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Talking and making meaning about parental mental health problems: the role of children's family caregivers

Abstract

When a parent is less able to meet their children's needs due to a severe and enduring mental health problem other adult family members often help with childcare. We present a Grounded Theory of how children's family caregivers construct meaning about the parental mental health problem and communicate about it with children. Nineteen caregivers participated in qualitative interviews. Each supported at least one related child aged 4-17 with a parent with mental health problems. We found that caregivers engaged in a core social process of *providing protection in uncertainty.* This comprised three categories: *shaping the interactional space*, *communicating through the developmental process*, and *engendering a sense of safety*. Caregivers appeared to act from a key social positioning of *developing a caregiver identity*. The findings implicate family-focused provision of mental health and social care. Clinical recommendations are made for whole family interventions and the role of marital and family therapists.

Introduction

An estimated 68% of women and 57% of men with mental health problems (MHP) in the United Kingdom (UK) are parents (Royal College of Psychiatrists, 2016). When a parent experiences MHP, the whole family are affected. However, despite an intention to shift from individualised to integrative care - and a whole family perspective (Department of Health, 2013; Health and Care Act, 2022) - mental health care in the UK and elsewhere most often remains focused on the needs of the individual whilst the impact on the wider family remains unaddressed (Gammage & Nolte, 2020; Reupert & Maybery, 2007). Marital and family therapists are ideally placed to offer integrated whole family care and highlight the needs of families impacted by parental mental health problems (PMHP). Therefore, increasing marital and family therapists' awareness of the family members' lived experiences of PMHP is essential. This study aims to increase this awareness.

The impact of PMHP on different members of the family can be wide ranging. Children can encounter psychosocial challenges both in childhood and into adulthood including attachment difficulties, poor adjustment and coping, internalising and externalising behaviours, intimacy problems, anxiety, depression and caregiver burden, and higher use of statutory mental health services (Foster, 2010; Foster, 2015; Knutsson-Medin, Edlund, & Ramklint, 2007; Sharp & Fonagy, 2008). Their relatives can experience a range of challenges to emotional wellbeing, family relationships and disruption to work and social life (Gammage & Nolte, 2020). Therefore, families need to adapt to provide childcare and support children through these challenges.

Support can take many forms, both practical and emotional: e.g. the child's other parent or step-parent may do more parenting and housekeeping; an aunt living nearby may do the school run; grandparents may take parental responsibility; an older sibling may comfort a younger sibling when a parent acted unusually; and many other scenarios (Reupert &

Maybery, 2007). Relatives may offer differing levels of support and this is not necessarily related to their role or position in the family. Family support has been associated with reduced frequency of acute parental mental health episodes and hospitalisation, parents retaining custody and better psychological outcomes for children (Ackerson, 2003; Rudder, Riebschleger, & Anderson, 2014; Winokur, Holtan, & Batchelder, 2014). Children's family caregivers (FC) contribute to the consistency of their emotional care, attachment relationships, and practical needs (Davey & Lynch, 2016; Fischer & Gerster, 2005; Reupert & Maybery, 2016). FC may practically support the parent-child relationship, such as facilitating contact if they live elsewhere or are in hospital (Cunningham, Oyebode, & Vostanis, 2000; Marrs, Cossar, & Wroblewska, 2014). Children report how helpful emotional support from relatives can be for managing the challenges of PMHP (Handley, Farrell, Josephs, Hanke, & Hazelton, 2001; Mordoch & Hall, 2008).

However, the informal (i.e. not legally formalised) provision of support for children means that FCs' needs and roles often go unrecognised (Afzelius, Plantin, & Ostman, 2018). Psychosocial challenges for family caregivers are widely recognised, including disruption of hobbies and career, isolation, emotional distress, parenting stress, financial burden, grief and burnout (Ostman, 2007; Rudder, Riebschleger, & Anderson, 2014; Gallagher & Mechanic, 1996). Stigma from peers, professionals and strangers can be challenging (Bruland, Lenz, & Wahl, 2017). Role change and loss is a unique challenge, especially for custodial grandparents (Ziminski, 2007) and when there are child behavioural difficulties (Goodman & Silverstein, 2006). A central issue for FC is whether they identify, or have been identified, as carers (Cowling, Seeman, & Gopfert, 2010); a father whose spouse has MHP may shoulder the childcare and support his partner but identify as 'dad' and not as 'carer'. Therefore, this population are often 'hidden'. Furthermore, most evidence of the impact on carers affected by PMHP comes from studies with FC of adults, not FC of children.

Family verbal communication has been identified as a key factor in familial coping in the context of PMHP (Reibschleger, Grove, Cavanaugh, & Costello, 2017; van Doesum , et al., 2019; Yates & Gatsou, 2022). Poorer outcomes for children correlate with a less communicative family environment (Plass-Christl, et al., 2017). Unexplained thoughts and feelings can lead children to blame themselves for the PMHP or to fear 'catching it' (Mordoch & Hall, 2008). Conversely, increasing mental health literacy can improve psychological outcomes for children and adults by reducing guilt and distress and enhancing family resilience (van Doesum , et al., 2019; Yates & Gatsou, 2022). Verbal communication about PMHP is thought to improve children's conceptualisation by providing shared mental health terminology and a more coherent narrative (Focht-Bickerts & Beardslee, 2000; Yates & Gatsou, 2022). It also helps them to predict and interpret parental behaviour (Cooklin, 2013; Pikhala, Sandlund, & Cederstrom, 2011).

FC are thought to promote family communication and support meaning-making about PMHP, which can protect children's psychological health and foster resilience (Reupert & Maybery, 2007). Parents with MHP report that supportive relationships with FC can improve family communication, permit children to talk about PMHP, express emotions and develop understanding about MHP (Nolte & Wren, 2016). Correspondingly, children report seeking reassurance from FC (Maybery, Ling, Szakacs, & Reupert, 2005; van Parys & Rober, 2012), particularly when their parent is acutely unwell (Cunningham, Oyebode, & Vostanis, 2000; Tabak, et al., 2016).

However, a number of factors have been shown to inhibit family communication about PMHP, including guilt and shame (Nolte & Wren, 2016), a belief that concealment can protect children (Ballal & Navaneetham, 2018), uncertainty about what to say and relational difficulies (Yates & Gatsou, 2022). In the absence of professional intervention, FC can find conversations about PMHP challenging (Reupert, Cuff, & Maybery, 2015) and it is widely

reported that FC would value support with talking to children about mental health (Jones, Pietila, Joronen, Simpson, Gray, & Kaunonen, 2016).

The importance of family communication in child and family wellbeing within the context of PMHP is of particular significance for marital and family therapists, given the potential to intervene at the level of relationships, interaction and meaning-making. However, the majority of research into family communication about PMHP has focused on the parent with MHP or their child (Nolte & Wren, 2016; Yamamoto & Keogh, 2018). FC's roles in supporting communication are clearly important, yet there is a dearth of research with this group (Gammage & Nolte, 2020). There have been calls to inquire specifically into the nature of child-caregiver communication (Nolte & Wren, 2016; Reupert & Maybery, 2016; Saunders, 2009). This study sought to address this gap by speaking with children's FC about their perceptions of PMHP and their experiences of verbal communication with children.

Method

We used constructivist Grounded Theory methodology (GT; 2014) to collect phenomenological data about FCs' communication experiences. Contesting the legitimacy of the physical world and questioning lived experience is not always helpful or therapeutic in clinical settings (Smail, 2005). We aimed to develop substantive theory about participants' constructed lived experiences and social worlds (i.e. the 'what' but also the 'how' and 'why'; Charmaz, 2014), whilst acknowledging the presence of an influential reality independent of the human mind. Taking a critical realist stance, we attend to how individuals make sense of their psychological and embodied experiences, and the cultural and structural contexts they occur within. Charmaz' (2014) constructivist GT supports critical positions, describing 'layers of reality', inter-subjectivity and the co-constructive role of the researcher. Qualitative interviews allow participants' experiences to be explored whilst acknowledging the co-

construction between interviewer and interviewee. The research team were qualified and trainee Clinical Psychologists with training in systemic psychotherapy, and a clinical and research interest in the topic area.

The guiding research questions were: (a) How do children's FC make sense of parental mental health problems? and (b) How do FC give an account of their communication with children about parental mental health problems, and what influences this?

Participants

Recruitment across the field of parental mental health is known to be challenging (Cunningham, Oyebode, & Vostanis, 2000), particularly of male participants (Nolte & Wren, 2016). Consequently, a recruitment strategy comprising multiple pathways was developed (Table 2) to recruit FC in the current study. This supported sample heterogeneity and reaching FC who were not service users and who did not identify as carers.

Table 1: Summary table of recruitment pathways and methods.

Pathway type	Example organisation/group	Recruitment methods
Children's Social Care	- Regional children's social care teams - Family fostering and kinship care teams	- Staff informed about study by researcher during presentations at meetings. - Staff approach potential participants and refer to the researcher if interested.
Charities and third sector organisations (local and national)	- Mental health charities - Carers charities - Drug and alcohol charities	- Staff and members informed about study by researcher during presentations at meetings. - Study information circulated online via mailing lists, Twitter or website.
User-led community groups (local)	- Mental health mutual support groups - Community service user involvement and consultation organistions	- Staff and members informed about the study by researcher during presentation at meetings. - Study information circulated online via mailing lists, Twitter or website. - Posters and flyers displayed in group premises.
Internet-based recruitment	- Twitter - Mental health forums - Parenting forums	- Study promoted via study Twitter account and website. - Posters and information posted on forums/groups.
NHS	- Local Child and Adolescent Mental Health Services (CAMHS) - Service user involvement networks	- Staff informed about the study by researcher during presentation at meetings. - Staff approach potential participants and refer to researcher if interested. - Circulation of study information via service-user involvement networks.

Inclusion criteria for participants were: aged 18+; parent/carer for a related child/children aged 4-17 with a parent with a MHP; willing to participate in a research interview; and did not have a severe and enduring MHP themselves. Participants were defined by their involvement in the child's practical and/or emotional support. The recruitment materials stated that they may/may not identify as a carer and may/may not have a kinship or other legal agreement. Time spent on caregiving was not specified as existing literature indicated that this varies significantly (Reupert & Maybery, 2007; Rudder, Riebschleger, & Anderson, 2014). Due to the focus on verbal meaning making, families where the children were under 4 or had a developmental or language acquisition disorder were excluded. It was expected that participants might experience mild low mood and anxiety as is common in caring populations; this was considered unlikely to significantly affect childcare or communication. Interpreters were available but not required.

Much recruitment was via opportunity sampling, and in some cases (e.g. service user groups) snowball sampling became possible via participants or organisation leads. Recruitment was purposive to try to obtain a sample diverse in age and gender, child age and gender, PMHP, culture and ethnicity (see Limitations). A further 16 potential participants either declined to participate, were ineligible following screening or had too many commitments to take part. Potential participants were provided an information sheet either by the researchers or a referrer (e.g. social care worker) and given a minimum of 24 hours before being contacted again. If interested, they had a telephone screening call with one of the researchers and were then given a further 24 hours to decide whether to participate.

In total, 19 participants took part in 18 interviews (see Table 2). Twelve were female and the age range was 24 to 69 (mean=49). All were white British except two white immigrants who had lived in the UK for more than 10 years. Between them, the participants looked after a total of 33 children, and between 1 and 4 children each. There were

considerably more male (n=22) than female children, with a mean age of 11.7 years. This is not a reported pattern in other literature and may have been coincidental. Eight spouses, three ex-spouses, six grandparents, one aunt and one sister participated. When asked their occupation, seven participants self-identified as either full- or part-time carers; the other 12 did not. Eight provided care to the parent with MHP as well as the child. Length of time in a childcare role ranged from 4 to 20 years. The parents with MHP were mostly female (n=13). All caregiving grandparents looked after the child of a mother with MHP. The sample was limited in ethnic diversity, FC gender balance and FC age. Attempts were made to address this, with most success in recruiting more males.

Table 2: Summary table of participant demographics

Name (Pseudonym)	Age	Gender	Relationship to child(ren)	Number of children cared for due to PMHP	Occupation
Liz	67	F	Grandmother	2	Full-time grandmother
Jon	45	M	Stepfather/ Father	1	Full-time carer / unemployed
Marcus	44	M	Father	2	Part-time manager; Dad; Carer
Connor	34	M	Father	1	Full-time clerk; Dad
Alice	24	F	Sister	2	Full-time student; support worker
Lucinda	42	F	Aunt	2	Full-time clerk
Christopher	48	M	Father	1	Full-time professional
Tash	42	F	Mother	1	Full-time carer; part-time clerk
Emilia	30	F	Stepmother/ Mother	4	Full-time professional
Marilyn	56	F	Grandmother	3	Carer
Rosie	62	F	Grandmother	3	Retired clerk
Kimberley	42	F	Mother	2	Homemaker; carer
Allen	69	M	Step-grandfather	3	Retired professional
Judy	67	F	Grandmother	3	Retired professional
Darcy	49	F	Mother	2	Full-time carer; volunteer
Sally	49	F	Mother	1	Support worker
Lorraine	58	F	Grandmother	1	Carer
Pete	60	M	Father	1	Full-time self-employed business owner
George	41	M	Father	2	Carer

Procedure

Ethical approval was granted by both a university ethics committee and NHS Research Ethics Committee, enabling participant recruitment from Children's Social Care, third sector organisations, online forums/websites and NHS services. A pilot interview and consultation with a local service user and carer committee guided the development of the initial interview schedule and study documentation. Individual semi-structured interviews used 'intensive interviewing' (Charmaz, 2014) to facilitate in-depth exploration of lived experience via interviewer-participant connection. Interviews lasted between 50 and 90 minutes. Most took place in participants' homes in a confidential space and/or when other family members were out. Due to participant preference one was conducted in a community location, three on university premises and one via video call, to overcome geographical distance. Participants provided informed consent before demographic information was collected and the interview began. Participants were offered debriefing at the end.

The interview guide comprised broad questions that focused on how FC communicated and made meaning with children about PMHP (e.g. 'Do you ever talk to the child about the mental health difficulty? What's it like?'; 'Can you tell me how conversations come up and how you decide what to say?'). Questions were added through the iterative data collection/analysis process to explore and test arising concepts, such as changes to communication as children get older and development of caregiver identity (e.g. Interviews 6-10: 'Do you feel your relationships with the children have changed?'; Interviews 11-16: 'How do you feel that the caregiving situation has impacted on you?').

Analysis

Data were analysed using Charmaz' (2014) guidelines for constructivist GT. For closeness to the data, the first author transcribed eight interviews, re-read all interviews multiple times and primarily coded all data. Transcripts were stored and analysed using

qualitative analysis software NVivo v.11. Initial line-by-line coding of four interviews was conducted, using gerunds to capture process. Secondary coding of four of the early interviews was undertaken by three other researchers for credibility. The initial codes were sorted, condensed and refined into focused codes within NVivo according to their analytical contributions, and applied to six more transcripts. Constant comparison of the data, returning to the research questions and collection of new data via interviews progressed in an iterative fashion. The interview schedule was updated for interviews 6-10 and again for 11-16 to test evolving theory. Theoretical sampling was used in the latter interviews to recuit males and particular types of relatives. Evidence of theoretical saturation was identified by interview 15. the focused codes were used to develop conceptual categories and theoretical codes on paper. Clustering and renaming allowed exploration of different groupings and models, alongside diagramming. The coding hierarchy was reorganised on NVivo numerous times as the analysis progressed to facilitate analysis of the evolving models against the raw data. Seeing how negative cases (Charmaz, 2014) contrasted with major conceptual patterns was particularly informative. Through these processes, the models and codes adjusted until the model appeared to account for the majority of the data. Two final interviews were sought to check the theory with participants and elaborate the categories, providing a means of triangulation. Memoing, a research diary and team reflective discussion were used throughout to support theory development and abstraction from the data.

Tracey's (2010) 'Big-Tent' framework was used to evaluate quality through the research process and Hutchinson, Johnston and Breckon's (2012) assessment criteria were applied to assure the implementation of GT method. The COREQ 32-item checklist (Tong, Sainsbury, & Craig, 2007) was used to maximise reporting quality.

Results

A core social process (CSP) of *providing protection in uncertainty* were conceptualised, which comprised three categories: (1) *shaping the interactional space*; (2) *communicating through the developmental process*; and (3) *engendering a sense of safety*. By contributing to children's meaning making, all FC described engaging in protective processes and communication with the child, parent, family and themselves, within a pervasive context of unpredictability due to the PMHP. FC were found to position themselves or approach the childcare role according to their view of the parent's and child's needs. This was conceptualised as a key social positioning (KSP) of *developing a caregiver identity*. Caregiver identity was understood to provide a reference point for FCs' meaning-making and communication choices with children. It was seen to evolve in response to interpersonal interactions and mental health-related events. FCs' communication with children appeared to vary in terms of verbalisation (i.e. whether meaning was conveyed through speech, intonation, silence or action), intentionality (i.e. whether FC intended to convey meaning or not) and awareness (i.e. whether FC appeared to recognise that they had communicated). These relationships between these processes and categories are depicted in Figure 1. How they manifested will be discussed throughout the presentation of the findings, as will the relationships between the categories. A diagram showing the hierarchy of the categories and subcategories can be found in Figure 2.

Category 1: Shaping the Interactional Space

The ways FC contributed to *shaping the interactional space* with children was seen to influence if, how and when communication occurred about PMHP. FCs' beliefs about what would protect children appeared to guide them towards *cultivating openness and curiosity* or *remaining silent* at different times. Most caregivers talked about using both approaches in

accordance with the arising needs of the child, parent or themselves, with child age and PMHP severity as important mediators. Whilst seemingly contradictory, it appeared to represent caregivers' flexibility and adaptability, but also at times confusion about what is best, responding moment to moment in uncertain circumstances.

Cultivating openness and curiosity. Most FC described the belief that communicating about PMHP-related experiences would benefit children's emotional wellbeing, drawing on a societal view that it is better to "not just bottle it all up" *(Liz)*. Even when the PMHP was not talked about often by either FC or children, FC appeared to understand that talking may be beneficial and aimed to provide a context where children could raise it if they wanted to:

> If they're worried about anything they can talk to us … And try and get them to open up about it, because if they open up then it helps them, because it's not inside them and it's not sort of like, laying inside them. Until they're in their (…) I dunno, until they're an adult and then all of a sudden it'll explode. (Rosie)

Some FC explicitly told the child that they could ask or talk about PMHP as needed, whereas others described constantly monitoring for it coming up in conversation and responding in the moment. The belief that communicating could help appeared linked to FCs' own experiences of talking: "That's what's helped me through it all" *(Jon)*. FC weighed up how to approach conversations as PMHP could be a distressing topic. This included not "pushing and pushing" (Darcy) and "try(ing) and be gentle as to what they've been through" (Rosie). FC thought about how to adapt to children's needs over time, including delaying communication until the child was more emotionally ready, older or asking questions:

> As she get's older, if Amber asks me questions, I will answer them as honestly and as age-appropriate as I feel she can deal with. *(Lorraine)*

Cultivating openness and curiosity also included creating a time, space or place for general communication about emotions and problems. Examples of these spaces included dinnertime,

bedtime and when out on a walk. There appeared to be an unspoken understanding that PMHP could be discussed at these times, giving FC a chance to learn how the child felt and to share mental health knowledge:

> It's mostly when we're walking outside. You've got space. Nobody else is gonna bother you. You know there's an end, because you're gonna arrive… I've always enjoyed conversations walking because it does feel (...) it feels somewhat freer. You're not gonna see an email appear (…) all the… all the distractions. *(Marcus)*

Many FC appeared to proactively engage children in conversations about PMHP. This was often in response to parental mental health crises, the child's distress or life transitions. Alice described engaging her brother when he was upset, seemingly trying to protect him from sadness and strengthen his resilience. This appeared to help over time, indicating active engagement as an effective strategy for emotional processing and containment.

> When I said about mum, if she's snapped at him and then he's been upset and I'll go upstairs and mull it over, try and tell him he's not stupid and stuff like that, he'll say things then. He used to be quite closed… but in the past like couple of months or so he's opened up really *(Alice)*

Remaining silent. Despite the value that FC placed on helping children cope with the PMHP, many described holding back from direct communication or said it was rare or intermittent. This appeared linked with the child's developmental stage, desire to control the flow of information, the presence of the parent and the need for emotional protection. Alice noted that "it's not necessary to talk about it all the time". This indicated how silence could be the FCs' preference, seemingly for emotional protection. Others described a fear of upsetting the child and not knowing what words to use:

> We have never known how to say, you know, "Daddy's unwell." How do you tell a

> six-year-old? Um, without them stressing that Daddy is gonna die? ...we just haven't told them. I don't know how you would tell a child that their father has bipolar. *(Kimberley)*

Kimberley and Darcy both felt they would value professional support with how to talk to the children, with previous attempts having provoked anxiety or arguments:

> I think a lot of parents would like to know how to talk mental health with their children without scaring them. Because the bipolar scares me. *(Kimberley)*

Several FC focused on everyone's physical safety whilst avoiding detail about the parent's mental state. This appeared to draw on societal views that "too much detail" *(Tash)* or not giving information in child-friendly ways "could do a lot of harm" *(Steve)* and that caregivers ought to protect children, enabling them to "be a child for a little longer" *(Liz)*. Some caregivers talked instead about lifestyle habits that could promote good mental health, such as play, sleep and diet. Some described minimising communication with children to limit what they could tell others, which played a role in protecting the family from external scrutiny or critique, which could be "hurtful" and "conversation (…) that I wasn't really comfortable with" *(Marcus)*. Minimising communication about PMHP was believed by some to help the parent-child relationship:

> It's hard to talk to her about her mother in a positive way. To be honest I'd rather not talk if I can, about that. If I keep talking negative about her mother which I have done … maybe I shouldn't have. So I try not to, I think. *(Pete)*

Many FC described that the amount of communication about the PMHP had fluctuated over time. Perceived safety appeared to be at the heart of the decision to talk or be silent:

> [We talk] more often now than before. When we were in crisis when it was, I dunno, you- you basically just had to live in the crisis. Erm, but we're beginning to

> do that and in a lot more erm (...) objective way? *(Marcus)*

Several FC described children unexpectedly raising PMHP during everyday activities, spanning the child age groups. FC appeared to seize these moments and valued the insights into the child's thinking.

> He's sitting on the toilet and he went- what was his words? "Am I going to live here now Nanny?" I went, "Yes, darling." Like he's on the toilet, okay! *(Marilyn)*

> I'd be cooking tea or something and he'd come into the kitchen and talk (…) whether he might go and see mum or not and how he was feeling about it. *(Judy)*

All FC described nonverbal and indirect meaning making with children via behaviour. However, their awareness of this and how intentional it was appeared varied. Several FC mentioned notes or letters being written by themselves, the child or the parent. Some suggested that writing could feel protective and overcome barriers to talking:

> So she didn't tell me, she wrote me a note. Yeah she would tell me, but not by actually speaking. So she had- in her head, she hadn't betrayed Mummy because she didn't actually say it. *(Liz)*

Many FC described communicating care to children through touch and presence rather than words. Examples were given of children seeking physical closeness to the FC. FC appeared to use these nonverbal communications to interpret the children's needs. Watching the child interact with the parent with MHP also gave clues about their level of understanding:

> But Cami (...) er, she's seen it, it doesn't upset her. She goes to him and she goes "It's alright Daddy". She just sits with him and says things, 'cause she must have heard me say it so many times, "Breathe (...) two (...)". *(Tash)*

Here, Tash shows awareness that her child had learned about PMHP by witnessing everyday caregiving scenes.

Category 2: Communicating through the Developmental Process

This category was characterised by FCs' efforts to provide appropriate, meaningful and useful information to children, in relation to their current age and cognitive level (*communicating age-appropriately*), and perceived developmental needs (*investing in the child's future*). FCs' communication decisions appeared to be guided by social knowledge about protection and parenting. They frequently made conscious choices about what to say and how, although it seemed that at times frustrations or concerns about the parent with MHP would likely be conveyed either through words or by what was unsaid.

Communicating age-appropriately. All FC described seeking a relatable explanation for the PMHP, with most using 'illness' as a comparative framework. This was considered understandable due to children's experiences of physical illness. Some FC felt that it oversimplified the MHP but was age-appropriate, which they judged by children appearing satisfied and asking no more questions ("He was quite happy with that" – *Marilyn*). Others noted that the parent had introduced 'illness' terminology ("So, she says, "Well, I'm ill, you know, I can't" – *Judy*). Several FC of younger children described 'softening' explanations for younger children and removing medical terminology, seemingly as a protective strategy, whereas older children sought more detail. Caring for children of different ages appeared to present a challenge, as did deciding whether getting older constituted a reason for disclosure:

> He's 17, he still doesn't know everything. It's on like a need-to-know basis… She is talked to a little bit more, but still she doesn't know the ins and outs. *(George)*

Emilia, the only FC to describe faciliating parent-child communication about PMHP, explained that professional advice had stimulated conversations that improved the children's understanding:

> So he [dad with MHP] explained what PTSD is, in sort of child friendly ways. He said that he's experienced some bad things, his head's not been able to process

> them… So they now, sort of, you know, tongue-in-cheek go "Oh Dad's like Ironman!" [laughs]. Which was a very positive turn because everybody was like "Ooh". I was half in tears. *(Emilia)*

There were differing views about the role of biology and genetics in the development of MHP and the helpfulness of using these explanations with children. Some worried that a biological explanation would give the child concern about their own risk of developing MHP:

> That's really, really unhelpful! Because you're basically saying to … this girl, "You're likely to get your mum's illness". (*Marcus)*

Others used 'illness' to externalise the MHP from the parent's personality, to protect the parent-child relationship:

> Say they were going for tea tomorrow and she rings tonight and says she can't have them (…) erm, I can't say that to them. I say "Mummy's not well". (*Liz*)

Regarding nonverbal communications, many FC described observing how children communicated with and about their parent to monitor their distress level and support needs. These child-led cues were guiding FC in giving reassurance, offering explanations and for considering practicalities like contact.

> Bethanie started to notice that her mum speaks differently, that she laughs differently. So that was a sign for me, like (...) Bethanie's starting to understand her mum's mental health. *(Connor)*

Several FC described metaphorically 'stepping into the child's shoes' as a perspective-taking technique. This appeared to enable them to pre-plan age-appropriate communication and to protect the child emotionally.

> Alanna (…) see, it breaks my heart, has gone straight up to her Mum and stood there. Not a word said between them. And it hurts, and it upsets and that's how I

> feel. So how on earth does that child feel? *(Marilyn)*

Perspective taking was conceptualised as a way that FC could explore what children understood. At times, FC appeared to assume what children would be thinking and worrying about. This seemed to help them plan for potential sources of distress:

> They're little boys, you know, they'll just worry. And "Daddy is sick, so when is Daddy going to get better?" - "Daddy is not going to get better." - "Is Daddy going to die?" You know, I can see these questions coming now. *(Kimberley)*

Notably, not all FC appeared to consider whether the child thought about PMHP during periods without PMHP communication. This may reflect FC sometimes needing to 'switch off' from PMHP, or some being less attuned to unverbalised experiences than others.

Investing in the child's future. FC talked about supporting children's futures by strengthening their emotional resilience, opportunities and relationships. In doing so, they intentionally and unintentionally shared meanings about mental health, help seeking and coping strategies. Many talked about using praise, encouraging self-reflection and supporting extra-curricular activities. This appeared linked to the understanding that PMHP puts children at risk of poorer psychological and social outcomes, that the child "could get ill some day" (*Connor)* and the hope to mitigate this.

FCs' beliefs about how MHPs may develop (e.g., genetically linked, environmental) were revealed to some extent through these comments; this could be expected to shape the meanings they shared with children. Some caregivers described using destigmatising and normalising narratives about MHP with children:

> But I think there's a big picture, so when he's older he would understand that, yeah, (...) nobody's protected from mental health and it happens. *(Emilia)*

As well as conveying meaning about PMHP, this was understood as a strategy to support the parent-child relationship, which several FC did as an investment in the child's future regardless of whether they had a good relationship with the parent themselves or not. Refraining from negative communication about the parent ("I never talk about her mother in a negative way" - *Steve*), discussing caregiving practices ("We'll be here, we'll look after him" – *Tash*) and naming emotional positioning towards the parent ("I make sure all the time that we're never angry at Mummy" – *Marcus*) were strategies to build empathy or protect the child's view of their parent with MHP.

They often communicated about the parent-child relationship being irreplaceable. However, the challenging considerations of issues like risk management and court-mandated contact were also communicated, often nonverbally via tone or implication. These indicated the potential for conflicting messages being communicated to children. Disagreements about parenting decisions sometimes led FC to step into the parent-child interaction:

> She came out with these stiletto shoes and I said, "Give them back to your mum". She said "Oh no they're mine", she said "I bought them I thought they'd be alright for dance". I said "Oh no", I- I- probably shouldn't have said it, and I said "She does street dance not pole dancing". [pause] She was ten *(Liz)*

Alongside these challenges, the same FC described highlighting when the parent's mental health improved, even in the short-term. This tied in with a sense of hope and future focus that imbued all the interviews, as a means of supporting children's resilience:

> "We're looking forward to the time when she's better (...) And shall we plan what we're going to do?" And then we're in (...) in the hopeful part." *(Marcus)*

Making plans appeared as a strategy for remaining positive and moving towards the hoped-for future. For others, such positivity could seem disingenuous ("I feel like I'm almost putting on a front, playing a game" – *Lucinda*), indicating a protective intention for the child

but an emotional cost to the FC. The meaning drawn from supporting the child despite these costs often came across strongly and emotionally ("It makes me feel happy. I'm gonna cry now" - *Rosie*). Many FC made jokes during the interviews, introducing lightness to serious topics, and talked about laughing with the children. Perhaps at times this hindered the sharing of sadness and anger, but it was understood as an adaptive coping strategy:

> *Marilyn*: And, you know, to be responsible on your own for three children that have suffered (…) abuse and stuff like that, you know, it's scary. … I know what- but I just need to hear it from other people. So I'll then make a phone call.
>
> *Interviewer*: Who do you call?
>
> *Marilyn*: Um, Ghostbusters most of the time. [laughs] Sorry, humour has to come into it.

Category 3: Engendering a sense of safety

All FC described establishing a predictable and emotionally containing childcare environment, somewhere that they could feel safe and nurtured. Beliefs about safety and protection were often presented as unquestioned, thus central in FCs' values and identities. FCs' protective positions sometimes appeared in contrast to the parent with MHP, creating a comparison from which children may draw meaning. Much communication in this category appeared to occur nonverbally, via actions.

Providing a stable base. Several FC described a sense that the child *"…needed someone. To fight their corner, to keep them safe" (Liz)*. By minimising exposure to potentially upsetting scenes, FC appeared to communicate to children about risk related to the parent with MHP. For example, some FC described calling the police or removing the child from their parent. Many described being 'on call' in case of PMHP crisis. Where the parent with MHP, FC and child lived together, distraction and appearing composed were described as

emotional containment strategies, especially with younger children:

> He was in some kind of medieval battle, running away from people on horses and stuff. You know, it's just like, oof. I suppose it's like someone being on an acid trip. And at those points you have to kind of go "Right okay, well the children are safe. They're watching TV", you have to try and keep it as normal as possible. *(Tash)*

Some FC of older children described talking explicitly with children about protective strategies and acceptance of these by children, showing a shared understanding of the PMHP. No matter the child's age, FC described prioritising schooling, socialising and routines ("School is like the stability in Bethanie's life" – *Connor*). This signalled the value placed on environmental consistency and 'normalcy'. Routine was also described as helpful for the parent with MHP and interaction with the child. Despite the importance FC placed on *prioritising protection and containment*, it was also associated with role confusion and loss. Distress associated with role confusion appeared particularly strong for grandparents, and likely affected children too:

> Well I suppose the last year I have been the parent, although I have been acting parent for three years. Erm (...) he [grandson] sometimes forgets himself and says "Mum" but I say "No, Nan". *(Liz)*

FC described the "very emotional rollercoaster" *(Liz)* of their experience, including anger, sadness, loss, self-doubt and loneliness. Some described controlling their emotions so that the child would experience them as predictable and they would feel in control:

> …Camille wanting my attention, Katerina starts crying and then Javi has psychosis, I might be a little bit more fraught than I would want to be. So I'm like "Arrghhh", whereas I wish I could be more "I got this, I've got this, I can deal with this". *(Tash)*

Alongside managing their own shifting identity, FC were required to tolerate the uncertainty of PMHP to meet children's needs. FC regularly named uncertainty about their childcare decisions – particularly females – including feeling "very conflicted" (*Alice*) and not knowing if they were "doing the right thing or the wrong thing" (*Lucinda*). It appeared that these feelings were not shared directly with children, a seemingly protective strategy. Others – particularly males – described reassuring children with certainties, such as "Daddy will fix it" (*Connor*) and "I'm not letting it happen" (*Jon*). FCs' accounts indicated that certainty reassured children and FC alike, representing a functional adaptive response. It raised the question, however, of what might be communicated to children about voicing or staying silent about uncertainties or worries.

Taking an authoritative stance. FC appeared to prioritise authoritative and supportive parenting. Most provided a significant amount of childcare and needed to establish age-appropriate boundaries with the child. Whilst many scenarios would be familiar to most parents, some included repairing or re-establishing boundaries that they felt the parent with MHP had misjudged:

> She has to know the two things are true and has to be able to cope with two things opposing being true at the same time in order to erm, meet the needs of both of her parents. *(Steve)*

Many FC described being transparent and providing explanations to children, in line with an authoritative parenting style. This appeared closely tied to making meaning about PMHP with children. FC recalled giving explanations when children asked questions or after setting new rules that they felt contradicted children's expectations:

> She would get cross, would get angry (…) and then there'd be no love afterwards… The art is- I feel personally, is to get that child and just say, "Look, the reason I got cross with you was because so-and-so" and then have a cuddle *(Marilyn)*

Although negative meanings about the parent with MHP might sometimes be conveyed, as in Marilyn's comment above, it appeared that FCs' attempts to explain their decision-making supported the child-caregiver relationship and could enhance children's mentalising.

Discussion

The current study aimed to investigate how FC, the third member of the child-parent-caregiver triad, communicated with children about PMHP. A substantive GT was generated, finding that FC contributed to children's understanding of PMHP by *shaping the interactional space*, *communicating through the developmental process*, and *engendering a sense of safety*. They engaged in an overall social process of *providing protection in uncertainty* to the child, the parent with MHP, themselves and the wider family.

FC related factors influencing FCs' communication about PMHP

This study enhances our understanding of how FCs' own understandings of PMHP and their sense of their (evolving) role in the family inform what, when and how they communicated with children. Of significance when considering family communication is the differences highlighted in FC beliefs about the parent experiencing MHPs' control over their actions and emotions, with FC who attributed parental behaviour and presentation to mental health expressing more sadness and forgiveness, and those who attributed it to personality expressing more anger. This shaped the messages that they shared with children, with most FC using 'illness' as an explanatory framework. While psycho-education would be one way to respond to these perceptions, marital and family therapists are able to explore all individuals' meaning-making of PMHP with the family, and consider together the implications of these for relationships and communication (Daniel & Wren, 2005), helping families move towards a more shared and mutually acceptable language and understanding.

A further important factor shaping family communication from FCs' perspective was perceptions of their role and identity as 'caregiver', which informed FCs' understanding of the child's needs and their responsibility in meeting them. Sometimes significant role change was required (either negotiated with the parent experiencing MHP or unnegotiated) and FC appeared to be constantly re-evaluating their role to meet the changing needs of the family. This was in part shaped by what sort of relation the FC was (i.e. co-parent, parent's ex-partner, child's aunt or sibling, grandparent, etc). Creating supportive therapeutic spaces for parents and FC to consider roles and avoid role-confusion or conflict seems essential.

Child-related factors influencing FCs' communication about PMHP

FC reported regulating information flow according to their perception of the child's age-related needs and their wish to protect the child. They considered age and need in making information relatable in order to facilitate children's understanding, whilst simultaneously protecting them from overwhelming detail. Most FC were attentive to children's verbal communications. Nevertheless, meaning could still be conveyed to or received from children without direct verbal communication, for example via body language, tone and what was unspoken. In some cases nonverbal communication occurred more behaviourally, such as hugging, or behavioural changes such as distancing were imposed by circumstances, e.g., spending time apart or via changes in family constitution (e.g. in the context of child removal due to safeguarding concerns). FC reported that much remained unspoken and implicit and there was significant opportunity for ambivalence, contradiction, misunderstanding and relational rupture. Furthermore, in addition to protecting the child, protection of the self and the parent appeared to be important implicit motives in whether communication about PMHP was invited or inhibited, which could at times prevent communication. This was understood as a way for FC to cope with the strong emotions and ever-present uncertainty that often surround PMHP. Considering with parents and FC what would be age-appropriate is

therefore important. Existing practical resources such as resources from the Australian Infant, Child, Adolescent and Family Mental Health Association (2004) that specifically focuses on what age-appropriate communication would look like, could be provided. However, this also highlights the importance of marital and family therapists working with families in the context of PMHP to be fully versed in developmental psychology, something that is not always the case in training curricula.

It came across strongly that FC cherished the children greatly – and often the parent with MHP too. Messages of hope and love pervaded their accounts. Importance was universally placed on building children's resilience and planning for the future. This supports the critique of much of the literature documenting FC burden for its often-negative bias, as many also described a sense of purpose and a wish to support their family (Hayslip & Kaminski, 2005) and a (e.g. culturally-informed) understanding of caregiving and perceived burden ((Goodman & Silverstein, 2006). Conversely, similar to most of the PMH literature, FC once again highlighted how mental health stigma (including internalised stigma) needed to be considered when deciding what children should be told about PMHP. The mutual love and care, the ordinary and everyday life alongside and outside of the PMHP, and the humour and playfulness FC shared can often become lost. Drawing on narrative therapy, marital and family therapy practitioners can develop double-stories and externalise the MHP (White, 2007), which can protect parental roles and family relationships (Nolte & Wren, 2016).

Clinical Implications

PMHP affect all in the family: FC, like parents and children, are managing complex and uncertain circumstances. Carer burden was apparent, as also shown in previous research (e.g. Ostman, 2007; Rudder, Riebschleger, & Anderson, 2014) and FC should be included in support. This emphasises the importance of considering the whole family when delivering interventions to families experiencing PMHP and the important role marital and family

therapists can play. Interventions for the whole family that encourage information-sharing, positive communication, shared coping strategies and problem-solving have been described (Cooklin, 2013; Giannakopoulos, Solantaus, Tzavara, & Kolaitis, 2021; Harvey, 2018).

There is a clear need for evidence-based therapeutic interventions tailored to FCs' needs, alongside those of children and their parents with PMHP. As highlighted above, this can include: providing mental health knowledge and/or collectively considering meaning-making of PMHP in the family; considering evolving roles and opening up conversations between parents and FC about role confusion and conflict (Maenhout, Rober, & Greeff, 2014); child development education and exploring beliefs about 'protection'; communication and emotion management skills; and opening up space for considering what is going well, mutual care and valuing happy times.

The research based on the importance of communication where a parent experiences MHP have underpinned the development of psychoeducational, peer support and family-focused interventions based around improving family communication (Beardslee, 2002; Grove, Melrose, Reupert, Maybery, & Morgan, 2015; Hargreaves, Bond, O'Brien, Forer, & Davies, 2008; Yates & Lina, 2017). Meta-analysis suggests that joint intervention attending to family subsystems is most effective (Thanhauser, Lemmer, de Girolamo, & Christiansen, 2017). However, appointment timings, other responsibilities (e.g. work), family relationship breakdowns and availability of sufficiently resourced and systemically/family-focused services mean that caregivers may rarely be included in interventions in reality (Maybery & Reupert, 2006). These are therefore important factors for marital and family therapy practitioners and those commissioning services to address.

Limitations

Sample characteristics were a limitation in this study, including e.g., younger caregiver under-representation. In particular, the absence of cultural and ethnic diversity in

the sample was a notable limitation. Reasons could include barriers to service access and mistrust in professionals by racially minoritized groups, and culturally or faith-informed understanding of psychological distress meaning that potential participants did not identify the study as related to them. There is an absence of a cultural lens across the PMH literature, which should receive urgent attention in future research. The wide and undifferentiated age range of the participants and lack of specificity of mental health problem in this study limit the comparisons that can be made across groupings.

Future Research

This grounded theory would benefit from being tested with larger and more diverse samples. As this study replicated prior findings that children's FC can experience profound role change due to PMHP, it would be helpful to further examine factors that ease or challenge these role transitions. Sampling for specific criteria may also be valuable for drawing comparisons and attending to the needs of particular groups, for example those affected by specific mental health diagnoses, categories of relatives (e.g. spouses vs siblings vs grandparents) and narrower age ranges (i.e. younger vs older caregivers).

Conclusions

This research has contributed a substantive theory about how children's FC communicate about and contribute to children's meaning-making about PMHP. Existing knowledge about FC experiences been built upon and child-caregiver communication processes have been elaborated for the first time. FC have the potential to make highly protective contributions to these children's lives.The findings support the family-focused health and social care agenda with clear support recommendations for this under-recognised group of FC.

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Figure Legend

Figure 1: The relationships between the Core Social Process (CSP) of 'providing protection in uncertainty', the Key Social Positioning (KSP) of 'developing a caregiver identity' and the main categories identified are represented here.

Figure 2: Diagrammatic representation of the grounded theory model, showing the Core Social Process (CSP) and the categories and subcategories identified. This is a hierarchical and linear representation for clarity, but it should be kept in mind that the categories and subcategories were seen to influence one another, as shown in Figure 1.