Original Article

Social support in chat sessions for adolescents and young adults living with a family member with mental illness

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ABSTRACT: Children from families with a mental illness are at risk of developing negative health outcomes. Online interventions are a new way to offer support to these children. The present study utilized a website that had been developed to support Dutch youth who had a family member with a mental illness. The objective was to analyse monitored and unmonitored chatroom conversations among these young people, and specifically to compare supportive messages and self-disclosures of experiences. We electronically imported session transcripts of 34 chatroom conversations into the qualitative analysis software Atlas.ti. A content analysis was performed on 4252 messages from 22 female participants. A correlational analysis was then conducted to identify significant associations between sent and received supportive statements and disclosing statements. We found supporting comments in approximately 34% of the conversations and disclosures of problems in the home in approximately 15–18% of the messages. Participants made approximately twice as many disclosing statements and approximately half as many supportive statements in the monitored sessions compared to the unmonitored sessions. The number of disclosures that were sent was positively correlated with the amount of social support that was received. The number of disclosures sent was negatively correlated with the amount of social support that was sent, but only in the unmonitored sessions. Considering the greater reach of Internet interventions, online chatroom sessions might be provided as complementary to, or as an alternative to, face-to-face groups for supporting youth with a family member who has a mental illness.

KEY WORDS: disclosure, family member, mental illness, online chat, support, youth.

INTRODUCTION

Children with a family member who has a mental illness are at increased risk of acquiring a mental illness when compared with other children in the community (Beardslee et al. 2011; Ma et al. 2014; van Santvoort et al. 2015). Preventative interventions for this group of young people are usually aimed at improving their knowledge about mental illness, enhancing their adaptive coping skills, encouraging self-disclosure, and exchanging social support (Reupert et al. 2012).

The present study utilized a website with a chatroom service that was designed to provide preventative support for Dutch adolescents and young adults with a family member who has a mental illness. The website’s supportive content is based on intervention modules previously used in preventative face-to-face groups for
these young people. The site offers anonymous chat-
room sessions that are intended to facilitate the
exchange of social support, and to give youth living
with a family member who has a mental illness the
opportunity to talk about their home situation. Both
counsellor-monitored and counsellor-unmonitored ses-
sions are provided. The counsellors are adults. They
are specially trained mental health nurses or junior psy-
chologists whose role is to moderate the chat sessions
and provide advice, when appropriate.

In a previous study, we found that delivering the
intervention online vastly increased the number of tar-
geted young people who were reached and that visitors
judged the common chatroom to be the most helpful
feature of the website (Drost et al. 2011a).

Background

There are various obstacles to finding adequate social
support for children from families in which a parent has
a mental-health problem. These obstacles include not
being identified by mental health services (Maybery
et al. 2014), parental denial of the impact of the mental
illness on their children (Stallard et al. 2004), and ado-
lescents’ and young adults’ increasing need for auton-
omy for which they do not easily seek help (Shaw 2001).

E-health interventions or online interventions help to
overcome barriers to the delivery of traditional face-to-face
programmes (Drost et al. 2011b; Meier et al. 2013).
Online interventions might be of particular benefit to
young people, because of their high level of anonymity,
easy access regardless of the time of day and the per-
son’s location, effectiveness in reaching large popula-
tions, and the potential to be perceived as less stigmatizing than traditional interventions (Ali et al.
2015). Studies indicate that adolescent visitors with
psychosocial problems consider online contacts in
chatrooms or forums positive and helpful (Barak &
Dolev-Cohen 2006; Fikkink 2011; Gerrits et al. 2007).
Furthermore, Woolderink et al. (2015) found that young people with a parent who has an addiction or
mental illness felt more protected, and thus were more
open to participating in an online intervention. Trond-
sen (2012) observed that participants in an online self-
help group for adolescents with a parent who has a
mental illness not only discussed the challenges related
to their parent’s mental illness but they also exchanged
strategies for actively managing the challenges.

When people perceive that they have social support,
they have the experience that they are being cared for,
are valued, and are part of a supportive social network.
Social support has beneficial effects on mental and
physical health (Taylor 2011). Five categories of sup-
portive communication can be distinguished: (i) infor-
mation support, such as factual input and practical
advice; (ii) tangible support, that is, having concrete
offers to provide the person with goods or services;
(iii) esteem support, which refers to expressions of
regard for the person’s abilities and intrinsic value;
(iv) network support, which entails a sense of belonging
among people with similar interests and concerns; and
(v) emotional support (Cutrona & Suhr 1992). The last
form of social support refers to the display of under-
standing of the other person’s experience, and includes
expressions of caring, concern, empathy, and sympathy.
Among other things, it is typified by having someone
disclose his or her emotional experiences (Tanis 2007).

Disclosing emotional experiences in writing has
been found to be associated with improved physical
and mental health (Pennebaker 1997). Chaudoir and
Quinn (2010) found that disclosing socially-devalued
personal information not readily apparent to other people,
such as having a family member with a mental illness,
was influenced by the amount of social support a per-
son experienced. Unsupportive reactions, such as blam-
ing others and self-centred responses, tend to result in
less self-disclosure and poorer psychological and emo-
tional well-being than supportive reactions (Sit &
Schuller 2015).

Given these findings, we examined whether the
goals of the website’s chatroom service were being
reached, and how social supports influence the results.
The following questions guided the analysis:

1. What are the characteristics of participants in this
online service?
2. What forms of social support can be identified, and
how prevalent are they in monitored and unmoni-
tored sessions?
3. Are there differences between the kinds of state-
ments that participants make and those that their
counsellors make?
4. Is social support given to others or social support
received by others related to participants’ degree of
self-disclosure?

METHODS

Design

We observed a sample of Internet chatroom sessions
for children with a family member with mental illness
and analysed the interactions. The chatroom in the
website is accessible at specified times. Monitored cha-
troom sessions, which last 90 min, are offered weekly.
At each session, a professional counsellor is present,
who introduces the theme of the session and leads the
discussion, if this is needed. Examples of themes are
‘ambivalent emotions’, ‘how to tell your friends’, and
‘What makes you happy?’.

At other times, the chatroom is open for unmoni-
tored sessions without a professional counsellor pre-
sent. At the entrance to the chatroom, the rules for the
sessions are clearly posted. They include ‘keep your
real name confidential’ and ‘be polite to other visitors,
even if you do not agree with them’. Also, it is expli-
citly stated that one of the counsellors will read the
script from each unmonitored session the following
day. Inappropriate posts can be deleted, and the
administrator can exclude participants from the chat-
room sessions if they do not comply with the rules.

**Data collection**

The sample consisted of 17 monitored and 17 unmoni-
tored chatroom sessions, all of which occurred within
4 months (April, 2014, October, 2014, April, 2015, and
September, 2015).

The software system recorded the number of min-
utes that each session lasted. All of the monitored ses-
sions lasted approximately 90 min. The unmonitored
sessions lasted between 5 and 90 min. All of the 17
monitored sessions that were observed occurred within
this time period. From the 40 unmonitored sessions,
we selected for analysis 17 sessions with the longest
duration. We reasoned that the longer unmonitored
sessions would be more comparable to the monitored
sessions, and that they would provide more information
about the self-disclosures and the support that was
exchanged.

From each participant in these sessions, the follow-
ning information was recorded: the participant’s age,
sex, the family member’s reported diagnosis, and the
number of visits to the monitored and unmonitored
chatroom sessions that the participant made. partici-
pants and counsellors were made anonymous by
replacing participants’ nicknames and counsellors’
names with numbers and letters, respectively.

All participants’ online interactions in the selected
chat sessions were coded. The session transcripts were
electronically imported into the qualitative analysis soft-
ware Atlas.ti, version 7.5.4 (Friese 2014a). Atlas.ti
allows for onscreen coding, and enables multiple codes
to be created, including groups (families) of codes. At-
las.ti also contains an advanced search option that facil-
itates the identification of multiple themes across
large amounts of text, and permits common participant
responses to be analysed (Friese 2014b).

Codes were assigned to the conversational state-
ments. A conversational statement was defined as a
separate line from a chatroom transcript that was rec-
ognizable as a distinct message (see also Fukkink
2011). For example, ‘Try to find people to talk with’
(statement 1), ‘You deserve it’ (statement 2), ‘Your gen-
eral practitioner will remain silent; he took an oath of
secrecy’ (statement 3). The 34 observed chatroom con-
versations contained a total of 4124 conversational
statements.

Two of the authors formed a coding team. After
initial coding, decisions were made about which
codes were most meaningful. A list of codes was then
developed based on the five categories of supportive
communication (Cutrona & Suhr 1992) described ear-
lier. To distinguish between support for disclosure of
problems in the home situation, which was coded as
emotional support, and support for disclosure of
other information (e.g. ‘I hope you pass your exams’),
the code ‘conversational support’ was included. The
list of codes was further extended by including the
following categories: (i) ‘disclosure’, defined as sharing
personal experiences and thoughts on the subject of
having a family member with a mental illness; (ii) ‘ac-
tion’ or ‘no action’, when the person who received
the advice made it clear that he or she would or
would not follow it; (iii) ‘unsupportive reaction’ (e.g.
unpleasant messages); and (iv) ‘chit-chat’ to indicate
small talk (van Uden-Kraan et al. 2008a) that was
unrelated to participants’ unique situation, such as
exchanging greetings, sharing the experience of hav-
ing a dental appointment, or being moved by a film
that had been seen. The sender and the recipient of
each conversational statement were indicated by
including ‘to’ between each speaker’s unique code
(e.g. ‘5 to 22/chit-chat’). Thus, all statements were
counted at least twice, once as a message sent by a
participant and once as a message sent to one or
more participants.

Following Friese’s (2014b) recommendations, the
code definitions were refined on a sample of transcripts
of chatroom conversations. Then, two coders indepen-
dently coded eight transcripts once more. Successively,
the third author coded the remaining chatroom conver-
sations. A new sample of a different four transcripts
indicated strong agreement among the coders. A
glossary of the code definitions is available from the corresponding author on request.

**Data analysis**

The characteristics of participating chatroom visitors were identified from the website’s database. To establish the prevalence of the different characteristics of the chatroom conversations, all of the coded statements were organized into groups (‘code families’ in Atlas.ti) for each code category. For each code family, the rate of occurrence was calculated. To identify differences in interactions between monitored and unmonitored sessions, the frequency of coded statements in the monitored and unmonitored chatroom sessions was compared.

To determine the relationship between sent and received social support, for each participant, all exchanged statements were organized into a code family. For example, the code family ‘participant 5 – all exchanges’ included among other statements the statements that were coded as follows: 5 to 22/(sent) informational support; 5 to (counsellor) K and to 7, and to 20/(sent) self-disclosure; and 20 to 5/(received) emotional support. The number of sent and received supporting statements and self-disclosing statements were summed, and correlations were run to identify relationships among the different types of statements.

**Ethical considerations**

When they registered for access to the secluded, interactive part of the website, all visitors were informed that anonymized data might be used for purposes of evaluation. When the chat sessions were analysed, this was announced as news on the homepage of the secluded part of the website. There was also a notice that chatroom participants could have their contributions removed from the files, if they so desired; however, no request for removal was received. In fact, some visitors even expressed enthusiasm for the analysis.

Before the research protocol was developed, the authors discussed the same ethical issues regarding studying a sample of Internet participants that Eysenbach and Till (2001) identified. Several conclusions were reached. First, the study involved passive analysis of messages that had been posted. The researchers themselves were not involved in any of the chatroom conversations. Second, participation in the chatroom sessions was anonymous. To ensure confidentiality, pseudonyms instead of names or nicknames used in the chatroom sessions are used in all of the quotations that were translated into English.

For these reasons, the ethics committee of the Institute for Mental Health Care (Assen, the Netherlands) that administers the website provided approval.

**RESULTS**

**Characteristics of participants**

In the chatroom sessions that were included in the analysis, there were 22 participants, all of whom were female, and their ages ranged from 12 to 23 years (mean: 17.5, ±3.2). There were 15 participants in the unmonitored sessions, and there was an average of three participants per session. There were also 15 participants in the monitored sessions, with an average of four participants per session; however, some of these participants were the same as those in the unmonitored sessions. There were seven counsellors (6 females, 6 males) who moderated the sessions.

Of the 22 participants, 10, three, one, and one, respectively, indicated that they had a mother, father, sister, or brother with a mental illness. The mental illnesses named and the number of participants who named them were as follows: anxiety disorder (1), borderline personality (2), depression (6), obsessive–compulsive disorder (1), and autism (pervasive developmental disorder–not otherwise specified) (1). Four participants revealed that they had a family member who had committed suicide. Some participants reported that they had more than one family member with a mental illness, but seven participants did not disclose information about their family member’s mental illness.

**Conversational statements in monitored and unmonitored sessions: Disclosures and types of support**

The statistics for the 4124 conversational statements that were observed are shown in Table 1.

Here, frequencies and percentages for the coded conversational statements are shown separately for the monitored and unmonitored sessions. The distributions are approximately the same for the two types of sessions. Approximately half of the conversational statements were characterized as small talk (i.e. chit-chat). Approximately one-third of the statements were judged to be supportive. In approximately 15–18% of the statements, participants disclosed problems in their home.
situation. Both unsupportive reactions and suggestions for taking action rarely occurred. There were no statements that could be coded as network support or tangible support.

Regarding only the participants' statements, twice as many disclosures were sent in the monitored sessions (29.4% vs 15.3%), and half as many supportive statements (mainly conversational and emotional support) were sent in the monitored sessions (15.4% vs 33.9%).

Differences between participants and counsellors
In contrast to the participants, the counsellors gave abundant conversational (28.3% of the statements) and emotional (19% of the statements) support, but as would be expected, they did not make any self-disclosures.

Social support that participants sent and received, and their level of self-disclosure
Participants differed widely in the number of statements that they were observed to make. The number ranged from 22 to 2012, the mean number was 349, and the median was 139. The percentage of statements that participants received from others ranged from 44.2% to 77.3%. The percentage of supportive statements that participants received ranged from 2.9% to 63.3%, with a mean of 33%. The percentage of supportive statements that participants sent ranged from 0% to 50.8%, with a mean of 25%. The percentage of disclosures that participants received ranged from 0% to 60%, with a mean of 22%.

In neither the monitored nor the unmonitored sessions was there a strong relationship between the number of socially-supportive statements that were sent and those that were received. The number of disclosures that were sent in both the monitored and the unmonitored sessions was strongly positively associated with the number of socially-supportive statements that were received.

There was a negative relationship between the number of disclosures that were sent and the number of socially-supportive statements that were received, but only in the unmonitored sessions. These results are summarized in Table 2.

DISCUSSION
To the best of our knowledge, the present study is the first to examine how visitors of monitored and unmonitored online chatroom sessions might be part of a preventive intervention for children from families with a

| TABLE 1: Participants’ and counsellors’ conversational statements according to type of session |
|-----------------------------------------------|----------------|----------------|----------------|----------------|----------------|----------------|
|                                              | Participants | Counsellors | All monitored sessions | Total statements |
|                                              | Unmonitored sessions | Monitored sessions | Total for participants | in monitored sessions | statements |
| Action/no action                            | 13 | 0.8 | 15 | 1.0 | 28 | 0.9 | 2 | 0.2 | 17 | 0.7 | 30 | 0.7 |
| Chit-chat                                   | 816 | 50.0 | 852 | 54.2 | 1668 | 52 | 307 | 33.4 | 1159 | 46.5 | 1975 | 47.9 |
| Self-disclosure                             | 250 | 15.3 | 463 | 29.4 | 713 | 22.2 | — | — | — | — | — | — |
| Unsupportive reactions                      | — | — | — | — | — | — | — | — | — | — | — | — |
| Total supportive reactions                  | 554 | 33.9 | 243 | 15.4 | 797 | 24 | 609 | 66.3 | 852 | 34.2 | 1406 | 34.4 |
| Conversational social support               | 222 | 13.6 | 64 | 4.1 | 286 | 8.9 | 260 | 28.3 | 324 | 13.0 | 546 | 13.2 |
| Emotional support                           | 232 | 14.2 | 128 | 8.1 | 360 | 11.2 | 174 | 19.0 | 302 | 12.1 | 534 | 12.9 |
| Esteem support                              | 46 | 2.8 | 20 | 1.3 | 66 | 2.1 | 47 | 5.1 | 67 | 2.7 | 113 | 2.7 |
| Informational support                       | 54 | 3.3 | 31 | 2.0 | 85 | 2.7 | 119 | 13.0 | 150 | 6.0 | 204 | 4.9 |
| Network support                             | — | — | — | — | — | — | — | — | — | — | — | — |
| Tangible support                            | — | — | — | — | — | — | 9 | 1.0 | 9 | 0.4 | 9 | 0.2 |
| Total                                       | 1633 | 100 | 1573 | 100 | 3206 | 100 | 918 | 100 | 2491 | 100 | 4124 | 100 |

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mental illness. The results provide a snapshot of such chatroom conversations, and they show how these conversations could be an important resource for social support.

The chatroom service that the website provided was designed to facilitate social support for adolescents and young adults with a family member who has a mental illness. This goal was achieved. Participants used the online chatroom sessions to exchange a considerable amount of social support and to disclose problems in their home situation. During both the monitored and the unmonitored sessions, the young people appeared to be able to engage in constructive online conversations about both their daily experiences and the difficulties they had while trying to cope with their relative’s mental illness. More than half of participants’ statements were coded as supportive or self-disclosing. Participants discussed their experiences at home, and they exchanged support with one another; however, the disclosures were intermingled with everyday conversation about, for example, experiences at school or on outings, as if they were talking with friends. Many of the females of our target group appeared to be ‘searching for normality’ (Fjone et al. 2009), and the chatroom conversations provided them with an opportunity to chat with peers who understood both their circumstances (Grove et al. 2015; Thomas et al. 2003) and the difficulties that they were experiencing at home.

Participants’ level of self-disclosure was strongly positively associated with the amount of social support that they received in the chatroom sessions. Although all of the participants were in the same situation, they probably felt that it was appropriate to reveal their experiences (Gladstone et al. 2014), but at the same time, they were aware of how hard this possibly was for some of their peers.

Self-disclosure was greater in the monitored sessions than in the unmonitored sessions; it was counsellors who offered most of the social support in the monitored sessions. The presence of a counsellor might have instilled confidence in the participants.

In the unmonitored sessions, some of the participants appeared to have assumed the role of counsellor when they invited their peers to engage in conversation and then frequently offered them emotional support. This might be viewed as positive, because giving support to peers might have enhanced their self-esteem (van Uden-Kraan et al. 2009b). Participants of the Australian On Fire programme, which was designed for young people aged 8–17 years who are from families affected by mental illness, reported that being able to contribute to others’ well-being made young people realize that they were not helpless, but had the capacity to help others (Foster et al. 2014). Another Australian programme, the PATS (Paying Attention to Self) programme for adolescent children of parents with a diagnosed mental illness, is facilitated by peer leaders, each of whom is the child of a parent with a mental illness. It aims to develop leadership skills in these young people (Hargreaves et al. 2008; Reupert et al. 2012).

However, more research is needed to understand the effects that peers assuming the role of a counsellor can have. This is because offering support to others might also be viewed as ‘parentification’ (i.e. assuming a parenting role), which has been associated with experiencing stress and internalizing one’s problems (van Loon et al. 2017).

In the unmonitored sessions, a negative relationship was found between the degree to which participants self-disclosed and the degree to which they offered social support. The explanation for this association is not clear. Revealing one’s own similar circumstances might be intended as emotional social support, where it displays an understanding of what the other person goes through (Grove et al. 2015). Adolescents prefer to turn to friends and family members as a source of help (Gould et al. 2004; Rickwood et al. 2007). Yet the fear of friends reacting negatively might often prevent young people from talking about the mental illness of a family member (Reupert & Maybery 2015). This could lead to isolation and despair (Hinshaw 2005). Karnieli-Miller et al. (2013) suggest that it is important for families with a mental illness to develop the ‘art of selective disclosure’, and to decide with whom to share what information. Anonymously disclosing the experiences that one has had at home with peers who

| TABLE 2: Correlations between social support that participants sent and received, and their level of self-disclosure in unmonitored and monitored chat sessions |
|-----------------|-----------------|-----------------|
| Spearman’s rho  | Received support| Sent support    |
| Unmonitored sessions |                |                | Self-disclosure |
| Received support | 1.000           | −0.257         | 0.756***        |
| Sent support     | −0.257          | 1.000          | −0.550*         |
| Self-disclosure  | 0.756***        | −0.550*        | 1.000           |
| Monitored sessions |                |                |                |
| Received support | 1.000           | −275           | 0.679**         |
| Sent support     | −0.275          | 1.000          | −0.136          |
| Self-disclosure  | 0.679**         | −0.136         | 1.000           |

*P < 0.05, **P < 0.005, ***P < 0.001.
presumably have had similar experiences implies that support was both given and received. The chatroom thus served to build a peer support network for young people who could not easily be reached by professional workers.

Another explanation is that the participants who assumed a counselling role behaved more like counsellors, and thus made fewer disclosing statements about themselves.

The most common types of social support were conversational support and emotional support. Consistent with earlier results (Fukkink 2011), tangible support (offers of goods or services) was rare in the context of the computer-mediated social support. Only a small proportion of the supportive statements were coded as informational support or esteem-enhancing support. This was true for both the counsellors and the participating peers. The adolescents in Trondsen’s (2012) study acknowledged that the information that had been provided to them on how to cope with their relative’s behaviour had inspired them to reflect on how they might handle their own situation. van Santvoort (2012) recommends that special attention be given to enhancing self-esteem in preventive programmes for children of parents with a mental illness. Additionally, Fukkink (2011) states that the quality of online support that participants provide is related to variations in their supportive communications. This suggests that counsellors should be more attentive to the informative and esteem support that is being communicated within chatroom sessions.

Some of the statements that were coded as ‘chit-chat’ indicated that participants frequently used two or more kinds of media concurrently. Remarks, such as ‘Sorry, I did not reply immediately, as I am also watching this television programme’ and ‘I might have missed a bit of the discussion, as I am playing games’, suggest that some of the chatroom participants did not specially focus on the preventive intervention; instead, they routinely opened their electronic devices and kept their eyes on what was happening in the chatroom. Rideout et al. (2010) reported that young people engage in such media multitasking more than 29% of the time; they might be engaging in some combination of the following simultaneously: watching TV, using a computer, playing a video game, listening to music, printing, talking on a cell phone, or watching a movie.

Finally, it was evident that some of the participants in unmonitored chats were able to function as mentors. Future providers of online interventions should take these experiences into account.

Limitations of the study and research implications

All of the chatroom participants were female. Further studies are needed to learn how males who live with a family member who has a mental illness can best be supported. In addition to the information the females themselves reported, there might be characteristics of chatroom participants that could affect their chatroom behaviour, but which were not taken into account in the current study. These characteristics might include being a young provider of care or having a family member with acute symptoms of a mental illness. In future, research should examine relationships between social support and self-disclosure and key variables, such as participant age, sex, and severity of mental illness of relatives that affect them. Finally, research is needed on the long-term outcome of chatroom participants, including their psychosocial functioning and their level of distress.

CONCLUSIONS

Despite its limitations, the current study provides some important insights into the behaviour of chatroom participants. The participants exchanged a considerable amount of social support, and they talked about how they were coping with the symptomatic behaviour of their relatives.

In the unmonitored sessions, some participants offered emotional support more frequently than in the monitored sessions where a counsellor was present. Giving support to peers might have been beneficial for these participants when they realized that they were able to help other young people in similar circumstances.

Interventions delivered over the Internet have the capacity to reach larger numbers of participants than face-to-face interventions, and they offer the opportunity for participants to experience companionship and develop their capabilities. Chatroom sessions help to build a peer support network for young people whom professional workers cannot easily reach.

RELEVANCE FOR CLINICAL PRACTICE

Professionals in mental health care, especially nurses, must be aware that mental illness might affect all family members. Mental health nurses are in a unique position to inform adult patients who are parents about the benefits of social support for their
children. If possible, they need to take time to help the children of their patients understand what is happening (Drost et al. 2016; Foster 2010), but also to recognize their capacities. Brochures to guide such a conversation and information about the available support can be downloaded from the Internet (e.g. www.copmi.net.au).

Chat participants presented their problems to peers, and counsellors often mingled with small talk and sometimes while they were busy doing other things. This corresponds to how young people normally make use of social media (Lenhart 2015). Interacting with youngsters in an ‘en passant’ (not formally structured) way might be a better way to get their attention than sitting with them in a group meeting (Gladstone et al. 2014).

In future, chatroom sessions might be offered either as complementary to or in place of face-to-face groups (Naslund et al. 2016) to support adolescents with a family member who has a mental illness. It is important, however, to note that online interventions, even more than face-to-face interventions, require maintenance. Once launched, websites have to be made widely known, they must be updated, both technically and in terms of content, and the counsellors need support. Institutions for mental health and child welfare should be given greater financial opportunities so that (anonymous) online support can be offered for children at risk.

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