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**TALKING OR KEEPING SILENT ABOUT PARENTAL MENTAL HEALTH
PROBLEMS – A GROUNDED THEORY OF PARENTS' DECISION-MAKING AND
EXPERIENCES WITH THEIR CHILDREN**

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Abstract

This Grounded Theory study explored parents' experiences of responding to their children's need for understanding parental mental health concerns. Fifteen parents with severe and enduring mental health difficulties participated in the study. The findings suggest four main social processes that influence parents' talk with their children about parental mental health issues. These are "Protecting innocence", "Acknowledging awareness" (this includes "Casting children as mature and knowing"), "Negotiating mutuality" (this includes "Maintaining their lives together" and "Protecting their children and being protected by their children") and "Relating to others". Implications of the findings for clinical practice and future research are considered. In particular, the need for more family-orientated services where parents experience parental mental health problems is highlighted.

INTRODUCTION

This paper presents a grounded theory of how parents with mental health problems (MHP) talk to their children about their difficulties. The study draws on the perspective that children need information about, and need to form an understanding of, parental mental health problems (PMHP). Currently adult mental health services often do not include children in their interventions and children's mental health services do not provide services for children who do not present with mental health issues themselves. Therefore, there is often no service with a focus on the whole family when a parent experiences MHP (Ofsted and CQC, 2013). Given this lack of service provision for families, the burden to share information and support children to develop understandings of PMHP most often fall on parents.

BACKGROUND

There is a significant body of research that shows that children can be negatively affected by PMHP, that their development and wellbeing can be negatively influenced and that they are at increased risk of developing mental health difficulties themselves (Felitti, et al., 1998; Manning & Gregoire, 2006; Singleton, 2007). It is therefore crucially important to understand the mechanisms by which PMHP increase the risk of poor outcomes for children. A number of factors have been shown to impact on the influence PMHP have on children, including the direct exposure to difficulties; the influences of associated factors (e.g. hostility, relational disharmony, poverty), attachment difficulties, disruptions to parenting and individual child-

related factors (e.g. self-esteem, coping strategies) (Rutter and Quinton, 1984; Smith, 2004; Van Loon, et al., 2015, etc.). Having a good understanding of a parent's MHP is one particular factor that has been shown to protect children against the negative influence PMHP can have (Mordoch & Hall, 2008; Scherer, et al., 1996). Furthermore, children who are knowledgeable about a parent's MHP were found to be better able to interpret their parent's behaviours and thus experience less uncertainty and hardship (Mordoch, 2010).

There is also a growing body of qualitative research that help us understand parents' and children's own views in relation to children's understanding of PMHP (Gladstone, Boydell, Seeman & McKeever, 2011). Most studies reported that children felt that they had little information about their parents' MHP (e.g. Riebschleger, 2004; Stallard, et al., 2004, etc.). Van Parys and Rober (p. 5, 2012) found that "overall knowing in the family was very diffuse and varied over time ... and what was known also differed from one family member to the other." There is a general view from this body of research that most children wanted more information and that having an accurate understanding of their parent's MHP could be helpful. However, some studies reported that it can be difficult for children to talk about PMHP and that some children did not want to feel burdened by their parent's MHP by having to talk about it (e.g. Stallard, et al., 2004). Finally, some information children wanted was factual, for example 'where is my parent?', 'how long will my parent be in hospital?', etc. However, some information children asked for, e.g. 'what will happen next?' or 'will my parent be okay?' could not be fully answered by providing information. Rather, this would require supporting children in learning to cope with the uncertainty and unpredictability often associated with PMHP.

There are fewer qualitative studies looking at the experiences of parents with MHP. Two main positions emerge from the literature. On the one hand some studies found parents were reluctant to discuss their MHP with their children (e.g. Stormont, et al., 1997). Some potential reasons for this reluctance included finding it difficult to acknowledge the influence of their MHP on their children, shame and guilt about their problems, a concern about the children being removed from their care, finding it distressing to talk to their children about the issues and uncertainty about how helpful it was for children to know more (especially about painful or frightening aspects like suicide). In contrast, other researchers found that parents had given thought to what their children knew about their MHP, were concerned about their children's lack of understanding and wanted them to be given explanations (e.g. Stallard, et al., 2004). They were keen for children to understand that the parent's MHP were not their fault, and to know that the parent could not help their behaviour or the treatment they received, e.g. hospitalization. Often parents wanted advice about how to talk to their children about their difficulties.

Finally, very little research exists that provides insight into how families actually communicate about PMHP. Researchers like Mordoch and Hall (2008), Riebschleger (2004), Totsuka (2010), Van Parys & Rober (2012) and others have begun to shed light on how difficult talking about PMHP in families can be. Van Parys & Rober (2012) describe multi-layered circular understandings, fluctuating and evolving over time, with each person in the relationship shifting and responding to the other. These authors describe the moral dilemmas faced by parents and children in relation to talking (often within the context of mutual love, concern, compassion and care). Within such a context of fragmented talk children can often be said to develop a "kaleidoscope" (Mordoch, 2010, p. 20) perspective of their parent's

MHP. They have to piece together parts of the story through what they are directly told, information they find out and what they see. Mordoch (2010) concludes that research on when and what to tell children about PMHP is needed to ensure that all children receive timely and developmentally appropriate and helpful information.

The work and research of Beardslee and colleagues (e.g. Focht & Beardslee, 1996; Focht-Birkerts & Beardslee, 2000) also show that initiating communication about PMHP can often be a challenging task for parents, partly because of feelings of guilt and shame and partly because of the difficulty of finding appropriate words to describe MHP. Focht-Birkerts & Beardslee (2000) observed that the pain of the children seemed to be “bulging through the seams of the ‘not-yet-said’” (p. 421). However, they found that talking could have benefits for parent-child relationships and the child’s understanding and wellbeing.

Thus, conversations about PMHP between parents and children can be seen as central to improved wellbeing for all in the family, but is also likely to be full of challenges and dilemmas for parents. The aim of this study was to explore how parents think about and experience talking to their children about their MHP.

METHOD

Participants

Purposive sampling was used to recruit participants from an inner city National Health Service Trust in England. In line with a Grounded theory method the aim was to recruit a varied sample in relation to age, gender, mental health diagnosis, age of children and cultural background. Participants all had been diagnosed with severe and enduring mental health difficulties. However, participants needed to be stable in the mental health to be included in

the study. Fifteen parents participated in the study (13 mothers and 2 fathers). They all had at least one child between the ages of 4 and 18 (with a total of 35 children between them). Six parents were co-parenting with a partner while the others were lone parents. Their formal psychiatric diagnoses included schizophrenia (6), bipolar disorder (3), depression/post-natal depression with psychosis (3), substance induced psychosis (2) and multiple personality disorder (1). Contact with mental health services ranged from one to 21 years. The majority were from a low socio-economic background and none were in formal employment, with four involved in sporadic part-time work. They were from a wide range of ethnic and cultural backgrounds, including White British, Black African, African-Caribbean and Turkish (see Table 1 (supplement) for a detailed table of participants).

Recruitment in this field is notoriously challenging (e.g. Pihkala, et al., 2011; Stallard, et al., 2004; Stormont, et al., 1997; etc.) and it is worth pointing out that this was also the case in the current study, particularly in relation to recruiting fathers. This impacted on sample size. This point is returned to in the discussion of limitations of the study.

Procedures

Ethical approval for the study was obtained from the NHS Research Ethics Committee and the specific Research and Development department of the Trust from which participants were recruited. One-off in-depth individual semi-structured interviews were carried out with all participants by the first author, an experienced clinician and qualitative researcher. The questions for the semi-structured interview were guided by the literature within the field of parental mental health and the researchers' disciplinary experience of working with parents with MHP. It was further refined through service-user consultation from a service-user research group and a third-sector support group. Finally, the interview was piloted before use

in the study. The interviews lasted between one and one and a half hours. The focus was on how parents talked to their children about PMHP. Questions included for example “Can you tell me about your understanding of the reasons you use mental health services?”, “How do you think your children have come to know about (your mental health difficulties)?” and “Do you think children need to understand (your mental health difficulties) or do you think it is better for them not to know too much?” (see full interview schedule in Table 2 (supplement)).

Data analysis

All interviews were recorded, transcribed and analysed using Interpretive Grounded Theory (Charmaz, 2006; Clarke, 2005) [for two participants limited data were available (participant 6 & 14) due to recording issues – however at their request their data was still included. Detailed notes were made during/immediately following the interviews and checked with them before inclusion]. In line with this method, constant comparative approaches as well as memo-writing were employed throughout the data collection and analysis. Data coding was conducted starting with open coding, that is line-by-line coding, defining for each word, line or segment what activity is occurring. Axial coding where connections were made among the initial codes to construct broader themes followed this. Finally, selective coding brought the themes together into a coherent whole. Following this, a situational analysis was conducted, using the diagramming tools of situational maps, social worlds/arenas maps and positional maps as described by Clarke (2005).

Coding and data analysis occurred concurrently. Early engagement with the data led to some specific shifts in perspective and initial theoretical sampling. Further theoretical sampling brought shifts to include a more in-depth explorations of participants’ own understandings of their mental health difficulties, moving beyond exploring specific ‘telling’ events to include

more exploration of how PMHP enter everyday talk in the family, and exploring silences and communication beyond words. Saturation was achieved when at the end of the analysis of an interview no new categories emerged and all data in the interviews could be accounted for within the structure that had been achieved at that point.

The first author coded all interviews and the second author checked all coding. Furthermore, a peer research group and an outside consultant also commented on coding. The researchers drew on the criteria of credibility, originality, resonance and usefulness as set out by Charmaz (2006) to ensure the quality of analysis (for definitions of these and how they were implemented, see Table 3 (supplement)).

RESULTS

The findings of this study were constructed as four social processes that impact on parents' talk with their children about PMHP. These were "Protecting innocence", "Acknowledging awareness" (including "Casting children as mature and knowing"), "Negotiating mutuality" (including "Maintaining their lives together" and "Protecting their children and being protected by their children") and "Relating to others" (Figure 1). These social processes and the relationship between them will now be discussed.

** Figure one: Social processes that influence parents' talk with their children about parental mental health problems*

Protecting innocence

All parents of young children in the study wished for their children to have a 'normal' childhood. For these parents this meant that their children should not be aware of or affected by PMHP. They saw their children as innocent, unaware and unable to understand a PMHP.

Faith²: “They have no idea. They are very young. They don’t understand it, they don’t know. They are still very young – they won’t understand anything like that. When they are big, I’ll explain everything to them.”

Parents assumed that (or maybe hoped that) their young children did not notice any aspects related to their MHP. When parents considered that the children might have noticed, there was a sense that younger children could ‘forget’.

Omette: “It was quite a long time ... that they were out of the house so I don’t know if we can say children forget what their parents are like but, you know, it was ... the same mother, I looked exactly the same so ... um ... while, while they were out of the house I was sleeping all the time but they didn’t know that, so when they came home I was with them and, you know, there was no, there was nothing different so ...”

Thus, through not talking about their MHP and through trying to hide the signs of their difficulties from their children, they were hoping to protect the innocence of their children.

However, as children became older this position became unsustainable. Due to the nature of their difficulties parents were not always able to hide PMHP from their children. Furthermore, children were noticing and observing and would ask the parents questions about what was going on. This moved the parents toward a position of *Acknowledging awareness* (Faith and Omette, parents with younger children, were the only participants who remained in a position of *Protecting innocence*). For the remaining parents the shift occurred at different developmental stages, rather than at any one particular age. Also, it was not a linear shift, with *Acknowledging awareness* ‘a point of arrival’. Rather, parents appeared to move back

² All names are pseudonyms to protect the identities of participants

and forth between *Protecting innocence* and *Acknowledging awareness* (this occurred even within the research interviews).

Acknowledging awareness

As children became older there came a time described by all parents (excluding the two mentioned above) when parents had to acknowledge that their children were aware of the parent's MHP. For many parents this was because their children witnessed difficult and at times bizarre situations or heard potentially disturbing or unusual information.

Researcher: So if I asked her what sort of experiences you've had, would she know anything about hearing voices?

Izzy: She (1) she um yeah, she would probably [quietly] know... because sometimes I swear back, you know what I mean [laughs], sometimes I get annoyed (...).

Researcher: Would she ask you about that – who you're talking to?

Izzy: Yeah. I say just stupid people talking in me head.

Many parents also described how their children would ask them questions about what they were observing in relation to the mental health problems. A few parents described how they might try to explain away what their children were noticing.

Hannah: "I was just telling her 'I am just a bit tired, because I have just come out of hospital so I am just a bit tired' (...) Yes, it was very hard for me to deal with, because I was thinking 'I'm just lying to my own kid', but at the same time I just ... wanted her to get on with her school work instead of thinking about me too much."

However, they found that the children would not always be satisfied with such answers to their questions, and would keep probing, using their observations to judge their parent's explanations. Most parents experienced their children as actively seeking to understand what was happening and wanting to make sense of their observations and experiences.

Often a decision to share some information appeared to be an in-the-moment decision, often responding to their child's probing, rather than being based on a pre-considered and thought-through process.

Karen: "It probably happened because there was a difficult moment or she said 'but I have told you this' or ... she would be like 'Mum! Mum' like she would say it's like you are completely not here... and I think I told her then and said well actually it is because the other person [one of multiple personalities] is dominant..."

Thus, rather than pre-planned conversations where detailed information about e.g. a parent's mental health diagnosis was explained, decisions about talking and talking itself appeared to happen in a more immediate and informal way, interwoven with everyday conversations.

Acknowledging awareness was painful for many parents and they appeared to use two strategies to help them cope with acknowledging their children were aware of and influenced by their MHP. Firstly, parents often described their children as particularly mature. Secondly, parents often believed that their children already knew much about the MHP. This was constructed as *Casting children as mature and knowing*.

Casting children as mature and knowing. Almost half of participants described their children as particularly mature, independent of the child's age.

Lamine: "My old daughter, she quite, she's started to understand...because she's quite, not, not a child, she's nine, she's getting nine old, you know what I mean..."

Seeing the children as mature appeared to allow these parents to feel more comfortable with the knowledge that their children knew about their MHP. Worryingly, this could potentially mean that they felt less of a need to protect them from PMHP.

Most parents also made many assumptions about what the children understood about PMHP. This was most often based on what the children had witnessed and experienced and how they acted, rather than what had actually been explained to them.

Carla: "Um... I don't really talk about my illness you know, with the boys, but I think as they have seen me and observed me being well and unwell, they've just you know, know, they know. They've just picked it up, you know."

Carla, mother of 13-year old twin boys, justified this claim by describing how the boys would help her around the house and not make noise when she needed rest. However, it remained unclear what the children actually understood of their parent's MHP. Parents varied in how much they assumed children understood through what they had observed. However, most parents felt that there were important details about their MHP that was known and therefore did not have to be explained. This assumption of existing knowledge powerfully deterred parents from having more direct and detailed conversations about PMHP with their children.

In summary, all the parents (apart from two with only very young children) described arriving at a point of acknowledging their children's awareness of their MHP and most parents then viewed their children as knowledgeable about aspects to their difficulties. However, this proved not to resolve the dilemma of talking or remaining silent for parents.

Rather, a number of social processes were constructed to detail the factors influencing parents' ongoing decision-making in relation to talking or remaining silent about PMHP. These were conceptualized as *Negotiating mutuality*, which included *Maintaining their lives together* and *Protecting their children and being protected by their children*.

Negotiating mutuality

With acknowledgement of awareness came a relational shift towards mutuality and reciprocity for all the parents. Where as with younger children parents were attempting to hide, protect and maintain innocence, there was now a shift towards seeing the children as more active in shaping a shared understanding of the parent's MHP. However, despite this shift, parents' accounts of their children's knowing often remained filled with contradiction and ambivalence. Thus, it is argued that a number of social processes interact in a complex way to continuously invite parents into different positions in relation to talking and keeping silent about MHP.

Maintaining their lives together In most of the parents' view, both parents and children worked hard to maintain their lives together. Parents often deeply valued their relationships with their children and it frequently provided them with hope and happiness within challenging times. Almost all parents reported that it was extremely important to them (and in their view to their children) to maintain a close bond and remain connected. At times their children were all they were living for, and many felt that having the children kept them well.

Izzy: "She cheers me up. She's the light of my life, you know, she's like the light – if she wasn't here ... I would kill myself because I just don't see the point of [it]."

However, mental health issues could at times interfere with their connection with their children. Closeness and connection needed to withstand the onslaught of severe and enduring mental health difficulties again and again.

Izzy: “Well, sometimes I don’t think I always prioritise her – sometimes she just needs to go beside, walk beside me, because I can’t... sometimes that’s what she has to do, but most of the time I try to meet her needs.”

At such times some parents experienced that talking about their mental health problems could protect, enhance or restore closeness with their children. These parents thought of talking as a way to maintain the relationship, protect their child and keep close, despite the challenges.

Izzy: “It’s made us closer, real close, very plain speaking and open to each other...”

When closeness and staying connected were threatened by periods of acute mental distress and hospitalization, tentative talking could enable reconnecting after these difficult times.

R: Do they ask you about what happened or comment on what happened?

Beverly: They just ask me if I’m alright, ‘are you okay, mummy’, and I go ‘Yeah, I’m fine, I’m alright’ (spoken quietly, tenderly).

Where talk was used to maintain closeness, talking about PMHP most often happened in the everyday and ordinary conversations of family life. Humour often played an important part. Very difficult things could be talked about in a playful manner and this enhanced intimacy and enabled a more shared and coherent understanding.

Dayo: “We were like joking [laughs]. Sometimes when I was ill... I was dancing, then they were seeing me dancing then when I get well they remember me ‘mum, you know

what you was doing? You were dancing'. You know the song [laughs] and they started dancing the way I was dancing! And then ...everyone laughing..."

However, closeness did not always need words to be communicated and at other times not talking was seen as a way to remain close and connected.

Mualla: "I tried to make her forget about this...by hugging."

Thus, both talking and remaining silent could help parents at different times with staying close and connected.

Parents also described striving for normalcy and valuing the everyday. Most parents felt that they and their children appreciated sharing everyday tasks related to parenting and family life, free from having to consider the MHP.

Izzy: "They can still lean on me – I'm not all the time um... indisposed. Just sometimes. And summer's coming, so it should be better. It's brighter outside. Yeah, when it's summery I can take [my daughter] to the park. I'll take some little cousins."

Here we see Izzy, mother of a 10-year old daughter, longing for the normalcy of talking her daughter to the park. She almost appears to be trying to convince herself that this everyday activity can indeed happen. Being able to focus on school related events, future plans, exams, boyfriends and the 'normal' activities of meals, getting ready for the day, etc. became valued and significant for many parents.

Dayo: "...when I am getting better, like now getting better, they are happy now, happy...They go to school, they come back home, 'mum, what are you doing? What

are you doing during the day? ... What is it for eating?' such things, yeah. I can make food for them, yeah yeah."

Dayo, mother of four, enjoys with her children the fact that she can cook a meal for them again. Such times where they were able to get on with everyday tasks untouched by the MHP, was for many parents a time when they were very reluctant to talk about PMHP, preferring to talk and think about 'normal' things. Thus, this invited silence about PMHP.

In summary, both talking and keeping silent could at different times help parents to achieve their aim of *Maintaining their lives together*. However, aspects of these aims could also be in conflict with one another, causing dilemmas for parents around talking or keeping silent.

A further social process impacting on *Negotiating mutuality* was *Protecting their children and being protected by their children*.

Protecting their children and being protected by their children

Almost all parents described a mutual vigilance for them and for their children, constantly monitoring one another and working to ameliorate the influence of the MHP. At times this involved the parents *protecting their children*. However, at other times the parents were *being protected by their children*.

Protecting their children. Most parents expressed a strong wish or intention to protect their children and ameliorate the influence of their MHP on them. Many parents appeared to be watchful, trying to 'read the signs' in their children, trying to determine how their children were coping. Some parents worried that their children could develop MHP themselves.

Carla: "A worry is um I hope it is not hereditary, you know, because I wouldn't want to see none of my children go through what I've been through..."

However, not all parents shared this concern of children developing mental health issues themselves. For example, Gareth stated that he had no concern that his children would develop similar difficulties to him, as he felt they were very different in temperament to him.

At times some parents tried to talk to their children to determine how they had been affected by PMHP. They wanted to reassure themselves that their children were doing well and were not hurt or 'damaged' by their problems.

Izzy: "I think [my son] was more affected...but he don't talk, he's introvert, he won't want to talk to no one. [He] experienced me going through an addiction. Um, so he's probably got a lot of resentments, angry, you know what I mean? And not able to express it. I want him to be able to... express any frustrations or anger..."

Here Izzy appears to be guessing how her 22-year old son is feeling about PMHP he witnessed when he was younger. However, her son does not want to talk about it, leaving her worried and frustrated. At other times some parents saw not talking as the way to protect children. This was a way to not let the parent's MHP become the focus of their lives.

Gareth: "...and with the children I left it for a while and I wasn't going to, I didn't want to say (2) ... No I don't want to remind them."

It is important to note here that it is no the case that some parents talked to their children to protect them while others remained silent. Rather, most parents experienced both these positions at different times and in different circumstances. For example, at a different point in

his interview, Gareth, father a 20- and 16-year old, talked about the importance for him of an open relationship with his children where they can talk about everything, including PMHP.

A few parents felt that their children needed protection from them, rather than just the MHP. There was a sense that, as ‘the cause’ of the child’s difficulties, they were in some way harmful or even ‘toxic’ to the child, and ‘contaminated’ as a parent. Therefore, they felt they could also ‘contaminate’ or damage their child.

Karen: “I worry that I am a bad influence on her, that I will be detrimental to her long term...health, happiness, mental state [sad laugh] And that she um yeah that it’s not good for her around me.”

This sense of potentially being a danger to their child could lead the parent to distance themselves from the children. This could powerfully inhibit talking, including about PMHP.

Finally, there were times when the children of a few parents appeared to be protecting themselves by not talking to their parent about PMHP.

Beverly: “It’s like she don’t want to hear it. I’ve tried many a times, many occasions, I would go in her room and I sit on her bed and ... every time I bring it up it’s like she don’t want to hear it, she don’t want to know. So I just, I just leave it...”

When children need to create distance to protect themselves as Beverly describes here, this reduces the possibility of talking about PMHP.

Being protected by their children. Due to the nature of the MHP a number of parents at times also hoped for or required the help and protection of their children. Furthermore, it

appears that children's love for their parents and their concern about the situation led to them at times working hard to check up on the parent and reduce the influence of the MHP.

Mualla: "She doesn't seem like, I mean ... If there's sad music, a kind of song, when I was crying she just stopped the music She doesn't want to see me like that, crying and sad."

Surprisingly, a few parents also described how at times their child helped them make sense of their PMH, rather than the other way around. The parent might be unable to remember what happened during a period of mental distress, and the children, having been witnesses to what happened, may be the holders of these memories and may help the parent fill in the gaps.

Ann: "Some things are very clear in my mind, but other things are not clear like [my partner] and [my daughter] would tell me that ...I would rush up to people and say oh, where did you buy that jumper or where did you buy that coat..."

Here Ann's 16-year old daughter is seen to fill in the gaps in her mum's memory of what happened during a time she was very unwell.

Finally, a few parents felt a more urgent need for protection by their children. They described that they needed their children to notice, understand and respond caringly to their MHP at times of particular distress. When the child noticed and responded in a supportive way to the parent's needs at these moments, parents framed this as the child being 'good'. Children were framed as helpful when they noticed and responded to the parent's mental health difficulties by not being troublesome. However, at these difficult times parents appeared less able to consider the possible implications for their children.

Mualla: “You can’t hide from the child It’s better if the child accepts you as you. Maybe then she doesn’t make her mother angry ... I want her to be understanding I want her to understand my pain but of course I can’t ...expect that she can understand all the pain that I feel.”

These few parents found it challenging when the children did not respond as they needed them to. This could lead to more severe explanations from the parent to try and ensure a full appreciation of the MHP and the relational implications that could follow for the child. At times this could take a very worrying and disturbing turn.

Jiyan: “Once I said I would go up to upper floors to jump off – the husband and the son stayed up all night and watched me.”

Here the threat of selfharm from Jiyan is a powerful strategy as it is presented as non-negotiable and the stakes are very high, e.g. the threat of return of the ‘illness’ or of suicide.

In summary, again both talking and keeping silent could help parents protect their children or be protected by them at different times and in different circumstances. However, again there could be conflicting needs at any one time, pulling parents in different direction in relation to talk about PMHP with their children.

The three previous social processes, *Protecting innocence*, *Acknowledging awareness* and *Negotiating mutuality*, all focus on the relationship between parent and child. These social processes interact with the process *Relating to others*, which will now be discussed.

Relating with others

Parents and children did not deal with the influence of the PMHP in isolation. Due to the nature of MHP parents in this study were hospitalized and heavily medicated for periods of time following a mental health crisis or sharing responsibilities of parenting with others when unable to meet these themselves. In these times of intense difficulties parents found themselves at the mercy of the help and kindness of others. Others gained influence over the parent-child relationship in these times and the responsibility for explaining a parent's MHP to a child (or not) fell on others' shoulders. This could be a mental health practitioner, the other parent, a family member, a friend or neighbour or even another sibling.

Dayo: "But when it come to the second time [my eldest son], he understood a little bit, because he was a little bit grown up (...) at home he says he was telling [the younger siblings] 'mum's not well, she's sick – we have to work'."

Interestingly, most parents in this study did not see it as a problem that others were talking to their children about PMHP. For most of the parents there seemed to be a lack of curiosity about these conversations and sometimes parents preferred others taking the role of speaking to their children, with a few parents actively trying to find someone (e.g. a counsellor) for their child to talk to. There was a sense that others could get to 'the truth' of what their children were experiencing and this could be reassuring for parents.

Mualla: "I want to know more about what she wants. She talks about it but still ... she might still keep something to herself and ... (mental health professionals) can get more from conversation with my daughter for instance ..."

Also, for a few of the parents there was an awareness that children have many other sources of information available and that their children were learning about MHP in other ways.

Ann: "...she did her own research anyway and got on the computer and found out and her friend went on the computer for her and was looking up this and looking up that so I think to be honest she knows more about it than I do (laughs)"

For a few parent however, there was a more complicated or negative view of the talk about PMHP between their child and others. For example, Karen tells here how her 15-year old daughter's sessions with a counsellor made her feel uncomfortable and insecure.

Karen: "Yeah, ... I think 'what are they saying?' and like is she gonna hate me... is she gonna come back with an image that I'm a crap mother and that I've really not done a good job of bringing her up, so I'm anxious about that."

In summary, there was a notable absence of awareness or curiosity for parents about the conversations their children were having with others (including spouses, mental health practitioners, etc.) about PMHP. Mostly parents viewed these conversations as helpful. However, a small number of participants had concerns about particular conversations.

All the social processes discussed led at times to talking, while at other times to reluctance to talk about PMHP. Also, the interaction between these social processes could at times lead to real dilemmas for the parent about whether to talk or remain silent.

DISCUSSION

For many of the parents in this study severe and enduring mental distress is like a violent storm sweeping into their and their families' lives, often without warning. However, in between, around, alongside and despite these experiences, the ordinary and the everyday survive. Within these ebbs and flows of life around mental distress, families have to make

sense of their experiences while also living their lives. This study has shown that both talking about PMHP and keeping silent were part of this process.

It was shown how parents were anxious to keep their mental health difficulties from their young children in order to protect them and maintain their innocence. However, it was apparent that this position was not sustainable. Children's questions and comments confronted parents with the children's awareness of their mental health difficulties. This is in line with previous research with children (e.g. Mordoch & Hall, 2008; Riebschleger, 2004). Even though we see children here as active agents in their attempts to make sense of their experiences, research involving children themselves needs to be held in mind. Researchers such as Totsuka (2010) and Van Parys and Rober (2012) have emphasised the recursive process between parents and children. Thus, just as parents are influenced here to open up conversations by their children's questions, these authors have speculated that parents' own ambivalence about talking could inhibit the child from asking questions. One could therefore assume that despite these parents' experience of the insistence of their children on explanations, there might have been many questions the children felt unable to ask or observations and experiences they felt unable to explore with their parent. Where parents acknowledged awareness they had to consider whether and how to talk to their children about their MHP. The decisions around this appeared to be made in the moment, depending on the context and the function talking or keeping silent could serve. Talk, when it happened, was often informal, interwoven with everyday conversations and often general and partial. This broadens the current literature where the focus is often on information about the mental health diagnosis being passed on to children (e.g. Cooklin, 2008) and encourages clinicians to also explore the everyday talk in families.

Parents in this study appeared to make many assumptions about what children knew about PMHP, based on what the children had experienced or witnessed. However, witnessing and experiencing is likely not to equal understanding or coping in the way that parents appeared to assume or hope for here. One could argue that actually this assumption that the children understood could hinder the very development of such understanding. Overall, the findings of the study, in line with most other research in this area, highlight again the importance of supporting children in their meaning-making in relation to PMHP.

The clinical implications of the study will now be discussed, drawing primarily on Systemic and Narrative therapy frameworks.

Implications for therapeutic work

It was highlighted in the introduction that services for children of parents with MHP are lacking and that the responsibility to help children make sense of PMHP therefore most often fall on parents. This study has shown the real challenges this can pose for parents. Therefore, the study highlights again the need for a family-orientated approach within adult mental health services and for the inclusion of children in service-provision for parents with MHP.

Where practitioners do work with parents with MHP and their children, the following should be considered:

A different relationship with 'information' and communication about mental distress. The findings of this study challenge the idea of 'information' as presented in the literature, namely that children (only) need explanations about the diagnosis and treatment of the parent's 'mental illness'. Rather, this study shows that parents and children interweave talk about PMHP into everyday conversations. It has also been shown that talk does not only

happen once, but rather that there is an ongoing need for conversation around evolving family circumstances and unfolding events and in response to the child's development. In the context of these findings, the main approach offered in the literature of providing children with psycho-education about their parent's mental health diagnosis can be seen as only one intervention into children's developing understandings that began to form before the intervention and will continue to form after the intervention. Thus, opening up space to include the existing understandings of both parents and children, rather than presenting children with a fixed practitioner-led explanation of PMHP, would enhance such psycho-educational interventions. Furthermore, following psycho-educational interventions parents and children would benefit from continued accompaniment in developing their evolving understandings of mental distress. Finally, parents' silence as much as their talk have been shown to be meaningful and purposeful. Thus, the meaning of not talking should be explored rather than assumed.

Acknowledging parents' role in supporting children's meaning-making. In the literature parents with mental health concerns are often marginalized in the consideration of support for children's meaning-making. However, this study shows that parents are active in their consideration of children's development of understanding and face many challenges in this regard. It is argued here that, whenever possible, parents should be seen as key persons in responding to and mediating the influence of their MHP on their children (Focht & Beardslee, 1996). Parents should be actively supported in their deliberations of what children should know and the implications of information. Given some parents' sense of themselves as contaminated or 'toxic' to their children, this might need to include addressing parents' own meaning-making and internalized self-stigma. This is likely to require practical guidance and on-going support from mental health practitioners.

Responding to the need for talk and silence. This study has shown that at times following psychological crises, parents and children can purposefully value silence about MHP. It is important that therapists acknowledge and celebrate opportunities for normalcy and the everyday, while also working to gently open spaces to address what occurred and learn from a crisis to help ameliorate the impact of future crises. In this study families have shown how contexts of tenderness, togetherness and humour could hold and facilitate these potentially painful conversations. Carefully facilitating these conversations, while actively supporting the parent and managing the intensity of the conversations (Pihkala, Sandlund & Cederström, 2011) is important. Here the role of the therapist can be conceptualized as, where possible, strongly aligning with the parent to mediate the influence of PMHP on the child.

The position from where the family have these conversations is important. Externalizing practices (White, 2006) allow family members to see the parent as separate from the problem, thus enabling parents and children to unite in exploring together their hopes for family life. There should be allowance for the mental health issues not to dominate life where possible – that is, that parents and children could have a secondary relationship (Mason, 2004) with the difficulties, allowing for their relationships with one another to remain central and making space for the ordinary and everyday.

Furthermore, telling ‘double-stories’ (White, 2006) could be particularly useful here. It is important to fully hear, acknowledge and validate the difficulties and challenges faced, but also to fully hear, acknowledge and validate the skills and knowledge developed by living with PMHP (Denborough, 2010). This could include finding the relational places the mental distress could not touch (Mason, 2004). The aim of these therapeutic interventions is thus not to justify the parent’s actions of hurt, abuse or neglect or to dislodge or replace memories of

hardship (Denborough, 2010). However, it seeks to accompany these recollections with memories of responses, skills and specific lessons learned.

In addition to these shared spaces for talk, the findings also point to the potential importance of providing individual spaces for both parents and children to talk through their experiences. Parents' experiences were shown to include suicidal thoughts or actions, bizarre, frightening and confusing mental experiences and traumatic events. Modelling clear boundaries about what to share with children, while also allowing parents opportunities to process such experiences, seem important. Parents also described on occasion needing the care and protection of their children. These perceptions and interactions potentially pose challenges to the parent-child relationship and to the wellbeing of the child. It could also restrain the child's own meaning-making. Furthermore, the struggles the parent themselves may be experiencing at these times, could obscure these influences on their children. Thus, it is important to create a safe space for parents to develop an awareness of the implications of such relational patterns. Parents could consider their needs at these times and develop strategies to respond in ways that may be less detrimental to the child.

Also, many parents indicated that they wanted their children to have a space to talk about their experiences free from a need to protect the parent. Therefore opportunities for children to have such conversations could be important where appropriate. Helping children make meaning of their experiences and develop the skills of living in difficult circumstances could go a long way to helping them experience their situation as more manageable and strengthening their resilience.

Supporting parents in talking to their children Finally, as most families will not have access to family-orientated services, parents who access adult mental health services should

be supported in how to talk to their children about PMHP. Guidance for parents about what is developmentally appropriate for children to know, how to talk to their children about their difficulties and how to respond to their children's questions all seem important here.

Limitations of the study. Recruitment to this study was challenging, particularly recruiting fathers, and therefore participant numbers remained small and fathers' views underrepresented. Reasons for this included lack of consideration of the parenting role of mental health service-users, concerns of mental health practitioners about asking their clients to talk about their children and similar concerns from participants themselves. Also, men did not appear to be considered within their roles as fathers. These are often-reported challenges within the field of parental mental health research (e.g. Pihkala, et al., 2011; Stallard, et al., 2004). Furthermore, children's experiences are seen here through the perspectives of the parents and this research should be considered within the context of studies that have explored the experiences of children themselves.

Future research. Despite these limitations this study provides a richer understanding of the social processes that impact on parents' decisions about whether to talk to their children about PMHP or remain silent. Given the clear evidence for the importance of understanding and meaning-making as protective factor for children where there are PMHP, further research that helps us understand family dynamics around talking and remaining silent is indicated.

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Figure one: Social processes that influence parents' talk with their children about PMHP

“Protecting innocence”, “Acknowledging awareness” (including “Casting children as mature and knowing”), “Negotiating mutuality” (including “Maintaining their lives together” and “Protecting their children and being protected by their children”) and “Relating to others”