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Research Article

# Promoting mental health and wellbeing for a young person with a mental illness: Parent occupations

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***Background/aims*:** *Parenting is a critical and complex occupational role, requiring different occupations and abilities depending on the developmental stage and specific characteristics of each child. When a young adult child develops a mental illness, assisting and supporting them to overcome or adapt to the mental illness becomes a crucial aspect of this occupational role to which many parents devote a great deal of time and energy. The way parents respond to mental illness can have an important impact on young people. However, to date, research on these parents has focussed almost exclusively on their characteristics and personal coping rather than what they do to try to assist and support young people. The aims of this study were to identify the occupations parents currently engage in to promote mental health and wellbeing for a young person with a mental illness and to explore the perceived helpfulness of these occupations.*

***Method*:** *Interviews with 26 young people (15–24 years old) and 32 parents were analysed using constant comparative analysis.*

***Results*:** *Participants reported 78 conceptually distinct mental illness related occupations aimed at promoting: appropriate treatment; positive activities and actions; positive thoughts and feelings; and an ordinary life. Importantly, few participants could evaluate with confidence the helpfulness of individual mental illness related occupations.*

***Conclusion*:** *This research demonstrates the breadth of the mental illness related occupations parents employ and provides a framework for understanding their complexities. It highlights the need to establish an evidence base for various mental illness related occupations so that parents can have more knowledge and thus confidence in these critical occupations.*

**KEY WORDS** *adolescent, caregivers, mental disorders, qualitative, social support, young adult.*

## Introduction

An increasing majority of young people live with their parents until at least 24 years of age (Australian Institute of Health & Welfare, 2007; United States Census Bureau, 2011). This is also the period of life when first onset of mental illness typically occurs (Kessler *et al*., 2007). Therefore, parents have the potential to be an invaluable natural support for many young people who experience mental illness. Research suggests that a parent's responses to mental illness can have an impact on the young person. This has been evidenced particularly with regard to involvement with professional treatment (e.g. Addington, van Mastrigt, Hutchinson & Addington, 2002; Judge, Perkins, Nieri & Penn, 2005; McFarlane, Dixon, Lukens & Lucksted, 2003), and interpersonal relationships (e.g. Norman *et al*., 2005; O'Brien *et al*., 2008; Stice, Ragan & Randall, 2004).

Current understandings of how parents influence young people with mental illness primarily come from three sources. First, studies of the association between outcomes for young people and parent characteristics or attitudes, such as psychopathology or expressed emotion indicate that parents' influence is strong. For example, living with family members whose reaction to mental illness *does not* involve highly critical attitudes or emotional over-involvement (high expressed emotion) is a strong predictor of reduced relapse across numerous disorders (e.g. Butzlaff & Hooley, 1998; McFarlane, Cook, McFarlane & Cook, 2007). However, this research does not identify what parents actually do; that is, the mental illness related occupations (MIROs) that parents engage in that may explain the relationships between these variables.

Second, a wide range of different family interventions have been demonstrated repeatedly to influence outcomes for adolescents and adults with a range of

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psychiatric diagnoses (e.g. Diamond & Josephson, 2005; Lock, Agras, Bryson & Kraemer, 2005; Lucksted, McFarlane, Downing, Dixon & Adams, 2012; McFarlane *et al*., 2003). However, this research has been silent on how, why or what aspects of the interventions work (Diamond & Josephson; Kazdin & Nock, 2003; Pinsof & Wynne, 2000; Sander & McCarty, 2005). We do not know how interventions such as family psycho-education and family therapy translate into parents modifying their MIROs, nor the extent to which intervention outcomes are attributable to particular changed MIROs.

Third, studies of related areas, such as help-seeking or experiences of illness and caregiving have illuminated some of the occupations parents undertake to help young people. Qualitative studies investigating the experiences of young people with mental illness and their parents have identified numerous MIROs, such as seeking treatment, advocating with health professionals and monitoring medication adherence (Gearing, Mian & Charach, 2008; Gerson *et al*., 2009; Milliken & Rodney, 2003). However, MIROs are incidental to the main foci of these studies and tend to be briefly mentioned or described in relation to the main theme of the article, such as parents' support needs (Sin, Moone & Wellman, 2005). Other research has suggested the usefulness of specific activities often undertaken by parents. In particular, research on help-seeking indicates that parents and other caregivers are the people most likely to initiate treatment-seeking for young people, and that their involvement increases the chances of getting appropriate treatment (Addington *et al*., 2002; Judge *et al*., 2005; McCann, Lubman & Clarke, 2011). However, this research is unable to capture the full scope of parent MIROs. No research to date has identified the complexity and breadth of the occupations involved with parenting a young person in the context of mental illness and the wide variety of ways in which parents actively assist and support these young people.

Parents and other carers are increasingly being viewed as a resource to assist in facilitating recovery for young people with mental illness (Commonwealth of Australia, 2009). Mental health recovery refers to more than just symptom remission and includes the attainment of a meaningful, productive and satisfying life regardless of the presence or absence of reoccurring symptoms (Anthony, 1993). To comprehend and optimise parents as a recovery resource, it is necessary to understand what parents actually do: the scope and diversity of the occupations they engage in to try to support young people with mental illness. This is a fundamental first step towards determining which MIROs are most effective and developing the evidence-based parent guidelines needed and sought by parents (Mental Health Council of Australia, 2010). Focusing on what parents *do* rather than what they *are* suggests greater avenues for positive change and will provide an empirical basis for developing parent guidelines and interventions.

The aims of this study were to identify the MIROs parents currently employ to promote mental health and wellbeing for a young person with a mental illness and to explore the perceived helpfulness of these MIROs.

# Methods

A qualitative approach was adopted to identify the perceptions of young people who have mental illness and their parents. This approach was needed because of the lack of previous research on parent MIROs and the need to explore and understand participants' actions and the meanings attributed to them (Schreiber & Stern, 2001). Human Research Ethics Committees at the University of Sydney and the Area Health Services in which recruitment took place granted ethical approval for the study.

## Recruitment and participants

Eligible young people were 15–24 years old, were being treated for a mental illness and had frequent (at least fortnightly) contact with their parents. Eligible parents were the biological parents or guardians of eligible young people. Because this study sought to map the breadth of parent MIROs, it included young people who were being treated for a range of different mental illnesses. The study used criterion sampling (Patton, 2001), selecting all available volunteers who met the eligibility criteria. All mental health services in the Sydney Metropolitan area that specialised in treating adolescent, youth or first episode mental illness were identified, contacted and asked to assist by informing eligible clients and, where possible, their parents about the study and gaining permission for researchers to contact potential participants. This inclusive sampling technique was used because of well documented difficulty in recruiting young people with mental illness into research studies (Draucker, 2005). Participants were recruited from four mental health services, specialising in treatment of adolescents or young adults, an adolescent outpatient unit at a general hospital, and two university disability services. Participants were 26 young people with mental illness and 32 parents from 28 families, all of whom gave written informed consent. Demographic information about participants is provided in Table 1. Group data only is provided to protect the identity of participants.

## Data collection

Qualitative in-depth interviews were conducted with parents by the first author and with young people by a trained research assistant of a similar age to enhance rapport and participant comfort. Parents were asked to describe their experience of the young person's mental illness with an emphasis on the things that they had done to try to help or support the young person. Young people were asked about how they perceived their parents' attempts to assist them and how these actions

**TABLE 1:** *Participants*

| | |
|---|---|
| Young people | |
| Gender | |
| Male | 9 |
| Female | 17 |
| Age | |
| Mean | 17.4 |
| Range | 15–24 |
| Diagnosis | |
| Psychosis | 8 |
| Mood disorders | 13 |
| Anxiety disorders | 8 |
| Eating disorders | 6 |
| Other diagnoses | 1 |
| More than 1 diagnosis | 8 |
| Time since diagnosis | |
| Less than 1 year | 11 |
| 1–4 years | 9 |
| >4 years | 6 |
| Living arrangements | |
| Living with parent/s | 22 |
| Living independently | 4 |
| Occupation | |
| Secondary school student | 16 |
| University student | 5 |
| Employed full-time | 1 |
| Employed casually (not studying) | 2 |
| Not in employment or education | 2 |
| Parents | |
| Relationship | |
| Biological mothers | 21 |
| Biological fathers | 8 |
| Step-fathers | 1 |
| Biological grandmothers | 2 |
| Age | |
| Mean | 49 |
| Range | 36–66 |
| Living arrangements | |
| Living with young person | 27 |
| Living separately | 5 |
| Married/de-facto | 27 |
| Single/widowed/ divorced | 5 |
| Employment | |
| Full-time | 15 |
| Part-time | 8 |
| Casual | 3 |
| Not employed | 6 |
| Cultural background | |
| Born in Australia | 17 |
| Born overseas (10 different countries) | 15 |
| First language English | 24 |
| First language other | 8 |
| History of mental illness | |
| Yes | 10 |
| No | 21 |
| Unknown | 1 |

affected them. With permission from participants, interviews were audio recorded and transcribed verbatim for detailed analysis. Copies of interview transcripts were sent to participants for verification and correction. No participants made corrections, but one parent provided further thoughts.

### Analysis

Constant comparative analysis was used to analyse interviews (Huebner, Brantley, Nagle & Valois, 2002). This involved inductively coding transcripts and systematically comparing data and codes to ascertain similarities and differences in order to group data into higher level codes. Thus, all identified MIROs represent a number of different but conceptually similar activities. Data from seven interviews were coded by two authors, with codes extensively discussed and agreed upon to enhance validity. All remaining data were coded by the first author, with codes and their groupings reviewed by the other authors.

## Results

Seventy-eight conceptually distinct MIROs were identified. Each is an occupation parents engaged in that was aimed at facilitating the mental health and wellbeing of the young person with mental illness. MIROs are defined as responses to the mental illness above and beyond the typical occupations involved in parenting, given the young person's age and circumstances. The 78 MIROs were distinguishable along two dimensions: the overall purpose they were deemed to serve (or attempted to serve); and the type of action they represented. The framework described below is depicted in Figure 1.

To ensure anonymity, quotes are not associated with any identifying information except participant group and gender.

### Purpose of mental illness related occupations

Parent MIROs were attributed to the four primary purposes of promoting: appropriate treatment; positive activities and actions; positive thoughts and feelings; and an ordinary life.

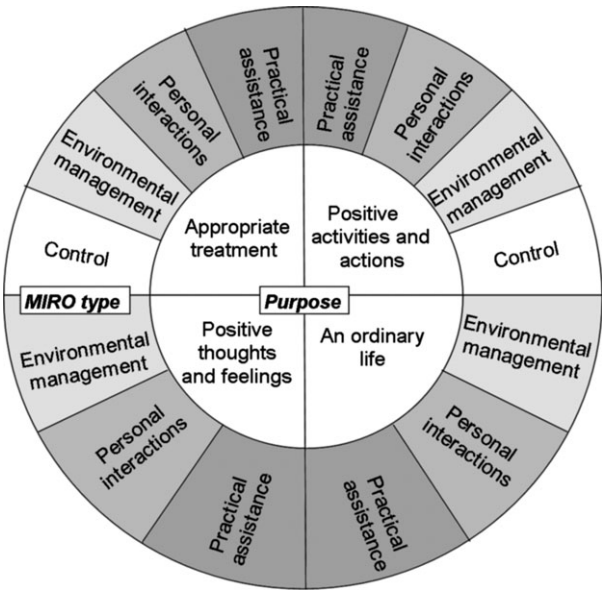


**FIGURE 1:** *Framework for parent mental illness related occupations (MIROs).*

### *Appropriate treatment*

Parents devoted considerable time and energy to obtaining appropriate professional treatment for young people. This included contacting and evaluating relevant services and getting the young person to attend treatment, sometimes despite their reluctance. Parents also sought to influence the treatment itself, for example, by providing information to health professionals or advocating on the young person's behalf.

> "So I finished up taking her back to the community health. And I said I'm staying here until I get help. I'm not leaving." (mother)

> "Just, you know, when I don't feel like talking she'll just be in there and she'll kind of tell the counsellor how I've been, you know." (young woman)

### *Positive activities and actions*

Parents tried to influence young people to engage in activities and behave in ways they saw as beneficial for their mental health or life situation in the context of the mental illness. These desired activities and actions included such things as complying with treatment advice, interacting appropriately with others, attending school, self-care tasks, socialising with peers, seeking employment and using coping strategies.

> "If mum goes to work she'll ring me in the morning to make sure I take my medication and to make sure that I get my sleep." (young woman)

> "Some of the things we tried to get her to school would be 'just go for the day' or 'just go between lunch and recess.'" (mother)

### *Positive thoughts and feelings*

Parents sought to promote feelings such as safety, hope, belonging and self esteem in young people and to help them to think about their illness in helpful and positive ways. They also often tried to minimise or protect young people from experiencing stress and distress, which were seen as exacerbating their difficulties.

> "Assuring him that it's only like a certain time and things will get better. And giving him the message over and over and over and never giving up, that things will be better, this will not be like this forever and things will get better." (mother)

> "He always says nice things about me and stuff so that I feel better about the way I am." (young woman)

> "[My husband] and I just had to play tag team with her, getting her homework done. Cause she just got so uptight and decompensated so much." (mother)

### *Ordinary life*

Parents tried to make daily life as 'normal' as possible for young people by not centralising the illness and allowing it to define their child's existence. A number of parents tried to treat the young person the same as their siblings or focussed on facilitating age-appropriate development and responsibility.

> "Like now she doesn't have a phone … I said well, you've started work at my work. You save your money, you get your own phone. 'Cause I'm not getting you any more phone, because I feel at times that I've been spoon-feeding you too much.'" (mother)

However, sometimes parents also provided additional assistance to bridge the gap between what was needed for an age-typical life and what the young person was able to obtain or do independently.

> "When he moved out we set up a calendar and wrote his work schedule out on it. Got a phone book with everybody's numbers. All of those basic things." (mother)

Whereas most participants reported that parents engaged in occupations relating to each of the above purposes, the relative importance placed on the different purposes varied considerably between families. Some reported similar emphasis on MIROs directed at all four purpose, whereas for others, MIROs emphasised one or two particular areas of concern, such as appropriate treatment or positive thoughts and feelings.

The wide range of factors parents described as influencing the MIROs they chose to and were able to use are beyond the scope of this article and reported elsewhere (Authors, in preparation).

## Types of mental illness related occupations

Parents attempted to achieve their aims using four types of MIROs: practical assistance, personal interaction, environmental management and control.

### *Practical assistance*

Participants described parents providing young people with practical help, additional to what they thought would be needed if the young person had no mental illness. For example, they provided young people with resources such as money, and did things for them, such as driving them to school, doing their housework and organising their appointments.

> "Well they're always taking me to the checkups. They're always making sure I'm there on time. They always make sure that there's enough food in the house that I want to eat kind of thing." (young woman)

> "So they do support me [financially] with my medication. They've tried to make me pay for it a few times but I've refused to take it." (young man)

### *Personal interactions*

Parents tried to use their interactions with young people to communicate particular ideas, for example, by giving advice or suggestions and reassuring or comforting the young person. Many parents also had changed the way they interacted with the young person. Often this involved making an effort to communicate in calmer, less demanding ways, such as reducing nagging and displays of anger or making a greater effort to encourage the young person to talk about their feelings.

> "They kept on saying they care for me and they'll support me. They've been trying to interact with me differently, in a way that suits my emotions better." (young man)

> "Now I don't scream at her … sometimes it comes to me but I try and hold myself back." (mother)

### *Managing the environment*

Parents not only sought to be a positive influence on young people directly, but also to influence the young person's experiences with other people and in other situations. They tried to place the young person in environments that they saw as conducive to good mental health and functioning, and to facilitate positive interactions with other people, for example, by explaining the situation and the sort of support the young person needed.

> "My mum spoke to my sisters. My little brother don't understand much, but they spoke to him. Like they know that I'm sick and wouldn't interfere with me." (young man)

> "So social engagements, having people to dinner, having them around just so she doesn't get too socially isolated, which is what she wants to be." (mother)

### *Control*

Parents sometimes gave young people little choice but to do what parents believed was best. Often this involved simply using parental authority to insist on a course of action, but other methods, such as force or deception were also sometimes used. Whereas participants reported that practical support, personal interactions and environmental management were used for all four purposes, MIROs that involved control related only to young people's treatment and activities.

> "She insisted that there was nothing wrong and 'no I don't want to go [to treatment]'. And I said 'yes, you are going.' And luckily, I mean, I don't know how I fluked it all those times to get her to these places really." (mother)

> "She makes me do things that I don't want to do but she knows I need to do. Like going to see the counsellor and going to school." (young woman)

The specific MIROs identified are listed in Table 2, grouped firstly according to primary purpose, then type of MIRO. Of the 78 MIROs identified, 67 were identified in interviews with both parents and young people, whereas 11 were reported only by parents (identified with †). While it is unusual in qualitative studies to report detailed codes, these are included to depict the breadth of MIROs used and to facilitate future study.

## Helpfulness

Very few individual parents or young people commented with certainty about the helpfulness of the MIROs used. While parents often reported using 'trial and error', this was limited to very short-term outcomes, such as the young person taking medication on a particular occasion or being seen by a health professional.

A small number of MIROs were commonly reported as being unhelpful and consequently changed. These were usually particular types of parent interactions with the young person, such as pushing, nagging, showing anger and other strong negative emotions and being

**TABLE 2:** *Parent mental illness related occupations (MIROs)*

| | |
|---|---|
| Purpose 1. To promote appropriate treatment | |
| Practical assistance | • Searching for appropriate professionals (e.g. suitable qualifications, attitudes and personality) |
| | • Making treatment easy for the young person (e.g. organising, paying for and transporting to treatment) |
| | • Participating in treatment (e.g. family therapy) |
| Personal interactions | • Advising or convincing to attend treatment |
| | • Accompanying to treatment (for support/comfort) |
| Environmental management | • Providing history to health professionals |
| | • Informing professionals about current status and behaviour at home |
| | • Advocating for changes to treatment |
| | • Working with professionals (e.g. contributing to decision making)† |
| | • Seeking assistance from a higher power (e.g. praying) |
| Control | • Insisting on treatment (using parental authority) |
| | • Using force to obtain treatment (e.g. calling an ambulance) |
| | • Using deception to obtain treatment (e.g. getting young person to hospital on pretence of having a 'check up') |
| Purpose 2. To promote positive activities and actions | |
| Practical assistance | • Organising, paying for and transporting to activities (e.g. sport, social) |
| | • Making treatment compliance easy (e.g. administering medication, providing and preparing appropriate and acceptable food) |
| | • Negotiating and rewarding desired behaviour (e.g. with money, presents) |
| Personal interactions | • Reminding (e.g. take medication, use behavioural strategies) |
| | • Suggesting, advising or convincing (e.g. explaining benefits) |
| | • Accompanying (e.g. exercising together) |
| | • Tolerating or ignoring undesirable behaviour† |
| | • Praising positive behaviour |
| | • Modelling behaviour (e.g. complying with medical advice)† |
| | • Overtly monitoring activities (e.g. watching take medications or eat) |
| | • Describing impact of young person's actions on the rest of the family |
| | • Showing strong emotions in relation to behaviour (e.g. fear, anger, distress) |
| | • Criticising, teasing or pressuring about negative behaviour |
| Environmental management | • Recruiting others to advise |
| | • Reducing situations that promote or allow negative behaviours (e.g. not leaving alone, removing medicines, removing environmental rewards for negative behaviour) |
| | • Modifying peer relationships (e.g. not allowing contact with particular friends)† |
| | • Advocating for or providing more suitable environments (e.g. advising or changing schools) |
| | • Grading activities (e.g. hours at school)† |
| Control | • Using authority and insistence to influence behaviour (e.g. go to school, eat, not drink alcohol) |
| | • Using threats (e.g. hospitalisation)† |
| | • Physically controlling behaviour (e.g. force feeding, physical restraint) |
| | • Using deception to influence behaviour (e.g. lying about the fat content of food)† |
| | • Punishing (e.g. taking away phone, grounding) |
| | • Limiting choices (e.g. allowing the young person to choose between 2 acceptable meal options)† |
| Purpose 3. To promote positive thoughts and feelings | |
| Practical assistance | • Providing happy experiences and anticipation (e.g. holidays, treats) |
| | • Assisting with stressful situations (e.g. assignments, advocating with authority figures) |
| | • Helping with stress management techniques (e.g. visualisation) |
| Personal interactions | • Articulating love and concern |
| | • Demonstrating love and commitment through actions (e.g. ongoing availability) |
| | • Reassuring and comforting |
| | • Physical comfort (e.g. hugs, foot massage) |
| | • Reminding young person of their achievements, talents and assets |
| | • Company (e.g. spending time together, developing common interests) |
| | • Distracting from problems (e.g. activities, jokes) |
| | • Encouraging communication about illness, feelings, problems |

**TABLE 2:** (*Continued*)

| | |
|---|---|
| | • Listening to and addressing their requests/issues<br>• Communicating understanding of feelings and situation<br>• Staying calm and withholding own negative emotions (e.g. distress, fear, anger, criticism)<br>• Reducing authoritarianism in day to day interactions (e.g. using polite requests or negotiation rather than insistence)<br>• Giving space (e.g. abstaining from nagging, advice giving, questioning)<br>• Tailoring interactions to current mental state<br>• Acknowledging and apologising for own negative actions<br>• Anticipating stressors and helping prepare (e.g. talking about return to school)<br>• Reasoning and using logic (e.g. that fears aren't real)<br>• Modelling positive attitudes (e.g. acceptance of illness, taking it seriously, confidence in coping and recovery)<br>• Sharing own experiences of mental health issues<br>• Limiting demands and requirements (e.g. for school performance, household tasks)<br>• Encouraging the young person to reduce their expectations (e.g. school)<br>• Being consistent and predictable with rules<br>• Softening controlling strategies (e.g. explaining, sympathising) |
| Environmental management | • Encouraging and advising other people to provide support and positive interactions<br>• Encouraging support-seeking (e.g. from friends)†<br>• Withholding distressing or stressful information†<br>• Modifying the home environment (e.g. avoiding conflict, addressing sibling behaviour) |
| Purpose 4. To promote an ordinary life | |
| Practical assistance | • Assisting with activities of daily living (e.g. cleaning, personal care)<br>• Teaching life skills (e.g. time management, housekeeping)†<br>• Providing resources and financial assistance (e.g. phone, car, paying bills)<br>• Consciously stepping back (e.g. not providing assistance or advice) |
| Personal interactions | • Treating the young person normally (e.g. same as their siblings)<br>• Encouraging age-appropriate activities and routines<br>• Facilitating participation in family decisions<br>• Allowing autonomy in treatment and lifestyle decisions<br>• Tailoring support and involvement in decisions to mental health status |
| Environmental management | • Explaining the situation to other people (e.g. family, teachers – to enable allowances to be made)<br>• Hiding the illness from others (e.g. to avoid the young person being treated differently) |

†Reported by parents only.

strict. These led to arguments and the young person becoming stressed, upset or angry, which was thought by participants to contribute to exacerbation of symptoms.

> "Because I was getting very emotional. When she'd get in trouble I'd just add more fuel to the fire and there would be a volcano." (mother)

For most parents, the MIROs they described feeling most confident about were those that they believed were *likely* to be helpful, often based on advice from a trusted information resource or health professional.

> "That knowledge that they have from all the work that they've done over the years has just been really helpful. Just to have that, I guess the access to that experience and confidence. That's something they can pass on to us and we can sort of then vicariously have some of that authority." (father)

While individual young people saw different parent MIROs as helpful or unhelpful, they were often ambivalent or reported that their views on particular MIROs changed over time.

> "There's good and bad things. They give me the space. Yeah. I mean it's good, it doesn't provoke me. Then again it makes me worse I guess." (young man)

> "I thought at the time that wasn't the right thing, but now I think it was the right thing." (young man)

## Discussion

This research was based on two assumptions, both of which are foundational to occupational therapy practice. The first is the centrality of natural rather than profes-

sional supports. For many young people with mental illness, parents have the potential to be a primary environmental support system, and one that remains stable through multiple changes in treatments and health professionals. Consequently, parent MIROs or interventions are at least as important and worthy of research as professional interventions. Researching parent MIROs is consistent with our interest, as occupational therapists, in empowering our clients and maximising the use and usefulness of natural environmental supports.

The second assumption is that many of the things that parents do with regard to a young person's mental illness are purposeful in that they are not simply patterns of behaviour or reactions to a situation, but are actively intended to have some positive impact on the young person. Working with families in the context of a young person's mental illness often implies remediating dysfunction assumed to exist within the family or addressing parents' own psychological or coping issues. Whereas this may be valuable in some cases, the current research assumes a potential to work with parents as active agents of assistance and support for young people with mental illness. This approach, often espoused in psycho-education (Lucksted *et al*., 2012; Pollio *et al*., 2012), neither focuses on changing parents nor implies causal responsibility. Rather, it suggests a clinical and research focus on helping parents to find and use the most effective MIROs in the specific occupational role of parenting and supporting a young person with mental illness.

This study highlights the large number and diversity of MIROs parents use and suggests a framework by which to group and understand these various MIROs. It confirms and brings together a number of parent MIROs mentioned in the diverse related literature, such as providing financial assistance (e.g. Milliken & Rodney, 2003) and searching for appropriate professionals (e.g. Honey & Halse, 2005). It also identifies additional MIROs, such as: recruiting others to advise; encouraging support-seeking; and modelling behaviour. The importance of parents and other carers, and the need to appropriately support them, is increasingly being acknowledged internationally in mental health policy (Commonwealth of Australia, 2009; Crombie, Irvine, Elliott & Wallace, 2007; Department of Health, 2011). Yet, little previous research has investigated parents' active efforts to support young people with mental illness. This research contributes to facilitating a better understanding of this previously undervalued, but potentially substantial resource for young people. Such understanding is critical for occupational therapists seeking to support and work in partnership with young people with mental illness and their parents.

This research emphasises that parents are not concerned just with clinical outcomes such as symptom remission but with a broad range of issues that resonate with recurrent themes in the mental health recovery literature (e.g. Anthony, 1993). While parents were concerned with alleviating symptoms, many MIROs also related to optimising the young person's wellbeing in the context of mental illness, including assisting the young person to accept the illness, be active in their own recovery, engage in purposeful activity, experience social inclusion and positive social relationships, be hopeful and re-establish a positive sense of self (e.g. Onken, Craig, Ridgeway, Ralph & Cook, 2007; Substance Abuse and Mental Health Services Administration (SAMHSA), 2006; Tooth, Kalyanasundaram, Glover & Momenzadah, 2003). The current research implies that working with parents of young people with mental illness to facilitate their support is consistent and well aligned with a recovery oriented approach.

It was not possible to tell from our data or previous research whether or how the MIROs reported by participants ultimately influenced young people's mental health and wellbeing, nor which MIROs contributed more significantly than others. Participants in the study were, for the most part, unable to isolate MIROs that were more and less helpful except in the short term, and these perceptions might not necessarily reflect long term outcomes. For example, giving the young person their medication everyday ensures it is taken at that time but may lead to dependence, lack of responsibility or submissive behaviour. Difficulty with evaluating the helpfulness of MIROs is also likely to be due to the many different MIROs used concurrently, and difficulty in distinguishing how much of any change in the young person was due to parent MIROs or other factors, such as medical treatment, the young person's own efforts, other sources of support, or the young person simply maturing. Furthermore, many of the MIROs used, such as those aimed at promoting age-appropriate development, were unlikely to result in immediate feedback. While previous research suggests that parents can influence outcomes for young people, the parent MIROs associated with outcomes are unclear. For example, while young people's perceptions of emotional support have been prospectively linked to favourable outcomes such as reduced symptoms (e.g. Norman *et al*., 2005; Stice *et al*., 2004), it is unclear what specific parent MIROs in the context of mental illness result in these perceptions. There is a clear need for empirical evidence as to the effectiveness of individual MIROs and patterns of MIROs.

## Limitations

Being a qualitative study, the findings presented provide insight into participants' perceptions. The applicability of findings to other groups of young people with mental illness should be assessed by reference to the description of participants presented. In particular, although participants came from a number of cultural backgrounds, all lived in or near Sydney. Experiences of

young people living in other countries and in rural or remote areas may differ. For example, community knowledge about and attitudes towards mental illness and parenting, and access to services are likely to influence parent MIROs. As with most research using volunteer participants, there is also the possibility that young people and parents who agreed to participate in this study differed from those who did not. For example, participation in a study such as this suggests a degree of engagement with the issues of supporting a young person with mental illness that may not be shared by all parents.

## Conclusion

This study identified and categorised the variety of occupations parents engage in to promote mental health and wellbeing for a young person with a mental illness and the need for outcome research to evaluate the helpfulness of the different MIROs employed. The findings have the potential to contribute to an area of mental health and clinical research that has seldom been considered in the past. First, they enhance our understanding of the complex occupational role of parenting a young person who has mental illness. For current therapists, this highlights the importance of acknowledging and exploring MIROs with parents and young people. Although empirical evidence of effectiveness is as yet unavailable, therapists can use their clinical knowledge and experience to support parents to consider and articulate the types of MIROs they use, the purposes and possible outcomes of these, and the range of alternative MIROs possible to achieve their purposes. In this way, therapists can facilitate more strategic and well thought-out use of MIROs.

Second, the research is a critical first step towards the provision of empirically based information about what parent MIROs are likely to be effective. Having identified the range of MIROs parents use, the authors are currently developing a parent-report instrument to identify patterns and frequency of parent MIROs. Once adequately validated on a diverse sample, this instrument will make it possible, using longitudinal research, to ascertain what MIROs and patterns of MIROs are associated with positive outcomes for young people. It will be important to include outcomes beyond symptom remission that reflect critical domains of mental health recovery such as social, personal and functional factors. It will also be necessary to identify how effective parent MIROs differ based on potentially important clinical and demographic variables, such as diagnosis, symptom severity, age, gender and culture. The identification of evidence-based best practice for parents is critical to address their 'urgent need to know how to better support the mental health of the young people they care for' (Rickwood, 2011).

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