved one increases stress (Faber et al., 2008; Landau & Hissett, 2008; O’Brien,

2007). Studies have found that children are often uncertain of what mood and behavior to anticipate from their depressed parent (Ahlstrom et al., 2011; Baik & Bowers 2006; Fjone et al., 2009; K. Foster, 2010; Knutsson-Medin et al., 2007). In one retrospective study of adult children of depressed parents ( $n = 126$ ; ages 18 – 21), significant associations were found between having a depressed parent and unpredictable discipline ( $F(1, 3.06) = 4.15, p = .044, \eta^2 = .07$ ) and unpredictability of family life mediated the effect of parental depression on the adult child's anxiety and depression (Ross & Wynne, 2010).

**Boss and aspects affecting the child's coping capacity.** In coping with ambiguous loss, the ability to understand the illness can help combat boundary ambiguity and promote more positive outcomes (Boss & Greenberg, 1984). In cases of ambiguous loss the lack of information often facilitates persistent confusion (Boss, 1999, 2004, 2009; Boss, Caron, et al., 1990). Many times the loved one's diagnosis and associated behaviors are misunderstood by family members. For example, family members tend to view their loved one's behaviors as deliberate malingering or laziness, only adding to the frustration in the relationship and hindering coping (Blieszner et al., 2007; Landau & Hissett, 2008).

One proposition in Boss's theory is that the value system of the family (e.g., favoring mastery versus fatalism) influences the perception of boundary ambiguity. Fatalism is the belief that what happens in life is predetermined by a higher power and having this belief is more likely to inhibit the family taking action as they believe it is beyond their control (Boss, 2002). Boss (2009) determined that fatalistic beliefs are associated with deficits in mastery, or a reinforcer for helplessness. Research on ambiguous loss indicates that deficits in mastery (parallel to increased helplessness) that lead to depression are predicted by the degree of boundary ambiguity in family relationships (Boss, Caron, et al., 1990; Boss, 2009). Because

uncertainty is high, the stress of boundary ambiguity is more debilitating for individuals oriented toward mastery and control compared to those who are more relaxed and flexible in problem-solving (Faber et al., 2008; Boss, 2009).

Perception of mastery seems to be related to the degree of understanding family members have regarding the illness as well as perceptions of effective caregiving. If family members perceive that they are not mastering and understanding their roles with regard to the ill loved one, it often enhances helplessness, boundary ambiguity, and stress (Boss, 2007). Children of depressed parents may use their caregiving role to achieve a sense of mastery, but are likely set up for failure as this role is usually beyond their maturity level (Byng-Hall, 2008). According to ambiguous loss theory, when people cannot master one area of life, they may seek mastery in other areas such as meditation, painting, or playing a musical instrument (Boss, 2009). Resiliency work with children has shown that mastery in academics, sports, art, drama, or music can allow some positive feedback about themselves and have a life apart from their mentally ill parent (Fraser & Pakenham, 2009; O'Connell, 2008; Polkki et al., 2004).

It seems understanding is still not enough for a loved one faced with an ambiguous loss to achieve mastery, but must transcend to some degree of sense or meaning-making. When one tries to understand something, it often determines whether one feels a sense of meaning, value, and purpose (Abrams, 2001). Ambiguity prohibits meaning-making (Boss, 2002). To cope, family members must first confront the changes occurring, which can become a delicate balance between holding onto something meaningful from the past relationship with the loved one and letting go of what is no longer there (Boss, 1999). Refer to Table 2.1 for more details.

One consistent finding in research with ambiguous loss theory is ambivalence, or holding conflicting thoughts and feelings about the ill loved one (Boss, 2002; Kristoffersen & Mustard, 2000; O'Brien, 2007). While encountering a loss, ambivalent feelings are normal, but when an individual has lost parts of who they once were, it adds great confusion. One way a family can battle boundary ambiguity and strive for resiliency is by engaging in “both/and thinking,” or learning to adopt a paradox, such as, my family member is simultaneously present and absent (Boss, 2004, 2007). Perhaps the child of a depressed parent may cope better if they can adopt a stance such as, “My parent is here physically, but at times his or her illness prevents him or her from being here emotionally.” According to Boss (2009), this type of dialectical thinking, is a gateway to sense and meaning-making. Taken together, these elements of understanding, sense-making, and mastery might relate to second control coping strategies used by individuals to cope with stressful situations beyond their control. For example, Langrock et al. (2002) and Fraser and Pakenham (2009) found that children of depressed parents that utilize secondary control coping strategies such as positive thinking and cognitive restructuring, cope more effectively than those children who utilize primary control (problem-solving and emotional regulation) and disengagement control (denial, avoidance, and wishful thinking) coping strategies.

Individuals have a greater ability to master difficult and uncertain situations when they have social resources (Abrams, 2001). With social support often comes varying perspectives, which can influence family member’s perception of their loved one’s illness (Boss, Greenberg, et al., 1990). Boss (1999) states that there are two ways in which the receipt of information affects boundary ambiguity, when family members cannot get the facts surrounding the loss, i.e., the illness is either hidden or denied (inside), or when the condition

of the family member goes undiagnosed (outside). Either adds to the boundary ambiguity and the struggle for family members to make sense of the situation (Boss & Greenberg, 1984).

For example, participants in Landau and Hisset's 2008 study discussed how they were embarrassed by their loved one's brain injury and tried to conceal it to prevent humiliation. Since society does not readily recognize ambiguous loss, families can feel that their emotions are unjust and invalidated (Betz & Thorngren, 2006; Boss, 1999, 2002, 2006), adding to the isolation and lack of social support. Societal misinformation and stigma often surround depression and can impede establishing intimate relationships which are pivotal contributors to psychosocial well-being (Arnett, 2010). Emerging adults who have grown up with a depressed parent find it difficult to establish relationships as it makes them uneasy and causes stress (Fjone et al., 2009; Frederick & Goddard, 2008). For a summary of the potential for both theories to explain the experience of growing up with a depressed parent, see Table 2.1.

### **Explanatory Power of Both Theories in Understanding the Emerging Adult's Experience of Growing Up with a Depressed Parent**

#### **Timing**

Research remains inconsistent in finding a stage of development when the child is most vulnerable to parental depression. One thing is clear that the experience of growing up into an emerging adult having had a parent with depression carries some degree of loss and has cumulative and ongoing effects. As an emerging adult, not only might these individuals have missed significant benefits of being a child (e.g., progressively taking on developmentally appropriate responsibilities, carefree play and socialization with peers), for so many, they lost a piece of the relationship they once had with the parent or aspects of what a typical parent-child relationship might be; reciprocal, consistent, and undaunted.

In considering the impact of timing, ambiguous loss theory emphasizes that boundary issues are more likely to occur during times of change in families, but has yet to examine ambiguous loss and the impact on specific stages of development. Although later work addressed adult attachment styles and the correlations that tend to exist with early attachment bonds, attachment/loss theory originally focused on earlier stages of childhood development. For example, in his work with parent-child separation, Bowlby (1951) specified that a time span of at least two years and the separation occurring prior to the age of 5 would pose the most detriment to the parent-child attachment relationship as well as with others in future relationships (as cited in McLeod, 2007). It is known that although susceptible to some change via later experiences, the attachment style established in infancy is generally set and very difficult to change. Parental depression can occur at any time, is often a chronic condition, or can occur intermittently. This can add confusion and prompt necessary revisions to the parent-child relationship at any stage. Some scholars have argued that while attachment patterns are unlikely to change, internal working models are more malleable in light of positive relationship experiences, even if those experiences occur in emerging adulthood (Hooper, 2007). Overall, the theory of attachment/loss seems to show greater utility in explaining what occurs across development within the parent-child relationship when a parent is depressed.

### **Changes in Parent-Child Roles and Relationships**

While the focus of Bowlby's attachment/loss theory remained on the parent-child dyad, Boss's ambiguous loss theory considers family perceptions and understanding of the loss, reconstruction of roles, and assistance in coping (e.g., spirituality, hope, and social support). This is essential when examining the effects of parental depression on children



since depression is a family illness (Meadus & Johnson, 2000, Peisah et al., 2005). In attachment/ loss theory the family as a whole is minimally addressed. In fact, empirical work testing attachment/loss theory has been criticized for not considering the structural aspects that might affect child outcomes later in emerging adulthood.

Conversely, ambiguous loss theory addresses the parent-child relationship. When a parent suffers from depression, there is no physical absence or finality as the parent remains physically present, which likely adds confusion and uncertainty to the child's experience. Boss (2009) contends that given uncertainty, family members lack closure and are prohibited from moving past the experience. Boss (2009) noted that Bowlby's theory did not address partial death nor refer to losses that were ambiguous. In his loss of bonds theory, Bowlby does express that the child's goal of physical proximity shifts to a goal of psychological proximity (known as the reorganization phase). Here, rather than being pre-occupied with the parent's return, the child focuses inward, or on aspects of his or her own life. Bowlby and Ainsworth's concept of rejection (e.g., the parent is unresponsive to the child) might explain the loss of a parent who might have once been emotionally available, nurturing, and encouraging to the child, as in parental depression. However, in cases where the parent suffered from depression from the child's birth and beyond, rejection has less explanatory power as this would be all that the child knew. Therefore, deprivation (e.g., the parent cannot give the love and care for normal growth and development), another concept in attachment/loss theory, would better explain the experience of having a depressed parent.

Still, Bowlby's attachment/loss theory has been documented as a theory that addresses the "so-called normal response to grief" (Rando, 1993, p. 4). With a partial or ambiguous loss, there is increased confusion and uncertainty as to who is in and out of the

family and supposed to perform which tasks. When a parent is depressed, boundary ambiguity likely occurs in the parent-child relationship. There is often confusion regarding both the child's and parent's roles and responsibilities or "parentification" occurs. Depressed parents may even require hospitalization to keep them safe from self-harm, causing separation and is often cited as the most stressful time in these children's' lives (Reupert & Maybery, 2007; Polkki et al., 2004). While attachment/loss theory might better explain the process of separation for the child when a depressed parent is hospitalized, ambiguous loss theory might better explain specific changes in the family dynamic during hospitalizations. For example, many times hospitalization means the child's constant care for siblings and the household while the other parent, if present, works (Polkki et al., 2004). Upon the parent's return, children of depressed parents tend to respond with worry over a parent attempting suicide (Ahlstrom et al., 2011; Knutsson-Medin et al., 2007; Meadus & Johnson, 2000; O'Connell, 2008). The most important difference between the two theories seems to be boundary ambiguity. It can be argued that boundary ambiguity can lead to role reversal, which might be a key threat to the well-being of an emerging adult who grew up with a depressed parent. Therefore, ambiguous loss theory appears more useful in assessing the role changes that likely occur within the depressed parent-child relationship.

### **Aspects Affecting the Child's Coping Capacity**

Coping with a loss requires adjusting, redefining identity, and altering roles. Boss (2009) addresses attachment stating that, "although there is altered communication and affection, attachments often remain" (p. 8). Bowlby also defined alterations in ties between parent and child as a disrupted attachment. Children of depressed parents are more prone to developing attachment patterns that are avoidant, ambivalent, or disorganized, which could

explain outcomes such as low self-esteem, internalizing and externalizing behaviors, and difficulty in relationships (Murray et al., 2006). In order for an individual to cope effectively, he or she must revise the attachment. Bowlby (1980) contended that when attachment is disrupted, such as in the case of the loss of bonds, successful mourning requires modification of the individual's internal working model or the cognitive framework used to understanding self, others, and relationships. Boss (2009) describes attachment revision as a way to find new balance in social connections and activities with the loved one who is attached, but also is fading away. Revising attachment means acceptance of ambiguity in the relationship or feeling happy for those parts of the person that are still available while grieving the connections that are no longer present. This helps normalize stress, combat confusion, and clarify ambivalence. Both theories view meaning making as an ultimate outcome from attachment revision. The difference between the two theories is the added element of ambiguity in the relationship in which Boss's theory offers. When a parent is depressed, the child still has that parent in his or her life and both need to find ways to revise their relationship, but as Boss stresses meaning must now be derived while ambiguity endures.

In a parent-child relationship where the parent is depressed, studies show that common resiliency factors for children include understanding their parent's illness, mastering roles or an area of life where they receive recognition, and access and utilization of social support (Mowbray et al., 2004; Polkki et al., 2004). Secondary control coping strategies utilized by children to cope with parental depression have been shown to contribute to positive outcomes into emerging adulthood. These strategies include things like positive thinking and cognitive restructuring which might relate to Boss's findings that boundary ambiguity and stress are reduced in individuals who can engage in dialectical thinking to

cope with the ambiguous loss of the loved one (Boss, 2009). Maintaining hope is another proposition in ambiguous loss theory that may be connected to second control coping and more positive outcomes for children of depressed parents. Bowlby does not address the impact and value of the child understanding a parent's affective state and subsequent behaviors or maintaining hope as potential resiliency factors for children growing up with a depressed parent. However, later scholars like Stroebe (2002) built upon the concept of the internal working model derived from attachment patterns, illuminating the crucial role of the need to understand or make sense of the self and others' thoughts, feelings, and behaviors, impacting relationships.

As development continues the importance of peer relationships becomes increasingly significant. In an intimate relationship, individuals have mutual acceptance, there is shared disclosure of thoughts and feelings, and consideration for each person's needs, but both people remain emotionally close while also being separate individuals (Arseth et al., 2009). Securely attached children tend to be more likely to build intimate relationships as adults. While Boss better explores the role of social support in coping with an ambiguous loss, Bowlby better addresses the factors within the parent-child relationship that affect the course for how an emerging adult builds relationships that comprise social support. When examining other resiliency factors such as the child's understanding of the parent's depression, areas of mastery in the child's life, and maintenance of hope, Boss addresses these factors more directly and her theory seems more efficient.

### **Gaps in the Literature**

Work focused on the coping and cumulative effects for children growing up with a depressed parent during the first 18 years of life and then outcomes during emerging

adulthood is lacking in regards to this critical developmental stage and theoretical underpinnings. Stroebe (2002) suggested that a major connection exists between attachment, the internal working model, and coping behaviors which explicates how views of the self, others, and relationships are formed and subsequently influence how an individual handles loss. Exploring this link might be beneficial in understanding the loss experience and subsequent coping for emerging adults who grew up with a depressed parent. While parental depression and potential associations with attachment patterns, relationship problems, and psychopathology have been studied, no studies have been conducted using ambiguous loss theory as the foundation for research with children of depressed parents. There may be an important link between parentification, caregiving in children who grow up with depressed parents, and the concept of boundary ambiguity in the parent-child relationship that requires more investigation. D. R. Nelson et al. (2003) argued that research on depressed parents and children's outcomes should expand and address role changes in the family. In addition to these factors, primary, secondary, and disengagement control coping strategies by children growing up with depressed parents might also be important to investigate, especially how utilization of these strategies apply to the emerging adulthood.

### **Implications for Nursing Research and Practice**

The loss and grief response experienced by children of depressed parents is a non-normative loss. Rando (1993) argues that when someone is faced with loss that exceeds the norm, it requires different primary, secondary, and often tertiary levels of intervention. Research indicates that both ambiguous loss and issues with attachment/loss affect an individual physically, cognitively, behaviorally, and emotionally. Stress is perhaps the most blatant outcome. Somatic symptoms such as sleeplessness, fatigue, headaches, or GI

discomfort; cognitive manifestations including worry, forgetfulness, nightmares, or preoccupation with the loss; behaviors such as withdrawal, inactivity to hyperactivity; and emotional symptoms like overwhelming sadness, loneliness, anger, irritability, confusion, guilt, or fear are all documented symptoms of ambiguous loss. These symptoms can be overlooked or misdiagnosed as depression or anxiety (Boss, 1999). Bowlby and others utilizing his theory of attachment/loss in their work have identified increased internalizing and externalizing symptoms, anxiety, depression, and impediments to achieving intimate relationships in children who encounter a depressed parent. Nurses are in an optimal position to identify and assist children trying to cope with a depressed parent in the home as they are often the health professional interacting with the child or family.

In conclusion, Boss has added boundary ambiguity along with a specific blend of other factors that we know about grief and coping that can add significant explanatory power when applied to the issue of children exposed to parental depression. Using ambiguous loss theory as a lens may help mental health professionals better identify, understand, and treat these children. Specifically, it might help build or refine interventions through psycho-education, encouraging peer support, and aligning them with other resources to buffer the experience of depression with the parent and enhance well-being and resiliency into emerging adulthood.

## **CHAPTER 3**

### **PAPER 2: ISSUES IN USING RETROSPECTIVE SELF-REPORT MEASURES IN MENTAL HEALTH RESEARCH WITH EMERGING ADULTS WHO FACED ADVERSE EXPERIENCES IN CHILDHOOD**

#### **Introduction**

Adverse childhood experiences (ACEs) are defined as growing up experiencing any of the following conditions at home prior to age 18: emotional, physical, or sexual abuse, emotional or physical neglect, witnessing intimate partner violence, or having a family member in the home who suffered from substance abuse, mental illness, an incarceration, or a suicide attempt or completion (Dube, Anda, Felitti, Chapman, et al., 2001). Research with emerging adults, or those between the ages of 18 and 25, shows linkages between ACEs and both mental and physical health problems, including depression, psychosis, anxiety disorders, substance abuse, suicidal tendencies, antisocial behaviors, relationship difficulties, sexually transmitted diseases, and risk for complicated grief (Alexander et al., 2005; Anda, Brown, Felitti, Dube, & Giles, 2008; Chapman et al., 2004; Dong et al., 2005; Dube, Anda, Felitti, Chapman, et al., 2001; Dube, Anda, Felitti, Edwards, & Croft, 2002; Dube, Anda, Felitti, Edwards, & Williamson, 2002; K. Foster, 2010; Hillis, Anda, Felitti, Nordenberg, & Marchbanks, 2000; O'Connell, 2003, 2008; Lu, Mueser, Rosenberg, & Jankowski, 2008; McHolm, MacMillan, & Jamieson, 2003; Mowbray, Bybee, Oyserman, MacFarlane, & Bowersox, 2006; Mowbray & Mowbray, 2006; Ross & Wynne, 2010; Schilling, Aseltine, & Gore, 2007; Schraedley, Turner, & Gotlib, 2002; Timko et al., 2008; Vanderwerker, Jacobs,

Parkes, & Prigerson, 2006; Whitfield, Dube, Felitti, & Anda, 2005; Wise, Zierler, Krieger, & Harlow, 2001).

Self-report has been declared an accurate method for obtaining individual health histories, including populations exposed to trauma (Alexander et al., 2005; Anda et al., 2004; Brewin, Andrews, & Gotlib, 1993; Prescott et al., 2000; Schwarz, 2004). Having individuals engage in retrospective self-report entails an active process of reconstructing past experience accompanied by the likelihood of distortion (Ebner-Priemer et al., 2006; Schwarz, 2004; Whitfield et al., 2005). The method has been debated and identified as having issues with reliability and validity, potentially altering findings.

To date, most of the research regarding ACEs has focused on retrospective self-report of past childhood abuse. However, other childhood adversities also tend to accompany child abuse such as witnessing intimate partner violence, experiencing family members who abuse substances, have been in prison, have a mental illness, or are suicidal (Chapman et al., 2004; Hillis et al., 2000; Wise et al., 2001). Or, often when one ACE is reported, then others are also disclosed (Anda et al., 2009; Dong et al., 2004, 2005; Dube, Anda, Felitti, Croft, et al., 2001; Dube, Williamson, Thompson, Felitti, & Anda, 2004; Turner & Butler, 2003). The prevalence of other emotional issues, behavioral difficulties, and diseases affiliated with mortality and morbidity usually increase as the number of reported ACEs increase (Anda et al., 2006, 2008, 2009). All of these factors can make it difficult to decipher the impact of one particular ACE. Chapman et al. (2004) found that one in five women and one in six men endorsed growing up with a mentally ill individual in the home and a strong dose – response relationship between the cumulative ACE score and lifetime prevalence of depressive disorders ( $p < .001$ ); ( $N = 9,460$ ;  $M_{\text{age}} = 55$ ). Lu et al. (2008) found that retrospective self-



report of parental mental illness was associated with the greatest number of co-occurring ACEs ( $M = 3$  ACEs). McHolm et al. (2003) examined parental depression and suicide attempts among several other ACEs. In their sample of 347 individuals ages 15 to 64 ( $M = 39$  years, with oversampling of those ages 15 to 24), 41% endorsed that a parent had a history of depression and 10% of parents attempted suicide. These findings suggest that parental mental illness may have been the main factor predicting later sequelae for these children. There is also evidence that growing up with a mentally ill parent might mediate the relationship between other ACEs and adult outcomes. Timko et al. (2008) concluded that among their sample of 6,942 women ( $M_{\text{age}} = 32.6$ ), that for those who grew up with a mother who was mentally ill and/or a victim of domestic violence exhibited more dysfunction in their own adulthood ( $B = .31, p = .01$ ), after controlling for other ACEs. Findings from a study of relationships between ACEs and later acquired STD's (unspecified) showed increases in STD's in 50% of females (2530/5060) and 20% of males (853/4263) who grew up with a mentally ill parent home (Hillis et al., 2000). Still, studies that investigate mental illness as the primary ACE are rare as seen in Tables 1 and 2.

### **Statement of the Problem: Parental Depression as an ACE**

Growing up in a home in which a parent suffers from depression is classified as an ACE. Parents struggling with depression often experience symptoms that can cause less effective parenting (Knutsson-Medin, Edlund, & Ramklint, 2007; Mowbray et al., 2006; O'Connell, 2008). Disengagement, unpredictability, inconsistency, and low parental warmth can lead to more difficult parent-child relationships, poor social adjustment, and low self-esteem in the child (Baik & Bowers, 2006; K. Foster, 2010; O'Connell, 2008; Ross & Wynne, 2010). Studies show that these experiences can be very stressful for the children and

pose an increased risk for developing depression as well as anxiety disorders, substance abuse issues, and relationship difficulties, especially in emerging adulthood (Baik & Bowers, 2006; K. Foster, 2010; Knutsson-Medin et al., 2007; Mowbray & Mowbray, 2006; Mowbray et al., 2006; O'Connell, 2008). Research remains inconsistent in explaining what it is about growing up with a depressed parent that contributes most to these outcomes (Mowbray & Mowbray, 2006).

### **Purpose**

Given the array of possible adult outcomes and that often these outcomes make the case for interventions, it is essential that investigators retrieve the most accurate personal accounts of ACEs. The purpose of this paper is to examine both utility and issues of *validity* (meaning *accuracy*) and *reliability* (meaning *stability*) when using retrospective self-report as a methodology with adults who experienced ACEs, specifically those who grew up with a mentally ill, depressed parent. Safeguards used by previous investigators were also assessed.

### **Method**

Empirical studies that investigated adult outcomes utilizing retrospective self-report of ACEs within the past 15 years were analyzed (1997 – 2012). This range was chosen in lieu of research in the 1990's that emerged and indicated a different, innovative way to view validity and reliability of retrospective self-report (Widom & Morris, 1997). Inclusion criteria included: studies in which the majority of participants were over 18 years of age recalling ACEs from the first 18 years of life. Since the research focusing on adult retrospective self-report of only parental depression and meeting the inclusion criteria was so limited, all studies that evaluated ACEs, but also included questions regarding the experience of mental illness in a family member in the home during upbringing were included.

Databases searched included: CINAHL, Psych Info, and Google scholar using the search terms: retrospective self-report, retrospective recall, parent depression, and adverse childhood experiences. Twenty-nine studies met criteria, of which  $n = 12$  were individual studies and  $n = 17$  were research reports derived from the largest longitudinal ACE study utilizing retrospective self-report, a collaboration between Kaiser Permanente's Health Appraisal Center in San Diego, California, the Center for Disease Control (CDC), and Emory University in Atlanta, Georgia. To summarize the studies, works were first grouped by which ACEs were addressed (specifically which addressed parental mental illness among various other ACEs, mental illness alone, and depression alone). The studies were grouped again pertaining to emerging adult outcomes. Lastly, the studies were categorized by limitations cited in the use of retrospective self-report (see Tables 3.1 and 3.2).

## **Results**

Considerations and subsequent recommendations to improve the validity and reliability of retrospective self-report and strength of findings were identified. These considerations include general limitations in memory, infantile amnesia, autobiographical memory disturbance, self-referential memory bias, affective valence, mood congruency bias, and the issue of stigma. Refer to Table 3.1 (research reports) and Table 3.2 (research studies) to view these limitations in which were either cited by the investigators as a limitation or identified by this writer.

### **Factors Shown to Impact Retrospective Report**

**General limitations in memory.** Memory is susceptible to a degree of forgetting and any delay that occurs between an experience and its recall promotes loss of information (Robinson & Clore, 2002). It is well known that the reliability of responses to questions

Table 3.1

*Research Reports from The ACE Study: A Collaboration between Kaiser Permanente & Emory University*

Study	Purpose	Sample	Validity or Reliability Safeguards	Limitations identified*
<i>Mental illness in a household member</i>				
Anda et al., 2002	To examine how growing up with alcoholic parents and other ACEs relates to the risk of alcoholism and depression in adulthood.	$n = 9,346$ (ages 19-94) HMO enrollees	Findings compared with national studies	* Affective valence bias * Mood congruent bias
Anda et al., 2004	To examine the relationship between eight types of ACEs and three indicators of impaired worker performance (serious job problems, financial problems, and absenteeism).	$n = 9,633$ ( $M$ age = 48) HMO enrollees	Compared both respondent & non-respondent report to decrease bias (sensitive topics). Findings compared with neuroscience & development.	Sensitive topics/ underreporting More detailed measures needed * Affective valence bias * Mood congruent bias
Anda et al., 2006	To present a conceptual framework that integrates findings from recent studies of neuro-bio effects of childhood abuse and exposure to domestic violence on brain structure and function.	$n = 17,337$ ( $M$ age = 56) HMO enrollees	Findings compared with neuroscience & development.	Autobiographical memory disturbance (AMD) Sensitive topics/ underreporting * Affective valence bias * Mood congruent bias

Table 3.1 (cont.)

Study	Purpose	Sample	Validity or Reliability Safeguards	Limitations identified*
Anda et al., 2009	To assess the relationship between ACEs and premature death of a family member.	$n = 9,367$ ( $M$ age = 56) HMO enrollees	Compared premature family deaths with history given in a clinical evaluation Findings compared with national studies	Missing information re: family members who died. * Affective valence bias
Brown et al., 2007	To examine relationships between childhood AMD and ACEs.	$n = 9,460$ ( $M$ age = 57) HMO enrollees	Findings compared with neuroscience & epidemiology studies	Discussed over reporting. AMD * Affective valence bias
Chapman et al., 2004	To examine the relationship between total ACEs and prevalence of depression.	$n = 9,460$ ( $M$ age = 55) HMO enrollees	Findings compared with similar studies	* Affective valence bias * Mood congruent bias
Dong et al., 2004	To examine the degree to which ACEs co-occur as well as the nature of their co-occurrence.	$n = 8,629$ ( $M$ age = 55) HMO enrollees	Findings compared with national studies	Mood congruent bias Sensitive topics/ underreporting * Affective valence bias
Dong et al., 2005	To examine the relationship between childhood moves, ACEs, and adolescent- adult health problems.	$n = 8,116$ ( $M$ age = 56) HMO enrollees		One question assessed moves. Sensitive topics/ underreporting * Affective valence bias * Mood congruent bias

Table 3.1 (cont.)

Study	Purpose	Sample	Validity or Reliability Safeguards	Limitations identified*
Dube, Anda, Felitti, and Chapman, et al., 2001	To examine the relationship between the risk of suicide attempts and ACEs.	$n = 17,337$ ( $M$ age = 57) HMO enrollees	Repeated analysis after excluded missing information. Findings compared with neuroscience, epidemiology, & national studies	Missing information AMD Affective valence bias
Dube, Anda, Felitti, Edwards, and Croft, 2002	To assess the relationship between ACEs and risk of alcoholism as an adult.	$n = 17,337$ ( $M$ age = 56) HMO enrollees	Findings compared with neuroscience and genetics studies	Sensitive topics/ underreporting *Affective valence *Mood congruent bias
Dube, Anda, Felitti, Edwards, and Williamson, 2002	To describe the relationship between reports of witnessing IPV and the likelihood of other ACEs.	$n = 7,970$ adults ( $M$ age = 55) KP HMO enrollees	Findings compared with national studies	Premature mortality Sensitive topics/ underreporting Differential recall *Affective valence *Mood congruent bias *Gender effects
Dube, Williamson, and Thompson, et al., 2004	To examine test-retest reliability of retrospective reports of ACEs.	$n = 658$ ( $M$ age = 64) HMO enrollees	Test-re-test Reliability Findings compared with similar studies	Reliability only assessed as adults Social taboos/ underreporting

Table 3.1 (cont.)

Study	Purpose	Sample	Validity or Reliability Safeguards	Limitations identified*
Dube, Miller, et al., 2006	To study the relationship between ACEs and likelihood of ever drinking and age of first alcohol use.	$n = 8,417$ ( $M$ age = 56) HMO enrollees	Repeated analysis after excluding those with missing information. Findings compared with neuroscience, development, & national studies	Premature death Sensitive topics/ underreporting * Affective valence * Mood congruent bias
Hillis et al., 2000	To examine the relationship between ACEs and subsequent STDs for both men and women.	$n = 9,323$ adults $\geq 18$ ( $M$ age = 56) HMO enrollees	Findings compared with child psychiatric literature	Sensitive topics/ underreporting Developmental limitations: understanding STDs * Affective valence bias
Whitfield, et al., 2005	To examine relationships between ACEs and likelihood of reporting hallucinations.	$n = 17,421$ ( $M$ age = 57) HMO enrollees	Findings compared with similar studies	Only one question assessed hallucinations * Affective valence * Mood congruent bias

\*Indicates a potential limitation identified by this investigator, but not reported by the authors as a limitation.

Table 3.2

*Studies Addressing Mental Illness in the Home as an ACE*

Study	Purpose	Sample	Method	Validity or Reliability Safeguards	Limitations identified*
<i>Mental illness in a family member in the home</i>					
Timko, Sutkowi, Pavao, and Kimerling, 2008	To examine socio-demographic, physical health, mental health, and ACEs associated with binge drinking in women.	$n = 6,942$ women $\geq 18$ ( $M$ age = 56)	Interviews Mailed Survey	Findings compared with national studies	Affective valence bias More detailed measures needed *Mood congruent bias *Sensitive topics/ underreporting
<i>Mental illness in a parent in the home</i>					
K. Foster, 2010	To explore adults' experience and coping of a parent with serious MI.	$n = 10$ (ages =25-57)	Multiple, interviews		
Knutsson-Medin, Edlund, and Ramklint, 2007	To examine the experience of children growing up with a MI parent and their opinions re: contact with MH services.	$n = 36$ (ages =19-38) ( $M$ age = 25.8)	Mailed survey	Findings compared with other quantitative study findings	* Affective valence bias * Mood congruent bias



Table 3.2 (cont.)

	Study	Purpose	Sample	Method	Validity or Reliability Safeguards	Limitations identified*
	Lu, Mueser, Rosenberg, and Jankowski, 2008	To examine the clinical correlates among adults with severe mood disorders.	$n = 254$ adults with MDD or Bipolar Disorder ( $M$ age = 42.87)	Chart reviews Self-report measures In person & phone interviews	Outcomes compared with Child Behavior Checklist (CBCL) by parents Findings compared with epidemiology, national, & similar studies	* Affective valence bias * Mood congruent bias
2	O'Connell, 2008	To examine relationships among attachment, parenting, family mastery, and child stressors with well-being in adults of mentally ill mothers.	$n = 40$ ( $M$ age = 40.8)	Mailed Self-report measures	Findings compared with national & similar studies	* Affective valence bias * Mood congruent bias
	Schraedley, Turner, and Gotlib, 2002	To examine stability of retrospective reports where depression status changed between two assessments one year apart.	$n = 234$ depressed adults (ages =18-55)	Self-report measures Interviews	Test-Re-Test Reliability Assessed mood congruency Life calendar used Reliability addressed – short recall period.	More sensitive measure to assess depression change AMD Self-referential bias * Affective valence bias

Table 3.2 (cont.)

	Study	Purpose	Sample	Method	Validity or Reliability Safeguards	Limitations identified*
	Turner and Butler, 2003	To examine the impact of cumulative childhood adversity and to identify factors impacting psychological distress among young adults.	$n = 649$ college students (ages =18-24)	Self-report measures Interviews		Cumulative advantage” or the more educated the sample, the more access to resources * Affective valence bias
2	<i>History of family depression</i>					
	Wise, Zierler, Krieger, and Harlow, 2001	To assess violent victimization as a risk factor for depression in women	$n = 732$ women with MDD (ages = 36-45)	Mailed survey Interviews	Case-control design Test-Re-test reliability on SCID Findings compared with development, epidemiology, national, & similar studies	Measure Limitations AMD Mood congruent bias * Affective valence bias
	<i>Affective illness in a parent in the home</i>					
	McHolm, MacMillan, and Jamieson, 2003	To examine determinants of suicidal ideation and attempts in depressed women.	$n = 347$ women with MDD (ages = 15-64)	Structured interviews Self-report measures		Multiple informants to strengthen Affective valence Mood congruent bias

Table 3.2 (cont.)

Study	Purpose	Sample	Method	Validity or Reliability Safeguards	Limitations identified*
Mowbray and Mowbray, 2006	To describe the status of adult children of mothers with long-term, mental illness and to describe protective and risk factors while growing up.	$n = 61$ adults (ages =20-29)	Self-report measures Interviews	Data compared with mothers clinical history records Findings compared with national & similar studies	* Affective valence bias * Mood congruency bias
<i>Divorce &amp; depression in a parent</i>					
Ross and Wynne 2010	To examine relationships between parental depression and divorce with depression and anxiety in young adults.	$n = 126$ college students (ages =18-21)	Self-report measures	Findings compared with similar studies	Developmental limitations Mood congruent bias * Affective valence bias
<i>Depressed parent in the home</i>					
Baik and Bowers, 2006	To understand children's experiences of mothers with depression; esp. disclosing their experiences to others.	$n = 5$ adults (ages =26-50)	Eight in depth, in person interviews	Findings compared with development & similar studies	Reliability mentioned Qualitative findings: Stigma prevented disclosure. * Affective valence bias * Mood congruency bias

Table 3.2 (cont.)

Study	Purpose	Sample	Method	Validity or Reliability Safeguards	Limitations identified*
Peisah, Brodaty, Luscombe, and Anstey, 2005	To examine factors associated with lifetime MI in adult children who grew up with a depressed parent.	$n = 94$ (25 years post parent dx) ( $M$ age =36; $M$ age dx = 15 )	Self-report measures	Data compared with parent's clinical history records Findings compared with development & similar studies	Missing data AMD *Affective valence *Mood congruency bias

\*Indicates a potential limitation identified by this investigator, but not reported by the authors as a limitation.

regarding past experiences tends to diminish as the length of the recall period increases. Remembering the central details of an experience tends to occur more often than the peripheral details. For instance, in a study where college students ( $N = 142$ ; ages 18 to 49) participated in experiments regarding retrospective self-report, central details were remembered much better than peripheral details (.75 vs. .23 [ $t(142) = 17.61$ ],  $p < .001$ ) (Berntsen, 2002). Davis (1999) also discovered that participants ( $N = 395$ ;  $M_{\text{age}} = 18.5$ ) recalled more specific rather than generic memories ( $M = .66$  vs. .34,  $F(1, 340) = 218.14$ ,  $p < .001$ ). While peripheral details might not always be the clearest, the main features of an experience tend to remain consistent over time (Hardt & Rutter, 2004).

**Recalling factual events vs. perceptions and emotions.** Self-report is the only data collection method available to ascertain an individual's subjective experiences such as behaviors, emotions, and attitudes in behavioral and social science (Robinson & Clore, 2002; Schwarz, 2004). While adults can recall factual information like the number of childhood moves or when siblings were born, other memories regarding how they were parented (Dong et al., 2005; Henry, Moffitt, Caspi, Langley, & Silva, 1994; Schraedley et al., 2002) and past emotions (Brewin et al., 1993; K. Nelson & Fivush, 2004) are more vulnerable to error. However, Prescott et al. (2000) concluded that recollection of perceived parent-child interactions and family processes (e.g. punitive parenting) were as likely to be reconstructed and accurate as recall of any other childhood experience. In a literature review of studies utilizing retrospective self-report of ACEs, researchers concluded that retrospective self-report of parenting styles, where participants must make more global judgments about feelings of overprotectiveness or rejection, posed highly consistent results across studies (Brewin et al., 1993).

Some evidence exists that perhaps retrospective self-report of parental mental illness is more reliable than reporting feelings about quality of parenting (Peisah, Brodaty, Luscombe, & Anstey, 2005). Schraedley et al. (2002) observed that there was a difference in the way respondents report parenting qualities such as caring, warmth, and overprotection and parental mental illness. They proposed that the way that an individual was parented may be relevant to that individual in ways that differ from the ways that parental mental illness affects the child. One term frequently used in research where retrospective self-report is used is *self-referential memory*. Self-referential memory refers to memories recalled in relation to the self, which usually have priority emotional and cognitive processing (Rogers, Kuiper, & Kirker, 1977). Schraedley et al. (2002) argued that maybe memory bias exists more with self than with recall of parental mental illness. They found that young adults in their study ( $n = 234$ ,  $M_{\text{age}} = 34.8$ ) exhibited unstable reporting over time regarding past traumatic events (e.g. major medical illness, serious accident, physical abuse, parental divorce) and their own depressive episodes, however, retrospective self-reports of their parents depressive symptoms remained stable over time. Self-referential bias or that processing and recalling stimuli referencing the self tends to be remembered better than stimuli regarding others (Rogers et al., 1977). It might be more difficult to give a valid and reliable account of parenting since the participant was directly involved with that aspect of the relationship. Rather, when a parent is depressed, the child is on the periphery, experiencing the consequences of parental depression and not the illness itself. This is logical as individuals are parented once in their lifetime, do not know anything else until they are exposed to how peers are parented, mature into emerging adulthood, and then parent their own children.

Another common term used in research where retrospective self-report is used is *autobiographical memory*, or the explicit recall of an event in a specific time and place in an individual's personal past (K. Nelson & Fivush, 2004). It is a certain type of memory involving the recall of life experiences valued as significant to an individual's self and is affected by cognitive development and the way people are socialized with regards to emotion (Pillemer, 1998; Davis, 1999; K. Nelson & Fivush, 2004). This form of memory extends beyond recalling things like when an individual mastered a new skill to invoking emotions and personal meanings (K. Nelson & Fivush, 2004). Some argue that when individuals are asked to recall past events in their lives, most of what is remembered is emotional in nature (Davis, 1999; Robinson & Clore, 2002). For example, in a study investigating autobiographical memory ( $N = 395$  college students;  $M_{\text{age}} = 18.5$ ), over 75% described most experiences remembered were emotional vs. non-emotional in nature (Davis, 1999).

Findings also showed significant effects on all 10 emotions rated by participants; *happiness* =  $F(4, 200) = 381.89$ ,  $p < .001$ ; *sadness* =  $F(4, 200) = 276.93$ ,  $p < .001$ ; *fear* =  $F(4, 200) = 209.59$ ,  $p < .001$ ; *anger* =  $F(4, 200) = 289.09$ ,  $p < .001$ ; *anxiety* =  $F(4, 200) = 38.80$ ,  $p < .001$ ; *surprise* =  $F(4, 200) = 10.34$ ,  $p < .001$ ; *guilt* =  $F(4, 200) = 40.31$ ,  $p < .001$ ; *shame* =  $F(4, 200) = 82.45$ ,  $p < .001$ ; *contempt* =  $F(4, 200) = 78.82$ ,  $p < .001$ ; and *self-consciousness* =  $F(4, 200) = 136.41$ ,  $p < .001$ ) (Davis, 1999).

Many suggest that memories of highly emotional and perceived life-changing events of childhood are remembered best, persisting through adulthood (Alexander et al., 2005; Berntsen, 2002; Brewin et al., 1993; Davis, 1999; Pillemer, 1998; Robinson & Clore, 2002). Consideration must be made for *differential recall* or when some experiences and associated memories are more vivid than others and thus are remembered more easily (Dube, Anda,

Felitti, Croft, et al., 2001; Dube, Anda, Felitti, Edwards, & Williamson, 2002). For example, one might view an experience such as abuse as a more highly emotional experience and remembered more vividly than experiencing a mother who was so depressed she could not get up out of bed to cook her child dinner. There are other, perhaps more emotionally charged, memories of parental depression that might remain with a child throughout the lifespan. One instance might be when a child experiences a parent when they are suicidal, they tend to vividly recall their parent engaging in self-harm (McHolm et al., 2003). Still, in one mixed methods study ( $n = 36$ ), some of the common experiences remembered by adult children ( $M_{\text{age}} = 25.8$ , range 19 – 38 years of age) of mentally ill (primarily depressed) parents included struggling to understand their parent's mental illness, changes in the relationship with their parent, encounters while visiting their parent in psychiatric facilities, and specific feelings that they had during that time such as: sadness, shame, loneliness, fear, anger, deceit, and insecurity (Knutsson-Medin et al., 2007). Adult participants who grew up with a mentally ill mother in O'Connell's (2008) study ( $n = 40$ ), were able to recall feelings such as their mother had not made them feel safe as a child (80%). A common theme in retrospective studies of adults who experienced depressed parents growing up is "feeling different," from their peers (Ahlstrom, Skarsatar, & Danielson, 2011; Baik and Bowers, 2006; K. Foster, 2010; O'Connell, 2008; Knutsson-Medin et al., 2007). In conclusion if asked, most people who grew up with a mentally ill parent would probably consider it a unique and emotion laden experience. In comparing a person's perspective during childhood and then as an emerging adult, emerging adults have had sufficient life experience from which to make comparisons with how other families function and may have new insights and a well formed perspective.



Robinson and Clore (2002) explored how self-report of emotions differs from having been experienced in the past, currently, and prospectively. They discovered that the main difference between self-report of past, present, and future emotions is the type of knowledge and memory used to retrieve the emotion and how each source can produce a slightly different reported emotion. In reporting current emotions, individuals access directly from *experiential knowledge* whereas reporting of emotions experienced in the past requires tapping into *episodic memory* or past experiences. Episodic memory of an event is time, space, and location specific and self-awareness is certain within that experience; generating feelings of certainty, such as “I was there and I did that” (Tulving & LePage, 2000, as cited in K. Nelson & Fivush, 2004). Robinson and Clore (2002) argued that emotions recalled from the past through mental re-enactment result in a newly created, present emotion. In such a case, the contextual details of the experience can be recalled which helps with the recreation of the emotion felt during that time.

**Gender differences.** Many studies have found gender differences in retrospective self-reporting; primarily that females report sexual abuse more often than males. (Alexander et al., 2005; Dube, Anda, Felitti, Croft, et al., 2001; Dube, Anda, Felitti, Edwards, & Croft, 2002; Dube et al., 2006; Widom & Morris, 1997). Alexander and colleagues conducted a 2005 retrospective study of memory accuracy and errors 12 to 21 years after child abuse ended in adults with post-traumatic stress disorder (PTSD) and found that besides the most significant predictor of maternal support, female vs. male gender was also a predictor of fewer omission errors ( $B = -.21, p < .10$ ).

Specific to remembering emotions, Davis (1999) conducted a study on adult gender differences in recalling childhood emotions (grades 5 through 11), finding that girls

remembered more than boys ( $M = 7.25$  memories,  $M = 5.96$  memories respectively) and recalled experiences with more emotional intensity ( $M = 4.76$  vs.  $4.45$ ,  $F(1, 200) = 8.75$ ,  $p = < .01$ ). In similar experiments with young adult Australian participants ( $M_{\text{age}} = 20$ ), women ( $M = 5.96$ ) recalled more memories than men ( $M = 4.14$ ),  $F(1, 71) = 10.07$ ,  $p = < .01$ ) and recalled more emotions (happiness, sadness, fear, anger, and feeling self-conscious)  $F(1, 55) = 14.07$ ,  $p = < .001$ . Another sample from U.S. college students ( $n = 298$ ), showed similar results i.e. women recalled more memories than men ( $M = 6.49$  vs.  $4.88$ ,  $F(1, 229) = 211.23$ ,  $p = < .001$ ), recalling more memories per category (or experiences that elicited the emotions listed above; Davis, 1999).

Reasons for differences in retrospective self-report might be explained by looking at how females and males are socialized. For instance, roles that are assigned to a gender given societal definitions of femininity and masculinity and scientific findings support that women tend to be more emotionally expressive and emotionally aware (Robinson & Clore, 2002). It is speculated that females have a greater representation of ACEs such as childhood abuse because males are less willing to discuss such sensitive information (Widom & Morris, 1997; Alexander et al., 2005). This also seems to be the case in sharing of experiences like growing up with a mentally ill parent in the home as the majority of most samples are female.

In many studies, experiences and emerging adult outcomes for children of depressed parents differ by gender. This might be due to relationship differences between mothers and daughters vs. mothers and sons (depressed mothers primarily comprise the research). There is evidence that shows that mothers elaborate more with daughters than sons in conversations, including those of past events, which could account for more content, richer detail, stronger connections, and stronger internal representations of past memories (Davis, 1999; K. Nelson

& Fivush, 2004). Still, inconsistencies exist with gender differences for experiences and outcomes of children of depressed parents (Mowbray et al., 2006; C. E. Foster et al., 2008).

**Age considerations.** Emerging adulthood (individuals ages 18 to 25; Arnett, 2000) has been declared an excellent time to use retrospective report since memory is at its peak, especially in regards to validity (Schilling et al., 2007; Turner & Butler, 2003). In a study examining the direct and indirect effects of ACEs on emerging adults' depressive symptoms, evidence suggests that the relatively young age of participants ( $N = 649$  college students ages 18-29, 95% of which were 18-24, with a mean age of 19 years) added to the reliability of findings (Turner & Butler, 2003). In one study that assessed disruption in remembering ACEs as an emerging adult ( $N = 1,409$  of 9,460) where 77% identified memory deficits during ages 4-6, 57% for ages 7-9, 32% for ages 10-12, 15% for ages 13-15, and 9% for ages 16-18 (Brown et al., 2007). This might suggest that with time it was harder to recall ACEs. In another study where participants ranged from 3rd to 11<sup>th</sup> graders ( $n = 213$ ) to college students ( $n = 395$ ) the emerging adults in the sample recalled childhood experiences as being more emotionally intense ( $M = 5.22$  emotionally intense memories) than the children and adolescents ( $M = 4.60$  emotionally intense memories) (Davis, 1999). This might suggest that the ability to recall more affectively intense experiences peaks in emerging adulthood and may be related to maturity or that children may have more difficulty than emerging adults in making sense of and finding the words to describe intense emotions. In emerging adulthood there has been time to gather enough experience for a "lifetime report" (Schilling et al., 2007). Acquiring a report earlier might be prone to failed translation from immature child memory representations to more mature ones or memories are reinterpreted from an adult perspective (Pillemer, 1998). This coincides with what is known about the development of

autobiographical memory; early in life the focus is on single episodes, but into late adolescence, these episodes encompass a more comprehensive life narrative (K. Nelson & Fivush, 2004). The impact of parental depression might not be immediate, therefore, it is essential that research be conducted during emerging adulthood when outcomes might be better assessed.

Researchers utilizing retrospective self-report have documented that underestimations of relationships between ACEs and adult outcomes can occur when the sample consists of older individuals, citing debilitating illness or premature mortality as potential factors (Dube, Anda, Felitti, & Croft et al., 2001; Dube et al., 2006). Also, as a person ages and gathers more knowledge and life experience, how that person views earlier experiences is likely to change and could skew retrospective self-report and results (Brewin et al., 1993). Robinson and Clore (2002) discussed adult positivity or how the older people get, the more likely the desire to positively reflect on life. O'Connell (2008) found that adult children ( $n = 40$ ;  $M_{\text{age}} = 40.28$ ) of mentally ill mothers disclosed how they functioned better as they aged, contributing improved psychosocial well-being to education, psychotherapy, and positive relationships.

**Infantile amnesia.** Studies show that in general individuals can remember back to age 3 or 4 and that the ability to remember what occurred in the first two to three years of life is highly unlikely (Lewis, 1995 in Hardt & Rutter, 2004; K. Nelson & Fivush, 2004). First identified by Freud, infantile amnesia is defined as, “the difficulty most adults have remembering events from the first few years of their lives,” (Pillemer, 1998, p. 895). Explanations for infantile amnesia include developmental limitations before the age of 3 such as language development, cognitive abilities (e.g. object permanency, abstract thinking,

deductive reasoning), and socialization are lacking (Pillemer, 1998; K. Nelson & Fivush, 2004). Most deficits in recollection of ACEs occur when the ACE took place during the preschool years (Widom & Morris, 1997). However, ACEs rarely cease at age five, rather ACEs tend to exist or reoccur over the lifespan. A suggestion to counteract potential risks to validity with regards to infantile amnesia is to give the participant a timeline back to 5 years of age (Pillemer, 1998).

Another rationale for infantile amnesia is the degree of “memory talk” that takes place between parent and child which relates to how an individual’s memory is strongly influenced by the life stories that the parent and child discuss through the individual’s development (Pillemer, 1998). When examining memory talk throughout child development and its impact on retrospective report, there are differing views. Supporting this idea, one study assessed predictors of memory accuracy in adults ( $n = 94$ ) suffering from PTSD post (12 – 21 years) childhood sexual abuse and found that maternal support was a significant predictor of memory accuracy ( $B = .33, p = .003$ ). These findings also suggested that when mothers and children openly discussed the sexual abuse, this decreased the likelihood of omission errors ( $B = -.30, p = .01$ ), perhaps due to fostering a more comprehensive account of the abuse (Alexander et al., 2005).

Other scholars suggest that socio-cultural interactions play a significant role in cognition development and that children achieve forms of adult cognitive processing by interacting with adults, especially in conversing about the past (Davis, 1999; K. Nelson & Fivush, 2004). In the absence of parent-child dialogue regarding childhood experiences, a child tends to lack the tools necessary to construct meaning for those experiences (Pillemer, 1998). Depression can prompt changes in parenting including disengagement,

unpredictability, inconsistency, and low parental warmth, often leading to a more difficult parent-child relationship. Therefore, memory talk or processing is probably diminished. Still, while supportive mothers may talk more and assist their children in legitimizing experiences (Alexander et al., 2005), recalling past experiences can be misguided by a parent's account of the experience (Widom & Morris, 1997).

**Autobiographical memory disturbance.** When there is a memory disturbance in which an inability to recall events from childhood exists, it is termed autobiographical memory disturbance (Brown et al., 2007). Some have declared that before the age of 7, autobiographical memories are somewhat muddled (Davis, 1999; Kihlstrom et al., 2000). There is general acceptance that autobiographical memory is at minimum partly reconstructive (Davis, 1999; K. Nelson & Fivush, 2004; Widom & Morris, 1997). In connection with ACEs, a major factor to consider is the type of memory an adult research participant might be asked to recall from their childhood years. If unpleasant or blatantly tragic, the risk of repression exists or pushing memories from consciousness is a means of protecting oneself (Berntsen, 2002; Davis, 1999; Dong et al., 2004; Pillemer, 1998). Pillemer (1998) urged researchers to reframe how repression is perceived, stressing that forgetting certain experiences often has less to do with avoiding negative emotions, but more to do with a lack of reflection and understanding of the experience.

Anda et al. (2006), from the ACE study of 17, 337 adults, discovered that the risk for impaired memory of childhood experiences increased nearly four and a half fold for participants who endorsed four or more ACEs. Brown et al. (2007) found that when the number of ACEs reported by participants ( $N = 9, 460$ ) increased, the presence of autobiographical memory disturbance increased in a continuous, graded fashion or when

adult participants endorsed six or more ACEs, they were six times more likely to experience difficulty remembering childhood memories in comparison to those participants with no ACEs. The investigators pointed out a potential contributor might be the effects of accumulated traumatic stress on the developing child brain. Turner and Butler (2003) found that cumulative childhood adversities and subsequent childhood stress related to emerging adult outcomes such as low mastery, negative self-esteem, and depressive symptoms. These findings also showed that only 10% who reported having experienced none, one, or two ACEs experienced childhood depression vs. 28% who had seven or more ACEs suffering from early onset depression.

Still, despite the studies reported here, relationships between ACEs and the cumulative effects, autobiographical memory disturbance, and the validity and reliability of adult retrospective self-report remain unclear. For example, Brown and colleagues' (2007) study of autobiographical memory disturbance showed less than 15% of adult participants reported having one or more periods during childhood when they had difficulty remembering ( $N = 9,460$ ). Both Anda et al. (2006) and Brown et al. (2007) assessed the relationship between the number of ACEs reported and the ages where memory loss was endorsed (77% for ages 4-6, 57% for ages 7-9, 32% for ages 10-12, 15% for ages 13-15, and 9% for ages 16-18). These findings support that as individuals age into late adolescence, memory loss decreases.

**Stigma and social taboos.** Stigma as well as social and legal implications can often be barriers to data collection during actual occurrence of ACEs. Still, asking an adult to remember and report topics such as abuse, emotional or physical neglect, intimate partner violence, substance abuse, incarceration, mental illness, and suicide all carry a degree of

stigma or can be considered socially taboo. An individual might be embarrassed, ashamed, and unwilling to share such private information. Studies show that children of mentally ill parents often report feeling stigmatized in relation to their parent's illness and often this leads to concealing their experience and pushing away others who might serve as social support (Ahlstrom et al., 2011; Baik & Bowers, 2006; O'Connell, 2008). Baik and Bowers (2006) conducted eight individual interviews with five adults ages 26 to 50 regarding their experience while living with a chronically depressed mother. Consistency between participants included feeling stigmatized by their mother's depression, adding that they often covered up what was going on at home, would only discuss their mother's depression with siblings, and kept people away from their home life. A main contributor of disclosure regarding their mother's diagnosis was the degree of safety felt by participants, specifically childhood perceptions of other's abilities to listen and be empathetic (Baik & Bowers, 2006). In another retrospective study conducted with adult children of seriously mentally ill mothers ( $n = 40$ ), 72% reported that it was not okay to talk about family problems with outsiders, while 92% endorsed that it was not okay for them to discuss their mothers illness with relatives (O'Connell, 2008). Still, sometimes other aspects of an individual's life commonly stigmatized in society are readily disclosed. For example, in one study participants seemed to openly share their current prescription drug abuse, but seemed less likely to report ACEs (Anda et al., 2008).

Given potential issues such as infantile amnesia, autobiographical memory disturbance, repression of memories, and stigma or socially taboo topics, it is therefore likely that some may not report ACEs or minimize the experiences. Several investigators suggested that subsequently, underreporting can occur affecting testing for relationships between



variables and strength of those relationships between an ACE such as childhood abuse and adult outcomes (Anda et al., 2004; Timko et al., 2008; Widom & Morris, 1997). This would most likely underestimate the occurrence and magnitude and interrelatedness of ACEs. For example, Dube, Anda, Felitti, Edwards, & Croft (2002) cited underreporting as a weakness in their work which examined the relationships of eight ACEs and the risk of heavy alcohol use, alcohol abuse, and alcoholism in adulthood, stratified by parent's history of alcohol abuse. Although they had significant findings, they documented that the strength of those findings was most likely underestimated due to underreporting.

**Affective valence bias.** Affective valence is a form of recall bias in which information that related to a more positive affect is more easily remembered than information associated with a negative affect (Kihlstrom et al., 2000). Referencing stigma and social taboos, it is reasonable that variability in participant responses occurs in mental health research where the questions asked are often of a sensitive nature. Similar to the case made regarding infantile amnesia and repression of traumatic memories, researchers must also consider that ACEs are stressful and as an emerging adult, remembering these events can be impaired as a form of self-protection. However, other scholars have posited that highly negative experiences are remembered quite well. There is substantial evidence that adult survivors of childhood trauma exhibit heightened memory and are less likely to forget those experiences, especially when cued with trauma related words (e.g., rape, abuse, neglect) (Alexander et al., 2005). To support this, Berntsen (2002) found that shocking, negative events were remembered just as much as happy, positive events (99.9% and 100%, respectively).

Childhood experience such as having a mentally ill family member in the home can consist of both positive and negative memories. Perhaps those positive experiences were less frequent, but unique and therefore fairly simple to recall. Reporting more negative than positive memories is common when adult participants are asked to recall childhood memories of their experience with a parent's depression. They cite things like their parent's mood irritability, disengagement, isolation, and overall stress and dysfunction in parent-child relationships (Baik & Bowers, 2006; Knutsson-Medin et al., 2007; O'Connell, 2008; Ross & Wynne, 2010). Studies show that memories of many of the co-morbid features of experiencing a depressed parent in the home are recalled (parental discord, divorce, growing up in a single parent home, and socio-economic struggles) (Knutsson-Medin et al., 2007; O'Connell, 2008; Ross & Wynne, 2010). As for their own feelings from the past, adults report having felt hopeless, lonesome, confused, angry, scared of what might happen to their depressed parent and themselves, and uncertainty about the future (Baik & Bowers, 2006; K. Foster, 2010; O'Connell, 2008; Ross & Wynne, 2010).

Studies have indicated participants that grew up with a mentally ill parent have the ability to objectively assess their past experiences and outcomes as adults. While many studies discover negative childhood experiences and negative adult outcomes are reported, some find that adults who grew up with a mentally ill parent in the home also identify positives or buffers to the experience. For example, Mowbray and Mowbray (2006) found emerging adult outcomes such as, self-discipline, self-sufficiency, personal strength, and tolerance and empathy for others. In another study, gains such as independence and problem-solving abilities were declared positive outcomes from growing up with a mentally ill parent in the home (K. Foster, 2010). Affective valence bias could be a threat to validity

and reliability in all of the studies in this review, while only some investigators listed affective valence bias listed as a potential limitation in their work. (See Tables 1 and 2).

**Mood congruent bias.** Retrospective self-report can be affected by the reporter's mood or affective state at the time he or she is reporting that experience (Hardt & Rutter, 2004). Mood congruent bias is another type of recall bias in which one's current mood facilitates processing of past information with a similar mood, but tends to impair that of an opposite mood (Ebner-Priemer et al., 2006; Kihlstrom et al., 2000). Mood congruent bias suggests that clinical states such as depression, anxiety, and those diagnosed with certain personality disorders will recall more negative than positive experiences. For example, individuals with more severe vs. less severe depression tend to recall past negative experiences, such as separation from parents and less adequate parenting more often than non-depressed individuals (Schraedley et al., 2002; Prescott et al., 2000). To help counteract the potential risk of mood-congruent bias, some researchers suggest using ANOVA to compare differences between groups diagnosed with a mental illness and those without. Ebner-Priemer et al. (2006) used this approach in investigating recall bias between retrospective report in 50 female clients diagnosed with borderline personality disorder and 50 females who had no psychiatric diagnoses, those with borderline personality disorder exhibited an overall negative memory pattern ( $F = 16.48$ ;  $df = 1,49$ ;  $p = .0002$ ), while the control group showed an overall positive memory pattern ( $F = 103.70$ ;  $df = 1,49$ ;  $p = < .001$ ).

Several other scientists argue that there is little support that individuals suffering from mental illness are impaired in reporting their past experiences (Brewin et al., 1993; Dong et al., 2004; McHolm et al., 2003; Schraedley et al., 2002; Wise et al., 2001). On the contrary,

in a 2005 study examining predictors of memory accuracy and errors in adults with PTSD ( $n = 94$ ), who had experienced sexual abuse as a child, Alexander et al. (2005) found that severity of PTSD symptoms was positively associated with accuracy in memories of childhood sexual abuse ( $M = .72$ ,  $SD = .18$ , range = .29 - 1.00). They proposed that individuals who experienced trauma tend to be hypervigilant when asked to recall such memories and so memories are well retained.

While some mental illnesses alter cognition and mood (e.g., schizophrenia and depression), it makes sense that asking an adult to remember experiences from childhood could be challenging and the accuracy of those memories might be altered. Still, many researchers claim that there is no conclusive evidence to support that mental illness causes mood congruent bias or affect retrospective self-report. Authors of some studies in which the sample suffered from mental illness did not site current or chronic life stress or depressive symptoms as having a potential impact on results. For example, in Lu et al.'s 2008 study of 254 adults diagnosed with mood and anxiety disorders who were asked about experiencing ACEs, retrospective self-report was referred to in their limitations, but mood congruent bias was not (See Tables 3.1 and 3.2).

### **General Recommendations to Improve Reliability and Validity of Retrospective Self-report**

Some safeguards recommended to protect the reliability and validity of findings when using retrospective self-report of ACEs have already been discussed in this paper with respect to specific threats. Other suggestions are to use test-retest reliability, measures that are structurally sound, life charts, and other data sources in addition to the participant's report

(e.g. another individual's report, legal or medical documents). To see which investigators utilized such safeguards in their work, see Tables 3.1 and 3.2.

**Test-retest reliability.** A measure is distinguished as being reliable if the participant scores the same when that measure is completed twice and under the same conditions (test-retest reliability). In utilizing retrospective self-report in young adults who faced ACEs, test-retest reliability has consistently supported the reliability of study findings. For example, as part of The ACE Study, Dube and colleagues (2004) sampled 658 adults ( $M_{\text{age}} = 64$  years) to determine test-retest reliability of retrospective reports from the first 18 years of life of childhood abuse, parental discord, divorce, and domestic violence, and having a family member in the home who was incarcerated, mentally ill, or abusing substances. At an average time interval of two time measurements 20 months apart using Cohen's kappa (values between .40 and .75 representing good agreement and over .75 exhibiting excellent agreement), they found that for each ACE, kappa coefficients showed good reliability (from .41 to .86). With reference to recalling if a family member was "depressed or mentally ill," the kappa coefficient was at the lower end of the spectrum at .48 and the lowest for "did a household member ever attempt suicide," at .41. Still, these reliability statistics fall in the good reliability category. Some reasons for these lower numbers could again be the stigma of mental illness and suicidal behavior. Many times mental illnesses, especially depression, go undiagnosed and untreated. In addition, these ACEs could have been hidden from the children until later in their lives. Taking it one step further, where mood-congruent bias poses a threat to reliability and validity, Schraedley et al. (2002) explored the stability of retrospective report of parental depression and childhood traumatic events with depressed individuals who had changes in their depression between two assessment periods, one year

apart. To test the theory of mood congruent bias and reliability, 1,202 depressed adults, ages 18 – 55 with an approximate average age of 35 participated in face-to-face interviews. A sub-sample was extracted of “improvers” and “worseners” in reference to their depressive symptoms ( $n = 234$ ). Overall test-re-test reliability of traumatic events showed consistency ( $\alpha = .86$ ). Consistent with mood congruent reporting hypothesis, those who had an improvement with their depressive symptoms reported less traumatic events at time 2 than time 1,  $t(142) = 3.97, p < .001$  and, with those who had worse depression from time 1 to 2,  $t(81) = 1.09, p > .05$ . Consistency in retrospective self-reports for parent psychopathology from time 1 to time 2 regardless if depression improved or worsened (less than 15% of sample changed, re: substance abuse in parent, less than 10% changed). A way to combat threats to reliability and validity stemming from mood congruent bias is to do a purposeful two time measure (test-retest) once when there is an exacerbation of symptoms and another when participants are feeling well (Hardt & Rutter, 2004; Schraedley et al., 2002).

**Utilizing another family member’s report.** Some ways to protect validity when using retrospective report center around the use of other information sources, for instance, using a parent or sibling’s report. While some have found parent’s reports to be helpful, others have found low levels of agreement between retrospective reports from children and parents in reference to mental illness and life experiences (Brewin et al., 1993; Hardt & Rutter, 2004). For example, Mowbray et al. (2006) examined adult child outcomes of mothers diagnosed with bipolar disorder, utilizing only the mother’s self-report ( $n = 157$ ). These mothers were asked general questions about their adult children such as their current job, present relationship status, the number of children they had, highest level of education, and the age of their adult child when he or she moved out. Mothers also answered questions

pertaining to whether or not their adult child had any psychological problems, substance abuse or alcohol problems, or problems with the legal system. It is conceivable that the adult child may conceal such things. Surprisingly, the mothers also were asked to report their adult child's satisfaction with life on a 1 to 5 scale (1 = not at all satisfied to 5 = completely satisfied). The authors argued that the mothers had frequent contact with their adult children and that the mother's report may not been any more biased than the young adult's report regarding their experiences and current psychosocial functioning (Mowbray et al., 2006). Meanwhile, a consistent theme in a systematic review of retrospective studies by Brewin and colleagues (1993) was that parental accounts tended to be more positive than their adult children's accounts of an event as well as the sibling's and outside observer's recall. They suggested that there could be a self-serving bias by parents as they try to minimize their failures (Brewin et al., 1993).

Siblings have been declared as most reliable for a secondary retrospective self-report (Brewin et al., 1993; Hardt & Rutter, 2004). However, in a dissertation study using qualitative interviews of adults ages 18-34 who grew up with an affectively ill (Bipolar) parent ( $n = 47$ ), sibling pairs tended to show very different perceptions and experiences (E. Morningside, personal communication, August 8, 2011). Hardt and Rutter (2004) also found that when examining retrospective studies where sibling report was utilized, kappa values varied greatly from as low as .09 to as high as .77.

**Using records.** Some researchers argued that without a factual data source regarding past events that it is unlikely to confirm accuracy of retrospective self-report (Schraedley et al., 2002). Other epidemiologic data can support a participant's self-report, such as child protective services (CPS) reports, police reports, court documents, and patient charts.

Widom and Morris (1997) operationalized accuracy (validity) as “agreement between participant’s recall and either an objective record of the event or social consensus from other individuals’ experience of the same event” (p. 36). McHolm and colleagues (2003) documented that if they had used both multiple informants and third-party records, this may have strengthened their belief in participants’ self-reported data and findings.

**Adding a life chart.** In general, people’s recall of sequence or timing are less accurate than whether an event or experience actually happened (Hardt & Rutter, 2004). Brewin et al. (1993) argued that temporal details such as dates, time sequences, and frequency are less reliable than the central characteristics of events. Life charts or calendars have been used to assist in participant’s recall by placing different experiences within and across different periods (Turner & Butler, 2003; Schwarz, 2004). The purpose of this survey method is to improve the accuracy reporting the timing and order of events over a substantial period of one’s life.

At the very least, interviews should use anchoring points such as what school grade the participant was in, times when the family moved, or times when a sibling was born (Brewin et al., 1993; Schwarz, 2004; Turner & Butler, 2003). Anda et al. (2006) assessed impaired memory in their participants by asking the question, “Are there any large parts of your childhood after age four that you cannot remember?” and then dividing the yes responses among developmental age periods to help determine any specific time during development and to assess the relationship with ACEs that might have occurred during or around those periods. However, they could have used this to also determine the validity and reliability of reported ACEs and did not.



**The use of measures.** Measures used retrospectively must meet psychometric standards of reliability and validity (both accuracy and content validity). One major issue with using retrospective self-report is that most measurement tools used in psychosocial research are not designed for retrospective use. Measures that have specifically been designed for retrospective self-report of ACEs to increase reliability and validity are listed in Table 3.3.

Evaluating the validity (accuracy) of retrospective self-report of early childhood memories has posed more difficulty than evaluating the reliability (stability). This is partly due to not having a totally objective historian to verify the accuracy of the memories. One common feature of established validity in retrospective measures of ACEs is that they tend to record aspects of experiences like parenting (including feelings) over a period of time and can track consistency through different stages of the individual's development (Brewin et al., 1993).

Besides using measures which have established good psychometrics, investigators also need to thoroughly describe how they operationalized variables. There is strong evidence supporting the importance of first defining one's construct of interest and then asking participants about the specific behaviors included in that particular construct's definition (Widom & Morris, 1997; Hardt & Rutter, 2004). Hardt and Rutter (2004) found that when investigators thoroughly operationalized measures, this strengthened study findings. In one study utilizing ACE Study data, Anda et al. (2004) documented the limitation that had their measures for work performance been more detailed, stronger relationships between ACEs and work performance might have existed.

Table 3.3

*Measures Related to ACEs and Designed for Retrospective Self-report*

Measure	Author
Assessing Environments III Questionnaire	(Berger, Knutson, Mehm, & Perkins, 1988)
Authoritative Parenting in Mothers Measure – Retrospective	(O’Connell, 2003)
Childhood Experiences of Care and Abuse Interview	(Bifulco, Brown, & Harris, 1994)
Child Maltreatment History Self-Report	(MacMillan et al., 1997)
Childhood Trauma Questionnaire	(Bernstein & Fink, 1998)
Composite Abuse Scale	(Hegarty, Sheehan, & Schonfeld, 1999)
Conflict Tactics Scale	(Straus, Hamby, Boney-McCoy, & Sugarman, 1996)
Family Behavior Questionnaire	(Melchert & Sayger, 1998)
Negative Family Atmosphere Scale	(Prescott et al., 2000)
Parental Bonding Instrument	(Parker et al., 1997)
Parental Bonding Inventory	(Schaefer, 1965)
Perception of Discipline Scale	(Prescott et al., 2000)
Retrospective Family Unpredictability Scale	(Ross & McDuff, 2008)

Another suggestion from the literature is to utilize more objective measures rather than questions that require global judgment (Brewin et al., 1993; Hardt & Rutter, 2004; Prescott et al., 2000; Schraedley et al., 2002). Questions that required global judgment were noted in this review of the literature in studies where emotional neglect was a retrospective variable (Dong et al., 2004; Dube, Anda, Felitti, Croft, et al., 2001; Dube, Anda, Felitti, Edwards, & Williamson, 2002; Dube et al., 2004). In those studies, emotional neglect was assessed by asking for a response to the statement: “There was someone in my family who helped me feel important or special,” and “I felt loved.” Others included, “My family was a

source of strength and support,” and “People in my family looked out for one another,” as well as responding to a question about how others felt, “People in my family felt close to each other.” All were questions on a sub-scale of the Childhood Trauma Questionnaire (CTQ) and were scored on a likert scale (“never true,” “rarely true,” “sometimes true,” “often true,” and “very often true,” respectively). If the score was 15 or higher (meaning moderate to extreme), the participant was considered to have experienced emotional neglect (Anda et al., 2008; Dube, Anda, Felitti, Croft, et al., 2001; Dube, Anda, Felitti, Edwards, & Williamson, 2002; Dube et al., 2004). Knutsson-Medin et al. (2007) gathered qualitative data from written responses to the question: “Describe in your own words what you perceived as good or bad regarding contact with psychiatric services and what your own preferences might have been” (p. 746)? In another qualitative study of adult children of mentally ill parents ( $n = 10$ ; ages 25 - 57), interviews began with the broad question, “Can you tell me what it was like growing up with a parent who had a serious mental illness?” (K. Foster, 2010). Baik and Bowers (2006) conducted two interviews with their participants, using more open-ended questions for the first meeting; “Tell me about your childhood, yourself, and then what it was like to grow up with a depressed mother.” Then in a second meeting, interview questions included, “Tell me about the first time you talked with someone about your mother’s depression . . .” followed by “How did you learn of your mother’s depression,” and other specific cues such as “When?” and “What happened?”

There were different ways in which researchers asked about exposure to parental mental illness, including depression, such as “When you were growing up, did your parent/caretakers ever see a counselor, psychologist, psychiatrist, or go to the mental hospital, or take medication for an emotional problem” (Lu et al., 2008)? Turner and Butler

(2003) assessed parental mental illness by asking, “When you were a child or teenager, did either of your parents or guardians ever have a mental illness or nervous breakdown” (p. 101)? For the number of research reports performed using the ACE Study data, mental illness for a *household member* was measured with a “yes” response to the question, “Was anyone in your household mentally ill or depressed,” *or* “Did anyone in your household attempt suicide” (Anda et al., 2006, 2008; Brown et al., 2007; Chapman et al., 2004; Dong et al., 2004, 2005; Dube, Anda, Felitti, Croft, et al., 2001; Dube, Anda, Felitti, Edwards, & Croft, 2002; Dube, Anda, Felitti, Edwards, & Williamson, 2002; Dube et al., 2004)? Hillis et al. (2000) also considered members in their sample as living with a mentally ill family member if the participant reported anyone in the household as mentally ill, depressed, or having attempted suicide. Ross and Wynne (2010) asked, “To your knowledge did your mother (or father) have any depression” (p. 758)? In one qualitative study, K. Foster (2010) asked one broad question of adults who grew up with a mentally ill parent: “Can you tell me what it was like growing up with a parent with a serious mental illness (p. 3145)? Schraedley et al. (2002) asked participants if either parent “had a problem with depression or their nerves” (p. 310) while the participant was growing up.

How these questions were asked to assess retrospective self-report of parental mental illnesses varied and most were very subjective. For example, what constitutes “depression” or a “nervous breakdown” to one participant could differ significantly from another. Researchers did not reference an established measure used to establish which symptoms the participant noted in their parent, leading them to the conclusion that the parent was depressed. Some studies seemed to infer that if a participant reported that they had a family member who attempted suicide, this meant that they were also depressed. While depression

is a major risk factor for suicide, when someone attempts suicide, it does not always mean that they are depressed.

Still, even when utilizing objective measures there can be issues with participant's question comprehension. For instance, Schraedley and colleagues' (2002) study, although appearing straightforward, the question as to whether or not one lost a loved one during childhood showed instability. Researchers must consider that to elicit a meaningful response it requires participants to think beyond the literal meaning of a question. As Schwarz (2004) pointed out, this process normally requires a participant to utilize aspects of the question that perhaps the researcher considered less important to the question's meaning. For instance, if asking an adult how frequently they felt their depressed parent criticized them, most may interpret "criticized me" on a continuum. This could range from times that their parent told them the dishes were not clean enough and to redo them to times when the parent was irritable and lashed out with hurtful words like, "You are no good."

Schraedley et al. (2002) concluded that researchers should use more objective measures of ACEs, instead of relying on subjective reports of things such as parental caring and parents being overbearing. Brewin et al. (1993) stressed that even with interview methods, trained investigators can use predetermined scales and offer recognition cues so that participants do not have to decipher what is being asked. Investigators should also be ready to assist their research participants to reduce misinterpretation of questions on measures. However, having a researcher present as an immediate resource might also bias participant's responses and should be used cautiously. In addition, investigators should structure the data collection process in such a way that minimizes unrealistic demands on the participant's memory. For instance as previously mentioned, by using anchoring points like,

“When you started kindergarten,” or “After your youngest sister was born.” It might also help when the researcher organizes the data collection into categories or chronological order.

Although not explicated as a means to boost validity and reliability in the studies within this review, it was noted that some researchers either asked questions in different ways or used multiple methods of data collection to help with validity. In contrast, Whitfield et al. (2005) cited asking only one question to assess hallucinations as a weakness in their study investigating eight ACEs and the relationship to experiencing hallucinations over the lifespan. In another study of 8,116 participants that examined possible relationships between childhood moves with other ACEs and adult outcomes, the authors cited that asking only one question regarding number of moves was a limitation (Dong et al., 2005). One risk here might be that if the participant misinterprets that one question, then validity is altered. By asking at least two questions or by framing in a different way, investigators can also compare responses to help ensure validity.

Many also used multiple methods of data collection. For instance, Lu and colleagues (2008) and Knutsson-Medin et al. (2007) utilized a number of data collection methods such as chart review, structured interviews, and self-report measures. Prescott et al. (2000) examined the validity of retrospective self-report utilizing retrospective measures as well as observed criterion measures independent of the participants. Others used mixed methods or structured interviews and self-report measures (McHolm et al., 2003; O’Connell, 2008; Turner & Butler, 2003; Schraedley et al., 2002). However, in these studies, no two methodologies were used to assess any one variable to assure accuracy of data.

**Comparisons to findings from national studies and surveys.** Often investigators argued that their findings were consistent with nationally representative surveys and studies

indicating that the experience reported by participants was comparable to those in other adult populations. Using this method as a means to establish validity of study findings where retrospective self-report is the chosen methodology can show that findings remain consistent for the population although different methodologies might have been used to elicit data, also reinforcing reliability. Other researchers cited comparable findings to biological and psychosocial or developmental processes to reinforce validity and reliability.

Various investigators suggest utilizing indirect comparison of retrospective and prospective self-reports in terms of differences in the two and in relation to risk correlations and outcomes (Anda et al., 2009; Baik & Bowers, 2006; Hardt & Rutter, 2004; Henry et al., 1994; Robinson & Clore, 2002; Schwarz, 2004). For example, Baik and Bowers (2006) found changes in participant disclosing of parental depression over time, concluding comparison studies with prospective studies might be more useful in determining how participants' childhood experiences occur. It is important to note than when comparing epidemiological studies, where prospective measures are commonly used and baseline data elicited to retrospective studies where data spans over childhood, much of what might have been missed in the prospective reporting could be accounted for in the retrospective report (Hardt & Rutter, 2004). Some researchers also used a prospective design with multiple waves of data as with The ACE Study (Schilling et al., 2007).

## **Discussion**

When adults endorse having been exposed to one ACE, findings across studies show that they are more likely to have experienced multiple ACEs. Given the co-existence of ACEs, it is difficult to determine which specific one might have had the most impact on outcomes later in adulthood. Still, few studies examined the relationship between having

experienced a mentally ill parent and retrospective report by the adult children. Even fewer studies were found where emerging adults (declared the best time for a retrospective self-report of childhood experiences) grew up with a depressed parent (the most common mental illness) and their outcomes.

Interviews were generally viewed as more valid than questionnaires in studies using retrospective self-report (Brewin et al., 1993; K. Foster, 2010; Hardt & Rutter, 2004; Schwarz, 2004). One reason might be that during interviews, investigators can exercise participant's memories, providing general to specific recognition cues to elicit the most accurate data pertaining to past experiences. Another rationale could be that the researcher can clarify if any misunderstanding has occurred. A risk to validity though is the investigator leading the participant or somehow influencing their responses. In addition, questions requiring more global judgments can be considered less valid and interviews vs. survey methodology are more likely to require more global judgment. Some recommend using semi-structured interview formats as it gives the participant an opportunity to elicit their own personal memories, and can help minimize interpretation of questions (Schraedley et al., 2002). However, interviews can pose other threats to validity. For instance, when issues discussed are sensitive, participants might be less truthful in an interview with less anonymity than when using anonymous surveys.

There were many strengths of retrospective self-report methodology noted in this review. The most prominent is that an individual's account of an event is their own experience. The meaning of certain childhood experiences and memories is essential as retrospective self-report is closely aligned with the concept of an individual's autobiographical narrative or life history. These types of data are considered to be valuable



standing alone without the issue of memory accuracy overshadowing (Pillemer, 1998). It is vital to consider that the incidence of an event occurring and the experience of it are two different things. An autobiographical narrative or life story from retrospective self-report is a reconstruction of a subjective experience where the individual is considered an expert in his or her own experience. A dominant piece of autobiographical memory and subsequent retrospective self-report is the recall of emotions. For validity, the evidence supports significant and consistent accuracy regarding retrospective self-report of emotions. Regarding reliability, it can be more difficult to establish consistency in retrospective self-report of emotions since factors such as cognitive and psychosocial growth, participating in psychotherapy, and changes in relationships with the parent can change reported feelings.

What is missing in many of the studies reviewed was discussion of the possible limitations when using retrospective self-report. For instance, possible cognitive factors, memory impairment, and mood congruent bias and potential effects on the validity and reliability of retrospective self-reports were not addressed when participants endorsed hallucinations, substance abuse, or depression (Schilling et al., 2007; Whitfield et al., 2005). Although Whitfield and colleagues (2005) cite some studies where individuals diagnosed with psychosis have given accurate histories, cognitive changes and memory impairments are often symptoms accompanying mental illnesses, especially psychotic and substance abuse disorders. This might suggest that things like cognitive changes, memory impairment, affective valence bias, and current mood states (mood congruent bias) did not influence memories of childhood negatively or that the investigators did not view them as a threat to validity.

## **Conclusions**

Despite having some potential methodological limitations, retrospective self-report has been used effectively in multiple studies that examine relationships between ACEs and emerging adult outcomes. While in the past (1980's to early 1990's), it appears that the majority of scholars viewed the method as more problematic than useful, in the past 15 to 18 years, more studies have shown significant utility with retrospective self-report. Still, to achieve optimal validity and reliability of retrospective self-report, researchers must first consider factors such as general limitations in memory, infantile amnesia, stigma and social taboos involving study topics, self-referential memory bias, affective valence, and mood congruency. In addition, the investigator should also examine trends with regards to gender and age. Recommendations to improve the validity and reliability when using retrospective self-report in mental health research have been to use structurally sound measures, test-retest reliability, another family member's report, records, a life chart or anchoring points, and to compare findings across national, epidemiologic, or similar studies. Using mixed methods or framing questions in different ways for comparison should also be considered.

Most of the empirical work on ACEs has focused on retrospective self-report of child physical, emotional, and sexual abuse and neglect. However, retrospective self-report in regard to emerging adults' reports of their experiences growing up with their mentally ill parent, especially a depressed parent, has had little attention. Comparisons between using retrospective self-report and real-time measurement as methodologies suggest that retrospective self-report adds the element of reflection, which gives the participant the ability to put his or her experience in to context. By doing so, retrospective self-report can be seen as a separate methodology, especially when the investigator utilizes additional methods such

as interviews. Given the array of adult outcomes and that these outcomes make a case for interventions, it is essential that investigators retrieve the most accurate accounts of such past experiences. The effects of growing up with a mentally ill parent frequently extend into emerging adulthood and many times are treatable or preventable. More research is needed examining the very common and distinct ACE of growing up with a depressed parent.

## **CHAPTER 4**

### **PAPER 3: LIVING IN A SHADOW: PSYCHOSOCIAL WELL-BEING OF EMERGING ADULTS WHO GREW UP WITH A DEPRESSED PARENT**

#### **Introduction**

Growing up with a parent who suffers from mental illness is a family experience that differs from that of most other children (Reupert & Maybery, 2007). Depression has the highest prevalence of all mental illnesses, or 18.8 million adults suffer from depression in a given year (National Institute of Mental Health [NIMH], 2009). The World Health Organization (WHO, 2008) projects that by 2020, depression will be a leading cause of disability in both women and children. Evidence supports that children who encounter a parent who is depressed have an increased risk for depression (Mowbray, Bybee, Oyserman, MacFarlane, & Bowersox, 2006; Peisah, Brodaty, Luscombe, & Anstey, 2005; O'Connell, 2008; Ross & Wynne, 2010; Sarigiani, Heath, & Camarena, 2003; Timko et al., 2009; Weissman, Wickramaratne, Nomura, et al., 2006) anxiety (Ross & Wynne, 2010; Timko et al., 2009; Weissman et al., 2006), substance abuse disorders (Mowbray & Mowbray, 2006; Timko et al., 2009), as well as difficulties establishing and maintaining personal relationships, especially in early adulthood (Knutsson-Medin, Edlund, & Ramklint, 2007; Lieb, Isensee, Hofler, Pfister, & Wittchen, 2002; Mowbray et al., 2006).

For those who experience a depressed parent in the home during their upbringing, it has been difficult to decipher the most important elements in the experience that impact emerging adult outcomes. Depressive symptoms in a parent can alter their relationships with

the entire family, especially their children. Studies show that the parent often becomes withdrawn, disengaged, inconsistent, and overly critical, yielding communication difficulties and increased conflict in the parent-child relationship (Ahlstrom, Skarsatar, & Danielson, 2011; Trondsen, 2011). This can lead to feelings of rejection, anger, and despair for children with lasting effects through adulthood, impairing psychosocial well-being (Knutsson-Medin et al., 2007; Mowbray et al., 2006; Mowbray & Mowbray, 2006; Weissman et al., 2006).

### **Significance and Purpose**

Emerging adults, or those in the period of development between ages 18 and 25, who encounter depression in a parent, are at increased risk for psychosocial problems as they transition into adult roles and relationships. Most studies to date have examined children (under the age of 18) of depressed parents. Few studies have examined emerging adults who have a better capability to think abstractly and begin to separate from parents. Individuals in this age group (18 to 25) might also be open to intervention as they reflect on their experience of depression in their parent at a pivotal time in their lives. Much of the research on growing up with a depressed parent lacks theoretical underpinnings. No studies have utilized a theory such as Pauline Boss's ambiguous loss theory to explain what children encounter or have compared the interplay of *boundary ambiguity* and other factors that may influence outcomes as they transition into adulthood. Boss (2007) took "a universal family experience—loss—and examined that experience in the context of an added stressor" (p. 105) in the form of boundary ambiguity. Boundary ambiguity is "a state in which family members are uncertain in their perceptions of who is in and out of the family and who is performing what roles and tasks within the system" (Boss, Greenberg, & Pearce-McCall, 1990, p. 1).

The purpose of this study was to examine boundary ambiguity and other factors (e.g., the length and understanding of the parent's depression, caregiving involvement, stress, social support, and hope) that contribute to psychosocial well-being of emerging adults who have experienced depression in a parent. Consistent with the propositions of ambiguous loss theory, it was hypothesized that in emerging adults who have experienced depression in a parent during their upbringing boundary ambiguity, perceived stress, perceived duration of parental depression, understanding of parent's symptoms, outcomes of caregiving, hope, and perceived social support would be associated with psychosocial well-being.

### **Theoretical Framework**

Changed roles within the parent-child relationship when a parent is depressed can often occur. Utilizing ambiguous loss theory as a lens to examine growing up and current functioning could help explain what emerging adults of depressed parents experience. The next section will describe emerging adulthood as a critical developmental period as well as the theory of ambiguous loss and how the theory might apply to the experience and outcomes of growing up with a depressed parent in the home.

### **The Emerging Adult**

Emerging adulthood (individuals ages 18 to 25) is a stage when distinct developmental characteristics exist such as, refinement of abstract thinking and decision making abilities, expansion in self-understanding, independence from parents (physically and emotionally), solidifying sexual identity, and increased ability to connect physical intimacy to emotional intimacy (Arnett, 2000, 2007, 2010). It is during this stage in life when a person experiences changes in family, peer, and romantic relationships and begins to establish adult roles (Arnett, 2007). It is a time when there is an increase in mental health

risks as well. National studies have shown that three quarters of mental illnesses are diagnosed by age 24 and that for emerging adults, suicide is the second leading cause of death (American College Health Association, 2009). Thus, it is imperative that we have a better understanding of the interplay among developmental changes during emerging adulthood, the experience of growing up with a parent who suffers from depression, and increased risks for socialization difficulties, mental illness, and suicide. In addition, a factor that has been minimally explored is the perception of loss that these youth have experienced as a result of growing up in a household with a depressed parent.

### **Ambiguous Loss**

A conceptualization of loss that may have great explanatory value for emerging adults who grew up with a depressed parent is *ambiguous loss theory*, defined as “a situation of unclear loss resulting from not knowing whether a loved one is dead or alive, absent or present” (Boss, 2004, p. 554). Unlike death which is a more definitive ending accompanied by rituals that yield some sense of closure and recognition from society, ambiguous loss may endure over a longer period of time, and causes feelings of confusion and uncertainty (Boss, 1999, 2004, 2009; Boss, Caron, Horbal, & Mortimer, 1990). Boss (1999) describes a type of ambiguous loss, *ambiguous presence*, that exists when an individual is physically present, but is psychologically absent or emotionally unavailable. Ambiguous loss situations of this type that have been studied include loved ones of individuals afflicted with Alzheimer’s disease, traumatic brain injury (TBI), autism, and schizophrenia (Boss, 2009). The term ‘ambiguous loss’ will refer to this specific type of ambiguous loss and will be used in this dissertation.

Studies of children growing up with a depressed parent have suggested that the child encounters a parent that is physically there, but often emotionally unavailable (O'Connell, 2008). Symptoms of depression include a sad affect, irritability, changes in eating habits (either eating too much or not enough), altered sleep patterns (usually hypersomnia), lack of energy, loss of interest in activities, social isolation, and suicidal thoughts and at times, attempts (American Psychiatric Association, 2000). The parent may struggle to fulfill responsibilities like cleaning the home, preparing meals, or being there to emotionally support their child. This can cause changes in the parent-child relationship and create confusion for children regarding their and parent's roles and responsibilities. The term, "parentification," has been documented in the literature as these youth often adopt more of a parental role, while the parent takes on more of the child's role (Fraser & Pakenham, 2009; Meadus & Johnson, 2000; Polkki, Ervast, & Huupponen, 2004). Boss and Greenberg (1984) described parentification as "a change in family structure characterized by boundary ambiguity" (p. 6). They posit that parentification and abandonment of parental responsibilities occurs because family members are functioning in developmentally inappropriate roles. Lack of clarity regarding who should be doing what in the relationship, blurred boundaries, ignored parental roles, halted family decisions, undone tasks, and subsequent boundary ambiguity can negatively impact well-being (Boss, 2004). While Boss does not explicitly address the experience of ambiguous loss for children, she does discuss how long-term boundary ambiguity is particularly difficult for children to manage, tends to increase stress, and the effects can last into adulthood (Boss, 2002).



Ambiguous Loss Theory has six propositions:

1. Higher boundary ambiguity in the family causes higher stress and greater individual and family dysfunction.
2. Over a short period of time, boundary ambiguity may not cause dysfunction.
3. If boundary ambiguity is high and persists, family members become increasingly stressed and dysfunctional.
4. The value system of the family (i.e. religious beliefs, illness beliefs, beliefs over mastery vs. fatalism, degree of hope) influences the perception of boundary ambiguity.
5. The length of time boundary ambiguity can be tolerated is influenced by those values.
6. The family's perception of an event is influenced by the amount of perceived support available to assist the family and its members (Boss, Greenberg et al., 1990).

Ambiguous loss affects an individual physically, cognitively, behaviorally, and emotionally (Boss, 1999). Ambiguous loss creates stress within the individual and the family system, and can lead to difficulty identifying and utilizing effective coping strategies (Boss, 2004). Often this stress can progress and manifest in ways similar to anxiety, depression, or psychic numbing (Boss, 1999, 2009). Somatic symptoms associated with ambiguous loss include sleeplessness, fatigue, headaches, or GI discomfort. Cognitively, manifestations can be worry, forgetfulness, dreaming of the loss, or having a preoccupation with the loss. Behaviors can include withdrawal, inactivity or hyperactivity, being hypervocal or quiet. Emotional symptoms can be overwhelming sadness, loneliness, anger, irritability, or fear

(Betz & Thorngren, 2006). Symptoms of ambiguous loss can be overlooked or misdiagnosed as depression or anxiety (Boss, 1999). However, ambiguous loss “is not an illness, but a situation of stress that is potentially debilitating” (Boss, 2004, p. 560).

### **Literature Review**

Studies have explored various risk and protective factors that might contribute to outcomes for emerging adults who grow up with a depressed parent in the home. These factors include but are not limited to: the age and developmental stage of the child when their parent’s depression began, length and severity of parent’s depression, degree of understanding that the child has about the parent’s depression, parentification, maintaining hope, and utilization of social support.

#### **Factors that Impact the Experience of Growing Up with a Depressed Parent**

The age of the child when a parent’s depressive symptoms begin, how long the symptoms last, and the severity of symptoms are factors to consider regarding the impact of parental depression. Many investigators argue that earlier onset of parental depression is most detrimental to the parent-child relationship and child outcomes throughout development and into emerging adulthood (Lieb et al., 2002; Lovejoy, Graczyk, O’Hare, & Neuman, 2000; Peisah et al., 2005). Other research indicates that if the onset of parental depression does not occur until adolescence, it might be more challenging for the child to cope during a time when changes in parent’s mood and behavior can cause more anger, confusion, and resentment (Campbell, Morgan-Lopez, Cox, & McLoyd, 2009; Meadus & Johnson, 2000; Sarigiani et al., 2003; Smith, 2004).

Depression can last for several weeks or several years and can be recurrent or occur as a single episode. Some studies examining children who grow up with a depressed parent

show that chronicity (lengthy, reoccurring) of parent's symptoms are more related to emerging adult outcomes than the severity of those symptoms (Peisah et al., 2005). Timko et al. (2008) found that adults who grew up with a parent with chronic, non-remittent depression showed the most severe rates of depression  $F(3,317) = 5.03, p < .01$  over those whose parents had partially remitted depression  $F(3,317) = 3.82, p < .05$ . It might be that when there is some remission, children are able to build some coping skills toward resiliency. However, if parental depression is chronic, this may be all that the child knows. For instance, Kaimal and Beardslee (2010) discovered that emerging adults who had grown up with a chronic and severely depressed parent exhibited more adaptive coping strategies than those who had a parent experiencing remitted or milder depression. This suggests that it might be more difficult to cope with a parent who is not depressed for many years and then has their first episode as the sudden change can cause increased confusion for the child.

Symptoms of depression can be mild to severe and erratic or unpredictable. Campbell et al. (2009) discovered in their sample ( $N = 1,357$ ), that in situations of chronic maternal depression, both sub-clinical and severe symptoms were almost equally predictive of adolescent internalizing (e.g. withdrawal, depression, anxiety, or passivity) ( $p = .002, R^2 = .010$ ;  $p = .002, R^2 = .011$ ) and externalizing symptoms (e.g. aggressive or risk-taking) ( $p < .001, R^2 = .017$ ;  $p < .001, R^2 = .018$ ). In a study that examined relationships between adolescent ( $N = 816$ ) outcomes and length and severity of maternal depression, findings showed that both chronic/mild and brief/severe depressive symptoms in mothers were equally associated with adolescent depression (Hammen & Brennan, 2003). Since parental depression is often chronic and severity can vary, many scholars agree that the accumulating

effects impact the child the most during the transition to adulthood (K. Foster, 2010; Lovejoy et al., 2000; Mowbray et al., 2006; Timko et al., 2009).

Having a parent who suffers from depression can be perplexing for a child of any age, particularly when the parent's mood, affect, thought processes, and behaviors fluctuate. A parent battling depression might experience feelings of worthlessness, extensive guilt, overall negativity, and isolative behavior. Children struggle to understand their parent's mental illness and associated behaviors and often indicate feeling confused about what is happening with their parent (Baik & Bowers, 2006; Kaimal & Beardslee, 2010; Knutsson-Medin et al., 2007; Meadus & Johnson, 2000; Polkki et al., 2004; Trondsen, 2011). Emerging adults often report that they learned of their parent's depression over time or slowly realized how their family life differed compared to their friends (Ahlstrom et al., 2011; Baik & Bowers, 2006). Family members might try to hide or minimize the depression, perhaps in an attempt to shield the child. Unfortunately, at times children first learn of a parent's depression during a crisis period such as a suicide attempt and/or an acute psychiatric admission (Trondsen, 2011), for which the child is unprepared. Studies also show that children growing up with a depressed parent voice that mental health professionals did not explain or ask about their understanding of their parent's mental illness (K. Foster, 2010; Knutsson-Medin et al., 2007; Polkki et al., 2004; Trondsen, 2011).

Children may have difficulty contributing mood, behavior, and relational changes with their parent to something external from themselves (K. Foster, 2010; Kaimal & Beardslee, 2010). Understanding depression and recognizing the signs can help the child separate themselves from the emotional experiences of the parent (K. Foster, 2010). For instance, realizing that the parent's depression is not their fault, but rather a disease process,

has been shown to be a protective factor (Fjone, Ytterhus, & Almvik, 2009; Fraser & Pakenham, 2009; Kaimal & Beardslee, 2010; Meadus & Johnson, 2000; Polkki et al., 2004).

Parentification can occur in the parent-child relationship especially when families do not have the support needed for the depressed parent and responsibilities such as caregiving fall on the child (Byng-Hall, 2008; K. Foster, 2010). The child might care for both the parent(s) and sibling(s), and become responsible for maintaining the household (Fraser & Pakenham, 2009; Meadus & Johnson, 2000). Some children even oversee the depressed parent's medication and are the primary source of emotional care (Ahlstrom et al., 2011; Knutsson-Medin et al., 2007; Meadus & Johnson, 2000; O'Connell, 2008; Riebschleger, 2004; Trondsen, 2011). Caregiving duties can be in excess, are often prolonged, can interfere with youth's much needed socialization with peers, and may go unrecognized (Byng-Hall, 2008; Fraser & Pakenham, 2009; Polkki et al., 2004; Reupert & Maybery, 2007). Some findings show that emerging adults who cared for a depressed parent are less likely to pursue educational or vocational goals (Ahlstrom et al., 2011; Mowbray et al., 2006).

There are some positive outcomes to caregiving, such as providing children with a constructive family role during times of stress, fostering empathy, and striving for excellence in school performance (Byng-Hall, 2008). Adult children who grew up caring for a depressed parent and the family have endorsed gains such as learning how to be responsible, effectively solve problems, and function independently (K. Foster, 2010). In some studies, adult children of depressed parents had finished high school, completed some college, or obtained a college degree (Knutsson-Medin et al., 2007; O'Connell, 2008; Mowbray et al., 2004). Rationales for academic success include that children may have studied harder as a way of

controlling an area in life, avoiding the depressed parent, or showing that they are different from their parent (O'Connell, 2008).

Children of depressed parents often encounter difficulties such as lacking in social competence, avoiding socialization, and overall poor social adjustment (Campbell et al., 2009; K. Foster, 2010; Mowbray et al., 2006; Timko et al., 2009). When a depressed parent cannot provide social interaction and emotional support, these needs can be met by others (Campbell et al., 2009; Kaimal & Beardslee, 2010), especially a non-depressed parent. For example, in a study of  $n = 126$  emerging adults (ages 18 – 21) most of whom had depressed mothers, the uncertainty or unpredictability in family life impacting the participant's experiences of anxiety and depression was buffered by paternal nurturance  $F(1, 5.5) = 7.7, p = .007, \eta^2 = .04$  (Ross & Wynne, 2010). Social support from family and friends during childhood is often associated with higher life satisfaction in adult children of parents with depression (Mowbray & Mowbray, 2006; Fraser & Pakenham, 2009). Having at least one close friend to talk with has frequently been cited as a protective factor for children experiencing a depressed parent (Baik & Bowers, 2006; Meadus & Johnson, 2000; Mowbray & Mowbray, 2006; Polkki et al., 2004). Utilization of available social support has been shown to contribute positively to emerging adult outcomes (Fraser & Pakenham, 2009; Mowbray & Mowbray, 2006). Studies show that as children of depressed parents age and function as adults, they face difficulty establishing trust and forming friendships (Baik & Bowers, 2006; Mowbray et al., 2006; O'Connell, 2008; Trondsen, 2011).

Many barriers to socialization tend to exist for children of depressed parents (Campbell et al., 2009; K. Foster, 2010; Mowbray et al., 2006; Timko et al., 2009). One barrier is likely the stigma attached to having a parent with a mental illness. Often parental

depressive symptoms (isolation, irritability, fatigue, and lack of attention to self-care and the home) can cause fear of embarrassment and prevent the child from inviting over friends (Trondsen, 2011). Children of depressed parents may hesitate to even disclose their parent's depression and what they are dealing with at home to peers. In fact, many times they are taught not to talk about it (O'Connell, 2008; Polkki et al., 2004). Or adult children have reported that out of loyalty and respect for their parent, they did not talk about the depression outside of the home (Ahlstrom et al., 2011; Fjone et al., 2009).

Hope is "having an expectation of or believing in fulfillment or success" (Merriam-Webster, 2013). Some evidence shows that having hope when growing up with a depressed parent can be a protective factor. For example, Mowbray and Mowbray (2006) found that adult children of depressed and Bipolar mothers had a mean score on *The State Hope Scale* of 3.24 (on a 4- point scale), and suggested that having hope facilitated participants' positive self-regard and effective coping. Maintaining hope has also been a protective factor found in work with ambiguous loss (Abrams, 2001; Boss, 2009; Kristoffersen & Mustard, 2000; Landau & Hissett, 2008). For example, Kristoffersen and Mustard (2000) found a sub-theme of "fluctuating processes," and discussed how when the ill sibling relapsed or became psychotic again, grief was summoned, but then when well and showing high functioning, it instilled hope. The researchers also found that for these siblings grief was often prohibited since grieving the loss of the brother or sister that they once knew meant that they had abandoned hope.

## **Method**

### **Sample and Setting**

In this exploratory study, a cross-sectional, correlational, mixed-methods design was used to examine relationships between psychosocial well-being in emerging adults and the length and understanding of parent depression, caregiving involvement, stress, social support, hope, and boundary ambiguity encountered during their first 18 years of life. A sample of 120 emerging adults (ages 18 to 25) who experienced depression in a parent while growing up was recruited from a small southeastern university. The study was approved by the Internal Review Board (IRB) at the university. Inclusion criteria included that the participant was between the ages of 18 and 25 years. He or she initially endorsed perceived depression in either parent. The emerging adult may have lived with their depressed parent at any time during their first 18 years of life in which they could recall the experience, but for a minimum of two years.

After securing informed consent (see Appendix A) and the parent's depressive symptoms perceived by the participant were assessed through a brief (approximately 10 minutes) interview. To assess for validity of the parental depressive symptoms interpreted by the participant, the researcher utilized components from the Structured Clinical Interview for the DSM-IV (SCID) (American Psychiatric Association, 2000) to devise a brief screening tool (see Appendix B). The SCID has shown good reliability in assessing individuals with major depressive disorders ( $\kappa = .61$ ) as well as other mood disorders (Zanarini, Skodol, Bender, et al., 2000). The sample size for this study was determined from gathering background data regarding the census of emerging adults at the data collection site and by conducting a power analysis utilizing an online resource. It was determined at a minimal



desired statistical power level of .80, with a  $p$ -value of .05, a regression effect size  $f^2$  of .15, and seven predictor variables, the minimum required sample size equaled  $N = 103$ .

Oversampling was conducted to compensate for potential attrition.

Of the 138 individuals who responded during the data collection period to participate in the study,  $n = 120$  met inclusion criteria for the age range of 18 to 25 and after screening for perceived parental depressive symptoms based on the DSM – IV- TR Structured Clinical Interview for Depression (SCID) (Appendix B). For those who did not meet inclusion criteria ( $n = 18$ ), reasons for exclusion included things like the participant was either inquiring before their 18<sup>th</sup> birthday or was beyond 25 years of age; misunderstood and thought that they qualified for the study if their sibling rather than parent was depressed; endorsed symptoms that appeared more indicative of a post grief response; either the participant was sent away to boarding school for a large portion of their upbringing or the parents was incarcerated; or they decided on their own accord that they did not meet criteria or did not want to participate further.

## **Measures**

**Demographics.** A data collection form was used (see Appendix C) that included gender, current age, and age when the parent's depressive symptoms began for both the participant and parent. The number of parents (perceived as depressed and not) present in the home during the participant's upbringing was also asked along with the number of individuals (and relationship to the participant) residing in the home during that time was asked. Participants were also asked if they themselves have ever received psychotherapy and if so, for how long.

**Current psycho-social well-being.** *Psychosocial well-being* was measured by the *Mental Health Inventory* (MHI) (Veit & Ware, 1983) (Appendix D). This is a 37-item self-report measure that assesses domains such as depression, anxiety, loss of behavioral/emotional control, positive affect, and emotional ties. The participant circles a response on a 1-6 scale (1 = always, 2 = very often, 3 = fairly often, 4 = sometimes, 5 = almost never, or 6 = never) to statements such as, “How much of the time in the past month have you felt calm and peaceful?” All items are scored so that a higher score reflects higher psychological well-being, therefore some items require reverse scoring. Psychological well-being is measured by one of two global scales of the MHI (the other is psychological distress). Other sub-scales of the MHI include: anxiety, depression, loss of behavioral and emotional control, overall positive affect, emotional ties, and life satisfaction. Finally, a total, overall global mental health score can be tabulated. The MHI has shown good reliability as demonstrated by Cronbach’s coefficient  $\alpha$  ranging from .92 to .94 and test-retest correlations of ( $r_{12} = .73$ ) (Heubeck & Neill, 2000). Cronbach’s  $\alpha$  for the MHI global scale psychological well-being used in the present study was also .92.

**Length of parent’s depressive symptoms.** The length of depressive symptoms was measured in years and collected first by the parental depression screen based on the SCID. In order to further validate the participant’s perceived duration of depressive symptoms, a question about length of parental depressive symptoms also was asked on the demographics form. In addition, participants were asked questions such as, “What is your earliest memory of depressive symptoms in your parent?”

**Boundary ambiguity.** Boundary ambiguity was measured using the *The Boundary Ambiguity Scale for Caregivers of Patients with Dementia* (Boss, Greenberg, et al., 1990)

(Appendix E). An example of an item includes, “Sometimes I am not sure where (depressed parent) fits into my family.” Items were scored on a 1-5 scale (1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree, or 5 = not sure how I feel) and then summed for a final score. A limitation of this instrument is that it has not been used before with a sample like the one in this study. However, the items are not written with specific regard to Dementia or any other specific disease entity. Rather, the key is that this measure examines boundary ambiguity in a family relationship where a loved one is physically present, but psychologically absent, as in the case of a child of a depressed parent. Reliability has been established with internal consistency values or Cronbach’s  $\alpha$  of .70 to .80 (Boss, Greenberg, et al., 1990; Carroll, Olson, & Buckmiller, 2007). For this study, Cronbach’s  $\alpha$  was .78.

**Understanding of depression.** Understanding of parent’s depression was measured by a modified version of the *Mental Health Literacy Scale* (MHL) (Khan, Sulaiman, & Hassali, 2010) (Appendix F). Subscales included knowledge of depressive symptoms which included eight symptoms (e.g., sadness or bad moods, lack of energy, changes in behavior). Items were scored with yes = 1 factual symptom identified and no = 0. Awareness of parental depression was assessed with three items (two yes/no and one open-ended questions). One example of a yes/no question used was, “Had you ever heard of a mental illness called depression?” These two questions were answered with yes (= 1 point) and no (= 0 points) responses. The open-ended question in this subscale addressed where the participant first ascertained information regarding what depression was. Although not scored as part of the MHL, this data was elicited. Perceptions of causation were assessed with eight facts regarding what can cause depression (e.g., genetically inherited, chemical imbalance in the brain, death of a loved one). Items were scored with yes = 1 factual symptom identified and

no = 0. Finally, knowledge regarding treatment for depression was assessed with five facts regarding treatment modalities (e.g. medication, psychotherapy, support groups). Again, items here were scored with yes = 1 factual symptom identified and no = 0. An overall total score of 23 points was possible. Internal consistency values for the original measure have shown good reliability (Cronbach's  $\alpha = .76$ ; Khan et al., 2010). For this study, Cronbach's  $\alpha$  was .80.

**Perceived stress.** Stress experienced by participants during the parent's depression was assessed using the *Perceived Stress Scale* (PSS), a 14-item self-report measure that assesses the degree to which situations in an individual's life are perceived as stressful (Cohen, Kamarck, & Mermelstein, 1983; see Appendix G). The items are designed to tap the degree in which the rater feels their life is uncontrollable, overloaded, and unpredictable. Items are rated on a five point scale (0 = never, 1 = almost never, 2 = sometimes, 3 = fairly often, and 4 = very often). Then, a total score is obtained by summing all items after reverse coding was completed where appropriate. The PSS has exhibited good reliability with a Cronbach's  $\alpha$  of .89 (Roberti, Harrington, & Storch, 2006). In the present study, internal consistency or Cronbach's  $\alpha$  was .82.

**Social support.** The *Multidimensional Scale of Perceived Social Support* (MSPSS) was utilized to determine social support (Zimet, Farley, & Dahlem, 1988) (Appendix H). For this 12-item self-rated measure, items 3, 4, 8, and 11 evaluate family support, items 1, 2, 5, 6, 7, 9, and 12 measure support from friends, and item 10 evaluates support from a "significant other." An example of an item on the scale is, "I can talk about my problems with my family." Items are answered on a 1-7 scale (1 = very strongly disagree, 2 = strongly disagree, 3 = mildly disagree, 4 = neutral, 5 = mildly agree, 6 = strongly agree, and 7 = very

strongly agree). The MSPSS has shown excellent reliability with Cronbach's  $\alpha$  for the total scale at .91 (Zimet et al., 1988) and ranges from .92 to .94 for each subscale (Clara, Cox, Enns, Murray, & Torgrud, 2003). In the present study, the entire scale was used to assess social support and the internal consistency or Cronbach's  $\alpha$  was .91.

**Hope.** To evaluate degree of hope, the *Herth Hope Scale* (Herth, 1991) was administered (Appendix I). This is a brief, 12 item self-rated tool that is answered on a 4 point scale (1 = strongly disagree, 2 = disagree, 3 = agree, and 4 = strongly agree). One example of a statement on this measure is, "I have a positive outlook on life." The measure has established reliability, with internal consistency or Cronbach's  $\alpha$  of .84 and test-retest reliability of  $r = .79$  (Gestel-Timmermans, Bogaard, Brouwers, Herth, & Nieuwenhuizen, 2010). In the present study, the internal consistency or Cronbach's  $\alpha$  was also .84.

**Caregiving.** Child caregiving for the depressed parent was examined using the *Multi-dimensional Assessment of Caring Activities Checklist* (MACA-YC18; see Appendix J) and the *Positive and Negative Outcomes of Caring Questionnaire* (PANOC-YC20; see Appendix K; Joseph, Becker, Becker, & Regel, 2009). The first tool, the MACA-YC18, consists of 18 self-report items that provide an index of total caregiving activities that the young person takes on, with a total possible maximum score of 36. There are six sub-scales including: domestic tasks, personal care, emotional care, sibling care, household management, and financial/practical care. Internal consistency values for the MACA-YC18 have shown good reliability (Cronbach's  $\alpha = .78$  for the entire scale), however, for the subscales Cronbach's  $\alpha$  ranges are .45 to .91 (Joseph et al., 2009). For this study, the Cronbach's  $\alpha$  was .79 for the overall scale. The second tool, the PANOC-YC20, is a self-report measure that provides an index of both positive and negative outcomes of young caregiving. The items are summed to

give two separate sub-scores (one for positive outcomes and one for negative outcomes), with a potential score on each of 0 to 20. On both measures, each item is rated on a 0 to 2 point scale (0 = never, 1 = some of the time, and 3 = a lot of the time). Internal consistency values for the PANOC-YC20 have shown good reliability (Cronbach's  $\alpha = .90$  for the positive outcomes of caring subscale and Cronbach's  $\alpha = .89$  for the negative outcomes subscale; Joseph et al., 2009). For this study, the Cronbach's  $\alpha$  was .78 for the overall scale, .82 for the positive subscale, and .79 for the negative subscale.

### **Procedures**

Participants were recruited via flyers posted in common areas across campus (e.g. bulletin boards as well as bathroom stalls (see Appendix L). The principal investigator (PI) contacted the head of the Student Health Center and Student Counseling Services requesting flyers be placed in the reception areas. Contact was also made with the campus chapter of the National Alliance for the Mentally Ill (NAMI), where emerging adults of depressed parents might be more apt to participate and may foster greater likelihood for snowball sampling. To further assure anonymity and boost recruitment, four random samples of 250 students in each sample were conducted and then these students were sent a mass email. Eligible participants were also encouraged to refer friends or family (snowball sampling) that might be interested in participating. As part of the plan for retention of participants, a \$20.00 Target gift card was issued as an incentive and was received upon completion of the interview and measures.

Meeting the basic inclusion criteria for the study was primarily established via email or private telephone communication and then if the criteria were met, a face-to-face meeting was scheduled. Participants were interviewed in a private room in the School of Nursing where the study was explained once more. Participants were asked to first complete a one

page demographics form. Then, each was instructed to complete the first packet of measures retrospectively or by “thinking back to the time when they lived at home with their parent and first recalled something was “off” or noticed symptoms of depression to either the point when the parent recovered from depressive symptoms or when they were getting ready to graduate high school and move on to college.” This packet included in the following order: the *Boundary Ambiguity Scale for Caregivers of Patients with Dementia* (Boss, Greenberg, et al., 1990), the *Mental Health Literacy Scale* (Khan et al., 2010), the *Perceived Stress Scale* (PSS) (Cohen et al., 1983), the *Herth Hope Index* (Herth, 1991). The last measure that was administered was the *Mental Health Inventory* (MHI; Veit & Ware, 1983). It was explained to the participants that this measure should be answered according to how they are feeling at present.

After explaining all of the measures, the researcher left the room to give the participant some privacy in answering the items. He or she returned to check on the status of completion and to ask if anything was unclear or if the participant had any questions. Early in the data collection process, one area that seemed to confuse participants regarded the *Boundary Ambiguity Scale for Caregivers of Patients with Dementia* (Boss, Greenberg et al., 1990). A few participants questioned the word “dementia.” It was explained that this particular tool had never been used to assess adult children of depressed parents and for them to ignore the word “dementia.” From that point when giving instructions, the researchers addressed this and crossed through the word “dementia” on the measure to minimize any confusion. Another question arose regarding “being separated from the parent.” Participants asked if their parents were divorced and they resided with the parent who was not depressed for a period of time, should they answer, “yes.” Participants were instructed to answer “yes”

and indicate the reason. Participants were asked to complete a total of ten brief measures (approximately 30–40 minutes).

Three RA's assisted the PI in data collection. These graduate students in psychology had previous experience as an RA and underwent training in conducting interviews and supervising completion of instruments by the PI. While all three RA's were trained in data collection, one was assigned primarily to enter data into the SPSS database and then the remaining others were assigned to cross-check and verify the data against completed measures for accuracy.

### **Analysis**

Data were analyzed using SPSS for Windows statistical software, Version 17. During the data collection period, any identified missing data identified was handled by contacting the participant and obtaining the information. Post data collection, SPSS v21 was used to investigate missing values. The following variables contained missing data: age received therapy, understanding measured by the Mental Health Literacy Scale (MHL), amount of caregiving measured by the Multi-dimensional Assessment of Caring Checklist (MACA-YC18), outcomes of caregiving measured by the Positive and Negative Outcomes of Caregiving Questionnaire (PANOC-YC20), hope measured by the Herth Hope Index (HHI), and stress measured by the Perceived Stress Scale (PSS). (More specifically, the items on the scales which contained missing values were: MHL1, MHL2, MHL3, MACA8, PANOC4, PANOC5, HHI9, and PSS4). These variables were entered into the expectation maximization function of SPSS v21 and a new spreadsheet was created without missing values. Multiple regression analysis was used to assess the degree to which the predictor variables (participant's perceptions of length and understanding of parent's depression, caregiving



involvement, stress, social support, hope, and boundary ambiguity during their first 18 years of life) could explain the outcome variable (present psychosocial well-being as an emerging adult).

Significance levels were set at  $p < .05$  and all tests were two-tailed. Analyses were conducted using the stepwise, forward selection, then backward selection methods in SPSS to compare for consistency in results and to determine which method was preferred by the investigator. To assess the best fitting regression model,  $R^2$  values, or the amount of variability of the outcome variable accounted for by the predictor variables, were assessed. The  $R^2$  is a statistic that provides some information about the goodness of fit of a model or the statistical measure of how well the regression line approximates the real data points. An  $R^2$  of 1.0 implies that the regression line perfectly fits the data. The adjusted  $R^2$  ( $R^2_{adj}$ ) is a modification of  $R^2$  that adjusts for the number of explanatory terms in a regression model. Unlike  $R^2$ , the adjusted  $R^2$  increases only if the new term improves the model more than would be expected by chance. Overall adjusted  $R^2$  values were considered clinically significant as follows: below 25% = poor, 25-50% = fair, 50-75% = good, and 75% and above very good (Portney & Watkins, 2008).

Per Boss (2007), richness of ambiguous loss research can be lost when only quantitative measures are used and a combination of qualitative and quantitative methods is recommended. From the overall sample, a smaller purposive subsample ( $n = 10$ ) was derived and brief, semi-structured interviews were done with those participants by the PI. One, open-ended question was asked to elicit a description of the participant's experience of growing up with a parent suffering from depression: "Describe for me what your experience was like while growing up with your depressed parent?" And then a later cue was used:

“And how has this experience affected you today?” The interviews were audio recorded and then transcribed by an RA. In addition, the PI kept field notes taken during and immediately after the individual participant interviews. The PI reviewed the transcripts and conducted initial open coding. Thematic analysis was used to analyze data and then general themes were discussed to enhance quantitative findings.

## Results

### Findings

**Characteristics of participants.** The final sample consisted of  $n = 98$  (81.7%) females and  $n = 22$  (18.3%) males who participated in the study. The ages ranged from 18 to 25 years ( $M = 20.36$ ) with 91 of the 120 participants or 75.8% of the sample ranging from ages 18 to 21. Ninety-percent of the sample was Caucasian ( $n = 108$ ; see Table 4.1 for additional demographics pertaining to participants).

Table 4.1

#### *Participant Demographic Characteristics*

	<i>n</i>	Percent (%)
Age ( $\mu = 20.37$ )		
18	20	16.7
19	25	20.8
20	22	18.3
21	28	23.3
22	11	9.2
23 and older	14	11.7
Gender		
Female	98	81.7
Male	22	18.3

Table 4.1 (cont.)

	<i>n</i>	Percent (%)
Race		
Caucasian	108	90.0
Hispanic	2	1.7
African American	2	1.7
Asian	1	0.8
Mixed	7	5.8
Received Therapy for Depression?		
Yes	49	41.2
No	70	58.8

**Characteristics of parents as reported by participants.** Of the parents endorsed by participants as suffering from depression, 73.3% ( $n = 88$ ) were mothers and 26.6% ( $n = 32$ ) were fathers. Meanwhile, 10.8% ( $n = 13$ ) participants reported that both of their parents suffered from depression. When this was assessed during screening, the participant was directed to complete the measures regarding only one parent. Participants reported that their parents were either married (47.5% or  $n = 57$ ), divorced (49.2% or  $n = 59$ ), or never married (3.3% or  $n = 4$ ). Meanwhile, only 27.5% (33 of 120) depressed parents were single parents or at least during the time when the participant recalled their parent suffering from depression (see Table 4.2 for additional demographics pertaining to parents).

Table 4.2

*Parent Demographic Characteristics*

	<i>n</i>	Percent (%)
Which parent was depressed?		
Mother	88	73.3
Father	32	26.7

Table 4.2 (cont.)

	<i>n</i>	Percent (%)
Were both parents depressed?		
Yes	13	10.8
No	107	89.2
Parent(s) divorced?		
Yes	59	49.2
No	57	47.5
Never married	4	3.3
Length of symptoms (yrs.) ( $\mu = 9.83$ )		
0-5	23	19.2
6-10	43	35.8
11-15	39	32.5
16-20	15	12.5

**Characteristics of relationships between children and parents.** The participants were asked at what age they first noticed depressive symptoms in their parent. The average age recalled was 9.5, with a range of 2–17 years of age. The ages in this study were then broken down into categories based on Erikson’s (1963) stages of psychosocial development (1.5–3 years for early childhood; 3–6 years for late childhood; 6–12 years for school-aged; and 12–18 years for adolescent). The age range in which most could recall first noticing depressive symptoms in their parent was 7 to 11.5 or school aged children (43.3%). This coincides with what several participants endorsed either in their screening or qualitative interviews, which many stated something like “I remember noticing then as I went to school and others’ homes to play. I knew my parent was different from my friends’ parents” Many (40%) found out about depression or learned of what it was from their parent or another member of the family. Others learned about depression from their peers (15%), or from TV

(11%). See Table 4.3 for additional demographics pertaining to the relationships between participants and parents.

Descriptive statistics for all continuous variables included: minimum, maximum, median, mean, and standard deviation (see Table 4.4). Categorical variables were assessed with frequencies. Bivariate relationships between the independent or predictor variables and the dependent or outcome variable were first analyzed using Pearson's  $r$  (see Table 4.5). To examine potential co-variables that might produce other possible effects, additional factors were assessed for bivariate relationships using Pearson's  $r$  (see Table 4.6).

Table 4.3

*Participant-Parent Relationship Demographic Characteristics*

	Frequency	Percent (%)
Known parent whole life?		
Yes	116	96.7
No	4	3.3
Depressed parent always in the family home?		
Yes	96	80.0
No	22	20.0
Ever separated from the depressed parent?		
Yes	35	29.2
No	84	70.0
Earliest memory of depression ( $\mu = 9.54$ )		
Below 3 yrs. old	1	0.8
3-6 yrs. old	27	22.5
7-11.5 yrs. old	52	43.3
12-17 yrs. old	40	33.3
Who else resided in the family home?		
Siblings	96	80.0
Grandparents	3	2.5
Single parent home	33	27.5
Only child	24	20.0

Table 4.4

*Descriptive Statistics*

	<i>M</i>	<i>SD</i>	Min.	Max.	<i>N</i>
Psychosocial Well-being	53.8917	12.07038	27.00	78.00	120
BA_Total	35.6417	7.70659	16.00	57.00	120
MHL_total	12.84	4.188	2.00	29.00	120
PSS_total	46.14	6.88	21.00	60.00	120
HHI_total	36.79	5.456	23.00	48.00	120
MACA_total	12.79	5.459	2.00	29.00	120
Positive Caring Outcomes	12.16	4.581	0.00	20.00	120
Negative Caring Outcomes	6.3983	4.2960	0.00	18.00	120
MSPSS_total	63.18	13.862	16.00	84.00	120
Parental Depression (years)	9.8264	4.50538	0.20	19.00	120

Table 4.5

*Bivariate Correlations among Study Variables*

Measure	1	2	3	4	5	6	7	8	9	10
1. PWB	—									
2. PD	-.230*	—								
3. BA	-.210*	.216*	—							
4. MHL	.201*	.031	.170	—						
5. MACA	-.015	.084	.394**	.317**	—					
6. PCO	.259**	-.057	-.173	.172	.171	—				
7. NCO	-.260**	.241**	.583**	.088	.370**	-.162	—			
8. HHI	.449**	-.098	-.096	.259**	.122	.457**	-.308**	—		
9. MSPSS	.239**	-.148	-.387**	.153	-.060	.461**	-.369**	.498**	—	
10. PSS	-.375**	.185*	.466**	.032	.323**	-.287**	.547**	-.427**	-.386**	—

Note. \*Correlation is significant at the .05 level (2-tailed). \*\*Correlation is significant at the .01 level (2-tailed).

PWB = Psychosocial Well-Being; PD = Parental Depression (Years); BA = BA Total; MHL = MHL Total; MACA = MACA Total; PCO = Positive Caring Outcomes; NCO = Negative Caring Outcomes; HHI = HHI Total; MSPSS = MSPSS Total; PSS = PSS Total.

Table 4.6

*Bivariate Correlations with Co-variables*

Variable	Psychosocial Well-Being
1. Participant's Age	-.070
2. Participant's Gender	-.032
3. Participant's Race	-.114
4. Which Parent was Depressed	-.017
5. Parental Divorce	.079
6. Participant's Age when Parent's Depression Began	.153
7. Parent's Age when Depression Began	.058
8. Participant Received Therapy	-.067
9. Amount of Therapy (in months)	.020
10. Participant's Age Received Therapy	-.191 <sup>**</sup>

Note. <sup>\*</sup>  $p < .05$ , <sup>\*\*</sup>  $p < .01$ , <sup>\*\*\*</sup>  $p < .001$

**Multiple regression.** Assumptions of regression were inspected including: normality, linearity, independence, homogeneity, and non-collinearity. Normality was assessed by examining the unstandardized residuals, which showed a normal distribution. There was evidence of linearity noted in the scatterplot of residuals. The Durbin-Watson statistic was 1.69, which is considered acceptable (this value should be close to 2) and suggests that the residuals are independent of one another. Scatterplots also showed a random display of points, suggesting homogeneity of variance. As shown in Table 4.5, the bivariate correlations did not indicate substantial intercorrelations among the independent variables ( $> .70$ ). This meant that the likelihood of multicollinearity was low. In addition, tolerance tests for all variables were evaluated to combat the potential complication of multicollinearity. Any variable exhibiting a tolerance test value smaller than .10 might indicate multicollinearity. All correlations were  $> .50$  and all tolerance values exceeded .10, indicating little chance of multicollinearity (Portney & Watkins, 2008).

Predictor variables that showed the lowest intercorrelations (below .50), which indicate low conceptual overlap, were entered into SPSS for multiple regression analysis. In the bivariate relationships, all predictor variables (participant's perceptions of length and understanding of parent's depression, caregiving involvement, stress, social support, hope, and boundary ambiguity during their first 18 years of life) showed significance except for the total amount of caregiving (measured by the MACA), so this variable was excluded from further analysis. The remaining eight predictors and one outcome variable were then entered into the regression analyses using three different entry methods: forward selection, then backward deletion, and finally stepwise selection. After comparing the  $R^2$  ( $R^2_{\text{adj}}$ ) values and the  $p$ -values for each entry method, each model within each method, and of individual predictors in each of those models, backward deletion was chosen as the entry method best suited for analyzing these data. In backward deletion, SPSS enters all predictors into the model and removes the weakest, re-calculating the regression. Backward deletion was the entry method that provided the most logical sequence for examining weakest to strongest predictors of the dependent variable, psychosocial well-being, in this study. Each model 1-7 (in the order determined by backward deletion) showed statistical significance ( $p < .001$ ). The best fitting regression model that predicted psychosocial well-being included hope ( $B = .353, p = .001$ ) and perceived stress ( $B = -.225, p = .013$ ), accounting for 23% of the variance ( $R^2_{\text{adj}} = .230$ ).

The Mental Health Literacy Scale (used to assess understanding of parental depressive symptoms) has four sub-scales (awareness, perceived causation, knowledge of symptoms, and knowledge of treatment available). This variable had approached significance in the first regression analysis, but was not part of the best fitting model. Upon



statistical consult, to possibly obtain a more precise evaluation of participant's understanding of their parent's depression while growing up, the Mental Health Literacy (Total) was replaced by the four sub-scales, which were entered into the multiple regression using the backward deletion method. In the final regression model, the following variables accounted for 26% of the variance for psychosocial well-being ( $R^2_{\text{adj}} = .260$ ;  $p < .001$ ): Hope ( $B = .426$ ,  $p < .001$ ), Mental Health Literacy (awareness) ( $B = -.206$ ,  $p = .010$ ), and the number of years the parent was depressed ( $B = -.195$ ,  $p = .015$ ; see Table 4.7).

Table 4.7

*Multiple Regression Model Predicting Psychosocial Well-being*

Predictor Variable	<i>B</i>	SE <i>B</i>	<i>B</i>
Hope (HHI)	.94	.17	.42***
Understanding (MHL- awareness)	-3.48	1.33	-.20**
Parental Depression (in years)	-.52	.21	-.19*

Note. \*\*  $p < .01$ , \*\*\*  $p < .001$

Other factors might have influenced these three variables that accounted for the variance for psychosocial well-being. In this study, the following factors were entered as co-variates: (participant's gender, age, race, and age when parent's depressive symptoms began; age in which the participant entered psychotherapy and for how many months; depressed parent's gender and age when symptoms began; which parent was depressed, were the parents ever divorced; and length of separations from the parent). Only one co-variate (the age at which the participant entered psychotherapy) exhibited statistical significance in the bivariate analysis ( $r = -.207$ ,  $p = .003$ ; see Table 4.6). This co-variate was then added into the final regression model, but did not add substantial variance accounting for psychosocial well-being nor was it statistically significant ( $R^2_{\text{adj}} = .269$ ;  $p = .255$ ).

Having hope was the strongest predictor for psychosocial well-being for those emerging adult children who grew up with a depressed parent in the home ( $B = .426, p < .001$ ). Data extracted from the qualitative interviews also emphasized the role of hope while growing up with a parent suffering from depression. For example, two participants voiced that both parent and child sustaining hope helped them get through the “tough times.” One of whom had seemed to make meaning of her experience of growing up with a depressed mother in a unique way, incorporating the word hope:

*“Hope. We used that word a lot when I was growing up. We talked the last time I was home and decided that we are going to get matching tattoos with the word “Hope.”*

Having an awareness of the parent’s depressive symptoms (having heard of the mental illness called “depression” before and identified in their parent when growing up) was the second strongest predictor of psychosocial well-being as an emerging adult ( $B = -.206; p = .010$ ). The length or chronicity of the parent’s depressive symptoms was the third strongest predictor of psychosocial well-being as an emerging adult ( $B = -.195; p = .015$ ), with an average length of parental depressive symptoms of 9.8 years, ranging from only a few months to 19 years.

Social support was not a significant predictor of psychosocial well-being in the final regression model, however, it was positively correlated with hope  $r = .50, p < .001$ , and negatively correlated with stress  $r = -.39, p < .001$ , while growing up with a depressed parent. The final regression model indicates that the possible effects of social support on psychosocial well-being had been explained away by the predictors of the number of years that the parent was depressed, degree of participant’s hope, and the amount of awareness that the participant had that their parent was depressed.

Boundary ambiguity experienced by an emerging adult who grew up with a depressed parent was not a significant predictor of psychosocial well-being in the final regression model, however, it was significantly correlated with psychosocial well-being in the bivariate analysis  $r = -.230, p < .012$ . In addition, this variable was significantly correlated with length of depressive symptoms  $r = .22, p = .018$ , with total caregiving involvement  $r = .394, p < .001$ , with negative outcomes of caregiving  $r = .583, p < .001$ , with stress  $r = .466, p < .001$ , and with perceived social support  $r = -.387, p < .001$ . The final regression model indicates that the possible effects of boundary ambiguity on psychosocial well-being had been explained away by the three best predictors accounting for the most variance.

**Qualitative themes.** The central themes that emerged from the qualitative interviews also indicated a connection to the concept of boundary ambiguity. These included: *uncertain expectations, parent hiding symptoms, and still worrying*.

For the theme uncertainty, participants discussed how they did not know what to expect in the day to day life with their depressed parent. Of the ten interviews, during three, the phrase, “*I felt like I was walking on egg shells around my mom or dad*” was stated. Rather than descriptions of depressed mood, withdrawal, and chronic sadness, participants seemed to recall more emotional lability in their depressed parent, especially periods of anger. Findings from other studies show that manifestations of depression can occur on such a wide spectrum from the parent being isolative and withdrawn to screaming obscenities at their children or other uncharacteristic behaviors (Knutsson-Medin et al., 2007; Riebschleger, 2004; Trondsen, 2011). Consistent with other research findings (Ahlstrom et al., 2011; Knutsson-Medin et al., 2007; Trondsen, 2011), having to monitor the parent’s mood and feeling afraid to anger them, participants voiced this cued them as to how to behave.

Still, many participants expressed how their parent did well hiding depressive symptoms; primarily their suicidal thoughts and behaviors. Some reported that both their depressed and remaining parent hid aspects such as parent's suicide attempts, hospitalizations, diagnosis, the fact that the parent was under the care of a therapist or psychiatrist, and/or taking medications for depression. In this same theme, the PI discovered how participants learned of these aspects that their parents hid for significant lengths of time. Some participants described how they found things like parent's journals or previously written suicide notes:

*"I knew there was something going on with my mom, but not exactly what. She had changed. How I really discovered what was going on with my mom was that I found her journal one day. She wrote about what she was feeling. She talked about feeling chronically sad. She wrote down all of the worries she had. Some of what she wrote really bothered me. I remember reading her thoughts like, 'My family would just be better off without me'."*

Sometimes participants added that they almost wondered if their parent wanted them to discover these things perhaps so that it was no longer a secret in the family or to gain the child's empathy and support. Another participant shared, as an adolescent, how he realized his mother was depressed and how bad it actually was:

*"We were driving one day and talking. I noticed that the door handle on the passenger side was broken. I asked her how this happened. She said that a while back she wanted to 'end it' and tried to jump from the car while my dad was driving. I remember sitting there thinking, 'What am I supposed to do with that' [what his mother just told him]."*

For the theme still worrying, half of the participants spoke of how even now and even if their parent was in remission from the depression for some time, they still worried about

their parent's well-being. Findings within this theme were also consistent with other studies conducted with emerging adults of depressed parents (Ahlstrom et al., 2011; Knutsson-Medin et al., 2007; Trondsen, 2011). The participants in the present study worried if their depressed parent was taking their meds, keeping psychiatric appointments, getting adequate sleep, eating enough, and if things got so bad, might they try and commit suicide like in the past? One commented, *"To this day when I call home, I can tell just by the way she answers the phone that she is depressed. I feel bad that I cannot be there and ask her what is wrong. Even now I worry about her being okay."* It should be noted that when the participants spoke of their continued worry, rather than an overtone of burden or frustration, there was an overtone of compassion and positive regard for that parent. This paralleled findings from another study of emerging adults' perspectives on parental depression found that participants' views changed dramatically after moving away either to attend college or start a career. Those findings showed that perspectives shifted from self-oriented (described as negativity and resistance to acknowledge and discuss their experience of parent's depression) to other-oriented perspective (described as showing acceptance and compassion for the parent; Kaimal & Beardslee, 2010).

## **Discussion**

The first three propositions of Boss's theory relate to how the higher and lengthier the boundary ambiguity in the family the higher the stress and individual and family dysfunction. Boundary ambiguity might not have been a significant predictor of psychosocial well-being in the final regression model, but it was significantly correlated with psychosocial well-being in the bivariate analysis  $r = -.230, p < .012$ , as well as other variables that coincide with ambiguous loss theory. For example, the longer that the emerging adult had been exposed to

depression in their parent as they grew up, the higher the boundary ambiguity in the parent-child relationship ( $r = .22, p = .018$ ). Boundary ambiguity was also significantly correlated with total caregiving involvement  $r = .394, p < .001$ , or the more that the emerging adult had been involved in caregiving for their parent, the higher the boundary ambiguity in the parent-child relationship. In relation, boundary ambiguity was positively correlated with negative outcomes of caregiving  $r = .583, p < .001$ , or the more that the emerging adult had experienced negative outcomes from caregiving for their parent, the higher the boundary ambiguity in the parent-child relationship. Boundary ambiguity also showed a positive correlation with stress  $r = .466, p < .001$ , and a negative correlation with perceived social support  $r = -.387, p < .001$ . These two findings suggest that the higher the stress and the less the social support for the emerging adult while growing up with a depressed parent, the higher the boundary ambiguity in the parent-child relationship. Qualitative findings also indicated that boundary ambiguity existed in parent-child relationships. For example, the participant's *uncertainty* of what to expect from day to day regarding the depressed parent's behaviors and the participant's uncertainty of what the parent's expectations were of them as a child coincides with other research findings regarding ambiguous loss and boundary ambiguity. Often the family encountering an ambiguous loss cannot get the facts surrounding the loved one's illness. This resonated in the theme of the *parents hiding symptoms* in the current study. And finally, participants endorsed that even after they moved away from their parent's home as an emerging adult, they *still worry* about the depressed parent; he or she taking their meds, keeping psychiatric appointments, getting adequate sleep and nutrition, and future suicide attempts. This too is indicative of the confusion that takes

place regarding who in the family should hold which roles and perform which tasks, or boundary ambiguity.

Having hope while growing up with a parent suffering from depression was the strongest predictor of psychosocial well-being in emerging adulthood for this sample ( $B = .426, p < .001$ ). Hope as predictor of positive outcomes is consistent with other studies of adult children of depressed parents (Meadus & Johnson, 2000; Mowbray & Mowbray, 2006) and individuals faced with ambiguous loss (Abrams, 2001; Boss, 2009; Kristoffersen & Mustard, 2000; Landau & Hissett, 2008) and implies a positive self-regard and more effective coping. It is also important to consider that the opposite of hope is hopelessness, which is a common symptom of depression and suicidality (American Psychiatric Association, 2000). Boss (2007) also proposes that hopelessness is closely related to helplessness. All of those children growing up with a depressed parent ( $n = 18$ ; ages 15 to 18) in the classic study conducted by Beardslee and Podorefsky (1988) described feeling helpless or not knowing what to do. Rather, those participants identified as resilient were classed as “doers and problem solvers who reflected a strong sense of pride and self-efficacy” (p. 67).

Per Boss (2009), “without meaning there is no hope and without hope no meaning” (p. 3). Having hope is key to making meaning, which tends to foster resilience in the face of an ambiguous loss (Abrams, 2001; Betz & Thorngren, 2006) and in growing up with a depressed parent (Meadus & Johnson, 2000). Those experiencing ambiguous loss may or may not still hope for their loved one’s recovery, but can still have hope for how life with their loved one can still go on, just in a new way (Boss, 2009). Perhaps a key piece to coping effectively with a depressed parent is finding ways to have hope and make meaning. This

relates to two propositions set forth by Boss in her ambiguous loss theory; that the value system of the family influences the perception of boundary ambiguity and that the length of time boundary ambiguity can be tolerated is influenced by those values. In the literature on ambiguous loss, Boss (1999, 2007, 2009) and other investigators (Betz & Thorngren, 2006) have discussed hope as a value system within the family (a belief regarding illness, challenging family experiences and spirituality).

Historically, nurses have been characterized as professionals who foster hope in their patients and patient's families. For a nurse working with children of depressed parents, actively listening to the child discuss the experience and showing them empathy could be helpful. The nurse might simply encourage these children to find ways to have hope and make meaning of their experience with their depressed parent. Nurses might also advocate as part of the multi-disciplinary team to have children be involved in family therapy sessions. On a larger level, nurses could have a greater presence with organizations such as the National Alliance for the Mentally Ill (NAMI), an organization that offers support to individuals suffering from mental illness and their friends and families. For example, a support group tailored toward children of depressed parents could be an excellent platform for creating a sense of community among these children; finding ways to have hope and make meaning.

Having an awareness of the parent's depressive symptoms was a predictor of psychosocial well-being as an emerging adult ( $B = -.206$ ;  $p = .010$ ). I, as a child, the participant was aware that the parent was depressed, their current psychosocial well-being as an emerging adult suffered. It is important to note that awareness of parent's depression was not necessarily synonymous with knowing the diagnosis or understanding what depression



actually was. Rather, it was operationalized as having heard of the mental illness “depression” before and then could identify that perhaps something similar was happening in their parent. Most participants became aware of their parent’s depression at a time in their development when they were exposed to more social relationships (e.g. school-age), which is comparable to other findings in the literature (Kaimal & Beardslee, 2010; Meadus & Johnson, 2000). This suggests that awareness of parental depression tended to occur when observing distinct differences in parents’ behaviors and the realization that their parent was different from other parents (Fjone et al., 2009).

How these children find out that their parent is depressed and what this means to them is important. In this present study, many (40%) found out about depression from their parent or another member of the family. This might be promising as perhaps families are becoming more open in discussing depression with their children. But then, 15% learned about depression from their peers and another 11% from TV, both likely sources of misinformation. Misinformation can be fuel for uncertainty and fear. For example, one participant in Trondsen’s 2011 study disclosed hearing in the media how people with mental illness “go crazy” and kill themselves and sometimes their families or innocent bystanders. A key issue here is as children realize something is different with their parent, then begin to self- disclose to peers, it is often before they have a clear understanding of parental depression. This finding is consistent in the existing literature where participants were more likely to disclose their mother’s depression to friends at a young age prior to achieving understanding of the illness (Baik & Bowers, 2006). This can have negative ramifications on a child feeling accepted by peers, harming the child’s self-esteem and successful establishment of social support.

Ambiguous loss often causes feelings of persistent confusion and uncertainty, particularly regarding the loved one's diagnosis or lack of information (Boss, 1999, 2004, 2009; Boss, Caron, et al., 1990). This increases the tendency toward self-blame and guilty feelings (Boss, 2002; Kristoffersen & Mustard, 2000; Sobel & Cowan, 2003). This same trajectory is consistent with findings of adults who grew up with a depressed parent in the home (Baik & Bowers, 2006), where changes in parent's mood and behavior caused confusion, worry, and fear for children long before ever being informed of the illness (Trondsen, 2011). In this present study, having knowledge of what causes depression, what the symptoms are, and knowledge of treatment were not significant predictors of psychosocial well-being as an emerging adult. However, other researchers examining children growing up with a depressed parent have tied awareness of the parent's illness, what the symptoms mean, and the realization that the mental illness is not the child's fault to resilient outcomes in emerging adulthood (Beardslee & Podorefsky, 1988). Kaimal and Beardslee (2010) argued that for emerging adults in their study reaching acceptance of the parent's depression involved awareness of the mental illness and his/her symptoms when both ill and well. They also added that by doing so the participant's relationship with that parent was less defined by the mental illness and that they could then make the choice to detach in such a way in which the emerging adult did not feel at fault for parent's illness. This is also supported by Boss (2007, 2009), who emphasizes the importance of giving ambiguous loss a name so that family members can attribute their feelings to an external source.

Educating children about their parent's depression is critical and often nurses have opportunities to teach these children what they need to know. Considering age and developmental appropriateness, nurses can teach children about the signs and symptoms of

depression, about medications used to treat depression, and what to do in case of an emergency. Through a psychoeducational approach, nurses might help to empower these children and help them to feel less responsible for their parent's moods, behaviors, and well-being.

It is also important to consider Boss's last proposition in the theory of ambiguous loss; that the family's perception of an event is influenced by the amount of perceived support available to assist the family and its members (Boss, Greenberg, et al., 1990). Social support while growing up with a depressed parent may not have been a significant predictor of emerging adult's psychosocial well-being in the final regression model, however, it was positively correlated with hope  $r = -.50, p < .001$ , and negatively correlated with stress  $r = -.39, p < .001$ . This suggests that perhaps having social support fosters more hope and lessens stress for a child when growing up with a depressed parent. The nurse could help the child to identify a support system and educate them as to how to share with their peers what they are experiencing with their depressed parent, if they choose to disclose.

The length or chronicity of the parent's depressive symptoms was a predictor of less psychosocial well-being as an emerging adult ( $B = -.195; p = .015$ ). Or, as the number of years that the parent was depressed increased, the less the participant's current psychosocial well-being. Still, this finding might have been distorted especially in the case of repeat bouts of depression dispersed among periods of remission. It would be understandably difficult for an emerging adult to remember back and precisely calculate the amount of time each episode of parental depression lasted. It is important to consider that sometimes the length and magnitude of depressive symptoms may not be significant enough to impair parenting. When

a depressed parent has periods of less or better managed symptoms, the child may have time to compensate, strengthening coping skills.

### **Limitations**

Reliability (stability) and validity (accuracy) are concerns addressed frequently in retrospective self-report studies of adverse life events, including having experienced a depressed parent as a child. Such issues identified in this present study were: general limitations in memory, self-referential memory bias, mood congruent bias, and the use of measures.

In regards to *general limitations in memory*, people's recall of timing or sequence of events are less accurate than whether an event or experience actually occurred (Hardt & Rutter, 2004). The PI and RA's used anchoring points (Brewin et al., 1993) such as what grade the participant was in school at a particular time or times when the family environment changed (e.g. when the family moved, parents divorced, or a sibling was born) to help the participant in giving an accurate account of timing or sequencing of parent's depression or associated information.

*Self-referential memory bias* refers to memories recalled in relation to the self, which usually have priority emotional and cognitive processing (Rogers, Kuiper, & Kirker, 1977). Although the screening for parental depressive symptoms was guided by the SCID in the current study, the emerging adult's perception of their parent's symptoms was the source of data for the study. Utilizing their perception was important because depression often goes undetected, undiagnosed, and/or untreated. In addition, other researchers also utilize alternatives to clinical diagnosis to assess parental depression which included the participant's perception of the parent's depressed mood (Ross & Wynne, 2010; Sarigiani et

al., 2003; Trondsen, 2011). And finally, to even further validate some participant's perceptions, many times during screening the participant spoke freely that their parent had in fact been diagnosed with a depressive disorder.

*Mood congruent bias* is a type of recall bias in which one's current mood facilitates processing of past information with a similar mood, but tends to impair that of an opposite mood (Kihlstrom, Eich, Sandbrand, & Tobias, 2000). These data were collected during the academic year. Although data collection was avoided near final exams, other stressful time frames such as the start of a new semester, midterms or an upcoming exam in any course could have contributed to a negative mood and possibly skewed some responses on the Mental Health Inventory (MHI). Other examples that might have impacted validity on the MHI included recent life stressors such as health issues or relationship changes like a recent break-up with a significant other.

*Utilizing measures* in which were not originally designed for use in retrospective self-report might adversely impact findings. For instance, the boundary ambiguity scale utilized had never been used with this population and was not specifically designed for retrospective use. Toward the end of data collection, the Relationships with Parents Scale (Alexander, 2003) was found during a literature review. This tool was designed for retrospective report and might have been more efficient in measuring the changes that take place in the parent-child relationship when a parent suffers from depression. Still, it is specific to past *emotional* role reversal and might not address the full spectrum of changes in the parent-child relationship.

When utilizing multiple analysis, there can be an increased risk in Type I error, or the results indicate a statistically significant relationship, but really there is not a statistically

significant relationship (Portney & Watkins, 2008). In the present study,  $p$ -values for regressions were set at  $p < .01$ . Therefore, the likelihood of Type I error is remote.

Generalizability of findings from a university setting may have been a limitation. It is important to consider that the participants in the study were part of a convenience sample, which can be prone to various biases. Heterogeneity of the population might be questioned and homogeneity can contribute to sampling error. For example, > 90% of the sample in this study was white/Caucasian. Certain cultural differences such as the way in which mental illness is viewed and coping strategies must be considered. In addition, some might argue that the sample underrepresented the emerging adult population as this group of individuals is less likely to include individuals from disadvantaged backgrounds and mental health issues themselves. It might be viewed that individuals who grow up with a depressed parent in the home, but attend college are resilient and are less representative of the general population. Meanwhile, in a dissertation study by O'Connell (2003), those who grew up with a depressed parent in the home and were college educated vs. those who were not, were more depressed. And, statistics show that depression, substance abuse, and other mental health issues are increasing on college campuses and that suicide is the second leading cause of death in college students ages 18 to 24 (American College Health Association, 2009).

Still, another possible limitation to the current findings, could be that those with a college education tend to have increased knowledge of mental illnesses such as depression. For instance, for those in the sample majoring in fields like nursing, psychology, sociology, or social work would surely have more knowledge about depression and this could have altered findings. Also, there is the "cumulative advantage effect" or that those attending

college have increased access to resources. Replication of these study findings in a more representative sample could further establish representativeness of the results.

### **Summary**

Few studies regarding children of mentally-ill parents focus on parental depression, even though it is the most common mental illness. The majority of the empirical work examining children of depressed parents focuses on infancy through adolescence. Most of the research specific to adult outcomes for children of depressed parents is either epidemiological in nature (clinical diagnoses such as, depression, anxiety, substance abuse disorders) or does not take into account the spectrum of psychosocial well-being. The existing research regarding adult children who grew up with a depressed parent is mostly qualitative and few studies use mixed-methods. Using multiple methods tends to provide a more in depth analysis. In this current study, there was value or catharsis in participants reflecting and discussing the experience of growing up with a depressed parent. The PI and RA's made some referrals for counseling services. Some participants asked questions such as, "What do you think my chances are of developing depression?" or "Have others come to you and said that they still worry about their mother or father?" These emerging adults seemed to be seeking validation for their experiences. And, even after data collection ended, an additional 18 email inquiries were made to participate either from continued snowballing or a posted recruitment flyer that had inadvertently been missed. This suggests that maybe we are winning the battle against stigma and these emerging adults wanted to share their experience.

Few studies regarding growing up with a depressed parent in the home have been done within the science of nursing. Meanwhile, the nurse is often on the front line to assess

family dynamics, determine the child's level of understanding and coping with parental depression, and perhaps has the greatest opportunity for intervention. For example, in an acute care setting, the nurse might be readily available during family visiting hours. In an out-patient setting such as a psychiatrist's office or functioning as part of an assertive community treatment team (ACTT), the nurse likely encounters children present with their parent. In the school setting, the nurse might be the most exposed to children of parents dealing with depression. Major budget cuts in mental health care mean that we as nurses must have a stronger presence in caring for families impacted by parental depression. Nurses are often in an excellent position to identify children of depressed parents, assess their needs, and intervene or refer these families to the right resources.



## **CHAPTER 5**

### **DISCUSSION AND CONCLUSION**

#### **Summary**

##### **Comparison of Two Theories Explaining Loss when a Parent is Depressed**

The first manuscript compared the utility of two theories (Bowlby's attachment/loss and Boss's ambiguous loss theories) in explaining the impact of parental depression on emerging adults' psychosocial well-being. Major findings showed that research in this area lacked theory as a foundation to guide the work. Furthermore, this population has rarely been investigated from a loss perspective. Findings also suggested that the experience of growing up into an emerging adult having had a parent with depression carries a degree of loss and has cumulative, ongoing effects. These individuals may have missed significant benefits of being a child by progressively taking on increased (and often developmentally inappropriate) responsibilities and missed socialization with peers. Many lost a piece of the relationship they once had with the parent or aspects of what a typical parent-child relationship might be.

**Timing of the parent's depressive symptoms.** Regarding the impact of timing of parental depression, this dissertation examined both the age of the child in which parental depression began as well as the duration of the parent's symptoms. In comparing Bowlby's theory and Boss's theory, attachment/loss showed greater utility in explaining what occurs across development within the parent-child relationship. Still, it is important to consider that

parental depression is often a chronic condition, yet one that can occur intermittently, adding confusion and prompting revisions to the parent-child relationship at any stage. Attachment patterns are established in infancy and are unlikely to change. Instead, research efforts might be better focused on internal working models, which are more malleable in light of positive relationship experiences even through emerging adulthood (Hooper, 2007).

**Parent depressive symptoms and changes in roles and relationships.** Depression is a family illness that can alter both roles and relationships. This is essential when examining the effects of parental depression on children. The focus of Bowlby's theory has remained on the parent-child dyad while Boss's theory focuses on both the individual as well as the family system. In particular, perceptions and understanding of the loss, reconstruction of roles, and assistance in coping (e.g., spirituality, hope, and social support) are addressed in Boss's theory. When a parent suffers from depression, there is no finality to the loss because the parent remains physically present. If that parent is perceived as being in or out of the family, there may be confusion and uncertainty as to what are the child's and parent's roles and responsibilities. The child takes on more of a parental role, or "parentification" occurs. Comparing the two theories revealed that attachment/loss theory might better explain experiences like the separation *process* that can occur such as when a depressed parent must be hospitalized. Meanwhile, ambiguous loss theory might better explain changes in the family roles and relationships.

**Parent depressive symptoms and children's coping capacities.** There were three main types of coping strategies found in the literature. Primary control/engagement coping involves direct action to change a stressful experience or the emotions about that experience and includes problem-solving and emotional regulation. Secondary control/engagement

coping involves adapting to the stressful experience by managing attention and thoughts with positive thinking and acceptance. Distraction/disengagement coping entails distancing oneself physically, cognitively, or emotionally from the stressful experience using denial, avoidance, and wishful thinking (Langrock et al., 2002).

Both theories contend that for an individual to cope effectively, he or she must revise the attachment with the lost person. Bowlby (1980) stressed that when attachment is disrupted, revision of the individual's internal working model, meaning the need to understand or make sense of the self and others' thoughts, feelings, and behaviors, is needed. In contrast, Boss (2007) described attachment revision as finding balance in social connections with the loved one who is attached, but also is fading away. This means managing the ambiguity in the relationship for instance by, thinking positively about those parts of the depressed parent that are still available while accepting the connections that are no longer present (i.e. dialectical thinking or "both/and thinking," an adoption of a paradox). This type of dialectical thinking is a gateway to sense and meaning-making (Boss, 2009) and seems to relate strongly with secondary control coping strategies. For example, findings have shown that boundary ambiguity and stress are reduced for those who can engage in dialectical thinking to cope with ambiguous loss (Boss, 2004, 2007). In addition, the process of maintaining hope is missing from attachment/loss theory, but is part of ambiguous loss theory. Hope may also be connected to second control coping and more positive outcomes for children of depressed parents. Secondary control coping strategies like positive thinking and cognitive restructuring utilized by children to cope with parental depression contribute to positive outcomes into emerging adulthood (Jaser et al., 2005).

When a parent is depressed, studies show that another common resiliency factor for children includes their understanding of their parent's illness (Fjone et al., 2009; Meadus & Johnson, 2000; Polkki et al., 2004). Bowlby does not explicitly address the role that understanding a depressed parent's affective state and behaviors might play in the emerging adult developing resiliency. However, exploring further the concept of the internal working model derived from attachment patterns might offer significant explanatory power. When examining understanding the parent's depression and maintaining hope as resiliency factors for emerging adults who grew up with a depressed parent, Boss's theory seemed more efficient.

Studies show that another resiliency factor for children of depressed parents is access and utilization of social support (Baik & Bowers, 2006; K. Foster, 2010; Meadus & Johnson, 2000; Mowbray & Mowbray, 2006). In emerging adulthood, intimate relationships become central and require mutual acceptance, exchange of thoughts and feelings, and consideration for each person's needs (Arseth et al., 2009). The comparison of the two theories revealed that while Boss better explores the role of social support in coping with loss, Bowlby better addresses the course in which factors within the parent-child relationship affect how an emerging adult might build relationships that comprise social support for them. In conclusion, although both theories had some unique contributions, overall it seemed that ambiguous loss, especially given the propositions of the theory, offered more explanatory power to what emerging adults experience and the outcomes of growing up with a depressed parent. This was further supported by the findings from the empirical study reported in this dissertation (Paper Three).

## **Retrospective Methodology in Mental Health Research**

The second manuscript examined the use of retrospective self-report of adverse childhood experiences (ACEs) and the methodological issues associated with its use in terms of reliability (meaning *stability*) and validity (meaning *accuracy*). Given the strong co-existence of ACEs, it is often difficult to determine which one might have had the most impact on outcomes later in adulthood. The review revealed that few studies examined retrospective self-report and the ACE of having a mentally ill parent. Even fewer studies were found where emerging adults, declared the best time for a retrospective self-report of childhood experiences (Schilling et al., 2007; Turner & Butler, 2003), were the focus. Finally, few studies were found that focused on emerging adults who grew up with a parent suffering from depression (the most common mental illness), and their outcomes.

Potential issues with using retrospective self-report that were found included: general limitations in memory, infantile amnesia, autobiographical memory disturbance, self-referential memory bias, affective valence, mood congruency bias, and the issue of stigma that surrounds ACEs, including parental mental illness. Still, there were many strengths of retrospective self-report noted. The most prominent was that an individual's account of an event can be seen as their own experience, meaning that certain childhood memories are closely aligned with the concept of an autobiographical narrative or life history. Self-report is a reconstruction of a subjective experience where the individual is considered an expert. These types of data are considered to be valuable apart from the issue of retrospective memory accuracy. The recall of emotions is a central aspect of autobiographical memory and subsequent retrospective self-report. For validity, the evidence that was reviewed supported significant and consistent accuracy regarding retrospective self-report of emotions.

Regarding reliability, retrospective self-report of emotions are less likely to be consistent due to factors such as cognitive and psychosocial growth, participating in psychotherapy, and changes in relationships with the parent which can change reported feelings. Interviews were generally viewed as more valid than questionnaires in studies using retrospective self-report. However, interview questions tend to require more global judgments and can be considered less valid than questionnaires. One recommendation that emerged from this review was to use semi-structured interview formats as it gives the participant an opportunity to elicit their own personal memories, and can help minimize interpretation of questions. What was missing in many of the studies reviewed was discussion of the possible limitations when using retrospective self-report, such as cognitive factors, memory impairment, and mood congruent bias and potential effects on the validity and reliability.

Despite having some potential methodological limitations, retrospective self-report was found to be more useful than problematic. In the past 15 to 18 years, more studies have shown significant utility with retrospective self-report. Still, to achieve optimal validity and reliability of retrospective self-report, safeguards to protect the accuracy, reliability, and validity and ensure optimal results were recommended, including establishing test-retest reliability, utilizing another family member's report, comparing findings across national or epidemiologic studies, using health and legal records, incorporating a life chart or anchoring points, and using structurally sound measures. Using mixed methods or framing questions in different ways for comparison were also suggested.

In this current study, one safeguard employed included using anchors for participants to recall the childhood experience with their depressed parent. For example, the PI and RA's referred back to what grade the participant was in school. An additional safeguard included

using mixed-methods which seemed to help clarify some of what participants reported. It was noted that recalling when the parent's depressive symptoms began and ended seemed to be more difficult for the participants than recalling specific incidences and thoughts and feelings at that time.

Another safeguard was having an investigator there to explain how to interpret the measures. For instance, participants were instructed to complete the first packet of measures retrospectively or by "thinking back to the time when they lived at home with their parent and first recalled something was "off" or noticed symptoms of depression to either the point when the parent recovered from depressive symptoms or when they were getting ready to graduate high school and move on to college." For the last measure that was administered, it was explained to the participants to answer items according to how they are felt at present. After explaining all of the measures, the researcher left the room to give the participant some privacy in answering the items. He or she returned to check on the status of completion and to ask if anything was unclear or if the participant had any questions.

A final safeguard that was utilized in the current study included using measures that were structurally sound. These included: the *Boundary Ambiguity Scale for Caregivers of Patients with Dementia* (Boss, Greenberg, et al., 1990), the *Mental Health Literacy Scale* (Khan et al., 2010), the *Perceived Stress Scale* (PSS; Cohen, 1983), the *Herth Hope Index* (Herth, 1991), and the *Mental Health Inventory* (MHI; Veit & Ware, 1983). Each measure had exhibited internal consistencies ranging from  $\alpha$  .70 to .94 and for use in the current study ranging from  $\alpha$  .78 to .91. Still, there were setbacks that had to be addressed, specifically with global interpretation of some items. For example, in the empirical study conducted, one area that seemed to confuse participants regarded the *Boundary Ambiguity Scale for*

*Caregivers of Patients with Dementia* (Boss, Greenberg et al., 1990). A few participants questioned the word “dementia.” From that point when giving instructions, the researchers addressed this, explaining that this particular measure had never been used to assess adult children of depressed parents and crossing through the word “dementia” on the measure to minimize any confusion. Another question arose from the data collection form regarding “being separated from the parent.” Participants asked if their parents were divorced and they resided with the parent who was not depressed for a period of time, should they answer, “yes.” They were instructed to answer “yes” and indicate the reason. In summation, it was determined that retrospective self-report in the current study elicited both reliable and valid data.

### **Predictors of Psychosocial Well-being in Emerging Adults**

The third manuscript reported the results of an original data set collected to explore the relationship of the psychosocial well-being of emerging adults who experienced depression in a parent while growing up. The study was framed using relevant factors from both the existing literature and using the propositions of ambiguous loss theory. The purpose of this study was to examine boundary ambiguity and other factors (e.g., the length and understanding of the parent’s depression, caregiving involvement, stress, social support, and hope) that contribute to psychosocial well-being of emerging adults who have experienced depression in a parent. Findings indicated that variables such as hope, awareness of parental depression, and the length of the parent’s depression (number of years) while growing up are predictive of current psychosocial well-being in the emerging adult.

**Hope.** Having hope while growing up with a parent suffering from depression was the strongest predictor of psychosocial well-being in emerging adulthood ( $B = .426, p <$



.001). Maintaining hope has been a protective factor found in ambiguous loss research with a variety of conditions and in children growing up with a depressed parent. However, this was the first study to bring these two lines of research together. Having hope is often a prerequisite to making meaning, which tends to foster resilience for those faced with an ambiguous loss (Abrams, 2001; Betz & Thorngren, 2006) and who grow up with a depressed parent (Meadus & Johnson, 2000). Taken together, these findings suggest that coping with a depressed parent entails finding ways to have hope and make meaning.

**Understanding of parent's depression.** Awareness of parent's depression was a significant predictor of psychosocial well-being ( $B = -.206, p = .010$ ). However, awareness is not necessarily the same as knowing the diagnosis or understanding what depression actually is. Past studies show that young adults often report that they became aware of their parent's depression at a time in their development when they were exposed to more social relationships (e.g., school-age). How these children find out that their parent is depressed and what this means to them is important. In this current study, many (40%) found out about depression from their parent or another member of the family. This might suggest families are becoming more open in discussing depression with their children. But then, 15% learned about depression from their peers and another 11% from TV, both likely sources of misinformation. A key issue here is as children realize something is different with their parent, and begin to self-disclose to peers, it may be at a time before they have a clear understanding of depression. This can have negative ramifications on a child pertaining to acceptance by peers, their self-esteem, and successful establishment of social support.

Ambiguous loss often causes feelings of persistent confusion and uncertainty, particularly regarding the loved one's diagnosis or lack of information. This tends to increase

self-blame and guilty feelings, two aspects that children are highly susceptible to when families face certain difficulties. This process is consistent with findings of adults who grew up with a depressed parent in the home, where changes in parent's mood and behavior often cause confusion, worry, and fear for children long before ever being informed of the illness. Awareness of the parent's illness, what the symptoms mean, *and* the realization that the mental illness is not the child's fault have been associated with increased resilient outcomes in emerging adulthood (Beardslee & Podorefsky, 1988; Kaimal & Beardslee, 2010).

**Length of parent's depression.** The length or chronicity of the parent's depressive symptoms was a predictor of less psychosocial well-being as an emerging adult ( $B = -.195$ ;  $p = .015$ ). Or, as the number of years that the parent was depressed increased, the less the participant's current psychosocial well-being. The average length of parental depressive symptoms was 9.8 years, with a range of only a few months to 19 years. Still, this finding might have been skewed especially in the case of repeat bouts of depression dispersed among periods of remission. It would be understandably difficult for an emerging adult to remember back and precisely calculate the amount of time each episode of parental depression lasted. It is important to consider that sometimes the length and magnitude of depressive symptoms may not be significant enough to impair parenting. When a depressed parent has periods of less or better managed symptoms, the child may have time to compensate, strengthening coping skills.

### **Implications for Nursing Research**

The loss and grief response experienced by children of depressed parents is a non-normative loss and when someone is faced with a loss that exceeds the norm, it requires different primary, secondary, and often tertiary levels of intervention (Rando, 1993).

Ambiguous loss theory contains an interplay of factors that can add significant explanatory power when applied to the issue of children exposed to parental depression and may help mental health professionals better identify, understand, and treat these families. Specifically, it might help build or refine interventions for these children through psycho-education, encouraging peer support, and aligning them with other resources to buffer the experience of depression with the parent and enhance well-being and resiliency into emerging adulthood.

The majority of the empirical work examining children of depressed parents focuses on infancy through adolescence vs. the cumulative effects of growing up with a depressed parent and then coping and outcomes during emerging adulthood is lacking. Stroebe (2002) suggested that a major connection exists between attachment, the internal working model, and coping behaviors which explicates how views of the self, others, and relationships are formed and subsequently influence how an individual handles loss. Exploring this link might be beneficial in understanding the loss experience and coping for emerging adults who grew up with a depressed parent. While research has explored parental depression and potential relationships with attachment, no studies have been conducted using ambiguous loss theory as the foundation for research with children of depressed parents. Research on depressed parents and children's outcomes should expand and address role changes in the family. More specifically, there may be an important link between parentification, caregiving in children of depressed parents, and the concept of boundary ambiguity in the parent-child relationship that requires more investigation. In addition to these factors, primary, secondary, and disengagement control coping strategies by children of depressed parents might also be important to investigate.

Few studies regarding children of mentally-ill parents focus on parental depression, even though it is the most common mental illness. The research specific to young adult outcomes for children of depressed parents that does exist is either epidemiological in nature (clinical diagnoses such as, depression, anxiety, substance abuse disorders) or does not take into account the spectrum of psychosocial well-being. The existing research regarding adult children who grew up with a depressed parent is mostly qualitative and few studies use mixed-methods, which can help provide a more in depth analysis.

### **Findings Suggesting Further Study**

In this present study, having knowledge of what causes depression, what the symptoms are, and knowledge of treatment were not significant predictors of psycho-social well-being as an emerging adult. However, other research indicates that knowing about what depression is, including symptoms and possible treatment, can help serve as a buffer to psychosocial well-being for children growing up with a depressed parent. This relates to two propositions in ambiguous loss theory; that the family value system influences the perception of boundary ambiguity and that these values influence the length of time boundary ambiguity can be tolerated by family members. For example, in the current study it is important to note that while boundary ambiguity and hope were not correlated, hope and stress were  $r = -.43, p < .001$ , or the higher the hope the emerging adult had as they grew up with their depressed parent, the less their reported stress. The first three propositions of Boss's theory relate to how the higher and lengthier the boundary ambiguity in the family the higher the stress and individual and family dysfunction. While this study did not measure the length of boundary ambiguity experienced by an emerging adult who grew up with a depressed parent, findings

did show a positive correlation between boundary ambiguity and length of depressive symptoms  $r = -.22, p = .018$ .

### **Implications for Nursing Practice**

Few studies regarding growing up and older with a depressed parent in the home have been done within the science of nursing. Research indicates that ambiguous loss can affect an individual physically, cognitively, behaviorally, and emotionally. Somatic symptoms such as sleeplessness, fatigue, headaches, or GI discomfort; cognitive manifestations including worry, forgetfulness, nightmares, or preoccupation with the loss; behaviors such as withdrawal, inactivity to hyperactivity; and emotional symptoms like overwhelming sadness, loneliness, anger, irritability, confusion, guilt, or fear are all documented symptoms of ambiguous loss. Stress is perhaps the most blatant outcome. These symptoms can be overlooked or misdiagnosed as depression or anxiety (Boss, 1999). It is interesting to think about how some of these manifestations found in individuals experiencing an ambiguous loss also are findings in the research conducted with children who grow up with a depressed parent.

Many children of depressed parents have endorsed receiving a lack of support from the mental health system, specifically the lack of information given to them about their parent's depression and care, even when a parent has been hospitalized for a suicide attempt. Major budget cuts in mental health care mean that we as nurses must have a stronger presence in caring for families impacted by parental depression. Nurses are often in an excellent position to identify children of depressed parents, assess their needs, and intervene or refer these families to the right resources as they are often the health professional interacting with the child or family. For instance, in an acute care setting, the nurse might be

the most readily available professional during family visiting hours. In an out-patient setting such as a psychiatrist's office or functioning as part of an assertive community treatment team (ACTT), the nurse likely encounters children present with their parent. In the school setting, the nurse might be the most exposed to children of parents dealing with depression. In all of these areas the nurse is on the front line to assess family dynamics, determine the child's level of understanding and coping with parental depression, and perhaps has an opportunity for intervention.

In reference to specific findings in this present study, nurses might foster hope perhaps by merely actively listening to the child discuss the experience and by showing them empathy. The nurse might encourage these children to find ways to have hope and make meaning of their experience with their depressed parent. Nurses might also advocate as part of the multi-disciplinary team to have children be involved in family therapy sessions. On a larger level, nurses could have a greater presence with organizations such as the National Alliance for the Mentally Ill (NAMI), an organization that offers support to individuals suffering from mental illness and their friends and families. For example, a support group tailored toward children of depressed parents could be an excellent platform for creating a sense of community among these children; finding ways to have hope and make meaning. Educating children about their parent's depression is critical and often nurses have opportunities to teach these children what they need to know. Considering age and developmental appropriateness, nurses can teach children about the signs and symptoms of depression, about medications used to treat depression, and what to do in case of an emergency. Through a psycho-educational approach, nurses might help to empower children of depressed parents and help them to feel less responsible for their parent's moods,

behaviors, and overall well-being. The nurse could help the child to identify a support system and educate them as to how to share with their peers what they are experiencing with their depressed parent, if they choose to disclose.

### **Conclusion**

The loss endured by children of depressed parents (Trondsen, 2011) is typically not recognized by others, but it is a loss that can impact their development and overall psychosocial well-being and the effects can endure throughout the lifespan. While we may not be able to stop mental illness in the parent, we can change how we intervene with their youth. Boss's work on ambiguous loss shows a distinct, prescriptive therapeutic approach to individuals suffering an ambiguous loss. Pauline Boss's theory has been utilized to explain the experiences and effects on family member's well-being for those patients suffering from a variety of illnesses, and might provide new insights regarding the empirical work with people who grow up with a depressed parent. If we could understand more about the experience, then we could decrease the incidence of labeling their outcomes as pathological and implement innovative approaches into practice to assist children of mentally ill parents to make healthy, effective transitions into adulthood. One of the National Institute of Health's (NIH) - Healthy People 2020 goals is to equip vulnerable adolescents with services and skills needed to transition into an independent, self-sufficient adulthood (NIH, 2010). Findings from these three works will help professionals, including nurses, better understand what factors contribute to the psychosocial outcomes for this population. This knowledge gained

could be important for developing or refining interventions aimed at supporting youth who experience depression in a parent and improve outcomes into emerging adulthood. The knowledge to be gained is important for developing or refining interventions aimed at supporting individuals who experience depression in a parent and improve outcomes.



## **Appendix A**

### **Informed Consent**

#### **Consent to Participate in a Research Study**

##### **"Psychosocial well-being in emerging adults who grow up with a depressed parent in the home"**

#### **What Is The Research About?**

You are being invited to take part in a research study about the experience and outcomes of growing up with a depressed parent. If you take part in this study, you will be one of about 120 people to do so.

#### **Who Is Doing The Study?**

The person in charge of this study is Brandy Mechling, or the principal investigator (PI), of the University of North Carolina Wilmington. There may be other people on the research team assisting at different times during the study, including a research assistant (RA).

#### **Do Any Of The Researchers Stand To Gain Financially Or Personally From This Research?**

This research is being funded by The University of North Carolina at Wilmington through a J. Richard Corbett Grant. None of the researchers participating in this study stand to gain financially or personally.

#### **What Is The Purpose Of This Study?**

The purpose is to examine factors that contribute to psychosocial well-being of young adults who, while growing up, have experienced depression in a parent.

By doing this study we hope to learn about certain factors that might influence a young adult's experience of growing up with a depressed parent. The information gained could help mental health professionals better understand the needs of children of depressed parents.

#### **Where Is The Study Going To Take Place And How Long Will It Last?**

The research procedures will be conducted at UNCW. You will need to come to McNeill Hall during the week between the hours of 8 a.m. and 5 p.m. Each visit will take about 45 minutes. The total amount of time you will be asked to volunteer for this study is (potentially) 90 minutes or 1 & ½ hours over the next 12 months.

### **What Will I Be Asked To Do?**

You will be asked to identify depressive symptoms that you perceived your parent has had. Then, using pencil and paper, you will be filling out various questionnaires (9 including a demographic form), each having 12 to 38 questions.

You might also be contacted to come in for a second interview. If you are asked to come back, you will be asked a couple of open-ended questions to further discuss your experience with your depressed parent while growing up. For that interview, you will be audiotaped. Tapes will be stored in a locked filing cabinet, separate from the consent forms, and will be accessible only to the PI and RA for research purposes. No identifiers will be used in the audio recordings, only an assigned code. Tapes will be kept by the PI for five years following the last publication from these data.

### **What Are The Possible Risks And Discomforts?**

To the best of our knowledge, the things you will be doing have no more risk of harm than you would experience in everyday life. Although, you may find some of the questions we ask to be upsetting or stressful. If so, we can tell you about some people who may be able to help you with these feelings, for example a counselor with Student Counseling Services. In the rare case that you become so upset that you voice thoughts to harm yourself or others, the PI or RA will need to contact emergency personnel to get you the appropriate help.

### **Will I Benefit From Taking Part In This Study?**

You will not get any personal benefit from taking part in this study.

### **Do I Have To Take Part In This Study?**

If you decide to take part in the study, it should be because you really want to volunteer. There will be no penalty and you will not lose any benefits or rights you would normally have if you choose not to volunteer. No one on the research team will behave any differently toward you if you choose not to participate in the study. You can stop at any time during the study and still keep the benefits and rights you had before volunteering.

### **What Will It Cost Me To Participate?**

There are no costs associated with taking part in this study.

### **Will I Receive Any Payment Or Reward For Taking Part In This Study?**

You will receive a \$20 Target gift card for taking part in this study. If you should have to stop participating before the study is over, you will still receive the full amount of the gift card.

### **Who Will See The Information I Give?**

Your information will be combined with information from other people taking part in the study. When we write up the study to share it with other researchers, we will write about the combined information. You will not be identified in any published or presented materials.

To ensure confidentiality, at the start of the proposed study, each participant will be assigned a code to accompany all data. Data will not reflect identifying information and will be stored on a password-protected computer and backed up on a password-protected external hard drive. Any data viewed by consultants on the proposed study will only be identified by code. A master list of participant's names and contact information and consent forms with the participant's names will be stored in a locked file cabinet. The PI and RA will be the only people aware of the location and have access to these data.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information or what that information is. However, there are some circumstances in which we may have to show your information to other people. We may be required to show information that identifies you to people who need to be sure that we have done the research correctly, such as the UNCW Institutional Review Board. Moreover, the law may require us to show your information in court, or to tell authorities if you are a danger to yourself or others.

### **Can My Taking Part In The Study End Early?**

If you decide to take part in the study you still have the right to decide at any time that you no longer want to continue. There will be no penalty and no loss of benefits or rights if you stop participating in the study. No one on the research team will behave any differently to you if you decide to stop participating in the study.

### **What If I Have Questions?**

Before you decide whether or not to participate in the study, please ask any questions that come to mind now. Later, if you have questions about the study, you can contact the investigator, Brandy Mechling at 910-962-7292. If you have any questions about your rights as a research participant, contact Dr. Candace Gauthier, Chair of the UNCW Institutional Review Board, at 910-962-3558.

### **What Else Do I Need To Know?**

I am required by federal law to provide you with a copy of this informed consent form.

I understand that my participation in this research study is entirely voluntary. I may refuse to participate without penalty or loss of benefits. I may also stop participating at any time without penalty or loss of benefits. I have received a copy of this consent form to take home with me.

---

Signature of person consenting to take part  
in the study

---

Date

---

Printed name of person consenting to take  
part in the study

---

Name of person providing information to  
the participant

---

Date

## Appendix B

### Screening Tool for Parental Depression

#### Screening Form for Participant's Perception of Parent's Depressive Symptoms

- First, for inclusion in the study, are you between the ages of 18 and 25?
- Second, I need to ask about what it was that makes you think your parent was depressed?

For instance, did they have (per their report or your observation):

- |   |              |   |
|---|--------------|---|
| 1) A <u>depressed mood</u> most of the day, nearly every day for at least two weeks.  | Y            | N |
| 2) (He/she endorsed <u>feelings of sadness or emptiness</u> or you observed <u>tearful episodes</u> or them appearing sad). | Y            | N |
| 3) <u>An irritable mood</u> most of the day, nearly every day for at least a two week period?                               | Y            | N |
| 4) Show markedly <u>diminished interest or pleasure in almost all activities</u> most of the day, nearly every day?         | Y            | N |
| 5) <u>Insomnia</u> (Sleeping too little) <u>or hypersomnia</u> (Sleeping too much) nearly every day?                        | Y            | N |
| 6) <u>Psychomotor retardation</u> (Moving too slowly) <u>or agitation</u> (Restlessness) nearly every day?                  | Y            | N |
| 7) Show signs of <u>fatigue or loss of energy</u> nearly every day?   | Y            | N |
| 8) Have feelings of worthlessness or excessive guilt nearly every day?  | Y            | N |
| 9) Show a diminished ability to think or concentrate?   | Y            | N |
| 10) Have recurrent thoughts of death, suicide (with or without a plan), or a suicide attempt?                               | Y            | N |
| 11) Did any of these symptoms make it hard for your parent to work, take care of things at home, or get along with others?  | Y            | N |
| 12) How long do you remember your parent having these symptoms?   | # Yrs. _____ |   |

## Appendix C

### Data Collection Form

Directions: Each question has several possible answers. There are no right or wrong answers. Please either fill in the blank or circle your answer for those indicated items.

Items (1-4) refer to only you:

1) Age: \_\_\_\_\_

2) Gender: \_\_\_\_\_

3) Race:      Caucasian                      Hispanic                      Native American  
                 African American      Asian                      Mixed/Other \_\_\_\_\_

4) Major: \_\_\_\_\_

5) Which parent has suffered with depression?      Mother              Father              Both

6) Have you known this parent all of your life?              Yes              No

If no, how many years have you known this parent? \_\_\_\_\_

7) Is your depressed parent divorced?              Yes              No

8) Was your depressed parent always in the family home?      Yes              No

If No, please explain \_\_\_\_\_

9) How many years was your parent in the family home with you? \_\_\_\_\_

10) Were you ever separated from your depressed parent?      Yes              No

If yes, please briefly explain (e.g. were you placed in foster-care or kinship care (with a relative)? Was your parent hospitalized and you had to stay with family or friends?)

\_\_\_\_\_

If yes, how long were you separated from your parent?

\_\_\_\_\_

11) What is your earliest memory of your parent suffering from depressive symptoms?

Your age: \_\_\_\_\_

Parent's age: \_\_\_\_\_

Length of depressive symptoms \_\_\_\_\_

12) Who else resided in the home with you and your depressed parent? (No names, just relationship) \_\_\_\_\_

13) Have you ever received psychotherapy and discussed depression in your parent?

Yes

No

If Yes, how many months of treatment did you receive and at what age?

\_\_\_\_\_

## Appendix D

### The Mental Health Inventory (MHI-38)

Instructions: Please read each question and tick the box by the ONE statement that best describes how things have been FOR YOU during the past month. There are no right or wrong answers.

**1.** How happy, satisfied, or pleased have you been with your personal life during the past month? (*Mark one*)

- 1 ☐ Extremely happy, could not have been more satisfied or pleased
- 2 ☐ Very happy most of the time
- 3 ☐ Generally, satisfied, pleased
- 4 ☐ Sometimes fairly satisfied, sometimes fairly unhappy
- 5 ☐ Generally dissatisfied, unhappy
- 6 ☐ Very dissatisfied, unhappy most of the time

**2.** How much of the time have you felt lonely during the past month? (*Mark one*)

- 1 ☐ All of the time
- 2 ☐ Most of the time
- 3 ☐ A good bit of the time
- 4 ☐ Some of the time
- 5 ☐ A little of the time
- 6 ☐ None of the time

**3.** How often did you become nervous or jumpy when faced with excitement or unexpected situations during the past month? (*Mark one*)

- 1 ☐ Always
- 2 ☐ Very often
- 3 ☐ Fairly often
- 4 ☐ Sometimes
- 5 ☐ Almost never
- 6 ☐ Never

**4.** During the past month, how much of the time have you felt that the future looks hopeful and promising? (*Mark one*)

- 1 ☐ All of the time
- 2 ☐ Most of the time
- 3 ☐ A good bit of the time
- 4 ☐ Some of the time
- 5 ☐ A little of the time
- 6 ☐ None of the time

**5.** How much of the time, during the past month, has your daily life been full of things that were interesting to you? (*Mark one*)

- 1 ☐ All of the time
- 2 ☐ Most of the time
- 3 ☐ A good bit of the time
- 4 ☐ Some of the time
- 5 ☐ A little of the time
- 6 ☐ None of the time



6. How much of the time, during the past month, did you feel relaxed and free from tension? (*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> All of the time        | 4 <input type="checkbox"/> Some of the time     |
| 2 <input type="checkbox"/> Most of the time       | 5 <input type="checkbox"/> A little of the time |
| 3 <input type="checkbox"/> A good bit of the time | 6 <input type="checkbox"/> None of the time     |

7. During the past month, how much of the time have you generally enjoyed the things you do? (*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> All of the time        | 4 <input type="checkbox"/> Some of the time     |
| 2 <input type="checkbox"/> Most of the time       | 5 <input type="checkbox"/> A little of the time |
| 3 <input type="checkbox"/> A good bit of the time | 6 <input type="checkbox"/> None of the time     |

8. During the past month, have you had any reason to wonder if you were losing your mind, or losing control over the way you act, talk, think, feel, or of your memory? (*Mark one*)

- 1 ☐ No, not at all
- 2 ☐ Maybe a little
- 3 ☐ Yes, but not enough to be concerned or worried about
- 4 ☐ Yes, and I have been a little concerned
- 5 ☐ Yes, and I am quite concerned
- 6 ☐ Yes, I am very much concerned about it

9. Did you feel depressed during the past month? (*Mark one*)

- 1 ☐ Yes, to the point that I did not care about anything for days at a time
- 2 ☐ Yes, very depressed almost every day
- 3 ☐ Yes, quite depressed several times
- 4 ☐ Yes, a little depressed now and then
- 5 ☐ No, never felt depressed at all

10. During the past month, how much of the time have you felt loved and wanted? (*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> All of the time        | 4 <input type="checkbox"/> Some of the time     |
| 2 <input type="checkbox"/> Most of the time       | 5 <input type="checkbox"/> A little of the time |
| 3 <input type="checkbox"/> A good bit of the time | 6 <input type="checkbox"/> None of the time     |

11. How much of the time, during the past month, have you been a very nervous person? (*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> All of the time        | 4 <input type="checkbox"/> Some of the time     |
| 2 <input type="checkbox"/> Most of the time       | 5 <input type="checkbox"/> A little of the time |
| 3 <input type="checkbox"/> A good bit of the time | 6 <input type="checkbox"/> None of the time     |

12. When you have got up in the morning, this past month, about how often did you expect to have an interesting day? (*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> Always       | 4 <input type="checkbox"/> Sometimes    |
| 2 <input type="checkbox"/> Very often   | 5 <input type="checkbox"/> Almost never |
| 3 <input type="checkbox"/> Fairly often | 6 <input type="checkbox"/> Never        |

**13.** During the past month, how much of the time have you felt tense or “high-strung”?  
(*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> All of the time        | 4 <input type="checkbox"/> Some of the time     |
| 2 <input type="checkbox"/> Most of the time       | 5 <input type="checkbox"/> A little of the time |
| 3 <input type="checkbox"/> A good bit of the time | 6 <input type="checkbox"/> None of the time     |

**14.** During the past month, have you been in firm control of your behavior, thoughts, emotions or feelings? (*Mark one*)

- |   |  |
|---|--|
| 1 <input type="checkbox"/> Yes, very definitely   | 4 <input type="checkbox"/> No, not too well                |
| 2 <input type="checkbox"/> Yes, for the most part | 5 <input type="checkbox"/> No, and I am somewhat disturbed |
| 3 <input type="checkbox"/> Yes, I guess so        | 6 <input type="checkbox"/> No, and I am very disturbed     |

**15.** During the past month, how often did your hands shake when you tried to do something?  
(*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> Always       | 4 <input type="checkbox"/> Sometimes    |
| 2 <input type="checkbox"/> Very often   | 5 <input type="checkbox"/> Almost never |
| 3 <input type="checkbox"/> Fairly often | 6 <input type="checkbox"/> Never        |

**16.** During the past month, how often did you feel that you had nothing to look forward to?  
(*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> Always       | 4 <input type="checkbox"/> Sometimes    |
| 2 <input type="checkbox"/> Very often   | 5 <input type="checkbox"/> Almost never |
| 3 <input type="checkbox"/> Fairly often | 6 <input type="checkbox"/> Never        |

**17.** How much of the time, during the past month, have you felt calm and peaceful? (*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> All of the time        | 4 <input type="checkbox"/> Some of the time     |
| 2 <input type="checkbox"/> Most of the time       | 5 <input type="checkbox"/> A little of the time |
| 3 <input type="checkbox"/> A good bit of the time | 6 <input type="checkbox"/> None of the time     |

**18.** How much of the time, during the past month, have you felt emotionally stable? (*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> All of the time        | 4 <input type="checkbox"/> Some of the time     |
| 2 <input type="checkbox"/> Most of the time       | 5 <input type="checkbox"/> A little of the time |
| 3 <input type="checkbox"/> A good bit of the time | 6 <input type="checkbox"/> None of the time     |

**19.** How much of the time, during the past month, have you felt downhearted and blue?  
(*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> All of the time        | 4 <input type="checkbox"/> Some of the time     |
| 2 <input type="checkbox"/> Most of the time       | 5 <input type="checkbox"/> A little of the time |
| 3 <input type="checkbox"/> A good bit of the time | 6 <input type="checkbox"/> None of the time     |

**20.** How often have you felt like crying, during the past month? (*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> Always       | 4 <input type="checkbox"/> Sometimes    |
| 2 <input type="checkbox"/> Very often   | 5 <input type="checkbox"/> Almost never |
| 3 <input type="checkbox"/> Fairly often | 6 <input type="checkbox"/> Never        |

**21.** During the past month, how often have you felt that others would be better off if you were dead? (*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> Always       | 4 <input type="checkbox"/> Sometimes    |
| 2 <input type="checkbox"/> Very often   | 5 <input type="checkbox"/> Almost never |
| 3 <input type="checkbox"/> Fairly often | 6 <input type="checkbox"/> Never        |

**22.** How much of the time, during the past month, were you able to relax without difficulty? (*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> All of the time        | 4 <input type="checkbox"/> Some of the time     |
| 2 <input type="checkbox"/> Most of the time       | 5 <input type="checkbox"/> A little of the time |
| 3 <input type="checkbox"/> A good bit of the time | 6 <input type="checkbox"/> None of the time     |

**23.** How much of the time, during the past month, did you feel that your love relationships, loving and being loved, were full and complete? (*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> All of the time        | 4 <input type="checkbox"/> Some of the time     |
| 2 <input type="checkbox"/> Most of the time       | 5 <input type="checkbox"/> A little of the time |
| 3 <input type="checkbox"/> A good bit of the time | 6 <input type="checkbox"/> None of the time     |

**24.** How often, during the past month, did you feel that nothing turned out for you the way you wanted it to? (*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> Always       | 4 <input type="checkbox"/> Sometimes    |
| 2 <input type="checkbox"/> Very often   | 5 <input type="checkbox"/> Almost never |
| 3 <input type="checkbox"/> Fairly often | 6 <input type="checkbox"/> Never        |

**25.** How much have you been bothered by nervousness, or your “nerves”, during the past month? (*Mark one*)

- 1 ☐ Extremely so, to the point where I could not take care of things
- 2 ☐ Very much bothered
- 3 ☐ Bothered quite a bit by nerves
- 4 ☐ Bothered some, enough to notice
- 5 ☐ Bothered just a little by nerves
- 6 ☐ Not bothered at all by this

**26.** During the past month, how much of the time has living been a wonderful adventure for you? (*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> All of the time        | 4 <input type="checkbox"/> Some of the time     |
| 2 <input type="checkbox"/> Most of the time       | 5 <input type="checkbox"/> A little of the time |
| 3 <input type="checkbox"/> A good bit of the time | 6 <input type="checkbox"/> None of the time     |

**27.** How often, during the past month, have you felt so down in the dumps that nothing could cheer you up? (*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> Always       | 4 <input type="checkbox"/> Sometimes    |
| 2 <input type="checkbox"/> Very often   | 5 <input type="checkbox"/> Almost never |
| 3 <input type="checkbox"/> Fairly often | 6 <input type="checkbox"/> Never        |

**28.** During the past month, did you think about taking your own life? (*Mark one*)

- 1 ☐ Yes, very often
- 2 ☐ Yes, fairly often
- 3 ☐ Yes, a couple of times
- 4 ☐ Yes, at one time
- 5 ☐ No, never

**29.** During the past month, how much of the time have you felt restless, fidgety, or impatient?

(*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> All of the time        | 4 <input type="checkbox"/> Some of the time     |
| 2 <input type="checkbox"/> Most of the time       | 5 <input type="checkbox"/> A little of the time |
| 3 <input type="checkbox"/> A good bit of the time | 6 <input type="checkbox"/> None of the time     |

**30.** During the past month, how much of the time have you been moody or brooded about things? (*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> All of the time        | 4 <input type="checkbox"/> Some of the time     |
| 2 <input type="checkbox"/> Most of the time       | 5 <input type="checkbox"/> A little of the time |
| 3 <input type="checkbox"/> A good bit of the time | 6 <input type="checkbox"/> None of the time     |

**31.** How much of the time, during the past month, have you felt cheerful, lighthearted?

(*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> All of the time        | 4 <input type="checkbox"/> Some of the time     |
| 2 <input type="checkbox"/> Most of the time       | 5 <input type="checkbox"/> A little of the time |
| 3 <input type="checkbox"/> A good bit of the time | 6 <input type="checkbox"/> None of the time     |

**32.** During the past month, how often did you get rattled, upset or flustered? (*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> Always       | 4 <input type="checkbox"/> Sometimes    |
| 2 <input type="checkbox"/> Very often   | 5 <input type="checkbox"/> Almost never |
| 3 <input type="checkbox"/> Fairly often | 6 <input type="checkbox"/> Never        |

**33.** During the past month, have you been anxious or worried? (*Mark one*)

- 1 ☐ Yes, extremely to the point of being sick or almost sick
- 2 ☐ Yes, very much so
- 3 ☐ Yes, quite a bit
- 4 ☐ Yes, some, enough to bother me
- 5 ☐ Yes, a little bit
- 6 ☐ No, not at all

**34.** During the past month, how much of the time were you a happy person? (*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> All of the time        | 4 <input type="checkbox"/> Some of the time     |
| 2 <input type="checkbox"/> Most of the time       | 5 <input type="checkbox"/> A little of the time |
| 3 <input type="checkbox"/> A good bit of the time | 6 <input type="checkbox"/> None of the time     |

**35.** How often during the past month did you find yourself trying to calm down? (*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> Always       | 4 <input type="checkbox"/> Sometimes    |
| 2 <input type="checkbox"/> Very often   | 5 <input type="checkbox"/> Almost never |
| 3 <input type="checkbox"/> Fairly often | 6 <input type="checkbox"/> Never        |

**36.** During the past month, how much of the time have you been in low or very low spirits? (*Mark one*)

- |   |   |
|---|---|
| 1 <input type="checkbox"/> All of the time        | 4 <input type="checkbox"/> Some of the time     |
| 2 <input type="checkbox"/> Most of the time       | 5 <input type="checkbox"/> A little of the time |
| 3 <input type="checkbox"/> A good bit of the time | 6 <input type="checkbox"/> None of the time     |

**37.** How often, during the past month, have you been waking up feeling fresh and rested? (*Mark one*)

- |  |   |
|--|---|
| 1 <input type="checkbox"/> Always, every day | 4 <input type="checkbox"/> Some days, but usually not   |
| 2 <input type="checkbox"/> Almost every day  | 5 <input type="checkbox"/> Hardly ever                  |
| 3 <input type="checkbox"/> Most days         | 6 <input type="checkbox"/> Never wake up feeling rested |

**38.** During the past month, have you been under or felt you were under any strain, stress or pressure? (*Mark one*)

- |  |
|--|
| 1 <input type="checkbox"/> Yes, almost more than I could stand or bear |
| 2 <input type="checkbox"/> Yes, quite a bit of pressure                |
| 3 <input type="checkbox"/> Yes, some more than usual                   |
| 4 <input type="checkbox"/> Yes, some, but about normal                 |
| 5 <input type="checkbox"/> Yes, a little bit                           |
| 6 <input type="checkbox"/> No, not at all                              |

## Appendix E

### The Boundary Ambiguity Scale

The following statements are about your relationship with your depressed parent (As you read, imagine his or her name in the blank space in each sentence.) Using the scale provided as a guideline, choose the number that best shows how you feel and place it in the blank to the left of each item. There are no right or wrong answers. It is important that you answer every item, even if you are unsure of your answer.

For questions 1-14, use the following scale as a guide in answering:

STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE	UNSURE HOW I FEEL
1	2	3	4	5

- \_\_\_\_ 1. I feel guilty when I get out of the house to do something enjoyable while \_\_\_\_\_ remains at home.
- \_\_\_\_ 2. I feel it will be difficult if not impossible to carve out my own life as long as \_\_\_\_\_ needs my help.
- \_\_\_\_ 3. I feel incapable of establishing new friendships right now.
- \_\_\_\_ 4. I feel I cannot go anywhere without first thinking about \_\_\_\_\_'s needs.
- \_\_\_\_ 5. I feel like I have no time to myself.
- \_\_\_\_ 6. Sometimes I'm not sure where \_\_\_\_\_ fits in as part of the family.
- \_\_\_\_ 7. I'm not sure what I should expect \_\_\_\_\_ to do around the house.
- \_\_\_\_ 8. I often feel mixed up about how much I should be doing for \_\_\_\_\_.
- \_\_\_\_ 9. I put \_\_\_\_\_'s needs before my own.
- \_\_\_\_ 10. My family and I often have disagreements about my involvement with \_\_\_\_\_.
- \_\_\_\_ 11. When I'm not with \_\_\_\_\_, I find myself wondering how s/he is getting along.
- \_\_\_\_ 12. Family members tend to ignore \_\_\_\_\_.
- \_\_\_\_ 13. \_\_\_\_\_ no longer feels like my spouse/parent/sibling.
- \_\_\_\_ 14. I think about \_\_\_\_\_ a lot.

## Appendix F

### The Mental Health Literacy Scale

Instructions: When responding, think back to what you thoughts during the time that you experienced depression in your parent. Circle Yes or No to all questions except for #2. For #2, you will need to provide your source of information.

#### Section One (General Knowledge/Awareness):

- |   |                         |    |
|---|-------------------------|----|
| 1. Had you ever heard of the mental illness called, "Depression?" | Yes                     | No |
| 2. Where did you hear about Depression for the very first time?   |                         |    |
| 3. Had you ever suffered from Depression yourself?                | Yes                     | No |
|   | Do not want to disclose |    |

#### Section Two (Knowledge of Symptoms):

During the time when you experienced Depression in your parent, were you aware that the following were symptoms of depression?

- |  |     |    |
|--|-----|----|
| 4. Sadness or bad moods                                | Yes | No |
| 5. Loss of appetite or overeating                      | Yes | No |
| 6. Suicidal thoughts or self-harm behaviors            | Yes | No |
| 7. Fatigue, feeling tired to exhausted, and body aches | Yes | No |
| 8. Sleeping problems                                   | Yes | No |
| 9. Lack of energy                                      | Yes | No |
| 10. Sexual dysfunction or loss of desire               | Yes | No |
| 11. Changes in behavior                                | Yes | No |

#### Section Three (Perceptions about causation):

- |                                     |     |    |
|-------------------------------------|-----|----|
| 12. Failure in achievements         | Yes | No |
| 13. Interpersonal sadness or guilt  | Yes | No |
| 14. Chemical imbalance in the brain | Yes | No |
| 15. Genetically inherited           | Yes | No |
| 16. Death of a loved one            | Yes | No |
| 17. Home/ family disharmony         | Yes | No |
| 18. Relationship break-up           | Yes | No |
| 19. Occurring automatically         | Yes | No |

#### Section Three (Knowledge regarding Treatment):

During the time when you experienced Depression in your parent, what treatments were you aware of for it?

- |   |     |    |
|---|-----|----|
| 20. Medication (such as anti-depressants) | Yes | No |
| 21. Psychotherapy                         | Yes | No |
| 22. Support groups                        | Yes | No |
| 23. Meditation/Yoga/Exercise              | Yes | No |
| 24. Religious/Spiritual Therapy           | Yes | No |

## Appendix G

### The Perceived Stress Scale

#### INSTRUCTIONS:

The questions in this scale ask you about your feelings and thoughts during **THE LAST MONTH**. In each case, you will be asked to indicate your response by placing an “X” over the circle representing **HOW OFTEN** you felt or thought a certain way. Although some of the questions are similar, there are differences between them and you should treat each one as a separate question. The best approach is to answer fairly quickly. That is, don’t try to count up the number of times you felt a particular way, but rather indicate the alternative that seems like a reasonable estimate.

	Never 1	Almost Never 2	Sometimes 3	Fairly Often 4	Very Often 5
1. In the last month, how often have you been upset because of something that happened unexpectedly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. In the last month, how often have you felt that you were unable to control the important things in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. In the last month, how often have you felt nervous and “stressed”?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. In the last month, how often have you dealt successfully with day to day problems and annoyances?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. In the last month, how often have you felt that you were effectively coping with important changes that were occurring in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. In the last month, how often have you felt confident about your ability to handle your personal problems?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. In the last month, how often have you found that you could not cope with all the things that you had to do?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. In the last month, how often have you felt that things were going your way?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. In the last month, how often have you been able to control irritations in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. In the last month, how often have you felt that you were on top of things?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## Appendix H

### The Multidimensional Scale of Perceived Social Support

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement using the following scale:

Circle 1 if you Very Strongly Disagree

Circle 2 if you Strongly Disagree

Circle 3 if you Mildly Disagree

Circle 4 if you are Neutral

Circle 5 if you Mildly Agree

Circle 6 if you Strongly Agree

Circle 7 if you Very Strongly Agree

1. There is a special person who is around when I am in need.	1	2	3	4	5	6	7
2. There is a special person with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
3. My family really tries to help me.	1	2	3	4	5	6	7
4. I get the emotional help & support I need from my family.	1	2	3	4	5	6	7
5. I have a special person who is a real source of comfort for me.	1	2	3	4	5	6	7
6. My friends really try to help me.	1	2	3	4	5	6	7
7. I can count on my friends when things go wrong.	1	2	3	4	5	6	7
8. I can talk about my problems with my family.	1	2	3	4	5	6	7
9. I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
10. There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7
11. My family is willing to help me make decisions.	1	2	3	4	5	6	7
12. I can talk about my problems with my friends.	1	2	3	4	5	6	7

## Appendix I

### The Herth Hope Index

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Listed below are a number of statements. Read each statement and circle the response that describes how much you agree with that statement right now. (The numbers are added here to illustrate the scoring, as questions 3 and 6 are reverse-scored).

<b>Statement</b>	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Agree</b>	<b>Strongly Agree</b>
1. I have a positive outlook toward life.	1	2	3	4
2. I have short- and/or long-range goals.	1	2	3	4
3. I feel all alone.	4	3	2	1
4. I can see possibilities in the midst of difficulties.	1	2	3	4
5. I have a faith that gives me comfort	1	2	3	4
6. I feel scared about my future	4	3	2	1
7. I can recall happy/joyful times.	1	2	3	4
8. I have deep inner strength	1	2	3	4
9. I am able to give and receive caring/love.	1	2	3	4
10. I have a sense of direction	1	2	3	4
11. I believe that each day has potential	1	2	3	4
12. I feel my life has value and worth.	1	2	3	4

---

## Appendix J

### The Multi-Dimensional Assessment of Caring Activities Checklist

(MACA-YC18)

Below are some jobs that young carers do to help. Think about the help you have provided over the last month. Please read each one and put an X in the box to show how often you have done each of the jobs in the last month.

	Never	Some of the time	A lot of the time
1. Clean your own bedroom			
2. Clean other rooms			
3. Wash up dishes or put dishes in a dishwasher			
4. Decorate rooms			
5. Take responsibility for shopping for food			
6. Help with lifting or carrying heavy things			
7. Help with financial matters such as dealing with bills, banking money, collecting benefits			
8. Work part time to bring money in			
9. Interpret, sign or use another communication system for the person you care for			
10. Help the person you care for to dress or undress			
11. Help the person you care for to have a wash			
12. Help the person you care for to have a bath or shower			
13. Keep the person you care for company e.g. sitting with them, reading to them, talking to them			
14. Keep an eye on the person you care for to make sure they are alright			
15. Take the person you care for out e.g. for a walk or to see friends or relatives			
16. Take brothers or sisters to school			
17. Look after brothers or sisters whilst another adult is nearby			
18. Look after brothers or sisters alone			

## Appendix K

### The Positive and Negative Outcomes of Caring Questionnaire

(PANOC-YC20)

Below are some things young carers like you have said about what it feels like to have to look after someone. Please read each statement and put an X in the box to show how often this is true for you. There is no right or wrong answers. We are just interested in what life is like for you because of caring.

	Never	Some of the time	A lot of the time
1. Because of caring I feel I am doing something good			
2. Because of caring I feel that I am helping			
3. Because of caring I feel closer to my family			
4. Because of caring I feel good about myself			
5. Because of caring I have to do things that make me upset			
6. Because of caring I feel stressed			
7. Because of caring I feel that I am learning useful things			
8. Because of caring my parents are proud of the kind of person I am			
9. Because of caring I feel like running away			
10. Because of caring I feel very lonely			
11. Because of caring I feel like I can't cope			
12. Because of caring I can't stop thinking about what I have to do			
13. Because of caring I feel so sad I can hardly stand it			
14. Because of caring I don't think I matter			
15. Because of caring I like who I am			
16. Because of caring life doesn't seem worth living			
17. Because of caring I have trouble staying awake			
18. Because of caring I feel I am better able to cope with problems			
19. I feel good about helping			
20. Because of caring I feel I am useful			

## **Appendix L**

### **Recruitment Flyer**

# **University of North Carolina at Wilmington School of Nursing**

## **PARTICIPANTS NEEDED FOR RESEARCH STUDY**

I am looking for participants to take part in a study of young adults ages 18-25 who experienced a depressed parent while growing up.

As a participant in this study, you would be asked to: Meet with the Principal Investigator (PI) or Research Assistant (RA) and complete various brief, self-report research measures. You might also be asked to return for a brief interview.

Your participation would involve one to two sessions,  
each lasting 45 minutes or less.

In appreciation for your time, you will receive  
a \$20 Target Gift Card

For more information about this study, or to volunteer for this study,  
please contact:

*Brandy Mechling PhD(c), RN, PMH CNS - BC*  
*School of Nursing*  
*at*  
*910-962-7292 or*  
*Email: (mechlingb@uncw.edu)*

**This study has been reviewed by, and received ethics clearance  
through, the Office of Research Services, University of North Carolina at Wilmington  
and the Office of Human Research Ethics, University of North Carolina at Chapel Hill.**

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