

FOSTERING RESILIENCE: EVALUATING THE EFFECTIVENESS
OF KIDS IN CONTROL

By

Gordon A. Richter

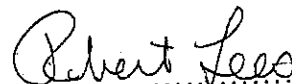
A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS

In

THE FACULTY OF GRADUATE STUDIES

GRADUATE COUNSELLING PSYCHOLOGY PROGRAM

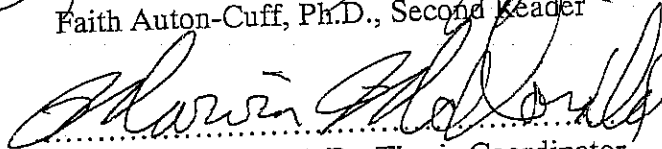
We accept this thesis as conforming
to the required standard



Robert Lees, Ed.D., Thesis Supervisor



Faith Auton-Cuff, Ph.D., Second Reader



Marvin McDonald, Ph.D., Thesis Coordinator



for Darryl Maybery, Ph.D., External Examiner

TRINITY WESTERN UNIVERSITY

September 2006

© Gordon A. Richter

ABSTRACT

Children of a parent with a mental illness are exposed to stressors that place them at an elevated risk of experiencing a variety of negative outcomes. Children of a parent with a mental illness who do not experience these negative outcomes are said to be resilient. Numerous protective factors contribute to the resilience of children of a parent with a mental illness. Kids in Control, an 8 week psychoeducation and support group, was designed to address the needs of children of a parent with a mental illness and to bolster their resilience. The present study represented the first effectiveness evaluation of the Kids in Control program. It examined 33 Kids In Control participants in seven groups from six communities in British Columbia. These groups were led by trained facilitators who reported high treatment fidelity. The study focused on program outcomes associated with resilience. Participants' level of self-esteem, use of coping strategies, and knowledge of mental illness were measured using a battery of child friendly self-report instruments. The study employed a recurrent institutional cycle design in which one cohort of Kids In Control program participants was assessed before and after their participation in the program and later compared to the next cohort of participants entering the program (future participants). Due to the small number of participants, a descriptive and exploratory analysis of the data was conducted for this group instead of an inferential analysis. An analysis of score distributions and statistical results were reported for their descriptive value and for the benefit of future research. The pattern of results suggest that some of these program participants tend to report a higher level of self-esteem, a diminished use of certain coping strategies, and a greater amount of knowledge about mental illness following their experience in the Kids In Control groups involved in this

study. Some of these program participants also tended to report higher self-esteem and knowledge of mental illness than the levels reported by future participants. The implications of the findings, the strengths and limitations of the data set, and recommendations for future research are also presented. The study represents a case study of the Kids In Control program from a resilience perspective.

TABLE OF CONTENTS

ABSTRACT.....	ii
TABLE OF CONTENTS.....	iv
LIST OF TABLES	viii
ACKNOWLEDGEMENTS.....	ix
CHAPTER 1: INTRODUCTION AND REVIEW OF THE LITERATURE.....	1
Introduction	1
Review of the Literature	4
Children of a Parent with a Mental Illness	4
Risk Factors	8
Resilience	16
What is Resilience?	16
How does Resilience Work?	18
Resilience Across Time	23
Protective Factors	24
Effective Coping Strategies	25
Social Connectedness	28
Self-esteem	30
Knowledge of Mental Illness	32
Interventions	34
Kids in Control	41
Purpose	44
Research Questions.....	44

Hypothesis 1	44
Hypothesis 2	45
Hypothesis 3	45
CHAPTER 2: METHODS	47
Participants	47
Recruiting Facilitators	47
Facilitators	48
Child Participants	50
Procedure	55
Ethical Considerations	59
Measures	61
Demographic Questionnaire for Parents and Guardians	61
Coopersmith Self-esteem Inventory.....	61
Kids Coping Scale.....	64
Kids Knowledge Scale	65
CHAPTER 3: RESULTS.....	68
Description of Score Distributions	68
Data Analysis	72
Internal Consistency	73
Correlations	73
Means and Standard Deviations.....	76
Self-esteem	76
Coping Strategies	79

Knowledge of Mental Illness	83
Summary	85
CHAPTER 4: DISCUSSION	87
Conclusions for Kids in Control	87
Knowledge of Mental Illness.....	87
Coping Strategies	89
Self-esteem	94
Implications	97
What do the Results Mean for Kids in Control?	97
What do the Results Mean for Resilience?	99
What do the Results Mean for Counselling Psychology?.....	101
Methodological Strengths and Limitations.....	101
The Resilience Framework.....	101
Real World Setting	102
Facilitators	102
Sampling	103
Sample Size	103
Non-equivalent Comparison Group Design	104
Change	106
Measures	106
Future research	108
Summary	110
REFERENCES.....	111

APPENDICES.....	121
Appendix A: Facilitator Information Letter & Consent Form	121
Appendix B: Facilitator & Site Information Questionnaire	127
Appendix C: Program Content Coverage Checklist (PCCC)	129
Appendix D: Parent/Guardian Information Letter & Consent Form	131
Appendix E: Parent/Guardian Demographic Questionnaire	135
Appendix F: Child Information Letter & Assent Form	137
Appendix G: Kids Coping Scale (KCS)	140
Appendix H: Kids Knowledge Scale (KKS)	141
Appendix I: Participant Debriefing Letter	144

LIST OF TABLES

Table 1: Selected Demographic Characteristics.....	52
Table 2: Elevated Correlations of Interest	74
Table 3: Means and Standard Deviations of the Outcome Measures.....	75

ACKNOWLEDGEMENTS

This project would not have been possible without the support and assistance of a large number of individuals. I would like to thank my thesis committee: Dr. Robert Lees, Dr. Faith Auton-Cuff, and Dr. Marvin McDonald. I would like to thank the British Columbia Schizophrenia Society for providing access to the Kids in Control program, the Facilitator's manual, and their list of trained facilitators. I would like to express special gratitude to the group facilitators who, in spite of their already hectic schedules, managed to carry out all of the additional work associated with the study. These individuals were Kashmir Belsa, Shannon Guiboche, Ian Mitchell, and Blaine Powel. I would also like to thank all of the children who participated in this study.

I would like to thank all of the other individuals who contributed to this project in some manner. I would like to thank Dr. Darryl Maybery who provided access to his Kids Coping Scale. I would like to thank those individuals involved in the development of the Kids Knowledge Scale. I would like to thank my parents, Rob Taylor, Dr. Jose Domene, David Langille, and Andrew Tarrant for their assistance.

Finally, I would like to thank God, my friends (with special thanks to Shivinder Shergill), my "little brother" Josh Humphrey, my colleagues, and my family for their ongoing support and encouragement throughout this project.

CHAPTER 1: INTRODUCTION AND REVIEW OF THE LITERATURE

Introduction

Children of a parent with a mental illness (COPMI) are sometimes referred to as “invisible children” because their unique struggles and needs are rarely recognized or adequately addressed by mental health service providers, researchers, or policy makers (Devlin & O'Brien, 1999; Finkelstein, Rechberger, Russell, & Vandemark, 2005; Maybery, Ling, Szakacs, & Reupert, 2005; Mordach & Hall, 2002; Polkki, Ervast, & Huupponen, 2004). According to Maybery et al. few researchers have given any scholarly attention to understanding the needs of COPMI. As a result, the specific needs of COPMI are still relatively unknown. The research that has been done suggests that COPMI are an at risk population whose needs should not be overlooked.

Research indicates that COPMI are at an elevated risk for experiencing negative outcomes including mental illness (Ahern, 2003; Beardslee, Gladstone, Wright, & Cooper, 2003; Cowling, Luk, Mileshekin, & Birlleson, 2004). These negative outcomes are due in part to the various adverse circumstances that COPMI face in their day-to-day lives. Both genetic and environmental factors contribute to the increased likelihood that COPMI will experience negative outcomes (Reinherz, Giaconia, Carmola, Wasserman, & Silverman, 1999). In spite of whatever adversities they encounter in their lives, many COPMI grow up without experiencing any more or worse negative outcomes than children from the general population (Harvey & Delfabbro, 2004; Rutter, 1981). These COPMI who overcome the various risk factors in their lives and experience normal development are demonstrating a developmental process known as resilience.

There are many characteristics of the individual and the environment that contribute to resilience among at risk children in general and among COPMI in particular (Werner, 1995; Werner & Johnson, 2004). In regards to COPMI, these protective factors and processes include understanding mental illness, utilizing effective coping strategies, and possessing a positive view of the self.

Research on the needs of COPMI and the nature of resilience is slowly being translated into interventions designed to improve outcomes for children in this population (Beardslee et al., 2003; Finkelstein et al., 2005; Orel, Groves, & Shannon, 2003). The development of such programs is an important first step in meeting the unique needs of COPMI. Pitman and Matthey (2004) observed that the majority of programs for COPMI have only been validated using anecdotal evidence and internal reviews and that empirical evidence for the effectiveness of these programs remains sparse. The existing research suggests that brief interventions have at least some short-term benefits for COPMI. Beardslee et al. (2003) found that two short psychoeducation programs were able to increase COPMI's understanding of mental illness and decrease their externalizing and internalizing behaviour. Finkelstein et al. (2005) showed that COPMI could acquire some knowledge and coping skills over the course of a 10-week intervention. Pitman and Matthey (2004) provided some evidence that a 3-day intervention could increase COPMI's knowledge of mental illness and life skills. These studies are described in more detail below. In spite of these encouraging preliminary findings, there remains a substantial need for further empirical research.

Kids in Control (KIC; British Columbia Schizophrenia Society, 2005) is an 8 week psychoeducation and support group program for COPMI developed by Dr. Rob

Lees and Marj de Lange in 1994 on behalf of the British Columbia Schizophrenia Society (BCSS). The program was originally designed for children between 8 and 13 years of age who have either a parent or sibling with a mental illness. The program provides an opportunity for COPMI to learn about mental illness and to practice coping and interpersonal skills. The program gives COPMI the opportunity to explore the stigma that affects them and their families, and to be strengthened through exposure to accurate knowledge of mental illness. It gives children the opportunity to be around other children who are dealing with similar circumstances, thereby normalizing these experiences. The program aims to foster new and stronger social connections and to increase self-esteem and self-efficacy. By promoting these and other protective factors, the program aims to make participants more resilient.

Although KIC has been running for 10 years, its effectiveness has never before been empirically evaluated. The present study represents the first effectiveness trial ever conducted. In order to evaluate the effectiveness of the program, the study investigated its operation and outcomes in the real world settings where it is typically offered. This study examined 33 COPMI from seven KIC groups offered in six communities across British Columbia between October 2005 and April 2006. A recurrent institutional cycle design was employed to explore whether or not the program could make a difference in participants' knowledge of mental illness, use of effective coping strategies, and level of self-esteem. The experimental condition featured an assessment on the first day of the program, the last day of the program, and at an 8-week follow-up session. The intention was to provide evidence of both immediate and short-term changes. Since the KIC program does not maintain a wait list, a traditional comparison condition could not be

used. Instead, the present study compared the first cohort of children at the end of their participation in the program to the next cohort of children prior to their participation in the program. The results of this study provide some preliminary evidence regarding the effectiveness of the KIC program.

This study will be described in four chapters consisting of an introduction and review of the relevant literature, an outline of the research design and methodology, results, and a discussion about the results, strengths and limitations of the study, with ideas for future research.

Review of the Literature

Children of a parent with a mental illness. Living with a mental illness could be a challenge for anyone at any age. Likewise, raising children presents an array of rewards and challenges to all parents regardless of age, marital status, family income, or other life circumstances. Parents who have a mental illness are obliged to face both of these potentially stressful situations simultaneously. Bassett, Lampe, and Lloyd (1999) interviewed mothers who had both a mental illness and a child under the age of five. These mothers expressed a number of concerns including losing custody of their children, being treated in a prejudicial manner as a result of their mental health status, having their children treated in such a manner, and the possibility of their children developing mental illnesses. They indicated that they take their parenting role seriously and value their relationships with their children. They reported that their parental role was often compromised by their traumatic hospitalization experiences and their social isolation. The findings from these interviews illustrate several of the common stressors facing parents who have a mental illness.

Even though it is important to acknowledge the significant struggles of parents who have a mental illness, it is equally important to recognize and address the unique difficulties and needs of their children. Unfortunately, COPMI have historically been overlooked by researchers (Finkelstein et al., 2005; Tanner, 2000) and by mental health professionals alike (Devlin & O'Brien, 1999; Mordach & Hall, 2002). This oversight has led many researchers to refer to COPMI as invisible or hidden children. Researchers have only recently started to take an interest in this special population and their needs (Maybery et al., 2005; Ostman & Hansson, 2002). The research to date suggests that there are a large number of COPMI and that they face a variety of stressors and adversities that place them at risk.

How many children are affected by parental mental illness? Given that researchers and mental health professionals have tended to overlook COPMI, it is not surprising that few studies have attempted to calculate the prevalence of COPMI in the general population (Cowling et al., 2004). Maybery, Reupert, Patrick, Goodyear, and Crase (2005) described two strategies that researchers have used to estimate the prevalence of COPMI. The first is a "top-down" approach that involves two steps: (a) determining the prevalence of mental illness among adults in a given population, and (b) determining how many of these adults are likely to be parents. The second is a "bottom-up" approach that involves creating an estimate by determining the number of parents in a given population of mental health consumers. Both of these strategies would likely underestimate the prevalence of COPMI because they do not take into account the fact that a single parent who has a mental illness could have more than one child.

According to Kessler et al. (1997) almost half of all Americans will experience some form of mental illness during their lifetime and 30% of Americans have experienced an episode of mental illness in the past 12 months. Beardslee et al. (2003) reported that one in every five Americans will experience an episode of depression during their lifetime. Nicholson, Larkin, Simon, and Banks (2001) reported that two thirds of the women who have a mental illness are mothers and over half of the men are fathers. Following a top-down approach, Beardslee and Knitzer (2004) estimated that there could be over 2 million COPMI living in the United States of America.

Researchers in Australia have attempted to estimate the number of COPMI living in different regions of the continent (Ahern, 2003; Cowling et al., 2004; Devlin & O'Brien, 1999; Maybery, Rupert, et al., 2005). Cowling et al. (2004) and Ahern (2003) surveyed mental health professionals and mental health consumers in different regions of Australia in order to determine the number of mental health consumers who are parents. The former study identified 136 of the 846 mental health consumers in their sample (approximately 16%) as parents. The latter study identified 242 of the 438 mental health consumers who responded to their survey (approximately 55%) as parents. The accuracy of the findings from both of these studies may have been influenced by different forms of sampling or responding bias. These researchers did not use their findings to create a bottom-up estimate of the prevalence of COPMI in Australia.

Maybery, Rupert, et al. (2005) estimated the number of COPMI in Australia by combining a top-down and a bottom-up approach. The top-down estimate was based on data from two large-scale Australian surveys. The survey data indicated that 12.5% of adult Australians have or have had a mental illness. The bottom-up estimate was made by

recording the total number of children of all persons who requested mental health services over a 2-year period. These researchers estimated that between 21.73 and 23.52% of Australian children live in a household where there is at least one parent who has a mental illness. In other words, they estimate that there are just over 1 million COPMI in Australia.

The prevalence of mental illness and COPMI in Canada is believed to be comparable to that in other countries. The Public Health Agency of Canada (2002) estimated that 20% of adult Canadians will experience some form of mental disorder in their lifetime. The Canadian Community Health Survey (CCHS; 2002) examined the prevalence of mental disorders in Canada during the 12 months prior to the survey. The CCHS estimated the prevalence of various mental disorders among Canadian adults as follows: 4.9% mood disorders, 4.7% anxiety disorders, and 3.0% substance dependency. Only 32% of individuals who had symptoms of a mental illness in the 12 months preceding the survey had consulted a health professional or received some kind of treatment for the disorder. This finding suggests that there are a large number of adult Canadians who have an undiagnosed or untreated mental disorder. The findings of the CCHS also suggest that the official prevalence statistics may substantially underestimate the true prevalence of mental illness in Canada.

The surveys outlined above provided an estimate of the prevalence of mental illness among Canadian adults rather than an estimate of the number of COPMI in Canada. Research by Gopfert, Webster, and Seeman (1996) suggested that approximately half of Canadian adults who have a mental illness live in a household where there is a child. This statistic is consistent with the American and Australian estimates previously

cited. Unfortunately, researchers have not yet produced an actual top-down estimate of the number of COPMI living in Canada.

Lees and Chovil (2006) investigated the prevalence of COPMI in British Columbia using a bottom-up approach. These researchers asked mental health service providers in three health regions of British Columbia to review their case loads and to determine how many of their clients have dependency aged children. Responding case managers reported on 3,423 mental health consumers. These individuals reported that 1,222 (approximately 36%) of their clients had dependency aged children. Approximately one-third of these children were pre-school aged, another third were school aged, and another third were high school aged. Older children were more likely to be living with a parent who has a mental illness.

Regardless of the precise prevalence, the number of COPMI living in Canada is presumably quite large. Given the large number of COPMI in Canada and around the world, it is important to pursue a greater understanding of the stressors that impact their lives and the factors that place them at risk.

Risk Factors

What are risk factors? According to Costello and Angold (as cited in Little, Axford, & Morpeth, 2004) the term risk originated in the field of epidemiology where it simply referred to the probability that an individual would develop a certain disease. The concept of risk was based on evidence that an individual is more likely to develop a given disease when factors associated with its pathogenesis are present in the individual's life. Therefore, any factor that increases an individual's probability of developing a disease is referred to as a risk factor.

The concept of risk is sometimes misunderstood or misinterpreted. The concept of risk relates to theoretical outcomes and probabilities rather than actual outcomes. Even though the presence of risk factors increases the probability of certain outcomes, it does not make those outcomes inevitable (Little et al., 2004; Rak & Patterson, 1996). For example, a person could be at four times the risk of developing a given disorder and still never develop it.

The concept of risk has been adopted by the field of psychology and applied in a wide variety of situations. The concepts of risk and risk factors are probably most closely associated with developmental psychology. Developmental psychologists are concerned with the biological and environmental factors that alone or in combination have the potential to reduce a child's ability to thrive or to increase a child's chances of experiencing some undesirable outcome (Howard, Dryden, & Johnson, 1999; Tebes, Kaufman, Adnopo, & Racusin, 2001). In other words, developmental psychologists are interested in risk factors and the outcomes that children are more or less likely to experience as a result of being exposed to them.

The relationship between risk factors and negative outcomes is quite complicated. Many variables including the number, timing, ordering, and type of risk factors moderate their effect. As a general rule, risk factors tend to have a cumulative effect. The larger the number of risk factors present in a child's life, the greater the likelihood that the child will experience a given negative outcome. The cumulative effect may be the result of the interaction of the various individual risk factors (Doll & Lyon, 1998). The same risk factor can have a different impact at different points in the child's development (Ungar, 2003). There are a wide variety of risk factors and each type may exercise a different

amount of influence (Doll & Lyon). Masten (2001) proposed that the most significant threats to children's development are factors that undermine their basic protective and adaptive systems. Garmezy (1994) said that it is the chronic stresses that are the most likely to contribute to undesirable outcomes. COPMI's level of risk is therefore influenced by the constellation of risk factors present in their lives.

What stresses, adverse circumstances, or risk factors affect COPMI? COPMI are often exposed to stressors, adverse conditions, and risk factors as a direct or indirect result of their parent's mental illness. COPMI may be exposed to chronic symptoms, acute episodes, or both depending on the nature of their parent's mental illness. Ahern (2003) argued that the chronic symptoms of mental illness are more harmful to COPMI than acute episodes. The severity of the symptoms is another moderating variable in the relationship between the parent's mental illness and the child's risk of experiencing negative outcomes.

A parental mental illness can put a strain on the entire family system and increase the amount of stress experienced by each member of the family (Ahern, 2003; Devlin & O'Brien, 1999). A parental mental illness may interfere with a parent's ability to perform his or her parenting role (Ahern; Polkki et al., 2004; Tebes et al. 2001). The break down of the parenting role is particularly serious given the finding that the mentally ill parent is frequently the child's primary caregiver. Comments from a study of fathers with a brain injury suggested that a problem experienced by one parent can be a drain on the resources, attention, and energy that the other parent would normally bestow upon the child (Butera-Prinzi & Perlesz, 2004). In this way, one parent's mental illness could interfere with the parenting role of more than one parent.

The distress experienced by the parent who has the mental illness or any other member of the family may lead to additional risk factors such as family conflict and the break down of various familial relationships. Tebes et al. (2001) observed that parental mental illness often increases a child's exposure to family distress and conflict, thereby increasing his or her risk of developing behavioural or emotional problems. Some researchers (Mordach & Hall, 2002; Young, Abelson, Curtis, & Nesse, 1997) have argued that the presence of family conflict is an important mediating variable in the relationship between parental mental illness and negative outcomes for COPMI.

As a result of the break down of the parenting role, COPMI may be obliged to take on adult roles as young caregivers taking care of themselves, their parent who has a mental illness, and their siblings (Polkki et al., 2004). The young caregiver role is stressful when the child is not developmentally ready to handle it. The role could lead to confusion as the child deals with his or her anxiety about the adult responsibilities while being praised by others for displaying maturity. Even though Werner (1995) found that children benefit from having the opportunity to help others, it is not beneficial for them to take on inappropriate roles and responsibilities.

Separation from one or both parents is another major stressor faced by many COPMI. COPMI may be separated from their parent who has a mental illness when the parent is hospitalized or when professionals believe that removing the child from the parent's custody would be in the child's best interest. Research suggests that frequent parent-child separations, especially early in life, can undermine the parent-child bond (Tebes et al., 2001). Two studies (Reinherz et al., 1999; Young et al., 1997) demonstrated that parent-child separation is a risk factor for the development of depression. A study by

Phillips, Burns, Wagner, Kramer, and Robbins (2002) demonstrated that adolescents who experienced the disruption of their families due to the incarceration of one of their parents were at a higher risk of developing attention deficit hyperactivity disorder and conduct disorder than their peers who had not experienced such a separation.

One of the other major sources of emotional distress for COPMI is psychic loss (Mordach & Hall, 2002). This chronic state of distress occurs when the parent is physically but not emotionally or psychologically available. A qualitative study of children whose fathers had a brain injury reported the same kind of distress resulting from the ambiguous nature of the loss (Butera-Prinzi & Perlesz, 2004). Psychic loss is often accompanied by feelings of grief, abandonment, or rejection.

The stigmatization of mental illness and persons who have a mental illness has been observed in operation on many levels in society and documented in both qualitative and quantitative studies (Beard & Gillespie, 2002; Corrigan, 2004; Phelan, Link, Stueve, & Pescosolido, 2000). In his article, Hinshaw (2005) described the serious impact of stigmatization on people who have a mental illness and their families. Individuals who have a mental illness may attempt to hide or deny their symptoms in order to avoid stigmatization and discrimination. As a result, these individuals may not seek social support or professional help to manage their symptoms. Cowling et al. (2004) found that 69% of the mentally ill parents they surveyed were reluctant to seek help and 19% of these parents reported not using any services at all. The tendency of some individuals who have a mental illness to conceal their mental health status could block open communication about the disorder in their families. The reluctance of parents who have a

mental illness to seek help and to talk about their mental illness adds to the risks faced by their children.

The stigmatization of mental illness in society may cause COPMI to experience confusion, guilt, and embarrassment (Hinshaw, 2005). Children receive negative messages about people who have a mental illness from the media. COPMI may experience confusion as they attempt to reconcile these negative messages with their personal feelings about their parents. Guilt is a serious source of emotional distress for many COPMI. Due to stigmatization and a lack of knowledge about mental illness, children often blame themselves or in some way accept responsibility for the mental illness of a family member (Mordach & Hall, 2002). When COPMI do not receive any explanation regarding a parent's absence or behaviour the tendency to blame themselves is heightened (Hinshaw). The children of fathers with a brain injury reported regularly feeling embarrassed by their fathers' behaviour and problems (Butera-Prinzi & Perlesz, 2004). The stigma associated with having a mental illness contributes to feelings of embarrassment and shame among COPMI (Hinshaw). This embarrassment and shame could have a negative impact on COPMI's view of their families and themselves.

Stigmatization also contributes to the sense of isolation and lack of social support experienced by people who have a mental illness and their families (Hinshaw, 2005). In this way, stigmatization may be a barrier to forming close relationships with supportive others (Tebes et al., 2001). COPMI may be stigmatized by peers and society as members of a deviant or atypical family (Hinshaw). Even the children in the study of children of a father with a brain injury reported a drop in social support from their friends and extended families following their fathers' accidents (Butera-Prinzi & Perlesz, 2004). The

consequences of stigma combined with other risk factors such as poor social skills could result in peer rejection which has been associated with an increased risk for conduct disorders, aggressive behaviour, and low academic performance (Masten & Coatsworth, 1998). The overall lack of social support is itself a general risk factor for a variety of interpersonal problems. The above are just a few examples of how the interaction of stressors from inside and outside of the family system can contribute to the likeliness that COPMI will experience some kind of unfavourable outcome later in life.

What negative outcomes are COPMI at greater risk of experiencing? Coming from a family in which there is a parent who has a mental illness has been established as a risk factor for a variety of undesirable outcomes. These outcomes can include developmental delay, behaviour problems, and emotional disturbances (Ahern, 2003). COPMI are at risk of experiencing interpersonal problems and low self-esteem (BCSS, 2005). Mowbray et al. (2004) reported that COPMI have an elevated risk of developing interpersonal and academic problems. In another study, Mowbray and Oyserman (2003) observed that COPMI are at an increased risk of experiencing problems with substance misuse. Many of the negative outcomes COPMI are at risk of experiencing have the potential to put these children at an even greater risk of experiencing other negative outcomes.

All of the stressors, adverse conditions, risk factors, and negative outcomes previously mentioned could contribute to COPMI's elevated risk of developing some form of mental illness (Ahern, 2003; Beardslee et al., 2003; Cowling et al., 2004). Beardslee et al. estimated that 61% of COPMI will develop some form of mental illness by the time they reach adolescence. Cowling et al. asked parents who had a mental illness

to complete the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997; 1999) in order to assess psychopathology in the children. The parent reports indicated that 25% of the children were in the clinical range. The COPMI in this study were 2.5 times as likely to have a mental illness as their peers in the community. Rutter (1981) conducted an extensive longitudinal study on COPMI and discovered that even though a large percentage of participants developed some form of mental illness, an equally substantial proportion did not develop any clinically significant symptoms. These findings underscore the point that the presence of risk factors does not guarantee negative outcomes.

Many studies have demonstrated that COPMI are at an elevated risk of developing depression (Ahern, 2003; Mowbray et al., 2004; Reinherz et al., 1999; Young et al., 1997). Beardslee et al (2003) claim that children who have a parent who has depression are between two and four times as likely to develop depression. There are genetic and environmental factors influencing this risk (Reinherz et al.). COPMI share both their parents' genes and the psychosocial stresses and losses experienced by the family. Mowbray et al. noted that due to the episodic nature of depression, children are often exposed to multiple episodes during their development. Depression, like other forms of mental illness, is a negative outcome in itself as well as in its tendency to function as a risk factor for other negative outcomes such as dropping out of school, substance abuse, anti-social behaviour, and suicide (Mufson, Gallagher, Dorta & Young, 2004; Rosenbaum, Lafreniere, & Sutton, 2000; Weersing & Weisz, 2002). These findings highlight the dynamic and reciprocal interaction of risk factors and negative outcomes.

Resilience

What is resilience? The research on risk factors and negative outcomes discussed above indicates that negative outcomes are neither automatic nor inevitable when children are faced with stress and adversity. Anecdotal evidence from adults who grew up under stressful circumstances and researchers alike illustrated that it is possible to be exposed to various risk factors without experiencing a greater number or more severe negative outcomes than anyone else in the general population (Harvey & Delfabbro, 2004). Several studies have demonstrated that a large proportion of children do not experience any atypical negative outcomes in spite of their exposure to a variety of risk factors (Rutter, 1981; 1999; Werner & Johnson, 2004). These insights and findings led to a dramatic shift of research interest in the area of developmental child psychology (Howard et al., 1999; Howard & Johnson, 2000). Researchers moved away from their traditional emphasis on identifying and studying individual risk factors associated with negative outcomes (Doll & Lyon, 1998) and began exploring the strengths and assets associated with positive outcomes (Howard et al.; Rak & Patterson, 1996). The question that researchers started to ask themselves was why do some children experience negative outcomes and others do not when exposed to similar risk factors? Researchers' attempts to answer this question have since grown into an interdisciplinary investigation of a phenomena known as resilience.

Resilience is a fairly new construct in developmental child psychology (Howard et al., 1999). What the term means is a highly debated issue in the literature (Milling-Kindard, 1998; Mordach & Hall, 2002). Harvey and Delfabbro (2004) noted that resilience seems to have a fluid definition that changes across studies and over time.

Another source of confusion about the meaning of the term resilience arises from the number of terms that researchers commonly use synonymously with it (Milling-Kindard, 1998).

In spite of these difficulties, or perhaps due to them, many possible definitions of resilience have been proposed. One definition of resilience suggests that it is the ability of an individual to overcome various risk factors and to either avoid negative outcomes or to enjoy positive outcomes (Howard & Johnson, 2000; Masten, 2001; Mordach & Hall, 2002; Rak & Patterson, 1996). Rutter (1999) claims that resilience is demonstrated when "there has been a relatively good outcome for someone despite their experience of situations that have been shown to carry a major risk for the development of psychopathology" (p. 119). Rutter's (1981) earlier definition stated that resilience reflects an individual's ability to develop in a positive and socially desirable way in spite of adversity. Another possible definition is an individual's ability to experience normal development or to remain in the normal range of functioning in spite of risks and adversity (Harvey & Delfabbro, 2004). In keeping with Harvey and Delfabbro's description of resilience as a dynamic and developmental process, many researchers have highlighted the role of adaptation and competence in their definitions of resilience. For these researchers resilience reflects an individual's effective adaptation when confronted by various forms of adversity (Howard & Johnson; Masten & Coatsworth, 1998; Milling-Kindard, 1998; Tebes et al., 2001; Ungar, 2003). Howard et al. (1999) added to the definition that resilience is not a discrete quality that people either possess or do not possess. Instead, it reflects individual differences in response style to threat and adversity.

Harvey and Delfabbro (2004) emphasized that resilience is an active response to adversity and not simply an avoidance of risk factors.

The difficulty in establishing a clear, general, and theoretically sound definition for resilience presents a challenge to researchers. The plurality of possible meanings of resilience contributes to the problem of trying to create an operational definition for this construct (Chassin, Carle, Nissim-Sabat, & Kumpfer, 2004; Harvey & Delfabbro, 2004). In spite of their apparent theoretical differences, the above definitions of resilience all share some core elements. Based on the above definitions, the researcher proposes the following definition of resilience: resilience is an individual's response to stress, risk, and adversity that minimizes the likeliness of negative outcomes and maximizes the likeliness of normal functioning, effective adaptation, or positive socially desirable outcomes. In order to understand and completely define resilience, it is important to take a closer look at how resilience operates.

How does resilience work? Even though resilience is a dynamic developmental phenomenon, the definitions found in the literature tend to focus on outcomes rather than on processes. The question of how resilience develops and produces its positive outcomes is a critical one. Many theoretical frameworks and models have been used to answer this question.

According to Birkerts (2000) there are many pathways to resilience. Risk and resilience are both linked to various aspects of the individual and the environment (Garmezy, 1994). Harvey and Delfabbro (2004) noted that there is an ongoing debate about whether resilience is shaped to a greater extent by nature or nurture. The research

on risk and protective factors, summarized elsewhere in this report, indicates that both biological and environmental factors make substantial contributions to resilience.

Several researchers have proposed theories to explain how resilience operates. Masten (2001) stated that resilience can only develop in the presence of risk or adversity. He argued that resilience is a very ordinary phenomenon that operates through a number of basic human adaptational systems. He does not believe that there is anything extraordinary about children who demonstrate resilience. His theory supports an understanding of resilience that highlights the importance of both environmental and biological factors.

One perspective on resilience involves a compensatory model (Rak & Patterson, 1996). This model suggests that the greater the number and severity of risks, the greater the probability of experiencing a negative outcome (Masten, 2001). Likewise, assets and resources, also known as protective factors, increase the likeliness of positive outcomes. This model suggests that protective factors can compensate for or counterbalance risk factors (Harvey & Delfabbro, 2004; Masten & Coatsworth, 1998). This compensation may occur because protective factors and processes have a mediating or moderating affect on risk factors (Garmezy, 1994; Howard et al., 1999). Another possibility is that protective factors buffer children against the risks and adversities that face them (Rak & Patterson). A third explanation is that protective factors may foster resilience by removing a deficiency state. This model makes it clear that resilience involves more than merely eliminating risk factors.

A moderator variable is a factor that affects the direction or strength of a relationship between two other variables. The moderation model proposed above

suggests that the protective factors that make up resilience moderate the relationship between risk and outcome. Tebes et al. (2001) investigated the moderating effect of socioeconomic status, social support, parenting distress, family stress, and the nature of the parent-child bond on the relationship between parental mental health status and outcomes for their children. In this study, 177 COPMI were assessed using multiple measures that addressed both their problems and their competencies. The inclusion of the mediating variables substantially improved the regression model's ability to predict outcomes. Disruptions to the parent-child bond and greater financial stress were stronger predictors of negative outcomes than parental mental illness on its own. Disruptions to parenting and the parent-child bond were statistically significant predictors of a greater likelihood of behaviour problems, pathology, and low self-esteem. Parent and family distress were statistically significant predictors of a childhood diagnosis of mental illness. Children from families receiving adequate social support and characterized by feelings of parent-child closeness displayed higher levels of self-esteem and other positive outcomes.

Some models of resilience focus primarily on the role and function of protective factors and processes. Rutter presented five possible mechanisms that could explain how protective processes function (Howard et al., 1999; Rutter, 1999). The first is through a reduction of the impact of risk factors. This may involve changing the meaning of the risk or decreasing the child's exposure to it. The second mechanism relates to preventing negative chain reactions or promoting positive chain reactions. This means reducing the child's exposure to interactions and situations that could worsen a negative experience. The third way that protective mechanisms contribute to resilience is through promoting and maintaining self-esteem and self-efficacy. This mechanism is enhanced by the

accomplishment of important tasks and by being a part of harmonious loving relationships. The fourth way is by providing children with an opportunity to engage in cognitive or affective processing of their experiences. The final mechanism relates to any protective factor or process that opens up opportunities for the child or provides them with necessary resources. Rutter (1999) argued that positive experiences by themselves are not particularly beneficial unless they serve to neutralize risk factors.

Bandura's social cognitive self-efficacy theory has been employed as a framework for understanding resilience (Harvey & Delfabbro, 2004). Bandura's theory suggests that resilience emerges from the interaction of personal, behavioural, and environmental factors. Outcome expectations influence what behaviours are likely to appear. People develop expectations of success based on their past experiences. This model accounts for the relationship between coping skills, self-efficacy, and resilience. Children develop better when they have someone available to provide them with positive reinforcement. This helps to explain the importance of social connectedness and social support.

The KIC program appears congruent with many aspects of these theoretical models of resilience (BCSS, 2005). The program seems particularly compatible with the model of resilience based on Bandura's theory. It seeks to increase participants' self-understanding and understanding of mental illness. Theoretically, increasing participants' knowledge could result in a shift in their outcome expectations. It also teaches coping and interpersonal skills that could influence participants' sense of self-efficacy in terms of handling their parent's mental illness. It provides an opportunity for reinforcement, modeling, and social support. The KIC program also makes use of several of the

mechanisms Rutter (1999) described in his explanation of protective processes. It aims to reduce participants' exposure to risk factors such as social isolation, to bolster participants' self-esteem, and to provide participants with an opportunity to cognitively and affectively process their experiences.

What constitutes negative and positive outcomes? The terms negative and positive outcomes have appeared frequently in the above discussion of risk and resilience without substantial definition. A description of negative and positive outcomes is not as simple and straightforward as one might expect. Ungar (2003) observed that there is an ongoing debate in the literature regarding what constitutes a substantial risk and a successful outcome. One approach is to use developmental patterns and milestones to compare a given child to his or her peers in the general population (Masten & Coatsworth, 1998). Positive and negative outcomes generally represent different ends of the same continuum in a given domain of functioning (Masten, 2001). For example, dropping out of school is typically considered a negative outcome whereas high academic achievement is perceived as a positive outcome. Harvey and Delfabbro (2004) pointed out that what the literature considers positive and negative outcomes is based on Western values including individualism and autonomy. Masten and Coatsworth echoed these concerns and noted how views of what outcomes are desirable and undesirable are passed down inter-generationally. Competence and appropriate behaviour are best understood within a specific cultural context. Mordach and Hall (2002) observed that the same behaviour could be adaptive or maladaptive in different contexts. The classification of a child who drops out of school to help his or her family would depend on many contextual factors.

These researchers encourage a culturally and contextually sensitive understanding of what represents a negative or positive outcome.

In spite of these caveats, it is necessary to have some working definition of negative and positive outcomes. Many negative outcomes, particularly those that COPMI are at greater risk of experiencing, have already been discussed. These include mental illness, poor interpersonal relationships, and behaviour problems. Other negative outcomes include dropping out of school, delinquency, and substance abuse. Positive outcomes include an absence of any form of pathology described in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000), healthy interpersonal relationships, academic achievement, and psychological well-being (Masten, 2001). Given the definitions stated above there are many other ways in which an individual could demonstrate a positive or negative outcome.

Resilience across time. The longevity of resilience is an important consideration for researchers and for program developers. Masten et al. (2004) extended a 20 year longitudinal study into the participants' thirties in order to determine whether or not resilience in childhood persists into adulthood and predicts outcomes later in life. After 30 years they only lost 10% of the original sample to attrition. The study addressed several variables typically viewed as adaptive or protective factors. The results suggested that there is both continuity and change in adaptive processes over time. Adaptability and competence in childhood tended to persist into adulthood. Participants who demonstrated academic, social, or behavioural competence in childhood showed competence in similar domains 10 to 20 years later. Resources and competencies that the participant possessed

in childhood determined resilience in adulthood and appeared to facilitate adaptation later in life.

Some of the most substantial research on risk and resilience comes from the Kawaii longitudinal study (Werner, 2004; Werner & Johnson, 2004). Its intent was to explore the long-term effects of early childhood experiences on later physical, cognitive, and psychosocial development. In order to address this question, these researchers followed a cohort of 698 individuals born on the Hawaiian island of Kawaii in 1955 from birth into their forties. For the purposes of this study a large number and variety of potential risk and protective factors were recorded. These researchers collected information at different points in time from different sources including participants, their family members, their teachers, and their official records. Children were assigned to groups based on the amount, number, and type of risk factors present in their childhood. The researchers managed to contact 80% of the high-risk group at the 40-year follow-up (Werner, 2004). The most recent follow-up indicated that children of alcoholics and COPMI are two sub groups of the study's participants who are at the greatest risk of experiencing serious negative outcomes. The results also illustrated the important role that protective factors play in moderating outcomes later in life.

Protective Factors

The Kawaii study made a major contribution to our awareness and understanding of protective factors and processes (Werner, 1995; 2004). Children who demonstrated resilience had a number of common characteristics. They knew how to ask for help when they needed it. In elementary school they demonstrated good communication and

problem solving skills. These children were able to make the most out of their unique talents and gifts. The ability to appraise and to deal with life events was also shown to be an asset. These characteristics could be clustered under the heading of coping skills.

Males in particular benefited from the opportunity to express emotions in a safe environment. These children selected environments that suited their life styles and that strengthened their competencies. Resilient children displayed strong self-efficacy beliefs, an internal locus of control, and a positive self-concept. The study also highlighted the importance of self-esteem and social support in promoting positive outcomes.

Effective coping strategies. The use of effective coping strategies is an important protective factor that contributes to resilience. Little et al. (2004) defined effective coping as a process of dealing with stress in a way that maintains equilibrium or prevents things from getting worse. A coping strategy could be a cognitive, affective, or behavioural response to a stressor, problem, or other adverse circumstance. The effectiveness of a coping strategy depends on its ability to enable an individual to cope successfully. The effectiveness of a coping strategy can only be evaluated when an individual is confronted by an applicable stressor. For example, problem solving skills are only an effective coping skill when the individual faces a risk that can be resolved by using those skills.

Two of the longitudinal studies previously mentioned noted the importance of the use of effective coping strategies as a protective factor. The Kawaii study found that resilient children possessed problem solving skills and an ability to appraise and cope with situations in their lives (Werner, 1995). The longitudinal study extended by Masten et al. (2004) showed that children who had the necessary skills to cope with stressful situations experienced fewer negative outcomes and more positive outcomes than

children who lacked these skills. These studies illustrated the long term benefits of possessing effective coping strategies.

Little et al. (2004) suggested that there are three major types of effective coping skills; problem solving skills, skills for dealing with emotions, and skills for appraising adversity and its meaning. Maybery et al. (2005) identified three sub-types of coping strategies employed by COPMI. These sub-types were problem-focused, emotionally focused, and social support based coping strategies. These models cover coping skills in the cognitive, affective, and social domains.

The cognitive coping skills include problem solving and appraisal skills. These skills are adaptive when they allow the individual to evaluate a situation and to take appropriate action. Several researchers have argued that in order to qualify as an effective coping strategy, problem solving must be an active and engaged process rather than a simple avoidance of the problem (Harvey & Delfabbro, 2004; Howard et al., 1999; Prilleltensky, Nelson, & Peirson, 2001; Todis, Bullis, Waintrup, Schultz, & D'Ambrosio, 2001). Some researchers consider problem focused (i.e., cognitive) coping strategies to be the most effective type of coping strategy. These skills could enhance children's ability to cognitively process their experiences (Rutter, 1999). As noted above, the findings from the Kawaii study (Werner, 1995) demonstrated the important role that cognitive coping skills play in promoting resilience.

Emotionally focused coping skills include relaxation techniques, anger management, and other techniques that permit the healthy expression or regulation of emotions (Chassin et al., 2004). These strategies are adaptive when they prevent individuals from becoming overwhelmed with distress, expressing emotions in

inappropriate ways, and internalizing emotions. Birkerts (2000) reported the importance of communication skills and the ability to express emotions in the lives of resilient COPMI. These skills permit the affective processing of experiences (Rutter, 1999). Restricting affect is a risk factor whereas expressing affect is a protective factor. Therefore, emotionally focused coping skills may reduce children's exposure to risk or prevent negative chain reactions (Rutter, 1999). Emotionally focused coping skills could also potentially enhance self-efficacy by giving children a sense of control or mastery of their emotions.

Polkki et al. (2004) investigated the coping strategies used by COPMI by interviewing six children and by reviewing narratives written by 17 adult COPMI. They compared the coping strategies of resilient COPMI to those who experienced negative outcomes. Avoiding their parents during episodes of the mental illness and focusing on other people's feelings instead of their own allowed the children to cope with difficult situations for a while, but they were not effective long-term solutions. This finding suggests that some emotionally focused coping strategies could be maladaptive despite their short-term benefits. Resilient children used a variety of cognitive and emotionally focused coping skills. They were able to verbalize their thoughts and feelings. They also demonstrated the ability to separate their emotional experiences from those of their parents. These children also displayed social competence and the ability to build strong relationships with adults from outside of their families. These findings indicate that resilient children possess effective problem focused, emotionally focused, and social support based coping strategies.

Social connectedness. Although the Kawaii study demonstrated the importance of numerous protective factors, it provided particularly strong evidence that social support and social connectedness are substantial protective factors (Werner, 1995; 2004). The study indicated that children who had a close bond to an emotionally stable and competent adult attuned to their needs experienced greater levels of self-esteem and other favourable outcomes. Werner and Johnson (2004) looked at the 65 participants from the Kawaii study who had experienced parental alcoholism between the ages of 2 and 10. They found that children who had support from a caring adult such as the non-alcoholic parent, grandparents, aunts/uncles, teachers, mentors, and friends' parents experienced fewer negative outcomes and more positive outcomes than children who did not have support from such a person. Relationships with peers, friends, and siblings were also shown to be important sources of social support.

Many other studies support the finding that social support and social connectedness are important protective factors (Garmezy, 1994; Howard & Johnson, 2000; Little et al., 2004). Different studies have focused on the value of social support from different people at different points in the child's development. Two studies indicated that peers have a powerful influence on children's development (Doll & Lyon, 1998; Masten & Coatsworth, 1998). The majority of the research focuses on the importance of relationships between children and caring adults. Rak and Patterson (1996) emphasized the importance of a close bond between the child and a caregiver early in life. Many studies have demonstrated the importance of a relationship with a caring adult from outside of the family (Chassin et al., 2004; Doll & Lyon, 1998; Harvey & Delfabbro, 2004; Rak & Patterson, 1996; Todis et al., 2001). Other studies have

illustrated the value of having either formal or informal adult mentors (Brown, 2004; DuBois & Silverthorn, 2005). Similarly, Doll and Lyon (1998) reported the important role that caring teachers play in the lives of resilient children. Collectively, these studies show the importance of social connections to and social support from a variety of sources.

Mowbray et al. (2004) examined the academic, social, and behavioural functioning and mental health of 165 adolescent COPMI. They clustered the adolescents into five different groups based on their current level of functioning in these domains. Almost half of the participants in this study fell into one of the clusters associated with serious negative outcomes. The adolescents who fell into one of the clusters associated with negative outcomes tended to have poor social competencies and peer relationships. The participants who fell into one of the clusters associated with positive outcomes, those who experienced functioning at or above the normal level in all of the assessed domains, frequently reported having regular supportive contact with an adult outside of the family. This study illustrated many of the common findings in this area of research.

There are many possible explanations for the relationship between having social support and experiencing positive outcomes. The presence of a caring adult from outside of the immediate family could act as a buffer against stressors and risk factors either by decreasing the child's exposure to those risks or by providing an alternative to other more problematic relationships (Beardslee & Knitzer, 2004; Garmezy, 1994; Werner & Johnson, 2004). Werner and Johnson suggested that social support from a caring adult enhances children's self-esteem by allowing them to feel unconditionally accepted and special. Brown (2004) also highlighted the ability of caring adults to make children feel

special as well as their ability to provide them with opportunities to experience new things and to develop various skills. Caring adults could also help children to acquire various competencies and skills (Masten & Coatsworth, 1998). Any skills or competencies could be transferred to other domains or settings and contribute to positive chain reactions. These possible rationales for the relationship between social support and resilience are consistent with Rutter's (1999) explanation of the mechanisms underlying protective processes.

Self-esteem. The self is a complex multifaceted construct. Self-concept, self-efficacy, and self-esteem are a few aspects of the self that are commonly discussed in relation to resilience. The views and beliefs that a person has about the self have a strong influence on the outcomes that person is likely to experience. Self-esteem has the potential to be a risk factor if it is low (Reinherz et al., 1999) and the potential to be a protective factor if it is high (Werner, 1995; 2004).

Reinherz et al. (1999) conducted a 20-year longitudinal study exploring the relationship between risk factors present between birth and nine years of age and major depression assessed between 18 and 21 years of age. The original cohort had 375 participants. Two groups were created based on the presence or absence of depression in adulthood. The results indicated that low self-esteem and self-efficacy in childhood often preceded depression in adulthood. The results demonstrated how low self-esteem can function as a risk factor for negative outcomes. This finding is noteworthy in the light of the BCSS (2005) observation that COPMI often experience low self-esteem as a result of the circumstances of their lives.

The Kawaii study reported that resilient children were characterized by high self-esteem (Werner, 1995; 2004). Werner and Johnson's (2004) study of former children of alcoholic parents provided additional evidence of the important role that high self-esteem plays in resilience. Resilient children displayed an awareness of their unique characteristics and special abilities. These children adapted by putting their abilities to good use and by seeking out opportunities to enhance their competencies. The results of this study led the researchers to conclude that the promotion of self-esteem and self-efficacy should be a major focus of any intervention program for at risk children. Other studies (Harvey & Delfabbro, 2004; Little et al., 2004) have provided additional evidence that there is a substantial relationship between having a positive view of the self and displaying resilience.

The presence of high self-esteem could contribute to positive outcomes in a number of ways. According to Rutter (1999) fostering self-esteem is one of the mechanisms underlying the operation of all protective factors, and therefore, self-esteem is a protective factor by definition. High self-esteem could serve as a buffer against distress and adversity; it could reduce negative chain reactions and permit positive chain reactions. According to Bandura's social cognitive theory both strong self-efficacy beliefs and positive outcome expectations are important protective factors (Doll & Lyon, 1998; Rak & Patterson, 1996). Self-esteem inevitably interacts with various other risk and protective factors and has a moderating influence on them.

Several studies have explored the ability of time-limited interventions to change children's level of self-esteem (Cameron, 1999; King, Vidourek, Davis, & McClellan, 2002; Rousseau, Drapeau, Lacroix, Bagilishya, & Heusch, 2005). Cameron investigated

the effects of a 12-week long weight management program on the self-esteem of children between 10 and 15 years of age. She compared 54 obese children who participated in the program to 60 obese children who did not participate in the program. She found that children who participated in the program experienced a statistically significant decrease in self-esteem from pre-test to post-test. She speculated that singling out children for treatment made them more self-conscious and thus negatively affected their view of themselves. King et al. (2002) evaluated pre-test to post-test changes in the self-esteem of 28 fourth grade students enrolled in a 4 month long mentoring program. They created their own instrument to measure self-esteem. They reported a statistically significant improvement in self-esteem over the course of the program. Rousseau et al. (2005) studied changes in the self-esteem of 138 immigrant children who participated in a series of creative expression workshops over a period of 12 weeks. The pre-test post-test comparison showed an improvement in self-esteem over the course of the program. None of these studies had follow up assessments, and therefore, they failed to demonstrate the stability of change over longer intervals of time.

Knowledge of mental illness. Unlike many of the protective factors previously discussed, knowledge of mental illness is more relevant to the resilience of COPMI than to the resilience of any other sub group of at risk children. Although knowledge of mental illness could be beneficial to anyone, it would not necessarily contribute to the resilience of children who do not have a parent or other family member who has a mental illness.

Knowledge of mental illness is a protective factor for COPMI because it addresses one of their most substantial needs. Handley, Farrell, Josephs, Hanke, and Hazelton (2001) and Polkki et al. (2004) interviewed 10 COPMI and 17 adult COPMI

pectively in order to better understand their needs. These COPMI indicated the value having information about mental illness. The COPMI expressed a strong desire to know more about their parents' mental illness. The children reported having difficulty understanding the nature and symptoms of their parents' mental illness and their parents' subsequent behaviour. As previously discussed, COPMI may experience confusion, guilt, shame, and anxiety as a result of not understanding their parents' mental illness (Linshaw, 2005; Mordach & Hall, 2002). These findings are consistent with Birkerts' (2000) observation that COPMI experience considerable distress because they do not have a framework for interpreting or understanding their parent's mental illness. Collectively, these results indicate how a lack of knowledge about mental illness could be a substantial risk factor for COPMI and how knowledge of mental illness could counteract this risk.

Birkerts (2000) evaluated a brief family based psychoeducation intervention for COPMI. The program provides information about the symptoms of depression and about various risk factors. The adolescent COPMI learned that their parent's mental illness is not their fault or responsibility. The researchers employed interviews and behaviour check lists in order to evaluate the program. The adolescents reported a greater understanding of their parents and an increased ability to recognize symptoms as symptoms. They learned that the parent is ill rather than miserable or uninterested in them. The adolescents reported a decreased sense of loneliness and isolation. Although the benefits of the program were not immediate, they were meaningful when they emerged.

ence 35

ed, and

m.

ay to

ping

s or

sten;

et

n

ic

m

Research has shown that the resilience of COPMI is increased when their self-understanding and understanding of their parents is increased (Rak & Patterson, 1996). Mordach and Hall (2002) said that when COPMI understand mental illness more clearly they express more compassion for their parent and experience a greater sense of security. Rutter's (1999) framework for understanding protective factors could be employed to understand the impact of knowledge of mental illness. Knowledge about mental illness decreases COPMI's exposure to risks such as emotional distress and self-blame. In this way it also helps to prevent negative chain reactions. Birkerts (2000) argued that talking about mental illness could strengthen family cohesion and lead to greater social connectedness. This change in the family could lead to positive chain reactions. Knowledge of mental illness would also give COPMI the necessary language to talk about mental illness and thereby to cognitively and affectively process their experiences. Knowledge of mental illness could enhance COPMI's self-esteem by improving their view of their family and themselves. Giving COPMI knowledge of mental illness would open up opportunities for them to articulate their needs and to access resources. Overall, knowledge of mental illness may contribute to resilience by removing barriers that interfere with COPMI's ability to experience other protective factors.

Interventions

The research on risk and protective factors has been translated into various approaches to promoting resilience in at risk children such as COPMI. These programs represent a departure from traditional programs that provide services exclusively to individuals who have a mental illness (Tanner, 2000). Tebes et al. (2001) argued that programs for parents who have a mental illness may not actually have any direct benefits

for COPMI. The resilience based programs currently being developed, implemented, and evaluated focus on children directly and are believed to have direct benefits for them.

There are a number of different perspectives on what constitutes the best way to foster resilience in at risk children. Some interventions focus exclusively on developing assets and instilling resources (Masten, 2001). These interventions are based on the assumption that enough assets or resources will compensate for whatever risk factors or adversities are present in the child's life. The majority of interventions address both reducing risk factors and enhancing protective factors (Devlin & O'Brien, 1999; Masten; Masten & Coatsworth, 1998; Tebes et al., 2001). Many programs claim success or positive outcomes without any empirical evidence to support these claims (Beardslee et al., 2003; Pitman & Matthey, 2004). The majority of program evaluations are done internally and are never published. All of these limitations and gaps in the literature reveal a need for more empirical program evaluations in this area.

Chassin et al. (2004) examined an intervention targeted at children with an alcoholic parent. The program taught the children social skills and accurate information about alcoholism and its affects on the family. Participants reported that as a result of being in the program they had more friends, stronger social relationships, a greater sense of control, and an improved self-concept. In addition, the children showed lower scores on a measure of depression.

Finkelstein et al. (2005) conducted a study of a 10 week long manualized program designed to foster resilience in COPMI between 5 and 10 years of age. The program's goals included increasing coping skills, improving social relationships, enhancing self-concept, and raising self-esteem. The researchers state that building trust and inner

strengths that allow children to deal with difficulties in a positive manner are objectives of the program. These objectives sound similar to what other researchers call promoting social connectedness and cognitive coping skills. The program included activities in verbalizing feelings, psychoeducation, learning coping skills, assertiveness skills, safety planning, and relaxation training. The 115 children in this study had mothers with co-occurring mental illness, substance abuse disorders, and histories of experiencing violence. The program was part of a 5-year initiative carried out at nine different sites. Participants were intentionally selected to ensure an equal number of males and females. Children from 5 to 7 years old and from 8 to 10 years old were in separate groups. Semi-structured clinical interviews and behaviour rating scales were used to gather baseline information for screening and treatment planning.

The effectiveness of the program was evaluated qualitatively from the perspectives of the participants' mothers and program staff. The participants' mothers and clinicians were asked a series of standardized questions at different points over a one year follow-up period. Participants' mothers were asked what they liked about their children's participation in the program, how helpful they felt the program had been, and whether or not they had noticed any changes in their children since their participation in the program. Seventy-seven percent of the mothers reported noticing changes in their children's attitudes, behaviours, communication skills, and use of coping skills. One-third of the mothers reported that their children learned useful information and coping skills from the program. One-fifth of the mothers indicated that their children were able to express their feelings more openly after participating in the program. Approximately half of the mothers reported that they felt that the program had helped their children very

much or a lot. During their interviews, several mothers and clinicians reported hearing spontaneous recitations of key program messages and content from the participants. This study had several strengths including its fairly large sample size and its use of multiple sites and facilitators. They did not use any quantitative measures or seek any feedback from the participants themselves in evaluating the outcomes of the program. The study did not clearly discuss the relationship between the results and the program's goals. The results suggest that the program may have accomplished its goal of increasing participants' coping skills.

In their study, Beardslee et al. (2003) compared two preventative family based interventions designed to help children whose parent or parents have depression. The primary aim of these interventions was to reduce risk factors and increase protective factors. The programs were intended to foster strong relationships between parents and their children and to increase every family member's understanding of mental illness. The interventions target children between 8 and 15 years old because they are at the highest risk. The premise of this program is that reducing internalization and increasing understanding of mental illness will enhance resilience and prevent the onset of depression. The first intervention featured two-group format psychoeducation sessions for parents provided by trained facilitators. The facilitators were available for consultation throughout the study period. In the second intervention, a trained clinician spent 6 to 11 sessions working with an individual family; the intervention featured sessions for the parents, sessions for the children, and sessions for the whole family. The clinicians scheduled several follow-up sessions during the study period. Both of these interventions were manualized treatments. Ninety-three families including 121 children

participated in this study. Participants were randomly assigned to one of the two interventions. The children were assessed for pathology and functioning before and after participating in one of the interventions and at two follow up sessions.

Parents reported a statistically significant improvement in their children's attitudes and behaviour following the interventions. The follow-up assessments indicated that these improvements continued to increase over time. The children reported an increased understanding of their parent's mental illness. The results demonstrated a statistically significant decrease in the children's internalizing behaviour. The changes observed in and by the children were also maintained over the follow-up period. Even though both interventions produced statistically significant benefits, the intervention involving the 6 to 11 sessions with segments of the whole family produced slightly larger improvements. The authors note several limitations to their study. The majority of their participants were members of white middle class families. They also suggest that effectiveness trials will still be necessary to determine whether or not the interventions would have value in the real world. Use of a non-treatment control group would add further value to future evaluations.

The Simplifying Mental Illness plus Life Enhancing Skills (SMILES) program is a 3 day group counselling intervention for COPMI between the ages of 8 and 18 (Pitman & Matthey, 2004). It combines psychoeducation about mental illness and life skills training. The program's goal is to foster resilience through increasing children's coping skills, knowledge of mental illness, self-esteem, and social support. These goals are addressed through psychoeducation, communication, problem solving, relaxation exercises, art, music therapy, and peer support. Three groups, two in Australia and one in

Canada, were considered in this study. This evaluation looked at 25 children between the ages of 5 and 15. Several self-report measures were completed by the child and their parents on the first and last day of the program. Participants were shown the answers they had given on the first day when they filled out the measures for the second time. The authors created an instrument to measure knowledge about mental illness. The results indicated a statistically significant increase in the children's knowledge of mental illness. There was also a self-reported increase in life skills in all of the intended domains. Anecdotal information reported by the authors suggests that the children found the program helpful. This study has a number of significant limitations. They assessed change after only three days and provided the participants' original answers when doing so. The children may have reported an improvement for the benefit of the facilitator regardless of how they actually felt. Moreover, it is unclear whether or not any gains produced by the program were maintained over time. Furthermore, the assessment instruments developed for this study only asked participants to rate how confident they felt about their ability to answer various questions about mental illness or to use various coping strategies. It did not assess their actual knowledge or use of coping strategies. Like the majority of effectiveness studies in this area, this evaluation did not make use of any kind of control group.

Positive Connections is a program designed for COPMI between the ages of 8 and 13 who are scared, upset, confused, embarrassed, or in some other way distressed by their parents' mental illness (Orel, Groves, & Shannon, 2003). The program is intended to increase children's ability to understand and to cope with their parents' mental illness through psychoeducation, support, and mentoring. The children learn how to identify and

to handle their feelings about having a parent with a mental illness. The program also aims to enhance children's self-confidence and self-esteem. The program involves a five-week psychoeducation group followed by a five-week support group and at least six months post group of one-to-one mentoring.

Orel et al. (2003) conducted a mixed methods evaluation of the Positive Connections program. The quantitative assessments included the self-esteem index, the family assessment measure, an instrument developed by Big Brothers - Big Sisters of North-western Ohio to assess parents' perceptions of their children's self-confidence, social competence, and caring, and a measure of knowledge of mental illness. These instruments were administered prior and subsequent to the children's participation in the program. The instrument used to evaluate the participants' knowledge of mental illness changed from the pre-test to the post-test assessment. Qualitative information was collected over the course of the program and follow-up period. The qualitative information included continuous observations made by clinicians, mentors, and parents, progress notes, journal entries, children's program graduation speeches, and a questionnaire with three open ended questions given at the conclusion of the program. Eleven children and their parents participated in this study.

The results suggest that Positive Connections was able to meet its stated objectives. The quantitative assessments demonstrated an improvement in self-esteem, knowledge of mental illness, sense of control, and social competence. The children's perception of parental dysfunction, parental involvement, and their role in the family also changed as a result of their participation in the program. The qualitative assessments supported the findings of the quantitative assessments. Clinicians' progress notes

indicated that 70% of the participants were able to name all of the types of mental illness discussed in the psychoeducation part of the program. The combination of sources of qualitative information provided further evidence of participants' improvements in the areas of knowledge of mental illness, knowledge of coping skills, self-confidence, social competence, decision-making abilities, and their ability to state their personal interests and goals. There are a number of notable limitations to this study that should be considered. Even though the qualitative data supports the quantitative findings, the use of different instruments to measure participants' knowledge of mental illness prior and subsequent to their participation in the program is a potential confound. This study had a very small sample size, only one site, only one facilitator, and no comparison group, and therefore, there are limitations on the generalizability of the findings. Other possible confounds include history, demand characteristics, and facilitator effects. The mixed methods nature of this study is one of its greatest strengths. The combination of sources of information helps to compensate for some of the study's limitations. The agreement between the quantitative and qualitative results strengthens the knowledge claims made by this study.

Kids In Control

In 1994, Dr. Rob Lees and Marj de Lange developed Kids In Control, an 8-week manualized psychoeducation and support group program for COPMI, on behalf of the BCSS. They based their program's design on the Circles of Encouragement, a manualized intervention for children of a parent with a substance use disorder. Children in the first group offered in 1995 helped to name the program. They said being in the program gave

them a sense of control over their circumstances. The overarching intent of the program is to foster resilience by enhancing a number of protective factors.

The program is designed for COPMI between 8 and 13 years of age. Participants must have at least one parent who has a serious mental illness. For the purposes of the program, the term mental illness refers broadly to any diagnosable psychiatric condition that interferes with an individual's ability to think, feel, behave, or function effectively in his or her daily life. Children who have a parent with a substance use disorder with no co-occurring mental illness are usually referred to other programs specifically designed for that population. The program is intended for children who are aware that their parent has a mental illness. They must also be able to recognize the similarities between themselves and the other members of the group. Children who have severe behaviour problems are excluded from the program due to their potential disruptiveness.

The manual recommends offering groups to 6 to 8 children at a time. When possible, groups should be composed of children of approximately the same age. The program is conducted by one or more facilitators. There should be one facilitator for every three to six children. The manual also recommends including a co-facilitator who as a child experienced parental mental illness.

The program's primary goal is to increase participants' knowledge and understanding of mental illness. It aims to develop self-understanding, close interpersonal relationships, and healthy coping strategies. The program is intended to increase healthy communication, self-care, and self-esteem. Some additional goals include decreasing internalization, helping participants to identify and express their feelings, and to develop skills for independent decision making.

In order to accomplish these goals, the group meets for an hour and a half per week for eight consecutive weeks. The first session involves group-building exercises, establishing group rules, and sharing stories. The program promotes normalizing and social connectedness by showing the participants that they are not alone. In the second session participants learn to identify and name basic feelings. They learn that they can be in charge of how they feel. In the third session participants learn about healthy boundaries, positive and negative defences, and appropriate ways of communicating emotions. The participants learn to distinguish between the things in their lives that they can control and those that they cannot control. They learn that their parent's mental illness is not their fault. In the fourth session, participants learn factual information about mental illness. They learn the terminology associated with mental illness. In the fifth session, participants learn about different methods for treating mental illness including hospitalization, medication, and psychosocial therapies. In the sixth session, participants learn about resilience and protective factors. They learn about things that they can do to help themselves to cope. They are aided in developing and practicing both intrapersonal and interpersonal skills. In the seventh session, participants learn about the stigmatization of mental illness. They learn about the myths that people often believe about people who have a mental illness. The eighth session is designed to increase the amount of self-care participants engage in and to enhance their self-esteem. They are aided in discovering their unique characteristics and special strengths. By listening to participants and taking their input seriously, facilitators aim to promote the participants' sense of self-esteem and internal locus of control throughout the entire program.

At the end of the program facilitators ask participants to discuss their experiences and impressions of the group. Participants also fill out a set of closed and open-ended questions. These measures assist the facilitators to evaluate the outcomes of the program. Even though these informal evaluations of the program are conducted every time a group is offered, no one has ever undertaken a formal empirical evaluation of the program.

Purpose

The present study undertook an effectiveness trial of the KIC program. It offered an empirical evaluation of the program in its real world context. The study investigated the program's ability to achieve several of its self-proclaimed objectives and its ability to foster resilience in COPMI in the process. The study investigated the program's ability to make changes in participants' knowledge and understanding of mental illness, use of coping strategies, and self-esteem. Even though it would have been valuable to investigate other program objectives and protective factors such as social connectedness or support, it was beyond the scope of this study to measure changes in all of these areas.

The present study also provided an opportunity to evaluate some new and innovative instruments designed specifically for COPMI. One instrument (i.e., Kids Coping Scale) was used for the first time in Canada and one instrument (i.e., Kids Knowledge Scale) was created and pilot tested in the course of the study. In these ways, the present study contributed to the development of specialized measures for use with COPMI.

Research Questions

Hypothesis 1. Research (Doll & Lyon, 1998; Rak & Patterson, 1996; Werner & Johnson, 2004) indicates that high self-esteem acts as a protective factor for COPMI, and

that intervention programs (Cameron, 1999; King et al., 2002; Orel et al., Rousseau et al., 2005) have the ability to effect change in children's level of self-esteem. It was therefore hypothesized that there would be a difference in participants' scores on the short form of the Coopersmith Self-Esteem Inventory (Coopersmith, 1981; 2002) at the conclusion of the 8 week long Kids in Control program and/or by the time of the 8 week follow-up assessment. It was further hypothesized that there would be a difference in scores on the Coopersmith Self-Esteem Inventory between participants who had completed the program and participants who were starting the program around the same time.

Hypothesis 2. Research (Birkerts, 2000; Masten et al., 2004; Polkki, Ervast, & Huupponen, 2004; Werner, 1995) indicates that the use of effective coping strategies acts as a protective factor for COPMI, and that intervention programs (Finkelstein et al., 2005; Orel et al., 2003; Pitman & Matthey, 2004) have the ability to effect change in children's use of various coping strategies. It was therefore hypothesized that there would be a difference in participants' scores on the Kids Coping Scale (Maybery, 2005) at the conclusion of the 8 week long KIC program and/or by the time of the 8 week follow-up assessment. It was further hypothesized that there would be a difference in scores on the Kids Coping Scale between participants who had completed the program and participants who were starting the program around the same time.

Hypothesis 3. Research (Handley et. al., 2001; Polkki et al., 2004; Rak & Patterson, 1996) indicates that possessing knowledge of mental illness acts as a protective factor for COPMI, and that intervention programs (Beardslee et al., 2003; Birkerts, 2000; Orel et al., 2003; Pitman & Matthey, 2004) have the ability to effect change in children's level of knowledge and understanding of mental illness. It was therefore hypothesized

that there would be a difference in participants' scores on the experimental Kids Knowledge Scale at the conclusion of the 8 week long KIC program and/or at the 8 week follow-up assessment. It was further hypothesized that there would be a difference in scores on the Kids Knowledge Scale between participants who had completed the program and participants who were starting the program around the same time.

CHAPTER 2: METHODS

Participants

Recruiting facilitators. At the outset of the study, I contacted the BCSS who publishes and disseminates the KIC Facilitator's Manual. The BCSS provided me with a list of organizations that had purchased the manual as well as a list of facilitators in each of these organizations who had been trained to facilitate the program. The lists contained the information necessary to contact these organizations and individuals.

Another graduate student (Rob Taylor) and I contacted the individuals on the list. Contact was initially made with the BCSS regional program co-ordinators and co-ordinators from community based organizations known to be offering the KIC program. Afterwards, permission was obtained to contact facilitators who were planning to offer KIC groups during the study period. These facilitators were given a brief overview of the intended study and invited to participate. The six facilitators who accepted the invitation were given Facilitator Information Letters (see Appendix A) describing the purpose of the study and their responsibilities as participating facilitators. Facilitators were asked to sign consent forms to indicate their informed consent to participate in the study as described. Facilitators also received a Facilitator and Site Information Questionnaire (see Appendix B) designed to collect information about the facilitator and his or her group.

Two facilitators withdrew from the study because they were unable to offer their intended groups. One group was cancelled due to the unavailability of resources. Two other groups could not be offered due to an insufficient number of eligible participants. One facilitator pointed to the stigma associated with mental illness in a small community as a potential reason for the difficulty in recruiting participants.

The other four group facilitators ran a total of nine groups during the October 2005 to April 2006 study period. These groups were offered in seven communities of various sizes and compositions across the Fraser Valley and interior regions of British Columbia. The groups were offered in what could be considered urban as well as rural areas. One group was dropped from the study because the participants did not meet the study's inclusion criteria.

The eight groups involved in this study differed in several ways. Three of the groups were offered by facilitators from the BCSS, three of the groups were offered by a facilitator from the Ministry of Children and Families of British Columbia, and two of the groups were offered by a facilitator from a community service organization. Six of the groups were run by female facilitators whereas only two groups were run by male facilitators. Three of the groups were run by a facilitator and a co-facilitator. Only one group included a co-facilitator who had personally experienced parental mental illness as a child.

The size of each group was influenced by the number of referrals received by the program, the budget for running the program, and the personal preferences of the group facilitator. The size of the groups in the study ranged from three to nine participants.

Facilitators. The four facilitators who participated in the study were mental health professionals who facilitated KIC groups as a part of their regular job duties and responsibilities. In other words, these facilitators did not run their groups specifically for this study. The facilitators represented diverse backgrounds, qualifications, and levels of experience. There were an equal number of male and female facilitators. The facilitators were educated at the Master's level. All of the facilitators had received individual training

in how to facilitate the KIC program using the Facilitator's Manual (BCSS, 2005). Each facilitator had run the program between three and seven times prior to the beginning of the study. As a result, the study involved facilitators who varied in terms of the amount of experience they had facilitating the program.

Since I intended to evaluate the effectiveness of the KIC program in the real world, it was necessary to evaluate how faithfully the group facilitators followed the manual when facilitating their respective groups. It was found that other intervention studies used content-based fidelity measures (Beardslee et al., 2003; Finkelstein et al., 2005). A content-based fidelity checklist was developed to determine how many program objectives each facilitator covered (see Appendix C). This questionnaire listed various program objectives outlined in the manual (BCSS, 2005) and asked facilitators to indicate whether they addressed these objectives using activities and methods directly described in the manual, addressed them using activities and methods from sources outside of the manual, or did not address them at all. The checklist was developed in consultation with group facilitators and program developers to ensure that all of the program's major objectives were reflected. Each facilitator received a copy of the checklist for each group that they facilitated. Facilitators were informed that their performance was not being evaluated through these checklists. Since this study is an effectiveness study where strict adherence to the manual is not required, it was decided not to use a more elaborate method of ensuring or checking fidelity.

Three facilitators completed the Program Content Coverage Checklist (see Appendix C). Their responses indicated that on average they covered 91% of the program objectives outlined in the manual. They indicated that an average of 65% of the program

objectives were addressed using materials, activities, and methods from the manual itself. They indicated that they covered an average of 43% of program content using materials and methods from sources other than the manual. Only an average of 8% of the program's objectives were not covered by any method. There did not appear to be any pattern to what content facilitators did not cover. These high fidelity scores increase the likeliness that any changes in participants' scores were the result of the manualized treatment rather than characteristics of the facilitator or other extraneous aspects of the intervention. Since all facilitators reported high fidelity, there was no opportunity to compare participants from high and low fidelity conditions.

Child participants. All of the children who participated in this study were participants in KIC groups offered between October 2005 and April 2006. These children were not specifically recruited for the study. They belonged to naturally occurring groups that happened to be involved in the study. The children were referred to the KIC program by various sources including mental health clinicians, school counsellors, and social workers.

In order to participate in the study, the children had to first be eligible for the KIC program (BCSS, 2005). Decisions about who would and would not be included in each group were left to the discretion of the group facilitators. Even though the program was designed for children between 8 and 12 years of age, facilitators had the option to adapt the program and to include children from a broader age range. One facilitator adapted the program for older adolescents; this group was excluded from the study due to the substantial changes that the facilitator had to make to the program in order to adapt it for this population.

A total of 39 children were enrolled in the groups that were researched in this study. All of these children were invited to participate in the study. Parent or guardian consent and child assent for 34 of these children were obtained. One child withdrew from the study during the first administration of the questionnaires. The final sample involved 16 participants in the experimental condition and 17 participants in the comparison condition.

Participants included 22 boys and 11 girls (see Table 1) between the age of 7 and 14 ($M = 10$, $SD = 1.89$). Each participant's parent or guardian was asked an open-ended question about the participant's ethnicity or cultural background. Responses to this question indicated that participants in the study were 30.3% generically "Canadian," 21.2% "Caucasian," 6.1% First Nations, 15.2% Asian-Canadian, and 6.1% European-Canadian. An additional 21.2% did not respond to the question.

Table 1

Selected Demographic Characteristics (N=33)

Characteristic	<i>n</i>	Percent
Gender		
Male	22	66.7
Female	11	33.3
Ethnicity		
Canadian	10	30.3
Caucasian	7	21.2
First Nations	2	6.1
Asian-Canadian	5	15.2
Euro-Canadian	2	6.1
Missing	7	21.2
Biological PMI		
Yes	28	84.8
No	3	9.1
Missing	2	6.1
Two PMIs		
Yes	7	21.2
No	24	75.8
Missing	2	6.1

Table 1 Continued

Selected Demographic Characteristics (N=33)

Characteristic	<i>n</i>	Percent
Living with PMI		
Yes	19	57.6
No	12	36.4
Missing	2	6.1
Type of PMI		
Major Depression	7	21.2
Bipolar Disorder	14	42.4
Schizophrenia	8	24.2
Personality Disorder(s)	2	6.1
Anxiety Disorder(s)	11	33.3

Note: Parental Mental Illness (PMI)

Some important information about the characteristics of the participants' families was collected using the demographic questionnaire for parents and guardians (see Table 1). Participants had an average of 1.97 siblings ($SD = 1.35$). The number of siblings ranged from 0 to 6. In the sample, 84.8% of participants had at least one biological parent with a mental illness, 15.2% had a guardian with a mental illness, 21.2% had more than one parent or guardian with a mental illness, and 6.1% reported having a sibling with a mental illness. The participants in the study came from families affected by a variety of different mental disorders. In the sample, 21.2% of parents and guardians reported major depression, 42.4% reported bipolar disorder, 24.2% reported schizophrenia, 33.3% reported anxiety disorders, 6.1% reported personality disorders, 9.1% reported substance use disorders, and 6.1% reported other disorders. In the sample, 54.5% of the parents and guardians reported a history of two or more mental disorders. At the time of the study, 57.6% of the participants were living with a parent, caregiver, or sibling with a mental illness.

The experimental condition had 16 participants whereas the comparison condition had 17 participants. The demographic composition of the two conditions appeared to be reasonably similar. The experimental condition had 10 boys and 6 girls compared to 12 boys and 5 girls in the control condition. Participants in the control group were slightly older on average than participants in the experimental condition ($M = 10.3$, $SD = 1.79$ vs. $M = 9.73$, $SD = 2.02$). Both conditions contained participants between 7 and 14 years of age. The percent of participants living with a parent or guardian who had a mental illness was comparable (56.3% vs. 58.8%). The most noticeable differences between the groups appeared to be related to the types of parental mental illness. Participants in the

experimental condition were less likely than participants in the control group to have a parent who has major depression (18.8% vs. 23.5%) and nearly twice as likely to have a parent who has bipolar disorder (56.3% vs. 29.4%). In comparison to participants in the comparison condition, participants in the experimental condition were somewhat more likely to have parents who have anxiety disorders (15.1% vs. 18.2%). These comparisons indicate that there are both similarities and differences between the participants in the two conditions. The similarities between the groups in regards to participants' gender, age range, and living arrangements, may indicate that these two groups represent samples drawn from the same underlying population of COPMI.

Procedure

The present study employed a recurrent institutional cycle design which is a type of non-equivalent comparison group quasi-experimental design. The design involves comparing different cohorts of participants who are participating in the same program, grade, or intervention. The design has been most widely used in educational research, and is a natural fit for effectiveness studies in real world settings where a traditional wait list control group is unavailable. In this design, participants who have completed the program (experimental group) are compared to the next cohort of participants who are entering the program (comparison group).

In the present study, changes in the experimental group were evaluated using a pre-test, post-test, post-post-test design. Participants' level of self-esteem, use of coping strategies, and knowledge of mental illness were assessed during the first and last KIC group sessions and at a reunion group session held approximately eight weeks after the

ast group session. In comparison, the comparison group was only assessed during the first group session.

Groups were assigned to experimental conditions based on their starting dates. Groups starting between November 2005 and January 2006 were assigned to the experimental condition whereas groups starting after February 2006 were assigned to the comparison condition. All of the groups in the experimental condition had finished before any of the groups in the comparison condition started. This assignment method is consistent with the recurrent institutional cycle design described above.

Facilitators were given study materials for each participant in their group. Each package contained a parent/guardian information letter and consent form (see Appendix D), a demographic questionnaire (see Appendix E), a child participant information letter and assent form (see Appendix F), and an appropriate number of questionnaires containing the Coopersmith Self-esteem Inventory, Kids Coping Scale (see Appendix G), and Kids Knowledge Scale (see Appendix H). Coding numbers were placed on all forms and instruments so that they could be tracked and linked in an anonymous manner. These coding numbers contained a three digit number representing the group, a three digit number representing the participant, and for the instruments, an A, B, or C, identifying its position in the order of administration (pre-test, post-test, or post-post-test). Only the parent or guardian consent form and the child assent form requested participants' names and other identifying information. Participants were told to avoid placing any identifying information on the questionnaire booklets.

The facilitators were responsible for distributing and collecting all of the study materials including information letters, consent forms, and questionnaires. Information

arbal

a

during

ible

buting

of the

n

e

ny

oud

al

ite

m

e

about the study and study documents were disseminated in a sequential fashion. Facilitators provided participants and their parents or guardians with an informal verbal description of the study as early in the process as possible. Facilitators delivered the information letters and consent forms to participants and their parents or guardians during an intake appointment, pre-group session, or the first group session. Whenever possible facilitators distributed and collected parent or guardian consent forms prior to distributing child assent forms. In the interest of time, the majority of facilitators distributed all of the information letters and related forms to children and their parents or guardians simultaneously. Even though only parent or guardian consent was legally required, I wanted to ensure that the study had been explained to the child participants in an age appropriate manner and that they were willing to participate. Once parent or guardian consent and child assent had been obtained, the child was eligible to participate in the study.

Throughout the process of filling out forms and completing instruments, facilitators were present to provide further explanation and clarification of forms, to answer any questions from participants or their parents or guardians, and to address any other concerns that arose during the process. Facilitators and/or co-facilitators were available to assist participants in many ways including reading forms and questions aloud to any child who could not read them. Facilitators also monitored participants for verbal and non-verbal indications of distress and responded appropriately to handle or alleviate this distress. In groups where there were children who were participating in the program but not in the study, facilitators were asked to provide quiet alternative activities for the non-participants while the participants were filling out their forms and questionnaires.

Participants completed a test battery containing the Coopersmith Self-Esteem Inventory, Kids Coping Scale, and the Kids Knowledge Scale. The whole test battery was designed to be completed in 20 to 30 minutes. In practice, facilitators reported that participants often required additional time to complete it. All participants completed the test battery during the first group session. For the experimental group, the first session administration was their pre-test assessment. For the comparison group, the first session administration was their only assessment. Participants in the experimental condition filled out the same test battery a second time during the last group session. Facilitators were asked to complete all of the program objectives they intended to cover before they administered the questionnaires for the post-test assessment. Some facilitators administered the second set of questionnaires at the very end of the last session whereas others administered them prior to their regular group closing activities. Facilitators were encouraged to go through the debriefing questions found in the manual (BCSS, 2005) if it was their regular practice to do so. At the same time, facilitators were asked to administer the study instruments to participants in place of the evaluation forms contained in the manual. Facilitators administered the standard evaluation forms to any children who were participating in the group but not in the study.

During the organizational stage of the study, facilitators who were running groups belonging to the experimental condition were invited to hold an eight week reunion group session in order to administer the test battery a third time as a post-post-test assessment. Although eight-week reunion groups are recommended by the Facilitator's Manual (BCSS, 2005), they are not an essential part of the program. Reunion groups required extra time and work on the part of the facilitators. Three of the groups in the experimental

condition held reunion groups approximately eight weeks after the last group session. All of these reunion groups took place between January and February of 2006. Facilitators administered the test battery at the beginning of these reunion group sessions.

Participants were offered \$5 for every time they completed the test battery. The amount of money each child received depended on the number of administrations that took place in their experimental condition. The participants were paid once they had filled out the questionnaires for the last time. The research incentives and debriefing letters (see Appendix I) were distributed to the participants by the group facilitators.

At the end of each group (or when all study related tasks had been completed), facilitators returned all of the forms and questionnaires to the researcher. Unfortunately, a few questionnaires were irretrievably lost during the process.

Ethical considerations. Steps were taken proactively to safeguard the interests of the child participants in this study. Either parent or guardian informed consent, as well as child assent, was obtained for every participant in this study. The purpose of the study was outlined in letters given to the participants and their parents or guardians. The participants' right not to participate or to withdraw from the study at any time were stated in these letters. As per the recommendation of Mishna, Antle, and Regehr (2004) the children were informed that neither the facilitator nor the researchers would be upset with them for discontinuing.

Facilitators were asked to make themselves available to assist participants who needed help understanding the letters, forms, or the instruments. Facilitators were asked to monitor participants while they filled out their forms and completed their instruments. Moreover, facilitators were asked to respond appropriately to any verbal or non-verbal

indication of distress during the administration of all study materials. Appropriate responses included debriefing, offering assistance, and asking the child if he or she wanted to continue his or her participation. This precaution was put in place to address the concern that children may not know how to discontinue their participation or may feel uncomfortable doing so (Mishna et al., 2004). The instruments involved in this study were not expected to cause any distress, discomfort, or embarrassment. Children were informed that the instruments were not tests and that they would not be graded on them. Some facilitators indicated that they had to repeat this point on more than one occasion.

In spite of careful precautions, it was impossible to know how children would respond to a novel instrument or to an assessment situation. Therefore, distress had to be considered as a potential risk. Both participants and facilitators were given access to the researchers via e-mail for any additional support or information they might require.

During the course of the study, all materials were stored in a fireproof, locked filing cabinet in the researcher's residence. Upon the completion of the study, all research data will be stored in a fireproof, locked cabinet within the Department of Graduate Counselling Psychology at Trinity Western University. As described above, identifying information only appears on the parent or guardian consent and child participant assent forms.

It was hoped that participating in the study would benefit participants in the following ways. Participants may have felt valued and respected from having the opportunity to provide data on their experiences as participants in the program. They may have felt empowered as a result of contributing to the evaluation and improvement or enhancement of the program.

Measures

Demographic questionnaire for parents and guardians. A demographic questionnaire (appendix E) was designed for this study to collect demographic and descriptive information about the participants and their families from the participants' parents or guardians. The informal, one page, pencil and paper questionnaire was attached to the parent or guardian consent form. The questionnaire was presented as optional in order to be sensitive to parents and guardians who might be uncomfortable revealing personal information about themselves and their families. The parents and guardians were asked basic demographic questions about the participants' cultural background and family composition. They were also asked questions about mental illness in the participants' families. They were asked to identify the person, in relation to the child, who has the mental illness (biological parent, caregiver, two parents or caregivers). They were asked to identify the types of mental disorders experienced by these family members. They were also asked whether or not the participant is currently living with a parent or caregiver who has a mental illness. Parents and guardians were not asked about the participants' age or gender because this information was collected from the participants themselves on the child assent forms (see Appendix F).

Coopersmith Self-Esteem Inventory. The Coopersmith Self-Esteem Inventories (Coopersmith, 1981; 1989) are questionnaires designed to measure self-esteem in children and adults. For the purposes of the test:

Self-esteem refers to the evaluation a person makes, and customarily maintains, of him- or herself; that is, overall self-esteem is an expression of approval or disapproval, indicating the extent to which a person believes him- or herself

competent, successful, significant, and worthy. Self-esteem is a personal judgement of worthiness expressed in the attitudes a person holds towards the self. (Coopersmith, 2002, p.1).

The instrument measures a person's perceptions, attitudes, beliefs, and evaluations of the self. According to the manual, the Coopersmith Self Esteem Inventory (CSEI) has many possible uses including individual assessment, program evaluation, and research studies.

The CSEI is a self-administered paper and pencil assessment that can be administered individually or in a group setting (Coopersmith, 2002). In the present study, participants' self-esteem was assessed using the school form version of the CSEI. The school form was developed for use with children between 8 and 15 years of age. Like all of the versions of the CSEI, the school form version evaluates several facets or dimensions of self-esteem. These dimensions are reflected in the instrument's four subscales: general self, social - peers, home - parents, and school - academic. The CSEI is composed of 58 items. Eight of these items belong to a "lie" scale that measures participants' defensiveness in responding and test wiseness. The remaining 50 items belong to one of the four subscales that make up the total scale. Each item consists of a short statement and asks the respondent to indicate whether the statement is *like me* or *unlike me*.

The manual provides evidence from numerous studies that support the reliability and validity of the CSEI (Coopersmith, 2002). The school form has a reported Kuder-Richardson internal consistency obtained coefficient between .87 and .92 for children in grades four through eight (Chiu, 1988; Coopersmith, 2002). The split-half reliability was reported to be between .87 and .90 and the test retest reliability was reported to range

from .42 to .64 over a 3 year period for children between 9 and 12 years of age.

Coopersmith (2002) reported a test re-test reliability of .88 over a 5 week period.

Reliability coefficients at or above the .80 level have been found in children from several different age groups (Spatz & Johnson, 1973).

The manual cites several studies demonstrating the CSEI's construct, concurrent, and predictive validity (Coopersmith, 2002). According to Chiu (1988), the manual provides adequate evidence of the CSEI's validity. Kokenes (cited in Chiu, 1988) demonstrated the construct validity of the subscales in a study of 7,600 school aged children. Fullerton (cited in Chiu, 1988) reported a correlation of .44 between the CSEI and behavioural ratings of self-esteem, thereby providing evidence of the CSEI's concurrent validity. The manual reported studies that showed correlations between CSEI scores and creativity, school achievement, and resistance to peer pressure. The manual also indicated that self-esteem scores are "significantly associated with personal satisfaction and effective functioning" (Coopersmith, 2002, p. 2).

The normative sample for the CSEI featured eight groups ranging in size from 129 to 7,593 participants (Chiu, 1998). One sample consisted of 7,593 public school students between 4 and 8 years of age from all socioeconomic levels and diverse backgrounds. Another sample consisted of 3,789 children between 8 and 14 years of age from both rural and urban areas and mostly lower to middle socioeconomic levels. The study's sample was composed of boys and girls between 7 and 14 years of age from diverse backgrounds and from both rural and urban communities. Therefore, the study's sample shared several characteristics of the normative sample.

Kids Coping Scale. The Kids Coping Scale (KCS) (see Appendix G) is a new instrument being developed by Darryl Maybery at Charles Sturt University in Australia (Maybery, Goodyear, et al., 2005). It was designed to measure COPMI's use of various coping strategies. It appears to be based in part on Maybery's research on COPMI and the types of coping strategies that they tend to use (Maybery, Ling, et al., 2005). Maybery is currently using the KCS in his program evaluation of the VicChamps program, an after school and holiday program for COPMI between 5 and 12 years of age living in the Victoria state of Australia.

According to Steer (2006), the KCS is based on a person-environment interaction view of stress and coping. The KCS was designed to measure cognitive and behavioural coping responses to everyday problems or stressors. Children are asked to identify what coping strategies they employed to handle a recent problem or difficult situation.

The KCS (Maybery, 2005) is a short self-report questionnaire that can be administered individually or in a group setting. The KCS was designed for children between 8 and 12 years of age. The KCS is composed of nine items employing 3-point Likert scales ranging from "never" to "a lot." Maybery, Goodyear, et al. (2005) theorized that the KCS assesses three distinct types of coping. The three dimensions are problem-focused coping, emotionally focused coping, and "seeking social support" based coping.

As a new instrument, the KCS is still in the process of being standardized, evaluated, and validated. The KCS is currently a non-standardized instrument. Dr. Maybery, his colleagues, and his students are conducting research on the KCS as well as other innovative measures designed for COPMI (personal communication, Maybery, 2005). They have collected data from approximately 700 children between 8 and 12 years

of age and their parents. An additional 120 COPMI are currently being assessed to construct sub-group norms for this population.

Steer (2006) evaluated the KCS in a sample of 629 children between 7 and 12 years of age from 20 public schools in Eastern Australia. The sample was 52% female and represented all socioeconomic levels. The factor analysis that she conducted revealed two distinct factors (problem focused coping and emotion focused coping). Her analysis did not support the third social support factor. The factor analysis did not clearly demonstrate the existence of a global factor. Her research found a Cronbach alpha level of .61 for the problem focused coping subscale and .28 for the emotionally focused coping subscale. These levels were below what is a traditionally acceptable level. Steer's study demonstrated the concurrent validity of the KCS; she found statistically significant correlations between scores on the problem focused coping sub-scale of the KCS and various scales on the Strengths and Difficulties Questionnaire (SDQ) including emotional symptoms, conduct problems, peer problems, and hyperactivity. She also found that emotionally focused coping scores were negatively correlated with scores on the self-esteem measure that she created for her study.

Kids Knowledge Scale. The Kids Knowledge Scale (KKS) (see Appendix H) is an experimental instrument developed specifically for this study. The KKS was designed to assess participants' knowledge and understanding of the content of the KIC program (BCSS, 2005) that relates to mental illness. The program covers content that includes understanding some facts about mental illness, different kinds of mental illness and their symptoms, treatment methods and outcomes, and myths about mental illness.

The development of the KKS involved several steps and individuals. Several sections of the KIC Facilitator's manual (BCSS, 2005) were used in the initial development of this measure. These sections include the following handouts: Do you know the facts about mental illness (a five question quiz), mental illness fact sheet, understanding mental illness (for younger children), understanding mental illness: our brain is a message centre, and mental illness myths and truths. Some items from the KIC evaluation form, also found in the manual, were adapted for the KKS. Other items consistent with the content of the KIC program were adapted from measures used in other COPMI program evaluation studies (Orel, et al., 2003; Pitman & Matthey, 2004). Additional items were added at the discretion of the test developer. Some of these items were included to broaden the scope of the instrument. Items were added, dropped and modified throughout the construction and validation process described below.

The final version of the KKS consisted of 20 true or false items. The order of the items was randomly selected using a random number generator. Scores on the KKS reflect the number of items answered correctly. The questionnaire should take approximately 5 minutes. The questionnaire was designed for children in the 8 to 12 age range targeted by the program and the study. Two 10-year-old boys in the fifth grade associated with the researcher were asked to read through the questionnaire (without filling it out) in order to verify clarity and a low enough reading level. The only words that provided a challenge were the names of different mental disorders such as bipolar and schizophrenia. Based on this limited trial, I assumed that the items were suitable for children in the desired age range.

The KKS is a non-standardized instrument. The present study represented the first pilot testing of the instrument. The following methods have been used to provide evidence of the validity of the KKS. During test development, I considered all relevant sections of the KIC Facilitator's manual (BCSS, 2005) and the measures used in other studies in order to ensure the construct validity of the instrument. Face validity was evident in the fact that every question is directly related to understanding mental illness. During development, versions of the instrument were sent to the program developers, program co-ordinators, group facilitators, and mental health service providers in order to receive feedback. The feedback was incorporated into subsequent versions of the instrument. The process of review and modification helped to provide some level of content validity for the KKS.

CHAPTER 3: RESULTS

At the outset of the study, I intended to conduct an inferential analysis consistent with the hypotheses and method outlined above. Unfortunately, the limited amount of data collected could not support such an analysis. As a result, I shifted from an inferential analysis to a more exploratory and descriptive analysis. The kind of analysis presented here could be conceptualized as a case study of the KIC program with a specific group of participants during a specific period of time.

Description of Score Distributions

An exploration of score distributions was conducted in order to describe the similarities and differences among program participants' scores. In spite of the fact that the analysis shifted from inferential to descriptive, examining the extent to which the data met the assumptions for inferential statistical procedures is still useful for descriptive purposes. These considerations provide a framework for presenting additional details about the data. Moreover, these details provide valuable background information that can be used in future meta-analyses.

Few items on the three questionnaires were left blank or marked in an ambiguous manner. Missing values on the KKS were counted as incorrect responses based on the theoretical assumption that an unanswered item could reflect a gap in the participant's knowledge of mental illness. For the CSEI and the KCS, missing values were handled by calculating item scores as the mean of the clearly marked items from the same subscale. No items, individuals, or variables had to be dropped from the study due to missing data.

Outliers were considered before and while running various analyses. Box plots showed two extreme scores on the CSEI total score. These potential outliers were

associated with CSEI total scores below 30. There were two additional scores below 30 that the box plots did not identify as extreme scores. A manual review of all below 30 cases found no evidence of scoring problems or random responding. In addition, these cases had low scores on the CSEI's lie scale. Therefore, these scores were considered valid for participants in this study of the KIC program. Some of the lowest CSEI scores came from two brothers in different groups and were measured around the same point in time. Since all cases were considered valuable for descriptive purposes, no individuals or cases were excluded from the analysis.

There was substantial attrition over the course of the study. The most substantial attrition took place at the post-post-test assessment. At the pre-test assessment a total of 16 children participated in the study. Two children dropped out prior to the post-test assessment leaving 14 participants. One more participant dropped out prior to the post-post-test assessment. Three participants were unable to participate in the post-post-test assessment because their group did not include an eight-week reunion session. The data from an additional three participants who completed the post-post-test assessment was irretrievably lost. As a result of all forms of attrition, the number of program participants participating in this study decreased from 14 to 7 between the post-test and post-post-test assessments.

Parametric statistical procedures require data measured at the interval level (Field, 2005). The presence of standard intervals across the full range of scores indicates that self-esteem and knowledge of mental illness were both measured at the interval level. The CSEI and the KKS both tap into underlying continuums. In comparison, the three point rating scales on each item of the KCS produce ordinal level data regarding the

frequency of use of various coping strategies. The total score and subscale scores have a fairly restricted range of scores. Nevertheless, these scores most likely represent underlying continuums. In this way, these scores satisfy the assumption of interval level data.

Parametric tests require independence of scores (Field, 2005). All of the scores used in comparisons between program participants and future participants came from different, and therefore, independent participants. The pairs of scores used to explore changes for program participants over the course of the program came from the same participants at different points in time. Field (2005) observed that repeated measures procedures account for this violation of the assumption. It is worth noting that some participants in the study had siblings who also participated in the study. This information came from personal communications with facilitators, and therefore, there was no official count of the number of sibling pairs in the study. As a result of the sibling pairs, there were a few instances of interdependence of scores at the level of the family.

Parametric statistical procedures require variables that are unbounded; they also assume that the variances in different groups are similar (Field, 2005). The total scores for the CSEI, KCS, and KKS had relatively unrestricted ranges of scores. The actual scores of participants in this program covered a large portion of the possible ranges for these scores. There appeared to be variability at all levels for self-esteem and use of coping strategies. Even though the KKS scores of participants in this program fell within a somewhat restricted range, there was variability at all levels within that range. The results of Levene's test were not statistically significant ($p > .05$) for any of the comparisons between program participants and future participants. These findings

suggest that the distribution of scores satisfied the assumption of homogeneity of variance.

The histograms for the CSEI, KCS, and KKS total scores showed approximately normal distributions of scores. The Kolmogorov-Smirnov statistics for these variables were not statistically significant ($p > .05$), and therefore, the distributions were not statistically significantly different than normal. The distribution of program participants' CSEI total scores at the post-post-test assessment was the only total score distribution described as statistically significantly different than normal.

Many of the KCS and CSEI subscale scores were used in the analysis, and therefore, it is important to consider their score distributions. All of the subscales had distributions that appeared less normally distributed than the total scores. The restricted range of scores most likely affected the shapes of the distributions. The Kolmogorov-Smirnov statistics indicated that some subscale distributions were statistically significantly different from normal and others were not. The most statistically significant violations of the KCS subscale distributions occurred for the program participants' pre-test assessment. None of the KCS' social support subscale score distributions were normally distributed. The majority of CSEI subscale score distributions were not statistically significantly different from normal. Only the general self-esteem scores of future participants and the home-parents self-esteem scores of program participants at the post-post-test assessment were statistically significantly different from normal. Therefore, the majority of CSEI subscale scores satisfied the assumption of normally distributed scores.

Data analysis

Statistical procedures were employed to explore the data. The analysis used a series of tests to describe the strength of relationships and patterns in the data. These analyses included correlations and ANOVA. The ANOVA is a robust enough test to compensate for mild violations of the assumption of normally distributed scores (Field, 2005). The ANOVA is also relatively robust when there is a limited amount of data. The analyses run in this study involved both repeated measures ANOVAs and between subjects ANOVAs. The analysis process considered both the total and subscale scores in order to provide the richest description of the data. The results of statistical tests have been retained below in order to provide descriptive information about the strength of relationships and to permit future meta-analyses using results from the present study.

The following conventions were established for the analysis and interpretation of data in the present study. At the outset of the study a standard p value of .05 was established as the level for statistical significance for all analyses. In the light of the small sample size and the exploratory focus of this study, a convention was established whereby effect sizes in the 4 to 10 percent range were considered "moderate." By the same convention, effect sizes below 4% were considered "weak" and effect sizes above 10% were considered "strong." In order to be consistent with the descriptive nature of the analysis, the term "effect" will be used to describe the strength of a relationship or pattern rather than to imply an inferential or causal relationship.

Additional conventions have been adopted to denote different kinds of findings. The first type includes robust findings that are statistically significant at the .05 level and have an effect in the moderate to strong range. The second type includes "clinically

significant findings" that show a trend towards statistical significance (p is between the .05 and .15 levels) and have an effect in the moderate to strong range. These findings are more ambiguous than robust findings because of weaker confidence in their replicability. The third type includes "promising findings" that show no trend towards statistical significance but nonetheless have an effect in the moderate to strong range. These findings are promising, but may only be true for the participants in the KIC groups investigated by this study.

Internal consistency. The internal consistencies of the instruments in the study were calculated using data collected from all participants ($N = 33$) prior to their participation in the KIC program. The Cronbach alpha level for the CSEI total scale was .86. The Cronbach alpha level for the KCS total score was .41. The Cronbach alpha level was .57 for the problem focused coping subscale, .52 for the emotionally focused coping subscale, and .63 for the social support based coping subscale of the KCS. The Cronbach alpha level for the KKS total scale was .56.

Correlations. Age and the scores from the CSEI, KKS, and KCS were entered into a correlation matrix for exploratory analysis. Only program participants' pre-test scores and future participants' scores were included in the analysis. In the light of the small number of participants and the non-parametric nature of some of the variables, Spearman's rho was used to calculate correlation coefficients. The exploratory analysis produced a limited number of interesting correlations (See Table 2).

Table 2

Elevated Correlations of Interest ($N = 33$)

Variables	1	2	3	4	5	6
1. General self esteem	-	.82	-	.28	-	-
2. Total self esteem	-	-	-	-	.26	-
3. Age	-	-	-	.31	-.35	.29
4. Knowledge	-	-	-	-	-	-
5. Problem focused coping	-	-	-	-	-	.30
6. Social support based coping	-	-	-	-	-	-

(p < .15)

Table 3

Means and Standard Deviations on the Dependent Measures Experimental and Control Groups

	M	SD
Time 1		
Knowledge	15.00	2.757
Total Self Esteem	68.25	16.57
Social Self Esteem	5.81	1.377
Family Self Esteem	5.19	2.136
School Self Esteem	6.06	2.048
General Self Esteem	17.00	4.546
Coping	1.41	.196
Problem Focused Coping	1.67	.326
Emotionally Focused Coping	1.19	.438
Social Support Coping	1.22	.546
Time 2		
Knowledge	16.79	2.045
Total Self Esteem	71.86	18.638
Social Self Esteem	5.86	1.791
Family Self Esteem	5.57	2.277
School Self Esteem	5.71	1.773
General Self Esteem	18.71	4.843
Coping	1.25	.214
Problem Focused Coping	1.57	.443
Emotionally Focused Coping	0.88	.499
Social Support Coping	1.18	.372
Time 3		
Knowledge	18.14	1.676
Total Self Esteem	80.29	23.478
Social Self Esteem	6.71	1.799
Family Self Esteem	6.14	2.734
School Self Esteem	6.71	1.799
General Self Esteem	21.29	5.314
Coping	1.27	.272
Problem Focused Coping	1.61	.283
Emotionally Focused Coping	0.72	.526
Social Support Coping	1.21	.267
Time 4		
Knowledge	15.53	2.787
Total Self Esteem	63.59	16.413
Social Self Esteem	5.76	1.786
Family Self Esteem	4.18	2.404
School Self Esteem	4.94	1.853
General Self Esteem	16.53	4.771
Coping	1.18	.283
Problem Focused Coping	1.40	.341
Emotionally Focused Coping	0.94	.413
Social Support Coping	1.12	.674

Note: Time 4 = Future Participants

Means and standard deviations. The exploratory analysis of the data revealed many interesting patterns. Table 3 shows the means and standard deviations for program participants at the pre-test, post-test, and post-post-test assessments on all of the outcome measures. It also shows the means and standard deviations for future participants on the same measures.

In this study program participants' mean KKS score showed an increase from pre-test to post-test and a further increase from post-test to post-post-test. Program participants' mean KCS total score decreased from pre-test to post-test then remained fairly constant during the eight-week follow-up period. Program participants' mean problem focused coping score underwent a decline between the pre-test and post-test assessments and then an elevation back towards the original level by the post-post-test assessment. The mean social support based coping score followed a similar pattern. Program participants' mean score on the emotionally focused coping subscale showed a progressive decline over the course of the program and follow-up period.

Program participants' mean CSEI total score went up from pre-test to post-test and again from post-test to post-post-test. The means for the social-peers, home-parents, and general self-esteem subscales reflected the same pattern as the total score. The school-academic self-esteem subscale mean decreased from pre-test to post-test and then returned to a pre-program level by the follow-up assessment.

Self-esteem. The CSEI can be interpreted in a number of ways (Coopersmith, 2002). The total self-esteem score ranges from 0 to 100 where 0 represents low self-esteem and 100 represents high self-esteem. The manual indicates that the population mean tends to be between 70 and 80 with a standard deviation between 11 and 13. In the

present study, the mean for program participants moved from below the normal range (within one standard deviation) at pre-test, to the lower end of the normal range by post-test, and then to the upper end of the normal range by post-post-test. This finding suggests that some participants in the program moved from a below average level of self-esteem to an average level over the course of the program and follow-up period. Regression towards the mean is one possible explanation for this finding.

Program participants' CSEI scores at the beginning of the program were compared to their scores at the end of the program. There was a promising finding that program participants' CSEI total scores increase from the pre-test assessment to the post-test assessment, $F(1, 13) = 2.12$, $p = .17$, $\eta^2 = .140$. The value of eta squared indicates that there was a strong relationship between experience in the program and program participants' total level of self-esteem.

Several facets of program participants' self-esteem were considered separately in order to describe what happened to them over the course of the program. School-academic self-esteem was excluded from the analysis because KIC was not intended to influence this dimension of self-esteem. Program participants' level of social-peers self-esteem did not increase in a descriptively meaningful way from the pre-test to the post-test assessment. There was a promising finding related to the increase in program participants' level of home-parents self-esteem from pre-test to post-test, $F(1, 13) = 1.09$, $p = .32$, $\eta^2 = .078$. There was a clinically significant finding related to the increase in program participants' level of general self-esteem between the pre-test and post-test assessment, $F(1, 13) = 4.34$, $p = .06$, $\eta^2 = .250$. The value of eta squared indicates that

there was a strong relationship between experience in the program and program participants' level of general self-esteem.

The self-esteem of the program participants ($n = 14$) at the end of the program was compared to the self-esteem of the program participants ($n = 7$) at the end of the eight-week follow-up period. Program participants' total CSEI scores did not appear to change in a descriptively meaningful way between the post-test and post-post-test assessments, $F(1, 6) = .11, p = .75, \eta^2 = .018$. There was also no descriptively meaningful change in program participants' level of general self-esteem over the same interval.

The self-esteem of program participants ($n = 16$) at the beginning of the program was also compared to the self-esteem of program participants ($n = 7$) at the eight-week follow-up session. The increase in program participants' mean CSEI total score from the pre-test to the post-post-test assessment was not supported by any statistical findings, $F(1, 6) = .17, p = .70, \eta^2 = .027$. There was a promising finding that program participants' level of general self-esteem increased between the pre-test and post-post-test assessments, $F(1, 6) = .50, p = .50, \eta^2 = .078$. The value of eta squared indicates that there was a moderate relationship between experience in the program and program participants' level of general self-esteem over the course of the program and follow-up period.

Program participants' ($n = 14$) post-test scores on the CSEI total scale were compared to future participants' ($n = 17$) CSEI total scores. There was a promising finding related to the difference between the scores of these two sets of participants, $F(1, 29) = 1.72, p = .20, \eta^2 = .056$. The value of eta squared suggests a moderate relationship

between experience in the program and total self-esteem. Descriptively, program participants at post-test had higher total self-esteem than future participants.

Program participants and future participants were compared in regards to several facets of self-esteem. There was a clinically significant finding that the home-parents self-esteem of program participants at the post-test assessment was higher than that of future participants, $F(1, 29) = 2.71, p = .11, \eta^2 = .085$. The value of eta squared indicates a moderate relationship between experience in the program and participants' level of home-parents self-esteem. There was a promising finding that indicated that program participants at the post-test assessment had a higher amount of general self-esteem than future participants, $F(1, 29) = 1.59, p = .22, \eta^2 = .052$. The value of eta squared suggests a moderate relationship between experience in the program and participants' amount of general self-esteem.

Given that the program participants' post-post-test assessment took place prior to the future participants' assessment, it made sense to compare future participants ($n = 17$) to program participants ($n = 7$) at the post-post-test assessment. When CSEI total scores were compared, there was a clinically significant finding that program participants had a higher amount of total self-esteem than future participants, $F(1, 22) = 3.99, p = .06, \eta^2 = .154$. The value of eta squared indicates a strong relationship between participation in this program and level of total self-esteem.

Coping strategies. The KCS was designed to produce three independent subscale scores related to the use of problem-focused, emotionally focused, and social support based coping strategies (Maybery, Goodyear et al., 2005; Steer, 2006). Scores for each subscale are equal to the mean of the items belonging to that subscale. Each subscale

covers a set of related coping strategies that COPMI might employ to handle the problems or difficult situations in their lives (Maybery, Ling, et al., 2005). For the purposes of this study, a composite total score was also created to explore participants' overall use of coping strategies. The mean of the nine KCS items was used to calculate this composite total score. The total score was included with an awareness that the three types of coping strategies that make up the scale do not necessarily represent equally effective ways for COPMI to handle the problems or difficult situations in their lives.

Program participants' scores on the KCS composite total score at the beginning of the program were compared to their scores at the end of the program. There was a robust finding suggesting that participants in this program had lower KCS total scores at the end than at the beginning of the program, $F(1, 13) = 10.37, p = .01, \eta^2 = .444$. The value of eta squared indicates that there was a strong relationship between experience in the program and participants' KCS total scores for the participants in the four KIC groups that were followed over time in this study. This finding points to a fairly clear decline in participants' use of the coping strategies measured by the KCS over the course of the program.

The three kinds of coping strategies covered by the KCS were explored separately in order to describe what happened to each over the course of the program. There was a promising finding suggesting that program participants had lower scores on the problem-focused coping strategies subscale at the end of the program than at the beginning, $F(1, 13) = .74, p = .41, \eta^2 = .054$. The value of eta squared indicates that there was a moderate relationship between experience in the program and participants' use of problem-focused coping strategies. In comparison, there was a robust finding in relation to program

participants' tendency to report lower scores on the emotionally focused coping strategies subscale at the end of the program than at the beginning, $F(1, 13) = 6.13, p = .03, \eta^2 = .320$. The value of eta squared indicates that there was a strong relationship between experience in this program and participants' use of the emotionally focused coping strategies covered by the KCS. There was no evidence of a meaningful change in program participants' scores on the social support based coping strategies subscale between the beginning and the end of the program. The fact that several KCS subscale score distributions were statistically significantly different from normal should be kept in mind as it adds an additional layer of ambiguity to the above findings.

Program participants' ($n = 14$) KCS total scores at the end of the program were compared to program participants' ($n = 7$) KCS total scores at the end of the eight-week follow-up period. There was a promising finding related to the change in program participants' use of the coping strategies measured by the KCS over the course of the follow-up period, $F(1, 6) = .36, p = .57, \eta^2 = .056$. The value of eta squared indicates a moderate relationship between experience in the follow-up period and participants' overall use of the coping strategies included in the KCS.

Program participants' ($n = 16$) KCS total scores at the beginning of the program were compared to program participants' ($n = 7$) KCS total scores at the eight-week follow-up assessment. There was a promising finding in relation to the decrease in program participants' KCS total scores from the beginning of the program to the follow-up assessment, $F(1, 6) = .96, p = .36, \eta^2 = .138$. The value of eta squared suggests that there was a strong relationship between experience in the program and participants' overall use of the coping strategies measured by the KCS. Program participants' ($n = 16$)

use of specific types of coping strategies at the beginning of the program was compared to program participants' ($n = 7$) use of these strategies at the post-post-test assessment. There were promising findings related to changes in program participants' scores on the problem-focused coping strategies subscale ($\eta^2 = .143$) and the emotionally focused coping strategies subscale ($\eta^2 = .365$). These values of eta squared suggest that there was a moderate relationship between experience in the program and participants' use of these two types of coping strategies. There was no evidence of a descriptively meaningful change in program participants' scores on the social support based coping strategies subscale.

The post-test KCS total scores of program participants ($n = 14$) were compared to the KCS total scores of future participants ($n = 17$). There was no evidence of a descriptively meaningful difference, $F(1, 29) = .49, p = .49, \eta^2 = .017$. The lack of descriptive findings suggests that at the post-test assessment program participants and future participants did not differ in terms of their overall use of the coping strategies measured by the KCS. Program participants' ($n = 14$) scores on the three KCS subscales at the end of the program were compared to future participants' ($n = 17$) scores on these subscales. There was a promising finding related to the higher problem-focused coping strategies subscale scores among program participants than among future participants, $F(1, 29) = 1.45, p = .24, \eta^2 = .048$. The value of eta squared indicates the presence of a moderate relationship between experience in the program and participants' use of certain problem focused coping strategies. There was no evidence of a descriptively meaningful difference between program participants at the end of the program and future participants in terms of their scores on the emotionally focused coping subscale and the social support

based coping subscale of the KCS. These findings suggest that there was little to no relationship between experience in the program and participants' use of the specific coping strategies covered by the KCS.

The KCS total scores of future participants ($n = 17$) were compared to those of program participants ($n = 7$) at the 8 week follow-up assessment. There was no evidence of a descriptively meaningful difference in program participants' and future participants' KCS total scores, $F(1, 22) = .51, p = .48, \eta^2 = .023$. This finding suggests that there was little to no relationship between experience in this program and participants' overall use of the coping strategies covered by the KCS.

Knowledge of mental illness. Program participants' knowledge of mental illness at the beginning of the program was compared to their knowledge of mental illness at the end of the program. There was a robust finding related to the increase in program participants' KKS total score from the beginning to the end of the program, $F(1, 13) = 8.55, p = .01, \eta^2 = .397$. The value of eta squared indicates that there was a strong relationship between experience in the program and program participants' knowledge of mental illness in this program.

Program participants' ($n = 14$) KKS scores at the end of the program were compared to program participants' ($n = 7$) scores at the end of the 8 week follow-up period. There was a promising finding that program participants' knowledge of mental illness continued to increase during the follow-up period, $F(1, 6) = .53, p = .49, \eta^2 = .082$. The value of eta squared indicates that there was a moderate relationship between experience in the follow-up period and participants' knowledge of mental illness.

Program participants' ($n = 16$) KKS scores at the pre-test assessment were also compared to program participants' ($n = 7$) KKS scores at the post-post-test assessment. The robust finding noted above was no longer present when program participants' scores were compared over the full length of the study period. There was a promising finding regarding the increase in program participants' KKS scores from the beginning of the program to the 8 week follow-up assessment, $F(1, 6) = 1.76, p = .23, \eta^2 = .227$. The value of eta squared suggested that there was a strong relationship between experience in the program and participants' knowledge of mental illness.

The post-test KKS scores of program participants ($n = 14$) were compared to the KKS scores of future participants ($n = 17$). Even though there was no evidence of a robust or clinically significant finding, there was a promising finding related to the greater knowledge of mental illness demonstrated by program participants than by future participants, $F(1, 29) = 1.97, p = .17, \eta^2 = .064$. The value of eta squared indicates that there was a moderate relationship between experience in the program and participants' knowledge of mental illness. As previously described, there was a positive correlation between age and participants' KKS scores prior to their experience in the program. Since future participants were slightly older on average than program participants, the difference in ages may have influenced the difference in KKS scores.

For the reasons stated above, future participants' ($n = 17$) KKS scores were also compared to program participants' ($n = 7$) KKS scores from the post-post-test assessment. There was a robust finding supporting the higher KKS scores shown by the program participants in this program, $F(1, 22) = 5.28, p = .03, \eta^2 = .194$. The value of eta

squared suggests that there was a strong relationship between experience in the program and participants' knowledge of mental illness.

Summary. Due to the small number of children who participated in the study, the originally intended inferential analysis was abandoned in favour of an exploratory and descriptive analysis. The analysis attempted to provide a clear and rich description of the data. Both score distributions and the results of statistical analyses were included for their descriptive value as well as their value to future meta-analyses. In order to produce as accurate and as unambiguous a description as possible, a number of conventions were adopted for the reporting of the results.

Prior to the description of statistical results, score distributions were considered in order to enrich the description of the data. Even though there were missing values and potential outliers, no individuals or variables were dropped from the analysis. A substantial amount of attrition at the post-post-test assessment was noted and should be considered in all statistical results involving data from that assessment point. The majority of variables used in the analysis satisfied the assumptions underlying parametric statistical procedures. The score distributions for the total scores tended to be approximately normal. In comparison, subscale distributions had a greater degree of skewness. Correlations between age and knowledge of mental illness and between age and the use of different coping strategies yielded associations of about 9%.

The results indicate that program participants tend to report higher levels of self-esteem and knowledge of mental illness after their experience in the KIC groups investigated in this study. The results indicate that program participants tend to report a change in their use of problem-focused and emotionally focused coping strategies

following their experience in the program. The scores of program participants who had completed the program were also compared to the scores of future participants who were attending their KIC groups for the first time. The results indicate that program participants tend to report higher levels of self-esteem and knowledge of mental illness than future participants. The results indicate that program participants and future participants did not differ in a descriptively meaningful way in terms of their reported use of the coping strategies measured by the KCS. The results suggest that there were both within-subjects and between-subjects differences in terms of self-esteem and knowledge of mental illness, but only within-subjects differences in terms of the use of coping strategies. Some possible explanations for these results are discussed below.

CHAPTER 4: DISCUSSION

The present study was designed to evaluate the KIC program during its normal operation in the real world. The descriptive approach taken in the analysis provided a summary of patterns for the participants who took part in the KIC groups investigated by this study. The findings suggest several noteworthy relationships between experience in the program and program participants' self-esteem, use of coping strategies, and knowledge of mental illness. The following sections discuss some tentative interpretations of these findings and potential implications for the KIC program. Furthermore, the current status of the program is reviewed from a resilience perspective, and implications are discussed for counselling psychologists. The present study had many methodological strengths as well as a number of limitations. Methodological issues are also discussed and recommendations for future research are presented.

Conclusions for Kids in Control

Knowledge of mental illness. The study described the amount of knowledge and understanding of mental illness reported by program participants and future participants in the KIC groups investigated by this study at several points in time. The results suggest that many program participants' knowledge of mental illness increased from the beginning to the end of the program and then continued to increase during the follow-up period. The findings also suggest that many program participants had a greater amount of knowledge of mental illness than future participants. The findings suggest that many program participants were able to learn and retain factual information about mental illness from their experience in the program. Even if these patterns only hold true for a

substantial minority of program participants, they still provide important information about the impact of the program for these children.

It could be argued that enhancing participants' knowledge of mental illness is the primary objective of the KIC program. Several group sessions focus on conveying factual information about mental illness (BCSS, 2005). Participants learn about mental illness through activities, hand-outs, and group discussions. The program is designed to teach participants about the symptoms, causes, treatment, and stigmatization of mental illness and to dispel any myths or misconceptions that they have about it. The goal is to strengthen COPMI by exposing them to accurate information about mental illness. The findings suggest that this objective was achieved for many of the participants assessed in this study.

Beardslee et al. (2003) found that two brief psychoeducation interventions could increase COPMI's knowledge of mental illness. They proposed that the intervention in which the clinician met with individual families was superior to the intervention in which the clinician lectured to a large number of families simultaneously because the former gave the clinician more of an opportunity to link the information being presented to the unique circumstances of each family than the latter. Since the KIC groups investigated in this study were relatively small and had a good facilitator-to-participant ratio, it is likely that facilitators had the opportunity to connect the information being presented to each participants' unique situation. Group discussions and story sharing activities may have provided additional opportunities for rehearsing the information and making these personal connections. Both rehearsing the information and making it personally relevant may have aided in memory consolidation and thereby in later recall of that information.

The amount of time required to consolidate memories may help to explain why some program participants' KKS scores continued to increase during the follow-up period.

Since the KKS is an experimental instrument developed specifically with this study and this program in mind, it may have been highly sensitive to changes in participants' knowledge of mental illness. Given that the KKS was based on the content of the KIC program, the increase in many program participants' scores suggests that the KIC groups investigated in this study were able to convey the content about mental illness that they were intended to convey. It is possible that exposure to the KKS at the beginning of the program primed participants to pay extra attention to relevant program content. Even though the weak and unknown psychometric properties of the KKS may compromise the clarity of the above descriptions of program participants' experience, these patterns provide a valuable starting point in documenting program impact.

Coping strategies. The study described program participants' and future participants' use of specific coping strategies at different points in time. The results suggest that many program participants' overall use of the coping strategies covered by the KCS decreased between the beginning and the end of the program. The results suggest that experience in the program was most strongly associated with program participants' scores on the emotionally focused coping subscale of the KCS. Even though many program participants reported lower KCS scores at the end of the program, some program participants reported an increase in their KCS scores between the end of the program and the eight-week follow-up session. The results suggest that there are few descriptively meaningful differences between program participants and future participants in terms of their use of the specific coping strategies measured by the KCS.

The only promising finding was that some program participants reported higher scores on the problem-focused coping subscale than future participants. This finding might not be meaningful given the negative correlation between age and the use of problem-focused coping strategies combined with the fact that future participants were slightly older on average than program participants. Collectively, these findings suggest that participation in the KIC groups in this study was associated with short-term changes in many program participants' use of the specific coping strategies covered by the KCS. Even if these patterns only hold true for a substantial minority of program participants, they still provide important information about the impact of the program for these children.

Although promoting the use of effective coping strategies is an objective of the KIC program (BCSS, 2005), it is not as central an objective as increasing participants' knowledge of mental illness. The program is supposed to give participants the opportunity to practice both coping and interpersonal skills. The manual calls for at least one session in which participants learn what they can do to help themselves to cope with the circumstances in their lives. The manual recommends teaching participants how to make independent decisions and how to identify and appropriately express their feelings. Facilitators tended to emphasize different coping strategies in their individual KIC groups. In addition, they used activities from the manual and from outside of the manual to teach coping strategies. The inconsistency in relation to what coping strategies program participants were taught might help to explain the equivocal patterns in the findings. Moreover, there is no guarantee that any of the KIC groups investigated in this study actually taught the specific coping strategies measured by the KCS.

The moderate relationship between experience in the program and decreases in some program participants' use of problem-focused coping strategies may be due in part to some discrepancies between the program content and the way problem-focused coping is operationalized by the KCS. The KIC program is supposed to teach participants how to make decisions and new ways of coping with the difficult circumstances in their lives. Item one on the KCS asks respondents to rate how often they try to think about different ways of solving a problem. Since brain storming or exploring alternatives is a key step in many models of problem solving and decision making, there is a good fit between the item and the program. Items four, seven, and nine on the KCS ask respondents to indicate how often they handle problems or difficult situations by trying to make things better, by trying to fix the problem, and by offering an apology when the problem or situation was their fault, respectively. Since the fact that parental mental illness is neither the child's fault nor responsibility is part of the knowledge of mental illness conveyed by the program, many participants likely learned and retained this piece of information. This information may have helped some participants to accept a more age-appropriate role in their families; a role that does not require them to handle all of their families' problems themselves (Orel et al., 2003). In other words, knowledge of mental illness may have influenced how participants appraised and handled problems in their families. Participants may have felt less of a need to make things better or to fix the problem because they felt less responsible for the problem. Likewise, they may have appraised fewer problems as their fault and thus had fewer occasions to offer an apology. In these ways the decrease in problem-focused coping could be explained in terms of the program content and can therefore be conceptualized as a potentially positive change.

The coping strategies covered by the emotionally focused subscale of the KCS may or may not be adaptive for COPMI. All three items on the subscale ask respondents how often they handle problems or difficult situations by engaging in different forms of avoidance. Chassin et al. (2004) indicated that even avoidance could be adaptive if it prevents the individual from becoming overwhelmed with distress. Polkki et al. (2004) reported that avoiding their parents during psychiatric episodes and focusing on other people's feelings instead of their own allowed COPMI to cope in the short term, but it was ineffective as a long-term strategy. The decrease in many program participants' use of emotionally focused coping strategies might reflect a shift away from avoidance towards other approaches for handling emotions.

It is unclear what connection exists between what the KCS and the KIC program regard as emotionally focused coping strategies. The KIC program teaches coping strategies aimed at emotional regulation. It is intended to help participants to identify feelings, manage feelings, and express feelings in appropriate ways. Since the KIC program is supposed to help participants recognize and deal with their feelings rather than avoid them, it is not surprising that many program participants reported a decrease in their use of emotionally focused coping strategies. The decrease may represent the fulfillment of program objectives and a change that could be viewed as beneficial.

Steer (2006) found a negative correlation between participants' scores on the emotionally focused subscale of the KCS and their scores on a measure of self-esteem. Even though there was no descriptively meaningful correlation between emotionally focused coping and self-esteem for participants in the KIC groups investigated in this study, the potential relationship is still worth considering for children in the KIC

program. If there is a negative correlation between use of emotionally focused coping strategies and self-esteem then the increase in some program participants' self-esteem may have contributed in some fashion to the decrease in their use of emotionally focused coping strategies. Harvey and Delfabbro (2004) pointed out that in Bandura's social cognitive learning theory there is an interaction between the use of coping strategies, self-efficacy, and self-esteem. Higher self-esteem is associated with greater self-efficacy and more favourable outcome expectations. Similarly, some participants may have felt more confident about dealing with their emotions and problems instead of avoiding them. Alternatively, participants' decreased use of emotionally focused coping strategies may have contributed to their increased level of self-esteem. The program is intended to teach strategies for handling emotions. These strategies may have helped some children replace more avoidant approaches and thus given those participants a greater sense of control, and self-efficacy, in dealing with their emotions. The sense of mastery may have contributed to their higher levels of self-esteem. In either case, there appears to be a plausible explanation for a relationship between using fewer avoidant coping strategies and having a higher level of self-esteem.

The lack of descriptively meaningful changes or differences in the use of social support based coping strategies may have been obscured due to weaknesses in the subscale. The restricted range of possible scores on the subscale is one difficulty. In addition, score distributions for that subscale were consistently different from normal.

Since the KCS asks respondents to reflect on what they did when handling a problem or a difficult situation, context is an appropriate consideration when interpreting the results. The reported changes in some participants' use of various coping strategies

may reflect changes in the type or number of problems that they are facing in their lives. It is possible that some participants' appraisal of problems and difficult situations changed such that they did not feel that they had to do as much in order to cope with them. It is also possible that some participants were dealing with fewer, or less serious, problems or difficult situations at the end of the program than they had been at the beginning and thus were not using as many coping strategies. Unfortunately, the present study did not collect data regarding the number or type of problems experienced by participants at any point in time, and therefore, the relationship between use of coping strategies and the presence of problems is unknown for these participants. The use of various coping strategies seems to be related in important ways to experience in the program for at least some participants, and these patterns warrant further exploration by researchers and program developers.

Self-esteem. The study described the amount of self-esteem reported by program participants and future participants at different points in time. The results suggest that many program participants' level of self-esteem increases between the first and last days of the KIC groups they attended. Even though there was some evidence of further increases for some children during the follow-up period, these changes were more ambiguous. The results suggest that experience in this program was most strongly, and least ambiguously, associated with an increase in program participants' general self-esteem. The findings also suggest that program participants had higher levels of self-esteem than future participants. Therefore, it seems plausible that participation in the KIC groups under investigation may have strengthened the self-esteem of many of these participants. Even if these patterns only hold true for a substantial minority of program

participants, they still provide important information about the impact of the program for these children.

Although enhancing participants' self-esteem is both an explicit and implicit objective of the KIC program (BCSS, 2005), it is not as central as enhancing participants' knowledge of mental illness. One of the last sessions in the program is intended to help participants to identify their unique characteristics and special strengths. Werner & Johnson (2004) noted that resilient children in the Kawaii study tended to recognize their unique characteristics and special abilities. Therefore, there is a plausible relationship between participating in that KIC group session and the increase in the program participants' self-esteem. Facilitators were also supposed to foster self-esteem by listening to participants and by supplying them with frequent validation over the course of the program. The attention and caring provided by facilitators may have influenced the increase in participants' self-esteem. The group format of the KIC program may contribute to the increase in program participants' self-esteem. Orel et al. (2003) noted that social isolation is often associated with low self-esteem. Some of the children in this study may have been socially isolated for various reasons including the stigma associated with having a family member with a mental illness. Participants may benefit from the social support provided by their peers and the group facilitators. Rutter (1999) pointed out that being involved in caring relationships can promote self-esteem. Similarly, the children in this study may have benefited from various forms of social support. The relationship between social support and self-esteem for program participants needs to be qualified with the lack of descriptively meaningful findings related to the increase in participants' social-peers self-esteem. Orel et al. (2003) noted that their participants'

perception of peer acceptance did not improve as a result of their intervention. They proposed that peer acceptance may be an ongoing concern for COPMI. In addition to basic social support, the group provides an opportunity for the sharing and normalizing of experiences. It is therefore possible that aspects of the group format helped to foster participants' general self-esteem without necessarily enhancing their social-peers self-esteem.

The increase in program participants' self-esteem may be connected to their increased knowledge and understanding of mental illness. COPMI may have negative views of their families and themselves due to the messages that they receive from society about people who have a mental illness (Hinshaw, 2005). The stigmatization of mental illness may cause COPMI to feel shame and embarrassment. The program is supposed to address the stigma associated with mental illness (BCSS, 2005). In this way, experience in the program may decrease the distress experienced by COPMI and improve their perception of their families and themselves.

An increase in knowledge of mental illness could contribute to self-esteem in a number of ways. Birkerts (2000) proposed that COPMI experience distress because they do not have a framework for understanding their parents' mental illness. COPMI may blame themselves for their parents' symptoms and behaviours (Mordach & Hall, 2002). COPMI may misinterpret their parents' symptoms and behaviours as indications of displeasure or disinterest (Birkerts, 2000). Knowledge of mental illness may fill a gap in participants' understanding that allows them to conceptualize and evaluate things differently. Possessing accurate knowledge of mental illness may grant COPMI a better understanding of their parents (Beardslee et al., 2003). Similarly, knowledge of mental

illness may help participants to view symptoms as merely symptoms instead of signs of parental disinterest or displeasure related to them. Understanding their parents and their symptoms may give COPMI a greater sense of personal security (Mordach & Hall, 2002; Orel et al., 2003). Orel et al. (2003) also suggested that understanding their parents' mental illness might give COPMI a greater sense of control and self-efficacy. Knowledge of mental illness may influence the way participants view their families and themselves as members of those families. In these ways, knowledge may have improved participants' self-perceptions and self-evaluations. Even though there was only a moderate relationship between experience in the program and program participants' home-parents self-esteem, there were some descriptive findings supporting an increase in this facet of program participants' self-esteem.

Since bolstering self-esteem is a fairly broad objective of the KIC program and is most likely influenced by multiple factors including changes in other domains such as knowledge of mental illness, it is not surprising that many program participants reported the greatest increase in the area of general self-esteem. Given the KIC program's emphasis on understanding mental illness, it seems likely that the increase in knowledge of mental illness is a substantial factor influencing the increase in participants' levels of self-esteem.

Implications

What do the results mean for Kids in Control? The study was designed to evaluate the effectiveness of the KIC program. Given the descriptive nature of the analysis, the findings only apply to the participants in the KIC groups investigated by this study. Therefore, the study only speaks to the effectiveness of the program for these individuals.

Nevertheless, the results of the study do have implications for the understanding of the KIC program.

In terms of the considered outcomes and program objectives, the study described some meaningful changes in many program participants' knowledge of mental illness, use of coping strategies, and self-esteem. The results suggest that the KIC groups under investigation achieved some level of success in accomplishing the program objectives of increasing participants' knowledge of mental illness and bolstering their self-esteem. In these cases there is a fairly clear connection between the results and the program objectives. It is more difficult to determine whether or not these KIC groups accomplished the objective of helping participants to cope more effectively with the circumstances in their lives. Based on the arguments stated above, it seems reasonable to conclude that the reported decrease in coping strategies used by program participants may represent either an increase in the use of other contextually appropriate coping strategies or at least a decrease in the use of contextually ineffective coping strategies. For these reasons it appears that the KIC groups investigated in this study also achieved some level of success in accomplishing the third and final program objective under consideration. Collectively, these findings suggest that the KIC program was relatively effective for the participants who participated in the groups being investigated in this study.

Since the present study did not include an inferential analysis, the results cannot be generalized to KIC groups offered in the future or to any segment of the COPMI population. The descriptive analysis may be transferable to other similar situations. The study presents considerable detail about the groups being studied and the design used to

study them in order to allow readers to determine the degree of similarity between the conditions present in this study and in their situations.

What do the results mean for resilience? The results have implications for resilience and the nature of resilience adds to the implications of the results. The study examined three protective factors (self-esteem, use of effective coping strategies, and knowledge of mental illness) that are associated with resilience in different domains of functioning. The results suggest that many program participants experienced a descriptively meaningful change in relation to each of these protective factors. Given the relationship between protective factors and resilience, it is plausible that the program participants in this study also experienced a descriptively meaningful increase in their level of resilience following their participation in the program.

Determining the amount of change needed to demonstrate resilience is one of the methodological issues in resilience research (Milling-Kindard, 1998). Hence, it is important to exercise caution when claiming that the descriptive changes noted in this study actually reflect an increased level of resilience. Luthar, Cicchetti, & Becker (2000) suggested that resilience is domain specific and that a change in any protective factor could represent a meaningful change in an individual's overall level of resilience. Therefore, any of the positive changes described above could represent an increase in some participants' level of resilience.

According to Luthar et al. (2000), it is possible for resilient children to have competencies in some domains of functioning and problems in other domains. This assumption indicates that the ability of the program to increase participants' resilience is not dependent on its ability to increase every protective factor to a substantial extent. In

spite of the domain specificity of resilience, the study demonstrated some possible interactions between different protective factors such as knowledge of mental illness and self-esteem. This interaction of protective factors may contribute to further increases in resilience over time and beyond the scope of the present study.

Even though the present study was only able to describe changes in program participants' scores over a period of 8 to 16 weeks, even these short-term changes could have implications for long-term resilience. As previously discussed, several researchers have found evidence that protective factors present in childhood influence resilience over substantial periods of time (Masten et al., 2004; Werner & Johnson, 2004). One possible implication of these findings is that increasing a protective factor at one point in time has the potential to influence the individual's future resilience.

In spite of the resilience framework, the present study did not directly address either risk or resilience. The COMPI in the study were assumed to be at risk based on the literature that indicates that COPMI in general are exposed to a variety of risk factors. Since the focus of the study was neither determining whether or not the program could change problematic behaviour nor determining whether or not COPMI who participated in the program were more or less likely than other COPMI to experience negative outcomes, the study did not collect information about the participants' behaviour, problems, or pathology. Behaviour change was not a direct objective of the KIC program and evaluating long-term outcomes was beyond the scope of the study. The study's ability to make any statements about participants' resilience rests upon the theoretical connections between the protective factors under investigation and resilience. This caveat is important when considering what implications the KIC program has for resilience.

What do the results mean for counselling psychology? Although the study did not address counselling psychology in a direct sense, it could have implications for counselling psychologists who are interested in the welfare of COPMI. In the broadest sense, the literature summarized and implemented in this study demonstrated the number of COPMI in our world and the reasons why clinicians should be concerned about them. The participants in the KIC groups investigated by this study as a group had a below average level of self-esteem before their experience in the KIC program. This finding supported the claim in the KIC Facilitator's manual (BCSS, 2005) that COPMI tend to have below average levels of self-esteem. Counsellors working with COPMI might want to keep self-esteem in mind as a possible area of intervention. The fact that COPMI were able to learn factual information about mental illness, and the impact that this knowledge had on other protective factors, is worth consideration. Since counsellors possess factual information about mental illness, they are in a strong position to provide such psychoeducation to COPMI. Overall, the value of the study to counselling psychologists relates to the awareness it brings to the needs of COPMI and the descriptive information it provides about one way of addressing these needs.

Methodological Strengths and Limitations

The study's design had many strengths and limitations that should be considered when interpreting the findings of the present study and when planning future studies. The following sections describe these strengths and limitations and present recommendations for future research.

The resilience framework. The present study used resilience as a framework for describing the value of the KIC program. The framework provided a useful theoretical

backdrop for evaluating the program. The framework was a good fit with the program due to the compatibility between the program's objectives and several protective factors that contribute to resilience among COPMI. Moreover, the manual (BCSS, 2005) indicates that the program was developed with a resilience framework in mind. Although the resilience framework invokes some of the methodological issues associated with resilience research (Luthar et al., 2000; Milling-Kindard, 1998), it is one of the strengths of the present study.

Real world setting. The present study represents an effectiveness trial and as such it is subject to all the positive and negative consequences of real world research. Effectiveness studies are a useful form of program evaluation because they describe the operation of a program under fairly typical conditions. Even though the study reduced the amount of time facilitators had to cover KIC content and objectives, the high fidelity scores suggest that the amount of interference was minimal. The real world emphasis of the study is associated with several strengths and limitations of the design. Since KIC operates in the real world, further effectiveness trials of the program should be undertaken.

Facilitators. The involvement of multiple facilitators was one of the strengths of this study. It is consistent with the real world nature of an effectiveness study. It decreases the likeliness that any changes in participants' scores were related to the influence of individual facilitators. The different backgrounds and levels of experience held by the facilitators combined with the high fidelity scores indicated that the manual is relatively accessible. Future research should attempt to quantify and describe the affect that facilitators have on program outcomes.

Sampling. Participants were drawn from naturally occurring groups taking place in seven communities over a period of six months. All of the children who participated in the program were invited to participate in the study. Since only three program participants declined to participate in the study, the study's sample represented nearly the whole population of program participants during the study period. The use of multiple naturally occurring groups is a strength of this study because it broadens the scope of the sample, increases the odds of bringing together a representative sample of COPMI, and offers the best alternative in a real world situation where random selection is impractical. The influence of culture is an important, yet often overlooked, factor in the study of resilience. Mowbray et al. (2004) observed that many studies involve samples that are not representative in terms of culture. These samples are typically composed of white children from lower or middle class families. The present study attempted to obtain a diverse sample by bringing together participants from across British Columbia. Some of the diversity of the population of British Columbia was reflected by the study's sample. The scope and diversity of the sample is a strength of this study.

Sample size. Small sample size is a fairly common problem in the literature related to studies of programs for COPMI and for promoting resilience. Although the present study had a larger sample than several other program evaluations in this area (Orel et al., 2003; Pitman & Matthey, 2004), it still had a relatively small number of participants. Many real world circumstances contributed to the small number of participants recruited for this study. Recruiting participants appeared to be one of the most substantial challenges for facilitators. The stigma attached to mental illness, the reluctance of some parents with a mental illness to seek help, and the tendency to

overlook COPMI may all have contributed to this difficulty. Two facilitators in small rural communities indicated that stigma was a major obstacle for them in recruiting participants. These difficulties should be taken into consideration when planning future research.

The small number of participants is a substantial limitation of the present study. It necessitated the shift from an inferential to descriptive analysis. In so doing it impaired the study's ability to accomplish its original purpose of evaluating the effectiveness of the KIC program. It also contributed to the ambiguity of findings in the descriptive analysis.

Future research should make every attempt to recruit more facilitators and participants. A larger sample would prevent or reduce some of the challenges faced by the present study. It would also facilitate the inclusion of additional variables and co-variants. A larger sample size could improve the study's ability to answer some research questions and to make some comparisons that could not be addressed in the present study.

Non-equivalent comparison group design. Researchers evaluating programs for COPMI often struggle to find a suitable comparison group. Many studies employ quasi-experimental designs without any kind of comparison group (Beardslee et al., 2003; Finkelstein et al., 2005; Pitman & Matthey, 2004). Many programs, including KIC, do not maintain wait lists, and therefore, a traditional wait list comparison group is not possible. Since recruiting participants is difficult in itself, recruiting extra participants for a comparison group is not a practical solution.

The present study addressed the difficulty in creating a suitable comparison group by employing a recurrent institutional cycle design. The design overcomes the logistical

problem of not having a wait list comparison group and the ethical problem of withholding a potentially beneficial service in order to create one. The presence of a comparison group, even a non-equivalent one, is a methodological improvement over many other studies in this area.

Since all of the children in the study were COPMI, they were likely exposed to many of the same risk factors. Even though future participants were not on a wait list during the 16-week period in which program participants were being assessed, they presumably lived under comparable conditions only without receiving any intervention. In this way, the design reduced the likeliness that changes in participants' scores were the result of history rather than experience in this program.

The recurrent institutional cycle design cannot control for as many potential confounds as an experimental design with a traditional comparison group. It cannot refute the possibility that changes in the participants' scores were the result of the priming effect, regression towards the mean, or maturation. These uncontrolled extraneous processes represent plausible alternative explanations for the relationships and patterns found in this study.

The recurrent institutional cycle design is superior to several other non-equivalent quasi-experimental designs because it provides a comparison group that at least controls for the influence of history. In the future, a number of cohorts should be assessed and compared. Assessing each cohort at several points in time would provide the richest information about the program. Each additional cohort would increase the sample size and strengthen the knowledge claims of the study by reducing the likeliness that changes are due to extraneous factors.

Change. The present study was intended to evaluate change over time. The goal was to determine whether or not the program could produce any immediate changes and to monitor the stability of these changes over a short follow-up period. The rationale included the assumption that some changes might not manifest themselves or reach their highest level by the end of the eight-week program. Likewise, some changes might not be maintained after the end of the program. The presence of a follow-up assessment is a methodological strength, but the length of the follow-up period is a methodological limitation. Eight weeks, or even 16 weeks, might not have been long enough to detect meaningful changes in some of the outcome measures. The timing of the assessments was structured around the timetable for the KIC program. Although the timetable provided a useful structure and rationale for the timing of assessments, it did limit the study's ability to monitor change over different intervals of time.

Future research should assess change over a longer period of time and/or at several different points in time. This strategy would provide the richest information about change over time. Researchers should be prepared to offer facilitators and participants appropriate incentives for their extra time and effort. Another option would be to find a way of assessing participants or outcomes without directly involving the group facilitators, such as mailing questionnaires to the participants' homes.

Measures. Milling-Kindard (1998) identified selecting sources of information about resilience and selecting how many sources of measures to use when studying resilience as two of the serious methodological issues in resilience research. He recommended considering multiple sources of information about resilience. He observed that even though children's reports may be inaccurate, it is very important to include their

perspectives. Moreover, several researchers argue that resilience is rarely assessed from the perspective of the children themselves (Milling-Kindard, 1998; Pitman & Matthey, 2004). The present study focused exclusively on the perspective of children who participated in the KIC program. The study did not collect any collateral information or investigate resilience from the perspectives of other concerned parties such as parents, facilitators, or other clinicians. Since self-reports could be biased, it would have been better to have additional sources of information. Even though the inclusion of the children's perspective is a strength, the absence of other perspectives is a short-coming. Future research should retain the children's perspective and add other perspectives and sources of collateral information.

There are several valid critiques of the instruments employed in this study that are worth consideration. Some facilitators reported that children found the CSEI too long and somewhat confusing. All of the measures were self-reports and thus subject to response bias. The CSEI was the only questionnaire that attempted to quantify response bias. The results of the CSEI Lie scale suggest that many participants were not responding in a defensive or test-wise manner. The greatest limitation of the KCS and KKS were their weak and otherwise unknown psychometric properties. Since the test re-test reliability for the KCS and KKS were unknown, it is impossible to know how sensitive they are to change over time. As a result, differences in scores over time could have been the result of normal fluctuations between test administrations. The KKS may have been too easy; there was a ceiling effect on several items on which 80% or more of respondents selected the correct response. The random ordering of items on the KKS had the unexpected consequence of creating large blocks of questions where the correct answer was either

true or false. These patterns could have made it easier for participants in this study to guess the correct answers.

The KKS was pilot tested for the first time in this study. In the future the KKS should be revised and further validated. Reliability testing and factor analysis could be employed to learn more about its psychometric properties and to improve the instrument. The items should be re-arranged in a manner that minimizes obvious patterns. In order to make the instrument more discriminating, additional items with varying degrees of difficulty should be incorporated. When the KKS is revised and validated, it could be employed as a regular component of the evaluation of the KIC program.

In spite of these limitations, the measures in this study also had some positive characteristics. The instruments were generally child friendly and age-appropriate. Another advantage was that both the KCS and KKS were specifically designed for use with the COPMI population. Moreover, the KKS was designed with the KIC program and the purposes of the present study in mind. Future research should attempt to strike a balance between using standardized instruments and supporting the development, validation, and use of innovative instruments designed specifically for the COPMI population.

Future Research

Resilience in COPMI is a fascinating topic that deserves further study. In order to fully understand resilience in COPMI, more research is needed on both the construct of resilience itself and the needs of COPMI. In addition to studying resilience and COPMI, more research is needed to evaluate the effectiveness of programs designed to foster resilience in COPMI or to meet their needs in some other way. Even though further

research is needed in all of these areas, the following recommendations apply most directly to future program evaluations as these recommendations follow naturally from the present study. The recommendations pertain to future evaluations of KIC in particular, but they could be applied to the evaluation of other similar programs.

Several recommendations have already been stated above. These recommendations include retaining the resilience framework and real world emphasis, involving multiple facilitators and multiple cohorts of participants, recruiting as many facilitators and participants as possible from diverse backgrounds, extending the length of the follow-up assessment period, considering multiple sources of information and multiple program objectives, and using both standardized and innovative instruments to assess program outcomes.

Given that the present study had to abandon its inferential analysis in favour of a descriptive one, it was not able to address the question of the effectiveness of the KIC program for anyone other than the children who participated in the specific groups under investigation in this study. Thus the original question remains to be answered by future research. The data collected for this study contains information that could still be explored to a further extent. In addition, the statistical results and score distributions described would provide valuable information for future meta-analyses.

Given the small number of children available for evaluating the effectiveness of the KIC program, it would be very useful to conduct a qualitative or mixed methods effectiveness study of the program. The qualitative component would help to identify what participants, and other concerned parties, think about the program and whether or

not they found it helpful. The quantitative and qualitative information could be combined to provide a clearer and richer evaluation of the effectiveness of the program.

Summary

The present study represented a useful first step in the evaluation of the KIC program. It provides a model for conducting future effectiveness trials and data for performing future meta-analyses. Even though the findings only apply to a single population of program participants, the findings do suggest that there was a moderate to strong relationship between experience in the program and beneficial changes in self-esteem, use of coping strategies, and knowledge of mental illness for many of the children who participated in the KIC groups investigated by this study. Since KIC has never before been evaluated in any official way, even a descriptive evaluation adds to what is known about the program. Another contribution of this study was the development and pilot testing of the KKS, a measure that could be used in future program evaluations. Overall, the study laid the foundation for future research on this and other programs and provided some important insights into areas of need for COPMI.

REFERENCES

- Ahern, K. (2003). At-risk children: A demographic analysis of the children of clients attending mental health community clinics. *International Journal of Mental Health Nursing*, 12, 223-228.
- American Psychiatric Association. (2000). *The diagnostic & statistical manual of mental disorders, 4th ed., text revision (DSM-IV-TR)*. Washington, DC: American Psychiatric Publishing, Inc.
- Bassett, H., Lampe, J., & Lloyd, C. (1999). Parenting: Experiences and feelings of parents with a mental illness. *Journal of Mental Health*, 8(6).
- Beard, J. J., & Gillespie, P. (Eds.). (2002). *Nothing to hide: Mental illness in the family*. New York: New Press.
- Beardslee, W. R., Gladstone, T. R., Wright, E. J., & Cooper, A. B. (2003). A family-based approach to the prevention of depressive symptoms in children at risk: Evidence of parental and child change. *Pediatrics*, 112(2), 119-131.
- Beardslee, W., & Knitzer, J. (2004). Mental health services: A family systems approach. In Kenneth I. Maton, Cynthia J. Schellenbach, Bonnie J. Leadbeater, & Andrea L. Solarz (Eds.), *Investing in children, youth, families, and communities: Strengths-based research and policy* (pp. 157-171). Washington, DC: American Psychological Association.
- Birkerts, L. F. (2000). A child's experience of parental depression: Encouraging relational resilience in families with affective illness. *Family Process*, 39(4), 417-435.

- British Columbia Schizophrenia Society. (2003). *Supporting families with parental mental illness*. Retrieved February 9, 2005, from <http://www.bcscs.org/resources/index.html>
- British Columbia Schizophrenia Society. (2005). *Kids in Control: Facilitator's manual*. Richmond, BC, British Columbia Schizophrenia Society.
- Brown, W. (2004). Resiliency and the mentoring factor. *Reclaiming Children & Youth*, 13(2), 75-80.
- Butera-Prinzi, F., & Perlesz, A. (2004). Through children's eyes: Children's experience of living with a parent with an acquired brain injury. *Brain Injury*, 18(1), 83-101.
- Cameron, J. W. (1999). Self-esteem changes in children enrolled in weight management programs. *Issues in Comprehensive Pediatric Nursing*, 22, 75-85.
- Canadian Community Health Survey. (2002). *Mental health and well-being*. Retrieved November 22, 2004, from <http://www.statcan.ca/english/freepub/82-617-XIE/index.htm>.
- Chassin, L., Carle, A. C., Nissim-Sabat, D., & Kumpfer, K. L. (2004). Fostering resilience in children of alcoholic parents. In Kenneth I. Maton, Cynthia J. Schellenbach, Bonnie J. Leadbeater, & Andrea L. Solarz (Eds.), *Investing in children, youth families, and communities: Strengths-based research and policy* (pp. 137-155). Washington, DC: American Psychological Association.
- Chiu L. H. (1988). Testing the test: Measures of self-esteem for school-age children. *Journal of Counseling and Development*, 66, 298-301.
- Coopersmith, S. (1981). *Coopersmith inventory-school form*. Palo Alto, CA: Consulting Psychologists Press.

Coopersmith, S. (1989). *Self-esteem inventories*. Palo Alto, CA: Consulting Psychologists Press.

Coopersmith, S. (2002). *Self-esteem inventories manual*. Redwood City, CA: Mind Garden, Inc.

Corrigan, P. W. (2004). How stigma interferes with mental health care. *American Psychologist*, 59, 614-625.

Cowling, V., Luk, E. S., Mileskin, C., & Birleson, P. (2004). Children of adults with severe mental illness: Mental health, help seeking and service use. *Psychiatric Bulletin*, 28, 43-46.

Devlin, J. M., & O'Brien, L. M. (1999). Children of parents with mental illness: An overview from a nursing perspective. *Australian and New Zealand Journal of Mental Health Nursing*, 8, 19-29.

Doll, B., & Lyon, M. A. (1998). Risk and resilience: Implications for the delivery of educational and mental health services in schools. *School Psychology Review*, 27(3), 348-364.

DuBois, D. L., & Silverthorn, N. (2005). Natural mentoring relationships and adolescent health: Evidence from a national study. *American Journal of Public Health*, 95(3).

Field, A. (2005). *Discovering statistics using SPSS (2nd ed.)*. Thousand Oaks: Sage Publication, Ltd.

Finkelstein, N., Rechberger, E., Russell, L. A., & Vandemark, N. R. (2005). Building resilience in children of mothers who have co-occurring disorders and histories of violence. *Journal of Behavioral Health Sciences & Research*, 32(2), 141-154.

- Garnezy, N. (1994). Vulnerability and resilience. In R. J. Haggerty, L. R. Sherrod, N. Garnezy, & M. Rutter (Eds.), *Stress, risk, and resilience in children and adolescents: Processes, mechanisms, and interventions*. New York: Cambridge University Press.
- Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A research note. *Journal of Child Psychology and Psychiatry*, 38, 581-586.
- Goodman, R. (1999). The extended version of the Strengths and Difficulties Questionnaire as a guide to psychiatric caseness and consequent burden. *Journal of Child Psychology and Psychiatry*, 40, 791-799.
- Gopfert, M., Webster, J., & Seeman, M. V. (Eds.). (1996). *Parental psychiatric disorder: Distressed parents and their families*. New York: Cambridge University Press.
- Handley, C., Farrell, G. A., Josephs, A., Hanke, A., & Hazelton, M. (2001). The Tasmanian children's project: The needs of children with a parent/carer with a mental illness. *Australian and New Zealand Journal of Mental Health Nursing*, 10, 221-228.
- Harvey, J., & Delfabbro, P. H. (2004). Psychological resilience in disadvantaged youth: A critical overview. *Australian Psychologist*, 39(1), 3-13.
- Hinshaw, S. P. (2005). The stigmatization of mental illness in children and parents: Developmental issues, family concerns, and research needs. *Journal of Child Psychology and Psychiatry*, 46(7), 714-734.
- Howard, S., & Johnson, B. (2000). What makes the difference? Children and teachers talk about resilient outcomes for children at risk. *Educational Studies*, 26(3), 321-338.

- Howard, S., Dryden, J., & Johnson, B. (1999). Childhood resilience: Review and critique of literature. *Oxford Review of Education*, 25(3), 307-324.
- Kessler, R. C., Anthony, J. C., Blazer, D. G., Bromet, E., Eaton, W. W., Kendler, K. et al. (1997). The US National Comorbidity Survey: Overview and future directions. *Epidemiologia e Psichiatria Sociale*, 6, 4-16.
- King, K. A., Vidourek, R. A., Davis, B., & McClellan, W. (2002). Increasing self-esteem and school connectedness through a multidimensional mentoring program. *Journal of School Health*, 72(7), 294-300.
- Lees, R., & Chovil, N. (2006). Adult mental health and addictions clients with children. *Provincial Working Group on Supporting Families with Parental Mental Illness*.
- Little, M., Axford, N., & Morpeth, L. (2004). Research review: Risk and protection in the context of services for children in need. *Child and Family Social Work*, 9, 105-107.
- Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guidelines for future work. *Child development*, 71(3), 543-562.
- Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, 56(3), 227-238.
- Masten, A. S., & Coatsworth, J. D. (1998). The development of competence in favorable and unfavorable environments. *American Psychologist*, 53(2), 205-220.
- Masten, A. S., Burt, K. B., Roisman, G. I., Obradovic, J., Long, J., & Tellegen, A. (2004). Resources and resilience in the transition to adulthood: Continuity and change. *Development and Psychopathology*, 16, 1071-1094.

- Maybery, D., J. (2005). *Kids Coping Scale*. Unpublished manuscript, Charles Sturt University, Wagga Wagga, NSW, Australia.
- Mayberry, D. J., Goodyear, M. E., & Reupert, A. E. (2005, September). *Measuring connections, problems, and coping in 8-12 year old children whose parents have a mental illness*. Paper presented at From Parents to children: The impact of parental mental illness on children. Athens, Greece.
- Maybery, D. J., Ling, L., Szakacs, E., & Reupert, A. E. (2005). Children of a parent with a mental illness: Perspectives on need. *Australian e-Journal of Mental Health*, 4(2) 1-11.
- Maybery, D., Reupert, A., Patrick, K., Goodyear, M., & Crase, L. (2005). *VicHealth research report on children at risk in families affected by parental mental illness*. Melbourne: Victorian Health Promotion Foundation.
- Milling-Kindard, E. (1998). Methodological issues in assessing resilience in maltreated children. *Child Abuse and Neglect*, 22(7), 669-680.
- Mishna, F., & Antle, B., & Regehr, J. (2004). Tapping the perspective of children. *Qualitative Social Work*, 3(4), 449-468.
- Mordach, E. & Hall, W. A. (2002). Children living with a parent who has a mental illness: A critical analysis of the literature and research implications. *Archives of Psychiatric Nursing*, 16, 208-216.
- Mowbray, C. T., Bybee, D., Oyserman, D., Allen-Meares, P., MacFarlane, P., Hart-Johnson, T. (2004). Diversity of outcomes among adolescent children of mothers with mental illness. *Journal of Emotional and Behavioral Disorders*, 12(4), 206-221.

- Mowbray, C.T., & Oyserman, D. (2003). Substance abuse in children of parents with mental illness: Risks, resiliency, and best prevention practices. *Journal of Primary Prevention, 23*(4), 451-482.
- Mufson, L., Gallagher, T., Dorta, K. P., & Young, J. F. (2004). A group adaptation of interpersonal psychotherapy for depressed adolescents. *American Journal of Psychotherapy, 58*(2), 220-38.
- Nicholson, J., Larkin, C., Simon, L., & Banks, S. (2001). The prevalence of parenting among adults with mental illness. Working paper, Center for Mental Health Services Research, Department of Psychiatry, University of Massachusetts Medical School.
- Orel, N. A., Groves, P. A., & Shannon, L. (2003). Positive connections: A program for children who have a parent with a mental illness. *Child and Family Social Work, 8*, 113-122.
- Ostman, M., & Hansson, L. (2002). Children in families with a severely mentally ill member: Prevalence and needs for support. *Social Psychiatry and Psychiatric Epidemiology, 37*, 243-248.
- Phelan, J. C., Link, B. G., Stueve, A., & Pescosolido, B. A. (2000). Public conceptions of mental illness in 1950 and 1996: What is mental illness and is it to be feared? *Journal of Health and Social Behavior, 41*, 188-207.
- Phillips, S. D., Burns, B. J., Wagner, H. R., Kramer, T. L., & Robbins, J. M. (2002). Parental incarceration among adolescents receiving mental health services. *Journal of Child and Family Studies, 11*(4), 385-399.

- Pitman, E., & Matthey, S. (2004). The smiles program: A group program for children with mentally ill parents or siblings. *American Journal of Orthopsychiatry*, 74, 383-388.
- Polkki, P., Ervast, S. A., & Huupponen, M. (2004). Coping and resilience of children of a mentally ill parent. *Social Work in Health Care*, 39(2), 151-163.
- Prilleltensky, I., Nelson, G., & Peirson, L. (2001). The role of power and control in children's lives: An ecological analysis of pathways toward wellness, resilience, and problems. *Journal of Community & Applied Social Psychology*, 11, 143-158.
- Public Health Agency of Canada. (2002). *A report on mental illnesses in Canada*. Retrieved November 22, 2004, from http://www.phac-aspc.gc.ca/publicat/miic-mmhc/chap_1_e.html.
- Rak, C. F., & Patterson, L. E. (1996). Promoting resilience in at-risk children. *Journal of Counseling & Development*, 74(4), 368-374.
- Reinherz, H. Z., Giaconia, R. M., Carmola, A. M., Wasserman, M. S., & Silverman, A. B. (1999). Major depression in the transition to adulthood: Risks and impairments. *Journal of Abnormal Psychology*, 108, 500-510.
- Rosenbaum, C.L., Lafreniere, J.N., & Sutton, K. (2000). Peer group counseling: An intervention that works. *Guidance & Counseling*, 15(2), 2-8.
- Rousseau, C., Drapeau, A., Lacroix, L., Bagilishya, D., & Heusch, N. (2005). Evaluation of a classroom program of creative expression workshops for refugee and immigrant children. *Journal of Child Psychology and Psychiatry*, 46(2), 180-185.
- Rutter, M. (1981). Stress, coping and development: Some issues and some questions. *Journal of Child Psychology and Psychiatry*, 22, 323-356.

- Rutter, M. (1999). Resilience concepts and findings: Implications for family therapy. *Journal of Family Therapy*, 21(2), 119-144.
- Spatz, K., & Johnson, E. (1973). Internal consistency of the Coopersmith Self-Esteem Inventory. *Educational and Psychological Measurement*, 33, 875-876.
- Steer, S. (2006). *The psychometric properties of the Kids Coping Scale: An analysis of the factor structure and factor consistency of a new measure of children's coping*. Unpublished doctoral dissertation, Charles Sturt University, Wagga Wagga, NSW, Australia.
- Tanner, D. (2000). Crossing bridges over troubled waters: Working with children of parents experiencing mental distress. *Social Work Education*, 19(3), 287-297.
- Tebes, J. K., Kaufman, J. S., Adnopoz, J., & Racusin, G. (2001). Resilience and family psychosocial processes among children of parents with serious mental disorders. *Journal of Child and Family Studies*, 10(1), 115-136.
- Todis, B., Bullis, M., Waintrup, M., Schultz, R., & D'Ambrosio, R. (2001). Overcoming the odds: Qualitative examination of resilience among formerly incarcerated adolescents. *Exceptional Children*, 68(1), 119-139.
- Ungar, M. (2003). Qualitative contributions to resilience research. *Qualitative Social Work*, 2(1), 85-102.
- Weersing, V. R., & Weisz, J. R. (2002). Community clinic treatment of depressed youth: Benchmarking usual care against CBT clinical trials. *Journal of Consulting and Clinical Psychology*, 70(2), 299-310.
- Werner, E. E. (1995). Resilience in development. *Current Directions in Psychological Sciences*, 4(3), 81-86.

- Werner, E. E. (2004). Journeys from childhood to midlife: Risk, resilience, and recovery. *Pediatrics*, 114(2), 492.
- Werner, E. E., & Johnson, J. L. (2004). The role of caring adults in the lives of children of alcoholics. *Substance Use & Misuse*, 39(5), 699-720.
- Young, E. A., Abelson, J. L., Curtis, G. C., & Nesse, R. M. (1997). Childhood adversity and vulnerability to mood and anxiety disorders. *Depression and Anxiety*, 5, 66-72.

Appendix A



Gordon Richter
 School of Graduate Studies
 Trinity Western University
 7600 Glover Rd.
 Langley, BC, V2Y 1Y1

Dear facilitator:

We would like to invite you to participate in an effectiveness evaluation of the Kids in Control Program being conducted between October of 2005 and March of 2006. The program's ability to achieve some of its primary goals such as promoting knowledge of mental illness, the use of effective coping skills, self-esteem, and ultimately resilience in children who have a parent with a mental illness will be evaluated. The evaluation will feature two phases. The first phase will involve the administration of a set of questionnaires on three occasions. The second phase will involve interviews with a few of the children who participated in the first phase of the evaluation.

Time Commitment

The questionnaires in the first phase of the study can be administered in 20 to 30 minutes. The questionnaires will be administered on three occasions. The questionnaires will be administered during the first group session, the last group session, and at the two month follow-up reunion. The interviews in the second phase of the study should not require much additional time on your behalf. You may be asked to help in the selection of participants to be interviewed.

Materials

We will provide you with the following:

- Parent / guardian information letters
- Parent / guardian informed consent forms
- Parent / guardian demographic questionnaires
- Participant information letters.
- Participant informed assent forms.
- Questionnaires.
- Mailing materials (envelopes, stamps, etc.)
- Envelopes containing debriefing letters and research inducements.

If there is anything else that you need, please let us know.

Duties & Responsibilities

As a participating facilitator, you would be expected to do the following:

- Hand out information letters, informed consent forms, and demographic questionnaires to the participants' parents or guardians, at or prior to the first group session.
- Once the participant's parent or guardian has given his or her consent (by returning his or her signed informed consent form), you may give an information letter and informed assent form to the participant. These letters and forms must be delivered and returned at or prior to the first group session in order for the child to be eligible to participate in the study.
- Ensure that parents / guardians and participants understand the purpose of the study, the consent / assent forms, their rights as participants, and so on. This information is laid out in the letters that will be provided to participants and their parents / guardians. We would like you to attempt to answer any questions that participants ask. You may contact us if participants raise any questions or concerns that you cannot answer or address.
- Ensure that a facilitator or co-facilitator is present when participants are completing their questionnaires. Monitor participants for verbal and non-verbal indications of distress and respond appropriately. Help participants who are having trouble reading or understanding items. Remind participants of their right to stop participating (if they appear to be experiencing significant distress). You can also respond to any distress using whatever counselling skills or debriefing procedures you would normally use.
- All forms and questionnaires will be labelled with a coding number. The code number will contain a number for the group, a number for the individual participant, and a number indicating the questionnaire's position in the administration sequence (A = first group session, B = last group session, and C = two month reunion). Please ensure that parents / guardians and participants receive forms and questionnaires with the same coding number. Please ensure that the set of questionnaires handed out in a given session are those intended for that administration day. Please collect consent forms and questionnaires directly from participants and do whatever you can to ensure that participants' information and responses are kept confidential. Please do not allow other children, staff, etc. to view the participants' responses.
- Hand out questionnaires to children participating in the study at the beginning of the first session. Provide quiet alternative activities for any

children who are not participating in the study. Collect the questionnaires when the participants are done.

- Hand out questionnaires during the last group session. Please complete all program content and objectives (that you intend to cover) prior to handing out the questionnaires. If you normally use the debriefing questions found in the manual, please use them. We would appreciate it if you would use our questionnaires in place of the standard evaluation form. You may give the standard evaluation form to children who are not participating in the study. Collect the questionnaires when the participants are done.
- Schedule the 8 week reunion (if you intend to hold one) prior to the last session of the program. Provide a verbal or written reminder to participants in the week prior to the reunion. Since our information letters assume that you will be holding an eight week reunion group session, please let participants and their parents / guardians know as soon as possible if you decide not to offer a reunion group session.
- Hand out questionnaires for the third time during the 8 week reunion session (if you offer one). Please hand out the questionnaires at the beginning of this session. Provide quiet alternative activities for children who are not participating in the study. Collect the questionnaires when the participants are done.
- When participants finish completing the questionnaires at the reunion session (or last group session if you are not planning to hold a reunion session) please give each one an envelope containing a debriefing letter and their research inducement.
- If you offer another group between January and March of 2006 we would like you to participate in one additional way. We would like to use children participating in the program between January and March of 2006 as a comparison group. We would be asking you to repeat the procedures outlined in the first six bullets above. The control group would only fill out the questionnaires once (during the first session).
- Keep the completed consent / assent forms and questionnaires in a locked file cabinet or other secure place until they can be returned to the researchers.
- Return the completed forms and questionnaires to the researchers. Researchers will either pick these documents up in person or provide you with the necessary mailing information and materials.

- Your input may be solicited in the selection of participants for the interview phase of this study.
- Complete the Facilitator & Site Information Questionnaire.
- Complete the Program Content Coverage Checklist (Recommended)
- On our debriefing forms we have indicated that participants who do not have computers to check our website can contact you if they would like to hear about the results of our study. If you do not wish to be contacted by participants for this information please tell them to ignore that part of the debriefing letter.

Confidentiality

Any information that you provide about yourself, your site, your administration of the Kids in Control program, or anything else related to this study will be kept confidential. Neither your name nor any of your identifying information will be used in data sets, presentations, or publications made using data collected during this study. Even though the outcomes for children participating in different groups may be compared, the specific sites and facilitators will not be identified. The information that you provide will not be disclosed to your supervisors, coordinators, employers, etc.

Risks & Benefits

Even though our intention is to evaluate the Kids in Control program and not its facilitators, you may feel at some times as if we are evaluating you. Since one of your jobs / duties is running the Kids in Control program, the results of this effectiveness study could have either positive or negative repercussions for your professional practice and/or employment. The research will give you valuable information about the effectiveness of the Kids in Control program. It may even contribute to improving the program. It may help you, your organization's, and your funders' ability to make decisions about whether or not to implement the Kids in Control program in the future. By participating in this study you will be helping to bring research attention to the Kids in Control program and to the work that you do as a facilitator in this program.

Results

The data collected during this study will be used in the writing of two Master's thesis projects at Trinity Western University. Information about our results and findings will be available by the fall of 2006. We also hope to publish these studies as a mixed methods study in a peer reviewed journal at some point in the future. As participating facilitators in this study you will be informed about the findings of our research. If you would like to check on our progress or results

then you may visit our website <http://www.cm.nu/~phoenix/research/kic.html> at any time.

Questions & Contact Information

If you would like any further information please contact Gordon Richter (604)-???-???? by e-mail at Gordon.Richter@agape.twu.ca or Rob Taylor (604)-???-???? by e-mail at ???@telus.net You can also contact our supervisor Dr. Rob Lees ???-???? or by e-mail at ?@gov.bc.ca

Thank you for your interest in participating in our study. Your time and effort is greatly appreciated.

Yours Respectfully,
Gordon Richter & Rob Taylor

September 26, 2005

FACILITATOR CONSENT: CONSENT TO PARTICIPATE

Project Title: Evaluating the Effectiveness of Kids in Control (Part 1)

a) I, (a Kids in Control group facilitator or co-facilitator) have read and understood the information sheets provided by the researchers about this research, and any questions I have asked have been answered to my satisfaction.

b) I agree that the research data collected for the study may be published or provided to other researchers on the condition that my name is not used, and that I cannot be identified in any other way.

c) I acknowledge that my responses may be put in an anonymous form and kept for further analysis after this study is completed.

d) I will take steps to safeguard the confidentiality of the children in my group who participate in the study. I will not share participants' information or responses with anyone other than the researchers.

e) A copy of the information sheets for this project have been provided to me to keep.

f) If you have any questions about ethical issues involved in this project you may contact Ms. Sue Funk in the Office of Research at 604-513-2142.

Please check one of the responses:

1. _____ I have read and understand the description of the study and I willingly consent to participate in this study.

Signature: _____

Date of signature: _____

OR

2. _____ I do not consent to participate in this study.

Site code: _____
(researchers to complete)

Appendix B

Facilitator & Site Information Questionnaire

1. Where in BC was your group offered? _____
2. What organization (if any) supported the running of your group? (please circle)

3. How many children (total) were in your group when you started?

4. How many children completed the entire program? _____
5. How many people (facilitators, co-facilitators, etc.) were involved in running your group (including yourself)? _____
6. Did your group include a facilitator or co-facilitator who had experienced parental mental illness as a child? (please circle) Yes No
7. On what date did your group have its first session? (dd/mm/yyyy)

8. Did you hold an 8 week reunion for your group? Yes No
9. If yes, what was the date for the reunion?

10. Your gender: (please circle) Female Male
11. Your education & Training (include most relevant education and training)

12. How many times have you facilitated the Kids in Control program (NOT including the group involved in this study. A reasonable estimate would be acceptable)?

13. Answer the following questions if you had a co-facilitator.
 - a) Gender: (please circle) Female Male
 - b) Education & Training (include most relevant education and training)

c) How many times has he or she co-facilitated the Kids in Control program?
(NOT including the group involved in this study. A reasonable estimate would be acceptable)?

Appendix C

Program Content Coverage Checklist

The present study represents an effectiveness evaluation of the Kids in Control program. Effectiveness studies do not require strict adherence to the manual. It is anticipated that facilitators will tailor the program to suit the needs of their unique group of children and the real world conditions under which they conduct the program. Nevertheless, it would be helpful to get a sense of the degree of treatment fidelity at the various sites. In other words, how much of the program content outlined in the manual is covered and in what fashion it is covered. We are interested in identifying the most frequently included and excluded elements. The following is not meant as an evaluation of your ability or competence in running the program. If you are willing to participate then please complete the following checklist. For each of the items below please indicate whether you addressed the objective using activities, methods, and means laid out in the manual, addressed them using other activities, methods, or means not specified in the manual, or did not cover them at all due to lack of relevance, time, and so on. The items are organized by session for convenience and clarity only. Please indicate every content areas you covered regardless of when you covered it.

In this group we used activities, methods, and means from (KM = the Kids in Control Facilitator's Manual, OS = Other Sources, or NA = Not applicable or Not covered) to help participants accomplish each of the following (please circle the appropriate letter beside each item)

Session #1

- KM OS NA Feel safe in an unfamiliar setting
- KM OS NA Experience a sense of belong
- KM OS NA Establish group rules
- KM OS NA Create an identity as a group
- KM OS NA Get to know one another
- KM OS NA Recognize their ability to make decisions that have an impact

Session #2

- KM OS NA Increase their awareness of basic feelings
- KM OS NA Increase their vocabulary of basic feeling words
- KM OS NA Learn that it is possible to control their feelings
- KM OS NA Learn that their feelings are important
- KM OS NA Learn that all feelings are acceptable

Session #3

- KM OS NA Learn what roles and responsible they should take
- KM OS NA Learn what roles and responsible they should not take
- KM OS NA Learn appropriate ways of communicating feelings
- KM OS NA Learn that mental illness is not their fault

KM OS NA Learn that mental illness is not anyone else's fault
 KM OS NA Learn about defences

Session #4

KM OS NA Learn factual information about mental illness
 KM OS NA Understand what causes mental illness
 KM OS NA Understand the physiological basis of mental illness
 KM OS NA Learn the terminology associated with mental illness
 KM OS NA Verbalize difficulties that the mental illness causes them

Session #5

KM OS NA Learn factual information about hospital treatment
 KM OS NA Learn about medications and how they work
 KM OS NA Learn about other treatments for mental illness

Session #6

KM OS NA Learn about what it means to be resilient
 KM OS NA Discover their own experiences of resilience
 KM OS NA Develop tools that increase resilience
 KM OS NA Learn what things they can control
 KM OS NA Increase awareness of resources and how to access them
 KM OS NA Recognize some personal worth and strengths

Session #7

KM OS NA Recognize and refute myths about mental illness
 KM OS NA Understand how stigma impacts the mentally ill and their families
 KM OS NA Explore personal feelings regarding attitudes towards parents with a mental illness
 KM OS NA Deal with personal feelings of shame / guilt

Session #8

KM OS NA Understand the importance of taking care of themselves
 KM OS NA Learn ways to affirm and value the self
 KM OS NA Identify their unique / special traits
 KM OS NA Recognize the special traits of others

Appendix D



Gordon Richter
 School of Graduate Studies
 #337 Northwest Building
 Trinity Western University
 7600 Glover Rd.
 Langley, BC, V2Y 1Y1
 E-mail: Gordon.Richter@agape.twu.ca

Dr. Rob Lees (Supervisor)
 C/O Counselling Psychology Department
 Trinity Western University
 7600 Glover Rd.
 Langley, BC, V2Y 1Y1
 Phone: ???-????
 E-mail: ???@gov.bc.ca

Project Title: *Evaluating The Effectiveness of Kids In Control (Part 1)*

Dear Parent / Guardian:

As the Kids in Control (KIC) group approaches its 10th anniversary, two researchers from Trinity Western University, Gordon Richter and Rob Taylor, under the supervision of Dr. Rob Lees, are conducting an effectiveness study of this program.

Mental health problems in children appear to be becoming more common and it is now recognized that early intervention (in childhood) can help alleviate problems in adult life. The project in which you and your child are invited to participate aims to investigate the effectiveness of the Kids in Control program. The researchers would like to determine whether or not the program is beneficial to children and how it could be improved for children in the future. The research may also help researchers to better understand the needs of children, to design better interventions to help them, and to improve the measures we use for studying them.

We would like children in the 8 to 13 years age groups to voluntarily participate in the study. Your child will receive a package of short questionnaires on three occasions; in the first session, the last session, and at the 8-week reunion. The survey will take approximately 20 to 30 minutes on each occasion. The survey will look at several areas of functioning targeted by the program. The survey will cover your child's basic knowledge and understanding of mental illness, how they cope with problems, and how they think and feel about themselves. Sometimes unfamiliar testing situations can make some children uncomfortable. If your child experiences distress for any reason while filling out these surveys, the facilitator will be present to respond appropriately to his or her needs.

You and your child's identity will be kept strictly confidential. The informed consent forms and questionnaires will be linked by a coding number known only by the researchers. Any data sets, reports, articles, and so on created using data collected during this study will not contain any identifying information about the participants.

The consent forms and questionnaires involved in the study will be handed out and collected by the group facilitators who will keep them securely until they are transferred to the student researcher named at the top of this letter. The student researcher will keep the consent forms and questionnaires in a locked file cabinet in his home residence. The information from the questionnaires will be converted into a computerized data set stored on a secure computer. The consent forms, questionnaires, and data set will be kept for a minimum of five years. The information will be used for the purposes described above. The research is being conducted for a Master of Arts in Counselling Psychology thesis.

It is important to note that even if you give permission for your child to be involved in the study, assent will also be sought from your child before he or she participates in the research. Children have the right to withdraw from the study at any time. No disadvantage or penalty will occur should you decide that your child is not to be involved in the study, nor will there be any penalty if your child decides to withdraw from the study. While participation is voluntary we do encourage your involvement in the study. By participating in this research, your child will feel valued and respected for his or her contribution to the evaluation and improvement of the Kids in Control program for future groups. They will also receive \$15.00 as an incentive for their participation which will be awarded to them after completing the questionnaires on the third and final occasion (8-week reunion).

Some children who participate in this phase of the study will be invited to participate in a second phase. The second phase will involve interviews conducted after the end of the Kids in Control program. If your child is selected to receive an invitation to this second phase you will receive an additional information letter and consent form. By giving your consent for your child to participate in this phase of the study, you are not committing yourself or your child to the second phase.

If you are willing to allow your child to be involved in this study please complete the attached consent form and return it to the person running your child's group as soon as possible. Along with the consent form you should have received a short demographic survey. Please answer as many of these demographic questions as you are comfortable answering. The demographic information is completely optional and you do not need to complete it in order for your child to participate in this research.

If you have any questions about ethical issues involved in this project you may contact Ms. Sue Funk in the Office of Research at 604-513-2142.

If you have any other concerns or questions about the study you may contact any of the researchers named at the top of this letter.

Thank you for taking the time to read this letter and for considering participating in this study.

This letter is yours to keep for your records and reference.

Yours Respectfully,
Gordon Richter

September 26, 2005

PARENT/GUARDIAN CONSENT FORM: CONSENT TO PARTICIPATE

Project Title: *Evaluating the Effectiveness of Kids In Control (Part 1)*

a) I, (the participant's parent/guardian) have read (or where appropriate, have had read to me) and understood the information sheet provided by the researchers about this research, and any questions I have asked have been answered to my satisfaction.

b) I agree to allow my child/ren (name/s:.....) to participate in this research, realizing that I may withdraw any or all of my child/ren at any time, without prejudice to myself or my child/ren.

c) I agree that the research data collected for the study may be published or provided to other researchers on the condition that my (child's) name is not used, and that I (he/she) cannot be identified in any other way.

d) I acknowledge that my child's responses may be put in an anonymous form and kept for further analysis after this study is completed.

e) A copy of the information sheet for this project has been provided to me to keep.

f) If you have any questions about ethical issues involved in this project you may contact Ms. Sue Funk in the Office of Research at 604-513-2142.

Please check one of the responses:

I have read and understand the description of the study and I willingly consent to my child's participation in this study.

Signature:

Date of signature.....

OR

2._____I do not consent to my child's participation in this study.

Code: _____
(Researchers to place code here)

Appendix E

Demographic information

As outlined in the information sheet, we are collecting some basic information about the family situation or circumstances of the children participating in this research. Please answer as many of the following questions as you feel comfortable answering. Remember you do not need to answer these questions in order for your child to participate in this study.

1. How would you describe the child's ethnicity / cultural background?

2. How many siblings does the child have? Younger _____
Older _____

Since the Kids in Control program is intended for children who have a parent / caregiver with a mental illness, we assume that at least one of the child's parents or caregivers has some form of mental illness. If this assumption is incorrect, please ignore the rest of these questions.

3. Does the child have a biological parent who has been diagnosed with a mental illness?

Yes No

4. Does the child have a non-biological parent / caregiver who has been diagnosed with a mental illness?

Yes No

5. Does the child have more than one parent / caregiver who has been diagnosed with a mental illness?

Yes No

6. Does the child currently live with the parent / caregiver who has been diagnosed with a mental illness?

Yes No

7. What mental illness have the parent(s) / caregiver(s) been diagnosed with?
(check all that apply)

☐ Major Depression

- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Substance Abuse Disorder

- ☐ Personality Disorder(s)
- ☐ Anxiety Disorder(s)

☐ Other _____

Appendix F



Gordon Richter
 School of Graduate Studies
 #337 NWB
 Trinity Western University
 7600 Glover Rd.
 Langley, BC, V2Y 1Y1
 E-mail: Gordon.Richter@agape.twu.ca

Dr. Rob Lees (Supervisor)
 C/O Counselling Psychology Department
 Trinity Western University
 7600 Glover Rd.
 Langley, BC, V2Y 1Y1
 Phone: ???-????
 E-mail: ???@gov.bc.ca

Title: *Evaluating the Effectiveness of Kids In Control (Part 1)*

Hello,

We would like to find out if the Kids in Control program is helping kids like you. The people who made up Kids in Control wanted to help kids with their problems and to make things better for them. We want to see if Kids in Control is doing a good job and to make it better. To do this we are going to be asking kids questions. We would like you to help us with our research.

It's up to you to decide if you would like to be a part of this research - it's your choice. You can even choose to stop being a part of it at any time. If you decide to take part in our research, no one will be able to tell that you filled out the forms - we will keep it private. When you have filled out the forms they will be collected by the person in charge of your group and given to one of the people whose name is at the top of this letter. No one else will see them. The forms will be kept in a safe place for the next few years.

The survey will take you about 20 to 30 minutes to fill out. You will be asked to fill out the survey on three different days. The first time will be before the group starts. The second time will be when the group is over. The third time will be at the two month reunion. You will be asked questions about what you know about mental illness, how you deal with problems, and how confident and happy you are. It's not a test, so you don't have to worry about getting the answers right or wrong.

If answering the questions makes you worry about things or makes you feel upset, you can talk to the person in charge of your group. Remember, you can

choose to stop being a part of the research at any time. No one will be upset with you.

To thank you for taking the time to be involved in our research you will be given \$15.00

If you have any questions you can talk to the person who is in charge of your group. If the person in charge of your group cannot answer your question you can talk to one of the people whose names are at the top of this letter. This letter is for you to keep.

Sincerely,
Gordon Richter

ASSENT TO PARTICIPATE

Title: *Evaluating the Effectiveness of Kids In Control (Part 1)*

I _____ (please print your name) agree to take part in this study about how well Kids in Control works. My parent/ caregiver has agreed for me to take part in the research. I understand that I will be asked to answer questions about mental illness, how I handle problems, and how I see myself. I understand that I don't have to answer any questions if I don't want to answer them. I won't get into trouble if I choose not to answer a question or if I stop taking part in the study.

I have been given a letter about the study. I have read it or had it read to me. I have asked all the questions I wanted to ask and I am happy with the answers I have been given. I know what the researchers want me to do and I am willing to do it. I understand that my answers will be kept private. That means that no one will know where the information came from and no one will be able to connect it to me. My information will be kept in a safe place for the next few years and used to develop and improve programs for children.

Signature.....

Date signed.....

How old are you? _____

What is your birthday? ____/____/____

Gender: Male Female
(please circle)

Code number.....
(Researchers to place parent code here)

KIDS COPING SCALE
WHEN YOU HAVE HAD A PROBLEM OR SOMETHING
HAS GONE WRONG, WHAT DID YOU DO?

Please circle HOW OFTEN you did the following?:

1. <i>You tried to think of different ways to solve the problem</i>	Never	Some times	A lot
2. <i>You did not want to think about it</i>	Never	Some times	A lot
3. <i>You thought about what others might do</i>	Never	Some times	A lot
4. <i>You tried your best to make things better</i>	Never	Some times	A lot
5. <i>You avoided the problem or where it happened</i>	Never	Some times	A lot
6. <i>You asked someone to help</i>	Never	Some times	A lot
7. <i>You tried hard to fix the problem</i>	Never	Some times	A lot
8. <i>You did things to stop thinking about it</i>	Never	Some times	A lot
9. <i>If it was your fault you would say that you were sorry</i>	Never	Some times	A lot

Appendix H
Kids Knowledge

For each question please circle either True or False
(This is not a test)

1. All mental illnesses have the same symptoms.

TRUE FALSE

2. Mental illness can happen when messages from the brain get jumbled up or lost.

TRUE FALSE

3. When someone has a mental illness there is nothing that can be done to help them.

TRUE FALSE

4. People who have schizophrenia find it hard to tell what is real and what is not real.

TRUE FALSE

5. Mental illness can make someone get angry for no reason.

TRUE FALSE

6. The brain uses chemicals and electricity to send messages to different parts of the body.

TRUE FALSE

7. A mental illness can be caught like a cold.

TRUE FALSE

8. Not being able to sleep even when really tired can be a symptom of depression.

TRUE FALSE

9. Bi-polar disorder is a disease that affects a person's moods.

TRUE FALSE

10. Medicine is the only kind of treatment for mental illness.

TRUE FALSE

11. Mental illnesses often happens when chemicals in the brain get out of balance.

TRUE FALSE

12. People who have a mental illness are not as smart as other people.

TRUE FALSE

13. Seeing things that other people cannot see may be a symptom of schizophrenia.

TRUE FALSE

14. One person can cause another person to have a mental illness.

TRUE FALSE

15. When someone has a mental illness, it is his or her own fault.

TRUE FALSE

16. People who have bi-polar disorder are very sad all of the time.

TRUE FALSE

17. People who have a mental illness will never have any friends.

TRUE FALSE

18. Most people who have a mental illness are dangerous.

TRUE FALSE

19. People who have a mental illness can learn ways to take care of their symptoms.

TRUE FALSE

20. Having a phobia of rabbits means that you really like them.

TRUE FALSE

Appendix I



Trinity Western University
7600 Glover Rd.
Langley, BC, V2Y 1Y1

Debriefing

Thank you for taking the time to answer our questions.

We will now be looking at what everyone said about Kids in Control to see if it helps kids like you.

There is a lot of stuff to look over, so it will take us a while. We might not be done until next fall (September, 2006). If you would like to know what we find out you can visit our website <http://www.cm.nu/~phoenix/research/kic.html> at any time. The website should be up and running until at least the spring of 2007. If you don't have a computer then you can get information by talking to the man or woman who ran your group.

If you have any questions or concerns please visit our website or contact Gordon Richter by e-mail at Gordon.Richter@agape.twu.ca

Thanks again for your help!

Sincerely,

Gordon Richter