MAJOR RESEARCH PROJECT

JOANNE MUELLER BSc (Hons) MSc

PARENTS’ COMMUNICATION TO THEIR PRIMARY SCHOOL-AGED CHILDREN ABOUT MENTAL HEALTH AND ILL-HEALTH

SECTION A: LITERATURE REVIEW
Communications to children about mental ‘illness’ and their role in mental health stigma: An integrative review.
Word Count: 5493 (plus 309)

SECTION B: EMPIRICAL PAPER
Parents’ communication to their primary school-aged children about mental health and ill-health: A grounded theory study.
Word Count: 7994 (plus 593)

SECTION C: CRITICAL APPRAISAL
Word Count: 1998

Overall Word Count: 15485 (plus 902)

A thesis submitted in partial fulfillment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

JULY 2012

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY
Please read the following candidate’s declaration, and tick the adjacent boxes to confirm that you have complied with each statement. Then complete the cover sheet below in full. Failing to do either will result in your assessment being delayed and/or returned to you for resubmission. Please raise any queries regarding this form with your manager well in advance of submission.

**CANDIDATE’S DECLARATION**

This is my own work except where I have acknowledged the work of others. I am aware that it is a breach of university regulations to copy the work of another without clear acknowledgement, and that attempting to do so will render me liable to disciplinary proceedings, both potentially through the University and my employer.

I confirm that, where appropriate and feasible, consent from research participants has been sought and obtained. If consent has not been sought and/or obtained I confirm that the reasons for this have been addressed in the body of the report.

I confirm that the word count cited below is exact, and within the limit allowed for this type of assessment. The count includes all free text as well as words and numbers contained in figures, diagrams and tables, quotations, footnotes etc. (though not the title page, contents page, references or appendices). I have presented the assessed work with line spacing, font size and page numbers as required in the relevant section of the assessment handbook.

I confirm that I have fully anonymised the context of this piece of work, such that no clients, personnel or services are identified. I am aware that should breaches of confidentiality be found, I may face both university and employer disciplinary procedures.

**NAME**

JOANNE MUELLER

**WORK TO BE ASSESSED**

(e.g. Clinical Portfolio Part 1, Child PPR, QIP)

Major Research Project

**SUBMISSION DATE**

20/7/2012

**OVERALL WORD COUNT**

15485

This cover sheet should be bound into your MRP after the title page.
ACKNOWLEDGEMENTS

Firstly, I would like to thank the parents who took part in this study. I am grateful for the time they generously offered, and for so openly sharing their thoughts and experiences with me.

I would like to thank my lead supervisor, Dr. Kathy Greenwood, for her guidance, encouragement, and insight throughout this project. I would like to thank her for always finding the time to offer thorough and thoughtful advice, and for inspiring me with her expertise and enthusiasm.

I would like to thank my supervisor, Professor Margie Callanan, for sharing her knowledge and wisdom with me, for her time and effort, and for remaining calm. I would like to thank her for her interest and belief in the value of this project.

My thanks to the Salomons Mansion Library staff for their caring and efficient help, and to my fellow trainees for their understanding and humour as we have navigated the ups and downs of our research together. I would also like to thank Adam, for his kindness, patience, and silliness, all of which has kept me going during this process.

Finally, I would like to dedicate this project to my own parents, Joe and Denise, whose belief in me has never wavered.
SUMMARY OF PORTFOLIO

SECTION A provides an overview of the role of social communication to children about mental ill-health in the development of stigmatized views, integrating disparate empirical and theoretical literature including key socio-cognitive theories of stigma and stigma development. Empirical research on what is communicated to children about mental ill-health across four key contexts (the media, school, peers, parents) on the development of mental illness stigma in children is critically reviewed in light of the theoretical literature. The review concludes by suggesting possible avenues for future research.

SECTION B is an empirical paper and presents the findings of a grounded theory study investigating parents’ communications to their primary-school aged children about mental health and mental health problems. Semi-structured interviews were carried out with ten parents of children aged 7-11. The constructed theoretical model highlights factors that govern parents’ communications to children about mental health issues, and the impact of this on communication purpose and approach. The model is discussed in relation to existing theory and empirical literature; clinical implications, study limitations, and directions for future research are presented.

SECTION C provides a critical appraisal and reflection on the research project by addressing four broad questions: skills learnt during this research and areas for further development; possible areas for study improvement; implications of the project upon personal clinical practice; and areas for future research.
# Table of Contents

## Section A: Literature Review

<table>
<thead>
<tr>
<th>Abstract</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>5</td>
</tr>
<tr>
<td>Stigma definitions and theory</td>
<td>6</td>
</tr>
<tr>
<td>Theories of mental illness stigma</td>
<td>6</td>
</tr>
<tr>
<td>Contact theory and stigma reduction</td>
<td>7</td>
</tr>
<tr>
<td>Mental illness stigma development in children</td>
<td>7</td>
</tr>
<tr>
<td>Socio-cognitive theories</td>
<td>7</td>
</tr>
<tr>
<td>Social theories</td>
<td>9</td>
</tr>
<tr>
<td>The present review</td>
<td>9</td>
</tr>
<tr>
<td>Communication to children about mental health and mental illness</td>
<td>10</td>
</tr>
<tr>
<td>Media</td>
<td>10</td>
</tr>
<tr>
<td>Earlier research on children's media</td>
<td>11</td>
</tr>
<tr>
<td>Recent research on children's media</td>
<td>11</td>
</tr>
<tr>
<td>Summary and limitations</td>
<td>12</td>
</tr>
<tr>
<td>Schools</td>
<td>13</td>
</tr>
<tr>
<td>Primary school interventions</td>
<td>13</td>
</tr>
<tr>
<td>Teachers' informal communications</td>
<td>15</td>
</tr>
<tr>
<td>Summary and limitations</td>
<td>15</td>
</tr>
<tr>
<td>Peers</td>
<td>16</td>
</tr>
<tr>
<td>Children's understandings of peer mental health</td>
<td>16</td>
</tr>
<tr>
<td>Adolescents' views on peer influence around mental health</td>
<td>17</td>
</tr>
<tr>
<td>Summary and limitations</td>
<td>18</td>
</tr>
<tr>
<td>Parents/family</td>
<td>19</td>
</tr>
<tr>
<td>Families not experiencing mental health problems</td>
<td>19</td>
</tr>
<tr>
<td>Families with experience of mental health problems</td>
<td>20</td>
</tr>
<tr>
<td>Summary and limitations</td>
<td>21</td>
</tr>
<tr>
<td>Conclusions and future research</td>
<td>21</td>
</tr>
<tr>
<td>References</td>
<td>24</td>
</tr>
</tbody>
</table>

## Section B: Empirical Paper

<table>
<thead>
<tr>
<th>Abstract</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>5</td>
</tr>
<tr>
<td>Theories of stigmatization</td>
<td>5</td>
</tr>
<tr>
<td>The socio-cognitive development of mental health stigma</td>
<td>6</td>
</tr>
<tr>
<td>Parental influence on stigma development in children</td>
<td>7</td>
</tr>
<tr>
<td>Empirical research on parental communication about mental health and ill-health</td>
<td>7</td>
</tr>
<tr>
<td>Related literature around parental communication</td>
<td>8</td>
</tr>
<tr>
<td>Rationale for the present study</td>
<td>8</td>
</tr>
<tr>
<td>Method</td>
<td>9</td>
</tr>
<tr>
<td>Participants</td>
<td>9</td>
</tr>
<tr>
<td>Procedure</td>
<td>9</td>
</tr>
</tbody>
</table>
References................................................................................................................................. 10
Quality Control ........................................................................................................................... 11
Ethical Considerations ................................................................................................................ 12
Results........................................................................................................................................ 12
Core category: Us and Them........................................................................................................ 12
What is Us .................................................................................................................................... 15
What is Them................................................................................................................................ 15
Taboo and stigma.......................................................................................................................... 16
Degree of overlap between Us and Them.................................................................................... 17
Unconscious confusions – contradicting intentions, beliefs and messages.............................. 19
Parental experiences impacting on communication about Us and Them................................. 20
Parental knowledge and experiences.......................................................................................... 20
Intergenerational parenting patterns............................................................................................ 21
Purpose and Approach.................................................................................................................. 22
Purpose – acceptance versus protection from Them .................................................................... 22
Balance........................................................................................................................................ 23
Approach around Them – non-deliberate, reactive, limited, avoided........................................ 24
Barriers to communication about Them – irrelevant, unknown, dangerous, taboo.................... 24
Facilitators and prompts............................................................................................................... 25
Purpose – promoting mental health for Us .................................................................................. 26
Balance........................................................................................................................................ 26
Approach to promoting mental health – indirect yet deliberate................................................... 26
Facilitators and prompts............................................................................................................... 27
Barriers to communication – desire for resilience....................................................................... 27
Discussion.................................................................................................................................... 27
‘Them’ and ‘Us’ – contradictions and ambivalence..................................................................... 28
Conscious and unconscious processes.......................................................................................... 29
Impact on children’s attitudes and behaviour............................................................................... 30
Clinical implications....................................................................................................................... 30
Stigma programs............................................................................................................................ 30
Help-seeking.................................................................................................................................. 31
Methodological limitations............................................................................................................ 32
Future research.............................................................................................................................. 34
Conclusions.................................................................................................................................. 34
References...................................................................................................................................... 35

SECTION C: CRITICAL APPRAISAL

Skills Learnt .................................................................................................................................. 4
Study Improvements....................................................................................................................... 6
Clinical Implications....................................................................................................................... 7
Future Research.............................................................................................................................. 8
References...................................................................................................................................... 10

SECTION D: APPENDICES

APPENDIX A: Section A Search Methodology ............................................................................. 3
APPENDIX B: Participant demographics ........................................................................................ 5
<table>
<thead>
<tr>
<th>APPENDIX</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Study leaflet and response form</td>
<td>7</td>
</tr>
<tr>
<td>D</td>
<td>Communications Notepad</td>
<td>9</td>
</tr>
<tr>
<td>E</td>
<td>Participant information sheet &amp; Consent form</td>
<td>11</td>
</tr>
<tr>
<td>F</td>
<td>Semi-structured Interview Schedule</td>
<td>14</td>
</tr>
<tr>
<td>G</td>
<td>Sample Theoretical Memos and Diagramming</td>
<td>18</td>
</tr>
<tr>
<td>H</td>
<td>Excerpts from Research Diary</td>
<td>33</td>
</tr>
<tr>
<td>I</td>
<td>Ethical Approval Letter</td>
<td>40</td>
</tr>
<tr>
<td>K</td>
<td>Sample uncoded transcript</td>
<td>75</td>
</tr>
<tr>
<td>L</td>
<td>Summary of findings for participants and ethics panel</td>
<td>76</td>
</tr>
</tbody>
</table>
MAJOR RESEARCH PROJECT

SECTION A: LITERATURE REVIEW

Communications to children about mental ‘illness’ and their role in mental health stigma: An integrative review

Word Count: 5493 (plus 309)

JOANNE MUELLER  BSc (Hons) MSc

A thesis submitted in partial fulfillment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

JULY 2012

SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY
Table of Contents

Abstract .................................................................................................................................. 4
Introduction ............................................................................................................................ 5
Stigma definitions and theory ............................................................................................... 6
  Theories of mental illness stigma ......................................................................................... 6
  Contact theory and stigma reduction ................................................................................... 7
Mental illness stigma development in children .................................................................. 7
  Socio-cognitive theories ......................................................................................................... 7
  Social theories ....................................................................................................................... 9
  The present review ............................................................................................................... 9
Communication to children about mental health and mental illness .................................. 10
  Media .................................................................................................................................. 10
    Earlier research on children’s media .................................................................................. 11
    Recent research on children’s media .................................................................................. 11
    Summary and limitations ..................................................................................................... 12
  Schools ................................................................................................................................. 13
    Primary school interventions ............................................................................................ 13
    Teachers’ informal communications .................................................................................. 15
    Summary and limitations ..................................................................................................... 15
  Peers .................................................................................................................................... 16
    Children’s understandings of peer mental health ............................................................. 16
    Adolescents’ views on peer influence around mental health ............................................. 17
    Summary and limitations ..................................................................................................... 18
  Parents/family ...................................................................................................................... 19
    Families not experiencing mental health problems........................................................... 19
    Families with experience of mental health problems ......................................................... 20
    Summary and limitations ..................................................................................................... 21
Conclusions and future research ....................................................................................... 21
References ............................................................................................................................... 24
Abstract

A wealth of theoretical and empirical literature has explored the presence, maintenance, and impact of the stigma of mental illness\(^1\) in the general public, including the (limited) effectiveness of existing stigma-reduction policy and interventions. However, attention has only recently begun to fall upon the development of stigma around mental health in children. It is understood that stigmatized views related to mental ill-health emerge in middle childhood (7-11 years), and that children’s attitudes are influenced by messages communicated to them across social contexts. This review aimed to integrate and critique disparate empirical and theoretical literature in order to begin to understand the role of social communication across four key contexts (the media, school, peers, parents) on the development of mental illness stigma in children. Following an overview of key socio-cognitive theories of stigma and stigma development, the review identified that little research has directly examined communications about mental illness to children of the age when stigmatized attitudes develop. This was particularly true for literature around parental communications. Overall, messages communicated to children across social contexts are stigmatized; such messages may impact upon the attitudes young children develop via a number of possible mechanisms. Interventions to reduce or prevent stigma in this age-group have so far involved only one context (schools), finding mixed results. Many available studies were limited by methodological weaknesses, and synthesis of literature is difficult. The review concludes by identifying implications for tackling the stigma of mental ill-health, and suggesting possible avenues for future research.

---

\(^1\) The terms mental illness, mental ill-health, and mental health problems will be used interchangeably in this review to refer to a broad spectrum of psychological difficulties. Whilst ‘mental health problems’ may portray more positive connotations of psychological distress, the term ‘mental illness’ is most commonly used in the extant literature.
Introduction

Mental ill-health is consistently rated as the most stigmatised problem a person can have (Hinshaw, 2005). Branded ‘the ultimate stigma’ (Falk, 2001), the stigma of mental illness may be more disabling than a person’s mental health problem (Hinshaw & Stier, 2008; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Wright, Gronfein, & Owens, 2000). Limited public knowledge and negative attitudes towards people with mental health problems have shown little change over time, despite campaigns, interventions and policies aimed at reducing stigmatised views (Crisp, 2000; Hinshaw, 2007; Leff & Warner, 2006; Link et al., 1999; Mehta, Kassam, Leese, Butler, & Thornicroft, 2009; Phelan, Link, Stueve, & Pescosolido, 2000; YouGov, 2011).

Understanding how and why mental health stigma is perpetuated is crucial in developing effective strategies to eliminate it. Stigma related to mental illness develops early in childhood (Angermeyer & Matschinger, 2004); most existing interventions aim to challenge stigma in adolescents or adults, although some authors have recently suggested that preventative approaches with younger children are warranted (e.g. Hinshaw, 2007; Pinfold et al., 2003). However, little research has reported on the processes by which children develop stigmatised views about mental health problems. In particular, there is a dearth of literature on the social influences on children’s attitudes towards mental health: what is communicated to children is central to the attitudes they develop (Bandura, 1977).

This review will be the first to integrate disparate literature in order to understand the role of social communication on the development of mental illness stigma in children. First, key theories will be summarized that relate to stigma and child socio-cognitive development of stigma relevant to mental illness, as identified via a comprehensive literature search. Empirical literature on social communication about mental ill-health to children will then be reviewed, focusing upon four
influences: the media, schools, peers, and parents. Quality of papers will be considered according to existing frameworks (Mays & Pope, 2000; Nathan & Gorman, 2002). The empirical review search terms and strategy are detailed in appendix A.

Stigma definitions and theory

Theories of mental illness stigma

Built upon Goffman’s (1963) seminal work, stigma is currently seen as a broad concept that comprises labeling, stereotyping, separation (‘us’ from ‘them’), status loss and discrimination, within the context of power differences (Link & Phelan, 2001; Link, Yang, Phelan, & Collins, 2004). Although Goffman argued stigma is defined through social interaction, stigmatization also incorporates cognitive and emotional processes (Corrigan, 2000). For example, labeling theory (Scheff, 1966, 1974) predicts that when a person’s behaviours are labeled as ‘mental illness’, negative stereotypes are triggered, leading to discrimination and social exclusion. Labeling enables categorization of people into out-groups (different from oneself) and in-groups (including oneself) that leads to increased self-esteem (social identity theory; Tajfel & Turner, 1979). Social exclusion exacerbates mental health difficulties and perpetuates stigma (modified labeling theory; Link et al., 1999), and internalized attitudes lead to self-stigma (Hinshaw, 2007).

Attribution theory (Heider, 1958; Weiner, 1995) alternatively posits attributions about a person’s responsibility for their mental health problems, and their dependence and/or dangerousness, lead to an affective response, such as fear or pity, and behaviour, such as avoidance (Angermeyer & Matschinger, 2003; Corrigan, 2000). The social psychological model (Angermeyer, Beck, & Matschinger, 2003; Angermeyer, Matschinger, & Corrigan, 2004; Corrigan & Watson, 2007b) suggests attributions are influenced by demographics, personal experience, and the socio-cultural contexts in which individuals exist. In general, males, older people, and those unfamiliar with mental illness, make the most negative attributions, and have the greatest desire for social distance
from people with mental illness (Jorm & Oh, 2009). Recently, Pescosolido, Martin, Lang, and Olafsdottir (2008) combined concepts from a variety of theories to develop a framework of influences maintaining stigma (FINIS), attempting to incorporate both socio-cognitive individual-level factors and wider social factors.

**Contact theory and stigma reduction**

Under the right conditions, contact between in-group and out-group members can reduce stigma (intergroup contact theory; Allport, 1954); this is supported by empirical evidence (Couture & Penn, 2003). In particular, contact-based interventions are more effective than educational strategies, and approaches that chastise stigmatisers (Corrigan & Shapiro, 2010). Contact strategies aim to increase ‘inclusion of other in the self’ – how much in-group members identify with out-group members (Aron et al., 2004; Aron, Aron, Tudor, & Nelson, 1991; McLaughlin-Volpe, 2005). Indirect contact strategies have recently gained empirical support, including via the media (Crisp & Turner, 2009; Dovidio, Eller, & Hewstone, 2011; Schiappa, Gregg, & Hewes, 2005; Wright, Aron, McLaughlin-Volpe, & Ropp, 1997).

Whilst the theories presented above address the presence, maintenance, and potential reduction of stigma about mental ill-health, they do not examine its development in childhood, and how such attitudes might be perpetuated intergenerationally.

**Mental illness stigma development in children**

**Socio-cognitive theories**

Hinshaw (2005) suggests the implicit biases implicated in mental illness stigma are likely learned at early ages, given their widespread circulation throughout a given culture. However, little has been written about the processes involved in the development of these attitudes. Corrigan and Watson (2007a) reviewed the literature on the development of ethnic prejudice in order to understand the
social-cognitive development of mental illness stigma in children, highlighting two key theories, the
cognitive stage model (Flavell, 1999; Piaget, 1985) and the incremental learning model (Katz, Sohn,
& Zalk, 1975). Together, these theories suggest that from a peak in prejudiced attitudes at age five,
children develop the cognitive ability to conceptualise difference more subtly than in terms of
‘good’ in-groups and ‘bad’ out-groups, simultaneously learning social desirability rules that
constrain endorsement of stigma. By age seven, explicit prejudice has reduced (Corrigan & Watson,
2007a). The ability to ‘include other in the self’ also develops during middle childhood, and this
ability in part mediates the positive effect of contact-based interventions on attitudes towards out-
groups in children aged 5-11 (Cameron, Rutland, & Brown, 2006, 2007).

Children may not, however, demonstrate mental illness stigma until a later age than ethnic
prejudice. Identification, conceptualization, and attribution about ‘concealable’ mental health
problems and latent out-groups requires more advanced cognitive development: theoretically, a
reduction in mental illness prejudice should not occur at age seven (Corrigan & Watson, 2007a).
Indeed, stigmatised attitudes and behaviours around mental illness are consistently reported from
age 7-8 (for reviews see Emerton, 2010; Wahl, 2002) and persist through adolescence into young
adulthood, despite increases in knowledge and understanding of mental health concepts (Reavley
& Jorm, 2011; Rose, Thornicroft, Pinfold, & Kassam, 2007; Weiss, 1994). Recent qualitative
research indicates mental illness emerges as an ontologically distinct concept to physical illness
during middle childhood (6-11 years) (Fox, Buchanan-Barrow, & Barrett, 2010). From age six into
late adolescence, attitudes towards mental health problems vary by similar demographic and
attributional factors as adults’, such as perceived responsibility and gender of the stigmatiser, while
older age predicts less acceptance of males with mental health problems (Swords, Heary, &
Hennessy, 2011). The middle childhood period appears to be particularly critical in the socio-
cognitive development of stigma around mental health. Messages and experiences around mental
health and ill-health at these ages are likely to impact upon the attitudes children develop.
Social theories

Children’s beliefs and behaviours are influenced by communications of important others across the social spheres they inhabit (social learning theory; Bandura, 1977; Allport, 1954) identified parents as the most influential source of young children’s prejudices. He proposed mechanisms of learning, whereby children connect labels verbalized by parents with associated emotions, and link these with certain individuals and social groups, and of conformity, whereby, at an unconscious level, children conform to implicit rules for how people behave in their home environment (Aboud, 2005). Another unconscious mechanism of transmission might be classical conditioning: for example, repeated pairing of child discomfort elicited by a parent’s grimace in response to a person with mental health problems would result in the child associating discomfort with people with mental illness. Alternatively, a child might misattribute this discomfort as being directly caused by the person with mental illness (Ottati, Bodenhausen, & Newman, 2005). Unconscious processes may be particularly relevant when negative attitudes are suppressed, or ambivalent (Fisak & Grills-Taquechel, 2007; Ottati et al., 2005). Because children see peers as similar to themselves and are less likely to censor their opinions to friends, peers may be a crucial role model in learning prejudiced attitudes, particularly as children get older and parental influence decreases (Aboud & Doyle, 1996; Aboud & Fenwick, 1999; Corrigan & Watson, 2007a). Social mechanisms of transmission are likely to apply to peer interactions, as well as to school communications, to media portrayals, and to wider social norms (Aboud, 2005; Allport, 1954; Ottati et al., 2005). Social influences may be particularly critical at the ages when children begin to develop stigmatized attitudes around mental ill-health.

The present review

Socio-cognitive and social theories have attempted to explain the presence and maintenance of the stigma of mental illness in the general public, and have recently begun to focus on the development of stigmatized views around mental health in children. Aboud (2005) has attempted to integrate research and theories of how children develop prejudiced attitudes in general, proposing a
theoretical framework indicating that cognitive and developmental mechanisms interact with children’s socializing experiences to lead to a child’s level of prejudice. As Aboud (pp. 318) notes, “It is generally accepted that learning, conformity, and contact are common mechanisms of acquisition [of stigmatised attitudes]... More valuable is knowing how prejudiced messages and behaviours are transmitted by different socializers.” Alongside the theoretical and empirical evidence presented above, this provides a clear framing for the focus of the present review on the role of social communications in shaping the developing views of children aged between 7 and 11 years on mental ill-health. The following sections will focus on reviewing the empirical evidence pertaining to what is communicated to children in middle childhood about mental ill-health across four key social contexts: the media, school, peers, and parents.

Communication to children about mental health and mental illness

Media

Much of the literature on media representations of mental health and illness is focused on adults. Although some media portrayals of mental health problems are becoming more realistic and positive (Henson et al., 2009; Leff & Warner, 2006), research across media sources finds a largely consistent picture of danger, violence, incompetence and unpredictability (Coverdale, Nairn, & Claasen, 2002; Diefenbach, 1997; Klin & Lemish, 2008; Signorielli, 1989; Stout, Villegas, & Jennings, 2004; Wahl, 1997) that does not reflect real-life statistics about people with mental health problems (Healthcare Quality Improvement Partnership, 2012). Negative media portrayals have been theoretically and empirically linked to increased mental illness stigma (Angermeyer & Matschinger, 1996; Pescosolido et al., 2008; Shapiro & Lang, 1991), yet, viewers believe others are more affected by this than themselves (Diefenbach & West, 2007). Recent research shows children aged 5-12 in the UK watch, on average, 186 minutes of television each day (Pearson, Salmon, Crawford, Campbell, & Timperio, 2011): this review will report on the child-focused media, but it should be kept in mind that children are also exposed to the general media (Wahl, Hanrahan, Karl,
Earlier research on children’s media

Coverdale and Nairn (2006) reviewed published research on depictions of mental illness in children’s media, finding four relevant empirical studies. Three studies reported on children’s films, and one on television programmes. Two of these studies were nonsystematic, finding that depictions of mental illness are common, with portrayals exhibiting extreme stereotypes (Beveridge, 1996; Wahl, Wood, Zaveri, Drapalski, & Mann, 2003). A third study (Lawson & Fouts, 2004) examined references to mental illness in 34 animated Disney films made between 1937 and 2001, finding eighty-five percent of films contained references to mental illness, which portrayed characters in terms of inferiority, amusement, fear and danger, whilst a fourth study used discourse analysis to explore a week-long sample of 128 episodes from children’s (under 10 years) television in New Zealand, finding 59 (46%) contained at least one reference to mental illness, such as slang terms (e.g. “crazy”, “losing your mind”) or stereotypical gestures (e.g. rolling eyes and head) (Wilson, Nairn, Coverdale, & Panapa, 2000). However, the latter study was limited by a failure to meet quality criteria (Mays & Pope, 2000; Nathan & Gorman, 2002) such as the lack of methodological detail regarding procedures, coding, and reliability and validity of ratings. Furthermore, the generalisability of the findings to the UK population is unclear. Coverdale and Nairn concluded that study replications are urgently needed, particularly for children’s television, and that a crucial limitation of the existing literature was the lack of distinction between references to mental illness from characters specifically portrayed as being ‘mentally ill’. The authors also called for future studies to examine positive, as well as negative, connotations of mental illness in children’s media.

Recent research on children’s media

A recent thematic examination of 22 Tintin books found references to mental illness in 18 books, all of which related to unwise and impulsive behaviours (Medrano, Malo, Uriarte, & Lopez, 2009). However, this study was not systematic, did not adequately describe coding procedures used and
results were not sufficiently detailed to be able to draw valid conclusions. Attempting to tackle limitations of previous studies, Wahl and colleagues selected a representative sample of children’s television programmes in the United States (Wahl et al., 2007). After coding two hundred and sixty-nine hours of television from 527 different children’s programmes over a five-week period, 21 characters were identified across 14 programmes (<3% programmes) as specifically depicted with mental illness. Two-thirds of these characters exhibited aggressive behaviour and characters were commonly unpredictable, cruel and dangerous villains. Characters did exhibit some positive attributes (intelligence, good-grooming), but these were less common than negative attributes and rarely included features such as being responsible, sociable and creative. Characters with mental illness were treated negatively by other characters (67%), labeled with slang terms, and feared (48%). However, disparaging slang relating to mental illness was much more common, and was present in 46% of programmes. The authors suggest this offers ample opportunity for children to learn that people with mental illnesses have undesirable traits and are to be feared and avoided, and that terms related to mental ill-health can be used to express disdain for others. This study represents the most methodologically rigorous to date (Mays & Pope, 2000) and therefore offers a baseline from which to understand the messages that are transmitted about mental illness via children’s television. However, as the authors point out, the link between media messages and children’s views has yet to be empirically investigated.

Summary and limitations
Research suggests children are exposed to high levels of insidious stigma about mental illness and people with mental health problems via language and characterization in children’s television programmes, films, and books, in addition to stigmatised messages via the general adult media. Conclusions are limited by the lack of literature and generally poor quality of study methodologies. It is not known what messages are transmitted on UK children’s television, and no cross-media (i.e. television/film) comparisons of messages were found. It is hypothesized that stigmatised messages in the media may contribute to children’s development of stigmatised views, in a similar way to
those of adults, however this has not yet been investigated; mechanisms and moderating factors are unknown. Nothing is known about what is communicated to children about mental health problems via social media. Although some more positive images have been recently noted in the adult media, indirect contact-based interventions via the media are being investigated (Schiappa et al., 2005; Time to Change, 2012), and research is underway to evaluate the effectiveness of mass media-based interventions to reduce stigma in the adult public (Clement et al., 2011), no studies were found exploring these issues in children’s media.

Schools

One social context that has been explored in terms of interventions to promote positive, anti-stigmatising messages to children is school: educational settings are now a well-established target for stigma campaigns (Corrigan, 2000; Pinfold, 2003a, 2003b; Watson et al., 2004). However, the majority of school-based interventions have targeted adolescents, with some making use of socio-cognitive theories (e.g. contact theory, developmental models) to develop appropriate curricula (Corrigan & Watson, 2007a). Two recent systematic reviews (Schachter et al., 2008; Yamaguchi, Mino, & Uddin, 2011) examined school-based stigma-reduction interventions, identifying that the majority of studies were short-term evaluations of brief interventions, using primarily education-based conditions. Whilst studies reported significant improvements in knowledge and attitudes around mental illness, the majority did not measure actual behaviour change (e.g. social distance, help-seeking) or long-term effects. Four interventions appeared to intensify some stigmatizing attitudes and language (Schachter et al., 2008), but harmful effects were rarely measured. Both reviews recommended direct contact interventions; one recommended curricula should be implemented early and repeatedly (Schachter et al., 2008).

Primary school interventions

Indeed, despite suggestions that preventative primary school-based interventions might be more effective than later interventions (Hennessy, Swords, & Heary, 2008; Pitre, Stewart, Adams, Bedard,
& Landry, 2007; Ventieri, Clarke, & Hay, 2011), few studies have intervened with children aged 11 years and under. The reviews above reported two such studies. Lauria-Horner, Kutcher, and Brooks (2004) reported that a teacher-led education-based curriculum in Canada improved elementary schoolchildren’s (age 6-13 years; n = 158) knowledge, and suggested improved attitudes, around mental health, but the study lacked a control group. Shah (2004) conducted 30-minute interventions of age-appropriate stories and games about mental illness with children aged 5-11 in the UK, anecdotally noting older children already had stigmatized views, and reporting only half of teachers responded to the feedback questionnaire, with ambivalent views on the utility of the intervention. The lack of measures of child outcome limits the conclusions to be drawn from this study.

Three further studies were identified by the current review. An education programme in the USA consisting of six 45-minute sessions resulted in significant improvements in knowledge about mental health and illness in 370 children aged 10-12 years, using a study-specific measure (DeSocio, Stember, & Schrinsky, 2006). Anecdotal evidence suggested improvements in students’ help-seeking behaviour; the lack of standardized outcome measures inhibits generalization of results. A randomized controlled trial in Canada of a hand-puppet educational/indirect contact program with 185 children aged 8-12 (Pitre et al., 2007) found significantly improved attitudes on the Opinions about Mental Illness scale (Ng & Chan, 2000). However, the parental permission rate was low (57%), and several schools and individual teachers declined to participate. Finally, Ventieri et al (2011) evaluated a 165-minute school-based educational intervention in Australia. There was significant improvement in the intervention group (n=69; age 9-11) as compared to 126 controls on knowledge, social distance and attitudes towards mental illness one week following the intervention. A significant change remained four months after the intervention. Only one of forty-three schools approached agreed to take part in the intervention. In these latter two studies, low participation may have resulted in biased samples. No study found with younger children has yet examined the impact of a direct contact condition, identified as the most effective with older
children, and in the general public (Corrigan & Shapiro, 2010). Of the five studies reporting on primary school interventions, only one (Pitre et al., 2007) met criteria for a Type 1 (most rigorous) study (Nathan & Gorman, 2002), and only one reported a longer-term follow-up (Ventieri et al., 2011). Limitations across the five studies are the lack of consistent outcome measurement, small sample sizes, and lack of measurement of possible negative impact.

**Teachers’ informal communications**

All but one intervention study within primary schools noted the hesitance of schools to take part, with teachers citing concerns about parental reactions. Teachers’ reticence to address mental health issues educationally may translate into similarly hesitant informal communications: no studies were found on teachers’ informal communications about mental health problems in primary schools. In one of the only studies to examine social influences on young people’s attitudes about mental health problems, Chandra and Minkovitz (2007) conducted qualitative interviews with 57 adolescents aged 13-14 years, recruited from two schools in the United States. Teenagers identified school staff as a key influence in their attitudes towards mental health issues, and whilst some staff were seen to be ‘tuned into’ student mental health problems, students noticed when staff were uncomfortable discussing these issues or did not understand the impact of mental health problems on school performance. Students also felt teachers’ sympathy for students’ mental health issues was conditional upon their academic attainment. However, this study was limited by its reliance on adolescent report of such communications; no other studies on informal teacher communications could be found.

**Summary and limitations**

Little is known about formal or informal school communication to young children in the UK specific context. Although research indicates that preventative, contact-based programmes in primary schools may be effective, supporting contact theories (Allport, 1954; Cameron et al., 2006; Dovidio et al., 2011), few studies have examined the impact of such interventions upon the development of stigma in younger children, and those that exist are limited by methodological problems. In
contrast to work around promoting mental health in schools (Weare & Nind, 2011), primary schools appear to be reticent to engage with interventions around reducing the stigma of mental illness, and few studies report involving parents.

**Peers**

Within the school context, children are also exposed to messages about mental illness from another social source: Hinshaw (2005) notes that even young children use stigmatizing words related to mental health to insult their peers. No literature could be found specifically reporting on what is communicated between children of primary-school age on the subject of mental health and ill-health. Related literature about children’s understandings of peers’ mental health, and from adolescents, may be important in considering what children might communicate to each other about these issues.

**Children’s understandings of peer mental health**

It is well established that children with mental health problems are more likely than their peers to be rejected (Deater-Deckard, 2001; Hay, Payne, & Chadwick, 2004) and that this has a similarly negative impact upon children as it does on adults (Dixon, Murray, & Daiches, 2012; Hennessy et al., 2008). Hennessy et al (2008) reviewed the peer-reviewed literature on children’s (up to age 18) understanding of childhood psychological problems, synthesizing 45 empirical studies and finding children as young as seven or eight are able to identify and offer causal explanations for emotional and behavioural difficulties in peers. As predicted by attribution theory, children’s beliefs about peers’ culpability for their problems were important factors in attitudes and behavioural intentions; the impact of children’s contact with peers with mental health problems was not reported. It is not clear how these attitudes translate to children’s communication to peers.

Hennessy and Heary (2009) qualitatively and quantitatively examined children’s (n=116, 8-15 years) beliefs about the causes of peer mental health problems (ADHD, conduct disorder, depression) and
potential help sources using vignettes, with children randomly assigned to either focus groups or to individual interviews. Children of all ages offered a range of external and internal explanations for the peer behavior described. Focus group data found most children suggested friends as a source of help for depression, and this was more likely for older compared to younger children. However, friends were statistically less likely to be suggested as a help source by individually interviewed children. The consideration of impact of study design on findings was a strength of the study. This finding may indicate that children’s communications positively influence each other in considering help-seeking; alternatively, peer pressures in a group setting may result in socially desirable responses from children that do not reflect their actual beliefs about seeking help from peers. A similar study used interpretative phenomenological analysis to examine focus group data on children’s (n=25, 8-9 years) understandings of vignettes of peers with emotional difficulties (Dixon et al., 2012). The study identified three themes: searching for an explanation; empathy versus blame; and consequences and solutions, with findings similar to previous research (Hennessy & Heary, 2009; Hennessy et al., 2008). Children drew upon their own emotional experiences in understanding peers’ difficulties, but expressed that friendship was conditional on the peer’s motivation to change, and their harmfulness, and viewed the characters as different to them. This study was judged to be of good quality, meeting appropriate criteria (Mays & Pope, 2000), although the authors could have been more reflexive about their own impact upon the study findings. The authors noted the limitations of the use of vignettes, but did not consider the impact of the focus group method. It may have been interesting to explore how children influenced each others’ concepts of the in-group (own mental health experience) and out-group (peer with problems).

Adolescents’ views on peer influence around mental health

Research with older children has focused more directly upon communications between peers. Peer conversations was a key factor that influenced teenagers’ attitudes towards mental health problems (Chandra & Minkovitz, 2007). Students described using conversations about feelings with friends to maintain good mental health, but conversations around mental health problems were
rare. Students thought peers would react negatively if they knew a classmate was using mental health services, and predicted teasing, peers thinking the person was ‘weird’, and them becoming ‘an outcast’. A grounded theory analysis of focus group data explored perceptions and behaviours in 21 girls aged 13-15 years in relation to depression in their peers (Pinto-Foltz, Hines-Martin, & Logsdon, 2010). Adolescent conceptualisations of mental ill-health mirrored that of adults’, but affective responses reflected both child and adult perspectives, for example, adolescents reported they would make fun of a peer’s depression, but also said depression was a serious issue.

Adolescents described peers with depression using stigmatised words such as ‘psycho’ and ‘mental’, and reported that even if their own initial attitude was one of empathy, this was liable to change if friends were teasing someone. In line with the findings of Chandra and Minkovitz (2007), adolescents reported they would be unlikely to tell peers if they experienced mental health difficulties, for fear of being labeled and socially excluded. The study demonstrated strengths in the clarity and depth of the data analysis and development of a theoretical model (Mays & Pope, 2000). Weaknesses were that teenagers’ familiarity with mental health problems was not reported, and the impact of social desirability and peer pressures within focus groups was not acknowledged. However, as stigma occurs within group and social contexts, this may be an appropriate method of study.

**Summary and limitations**

Studies with adolescents offer some insight into how the stigma around mental illness may be perpetuated within peer groups of older children, via peer pressures and the use of stigmatizing language, implicating theoretical considerations around conformity (Allport, 1954). Some evidence suggests children do look to peers for support around mental health (Hennessy & Heary, 2009), however the impact of social desirability on these responses is unclear. In line with attribution theory (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003) and socio-cognitive stage models (Corrigan & Watson, 2007a), primary-school aged children are already able to make complex attributions about peers’ behaviour, and these can lead to social exclusion of outgroups. It is not
well understood what contact younger children have with mental health problems, how attitudes are communicated between children, and what influence these factors have upon stigma development.

**Parents/family**

The family context and the influence of parents have been largely overlooked in understanding the development of mental illness stigma. Attitudes towards out-groups in general are transmitted intergenerationally (Chatard & Selimbegovic, 2008), and parent and child attitudes about ethnicity and race are significantly related (Sinclair, Dunn, & Lowery, 2005). However, only one study has investigated the relationship between parents’ views on mental illness and those of their adolescent children, finding a significant relationship (Jorm & Wright, 2008). Related literature in the field of ethnicity suggests child attitudes are shaped by parent-driven ‘socialisation’ processes, such as verbal and non-verbal messages around mistrust or preparation for discrimination (Hughes et al., 2006); almost nothing is known about similar communications involved in the development of children’s views about mental illness.

**Families not experiencing mental health problems**

The only study found to examine parents’ communications to children around mental health and ill-health in a normative sample was the qualitative investigation of Chandra and Minkovitz (2007) with adolescents aged 13-14 in two state schools in the USA. Approximately one in five adolescents reported open communication with their parents about mental health, with this group describing more positive attitudes towards talking about and seeking help for mental health problems than the remaining students. Students reported that parents expressed an attitude that mental health problems were to be kept within the family. This was particularly true for boys, and for Asian or African American students, indicating gender and cultural factors may be important. However, the study was limited by a response rate of 14%; parents and children with particularly negative views or those with more experience of mental ill-health may have declined to take part. Nevertheless,
the study was methodologically sound, describing context, methods, and analysis in detail (Mays & Pope, 2000) and generating a theoretical framework incorporating social influences upon adolescents’ attitudes towards mental health problems. Parent perspectives were not reported, so it was not possible to ascertain the relationship between parent and child views: the authors identify the need for future research to address this limitation.

**Families with experience of mental health problems**

Gladstone Boydell, Seeman, and McKeever (2011) reviewed qualitative literature published between 1997 and 2010 on children’s (aged up to 18 years) experiences of parental mental illness. The authors analysed recurring ideas across 20 relevant studies to identify three themes: impact on daily life; coping with everyday experiences; understanding mental illness. The latter theme highlighted that few children had been told about causes, symptoms and treatment of mental illness by either of their parents, or by professionals, and their knowledge was inadequate or inaccurate. Lack of child understanding led to worries and inaccurate beliefs about causes of parent’s difficulties, recovery prognoses, and their own vulnerability to mental illness. Children wanted more information about their parent’s illness to help them cope emotionally and practically. Some studies also reported parents’ views of communicating about their mental health problems: parents felt more information might be burdensome or upsetting for children, and felt children did not want or need to know, or children were too young to understand. However, the authors note the methodological quality of most reviewed studies was poor, lacking explicit theoretical bases and sufficient detail on designs and analyses; the secondary thematic analysis of study themes should be interpreted with caution. Recent work has focused on interventions to promote parental communication about their own mental illness to their children, with positive outcomes for both parents and children aged between 6 and 17 years (Pihkala, Sandlund, & Cederström, 2011, 2012; Solantaus, Paavonen, Toikka, & Punamäki, 2010).
Summary and limitations

No literature was found on parent-child communication about mental health or ill-health when the child has a mental health problem, or where no problem exists currently, either from the parent or the child’s perspective. Little is known about how parents influence their children’s development of stigmatized views, either in terms of an established association between attitudes, or in terms of what parents communicate to children about mental health problems. Evidence from one study of adolescents’ perspectives suggests mental health problems are not discussed; the larger evidence base from families affected by mental illness suggests similarly limited parent-child communication. This is in contrast to attribution and contact theory suggesting familiarity with mental illness reduces stigma (Corrigan, Edwards, Green, Diwan, & Penn, 2001; Couture & Penn, 2003), but in line with theory around self-stigma (Watson, Corrigan, Larson, & Sells, 2007). Parental concerns that children would not understand may prevent communication (Gladstone et al., 2011); it is not clear how this belief related to the child’s actual level of understanding (Cameron et al., 2007; Corrigan & Watson, 2007a; Fox et al., 2010). Stigma about mental ill-health may drive this silence, however this has not been explicitly established. An overarching limitation of this literature is the lack of studies with non-clinical populations, in particular in families with younger children.

Conclusions and future research

This review is the first to explore the role of communication across key social contexts on development of mental illness stigma in children, drawing together disparate empirical literature and theory. Evidence suggests that although children begin to show stigmatized attitudes from age 7, little is known about the social communications that children receive about mental health problems. Available research indicates stigmatized messages are portrayed in children’s media, but UK television has been overlooked, and little is known about positive representations, or indeed the impact of such messages on children’s views. School-based interventions to reduce or prevent stigmatized views have begun to target primary-school aged children, with positive initial results.
Schools are generally reluctant to participate and fear parental objection. Little is known about the long-term impact of programmes, or individual teachers’ informal communication. Evidence around peer communications suggests children have a sophisticated understanding of mental health issues, and that stigmatizing behaviour and attitudes can be influenced by those of peers from childhood through to adolescence. However, little research has examined these communications directly, particularly in younger children. Finally, literature around parental communications indicates an environment of stigma and silence, both for families affected and those unaffected by mental health problems. The impact of child age in this context is unclear. Children’s own reports suggest they would like more information and communication. The impact of children’s own contact with mental health problems on their attitudes and behaviour is rarely considered.

The overriding finding is that there is a dearth of literature on what is communicated to children about mental health problems, and available evidence is limited by methodological concerns. The breadth and diversity of research makes it difficult to synthesize, but largely paints a picture of silence and stigmatized messages across children’s key social contexts. Mechanisms of stigma transmission may include conscious and unconscious social processes around learning, conformity, conditioning, and misattribution, alongside socio-cognitive processes such as attribution and labeling. As stigma operates at multiple social levels, overcoming stigma will require change efforts spanning these interacting spheres of influence (Hinshaw, 2005; Schachter et al., 2008).

Numerous areas of research arise from this review. Foci could include:

1) The association between representations of mental illness in children’s media and child attitudes and behaviour, using evidence to develop effective media-based anti-stigma interventions for young children.

2) Primary school teachers’ communications to young children about mental health issues, with a view to developing acceptable and collaborative preventative curriculums.
3) How young children influence each other’s views and behaviour around peers’ mental health difficulties, and what mechanisms are involved.

4) Parents’ communications to their young children about mental health and mental health problems. Research should aim to address the lack of understanding about how, arguably, children’s most influential socializing agents contribute to their developing conceptualisations of mental illness, and potentially how stigmatized attitudes are transmitted intergenerationally.
References


Angermeyer, M. C., & Matschinger, H. (2004). Public attitudes to people with depression: have there been any changes over the last decade? *Journal of Affective Disorders, 83*(2-3), 177-82.


Parents’ communication to their primary school-aged children about mental health and ill-health: A grounded theory study

Word Count: 7994 (plus 593)

JOANNE MUELLER BSc (Hons) MSc

A thesis submitted in partial fulfillment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

JULY 2012

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY
Table of Contents

Abstract ................................................................................................................................. 4

Introduction ............................................................................................................................ 5
  Theories of stigmatization ................................................................................................. 5
  The socio-cognitive development of mental health stigma .................................................. 6
  Parental influence on stigma development in children ...................................................... 7
  Rationale for the present study .......................................................................................... 8

Method ................................................................................................................................. 9
  Participants .......................................................................................................................... 9
  Procedure ............................................................................................................................ 9
  Analysis .............................................................................................................................. 10
  Quality Control .................................................................................................................. 11
  Ethical Considerations ....................................................................................................... 12

Results ................................................................................................................................. 12
  Core category: Us and Them .............................................................................................. 12
  What is Us ......................................................................................................................... 15
  What is Them .................................................................................................................... 15
    Taboo and stigma ............................................................................................................ 16
  Degree of overlap between Us and Them ......................................................................... 17
    Unconscious confusions – contradicting intentions, beliefs and messages ..................... 19
  Parental experiences impacting on communication about Us and Them ......................... 20
    Parental knowledge and experiences ............................................................................ 20
    Intergenerational parenting patterns ............................................................................. 21

Purpose and Approach ....................................................................................................... 22
  Purpose – acceptance versus protection from Them ......................................................... 22
    Balance ............................................................................................................................ 23
  Approach around Them – non-deliberate, reactive, limited, avoided ............................... 24
    Barriers to communication about Them – irrelevant, unknown, dangerous, taboo .......... 24
    Facilitators and prompts ............................................................................................... 25
  Purpose – promoting mental health for ‘Us’ ........................................................................ 26
    Balance ............................................................................................................................ 26
  Approach to promoting mental health – indirect yet deliberate ........................................ 26
    Facilitators and prompts ............................................................................................... 27
    Barriers to communication – desire for resilience ......................................................... 27

Discussion ............................................................................................................................ 27
  ‘Them’ and ‘Us’ – contradictions and ambivalence ......................................................... 28
  Conscious and unconscious processes ............................................................................. 29
  Impact on children’s attitudes and behaviour ................................................................... 30
  Clinical implications .......................................................................................................... 30
  Methodological limitations ............................................................................................... 32
  Future research .................................................................................................................. 34
  Conclusions ....................................................................................................................... 34

References ........................................................................................................................... 35
Abstract

**Background:** Although it is understood that stigma about mental ill-health emerges in middle childhood, and that parental communications are highly influential in children’s developing attitudes, almost nothing is known about the messages parents communicate to young children about mental health problems and how these might contribute to the perpetuation of stigma. This study aimed to address this gap in the literature by exploring parents’ communications to their primary-school aged children around mental health and ill-health.

**Method:** Semi-structured interviews were carried out with ten parents of children aged 7-11 years in the UK. Data collection and analysis was performed according to a Grounded Theory approach; a theoretical model was developed.

**Results:** Parents’ communications to children about mental health issues were governed by the extent to which parents’ representations of ‘Them’ (mental illness) and ‘Us’ (mental health) overlapped or remained distinct. Communications about mental health were deliberate, comfortable, and aimed to promote child wellbeing, whilst unconscious processes driven by taboo meant communications about mental illness were characterized by avoidance, awkwardness, and ambivalence. Factors such as parent experiences, communication context, and child characteristics, fluidly influenced parents’ overlap of ‘Them’ and ‘Us’, and hence the purpose and approach of their communications to their children.

**Conclusions:** Parents’ context-dependent conceptualizations of mental health and ill-health mean children are receiving complex verbal and non-verbal messages from parents, which may contribute to children’s development of stigmatized views via conscious and unconscious processes. Interventions and policy that harness parents’ existing understandings of mental wellbeing to promote a spectrum model of mental health and ill-health may lead to more open parent-child communication, increased help-seeking, and reduced stigma.

**Keywords:** Mental health; mental illness; stigma; parents; parent-child communication; intergenerational transmission of attitudes; grounded theory.
Introduction

Public attitudes towards people with mental health difficulties are stigmatized: a desire for social distance is typical, despite commonly expressed views of sympathy (Crisp, 2000; Green, 2009). Stereotypes of dangerousness are frequently endorsed (Angermeyer, Beck, & Matschinger, 2003), and are reinforced by the media (Coverdale, Nairn, & Claasen, 2002; Diefenbach, 1997; Klin & Lemish, 2008; Stout, Villegas, & Jennings, 2004; Wahl, Hanrahan, Karl, Lasher, & Swayne, 2007). The negative implications of the stigma around mental ill-health are well documented (Hinshaw & Stier, 2008; Watson, Corrigan, Larson, & Sells, 2007; Wright, Gronfein, & Owens, 2000). Unfortunately, despite campaigns and policies designed to reduce negative attitudes in the general public, the stigma of mental health problems remains persistent and pervasive (Crisp, 2000; Hinshaw, 2007; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Mehta, Kassam, Leese, Butler, & Thornicroft, 2009; Phelan, Link, Stueve, & Pescosolido, 2000).

Theories of stigmatization

Stigma is currently seen as a broad concept that draws together socio-cognitive processes of labeling, stereotyping, separation (of ‘us’ from ‘them’), status loss, and discrimination within the context of power differentials (Link & Phelan, 2001; Link, Yang, Phelan, & Collins, 2004). Emotional and behavioural responses to people with mental health problems are driven by attributions about the causes of a person’s difficulties, and by perceived responsibility, dependency, and dangerousness (Corrigan, 2000; Weiner, 1995). In general, stigma about mental ill-health is endorsed most by men, older people, those with less education, and those less familiar with mental health problems (Angermeyer, Matschinger, & Corrigan, 2004; Corrigan, Edwards, Green, Diwan, & Penn, 2001; Corrigan & Watson, 2007a; Jorm & Oh, 2009). In line with this, contact theory (Allport, 1954) proposes that ingroup and outgroup contact can reduce stigma; this is supported by empirical evidence (Couture & Penn, 2003). Contact is associated with increased ‘inclusion of other in self’ – the extent to which ingroup members identify with outgroup members (Turner, Hewstone,
Voci, & Vonofakou, 2008). A recent framework attempted to portray individual-level factors implicated in the maintenance of mental illness stigma, alongside wider social factors, such as personal experiences, media portrayals, and culture (Pescosolido, Martin, Lang, & Olafsdottir, 2008). However this conceptualization failed to address how these attitudes develop initially: in order to design effective interventions to reduce the stigma of mental illness, it is crucial to consider how children acquire stigmatized views about mental health problems.

The socio-cognitive development of mental health stigma

Stigmatised attitudes towards people with mental health problems are consistently reported from age 7-8 years (for reviews see Emerton, 2010; Wahl, 2002), and persist through adolescence into young adulthood (Reavley & Jorm, 2011; Rose, Thornicroft, Pinfold, & Kassam, 2007). Child and adolescent (age 6-17 years) attitudes vary by similar demographic and attributional factors as adults’, such as gender and older age of the stigmatiser, perceived responsibility for the condition, and mental ‘illness type’ (Swords, Heary, & Hennessy, 2011). Theoretical and empirical evidence from a socio-cognitive perspective show that from 7 years, children develop the cognitive ability to conceptualise mental illness as distinct from physical illness, and to form attributions about ‘concealable’ mental health problems (Corrigan & Watson, 2007b; Flavell, 1999; Fox, Buchanan-Barrow, & Barrett, 2010; Piaget, 1985). At this age, children also develop greater complexity in their understanding of ingroups and outgroups, including the ability to ‘include other in the self’ (Cameron, Rutland, & Brown, 2006, 2007).

Aboud (2005) proposed a theoretical framework of how children develop prejudiced views, including cognitive and developmental mechanisms alongside children’s socializing experiences. A variety of social sources (peers, school, media) provide experiences through which children develop attitudes towards people with mental health problems (Hennessy & Heary, 2009; Hinshaw, 2005; Wahl et al., 2007). However, parents may be a particularly crucial social influence in the
development of prejudiced attitudes in children (Allport, 1954), and also exert influence upon children’s other social contexts (e.g. television viewing, school attendance).

**Parental influence on stigma development in children**

Prejudiced attitudes towards outgroups are intergenerationally transmitted from parents to children (Chatard & Selimbegovic, 2008). Parent and child attitudes about ethnicity and race are significantly associated (Sinclair, Dunn, & Lowery, 2005), however only one study to date has investigated adolescent and parent attitudes towards people with mental health problems, finding a significant relationship (Jorm & Wright, 2008). Child attitudes about race are shaped by parental ‘socialisation’ processes, such as verbal and non-verbal messages around mistrust or preparation for discrimination (Hughes et al., 2006): little is known about how similar processes might operate around mental health and ill-health.

**Empirical research on parental communication about mental health and ill-health**

Fear of stigma from others and/or self-stigma may prevent parents communicating to their children about their own mental health problems (Hinshaw, 2005; Watson et al., 2007). A qualitative review of child and adolescent perspectives suggest few are told about causes, symptoms and treatment of mental illness by parents experiencing these difficulties. Parents’ expressed reticence about discussing these issues with their children due to lack of knowledge, not wanting to burden or upset their child, or that children were too young to understand (Gladstone, Boydell, Seeman, & McKeever, 2011). Few empirical studies have examined communications of parents to their children about mental health issues in non-clinical samples. A qualitative study in the USA found around one in five adolescents reported open communication with their parents on the subject, with this group describing more positive attitudes towards talking about and seeking help for mental health problems than the remaining students (Chandra & Minkovitz, 2007). However, no studies found have yet specifically investigated parental communication about mental health and
mental ill-health, in particular to children at the age when stigmatized views begin to develop (Hinshaw, 2005).

**Related literature around parental communication**

Parents’ communications are likely to depend on their experiences and demographics (c.f. attribution theory). Mothers and fathers may differ: women are more likely to endorse dangerousness of people with mental illness (Corrigan & Watson, 2007a). It is not known how this might translate to parenting behaviours, however, media representations of mental illness and violence might have particular meaning for parents in terms of child safety (Backett-Milburn, 2004). Greater perceived danger promotes mother-child communication about health topics (e.g. drug taking) whilst taboo inhibits discussion (e.g. sexuality) (Boone & Lefkowitz, 2006), but it is not known how these factors may impact on discussion about mental health problems. Finally, parents’ communications to children about mental ill-health may be both intentional and unintentional. Allport (1954) emphasised conscious and unconscious social learning mechanisms of learning and conformity in the intergenerational transmission of prejudice, and literature about the unconscious transmission of parental anxiety suggests mechanisms of modeling and reinforcement of anxious behaviours (Fisak & Grills-Taquechel, 2007; Murray et al., 2008). Theoretical literature specifically around mental illness stigma additionally proposes classical conditioning and misattribution processes, linking child discomfort elicited by a parent’s negative expression in response to a person with mental health problems with the person themselves (Ottati, Bodenhausen, & Newman, 2005).

**Rationale for the present study**

As highlighted by Hinshaw (2005), almost nothing is known about the messages parents communicate to their children about mental health problems and people with mental health problems. It is important to investigate how these parental practices manifest themselves at the
ages when children begin to develop stigmatized attitudes towards people with mental health problems. Understanding how and why mental health stigma develops is crucial in designing effective multi-contextual strategies to eliminate it (Corrigan & Watson, 2007b; Hinshaw, 2005; Pescosolido et al., 2008), and may also inform policy and interventions around within-family communication and help-seeking.

The present study aimed to begin to address the identified gaps in the literature by exploring parent communications about mental health and mental health problems to children in middle childhood (7-11 years). The study aimed to gain a rich, qualitative understanding of how and why parents communicate (or do not communicate) with their children about mental health issues. The study also aimed to consider the impact of these communications upon children’s developing attitudes towards mental health problems.

Method

Participants

Ten parents (7 mothers, 3 fathers from separate families) of children aged between 7 and 11 years participated in the study. Participants varied demographically and in their familiarity with mental health problems (see Appendix B).

Procedure

Parents were recruited through three primary schools in the south-east of England that varied by geographical location and the socio-economic status of the community. An information leaflet and response form (Appendix C) was sent to parents of children aged 7-11 in each school (280 parents). A reminder letter was sent two months later. Parents who took part in the study were invited to
distribute the invitation leaflet to other eligible parents (“snowball” sampling; Morrow, 2005). As data analysis progressed, fathers were theoretically sampled, in accordance with the grounded theory (GT) process (Strauss & Corbin, 1998). Thirteen parents agreed to take part in the study; three withdrew prior to interview.

Participants were sent a ‘Communication Notepad’ up to one month prior to their interview, to facilitate noticing potentially relevant interactions with their child (Appendix D). Instructions emphasized that its use was optional, that parents should not aim to change their communications, and that it was simply a tool to help parents remember relevant examples during the interview. Full informed written consent was obtained from each parent before interview; participants’ right to withdraw at any time was verbally highlighted (Appendix E). Efforts were made to minimize socially desirable interview responses. Parents were interviewed face-to-face at their home or in a quiet neutral location (e.g. café). Interviews lasted 40-90 minutes and were audio-recorded.

A semi-structured interview schedule (Appendix F) was developed from the research questions and through a service-user group consultation. One pilot interview was conducted to assess the relevance and style of the interview questions; feedback was positive. Key interview questions remained constant, and some questions were adapted between interviews based on emerging themes. This process directed assessment of theoretical saturation (Strauss & Corbin, 1998). Communication notepads were used a springboard for discussion. Parents chose whether to submit their notepad; four parents’ notes were analysed. Interviews were transcribed by the principal researcher, whereupon identifying details were changed to preserve the anonymity of participants.

Analysis

Data were analysed according to the GT approach of Strauss & Corbin (1998). This “evolved” GT approach has been described as taking both a relativist ontological and constructivist position,
based on the assumption that multiple realities exist, and that data gathering and analysis is influenced by the researcher (Mills, Bonner, & Francis, 2006). The limited theoretical and empirical understanding in this area indicated the need for an exploratory, qualitative approach. GT was chosen to enable a rich exploration of parents’ responses, to allow hypotheses to emerge from the data without a priori assumptions, and the opportunity to move beyond theme description to develop a theoretical model.

Coding followed the three main stages proposed by Strauss and Corbin (1998):

1. **Open Coding**: identifying, examining and naming concepts in the data. All transcripts were analysed using a line-by-line ‘microanalysis’ process to promote data immersion. Theoretical comparisons were made to ensure analysis was rooted in the data and to stimulate coding. Codes were grouped to form initial categories.

2. **Axial Coding**: determining how categories and subcategories fit together, and how major categories might connect. Disconfirming data was searched for.

3. **Selective Coding**: identifying the core category and systematically relating it to all other categories, to integrate and refine the theory. The emergent theoretical model was reviewed against transcripts to ensure good fit.

Coding stages were used in a recursive, flexible manner throughout data analysis. Memoing and diagramming was used to record thinking around properties and dimensions of categories and to inform the emergence of the theoretical model.

**Quality Control**

The quality of the analysis was ensured through careful consideration of guidelines for qualitative research (Mays & Pope, 2000; Williams & Morrow, 2009). Data were triangulated through coding parents’ notes, and observations during interviews, to encourage reflexive analysis and reflect the dictum that “all is data” (Glaser, 2007). A supervisor independently coded one transcript; no major
discrepancies were found. Supervisors were consulted during the analysis process to cross-check and reach consensus regarding codes and the emerging GT. The trustworthiness and transparency of the GT has been supported by the widespread use of quotes in the results section (Mays & Pope, 2000; Williams & Morrow, 2009). Memoing and a reflective research diary (Appendices G, H) enabled the researcher to maintain awareness of possible assumptions and biases during analysis.

Ethical Considerations

Ethical approval for the study was obtained from the Canterbury Christ Church (Salomons) Research Ethics Committee (Appendix I). The research complied with ethical codes of conduct proposed by the British Psychological Society (BPS) and The Health Professions Council (HPC). (BPS, 2006; HPC, 2009).

Results

Core category: Us and Them

Weaved throughout parents’ responses was a distinction between ‘Us’, associated with mental health, and ‘Them’, people with mental illness. The extent to which parents were in the ‘Us’ or the ‘Them’ mode, and the extent to which these two concepts overlapped, governed all aspects of communication to their children about mental health and mental ill-health. The constructed theoretical model (Figure 1) gives an overview of the findings; categories and sub-categories are summarized in Table 1 (full details in Appendix J). This section will first elucidate the features of parents’ conceptualisations of ‘Us’ and ‘Them’, including the impact of stigma and taboo. It will then examine when these two models were distinct and overlapping and the effect upon communication. Parental experiences impacting upon their communications will be described, followed by the purposes and approaches of parents’ communications.
Table 1: Categories and sub-categories

<table>
<thead>
<tr>
<th>Meta-Category</th>
<th>Category</th>
<th>Sub-category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Us and Them</td>
<td>Us</td>
<td>What is Us</td>
</tr>
<tr>
<td></td>
<td>Them</td>
<td>What is Them</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Taboo and stigma</td>
</tr>
<tr>
<td>Degree of overlap-Us and Them</td>
<td>Disconnect-Us and Them</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Merging-Us and Them</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unconscious confusions and contradictions</td>
<td></td>
</tr>
<tr>
<td>Parental experiences impacting</td>
<td>Parental knowledge</td>
<td></td>
</tr>
<tr>
<td>communication</td>
<td></td>
<td>Parent personal experiences</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intergenerational parenting patterns</td>
</tr>
<tr>
<td>Purpose-Them</td>
<td>Acceptance and empathy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Protection</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Balance</td>
<td></td>
</tr>
<tr>
<td>Approach-Them</td>
<td>Non-deliberate, reactive, limited, avoided</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Barriers to communication</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Facilitators and prompts</td>
<td></td>
</tr>
<tr>
<td>Purpose-Us</td>
<td>Promote child mental health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Balance</td>
<td></td>
</tr>
<tr>
<td>Approach-Us</td>
<td>Indirect yet deliberate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Facilitators and prompts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Barriers to communication</td>
<td></td>
</tr>
</tbody>
</table>
Figure 1: Theoretical model: Parental communication to children around mental health and mental illness
What is Us

Within ‘Us’ were issues that parents were happy to talk about with their children. This concerned the psychological and emotional wellbeing of their family and people they know, and issues parents were confident in their knowledge of. Psychological difficulties were considered in terms of the understandable and recoverable impact of experience and personality, using lay language such as ‘stress’, ‘mood’ and ‘worry’.

“Ethan often refers to his teacher being very “stressy”. So stress in people is perhaps evident, and anxiety, fears, those sort of things we would touch upon” (Parent 1)

Parents were also comfortable discussing organic problems such as learning disability, physical disability, and dementia, and potentially taboo subjects such as ethnicity, death, and sex with their children.

“And I suppose where I can remember specific examples, it would be about people who were physically disabled or people from different ethnic backgrounds” (Parent 10)

What is Them

In contrast, when talking about ‘Them’, parents described people they did not know in terms of diagnostic categories. Parents described aspects of mental ill-health, including chronicity and treatment, and both the visibility and invisibility of mental health problems.

“We saw a man in the street actually... it turned out that he’d just been released from erm... a hospital, and he was bipolar. And he was wearing a dressing gown. And he had shaving foam all over his face.” (Parent 3)

These issues linked with parents’ descriptions of people with mental illness as needing help and protection, or as dangerous and unpredictable.

“You don’t know what’s going through somebody’s mind.[l] They need help and they’re not getting it. And it makes them do bad things.” (Parent 6)
Parents’ language delineated the difference between ‘Us’ and ‘Them’ to children. Parents used age-appropriate language to explain mental illness to their children, aiming to make the concepts understandable. Examples given by parents highlighted the use of diagnostic terms or simple, but stigmatized phrases.

“I think they’ve heard it on the radio and think I’ve brushed over it and I think I’ve said just some people who aren’t right in the head and do silly actions and hurt other people.” (Parent 1)

Parents’ intentions were often to teach children socially acceptable terms, and centred around teaching children not to use lay descriptions of mental illness.

Taboo and stigma

Taboo and stigma was a key, and often unconscious, influence on parents’ communication about ‘Them’ (mental illness). Parents’ descriptions of their communication to children about mental illness were characterized by fear and awkwardness, seen in the frequency of the use of ‘pausing’ terms such as ‘erm’ and ‘um’, and in non-verbal behaviours during interviews, such as fidgeting. Consciously, parents noted that mental illness is stigmatized, and identified commonly-used stigmatised language.

“She’ll know words like crazy, or words like loony. And yet she perhaps would use those every day not thinking about what she was doing in the same way that perhaps I do as well.” (Parent 10)

One parent noted the silencing effect of stigma upon herself, having experienced depression.

“I choose who I tell. I don’t want everybody to know. And I have learnt that from the fact that [...] when I first got depression I told people and I actually had people walk away.” (Parent 7)

Parents described situations from their childhood, often only realizing the taboo of mental health problems later.
“We weren’t encouraged to talk about that. [...] It was never explicit, it was only when I was older that I found out about his alcoholism.” (Parent 10)

Parents from a range of socio-economic backgrounds felt greater stigma about mental illness was related to a less privileged and less educated background. Parents noticed this stigma persists despite reductions in the stigma of other issues.

“I think if you compared it to say how race relations were, even when I was growing up in the 70s... [] I think mental health in its equivalent is still at that start point in a way.” (Parent 9)

However, most parents were unaware of the impact of stigma on their own communications (see barriers, below), and felt the taboo of mental illness only impacted other people.

“Well it’s obviously quite a difficult subject to broach... difficult to broach... it’s a touchy subject for some people.” (Parent 5)

The potential impact of silence about mental illness on the transmission of stigma went largely unrecognized, although a few parents did begin to reflect on this process.

“We’ve been at the pub, numerous times, and there’s been incidents where the police have had to come to take the client back to the Blue unit. So... something like that happens, we just say well they’re from the Blue unit... [] But he probably hasn’t got a very good perception of that place at all really. I should probably explain it to him better...” (Parent 4)

Degree of overlap between Us and Them

Parents’ models of ‘Us’ and ‘Them’, and of mental health and mental illness, were sometimes overlapping and sometimes distant. At times, parents made statements separating themselves from ‘Them’, and so creating distance, whilst in some cases acknowledging that they may be present in our midst, yet invisible.

“So pictures that spring to mind I guess are probably stressed mums, feeling like it’s all a bit too much, or erm... that would be one end of the spectrum, and then at the other
end of the spectrum you’d have the classic homeless person, addict, person with any one of several diagnoses.” (Parent 2)

“This isn’t that sort of area.” (Parent 3)

“I mean he’s met the girl who is bipolar once but I don’t think he realized [...] because it’s not that noticeable. I said, you know, they look like you and me.” (Parent 8)

At other times, parents’ descriptions showed a merging of these two models. For example, if mental illness is visible, the person may be physically removed from within ‘Us’.

“I had an uncle who was set aside from the family because he was... a raging alcoholic. And he was always blacklisted from the family and family events... [] People saying he’s “crazy”, or he’s “lost his mind” and things like that.” (Parent 10)

Depression was seen as a ‘grey area’ that is more easily accommodated in the concept of ‘Us’, seen as both a mental illness and part of a spectrum of wellbeing.

“It’s very common. So I’ve got... a lot of my friends who go through depressive phases and come out the other side. You know, it depends what’s going on.” (Parent 7)

“I’m sure that lots of people have depression at some point in their lives. Everyone gets down and everyone gets happy...” (Parent 8)

Parents were often unsure what ‘counted’ as a mental health problem, illustrating the blur between ‘Us’ and ‘Them’.

Parents also noticed that children had a greater overlap of ‘Us and Them’, describing children as being naturally accepting and empathetic, and not fazed by mental health problems.

“I think probably the limit of it would have been that this lady might not talk to you but don’t worry she’s not being rude []. And then Ava would have been very accepting of that, in a way that adults aren’t.” (Parent 10)

However, parents’ responses showed a particularly clear distinction between ‘Us’ and ‘Them’ when talking about children. Children were seen in terms of emotional wellbeing and resilience: parents
described a variety of influences upon this, both external (school, friends, family) and internal (self-esteem, physical state).

“I would probably tend to think of children as hopefully not having got to that diagnosis point of view... I would tend to think of children in terms of their general mental health. So things that are making them grumpy, or they’re feeling stressed.” (Parent 3)

However, parents had generally not considered the possibility of their child developing mental health problems.

“It’s very interesting because it’s the first time I’ve rationally thought about... I think I’ve always assumed she wouldn’t have any mental health problems. And whether that’s naivety on my part or hopefulness, I’m not sure. And possibly with a degree of not understanding explicitly how certain mental health problems are created. And possibly to a degree not really wanting to know. (Parent 10)

“I mean I think the figures are that 1 in 4 people will have some sort of mental health issues. And... everybody just always talks as though it will never be them. And I think its... most parents are, you’re quite naive, you just think all these really bad things happen to other people somewhere else, they don’t happen to you.” (Parent 9)

Unconscious confusions – contradicting intentions, beliefs and messages

Parents’ complex and overlapping understanding of mental health and illness, alongside the impact of taboo and stigma, led to contradictions that parents were often unaware of. These contradictions appeared to be due to unconscious confusions parents were navigating, rather than socially desirable responses. For example, all parents described aiming to be open in their communication with their children about both mental health and ill-health, however openness did not characterize the latter. Non-verbal communication such as social avoidance sometimes contradicted parents’ verbal messages of acceptance around people with mental illness. Similarly, parents described wanting to communicate more openly than did their parents, but few were aware they often repeated similar patterns (see below). At different times, parents reported
children were both able and unable to understand mental ill-health. Parents justified not discussing mental illness as it was not affecting their family, but later described their own or family members’ mental health problems. Some parents began to reflect upon the impact of these contradictory messages:

“’I’d dislike it very much if Ava thought that mental illness or mental health issues was sort of different... or that there was a stigma attached to it as opposed to being physically disabled or having a learning difficulty. I wonder if my lack of openness, or because I don’t talk to her about it...[] I wonder if that perhaps leads to a stigma attached to it because you don’t know about it.” (Parent 10)

Parental experiences impacting on communication about Us and Them

**Parental knowledge and experiences**

Greater parent knowledge about mental health issues from education or work promoted an overlap between mental health and ill-health, and promoted communications around mental illness. Limited knowledge was a barrier to communication (see below). Parents’ cultural background exerted its influence in terms of level of community connectedness, and cultural attitude towards mental health problems.

“I find from having an alternative lifestyle living as a traveller very tolerant. Because you get used to living in large groups of people, and you deal with people’s ups and downs in life. So I’m quite lucky that I’ve perhaps had that less prejudiced environment.”

(Parent 9)

Greater experience of cultural openness and contact with mental health difficulties gave parents a more overlapping view of mental health and ill-health and led to more open communication to children, while limited discussion about or community contact with mental illness in general had the opposite effect.
“I’ve grown up in a country in a very conservative country where things like that just weren’t spoken about, it was very typical, like you just don’t air out your dirty laundry, and you… if you have someone who’s you know, suffering from something in the family, or you don’t even talk about your problems.” (Parent 8)

“I was very lucky to have quite a shielded upbringing in a cathedral close…” (Parent 5)

However, personal or familial experience of mental health issues did not necessarily promote communication to children.

“Erm… I got post-natal depression [...] and obviously Daisy went through that. Now, I’ve never told her I had depression.” (Parent 7)

**Intergenerational parenting patterns**

Parents’ experiences of being parented were a key driver in parents’ approaches. Parents either aimed to replicate their parents’ approach to communication around mental health issues, or to do the opposite.

“If anything it would probably make me try to give Sam a better understanding really. Because I didn’t have a very good understanding of parts of mental health. So I’d probably try to do the opposite and make sure he does understand it as he gets older.” (Parent 4)

However, as described above, conscious intentions were often undermined by unconscious processes.

“I’m definitely not going to avoid it like the plague, I don’t think that’s right. I mean… I’m not doing any better than my parents did really, you know.” (Parent 8)

Parents’ comments about what was communicated to them by their parents clearly demonstrated how silence can contribute to the intergenerational transmission of stigma.

“Some of the male clients... I hadn’t really been explained what was wrong with them, so to speak, so I suppose it was the unknown really [...] and also because I knew that
my aunty used to come home with bruises, I had this vision of them being all violent, which
of course they’re not. But I suppose I was just a bit scared because I didn’t know much about
it.” (Parent 4)

Purpose and Approach

The Purpose and Approach of parents’ communications was governed by the ‘Us’ or ‘Them’ mode,
and what was conscious and unconscious within this process.

Purpose – acceptance versus protection from Them

Parents’ intentions in communicating about mental illness to their children clustered around two
main purposes: acceptance and empathy, and protection. Parents described consciously promoting
acceptance towards difference in general, and specifically towards people with mental health
problems.

“But I certainly know that I have talked to her about the fact that there are lots of
different people and people behave in lots of different ways and that just because
someone’s doing something that might be different to what we do, it doesn’t necessarily
mean that it’s right or wrong or normal or abnormal.” (Parent 10)

Parents described explaining mental illnesses to their children for education purposes, and to help
their child understand and cope with the world. Often in response to media portrayals, parents
reassured children that people with mental illnesses are not dangerous, and that violence is rare.
Parents also wanted to reassure children that others’ mental health problems were not their fault.

“That’s where I guess trying to make it clear that when the people show signs of
mental health problems, and something’s happening that that’s not about you, it’s not your
fault. You’re not to blame…” (Parent 9)

Some parents did also note positive effects of children’s experience with people with mental health
difficulties.
“She thinks it’s completely normal to get help... whereas I guess a lot of kids her age wouldn’t have even thought of that.” (Parent 9)

However, parents wanted to protect children from people with mental illness in the family and community, and from media portrayals. This was to protect children from fear, from being impressionable, and from danger potentially increased by children’s accepting natures. Parents appeared to communicate a more clearly separated view of ‘Us and Them’ to children based upon these concerns. Parents’ deliberate and verbal communications around protection were in the form of warnings.

“But again just to be careful of that and um, I suppose to warn him to some extent, to stay where people are acting in a way that’s not... doesn’t seem to be... reasonable or understandable to maybe steer clear or just to not engage.” (Parent 5)

Protecting children from negative emotions, from unnecessary knowledge, and to protect their innocence, were also reasons for parents’ lack of communication about mental illness (see barriers, below).

“Because I don’t really want to expose them to nasty stuff too soon... there’s things they need not know at this age.” (Parent 1)

Balance

A clear tension is noticeable between the two purposes of parents’ communications: messages of protection, verbal and conscious (e.g. warnings) and non-verbal and/or unconscious (e.g. emotion, avoiding communication) contradict parents’ messages around acceptance and empathy. Parents were aware of trying to find a balance between these two messages.

“And there might be a tiny percentage of people where psychosis might manifest itself in an aggressive or violent way towards him. And another is to say that just because someone is behaving a bit peculiarly as we see it, [...] it doesn’t necessarily pose a threat. I think that’s quite... [...] a difficult balance to strike and I suppose at this stage of his early life I
Parents also noted a balance between enough and too much information about mental illness for their primary school-aged children: this was reflected in their approach to discussions.

**Approach around Them – non-deliberate, reactive, limited, avoided**

Parents’ style of approach to communication about mental illness was not deliberate.

> “It’s not like...you know like you’d sit down with a child and tell them about I don’t know, the birds and the bees...[I don’t think id sit her down and say right, this is depression, this is what this means, this is schizophrenia, this is what this means.” (Parent 2)

Parents took a reactive, rather than a proactive, approach, using a matter-of-fact style with an emphasis on accurate information. Parents limited the amount and depth of information. Avoidance characterized parents’ approach, with tactics including delaying discussions, glossing over questions, using euphemisms, and claiming that mental illness in the media is ‘pretend’.

> “Well probably, what’s not right to say, I probably would have said don’t worry it’s just pretend. As opposed to saying actually these things can happen.” (Parent 4)

> “I do try and steer clear of it, not happening. I don’t wanna lie to them... so I do sort of jitter off that part of it. I suppose I would jump off the subject a little bit maybe but... I wouldn’t not answer them... I’d talk round it or give them a direct answer really.” (Parent 6)

**Barriers to communication about Them – irrelevant, unknown, dangerous, taboo**

Barriers were numerous and prevented and limited communication about mental illness. Parents felt mental illness was, in general, not an age-appropriate topic for primary school-aged children, and one they wouldn’t understand.

> “Erm... well at his age, well I probably wouldn’t go into like, I don’t know, other conditions, schizophrenia and things like that because he just wouldn’t understand.” (Parent 4)
Some parents felt the topic did not arise, or if it was not affecting their child then it was not necessary to discuss. Parents felt ill-equipped because they lacked sufficient knowledge, and because mental health problems are more difficult to explain than physical disabilities. These reasons all relate to the fact that mental illnesses were seen to happen to ‘Them’, and not ‘Us’. Parents were concerned about negative consequences of discussing mental ill-health, in terms of worrying, frightening or upsetting their child, burdening them, of ‘opening Pandora’s box’, or of children socially ‘misusing’ knowledge. One parent with personal experience of depression was wary about discussing this with her child:

“Partly that is to do with... she’s 9. And whatever I tell her is going to go back into the playground. Cos she’s not mature enough yet to understand that some things are not talked about. Openly.” (Parent 7)

Some parents felt more severe types of mental illness were less suitable to discuss, and distinguished between blameful and blameless aetiologies of mental illness.

“I think depression and things like that I’m not so worried about that because that’s a natural occurrence in life, well so is drug dealing but... that’s avoidable, whereas that’s not avoidable.” (Parent 6)

Overall, parents felt that their children were too young to be told about mental ill-health, but that they would talk to them about it once they were older. Barriers were symptomatic of stigma (e.g. parents may have little knowledge of the subject), and also conscious and unconscious justifications of behaviour driven by the taboo of mental illness.

**Facilitators and prompts**

Greater parent knowledge facilitated communication. Some parents felt they would only communicate about mental ill-health if it was affecting their child whilst others felt it was a ‘safer’ topic if it was not close to home. In line with a reactive style, more questions from children facilitated discussion. Prompts for communication about mental illnesses included parents’ jobs, the media, school, people in the community, or the family.
Purpose – promoting mental health for Us

Parents’ aim in communicating about ‘Us’ was to promote their child’s mental health, through increasing resilience and self-esteem, validating emotions and helping children recognize feelings, and teaching coping strategies. Parents’ major purpose in communicating about mental health with their child was to promote their child’s ability to discuss their feelings; in effect, promoting their ability to seek help.

“Yeah... chat... talk about things. I think that’s my main goal, is to get them to talk, really. To deal with it before it becomes a massive issue. [/] You need to get it off your chest.”

(Parent 6)

Balance

The theme of balance manifested itself in parents describing a tension between promoting resilience by reassuring and helping children with their concerns, and wanting children to be able to cope on their own. An effect of gender was noticed, as fathers were keener not to ‘mollycoddle’ children, particularly sons.

“I mean whilst I suppose I’m a relatively sensitive father... […] I’m keen to strike a balance where he can talk about the important stuff and that’s fine, but also some things you kind of have to deal with just yourself.” (Parent 5)

Approach to promoting mental health – indirect yet deliberate

Parents’ style of discussing mental health with their children was deliberate and parents described this as a consciously proactive process.

“I’m not sure that I particularly think about how I communicate mental illness. I think about how I would want to promote mental wellbeing in her.” (Parent 2)

Parents often used an indirect approach to communication, by asking around the subject or reminding children they can talk to them; this was more likely for boys, who were seen to share
their feelings less readily than girls. Parents described a problem-solving approach to communication about mental health; fathers tended to endorse this style more than mothers.

“I think I’m typically male in the way that... I always like to have solutions to problems... I don’t like to, well we’ll just see how we get along with that... I don’t really like that.[J] Right, you want to talk about it because you’ve got a problem? Right ok, well let’s try to solve it. “ (Parent 10)

Facilitators and prompts
Factors that promoted communication included the child’s ability to articulate their feelings, parents’ common ground with their child, and quality time and space. Prompts to conversation included the child seeming concerned, and known issues within the family or at school. In contrast to discussion about mental illness, prompts were cues for parents to begin conversation, rather than for children to ask questions. Parents felt younger child age promoted discussion about mental health, as they were concerned children may share their internal world less as they get older, but did not notice the tension with their desire to delay talking about mental ill-health.

Barriers to communication – desire for resilience
Few barriers were described, but they tended to relate to the balance between talking and coping alone, or not exaggerating children’s concerns. Parents also sometimes felt they might not notice signs that their child was worried.

“You know so I ask, not too often... I try not to because I don’t want to make it into a bigger thing than it is” (Parent 7)

Discussion
This study was the first to explore parents’ communications to their primary-school aged children about mental health and mental illness. This section examines key study findings in relation to
existing theory and research, before offering hypotheses around parent-child transmission of attitudes towards mental ill-health, and proposing directions for clinical practice and future research.

‘Them’ and ‘Us’ – contradictions and ambivalence

The psychological separation of ‘Them’ from ‘Us’ found in parents’ responses has previously been identified as a key component in the stigma of mental illness (Link & Phelan, 2001; Link et al., 2004). Similarly, the overlapping nature of parents’ models of ‘Them’ and ‘Us’ reflects the concept of ‘inclusion of other in the self’ (Aron et al., 2004). This study corroborates previous research in that, in general, parents who had greater familiarity with people with mental health problems displayed greater overlap between their concepts of self and other (Angermeyer et al., 2004; Corrigan et al., 2001; Corrigan & Watson, 2007a; Jorm & Oh, 2009; Turner et al., 2008), and thus described more open conversation about mental ill-health to children. A novel finding was that the extent of overlap in parents’ concepts of and communication about ‘Us’ and ‘Them’ was fluid and dependent on factors such as parents’ experiences and child characteristics (e.g. age), but also current context and purpose of communication. This led to unconscious confusions, contradictions, awkwardness, and ambivalence in parents’ communications to children. This study lends weight to the suggestion of Ottati et al (2005) that ambivalence towards people with mental health problems means expressed beliefs and behaviours are likely to be inconsistent and context-dependent.

Parents’ attributions about people with mental illness closely reflected those previously reported, such as dangerousness versus dependence (Angermeyer & Matschinger, 2003; Corrigan et al., 2001; Couture & Penn, 2003), and impacted upon the purpose of parents’ communications: protection versus acceptance. These findings support the recent conceptualization of intergroup anxiety as comprising ‘other anxiety’ about the impact of others’ behaviour (linked to protection), and ‘self anxiety’ about thinking or behaving in a prejudiced manner (linked to acceptance, and awkwardness) (Greenland, Xenias, & Maio, 2012). Mothers and fathers endorsed differing
perspectives around balance in communication to promote emotional resilience in children, but in contrast to some existing literature, appeared to endorse messages around dangerousness and protection at a similar level (Corrigan & Watson, 2007a); contextual differences around being male and being a father may result in differing attributions.

**Conscious and unconscious processes**

Theoretical literature suggests that when attitudes are ambivalent, unconscious processes may be particularly relevant (Ottati et al., 2005): contrasting messages may be communicated both consciously and unconsciously to children. While communication about mental health was characterized by openness, communication about mental illness was characterized by avoidance. This pattern reflects that previously reported both in families affected (Gladstone et al., 2011) and not affected by mental health problems (Chandra & Minkovitz, 2007). This study suggests silence, limited communication, and taboo are overarching drivers in parent-child communication about mental ill-health, but not mental health (Boone & Lefkowitz, 2006), often acting at an unconscious level, as illustrated by contradictions in parents’ responses. For example, a barrier to communication about mental ill-health was that children would not understand (see also Gladstone et al., 2011), however parents described children as accepting and able to understand other complex issues (e.g. learning disabilities), and children aged 7-11 do have the cognitive capability to understand mental health problems (Corrigan & Watson, 2007b; Flavell, 1999; Fox et al., 2010; Piaget, 1985). Parents’ belief that children would not understand did not vary across the child age range (7-11 years); neither did parents’ plans to discuss these issues when children were older. Indeed, previous studies suggest communication about mental ill-health does not increase in adolescence (Chandra & Minkovitz, 2007; Gladstone et al., 2011). The unconscious effects of stigma were also noted in parents’ non-verbal behaviours (e.g. avoiding contact) and language, which undermined their verbal messages of acceptance. Finally, parents were often unaware they were repeating taboo patterns of parent-child communication about mental illness from their childhood, despite conscious intentions to do otherwise (Byng-Hall, 1988).
Impact on children’s attitudes and behaviour

Based upon empirical and theoretical understandings, hypotheses may be offered as to how parents’ communications impact upon children’s attitudes. The finding that parents of children in middle childhood offer communications that separate ‘Us’ from ‘Them’ dovetails with existing findings that from age 7, children develop greater complexity in their understanding of outgroups of people with mental health problems (Cameron et al., 2006). Similarly, the socially normative parental communications noted around acceptance link to findings that children begin to learn and conform to social norms in middle childhood (Allport, 1954; Katz, Sohn, & Zalk, 1975). These findings suggest that ambivalent messages from parents about ‘Them’ and ‘Us’ might shape these aspects of children’s emerging attitudes around mental health issues. For example, the differential language that parents use in communicating to their children about ‘Them’ and ‘Us’ may both help children learn to distinguish these groups, and reinforce stigma and taboo (c.f. labeling theory; Link & Phelan, 2001; Scheff, 1974). Parents’ verbal and non-verbal awkwardness and fear when discussing mental illness may be transmitted to children via mechanisms such as conformity, modeling, or classical conditioning (Aboud, 2005; Allport, 1954; Fisak & Grills-Taquechel, 2007; Murray et al., 2008; Ottati et al., 2005). Finally, this study lends weight to the hypothesis that the stigma around mental health problems may be partially perpetuated via intergenerational patterns of parent-child communication. However, as only one study has so far found any association between parent and child attitudes around mental illness, measuring explicit rather than implicit views (Jorm & Wright, 2008), further research is clearly warranted.

Clinical implications

Stigma programs

Research has identified that anti-stigma campaigns must begin to cross multiple contexts in order to be successful (Hinshaw, 2007; Pescosolido et al., 2008; Rüsch, Angermeyer, & Corrigan, 2005). Interventions focusing upon parents might aim to develop parents’ awareness of unconscious
processes such as the impact of taboo and intergenerational patterns. Diagnostic and medicalised understandings of mental illness were overwhelmingly associated with ‘Them’ in this study, whereas parents were able to communicate about psychological wellbeing and resilience, even when describing significant difficulties of people classed as ‘Us’. Reducing the disconnect between ‘Us’ and ‘Them’ by harnessing parents’ existing language and understandings to promote a spectrum model of mental health and ill-health may be associated with reduced stigma and more open communication. Indeed, contact-based interventions promoting overlap between participants’ conceptions of self and other are more effective than educational strategies that seek to increase knowledge (Corrigan & Shapiro, 2010). This approach would be relevant for all families: ‘Us’ and ‘Them’ existed for parents affected and not affected by mental health problems. This study offers a hopeful picture in that previously stigmatized issues (e.g. cancer, autism, depression) were included in parents’ conceptualisations of ‘Us’. This study would also indicate the need for inclusion of parents in the design and delivery of school-based programmes to promote positive attitudes towards mental health problems, and supports the agenda for preventative interventions in primary schools. Collaborative interventions could allay parental concerns, encourage transparency, promote consistent messages across social contexts and provide an educational opportunity for parents.

**Help-seeking**

Parents aimed to promote their child’s mental health, but few had considered the possibility of their child developing a mental health problem, despite the fact that one in four people will experience a mental health problem in their lifetime (NHS Information Centre for Health & Social Care, 2009), and that many mental health issues emerge in adolescence (Meltzer, Gatward, Goodman, & Ford, 2003). Help-seeking for child and adolescent mental health problems may be delayed due to parental (mis)perception of problems (Ford, Hamilton, Meltzer, & Goodman, 2008; Sayal, 2006) and children’s emergent stigma and self-stigma. Interventions should aim to help parents identify that mental health problems can affect all of us, including our children, and should
be openly discussed to promote help-seeking. Parents could be reassured that children are able to, and want to, understand more about mental health difficulties (Corrigan & Watson, 2007b; Gladstone et al., 2011). Mental health practitioners should be supported to become more alert to issues around parenting and communication with their clients. These messages could also be incorporated into existing evidence-based, preventative policy and practice such as parenting initiatives aimed at promoting psychosocial wellbeing in families (e.g. Family Nurse Partnership; canPARENT), into collaborative school-based programmes, or into public anti-stigma campaigns.

**Methodological limitations**

This study has a number of strengths, particularly in addressing a crucial gap in the literature around what is communicated to children about mental (ill)health, and in developing a theoretical model; however limitations should be considered. Firstly, despite efforts to minimize these issues, parents may have omitted certain types of communications in their descriptions, and stigma and social desirability may have influenced parents’ responses. However, a strength of the study is that it coded for unconscious processes around stigma and taboo, using these influences as data to interpret; the GT method provides an abstract theory of “*what is really going on*” (Glaser, 2007; pp.12). The impact of the communication notepad on the data should be considered. It was anticipated that parents would not have actively considered their communications to their children around mental health issues, and the notepad aimed to draw parents’ attention to these interactions to ensure rich data could be generated. Despite efforts to mitigate against such effects, it is possible that asking parents to become aware of their communications around mental health issues to their children altered these communications, and parents’ interview responses. Anecdotally, the researcher’s impression was that there was little difference between the interviews of participants that did and did not make use of the notepad, except that parents who had not used the notepad tended to remember relevant examples later on during interviews. The study was able to conceptualise the lack of parents’ awareness of these communications and how some parents began to reflect upon this during the interviews (Glaser, 2007). Parents’ comments
on the notepad also provided a source of data triangulation, a process by which data is compared from two or more different data sources, collection or analysis methods, which aims to increase the credibility and reflexivity of results (Mays & Pope, 2000). However, it may be interesting to examine the impact of not using such a tool in future research.

In accordance with the GT method, theoretical sampling was used to direct the saturation of categories, and recursive analysis was employed to increase confidence that saturation had taken place. The lack of generation of new themes during analysis of final transcripts suggested that data saturation had been reached, particularly within the core categories. However, Strauss and Corbin (1998) recognize that it is difficult to assess if total data saturation has ever taken place, and that ‘sufficient saturation’ may be more realistic. This should be taken into account when interpreting the findings of this study, and the limited size and breadth of the sample should be acknowledged.

In particular, the role of culture could be examined in greater depth in future work, and the model generated by this study should be seen as a preliminary framework. As with all qualitative research, the influence of the researcher must be held in mind. Quality control measures such as the use of a reflexive research diary aimed to ensure the researcher was aware of implicit assumptions, beliefs and hopes for the research that might impact on the data. For example, early in data analysis the researcher noticed a bias towards coding and interpreting more negative aspects of parents’ responses, and reflected that being a mental health professional, alongside not being a parent, might have affected her interpretations of parents should communicate to children about mental health issues. This awareness meant the researcher was able to rebalance her perspective and to remain rooted in the data. However, as the researcher influences all aspects of the research, from the interview schedule, to the data analysis and model construction, the findings of this study are best understood as a social construction between the researcher and participants (Charmaz, 2006).

Finally, this study does not tell us how children internalize parents’ messages, nor do we know about children’s perceptions of parents’ communications, although interestingly we can see the
impact of grandparents’ generation messages upon parents’ perceptions. This study offers only theoretical hypotheses on these issues.

Future research

Future research should focus upon whether increasing parents’ understanding of mental ill-health as a spectrum, and as an issue that may affect their children, results in greater communication, greater help-seeking and/or reduced stigma. Finding the most effective ways of delivering these messages will also be crucial. Future research should aim to establish clear links between parental communication and child behaviour and attitudes on mental health issues. Research on parental communication from a child perspective would enhance the findings of this study.

Conclusions

This study is the first to shed light on the parental socialization practices that contribute to children’s development of stigmatized views. The theory generated by this study highlights that parents’ communications to children about mental health issues are governed by the extent to which parents’ representations of ‘Them’ (mental illness) and ‘Us’ (mental health) overlap or remain distinct. Parents aim to promote emotional wellbeing and resilience in their children through open communication about mental health, however, mental ill-health is not seen as relevant to ‘Us’, and limited communications are characterized by avoidance, ambivalence and awkwardness. The findings of this research suggest children are receiving complex and mixed messages about mental health and mental illness from parents, via verbal and non-verbal communication, which may contribute to their development of stigmatized views. Hypotheses of possible mechanisms of attitude transmission, such as learning, modeling and conditioning, were offered. This theory has clear implications for policy and interventions to promote parent-child communication and help-seeking, and for stigma-reduction programmes both in the general public and within schools.
References


MAJOR RESEARCH PROJECT

SECTION C: CRITICAL APPRAISAL

Parents’ communication to their primary school-aged children about mental health and ill-health:
A grounded theory study

Word Count: 1998

JOANNE MUELLER  BSc (Hons) MSc

A thesis submitted in partial fulfillment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

JULY 2012
SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY
Table of Contents

Skills Learnt ................................................................................................................................. 4
Study Improvements .................................................................................................................. 6
Clinical Implications ................................................................................................................ 7
Future Research ......................................................................................................................... 8
References ................................................................................................................................. 10
**Skills Learnt**

What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?

This project was the first time I have carried out qualitative research on this scale. Looking back, it has been a personally and professionally enriching experience, but also a challenging process. I chose to undertake a qualitative project as I had worked on quantitative studies prior to training and I was keen to broaden my research skillset. I was able to develop my existing research skills in writing the research proposal, and securing Salomons ethical approval. I anticipate navigating NHS ethics procedures in the future, and therefore this is an area for further learning. I developed skills in semi-structured interviewing, and learnt to be both able to guide participants back to the focus of the interview and to be flexible in following participants’ leads. At times, it was challenging to remain in the ‘researcher’ role, rather than responding as a clinician, particularly in more emotive interviews; I have been able to develop the skill necessary to manage this balance through reflection and supervision. I aim to further develop my skill in planning participant recruitment in future; this is further discussed under Study Improvements.

Undoubtedly the greatest area of learning in this research was related to the qualitative analysis approach I selected, Grounded Theory (GT). Simply the process of selecting GT led to learning around other qualitative methods, which were rejected because their focus did not match that of the study, such as language used (discourse analysis), stories in parents’ responses (narrative analysis), or what it is like to be the parent (interpretative phenomenological analysis). Following reading and reflection, I chose the ‘evolved grounded theory’ approach of Strauss and Corbin (1998). This was partly because it offered a structured and clear analytic process via which to develop a theory from data, and because it fit well with my epistemological position that falls between critical realism and social constructivism (Mills, Bonner, & Francis, 2006). By considering
the impact of the researcher upon the data, I learnt to become more aware of my own implicit assumptions, and I explored these through a research diary and memos. For example, I considered the fact that, as a professional with experience of working with people with mental health difficulties, alongside not being a parent, I may have idealized how parents should communicate to children about mental health issues. As a psychologist, I am interested in reducing the stigma about mental illness, and have personal experiences that make this important to me. I worked hard to be aware of these perspectives whilst collecting and analyzing data, and aimed to remain neutral and rooted in the data. However, it is inescapable that I influenced the data to some extent, as the data is a co-construction between the participant and researcher (Charmaz, 2006). This was the first time that I have considered the epistemology of psychological research, in particular in relation to my own views, and I have since noticed how little it is reflected upon in the extant literature. This is a skill I hope to nurture in conducting and critiquing research in the future.

Overall, I found the analysis process extremely difficult, in terms of the time and degree of immersion in the data needed. I was surprised by the amount of meaning that can be drawn out of even short excerpts, and the amount of data generated often felt overwhelming. I considered that my ‘ENFP’ Learning Style (Shindler & Yang, 2004) may have meant I found the early stages of line-by-line coding and slow progress frustrating, as ‘EN’ types (Exterovert Intuitive) “like to make things happen” and “don’t like details”. I learnt to cope with this by remaining focused on the research question when analyzing data, and to trust my instincts as categories began to emerge. I also discovered the value of memos and diagrams in guiding my thinking, as I am a visual learner. I initially found it difficult to move from description to allowing a meaningful theory to emerge, but I have realized that this is partly a case of trusting the ‘iterative process’ (Strauss & Corbin, 1998) of moving back and forward between the data and emerging categories, and finding my own confidence in abstracting. Finally, I found writing a concise report was challenging, particularly with a broad-based theoretical model to present alongside such rich data from parents. I feel I have learnt about being able to summarise clearly in order to present qualitative research to others.
Study Improvements

If you were able to do this project again, what would you do differently and why?

I feel that it would be difficult to make any considerable changes to the research given the limited time available and the necessary requirements as a doctoral dissertation. If I conducted this research again, I would plan my recruitment strategy more carefully. Originally, I aimed to ask parents about their views on a primary school-based programme to promote positive attitudes around mental ill-health, and anticipated parents would have a vested interest. However after changing my research question, I did not change my main recruitment strategy (of inviting parents via a school letter) and did not take full account of the impact of stigma, or apathy, and the limited responses from parents resulted in an unexpected reliance upon “snowball” recruitment (Morrow, 2005). This, however, had considerable benefits for the study. Parents who replied to the school invitation tended to be those with personal or professional experience of mental health issues, whilst those recruited via “snowballing” did so based upon ‘recommendation’, ensuring I interviewed parents with no particular contact with mental health problems, and enabling theoretical sampling of fathers. Strauss and Corbin (1998) recognize that it is difficult to assess if total data saturation has taken place, and that ‘sufficient saturation’ may be more realistic: although my eventual sample size resulted in my confidence in theoretical saturation, in conducting this project again I would aim for more interviews and greater cultural diversity to increase certainty. Although I was able to adapt to the recruitment difficulties and this may have benefitted the study, in future I will aim to take more account of possible recruitment limitations and barriers.

I have also considered the impact of the “communications notepad”. It was anticipated (and found) that parents had not considered the communications they make to their primary-school aged children around mental health and ill-health. The notepad aimed to draw parents’ attention to these types of communications prior to interview to ensure rich data could be generated, and was
careful to tell parents they need not change anything in their approach. However, it could be argued that that simply bringing these issues into parents’ awareness may have influenced their actions, or responses. However, this did not appear to be the case from parents’ responses, and the study was able to conceptualise the lack of parents’ awareness of these communications and how they, at times, reflected upon this during the interviews (Glaser, 2007). In conducting this study again, it may be interesting not to use this tool and to consider the impact of this on study findings. Parents’ comments on the notepad also provided a source of data triangulation, a process by which data is compared from two or more different data sources, collection or analysis methods, which aims to increase the credibility and reflexivity of results (Mays & Pope, 2000). Investigator triangulation via independent coding of a transcript by a supervisor, observational triangulation using parents’ non-verbal communications during interviews, and geographical triangulation from three different geographical and socio-economic locations, were incorporated into this study. However, if this study was conducted again with a broader scope, triangulation could form a more central part of the study, perhaps by using formal observational data of parenting, or by exploring both parents’ and their children’s perspectives on the issue.

**Clinical Implications**

_Clinically, as a consequence of doing this study, would you do anything differently and why?_

Undertaking this research has given me a deeper understanding of what it is to be a parent, particularly around mental health and ill-health. For example, I did not expect parents who had experience working in the field of mental health to nevertheless endorse views of danger and protection so strongly, or that parents would be so unlikely (and frightened) to consider their child developing a mental health problem. Although clinically we often work therapeutically with those whose experiences we do not share, I think this research has increased my empathy for parents and has undoubtedly given me a clearer perspective on the kinds of concerns parents have around
these issues. I will be more sensitive in future to the kinds of models parents hold in their minds about mental health and mental illness, and how this might be influencing help-seeking, coping and open communication in the home. The process also highlighted to me the powerful nature of intergenerational parenting styles and family scripts (Byng-Hall, 1988). Clinically, I feel I may pay more attention than before to thinking about these systemic factors when working with parents and families, particularly when I may be primarily working within a model that places less focus on these processes (e.g. CBT).

Although already a focus of the work of a clinical psychologist, I hope to specifically use my findings to guide my clinical work in aiming to reduce self-stigma and help parents develop more helpful communication approaches, by promoting a spectrum view of mental wellbeing and drawing on parents’ existing understandings of psychological distress. This greater sensitivity is likely to be important no matter what clinical setting I work in, as the experience of being a parent is lifelong. In a more formal way, I hope that the model generated by my research could be used in clinical settings, such as early intervention services offering out-reach to families in the community and in developing preventative anti-stigma programmes for young children that engage parents to offer a multi-contextual intervention to promote positive attitudes.

**Future Research**

*If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?*

A number of areas of research could usefully follow on from this study. As mentioned above, and in section B, the perspective of children as well as parents would be usefully employed in understanding more about the dynamic and reciprocal nature of parent-child communications around mental health and mental health problems. An initial qualitative investigation would be
warranted to extend the findings of this study to children’s perceptions of parental communications. Only one study so far has examined the relationship between parent and child views around mental health problems (Jorm & Wright, 2008) and this was with adolescents. A longitudinal, quantitative/mixed methods study should aim to explore the relationship between parent and child attitudes and understandings around mental health problems from the age when children begin to develop a concept of mental ill-health (around 6 years (Corrigan & Watson, 2007)) onwards.

In terms of intervention research, this study was originally going to focus upon parents’ views around a primary school-based programme aimed at promoting positive attitudes towards people with mental health problems and own help-seeking as part of a preventative agenda to reduce the stigma of mental ill-health: now that more is understood about parents’ conceptualisations of mental health and ill-health and their communications to their children on these topics, returning to the original focus may be pertinent in developing a collaborative programme with parents and teachers that would aim to address both parties’ concerns and promote consistent messages across children’s home and school contexts. A qualitative or mixed methods (e.g. Delphi study) approach would likely be most useful here. Finally, it would be useful to explore how can we most effectively promote parental understanding mental health problems are not something that only happens to other people, and that mental health and ill-health are part of a spectrum of experience. Understanding what impact this actually has upon parent child communication around mental health issues, help-seeking, and parent and child endorsement of mental illness stigma, will be key foci of future research studies.
References


MAJOR RESEARCH PROJECT

SECTION D: APPENDICES

JOANNE MUELLER  BSc (Hons) MSc

A thesis submitted in partial fulfillment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

JULY 2012

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY
APPENDIX A: Section A Search Methodology

Overview

A systematic literature search was conducted within electronic databases (Medline; Psychinfo; Pubmed Central; Cochrane; ScienceDirect; Google Scholar), and included papers published by April 2012. Searches focused separately on the following four sources of communication to children about mental illness covered by this review: 1) Parents/family; 2) Peers; 3) School; 4) Media.

Search terms

Mental ill*/mental health problems/mental health/*distress/psycholog*/psychosis/schizophrenia/
depression/

and

Communication/discussion/message/understand*/socializ*/transmission/influenc*/educat*/progr
am*/

intervention/curriculum

and

Child*/adolesc*/teenage*/young*

and

1) Parent*/family/*mother/*father/carer/guardian/intergenerational
2) Peer/friend
3) School*/primary/secondary/middle/junior/teacher*
4) Media/television/film/news*/cartoon/radio/video*

Each search was run with and without the following terms:

Stigma*/taboo/stereotype/discrimin*/prejudice/social distance/danger*/inclusi*/positive/

empathy/*group

and/or

Attitude/belief/attribution/label/knowledge/behaviour
Process

In excess of 1000 papers were generated. Duplicates were removed, non-English citations were excluded, and only published academic journal articles were included.

The time was taken to scan every title and examine abstracts in order to ascertain the degree of relevance. The review aimed to focus primarily on what is communicated within non-clinical populations about the subject of mental illness, but papers from related fields were drawn on given the limited directly relevant literature. Examples of non-relevant literature included studies examining general interactions between parents with mental illnesses and their children and/or the impact of parental mental health problems on children’s wellbeing; studies focusing upon children with learning disabilities or neurodevelopmental problems (e.g. autism); studies focusing specifically upon help-seeking for mental health problems. Non-selected reviews were searched for relevant papers and references were crosschecked to ensure all pertinent literature was gathered.

Studies were evaluated according to the quality guidelines of Mays & Pope (2000) and Nathan & Gorman (2002) during selection for and critique within the review. However, due to the lack of literature, no studies were excluded on the basis of quality; papers deemed most relevant were selected for inclusion. Nineteen key papers (including five review papers) were eventually selected for the review.
APPENDIX B: Participant demographics

<table>
<thead>
<tr>
<th>ID</th>
<th>Sex (M=male; F=female)</th>
<th>Age (years)</th>
<th>Child (G=girl; B=boy)</th>
<th>Ethnicity</th>
<th>Education</th>
<th>Professional experience of mental health problems (MHP)</th>
<th>Personal experience of MHP</th>
<th>Close familial (partner, child, parent, sibling) experience of MHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F</td>
<td>40</td>
<td>B10, B8, B7</td>
<td>Caucasian</td>
<td>A Level</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>33</td>
<td>G8, B5</td>
<td>Caucasian</td>
<td>A Level</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>41</td>
<td>B10, G12</td>
<td>Caucasian</td>
<td>Post-graduate</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>F</td>
<td>30</td>
<td>B7, B5mth</td>
<td>Caucasian</td>
<td>A level</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>5</td>
<td>M</td>
<td>30</td>
<td>B9</td>
<td>Caucasian</td>
<td>Professional qualification</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>6</td>
<td>M</td>
<td>34</td>
<td>G11, B12</td>
<td>Caucasian</td>
<td>School</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>42</td>
<td>G9, B4</td>
<td>Caucasian</td>
<td>Professional qualification</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>8</td>
<td>F</td>
<td>40</td>
<td>B11</td>
<td>Caucasian (African)</td>
<td>Undergraduate degree</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>9</td>
<td>F</td>
<td>40</td>
<td>G9, G13, G15</td>
<td>Caucasian (Traveller)</td>
<td>School (limited)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>10</td>
<td>M</td>
<td>30</td>
<td>G8</td>
<td>Caucasian</td>
<td>Post-graduate</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
APPENDIX C: Study leaflet and response form

Are you a parent of a child aged 7-11?

Would you like to contribute to a new research study?

‘Parents' communication with their children about mental health’

- **What is it about?**

  We are interested in how parents go about communicating with their children about mental health issues.

  We want to understand better what is important to parents and how they have come to these approaches with their children. We are interested in what parents really think and do.

- **Can I take part?**

  Yes, if you are a parent of a child aged 7-11! We are interested to hear from both fathers and mothers.

  You do not need to know anything about mental health to take part. We are interested to hear from a wide range of parents.

  Don’t worry if you have never thought about these issues before, many people haven’t. The researcher will be able to help you think about it.

- **What would I need to do?**

  Being part of the research would involve talking about these topics with a trained researcher in a confidential and anonymised discussion.

  This would last under one hour, at a place and time convenient to you.

If you would like more information on taking part please simply:
Return the attached form to your school office OR
Contact main researcher Jo Mueller at
j.m.mueller39@canterbury.ac.uk or on 01892 507673. Thank you!
‘Parents’ communication with their children about mental health’

Yes! I would like more information on taking part in this research project for parents of children aged 7-11.

My name is:............................................................................................................................

You can contact me on (phone/email):
................................................................................................................................................
................................................................................................................................................

OR

Contact main researcher Jo Mueller directly at:

j.m.mueller39@canterbury.ac.uk

or on 01892 507673.

Please note: Responding to this invitation for more information will not commit you to taking part in the project.

Thank you,

Jo
APPENDIX D: Communications Notepad

Thank you for agreeing to take part in our research. In a few weeks time you will be meeting a researcher to talk about how you communicate (or do not communicate) with your child aged 7-11 about mental health issues, and what is important to you in coming to this approach.

Please use this notepaper to informally keep a note of any times that you notice yourself communicating about mental health issues with your child over the next few weeks.

The notepad is just to help you to keep an eye out for these kinds of communications – any notes you make are simply to help jog your memory in the discussion. It should not take up much of your time, and it’s ok if you don’t notice anything. You will have the choice to either leave any notes you make with the researcher or keep them yourself.

PLEASE NOTE: You need only notice usual happenings and interactions – you should not make any changes to how you would normally behave. We do not yet know anything about how parents go about this type of communication, so we hope to get as realistic a picture as we can. We are interested in what you would count as mental health issues. There are absolutely no ‘right’ or ‘wrong’ things to do or to notice.

Finally, when keeping an eye out for instances of communication about mental health issues with your child, you may wish to bear in mind that they might be:

- Subtle or brief
- Initiated by your child, rather than by you
- Non-verbal (behaviours, body language, facial expressions, etc.)
- Times when you could have communicated something but did not do so
- Something on TV, or something someone else says or does (friend/family)

If you have any questions please do not hesitate to contact the principal researcher, Jo Mueller at j.m.mueller39@canterbury.ac.uk, or on 01892 507673.

Notes
APPENDIX E: Participant information sheet & Consent form

Parents' communication with their children about mental health

We would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read this information carefully and talk to others about the study if you wish.

Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the research about? We are interested in finding out what parents of primary school children think about mental health. We are interested in understanding how they communicate (or do not communicate) about mental health issues with their children.

Do I have to know anything about mental health to take part? No. We are interested to hear from a wide range of parents with a variety of experiences and views. We are interested in what parents really think and do.

Who can take part? If you are the parent of a child aged 7-11 years old we would like you to take part. We are interested to hear from both mothers and fathers.

Do I have to take part? It is up to you to decide. Please take time to read carefully about the study on this information sheet. We will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason. This would not affect your child’s education, or have any other negative consequences for you. Your responses would be confidential. Your participation in this study is voluntary. We can pay you reasonable travel expenses.

Why are we doing the research? No one else has done any research on this topic before. We want to understand how and why parents communicate with their primary-school aged children about mental health in the ways that they do. We hope this will give us a better understanding of what is important to parents in communicating with their children about mental health, and shed light on how children come to have certain views about mental health.

What will I have to do? If you decide to take part we will invite you to take part in an interview with a researcher. This will be at a time and location convenient to you. We may ask you to informally keep a note of any times that you notice mental health issues arising with your child for a few weeks before the interview. We will give you some information on how to do this. This is just to help jog your memory for the interview. You will have the choice to either leave any notes you make with the researcher or keep them yourself.
In the interview, you and the researcher will talk about how you communicate with your primary-school-aged child about mental health issues and what is important to you in coming to this approach. The interview will take up to one hour and will be audio recorded. Once we have drawn out some themes from all the parents’ responses together, we will invite you to a feedback session to ask for your views on the results of the study.

What are the possible disadvantages to taking part? Some people find talking about mental health issues uncomfortable or distressing. We will put a number of things in place to help make sure this risk is as small as possible. For example, the researcher will approach such issues very sensitively, and will make it clear that participants need only talk about what they feel comfortable with. The researcher is trained in this type of work.

What are the possible benefits? Many people find it an interesting experience to take part in studies like this one. Your participation will be very valuable to help us understand more about parents’ views on mental health and what they communicate to their children.

Will my taking part in the study be kept confidential? Yes. All the information that is collected about you during the course of the research will be kept strictly confidential. The only exception to this confidentiality is if we believe you or somebody else to be at risk of significant harm, and in this case we would aim to discuss this with you before contacting an outside party. Audio tapes will be kept in a locked cabinet on university premises, to which only the researchers will have access. Electronic transcripts of the interviews will be kept in password-protected files that only the researchers will be able to access. This data will be kept for 10 years. Your responses will be anonymised and no-one will be individually identifiable in the results. All data will be collected and stored in accordance with the UK Data Protection Act 1998.

What if there is a problem or if I have any questions? If you have any concerns or questions about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The main researcher Jo Mueller can be contacted at j.m.mueller39@canterbury.ac.uk, or on 01892 507673. The supervisor of the research study, Dr. Kathryn Greenwood, can be contacted on 07900 961587.

What will happen to the results of the study? The results of the study will be written up as part of a doctoral thesis. Your name or any identifying details will not be in any of the results. We also plan to publish the results of the study in an academic journal. A summary report of the project or a copy of the resulting academic paper will be provided to participants if requested.

Who has reviewed this study? The study was submitted to the Salomons (Canterbury Christ Church University) Research Ethics Committee for independent review. This is to protect your safety, rights, wellbeing and dignity. This study has been given full approval by the committee.
Consent form

Parents' communication with their children about mental health

Please put your initials into the box:

1. I confirm that I have read the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without penalty.

3. I agree that my responses can be used for this research study. I understand that this information will be treated as strictly confidential and handled in accordance with the UK Data Protection Act 1998.

4. I agree to take part in this study.

-------------------------------------------  ------------  -------------------------------------------

--
Name of parent     Date     Signature

Contact telephone number(s) and/or email address

When completed:

1 copy should be returned to the school office

1 copy is for the participant to keep
APPENDIX F: Semi-structured Interview Schedule

Introduction

Thank you very much for meeting with me today and for agreeing to take part in this project! I am looking forward to hearing what you’ve got to tell me. Now, if it’s ok I have a few things to run through before we kick off with the discussion.

- When I transcribe the recording I will make sure to change details that might identify you, such as your child’s name, so the transcription will become completely anonymous.
- When I eventually write up the themes that came out of everyone’s responses together, nobody will be individually identifiable.
- As soon as I’ve finished analyzing the responses and everything is transcribed I will delete the recordings.
- Until then they will be kept in encrypted files on a computer in a locked office.

Is it ok if I start the tape recorder now?

- I know that this is an unusual situation and that you might not have done something like this before!
- I hope to make you feel as comfortable as possible.
- If there’s anything you think of during our discussion that you’d like to ask or that would make things easier just let me know.

Now as you know, we are going to be talking about how you go about communicating with your child about mental health issues.

- I know some people find talking about mental health difficult.
- Lots of people feel that there are ‘right’ and ‘wrong’ things to say or think about mental health issues, or that there are certain things they should or shouldn’t be doing.
- I certainly don’t think that’s the case. Everyone has their own individual ideas, experiences and approaches and that’s what I want to find out about!
- Some people might also be concerned that I might be here to judge their parenting in some way.
- I want to reassure you that this is absolutely NOT the case!
- I’m not looking for any particular views or ways of going about things with your children. I am NOT here to judge anything you say or don’t say.
- I am JUST interested to find out what parents REALLY DO and what is important to them.
- I figured the best way to do this would just be to ask parents!
- So I know it is a lot to ask, but if you could try to be as open with me as you can I would be extremely grateful.

However, do remember of course that you do not have to tell me anything that you don’t feel comfortable sharing.

- Everything you say will be completely anonymous and confidential.
- The only possible exception to this is if you tell me something that makes me think you or someone you know is at risk of serious harm. If that happens, I would need to let somebody know who could help, but I would always discuss it with you first as long it was safe to do that.
- Does that make sense?

Ok so today we have up to an hour to talk. I do have a few things that I hope to cover so if it’s ok I might interrupt you at times to move it on to make sure we cover everything. Is that ok?

Are you ready? Do you have any questions?
Interview schedule

* Ensure focus remains on what they communicate rather than on what they think.

General

* How does that affect what you would communicate to your child?
* How do you feel this fits in with how you communicate with your child about mental health?

So to warm up, let’s start off thinking about what ideas you have when you think about mental health issues. Then we will move on to the main focus of our discussion, which will be how you go about communicating to your child about mental health issues and how come you go about it in that way. Is that ok?

* Tell me about what comes to mind when you think about mental health problems?

  [Do any images/feelings come to mind?] – Question added February 2012

  Tell me about a time when you remember issues about mental health coming up in your life? (e.g. when you were younger; friends/family; TV: magazines/newspapers)

* Does this change when thinking about mental health problems and children?

Now let’s think about how you communicate these kind of ideas to your child. Your notes might help with this!

General

* Tell me about how you think you generally approach talking or communicating about mental health with your child?
* What do you talk about/what don’t you talk about?

  Is there anything you would not talk about? How come?

Specific

* Tell me about a time, or a few different times, when you communicated (or did not communicate) with your child about mental health/ MH has come up between you and your child?

  What happened? How did it come about? What did you do? What did they do?

  What about if things came up on TV, or with a friend (yours or child’s) or a family member?

  • When you’re saying that, giving your child that message do you think that, or do you think differently?

  • If differently, or not 100% believe what you are saying do you think there are any signs of that the children might notice, that they might get wind of in some way?
I’m interested to know what may have influenced you in coming to that approach...

**General**

* How do you think you came to this approach?
  
  How come you go about it in this way?
  
  What sense do you make of how you came to go about it like this?
  
  What’s behind that?
  
  What drives your approach?

* What makes you more or less likely to communicate something?

* What is important to you when thinking about communicating with your child about mental health?

  What governs how you go about it?
  
  What factors do you think influence it?

**Specific**

* What leads you to respond in that way?

  What was going through your mind that made you respond in that way?

  What is driving how you’ve communicated like that with [child]?

  What sense do you make of how you came to say/do that?

  What do you put that down to?

* [If parent brings up trying to promote child mental health] Have you considered that in promoting his/her mental health, you are aiming to prevent mental health problems developing? – Question added March 2012

**Background**

* Where do you think your ideas about how to communicate to your child about mental health have come from?

  Where do you think that has come from for you?

  Can you tell me about your own personal experiences, or those of friends or relatives around mental health? How do you feel this might have influenced how you communicate with your child about mental health?

  Tell me about how issues about mental health were communicated to you by your parents?

  Can you tell me about a time when you remember your parents giving you a message about mental health?

  Tell me about how issues about mental health were communicated to you by others close to you when you were younger?
Demographic screen

- Has anyone in your family ever suffered from MH problems?
- Have any of your friends suffered from MH problems?
- If it’s ok to ask... have you ever experienced anything yourself?
- Number of children
- Age of child(ren)
- Age
- Gender
- Ethnicity
- Occupation
- Education level attained
APPENDIX G: Sample Theoretical Memos and Diagramming

The memos presented below are a sample of a large number of theoretical memos made at different stages of the GT process, and aim to illustrate some of the thinking around coding, emerging categories and the eventual theory. Some memos were recorded using data analysis software; some have been typed from notebooks to improve legibility. Diagrammatic sketches of selective coding and the emerging theoretical model are also included to illustrate this process.

Initial open coding and axial coding
Title: Protection from nastiness in media
Memo: Protect them from media messages and extreme accounts...
Even when discussing this, pointing out that it is very rare.
Recognition that only the most extreme scenarios usually make it into the media, skewed picture.
Conscious message to child is that this is not a danger.
But possibly unconscious message is that this is a danger because I am trying not to let you see it?
Seems to be almost justifying to herself that it is not a danger. Socially desirable response?
Later in interview does talk about passing on explicit message of danger to child.
Also at one point she says shooting is not an English thing, and how it is not a risk, but then she says later about how if someone went into their school and did something horrific... So is obviously contemplating it as a risk

Title: Depression "springs to mind"
Memo: Why might something spring to mind?
Common - lots of people have it, hear a lot about it, heard about it recently
Easy to think about - less stigmatised?
Concerning to think about - more stigmatised?
Personal experience with it
Knowledge about it?

Title: Untreated MH is dangerous
Memo: In others:
I'm not sure whether, in this excerpt, she is saying how important it is than MH probs are talked about and noticed and treated so that the stigma and the consequences of stigma (e.g. not help-seeking) don't have a detrimental effect on the person, or whether she is saying that it is frightening that you cannot see who has these problems, and you cannot know if they are getting help, and often they aren't, and maybe it's not treatable... and then suddenly the individual's internal problem will have an unpredictable impact on others - danger.
Suspect that she was trying to put across the first viewpoint, but her real concern may be the latter.
In own children:
Goes on to talk about the importance of ensuring open lines of communication with her children, suggesting that if people did not have this opportunity that's what made them 'snap' and have bad MH.
Indicates insight into development of mental health problems, and 'normal people' having 'abnormal' problems.
- normal/abnormal
- MH continuum
- attributions

Real sense of fear... use of the world "alarming", strange things that go on in the world...
Being "exposed to"
- vulnerability, not protected
- naked
- a positive thing, learning more about...
"The big bad wide world"

Title: What impacts on depth of explanation?, Folder: 1
Memo: Mum's lack of knowledge about MH and confidence means she 'can't' go into detail. Doesn't want to misinform them so says less.
Child age and understanding means she both simplifies the language and lightens the language she uses, different for different children.
- Protecting them? From nastiness? From too much knowledge? Why? What would this result in?
- Or making sure they understand as well as possible? Both?
Also, how close to home the event is, how much it is affecting them personally.
How risky it is to explain - proximity of pwmh
Type of mental health problem - schizophrenia not ok to talk about (broken brain ok, sadness ok)
A tendency to steer away from more extreme mental illness and not initialzing the conversation

Title: Planned discussion
Memo: mental illness isnt a planned discussion
sex is a planned discussion
feelings are
mental well being
why isn't it ok for children to be told about it?
is this about fear? is it about not knowing?
what other situations are there that parents take the lead from the child rather than bringing it up themselves?

Title: Multiple models
Memo: Holding of multiple models of mental illness
- medical model
- social model, less extreme view of someone needing help
- cognitive impairments
- physiological
- behavioural

A lot of illness language used (see memo about attribution/aetiology) - in interview 2 example of child thinking MI is contagious possibly because her mother has previously used a lot of illness language when describing mental health problems and she has associated it with physical disease.

Is it disease, can you catch it versus, it's someone's fault?

1) People being ill, doing things they wouldn't normally do
Depression can *make* you do strange things
It can make you do things that are *out of character*
It is an *illness*
- about not being a person's fault, making you someone other than who you *really* are, i.e. the person is not the illness/behaviour
- also about unpredictability? If the person themselves can be made to do something by the illness then who is in control?

2) Something about normal people doing extreme things - being pushed to the edge. Not coping.
- normal/abnormal

3) People who are 'not right in the head'
Problem located within person
See also 'Untreated MH is dangerous' memo

4) Person's fault - a choice (alcoholism) (eating disorder)
Is it disease, can you catch it versus, it's someone's fault?
in an immediate sense it's true - she is drinking the alcohol but is a simplified causality not considering wider factors
* These don't seem to be mutually exclusive

Title: Intergenerational patterns
Memo: Interviewee 2 is musing over the different ways in which her parents could have affected how she is parenting her child with respect to MH. She suggests a few mechanisms.
- a genetic transmission of emotional and communication style, the way your brain is wired
- how attached or emotionally close the parent is to the child could affect how they communicate about MH and emotions
- a personal choice about how you want to parent - based on what you have seen your parents do and whether you liked it or not
She explores why her own mother parented like she did in terms of emotional communication and mental health.
Looking over several generations - patterns
How much can you override genetic make-up
She suggests she 'doesn't know' why she is more open to talking, but has already suggested she is deliberately doing it that way so as not to recreate her own childhood. She goes on to talk about her knowledge gained from her job has helped this.
She previously said she thinks it gives people more hang ups if you don't talk openly - own experience?
- emotional closeness and attachment makes it possible to have conversations about MH, which in turn promotes MH and beaks the pattern of poor communication/poor MH?

Title: Rarity of extreme MI behaviour vs abnormalness
Memo: Two interviewees (1,3, also possibly 6?) have said that they try to impress on their child things along the lines of "people don't generally do this' in response to extreme issues related to MI (violence, suicide)
- unclear whether this is simply reassuring the child that it is a rare occurrence and not to be worried about it happening
- or whether there is something else in there too, such as this is 'abnormal'
Think the latter is more revelant to no. 3 who was talking about suicide (violence to self) as opposed to violence to others - seemed that she did not want son to be concerned about it happening to those around him but also to get across a message that it should not be something he consider, and also, that those who do it were outside social norms.
Does also seem to be some understanding of the separateness of MI and behaviours of some people with MI
- so I think there is a sense that parents are saying to children even if you have mental health problems, it doesn't mean you are going to do something extreme like this.

Title: "Close to home" - what makes it easier/important to discuss MH?
Memo: One parent is saying that it is easier to use hypothetical examples or examples from people they don't really know/in the media to discuss mental illness (specifically, not mental health and wellbeing), because it can be kept at a superficial level and it's not affecting them. I guess it can be more theoretical without muddying the water with emotion etc?
Another parent (interview... 8?) talked about only discussing things if it was actually relevant o the family, and deliberately not discussing issues from the media or outside as they are not relevant.
How does this fit with what the child brings up? Most parents do note that they will be more likely to discuss thing if it is important to the everyday life of the child - RELEVANCE, NECESSITY. However there is a sense that parents try to build up a child's understanding and attitudes for THE FUTURE.
Parents tended to use the future in a more abstract sense though as parent of the younger and older children said similar tings, imagining that in a couple of years they would behave differently...

Title: Being a parent is different to being an adult
Memo: Seems obvious... but being in parent role influences parent's behaviour and probably sharpens certain responses that might not be prevalent if 'just' an adult.
Rawness of being a parent
The interview seemed to take a very different turn at this point - up until now it's been about education, attitudes, quite surface level. This paragraph seemed much more raw - much more at the heart of what it means to be a parent and how that can skew your view of the world. Small risks become much more important. Safety takes precedence over everything. Safety and danger seem very fundamental.

Title: Acute vs chronic conditions spectrum
Memo: Distinction made between:
Chronic:
Underlying, diagnosable, homeless, addict, personality disorder, labels - abnormal, part of the person, not recoverable
Acute:
Stress, triggers, blips, overwhelmed - normal experience, external, recoverable
Language indicates a spectrum however, not just black and white

Title: Children not diagnosable...
Memo: Does this mean...
There hasn't been enough time yet for things to get very severe?
There is still time to alter things?
An underlying condition (as mentioned previously) hasn't had time to develop yet?
Or is it an acknowledgement that environmental factors impact on MI development?
If children having mh problems it's because of situational factors.... not an underlying condition
HOWEVER labels and diagnoses ok when it comes to neurodevelopmental disorders

Title: Community exposure - labels, categorising, Folder: 1
Memo: Linking odd behaviour and appearance in the community to psychiatric hospital, locking away to diagnosis/label for child
Teaching the child that there is a label for this type of person
Helping child to categorise experience? What function might this serve - to help the child feel safer?
Education? Simplify a potential complex discussion?
Changes child illness model language to a diagnostic model language

Title: verbal vs non-verbal
Memo: Verbally saying people with MI not dangerous but non-verbally? Saying just get off to school and not getting into too much detail about it - child may notice this is not something to be talked about. Saying "don't worry" sort of implies there is something to be worried about!
Also reinforcing notion that this person is outside social norms and has a label to describe him.

Title: What message do children receive?
Memo: Wondering what messages children take on board if parents avoid detail about a subject or avoid it... Parents are trying not to burden children and not scare them and allow them to be children. They are trying to keep them safe and happy. They are only really talking about strictly relevant things. Some avoid things close to home some avoid things further away.
Depending on the model used children will have a sense of blame, responsibility... if given tools to improve their own MH will they translate this to think about people with MI in terms of recovery or aetiology? Only if parents give the impression of MI on some kind of scale or spectrum.
Children will realise certain things are not talked about. Mystery = fear. Certain people are avoided. Certain people have labels.
Parents generally happy to go into detail about physical and learning disability but somehow feel children will not understand MI...?

Title: Children being children
Memo: Something about innocence... dont want to spoil their childhood... indicates it is a time when one should be free of burden of sad, unpleasant things, or of too much to think about... therefore MI is sad, unpleasant, complex...

Title: Parent gender roles
Memo: Father-son relationship more able to explain things about MH and other complex issues. Son looking up to father.
Other parents talking about child gender, esp both father describing not wanting their sons to be too dependent on talking about minor worries and to sort it out for themselves.
One father said he relied more on his wife to talk to the kids about MH issues. Did he say something about him talking to the son and the wife talking to the daughter?
First parent talked about boys being more vulnerable than girls in the community and girls being more emotional.
Second parent talking about husband being more laid back in parenting style than her

Title: Conscious vs unconscious
Memo: Planning to give child a certain message (pro-MH) to do the opposite of what experienced as a child (MH not talked abut, fear) but inadvertently repeating the pattern
- The message of "we’re all different" is clearly emphasised and one which she wants her children to hear.
- I’m not sure how much it fits with what was said before about behaving in a certain way to be socially included.
- It also relates more closely to her example of children with learning disabilities - this is more predictable, visible... links to previous ideas about 'normal' people just snapping. i.e. it’s ok to be different as long as you are always different and it is always in the same kind of way
Person on train
- outwardly demonstrating a non-stigmatised view to the children and others around her? - deliberate message to children of accepting differences and being sensitive to others’ feelings.
- Is she just saying she would try to be sensitive to the person acting strangely to give me a socially desirable response?
- More subconscious message is about danger - be quiet, don't say that, you don't know what they might do (unpredictability), avoid confrontation, strange behaviour means danger

Danger
- Saying that the only way to keep child safe is to tell them they are in danger. Explicitly passing on messages of danger, fear, anxiety associated with pwmh.
- In other circumstances though has talked about wanting to protect them from messages of danger and being afraid. And promote messages of difference and accepting.
- Minimising risk ("chances are it won't", "people don't normally do this")
- acknowledging small risk - in terms of what? that there isn't a mentally ill person around? or that if there was they wouldn't abduct your child?
- playing it safe?
- socially desirable statement?
"not right in the head"
- seems to contrast with attribution about illness, not person's fault etc. Seems more blaming, more located within person.

No messages of being afraid when talking about depression...? - type of mh prob matters
Parent 4 - says definitely tries to dispel messages of fear and danger about pwmi to son. Because as a child she was sheiled from it and this translated into fear and images of violence. But later in interview transpires she avoids these conversations at all costs and uses euphemism and says she cannot talk about it because she doesn't know enough

Euphemisms used ostensibly because the child understands it - does he? Is it because parent doesn't want to get into discussing it?
Parent acknowledging child must have bad perceptions of PWMI and psychiatric institutions because of experiences plus parental reaction
- police, unusual appearance and behaviour
- not talked about, euphemism
- kept away from, protected from

= FEAR

Selective coding & theoretical model development: diagrammatic sketches

I am a visual learner and most of my theoretical memos around relating categories and codes to each other, and in developing the theoretical model, were in the form of diagrammatic sketches, a sample of which are included below.
7/3/12

- only one parent (interviewee) truly seeing a spectrum -> child exp of MHP

- child

ok

US

talk to children

not talk to children

mental illness

diagnosis, chance, gene, disease, illness, "not right", situation, personal, underlying, non-random

not talked about

lots of rules about this

child resilient, fragile

personal experience specific
APPENDIX H: Excerpts from Research Diary

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>Thoughts</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2010</td>
<td>Research fair. Contacted two potential supervisors suggesting projects around parents and parenting. One is around evaluating a parenting intervention, which I am really interested in doing, but it is quite far away and the supervisor did not sound confident, plus she is interviewing other trainees to take on. The other person talked about a school-based intervention for primary school children to promote positive attitudes towards mental health problems. Worked around stigma in my previous job, and hope to focus on parenting in some respect, so am interested in this area and wonder if I could do some work with parents. Contacted Kathy – discussed that she has three projects to offer and we agreed I would take on the parent-based one. Happy with supervisor and project and looking forward to the research (although a bit nervous too!).</td>
</tr>
<tr>
<td>February 2010</td>
<td>Project taking shape, have met with Kathy, my main supervisor and talked about how my project would fit with a Surrey trainee’s work (in the year ahead), which is looking at how children understand vignettes of peers with mental health problems in order to inform the developing intervention in primary schools. Also discussed how it would fit with the two other Salomons trainee projects she is taking on, one of which is going to look at teachers’ views about the proposed intervention programme, and one will look at service users’ views. I am quite glad there will be three of us, as although we aren’t working together, it might give us a bit of support in this process! I also like that our work will be feeding into a bigger project, it feels as though it has some more purpose than a solitary project might. Need to find an internal supervisor, and Kathy has recommended it be someone with qualitative experience. Might contact Margie Callanan as I think she has expertise in this area.</td>
</tr>
<tr>
<td>October 2010</td>
<td>Have just had a meeting with FJ and JB regarding my initial IRP proposal. Topic has changed a bit since last diary entry, and since I submitted the original proposal. I have broadened the research questions to understanding how parents communicate views about mental health to their children more generally because we thought that the original focus was too narrow and not theoretical enough for the IRP, but have kept the research question about what parents would want from a school-based intervention. FJ &amp; JB felt that the third question may be difficult to justify theoretically, and that the proposed methodology for this question (Delphi process) might also be difficult to justify in theoretical terms. They were also concerned I might be taking too much on, trying to do a qualitative analysis and a Delphi study. We discussed that the themes drawn out from the qualitative analysis of the first stage of the project could be used to make</td>
</tr>
</tbody>
</table>
recommendations rather than explicitly gathering these from parents. I think this a good idea and to be honest, I need to be a bit pragmatic about what I can achieve in the time available. Given that I have not done a qualitative analysis before, maybe I should be careful!

JB and FJ made some really helpful suggestions such as looking at literature on intergenerational belief systems, and finding out if there is any existing literature on how parents communicate ideas about other stigmatised issues to their children to see if links can be made. This seems very sensible, and a good way to make sure I have a strong enough theoretical basis.

FJ stressed the importance of ensuring that my project remains distinct from the two linked projects being undertaken. I feel that efforts have already been made by all of us to ensure this and I will keep the issue in mind as the projects progress. Actually, if anything, our projects seem to be naturally diverging.

Even though I have more work to do now it feels as though the project is moving on, and I would rather get these issues sorted now than down the line.

<p>| November 2010 | Still trying to decide on a qualitative method for my project. Initial thoughts were thematic analysis or qualitative content analysis, but I think these feel too surface-level for this project. Also, I’m not sure about the positivist slant of these, especially QCA. I have been looking around for theory to inform the project, and although there is lots of related stuff around stigma, there doesn’t seem to be much at all written about how children develop their views, or what parents communicate to children about mental health problems. Can’t find any directly relevant theory. Thinking grounded theory might be a good option in this case? Other qualitative methods don’t seem such a good fit. I have not really had to opportunity to think about my epistemological position before but I can see it being relevant now... I am really interested in all the Kathy Charmaz stuff about social constructionism, and I think it reflects my ideas and I can definitely see how it would be important to acknowledge the construction of parents’ responses in my study, as I am analyzing this construction and not objective reality, and how I might influence the analysis of this. However, I have also started reading the Strauss and Corbin GT book and it makes it all seem quite clear and straightforward. Think I remember seeing somewhere that S&amp;C is also partially constructivist. Will have a think about which of these might be a better option for me. Need to resubmit my proposal form by the 19th of this month so need to make some decisions. |
| March 2011 | Meeting with Kathy to plan how I will contact parents through schools once I have got my ethical approval. Finalizing interview schedule, remembering to focus on how parents communicate to their children, and factors that influence this. |
| April 2011 | Ethical approval secured first time – am now ready to get going with contacting the two |</p>
<table>
<thead>
<tr>
<th>Month</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2011</td>
<td>Have been reading papers for my section A and coming across various interesting ideas... but I am aware that for “proper” grounded theory I would ideally not be doing this work. It could be tricky to completely ignore what I have read so I’m going to leave the literature review for a while, and try to bracket off what I have read whilst I’m collecting data.</td>
</tr>
<tr>
<td>June 2011</td>
<td>First interview. Went well, and think I have got some good data. Communication notepad went down well and seemed useful without being intrusive. I was quite surprised by how contradictory some of the parent’s responses were. She talked a lot about mental health and understanding people with problems, and wanting the kids to be accepting, and being open with them. But then she also used really quite stigmatizing language some of the time and towards the end of the interview she began to talk about danger related to people with ‘mental illness’. Going to keep this in mind and think about what it might mean. I am aware I am thinking back to the attribution theory stuff about dangerousness so I’ll just be aware of these ideas.</td>
</tr>
<tr>
<td>August 2011</td>
<td>Carried out two more interviews, both with mums who have had some contact with people with mental health problems. Noticed that they seemed a lot more comfortable talking about mental health problems, although there still seemed to be talk about danger and protecting children. I felt the mum who had worked more directly with people (rather than in a more academic context) seemed more accepting. Makes me think of contact theory. Will try to keep this assumption in mind as I go on because I can tell I am thinking it might come up as a theme. Must remain aware of this. Also struck by the impact of parents’ own experiences of being parented in these two interviews. Some of the impact seems conscious, and some doesn’t. Going to start initial coding of first three interviews today once finished transcription.</td>
</tr>
<tr>
<td>September 2011</td>
<td>Noticing non-verbal behaviours in interview transcripts now I am coding... lots of ums and erms, parents fidgeting on their chairs. Getting up to see to the baby/cat/dinner when we start talking about mental ‘illness’. I will aim to code for this in other interviews and notice as much as possible. Meeting with Kathy – went through what I have done already and discussed codes and emerging themes. Decided to adapt a question to ask parents about the emotions that come up for them.</td>
</tr>
<tr>
<td>October 2011</td>
<td>Fourth interview today. This mum seemed the most affected by stigma and taboo of the parents so far – she didn’t seem very aware of the very mixed messages she described giving to her son! I found it quite difficult today not to ask the kinds of questions I would ask in a clinical role and had to be very careful to stay in the research position. Interview went well though and mum was very engaging. The theme of parents contradicting themselves and one minute doing one thing and the next doing another, or planning to communicate in one way and doing the opposite, is becoming quite dominant. Taboo</td>
</tr>
<tr>
<td>Date</td>
<td>Notes</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>November</td>
<td>Finished 5 interviews. A few issues about gender have come up, but not as many as I might have expected... I have mainly interviewed mothers so far and just one father... so would be useful to get more data from fathers to explore this issue. Also I have interviewed two parents with professional experience of working with people with mental health problems so it would be useful to avoid this if possible. Aim to interview parents with and without personal or family experience of mental health problems in order to saturate emerging categories.</td>
</tr>
<tr>
<td>2011</td>
<td></td>
</tr>
<tr>
<td>December</td>
<td>Immersed in line-by line coding now. I think I might have begun to feel a bit blaming or judgemental towards parents. Quite of lot of what I am finding in my coding is parents making a distinction between mental health and mental illness, and saying they want to be open about both but in fact being quite closed about mental illness, giving across quite stigmatizing messages to children, and using lots of “excuses”. At times I have found myself feeling a bit irritated by this and I’m not sure why. I have reflected on the fact that I am a professional with experience of working with many people with mental health difficulties, and I am also not a parent. So, perhaps what seems obvious to me about the nature of distress will be very alien and scary to a lot of parents, and also I don’t know what it is like bringing up a child. Parents are understandably very wary of upsetting or worrying their child, or putting them in danger, or saying something that might mean they become less ‘child-like’, as there are so many things nowadays that can impact on children’s innocence. Parents also have so much else to think about that discussing mental health problems seems quite low down on the list, if it is not perceived as something necessary. I think reflecting on this has allowed me to be able to get alongside parents again and be aware of being balance when coding.</td>
</tr>
<tr>
<td>2011</td>
<td>Finished 9 interviews now. Really interesting interviews with two mums, one of whom has personal experience of depression, and one of whom has two of three children with mental health problems. I was surprised at the impact of stigma on the discussions of the mum with personal experience, especially in comparison to the other mum, who seemed to have a very open communication style, and a very spectrum understanding of distress. I wonder whether this perspective has come about because of her children’s difficulties, or</td>
</tr>
</tbody>
</table>
it came before? She talked about her cultural background as a traveller and this seemed to be important in her understanding of human experience and acceptance of difference. Thinking about this in comparison to another parent who grew up in a very conservative country where nothing was discussed. Aim to gather participants from other different cultural backgrounds?

**January 2012**

Moving between stages of analysis now, beginning to relate categories to each other... finding it very difficult and very slow. I have been making use of the structure and techniques (e.g. flip flop, focussing on process) recommended to by Strauss & Corbin to help me, but there is so much data... and doing this just seems to make more! A lot of my categories seem to overlap to some extent so I need to work on making it clearer. For example, barriers to communication about mental illness relates closely to stigma and taboo... I think I have identified my core category though (Us & Them), and so that is helping me to think about how everything else relates.

**February 2012**

Recent memos have helped me to elucidate my thinking. For example, I have noticed depression seems to straddle mental health and mental illness - people can envisage themselves as depressed, not real mental illness, but still diagnostic label, and still associated with self-stigma and public stigma. Language ‘depression’ is in common parlance as meaning either sad or a diagnosis – does this represent the ambiguity?

Parents are promoting talking about feelings to children very strongly but not linking this to help-seeking or to mental health problems. This linked to the fact they do not envisage themselves and their kids as being able to be psychotic or anything more serious than depressed. Also linked to the fact they do not see kids’ mental health in mental illness terms? What goes wrong when kids become adults? Why suddenly become diagnostic? Kids themselves use lay language. What changes? Adults using diagnostic terms to other adults. Mix between adults teaching kids diagnostic terms and explaining diagnoses and using age appropriate language. Does this possibly depend on purpose of communication? (Protect vs. educate?) I think all links to emotions, and to my code about balance. Note all this is ‘other’ not self....Links to spectrum/disconnect. Think about theory around ambivalence? Ambivalence about different messages and how much to communicate seems to be quite crucial in all of this.

**March 2012**

More recruitment problems – two more fathers who I recruited theoretically have withdrawn. Beginning to get a bit late to recruit new participants. Have done 9 interviews and have the tenth set up – think I might need to stop. Analysis so far indicates I have reached saturation in the central categories. Wondering whether I can use the fact that three parents agreed then withdrew as data about the taboo nature of the topic that is coming out? Think I could – have been reading Glaser paper about using everything as data.

Based on the fact that taboo seems to be a central theme, parents seem to give all kinds
of reasons why they can’t talk about mental ill-health but are fine talking about wellbeing, I aimed to adapt a question to ask remaining parents about this split directly. Did this in interview 10 - was a bit tricky to bring this in and I was careful to be tentative. Parent was surprised and reported feeling uncomfortable in thinking that his child could potentially develop a mental health problem and that he might have an impact on her resilience against this – very reflective parent but highlighted (& confirmed) that this does not appear to cross parents’ minds, and that mental health and mental ill-health are two quite separate issues. Made sure parent was ok, full debrief.

April 2012

I have been thinking about why I chose to do this project. I am interested in stigma as a concept, and in reducing the stigma about mental health problems, and I’m also interested in parenting. I went home to see my parents this weekend and I suddenly thought about how a relative with mental illness was never talked about as I was growing up and I only found out about the whole thing in my late teens when I thought to ask about it. I don’t know how I could have missed thinking about this, as it is so relevant! It just goes to show that unconscious processes can be very powerful – just the kinds of powerful unconscious processes I am noticing in my data that are influencing parents’ communications. My parents told me they thought there was no point talking about it, and they would wait until I asked – this really resonates with what parents are saying in my data. But as my parents now reflect, the avoidance was really because of the taboo of the subject – which is exactly what I am currently theorizing in this project. I’m really glad I have been able to bring this into my awareness now, so I can ensure I am not bringing these experiences into my coding, although, inevitably, it has influenced it to some extent, even in selecting the project. I will go back and check through my raw data and the codes and categories to check this personal experience has not had an impact. I can be reassured that Kathy went through and independently coded a transcript last year and found the same kinds of codes as me, and she has been very involved in my developing categories, so I think it is ok. In some ways, maybe it is extra data to support what I have found.

May 2012

Immersed in analysis and beginning to develop the model. Finding this very difficult, as I think I am scared to trust my own convictions in abstracting! Am using lots of diagrams to order my thinking about this final stage, which are really helping. Meetings with Kathy have helped me to pull out the most crucial aspects and she has challenged my thinking about the categories, which has helped me to make sure I am confident in the analysis.

June 2012

Meetings with Kathy and Margie – discussions about the final model. Helpful feedback from both. Margie’s advice is to make the model simple and go into more detail in the text – this makes lots of sense based upon the models I remember from other people’s work. It’s always confusing if people to try to make models too detailed. Will simplify down the diagram. Have a lot of work to get done on the write up... a little bit scared of starting it.

Continuing with the write up. Have far too many quotes and data for the results section –
<table>
<thead>
<tr>
<th>Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2012</td>
<td>Finishing off the write-up following feedback from Margie and Kathy. Actually quite surprised at how helpful it was to write the summary for parents. Really made me think in clear terms about what it was I have found and how it can help parents (and reduce stigma). This is helping me write section C too. Am confident in my findings and have high hopes for the usefulness of this research... once I have taken a break from it after hand-in!</td>
</tr>
</tbody>
</table>
APPENDIX I: Ethical Approval Letter

This has been removed from the electronic copy
**APPENDIX J: Categories, Codes, and Quotes**

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-category</th>
<th>Code</th>
<th>Descriptor</th>
<th>Quotes (selected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Us</td>
<td>What is Us</td>
<td>Issues parents</td>
<td>Organics issues: Learning disability and neurodevelopmental disorders (e.g. autism), physical disability and physical health problems, dementia</td>
<td>“Generally there are two children at school who have Down’s syndrome and I know that’s a physical disability that the children are aware of. I also explained to them about their learning ability is probably different to their own. Their mental age could be different. And that sometimes their behaviour will be different.” (Parent 1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>comfortable talking about to children</td>
<td></td>
<td>“I suppose just to try to explain to Sam that everybody has different needs, and what he might perceive as being normal – normal to someone else might not be to him. I suppose that’s what we try to put across to Sam really. So he’s got a bit of an understanding that everyone is really different. Not all like his friends at school or, not all into the same things. Especially with some of Paul’s guys because some of them are in their 50s, 60s but they like things that Sam likes so you know, he sometimes doesn’t understand that. So we sort of have to explain that they have a different understanding I suppose, they kind of have that mental age. Which I think he gets to a degree. But he quite likes it because they share DVDs and things like that.” (Parent 4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“But we try to think of them as children first, and take into consideration their diagnosis [of autism], but not allow the diagnosis to prevent us from inviting them to parties, or hanging out with them, or making them feel excluded in any way. So we try and be fairly inclusive and just get on with it, and just say, well that’s... so-and-so’s just like that because that’s what they’re like.” (Parent 3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“But I don’t think that I would try to brush it under the carpet in a way that I wouldn’t not try to explain to her about someone with a physical disability. For example, I’m hoping to watch as much of the Paralympics with her as I can. And in a way you can see that people with physical disabilities are having the opportunity to show themselves as world class athletes and the level of acceptance certainly seems a lot higher” (Parent 10)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
<td>------</td>
<td>------------</td>
<td>------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“He does know his great-grandfather died of Alzheimer’s and he knows his great-grandmother died of dementia. He knows. I often make jokes about it [laughs].” (Parent 8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Potentially taboo subjects: Ethnicity, death, sex, and violence</td>
<td></td>
<td>“Daisy was talking about sex the other day. To the point of... erm... oh yes we were talking about humans have sex for the sake of sex. [laughs] And animals just for reproduction. So that was quite interesting. So I decided, which I haven’t done yet, I was going to go and get a condom, and show her what a condom is.” (Parent 7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“And I suppose where I can remember specific examples [of communication about difference], it would be about people who were physically disabled or people from different ethnic backgrounds where... she was brought up in a very sort of... predominantly white Caucasian group of people, and obviously when she comes to stay in London it’s a lot more multicultural.” (Parent 10)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“If I became seriously ill, or Phil or somebody... I would not hide it from Daisy. Daisy went to my mothers’ funeral, I think that was... perfectly fine because it’s a family event and life and death are very interlinked.” (Parent 7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“But erm, but we have I suppose we have spoken on the topic of violence and things come up on the new like you say and I explain to him that some people in the world want different things and do very injurious things to other people in order to achieve them.” (Parent 5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“We’ve definitely discussed violent people. Stacey hasn’t experienced the family physically fighting, maybe her sisters but not often. So definitely talked about... and Alana’s been bullied as well. So we’ve definitely talked about you know, what to do if somebody’s violent and explaining things like, sometimes people just get angry, lose their temper. And you can still talk to that person you know, like say it’s me or your dad, we’ll never, even if we’re cross or we’re telling you off, we’ve never hit her and we just never would. So you can feel safe in being yourself. ” (Parent 9)</td>
</tr>
<tr>
<td></td>
<td>Lay Language</td>
<td></td>
<td></td>
<td>“Ethan often refers to his teacher being very “stressy”. So stress in people is perhaps evident, and anxiety, fears, those sort of things we would touch upon” (Parent 1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“They just become... so low and so down and so uninspired. And they’re both very artistic people, so they’ve got that typical artistic mindset. And erm, all the creativity just saps from them and they become very low and they... they just become sort of, difficult... as human beings, you know” (Parent 8)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------------</td>
<td>------</td>
<td>------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Erm, only general ones I suppose where my ex-partner’s grandmother is reaching, well she’s quite an old lady, I think she’s 85 or so, and there are aspects of her behaviour which are unusual at times, where my son is kind of aware of how she reacts to him. For example she gets very very worried and concerned to a very unusual level… such as… running, not doing anything, in fact wrapping him in cotton wool, which is not a mental health issue but is I suppose where he’s seen that there’s something impacting her. So I suppose when that’s occurred, I’ve just discussed with him why it happens, in that you know, he’s very important to her in her life and erm, and that maybe there aren’t so many other things she has to think about, and just try to make him understand why it might be happening.” (Parent 5)</td>
</tr>
<tr>
<td>Recoverability</td>
<td></td>
<td></td>
<td></td>
<td>“It’s very common. So I’ve got... a lot of my friends who go through depression phases and come our the other side. You know, it depends what’s going on.” (Parent 7)</td>
</tr>
<tr>
<td>Influences on child mental wellbeing</td>
<td>External factors: School enjoyment</td>
<td></td>
<td></td>
<td>“But Sophie, she loves school. So, that’s not an issue to her, she actually, she actually enjoys it. Which I think’s a major difference in maybe their mental state because they’re doing something all day that they love doing or they don’t love doing, isn’t it? I think that makes a huge difference in the way kids think and feel.” (Parent 6)</td>
</tr>
<tr>
<td></td>
<td>Bullying</td>
<td></td>
<td></td>
<td>“Erm but I mean there was occasion where a couple of her friends at school… she came home crying and that’s really unusual. She said I spent all lunchtime crying and I was like like wow, why? And she was like because my friends ran away from me.” (Parent 7)</td>
</tr>
<tr>
<td></td>
<td>Teachers</td>
<td></td>
<td></td>
<td>“But I think also the teachers, well, they have to I guess, but she was getting a lot of attention every time she said she was having a tummy ache. They were taking her out of the class, I think at one point she went to another teacher and had a hot chocolate and like a nice one to one time with her so I think, you know!” (Parent 2)</td>
</tr>
<tr>
<td></td>
<td>Peers</td>
<td></td>
<td></td>
<td>“And how he’s coping with things and how the children around him are coping with things... or not.” (Parent 1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I would say age, and I would say also, wanting to fit in. not wanting to be the grumpy one who nobody knows whether he’s going to fly off the handle or not. I think it was his peers, a lot of it actually.” (Parent 3)</td>
</tr>
<tr>
<td></td>
<td>Friends</td>
<td></td>
<td></td>
<td>“Yeah upset about it really when her friend’s not there and not liking the people she was sitting next to, erm… wasn’t her friends really, and didn’t get on with them other people. And yeah she did get very upset about that. She didn’t want to go to school and yeah all sorts.” (Parent 6)</td>
</tr>
<tr>
<td></td>
<td>Family environments</td>
<td></td>
<td></td>
<td>“Erm… I suppose the separation… I suppose there’s always been a sense of you know, we’ve put that on him and therefore conscious of the impact that’s had on him.” (Parent 5)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------------------</td>
<td>------</td>
<td>------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Internal factors</td>
<td></td>
<td></td>
<td></td>
<td>“No... well, yes probably. But for a very interesting reason. She erm, everything was all focused into Ed, erm, looking back with hindsight, and... about a year after ed was born Daisy suddenly had a major meltdown. And she was screaming and shouting, and duddlududdla, and I thought hold on a minute... this... we’ve forgotten all about this little girl, who’s sitting here, whos part of the family.” (Parent 7)</td>
</tr>
<tr>
<td></td>
<td>Self-esteem</td>
<td></td>
<td></td>
<td>“Yeah how children feel about themselves, their identity, all of that kind of thing.” (Parent 2)</td>
</tr>
<tr>
<td></td>
<td>Physical state</td>
<td></td>
<td></td>
<td>“But it was the end of term and I think she was really tired as well so...” (Parent 2)</td>
</tr>
<tr>
<td>Them</td>
<td>What is Them</td>
<td></td>
<td></td>
<td>“Mental health, if I think of mental health I think of schizophrenia, depression, dementia, I think of mental illness to be honest when I think of mental health initially” (Parent 2)</td>
</tr>
<tr>
<td></td>
<td>Diagnostic terms</td>
<td></td>
<td></td>
<td>“My grandfather on my mothers’ side suffered from Alzheimer’s and I believe, not that I ever knew I either of them, my grandmother on my father’s side had dementia so pretty strong in my family, that I might possibly go mad. But obviously I realize it’s much broader than that. You know there’s you know, schizophrenia and all sorts of things as well. I know someone who has a daughter who is bipolar as well.” (Parent 8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Erm I think probably... I think mental health I think probably because I’m a teacher, mainly problems... children with learning difficulties. Children who are... have Asperger’s, autism, erm... sort of concentration issues and things like that. I suppose when I think of mental illness I don’t particularly think of those I think more of things like schizophrenia and Alzheimer’s, and things like that.” (Parent 10)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“There is people with say Tourette’s that she knows, there’s people with brain damage, or you know, long term illness which just means they’re different. And maybe as time goes on to be a bit more specific. You know. Not exactly for me to go out and say, oh that person over there has multiple personality disorder.” (Parent 9)</td>
</tr>
<tr>
<td>Aspects of mental illness</td>
<td>Chronicity</td>
<td></td>
<td></td>
<td>“And erm how some people are always just like the way they are, and they’re unlikely to change. So you just have to help them as best you can.” (Parent 9)</td>
</tr>
<tr>
<td></td>
<td>Help-seeking and treatment</td>
<td></td>
<td></td>
<td>“And erm symptoms that people have when they’re mentally unwell, medication that they take, I guess things that come to mind are all around mental illness.”</td>
</tr>
<tr>
<td></td>
<td>Unseeness of mental health problems</td>
<td></td>
<td></td>
<td>“Erm... I think often mental health is not necessarily acknowledged because it’s not necessarily seen when you don’t know what is going on in someone’s head.” (Parent 1)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>----------</td>
<td>--------------</td>
<td>------</td>
<td>------------</td>
<td>-------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“You know. He’s not had... I mean he’s met the girl who is bipolar once but don’t think he realized you know, I don’t think he... because it’s not that noticeable. I said you know they look like you and me and there’s nothing physically, appearance-wise, it’s just in their general behaviour and things. So yeah I think that’s what I said to him.” (Parent 8)</td>
</tr>
<tr>
<td>Abnormal behavior</td>
<td></td>
<td></td>
<td></td>
<td>“We saw a man in the street actually. Erm, about 3 weeks ago. And um, he was... it turned out that he’d just been released from er, a hospital, and he was bipolar and he was wearing a dressing gown. And he had shaving foam all over his face.” (Parent 3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I mean apart from people on the tube who don’t operate with the social norms, I suppose that’s the kind of normal... or what I see as the day to day mental health stuff I see.” (Parent 5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“And me and Sam walked to Tesco and the lady that sits at the end f the road and she wears bells round her ankles and erm... she gets a bottle of vodka and sits at the end of the road and has it!” (Parent 4)</td>
</tr>
<tr>
<td></td>
<td>Attributions about people with mental illness</td>
<td>People with mental illness (PWMI) need help</td>
<td></td>
<td>“So, erm, I’ll say for instance that I look after people who are sad, are not coping very well with life and they need some help.” (Parent 2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“And they need looking after... and if there is a problem, they should have had someone looking after them. That’s why they’ve had an outburst.” (Parent 4)</td>
</tr>
<tr>
<td>PWMI need protection</td>
<td></td>
<td></td>
<td></td>
<td>“And... I suppose my first sort of image would perhaps be in relation to me that’s like a protective.... Whoever’s got mental health issues I feel maternal about. That’s what I feel like if I talk about it, I want to kind of help people and I’m quite comfortable with recognizing people who have got mental health issues.” (Parent 9)</td>
</tr>
<tr>
<td>PWMI need supervision</td>
<td></td>
<td></td>
<td></td>
<td>“So... something like that happens, we just say well they’re from the Blue unit, don’t know, perhaps they needed someone to be out with them. They shouldn’t be out by themselves perhaps” (Parent 4)</td>
</tr>
<tr>
<td>PWMI are dangerous</td>
<td></td>
<td></td>
<td></td>
<td>“But unfortunately some people have problems that either haven’t been helped or have been overlooked or people weren’t aware of, and then the scale has tipped for them and it has become so that perhaps they’re not in their right mind and do something crazy... so mental health disorders resulting in actions that harm others or themselves... something like a school shooting, things of that nature.” (Parent 1)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------</td>
<td>------</td>
<td>------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“My initial reaction is what goes through someone’s mind that they can be so unbelievably self-absorbed and so selfish to do something so disgusting and so low and so awful. And I guess I would just agree with his thoughts really. And I guess my answer would be, you don’t know what’s going through somebody’s mind. Do you know what I mean. They need help and they’re not getting it. And it makes them do bad things.” (Parent 8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“And there might be a tiny percentage of people where psychosis might manifest itself in an aggressive or violent way towards him. And another is to say that just because someone is behaving a bit peculiarly as we see it, that doesn’t necessarily mean that... it doesn’t necessarily pose a threat.” (Parent 5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“But I have... I really try not to scare her too much but I have explained that there’s people, when they’re like that and their brains are disturbed, they cant control themselves. So whether you’re 8 or 18, you’re at risk from that person.” (Parent 9)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“And also we’ve been at the pub, numerous times, and there’s been incidents where the police have had to come to take the client back to the blue unit.” (Parent 4)</td>
</tr>
<tr>
<td></td>
<td>PWMI are unpredictable</td>
<td></td>
<td></td>
<td>“And that’s a really hard question to answer, because why? I’m asking the same question, what goes through somebody’s mind... My initial reaction is what goes through someone’s mind that they can be so unbelievably self-absorbed and so selfish to do something so disgusting and so low and so awful. And I guess I would just agree with his thoughts really. And I guess my answer would be, you don’t know what’s going through somebody’s mind. Do you know what I mean. They need help and they’re not getting it. And it makes them do bad things.” (Parent 8)</td>
</tr>
<tr>
<td></td>
<td>Aetiology of mental illness</td>
<td></td>
<td></td>
<td>“Because there are unfortunately people that perhaps aren’t right in the head. Who might think well I’m going to have that child, I’m going to take that child to be my child.” (Parent 1)</td>
</tr>
<tr>
<td></td>
<td>Blame:</td>
<td></td>
<td></td>
<td>“So then I explained, I had to say look, she’s an alcoholic, which means that she has to drink alcohol all the time and it really makes her very very poorly. I said that’s something that she’s doing, she’s causing it by drinking the alcohol.” (Parent 2)</td>
</tr>
<tr>
<td></td>
<td>Person not right</td>
<td></td>
<td></td>
<td>“Erm like schizophrenia and depression, that’s a problem people have, they can’t help that. Which is life, that’s something that is unavoidable. As such. Whereas drugs and things like that are wrong.” (Parent 6)</td>
</tr>
<tr>
<td></td>
<td>Person’s choice</td>
<td></td>
<td></td>
<td>“Apparently there’s depression in my father’s side of the family as well I believe on the male side.” (Parent 8)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>--------------</td>
<td>------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“And then how we ended up coming to this town was because Kelsey and Alana have the same dad, who we hadn’t lived with since Alana was a baby, and he’s definitely got mental health issues. So I don’t know if partly the susceptibility is in the genes or something.” (Parent 9)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“And I do think that attachment and genes obviously has got a lot to do with mental illness.” (Parent 2)</td>
</tr>
<tr>
<td></td>
<td>Illness</td>
<td></td>
<td></td>
<td>“So Ethan then said “so depression can make you do strange things”. And I said depression is an illness, you can have mood swings and do things out of character.” (Parent 1)</td>
</tr>
<tr>
<td></td>
<td>Social circumstances/upbringing</td>
<td></td>
<td></td>
<td>“Yeah I think… I can’t remember what it was on now. But I know in the past there has been something about that and I’ve just said, you know it’s because of an illness, it’s because they’re poorly.” (Parent 2)</td>
</tr>
<tr>
<td></td>
<td>Coping ability</td>
<td></td>
<td></td>
<td>“And it depends on the individual doesn’t it. Different things affect different people. And their background. Bringing up, quality of life, or poverty. Classifying it isn’t it.” (Parent 6)</td>
</tr>
<tr>
<td></td>
<td>Language about ‘Them’</td>
<td>Teaching diagnostic/non lay language terms</td>
<td></td>
<td>“I would want to put some perspective into it and I would also want to talk about the person as a whole person and the fact that they probably had lots of other things going on in their life, lots of other problems.” (Parent 3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“For example something very extreme, like someone not being able to cope well with losing their job” (Parent 1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“He always used to – because he was little – he always used to say, call them the “poorly people”. And that’s you know… no they’re not poorly, they’ve just got different needs, sort of thing. And now he would never call them the poorly people. So that phrase isn’t used any more.” (Parent 4)</td>
</tr>
<tr>
<td></td>
<td>Language about ‘Them’</td>
<td></td>
<td></td>
<td>“And he sort of said, um, that man doesn’t look very well does he? And I said no, and he said um, what do you think’s the matter with him? And I said I think he’s probably bipolar.” (Parent 3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“So we’ve touched on the multiple personality disorder you know where people have that sort of… they may seem ok but they may just I put it to her as almost like swapping over a bit like fancy dress type thing.” (Parent 9)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“And I have, yeah, I have actually said to her, well, people can kill themselves when they’ve got something called depression and they feel really really low.” (Parent 2)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------------------</td>
<td>-----------------------</td>
<td>-----------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Age-appropriate</td>
<td>language</td>
<td>“And in that respect I might just use different language with them. I might perhaps explain the same scenario but use different language. I think id use age-appropriate language more noticeably with ben, to make it simplified. And again not make it quite so serious or grave if its something concerning I might lighten it... whereas I suppose with Lucas now id be a bit more open and.... You know explain it a bit more. Perhaps in a more adult way. Without making it too scary. That language differentiation.” (Parent 1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I’ll say that I’m a mental health nurse so, erm, I’ll say for instance that I look after people who are sad, are not coping very well with life and they need some help, or because I predominantly work with people with dementia now, I say that their brains are a bit broken and they don’t remember things. I mean I wouldn’t go into the ins and outs of a schizophrenic illness, necessarily with her... I might have said, erm sometimes people might hear voices that aren’t there or see things that aren’t there.” (Parent 2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I suppose he’s at an age now where he’s a little bit young to be engaged at that sort of specific mental disorder level. It’s more kind of general, I suppose what he’s come across is the term ‘madness’ or you know, which covers a lot of brackets...” (Parent 5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Oh yeah I’d say that they’re not right. They’re obviously not right in the head. They’re just obviously... they’re just not right. Unfortunately there are some really bad people out there, unfortunately they’re one of them and they’re just not right mentally. Id probably say it like that, they’re just not right... in the head. Which I think they can understand.” (Parent 6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I think they’ve heard it on the radio and think I’ve brushed over it and I think I’ve said just some people who aren’t right in the head and do silly actions and hurt other people.” (Parent 1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“But she said, in the end she said, auntie Debbie kissed me. And I said, well that’s ok! And she said well, what if I catch it? She thought that, because I’d said that auntie Debbie’s poorly, erm, and she thought that she could catch it.” (Parent 2)</td>
</tr>
<tr>
<td>Taboo and stigma</td>
<td>Mental illness is</td>
<td>Taboo and stigma</td>
<td>stigmatized</td>
<td>“I do find, I do think mental health is prejudiced sort of all the way through all different aspects of it. I find.” (Parent 9)</td>
</tr>
<tr>
<td></td>
<td>Stigma changing</td>
<td></td>
<td></td>
<td>“And what I quite like is, in this country and maybe now I suppose in the past couple of years I have noticed that erm I think we’re talking about it more and I think it’s a lot more open, which I think is a good thing because I think a lot of people have suffered a lot, when they could’ve actually been helped.” (Parent 8)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>----------</td>
<td>--------------</td>
<td>------</td>
<td>------------</td>
<td>------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I think if you compared it to say how race relations were, even when I was growing up in the 70s, say in 50 years how we’ve gone from being a nation of racist, intolerant people, and although that element is always going to be in society it’s now not politically correct to just be racist and I think mental health in its equivalent is still at that start point in a way.” (Parent 9)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“So 30 years ago, cancer was a taboo subject. And now, you can openly talk about it people go, oh I’m so sorry. And often they’ll go, what can I do for you, or how are you feeling, or, do you see what I mean? But the attitude to cancer has changed. Like it has for erm, a little bit I think not so much, for HIV and, you know illnesses like that. But I don’t think mental health. That’s still in the box.” (Parent 7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Erm... I think I’m probably more PC than my parents were but that could just be an age and generational thing.” (Parent 3)</td>
</tr>
<tr>
<td>Mental health taboo in childhood</td>
<td></td>
<td></td>
<td>“I think it’s a very big thing and I think I’ve grown up in a country in a very conservative country where things like that just weren’t spoken about, it was very typical, like you just don’t air out your dirty laundry, and you... if you have someone who’s you know, suffering from something in the family, or you don’t even talk about your problems, you know.” (Parent 8)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Erm... certainly I had an uncle who was set aside from the family because he was... a raging alcoholic. And he was always blacklisted from the family and family events. And there were lots of things, people saying he’s “crazy”, or he’s “lost his mind” and things like that. And we weren’t encouraged to talk about that. It was just a given fact that he’d lost his way and we didn’t have much to do with him. But um, it was never explicit, it was only when I was older that I found out about his alcoholism. And at the time I just thought oh we don’t see him any more.” (Parent 10)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Yeah I suppose some of the male clients... I hadn’t really been explained what was wrong with them, so to speak, so I suppose it was the unknown really, what they were going to,... and also because I knew that my aunty used to come home with bruises, I had this vision of them being all violent, which of course they’re not. But erm I suppose I was just a bit scared because I didn’t know much about it.” (Parent 4)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------------</td>
<td>------</td>
<td>------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“And we’d also... my parents would have strategies to deal with people in the family who might have particular issues. So um, we as children were probably not aware that people had particular issues until later on in life. And I think you know, if there were people who were er, [pause] yeah like, for example, my granddad suffered dreadfully from depression. And um, whenever we went to stay with them, my mother managed us so that we didn’t impact on him. Um, and I think I would probably... I don’t think that’s a right or a wrong way to do it but they definitely shielded us from things like that.” (Parent 3)</td>
</tr>
<tr>
<td>Stigma related to social background</td>
<td></td>
<td></td>
<td></td>
<td>“Cause a lot of people I think on our side of things that aren’t perhaps so educated, quite often just go “oh he’s schizo” or you know...” (Parent 9)</td>
</tr>
<tr>
<td>Taboo</td>
<td>Taboo - self</td>
<td></td>
<td></td>
<td>“I like to think I wouldn’t differentiate between telling her about people who have any sort of health issues, whether they be physical or mental. But it’s easier to explain to a child about physical health issues, because their level of understanding is greater but also because there is more of a tolerance, equality if promoted a lot more for people with physical disabilities than for people with mental health issues.” (Parent 10)</td>
</tr>
<tr>
<td></td>
<td>Taboo - other</td>
<td></td>
<td></td>
<td>“Well it’s obviously quite a difficult subject to broach... difficult to broach... it’s a touchy subject for some people. So it’s always better to broach it with sensitivity with him.” (Parent 5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I protect the children from quite a few things and yet I may discuss other areas that other parents would not think to discuss. They just might move their children on from the situation to just say, no don’t worry about that lets just move on.” (Parent 1)</td>
</tr>
<tr>
<td>Others lack understanding and knowledge</td>
<td></td>
<td></td>
<td></td>
<td>“Erm, I think often, it’s like anything, if you don’t understand... most peoples reaction to something if they don’t understand... my reaction to something if I don’t understand it I try to find out about it. Most people’s reactions to something they don’t understand is fear. And when you create fear it puts barriers up. And once you put a barrier up they’re not accepting to it.” (Parent 7)</td>
</tr>
<tr>
<td>Emotions about mental illness</td>
<td>Awkwardness</td>
<td></td>
<td></td>
<td>“Erm... yeah. That’s what I’m trying to think of the way... erm... erm... of putting it.” (Parent 6)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td>-----------------------------</td>
<td>-----------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Fear</td>
<td></td>
<td></td>
<td></td>
<td>“I know as a parent I am fearful of anything that would physically damage her, but if I was to think about her having a mental health problem that I couldn’t help her with, then that frightens the hell out of me, that would make me very, very scared.” (Parent 10)</td>
</tr>
<tr>
<td>Transmission of stigma</td>
<td></td>
<td></td>
<td></td>
<td>“I think erm… I dislike it very much if Ava thought that mental illness or mental health issues was a sort of different… or that there was a stigma attached to it as opposed to being physically disabled or having a learning difficulty. Erm but… I wonder if my lack of openness, or because I don’t talk to her about it, maybe not make a point of talking about it, I wonder if that perhaps leads to a stigma attached to it because you don’t know about it.” (Parent 10)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“She’ll know words like crazy, or words like loony. And yet she perhaps would use those every day not thinking about what she was doing in the same way that perhaps I do as well. And yet she would know not to use any derogatory words about people who are physically disabled.” (Parent 10)</td>
</tr>
<tr>
<td>Degree of Overlap between Us</td>
<td>Merging of Us and Them</td>
<td>Merging of Us and Them</td>
<td>“I don’t want him to feel that there’s something wrong with him. Or that he’s weird or anything like that, you know. I’m sure that lots of people have depression at some point in their lives. Everyone gets down and everyone gets happy so I don’t think it’s something to get massively concerned about.” (Parent 8)</td>
<td></td>
</tr>
<tr>
<td>and Them</td>
<td></td>
<td></td>
<td></td>
<td>“I’m kind of aware that if I didn’t do a lot of day to day stuff and still kind of work and do other things, that I’m probably exactly the sort of person that could sort of slip through the net myself as well. I don’t feel like I’ve got huge mental health issues but I can see how it could happen.” (Parent 9)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“That’s my personal feeling is… everybody has a mental health issue at some stage in their life. Probably… it depends how you classify it. You could have a mental health issue every day.” (Parent 6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“It’s very common. So I’ve got… a lot of my friends who go through depressive phases and come out the other side. You know, it depends what’s going on.” (Parent 7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Apparently there’s depression in my father’s side of the family as well I believe on the male side, so erm I would class that also as a slight sort of mental health issue.” (Parent 8)</td>
</tr>
<tr>
<td>Spectrum of mental health and</td>
<td></td>
<td></td>
<td></td>
<td>“So it’s not just about an absence of mental ill-health but it’s also about mental well-being. So I think those are probably the things that I would say I use as my definition of mental health and mental ill-health.” (Parent 2)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------------------------</td>
<td>------</td>
<td>------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“There’s a huge spectrum of autism... so again that’s slowly beginning to be understood... Um and I think it’s the same with mental health. I think it’s... again, there is a spectrum.” (Parent 7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“But I guess what I’ve talked to her about more, is about how people, if you’re... you know people have the right help and friendship and everything else, that you can, I believe, it’s just my opinion, I think you can cure nearly every mental health issue there is” (Parent 9)</td>
</tr>
<tr>
<td>Not knowing</td>
<td></td>
<td></td>
<td></td>
<td>“When you say mental health, do you mean things like a breakdown, or a... can you be more... because mental health is so general...” (Parent 7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“And I don’t know whether that could come under mental health as well... I’m not really sure. I don’t know the specific definitions. Erm...” (Parent 1)</td>
</tr>
<tr>
<td>Children are naturally accepting</td>
<td>Children naturally accepting</td>
<td></td>
<td></td>
<td>“I think probably the limit of it would have been that this lady might not talk to you but don’t worry she’s not being rude she doesn’t really talk to anyone except her husband. And then Ava would have been very accepting of that, in a way that adults aren’t.” (Parent 10)</td>
</tr>
<tr>
<td>Children naturally empathetic</td>
<td>Children naturally empathetic</td>
<td></td>
<td></td>
<td>“When he’s talking about other children, he’s very aware... if somebody’s going through a difficult time he’ll want to be friendly with them and want to kind of connect with them... because... say if a family break down, amongst one of his friends at school he’ll probably say to me, oh so-and-so’s been a bit grumpy do you think there might be something going on and do you think I should... what should I do, what could I do, that kind of thing.” (Parent 3)</td>
</tr>
<tr>
<td>Children not fazed by mental health problems</td>
<td>Children not fazed by mental health problems</td>
<td></td>
<td></td>
<td>“I think Stacey’s probably a really good example of how... I think sometimes people believe kids can’t deal with adult stuff... or not necessarily adult stuff just extreme stuff. And bad experiences. And I think what I’ve learned just from being a parent is they can actually deal with anything, whether it’s birth, death, illness, you know all sort of things. And I think it’s how you present it to them a lot of the time.” (Parent 9)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“But he’s never seemed scarred from it at all, or... he hasn’t asked any more about when we’ve got home. I forgot that [a psychiatric unit] was round the corner.” (Parent 4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Erm... but I don’t think it’s kind of been detrimental to them long term, do you see what I mean? I don’t think Sarah or Jack are going to... it’s not going to be something that they are going to worry about or anything now. It’s just they’re sort of matter of fact about it and she’s actually off the drink at the moment so they’ll say oh Auntie Debbie’s well at the moment.” (Parent 2)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Child positive outcomes of experience with mental health problems</td>
<td>“And so what she definitely has is she thinks it’s completely normal to get help. You know that’s how she… whereas I guess a lot of kids her age wouldn’t have even thought of that.” (Parent 9)</td>
</tr>
<tr>
<td>Disconnect between Us and Them</td>
<td></td>
<td></td>
<td>Disconnect between Us and Them</td>
<td>“So I would probably think about people who were feeling stressed because there was a particular trigger, compared to people who have an underlying mental health condition which is actually diagnosable. And I would think that we all have the capacity to have those stressful blips in our lives but that at the… chronic end you’d have people who actually have a diagnosis like personality disorder or whatever. So pictures that spring to mind I guess are probably stressed mums, feeling like it’s all a bit too much, or erm… that would be one end of the spectrum, and then at the other end of the spectrum you’d have the classic homeless person, addict, person with any one of another diagnoses.” (Parent 2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Disconnect between mental health and mental illness</td>
<td>“He’s not had… I mean he’s met the girl who is bipolar once but I don’t think he realized you know, I don’t think he… because it’s not that noticeable. I said you know they look like you and me.” (Parent 8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Children: mental health not mental illness</td>
<td>“Do you mean mental health in terms of disorders or just general emotional wellbeing?” (Parent 5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Yes… I think with children I… I would probably tend to think of children as hopefully not having got to that diagnosis point of view. Because there aren’t actually that many people…or maybe there are, I don’t know what that prevalence of mental health problems in primary school aged children is, but I don’t know…” (Parent 3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“But yeah… erm… it’s very interesting because it’s the first time I’ve rationally thought about… I think I’ve always assumed she wouldn’t have any mental health problems. And whether that’s naivety on my part or hopefulness, erm I’m not sure. And possibly with a degree of not understanding explicitly how certain mental health problems are created. And possibly to a degree not really wanting to know. I don’t like to think that I’m unaware, or more unaware than anybody else, but I suppose it’s not until you think about things explicitly that perhaps you start to question how much you know or how much you don’t know.” (Parent 10)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>----------</td>
<td>--------------</td>
<td>------</td>
<td>------------</td>
<td>-------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I mean I think the figures are that 1 in 4 people will have some sort of mental health issues. And I think what I’ve noticed from being here. And from Stacey’s school which is that 7-11 age range, that everybody just always talks as though it will never be them you know. And I think its… most parents are, you’re quite naïve, you just think all these really bad things happen to other people somewhere else, they don’t happen to you. So yeah.” (Parent 9)</td>
</tr>
<tr>
<td></td>
<td>Children mental health related to circumstances</td>
<td></td>
<td></td>
<td>“And kind of… I would tend to think of children in terms of their general mental health. So think that are making them grumpy, or they’re feeling stressed, or… there’s probably other things going on for them.” (Parent 3)</td>
</tr>
<tr>
<td></td>
<td>Children mental health in terms of bad behaviour</td>
<td></td>
<td></td>
<td>“And I said you know, she’s very worried about her mummy. Daisy said yes I know she cries all the time. And I said well, I think she’s worried that her mummy’s going to die… and um, that’s made her very anxious. And why she’s responding the way she is, is because she has to see her mummy all the time to be sure her mummy is still alive.” (Parent 7)</td>
</tr>
<tr>
<td></td>
<td>Unconscious confusions &amp; contradictions</td>
<td>Repeating parenting patterns</td>
<td></td>
<td>“I think the parents try to label it as ADHD, where it probably isn’t. I don’t think it is… I think they’ve been told it isn’t, but I think hey just want a label for to make themselves feel better. [laughs] in some ways. It’s not right. But it’s working out why he’s not right, and why he’s acting the way he is, and… yeah. Yeah.” (Parent 6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Yeah. Because my aunty always worked in homes, mental health and learning disability. And I used to go with her and I used to be really scared. And then I ended up working in that environment after… years later. And I thought, I didn’t have anything to be scared about really. So I didn’t want him to have that… because I was really really petrified [laughs]. So I suppose I didn’t really want him to feel like that as well… if anything it would probably make me try to give Sam a better understanding really. Because I didn’t have a very good understanding of parts of mental health. So I’d probably try to do the opposite and make sure he does understand it as he gets older.” (Parent 4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Erm, probably because every time he sees someone from the Blue [psychiatric] Unit there’s always been a bit of a scene. With Paul’s clients [with learning disabilities] they just do all these lovely things together, bowling, play golf. But he probably hasn’t got a very good perception of that place at all really I should probably explain it to him better. But I don’t know anything about it really…” (Parent 4)</td>
</tr>
<tr>
<td></td>
<td>Denying contact with mental health problems</td>
<td></td>
<td></td>
<td>“I don’t think you hide things. I don’t think you put your head in the sand. And pretend it’s not there. If it’s in your family you deal with it. But because we’re not in that situation I kind of can choose.” (Parent 7)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------</td>
<td>------</td>
<td>------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Erm... I got post-natal depression. But I got it two years after Ed was born. Erm... it was finally diagnosed. Erm... I didn’t understand it myself. Because I... like I’m sure there’s many people out there, assumed that... depression is an extreme and that’s it, and you don’t function. But actually I functioned for two years and I still function now. Erm, and obviously Daisy went through that. Now I’ve never told her I had depression.” (Parent 7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I’m definitely not going to avoid it like the plague, I don’t think that’s right. I mean... I’m not doing any better than my parents did really, you know.” (Parent 8)</td>
</tr>
<tr>
<td>Child understanding</td>
<td></td>
<td></td>
<td></td>
<td>“Yeah he probably wouldn’t really grasp it. He’s got such a great understanding of learning disabilities because he’s always been around it, from little. Since when I worked in a home and I used to take him there and... he’s got a brilliant understanding of that. But I don’t think he’d have a good understanding of mental health right now. I don’t know.” (Parent 4)</td>
</tr>
<tr>
<td>Open communication</td>
<td></td>
<td></td>
<td></td>
<td>“Erm... I try, I try to be as open and honest... I made myself a promise to always be open and honest with him about absolutely everything. If he asks me an intelligent question it deserves an intelligent, well rounded answer.” (Parent 4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I suppose I try to keep the communication channels open, doesn’t always work but we try to.” (Parent 1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“But no, I don’t think there’s anything I wouldn’t talk to him about.” (Parent 3)</td>
</tr>
<tr>
<td>Non-verbal communication</td>
<td></td>
<td></td>
<td></td>
<td>“Probably it’s bad. He probably thinks it’s a bit of a scary place perhaps. I don’t know, only because of what’s he’s seen, or my reactions to it at the time... if someone’s been walking past and I’ve kept him in the car. But that is literally because I don’t know anything about... I’m not going to get him out the car if there’s a guy walking past, swearing, shouting.” (Parent 4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Depending on the circumstances... to avoid a confrontation. If it was... in an environment where... that person then might approach you, and you’d then have your child to deal with as well as that person. And if the children were with me, and if the children were with me I think id encourage them to talk to me quietly, and if need be id say well we’ll chat about this later, and distract them from what’s going on.” (Parent 1)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>-------------------------------</td>
<td>--------</td>
<td>------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Parental experiences impacting on communication</td>
<td>Parental knowledge</td>
<td></td>
<td>Education</td>
<td>“If it came up, and it were in the context of... say he’s read something in a book or... I’d very happily talk to him about it. I mean as we discussed, I did psychology for my degree so I have a little bit more insight maybe...” (Parent 5)</td>
</tr>
<tr>
<td>about Us and Them</td>
<td></td>
<td></td>
<td></td>
<td>“But then I went to a... I went to a bit of a hippy school as well. I went to... I don’t know if you’ve ever heard of a Steiner school? Yeah so there everything was very open and we did discuss a lot of things and things were very open. So I think we had a more open-mindedness.” (Parent 8)</td>
</tr>
<tr>
<td>Professional</td>
<td></td>
<td></td>
<td></td>
<td>“Erm... I suppose just from the jobs that Paul and I have done, like I said before I just think it’s important that he has an open mind about things. Different problems that people can suffer with. I suppose that’s where it’s come from really. I suppose it the learning disability side really, it’s all me and Paul know, work-wise. So erm, I suppose it’s just something I’ve tried to instill in him really. Because I was always around it as well. I feel it’s important that he is.” (Parent 4)</td>
</tr>
<tr>
<td>Media</td>
<td></td>
<td></td>
<td></td>
<td>“Erm...I suppose the news and just reading about, inevitably, the newsworthy cases of mental health disorder which are obviously the most severe. That’s where I suppose my experience of it comes from.” (Parent 5)</td>
</tr>
<tr>
<td>Parent personal experiences</td>
<td>Parents’ cultural background</td>
<td></td>
<td></td>
<td>“But when I think of mental health issues in my mind... one flew over the cuckoos nest springs to mind. Me seeing that film and understanding that film and I suppose knowing a little bit about different problems that people might have.” (Parent 1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I find from having an alternative lifestyle living as a traveller very tolerant. Because you get sued to living in large groups of people, and you deal with people’s ups and downs in life. And some people obviously cope better than others. So I’m quite lucky that I’ve perhaps had that less prejudiced environment.” (Parent 9)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I was very lucky to have quite a shielded upbringing in a cathedral close...” (Parent 5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I think it’s a very big thing and I think I’ve grown up in a country in a very conservative country where things like that just weren’t spoken about, it was very typical, like you just don’t air out your dirty laundry, and you... if you have someone who’s you know, suffering from something in the family, or you don’t even talk about your problems, you know.” (Parent 8)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------------------------</td>
<td>------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Parent experience</td>
<td>associated with area</td>
<td></td>
<td></td>
<td>“No, I was thinking, partly I was thinking yes I need to reassure him, because it was very unusual. This isn’t that sort of area. Also the psychiatric hospital isn’t near here.” (Parent 3)</td>
</tr>
<tr>
<td>Personal or familial experience</td>
<td>of mental health issues</td>
<td></td>
<td></td>
<td>“I chose who I tell. I don’t want everybody to know. And I have learnt that from the fact that I have told… when I first got depression I told people and I actually had people walk away. Which is quite shocking. So therefore, I know that’s not bout me, that’s about their response, but, that means you’ve got to be careful as to who you tell.” (Parent 7)</td>
</tr>
<tr>
<td>Discussion with other parents</td>
<td></td>
<td></td>
<td></td>
<td>“Erm, id probably check it out with another friend and say if your child said such and such a thing to you what would you think, what would you do.” (Parent 3)</td>
</tr>
<tr>
<td>Intergenerational parenting</td>
<td>patterns</td>
<td></td>
<td></td>
<td>“So most of my parenting is actually based on… well, as it, most people will say this to you I expect, you pick the things that you thought worked well in the way you were parented, and then you do things differently when they didn’t work as well as you’d like them to work.” (Parent 3)</td>
</tr>
<tr>
<td>Opposite to parents</td>
<td></td>
<td></td>
<td></td>
<td>“So erm… I think we’ve got a good start for our children because I know what I didn’t have, if that makes sense.” (Parent 6)</td>
</tr>
<tr>
<td>Emotional communication style</td>
<td>of parents</td>
<td></td>
<td></td>
<td>“No, because I have a better understanding of it now. No, if anything it would probably make me try to give Sam a better understanding really. Because I didn’t have a very good understanding of parts of mental health. So I’d probably try to do the opposite and make sure he does understand it as he gets older.” (Parent 4)</td>
</tr>
<tr>
<td>Purpose (Them)</td>
<td>Acceptance and empathy</td>
<td></td>
<td></td>
<td>“But I just wouldn’t ever want to be like that really. So… perhaps it’s because of how I’ve been parented, perhaps I want to do it differently. Cos I don’t think that my mum was ever sort of emotionally there for me, whereas I am with Sarah.” (Parent 2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I think my dad was always very open minded about things like that believe it or not. My mum not. My mum still won’t talk about anything, she just… when she’s upset she’ll just lock herself indoors. You don’t cry, you don’t express yourself. You just… none of that, where the other side was very much more emotional and open. But I also think I’ve come away from them as well, and I have learnt that it’s actually ok to, you know, to talk about stuff like that.” (Parent 8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“And without going into too much depth I have tried to explain to the children that we are not all the same. And that we are all unique and learn things and do things in different ways and just because we do that it doesn’t mean we should be unkind, or criticize people or anything of that nature. I have tried to get them to be quite accepting and understand that not everyone is the same and it would be really boring if everyone was the same.” (Parent 1)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“So I’ll just say look Sarah, we’re all different, you have to accept people for the way they are. So I’ll have a lot of those conversations with her as well.” (Parent 2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I suppose just to try to explain to Sam that everybody has different needs, and what he might perceive as being normal – normal to someone else might not be to him. I suppose that’s what we try to put across to Sam really. So he’s got a bit of an understanding that everyone is really different.” (Parent 4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“But I also like to promote with him a sort of an acceptance and an understanding and that it’s... people can have treatment for it...” (Parent 5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“But I certainly know that I have talked to her about the fact that there are lots of different people and people behave in lots of different ways and that just because someone’s doing something that might be different to what we do, it doesn’t necessarily mean that it’s right or wrong or normal or abnormal. Erm and I’ve encouraged her to be open minded.” (Parent 10)</td>
</tr>
<tr>
<td></td>
<td>Increase children’s understanding of mental illnesses</td>
<td></td>
<td>General education</td>
<td>“I want them... I suppose all the time you are teaching your children... whether its helping them to learn, how to read, their times tables, you’re trying to educate them.” (Parent 1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Erm it has come up... I wouldn’t say much of a... an issue. Erm... because I think they’ve got to understand what depression is. And understand that people do have problems.” (Parent 6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Just saying there is people with say, Tourette’s that she knows, there’s people with brain damage, or you know, long term illness which just means they’re different. And maybe as time goes on to be a bit more specific. You know. Not exactly for me to go out and say, oh that person over there has multiple personality disorder. And erm... I mean that’s something we’ve touched on, that I guess is sort of educating her, is erm...” (Parent 9)</td>
</tr>
<tr>
<td></td>
<td>Child understand and cope with the world</td>
<td></td>
<td></td>
<td>“But again, you can’t hide from it. Because... it’s too late isn’t it really. And you can’t hide them from everything because again, otherwise when they do get older they’ll be in the big wide world themselves and not be... very naive and that won’t help them later on.” (Parent 6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“And erm... and always being careful I suppose to make sure... to impress upon him that there’s reason for it, erm... [pause] it’s... I suppose the main thing just want to do when I’m interacting with him is to make sure that he understands why it might happen, erm, not to judge or to be scared.” (Parent 5)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
<td>------</td>
<td>------------</td>
<td>------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Erm... whether its another child having a complete temper tantrum, or a hissy for some reason that might cause you react in a particular way... or whether its something they see on television that perhaps they find scary or difficult to process themselves, I think if there’s a way to help them start to learn the tools they need to cope with different things...” (Parent 1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“So if at school there’s been a problem I would try to talk to the children about and try to explain why someone has behaved in a certain way. To sort of put in in context. If to them it could be a random bit of behaviour they witnessed, or something serious that has concerned them I would try to get them to talk about so that we can understand it better.” (Parent 1)</td>
</tr>
<tr>
<td>Reassurance</td>
<td>Mental illnesses are not dangerous</td>
<td></td>
<td></td>
<td>“Um and then I said you know, he wont cause you any harm but you know just go to school and don’t worry abut it and it’s probably more difficult for the chap than it is for you because he’s probably feeling very wound up and anxious. Erm, and I think that’s probably all we said about that.” (Parent 3)</td>
</tr>
<tr>
<td></td>
<td>Violence related mental illness is rare.</td>
<td></td>
<td></td>
<td>“And I’ve tried to talk to the children about things that have come up, there haven’t been that many but... to try to explain not everyone is like this, people don’t generally do this.” (Parent 1)</td>
</tr>
<tr>
<td></td>
<td>Others’ mental health problems are not child’s fault</td>
<td></td>
<td></td>
<td>“That’s not right, it’s a very rare occurrence. I think they probably worry it’s going to happen to them. But I try to get through to the, the amount of people in this country, on this planet, the chances of it happening to you is very minimal so I try to reassure them... not that you can give them 100% reassurance ‘cause it’s obviously happened!” (Parent 6)</td>
</tr>
<tr>
<td></td>
<td>Protection</td>
<td></td>
<td></td>
<td>“That’s where I guess trying to make it clear that when the people show signs of mental health problems, and something’s happening that that’s not about you, it’s not your fault. You’re not to blame and then you’ve just got to try and look at how you can get that person to either calm down or be safe or whatever. So I guess that’s my number one reaction.” (Parent 9)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Now I’ve never told her I had depression. But she’s aware of my anger and my... my days where I didn’t function very well, ddudududaa. And I’ve sat and said to her, you know, that’s not about you. You haven’t caused how mummy is feeling.” (Parent 7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I think we’ve definitely discussed different forms of mental health but I think my main focus in a way has been putting things into her head so she doesn’t put herself in risky situations.” (Parent 9)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------------------</td>
<td>------</td>
<td>-------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Protection from negative emotions</td>
<td>Sadness</td>
<td></td>
<td></td>
<td>“Yeah... she’d get scared about things. Maybe when she’d meet boys when she gets older, you never know she could be worried he could turn into an axe murderer, like the bloke she saw on the tele’ that her dad told her all about. You can’t go around being worried all the time. Not saying it would go that far. But when you’re young you have flash backs of bits in your life and that could be that one flashback when dad sat her down and talked to her about this nutter, doing this, doing that. Erm... I’m not saying it’d affect her for the rest of her life but you don’t know do you. So...” (Parent 6)</td>
</tr>
<tr>
<td>Protect children from unnecessary knowledge</td>
<td>Worry/fear</td>
<td></td>
<td></td>
<td>“Erm, I don’t know, I just... there’s a bit of me that wants to keep... give her some security and shelter and... and it doesn’t feel that that would something I feel she should hear about yet.” (Parent 7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Because I don’t really want to expose them to nasty stuff too soon... there’s things they need not know at this age. Although Lucas now I’m a bit happier for him to listen to things so he knows what’s going on in the world, I think I would protect the younger two a little more... from the big wide ugly world that we live in...” (Parent 1)</td>
</tr>
<tr>
<td>Protect child’s innocence</td>
<td></td>
<td></td>
<td></td>
<td>“…and I... but equally I don’t want them to... I want... I don’t want to spoil their childhood.” (Parent 3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“And I think parents want to keep children in a childish state. Which is why even though Ava is nearly... she’ll be 9 this year, we’ll still be promoting the idea of father Christmas, and you know things that we know are complete lies but they are pleasant. And we potentially don’t want to explain that there are things that are quite so difficult to deal with and I mean... I’m not specifically referring to mental health issues when I say horrible, but there are things in the world that she would find horrific and you don’t really want to explain that to a child.” (Parent 10)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>----------</td>
<td>--------------</td>
<td>------</td>
<td>------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Protect from people with mental illness</td>
<td>Community</td>
<td></td>
<td></td>
<td>“Oh yeah. Well with one guy, he walked down the road, just really shouting, swearing, to himself but it’s so loud. And I’m getting Sam out the car, I’ll wait till the chap walks past because I don’t know anything about him.” (Parent 4)</td>
</tr>
<tr>
<td></td>
<td>Family</td>
<td></td>
<td></td>
<td>“Erm, I think in some ways it’s about protecting your family and your children. And certainly I know that if one of my siblings I thought could be harmful or dangerous then I would find it very difficult to keep trying to expose Ava to what I thought I thought could be potentially dangerous.” (Parent 10)</td>
</tr>
<tr>
<td></td>
<td>Media exposure</td>
<td></td>
<td></td>
<td>“Erm... yeah some things I don’t like them to watch. You look at the time and think, well, I don think there’s a lot of stuff on tele that shouldn’t be on tele at that time. I think it’s more mental stuff that shouldn’t be on there. I think the immediate, sex, drugs and swearing, they cut off. But they don’t cut off certain mental things.” (Parent 6)</td>
</tr>
<tr>
<td>Protect because children are impressionable</td>
<td></td>
<td></td>
<td></td>
<td>“I think again that’s perhaps why I don’t turn on the news for them frequently and stuff. Its one thing listening to Newsround it’s quite different listing to the 10oclock news, or even the 6oclock news when it’s not really age appropriate. And I want to protect them from mass murder and other things going on.” (Parent 1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Erm... and not so much physical danger or anything like that, but as children are older, 14, 15, then I think parents would worry about their children being impressionable. and that they might consider people not to be good role models for them. And that they don’t want them to have contact because they don’t want their children to have the life that they perceive the other person to have.” (Parent 10)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I wouldn’t want him to think it was something that everybody did.” (Parent 3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Cos you do worry, I do worry thinking them seeing some things and thinking that’s normal.” (Parent 6)</td>
</tr>
<tr>
<td>Protect because children’s accepting nature is dangerous</td>
<td></td>
<td></td>
<td></td>
<td>“So he’s very empathetic. It’s actually a lovely trait of his but I do sometimes worry that people are going to take advantage of him because of it but that’s just I think a typical mothers’ worry isn’t it!” (Parent 8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“But what I worry about because she is so kind of, unique, that she might feel she can say things to people that will help, or intervene, which you know could quite possibly go the wrong way.” (Parent 9)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>----------</td>
<td>--------------</td>
<td>------</td>
<td>------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Warnings</td>
<td></td>
<td></td>
<td></td>
<td>“I think with the children, particularly when they were a bit younger I would always say, you’ve got to stay near mummy in the shops you can’t go wandering off. I’m worried that someone will take you. And although some people are thinking, you can’t say that to your children... how else can you get them to understand?” (Parent 1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“But again just to be careful of that and um, I suppose to warn him to some extent, to stay where people are acting in a way that’s not... doesn’t seem to be... reasonable or understandable to maybe steer clear or just to not engage.” (Parent 5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“But I have... I really try not to scare her too much but I have explained that there’s people, when they’re like that and their brains are disturbed, they can’t control themselves. So whether you’re 8 or 18, you’re at risk from that person.” (Parent 9)</td>
</tr>
<tr>
<td>Balance</td>
<td>Balance between protection and acceptance and empathy</td>
<td></td>
<td></td>
<td>“And there might be a tiny percentage of people where psychosis might manifest itself in an aggressive or violent way towards him. And another is to say that just because someone is behaving a bit peculiarly as we see it, that doesn’t necessarily mean that... it doesn’t necessarily pose a threat. I think that’s quite a difficult message however to get... a difficult balance to strike and I suppose at this stage of his early life I suppose I’m erring on the former side. Though I aspire as he gets older to the latter. If I’m being perfectly honest.” (Parent 5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“…and I think you also need to find the balance of things.... I think that on that side I wouldn’t want him to become imbalanced about things and suddenly think that everybody out there is a child abuser or going to snatch him.” (Parent 8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Um, I think as a parent you want to keep your children safe but you want them to grow up with a whole range of experiences and be fairly rounded, but you don’t want them to be the guinea pig.” (Parent 3)</td>
</tr>
<tr>
<td></td>
<td>Balance between enough and too much information</td>
<td></td>
<td></td>
<td>“So her idea of bad isn’t real in a way, she doesn’t realize how awful the world really is. So I guess it’s about keeping her in a bit of a bubble. But at the same time really trying to educate her about mental health issues” (Parent 9)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“So I’m trying to get a balance... that’s what I mean by there are something you do see, some things you don’t. I think generally, naturally as part of life there are certain things that are ok but... yeah.” (Parent 7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I don’t want there to be a mystery or a secret, but equally I don’t want to overload him with information.” (Parent 3)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------</td>
<td>------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Approach (Them)</td>
<td>Deliberateness</td>
<td></td>
<td></td>
<td>“Erm... I don’t really know to be honest, I can’t think of a specific time when something’s come up... like if he’s seen something on the tel or anything like that. There probably has been but I just can’t think of a situation” (Parent 4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Yeah, cos when you got in touch I was thinking, you know I was trying to think of times and examples of when I have talked about it... erm, and I suppose its difficult to think about genuine examples... I don’t think I can put my finger on and say well look I remember this time last year...” (Parent 10)</td>
</tr>
<tr>
<td></td>
<td>Not deliberate</td>
<td></td>
<td></td>
<td>“But yeah I wouldn’t... it’s not like...you know like you’d sit down with a child and tell them about I don’t know, the birds and the bees, or tell them something specific. I don’t think id sit her down and say right, this is depression, this is what this means, this is schizophrenia, this is what this means.” (Parent 2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Erm... but it’s generally not something we’ve spent a huge amount of time discussing. I suppose it’d be more inadvertently we’d discuss it.” (Parent 10)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“But I can’t say as I’ve actually sat down and discussed with him mental health specifically” (Parent 4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“He’s asked me lots of questions about suicide for example in the past erm.... but I wouldn’t sit down and talk to him about it. I wouldn’t consider it appropriate unless he asked me a question.” (Parent 3)</td>
</tr>
<tr>
<td>Reactive</td>
<td></td>
<td></td>
<td></td>
<td>“Yeah, yeah. I mean if she asked a question she’d get an answer. But ultimately I wouldn’t bring the subject up.” (Parent 7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I don’t think I usually initiate conversation, it will be to try to explain something the children have made me aware of more than anything else. Erm... you know I think I let them discover things and learn stuff and come and talk to me about it and them I’ll have a conversation.” (Parent 1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Yeah, it’s reactive rather than proactive certainly.” (Parent 5)</td>
</tr>
<tr>
<td>Matter-of-fact style</td>
<td></td>
<td></td>
<td></td>
<td>“If she asks the next question then she’s ready to hear the answer. But if she doesn’t ask the question, that’s the end of the conversation.” (Parent 7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I never try to discuss anything with any extreme emotions really whether its sadness, anger. So I guess presenting it in a calm, but diplomatic way.” (Parent 9)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“It’s erm, it’s no good sugar coating things I don’t think. Erm I think you are more likely to give somebody hang-ups if you don’t talk about stuff openly... So I’m always quite sort of open about that kind of thing and just sort of matter of fact.” (Parent 2)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>----------</td>
<td>--------------</td>
<td>------</td>
<td>------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Honest and accurate</td>
<td></td>
<td></td>
<td>“I think if he’s been intelligent enough to ask me a question I think he deserves an honest answer. You know. I know some parents wouldn’t, because they kind of want their children to believe that the world is a pretty, beautiful place the whole time. And that no-one’s ill and no-one’s upset and stuff like that.” (Parent 8)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>“So erm, yeah, to be honest my knowledge of it grows hazy as time goes on, so I’m not necessarily comfortable from my perspective that I’d give a true and clear picture of what it is. Because I think it’s important you know, if I do tell him something, that it’s not just a general, making something up…” (Parent 5)</td>
<td></td>
</tr>
<tr>
<td>Examples related to child’s world</td>
<td></td>
<td></td>
<td>“I think what I would normally do is that I would normally try and find either a person that he knows about r a situation that he can relate to. Or possibly even a story, but probably not because now he’s a bit older, erm, it’s probably people that we know. Either friends or family, or even characters in films, on the television. So make it something he can connect with.” (Parent 3)</td>
<td></td>
</tr>
<tr>
<td>Limited depth of information</td>
<td></td>
<td></td>
<td>“But I wouldn’t want to dwell on things too much, I think I would probably be quite kind of… sort of… not vague, because I would give him the right answer. But I would keep it very low key and move onto the next thing.” (Parent 3)</td>
<td></td>
</tr>
<tr>
<td>Avoidance</td>
<td>Delaying discussions</td>
<td></td>
<td>“I don’t think there’s anything I wouldn’t talk to him about but I have said in the past, that’s not something you need to think about right now.” (Parent 3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Glossing over questions</td>
<td></td>
<td>“I do try and steer clear of it, not happening. I don’t wanna lie to them… so I do sort of jitter off that part of it. I suppose I would jump off the subject a little bit maybe but… I wouldn’t not answer them… I’d talk round it or give them a direct answer really.” (Parent 6)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Using euphemisms</td>
<td></td>
<td>“So… something like that happens, we just say well they’re from the Blue unit, don’t know, perhaps they needed someone to be out with them.” (Parent 4)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental illness in the media is ‘pretend’</td>
<td></td>
<td>“Well probably, what’s not right to say, I probably would have said don’t worry it’s just pretend. As opposed to say actually these things can happen. Erm, but at the time, at that moment I probably would have said don’t worry about it, its just made up.” (Parent 4)</td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------</td>
<td>-----------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Barriers to communication</td>
<td>Not an age-appropriate topic</td>
<td></td>
<td></td>
<td>“Erm, which I think is probably the reason why I would... I like to think I would go into it in more depth and explain why someone was unwell. But she would have to be of what I would think is an appropriate age to understand those things.” (Parent 10)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“And as she gets older I’ll be able to say, you know when she’s probably 12 or 13 actually mummy had depression. Mummy had post-natal depression and this is why she had it. But I don’t think, I don’t think she’s old enough to have that information. Because of her age, fundamentally. That’s... there’s age-appropriate information. But I think you can build building blocks towards understanding of it.” (Parent 7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I’m quite keen on children being children while they still can. And not sort of taking them outside of their age-appropriateness. So, I think that’s what I would do. I’d think, is this age appropriate? And how can I, in an age-appropriate way, use an example of something or someone that he’s familiar with.” (Parent 3)</td>
</tr>
<tr>
<td>Children wouldn’t understand</td>
<td></td>
<td></td>
<td></td>
<td>“…but to kind of vaguely talk about... it’s like describing a monster that’s not there. You know, even in a 9 year old, and she’s a very bright child, I think you do need something more tangible to be able to explain... I don’t think mental health’s not tangible, it’s tangible, it’s just the situation.” (Parent 7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I think so... schizophrenia is a pretty complex topic and I suppose... it’s debatable whether anyone really understands it properly anyway to be able to explain it... I certainly wouldn’t engage him at a level where I’d be taking him through Jung or whatever!” (Parent 5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I suppose his age really, if he was older, I think probably slightly different, say he was 11 or 12... I don’t know. He’d be completely different to how he is now in his understanding. So I suppose I just bring it up as it comes along because he is only 7 really. I don’t think he’d have that much of an understanding, or be able to take it all in. when its too much detail.” (Parent 4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Erm... well at his age, well I probably wouldn’t go into like, I don’t know, other conditions, schizophrenia and things like that because he just wouldn’t understand.” (Parent 4)</td>
</tr>
<tr>
<td></td>
<td>Topic did not arise</td>
<td></td>
<td></td>
<td>“Erm but if he asked me any questions I would discuss it with him. But he’s never really asked me anything. So I don’t know really, I don’t think so. I’m sure something will crop up.” (Parent 4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“If she asked the question, I wouldn’t hesitate. Same principle I have in anything. Erm, I would sit her down and answer whatever that question was. But that question hasn’t come up.” (Parent 7)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>----------</td>
<td>--------------</td>
<td>------</td>
<td>------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Not affecting child so not necessary</td>
<td></td>
<td></td>
<td></td>
<td>“Erm... and I think also unless there was a reason to have that sort of discussion in the first place, then perhaps I don’t see it as a necessary thing. But sort of I suppose we spend our time doing other things.” (Parent 10)</td>
</tr>
<tr>
<td>Parents lacked sufficient knowledge</td>
<td></td>
<td></td>
<td></td>
<td>“…and they don’t really need to know the ins and outs of it yet. Which I think that’s something they will learn for themselves.” (Parent 6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“But also if she asked questions such as why do people have mental health issues? I think I would then find that difficult to explain. Probably because I don’t know very much about it myself. And I’ve got vague ideas and notions and things which I assume might be correct, but then if you’re trying to make that something that’s understandable for a child and expect further questions on it then that’s something I’d like to be a lot more prepared to answer questions on.” (Parent 10)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I haven’t... I’m perhaps not knowledgeable about schizophrenia to really talk about things like that in detail. Because I was under the impression that’s it’s not supposed to exist any more. And it’s all got different names.” (Parent 9)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Again because I don’t know what their condition is. So I’d just be giving him false information.” (Parent 4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I suppose I feel quite inexperienced... I don’t know nearly enough to explain thing probably adequately. So I think that’s why I would talk... in brief terms about things... I don’t think id go into an awful lot of depth trying to explain how the brain works, or something. I think I’d keep things light a bit because I wouldn’t want to... misinform them.” (Parent 1)</td>
</tr>
<tr>
<td>Unseen psychological problems hard to explain</td>
<td></td>
<td></td>
<td></td>
<td>“When you can see a physical manifestation... but I think potentially it’s easier to explain something like that. So if you can see it readily in... their body or perhaps if you can see a behaviour where they’re obviously having some sort of difficulty but it’s explainable in quite a straightforward way. The openness would be a symptom of the fact that it’s easier to explain that to a child. Than it would be to ask a child to imagine that someone looks on the outside completely fine, and yet mentally... so asking the child to have a concept of a mental person as well as a physical person... to understand that people have bodies and minds, that’s quite difficult in itself. And then to ask them to understand that that person has difficulties with the health and the state of their mind, that becomes really difficult to explain.” (Parent 10)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“It is easier to have a conversation about someone’s mental health if you can see physical differences in their behaviour.” (Parent 1)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------</td>
<td>-------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Negative consequences of</td>
<td>Worrying and frightening child</td>
<td></td>
<td>“Erm, I don’t particularly like it because I prefer to understand as much as I can about something but I think parents either don’t feel comfortable explaining things to children because they don’t want them to worry about those things. So A they don’t want them to worry about the person if they know them or B they don’t want them to worry about will this happen to me.” (Parent 10)</td>
<td></td>
</tr>
<tr>
<td>discussion</td>
<td></td>
<td></td>
<td></td>
<td>“But no I don’t think there’s anything I wouldn’t talk to him about. Erm… I think I’m quite boundaried though, I wouldn’t tell him anything that I didn’t think he either needed to know… I wouldn’t want him to be scared or worried or frightened or… think that something might happen to him or me, or his sister or his dad or anybody that he cared about.” (Parent 3)</td>
</tr>
<tr>
<td></td>
<td>Burdening child</td>
<td></td>
<td></td>
<td>“And I also think there’s a bit of it… I think we’ve got enough on our plate. I think Daisy has got a lot she’s already dealing with, that any more information is not necessarily needed, at this moment.” (Parent 7)</td>
</tr>
<tr>
<td></td>
<td>Child ‘misusing’ knowledge</td>
<td></td>
<td>“Yeah like if, for an example, if you were... if there was a particular person with a mental illness you were talking about then she would go and talk to them. What kind of... be inappropriate or something or use that knowledge inappropriately... You know like as kids get older you have to be careful what you say in front of them in case they go and say something inappropriately in front of somebody that you’ve been talking about.” (Parent 2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Partly that is to do with... she’s 9. And whatever I tell her is going to go back into the playground. Cos she’s not mature enough yet to understand that some things are not talked about. Openly. I chose who I tell. I don’t want everybody to know.” (Parent 7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I don’t want her to go and tell people. Because then she needs to choose who she tells, and she’s not discerning enough yet. And I don’t think any child would be discerning... I don’t think it’s just about Daisy. She’s actually quite mature.” (Parent 7)</td>
</tr>
<tr>
<td></td>
<td>More and more questions</td>
<td></td>
<td></td>
<td>“Because I think the more you go into it, the more questions they’re gonna ask... and the more I’ll have to answer them questions...” (Parent 6)</td>
</tr>
<tr>
<td>Type of mental illness</td>
<td></td>
<td></td>
<td></td>
<td>“Yeah it depends on the level of it. I mean if they were... So abject that they were going to commit suicide I probably wouldn’t talk about it. I think that’s slightly a step too far for a 9 year old... [] erm... because it’s not a natural death, it’s a chosen death.” (Parent 7)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>---------------------------</td>
<td>--------------</td>
<td>------</td>
<td>------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Erm like schizophrenia and depression, that’s a problem people have, they can’t help that. Which is life, that’s something that is unavoidable. As such. Whereas drugs and things like that are wrong. Erm... so again you want them to know about that, they’ve got to understand it. Erm... it’s just the level of... when they should understand it. I think depression and things like that I’m not so worried about that because that’s a natural occurrence in life, well so is drug dealing but... that’s avoidable, whereas that’s not avoidable.” (Parent 6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Well I think there are very serious things in life that happen that I think you’ve got to be a certain age to... to hear them. Erm... I think there’s... when she’s a bit older I have no hesitation in telling her.” (Parent 7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“No. And I probably will talk to him about it one day. Because it’s important isn’t it. No I wouldn’t have any concerns at all, I think Sam should understand things like that.” (Parent 4)</td>
</tr>
<tr>
<td>Facilitators and prompts</td>
<td>Greater parent knowledge</td>
<td></td>
<td></td>
<td>“If it came up, and it were in the context of... say he’s read something in a book or... I’d very happily talk to him about it. I mean as we discussed, I did psychology for my degree so I have a little bit more insight maybe...” (Parent 5)</td>
</tr>
<tr>
<td>Relevance</td>
<td>Affecting child</td>
<td></td>
<td></td>
<td>“And I suppose introducing things on a... you might call it a superficial level... because it’s at arm’s length, it’s not affecting us. It’s easier to have a chat about that, than if something happened close to home.” (Parent 1)</td>
</tr>
<tr>
<td></td>
<td>Not affecting child</td>
<td></td>
<td></td>
<td>“I mean if it was part of our world it would be something you have to deal with... So if schizophrenia or something like that was in our family, is what I’m trying to say, then yes we would deal with it because it’s there and it’s part of this family and it’s... and we would have to.” (Parent 7)</td>
</tr>
<tr>
<td>More questions</td>
<td></td>
<td></td>
<td></td>
<td>“Because I think the more you go into it, the more questions they’re gonna ask... and the more I’ll have to answer them questions...” (Parent 6)</td>
</tr>
<tr>
<td>from child</td>
<td></td>
<td></td>
<td></td>
<td>“But it seems to be such a wide field, with so many different difficulties... whereas there might be 50 different reasons why someone can’t run or walk but the end result is the same, and you can explain that to a very young child. But I can almost see a “but why?” cycle happening with questions about mental health.” (Parent 10)</td>
</tr>
<tr>
<td>Prompts</td>
<td>Parent’s job</td>
<td></td>
<td></td>
<td>“I mean conversations that we’ve had for instance about what I do, I’ll say that I’m a mental health nurse...” (Parent 2)</td>
</tr>
</tbody>
</table>

Erm = Error; Parent = Parent of Child; Codes: (Parent 1) = Parent 1; (Parent 2) = Parent 2; (Parent 3) = Parent 3; (Parent 4) = Parent 4; (Parent 5) = Parent 5; (Parent 6) = Parent 6; (Parent 7) = Parent 7; (Parent 8) = Parent 8; (Parent 9) = Parent 9; (Parent 10) = Parent 10.
<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-category</th>
<th>Code</th>
<th>Descriptor</th>
<th>Quotes (selected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Media</td>
<td></td>
<td></td>
<td>Category</td>
<td>“But I think... no even if... because he does, he listens to the news. You know. And you often hear about you know, terrible stories where a father’s jumped off a balcony and taken his kids with him, you know, so... he’s often... to be fair he’s often asked me like, cos you know you get those cases where the father’s taken the kids and gassed them all in the car and stuff like that, and he... it horrifies him that someone could do something so awful. It horrifies me. And he has said to me, why would somebody do something like that, you know what I mean.” (Parent 8)</td>
</tr>
<tr>
<td>School</td>
<td></td>
<td></td>
<td>School</td>
<td>“Soaps we definitely watch. And Sam does watch sometimes if I’m watching them. I suppose in things like Eastenders there’s always issues isn’t there. I can’t think of a specific example where he’s asked me a question. But he would’ve definitely asked me, I’m sure, things related to different storylines I expect.” (Parent 4)</td>
</tr>
<tr>
<td>Children noticing</td>
<td>behaviour in community</td>
<td></td>
<td></td>
<td>“And me and Sam walked to Tesco and the lady that sits at the end of the road and she wears bells round her ankles and erm... she gets a bottle of vodka and sits at the end of the road and has it! So Sam will ask about things like that.” (Parent 4)</td>
</tr>
<tr>
<td>Issues in family</td>
<td></td>
<td></td>
<td></td>
<td>“Initially when Alana came back she seemed ok, but she’d lost a lot of weight and she started to show signs probably within maybe a few weeks, couple of months, of sort of, what I didn’t know at the time was sort of post-traumatic things. And behaviour at that point was quite off the scale. And that’s probably when Stacey would have had most conversations and things, so it’d be me going oh look Alana’s doing that because she feels like this.” (Parent 9)</td>
</tr>
<tr>
<td>Purpose (Us)</td>
<td>Promote child mental health</td>
<td></td>
<td>Promote resilience</td>
<td>“But I think the day-to-day stuff... so just trying to build up her immune system to a degree.” (Parent 6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Yeah, I think we try and sort of... we talk about how she thinks about things and how she approaches things and her own image of herself and her own self-esteem, and without trying to make it explicit.” (Parent 10)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“We’ve talked a bit about that. How to avoid stress, how to cope with it.” (Parent 1)</td>
</tr>
<tr>
<td></td>
<td>Promote good self-image</td>
<td></td>
<td></td>
<td>“I mean I bought him a book that had some techniques in it, like CBT type techniques, and he went through the book and picked a couple that he liked the look of himself and chose some strategies and we talked about how he might apply them.” (Parent 3)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------------------------------</td>
<td>------</td>
<td>------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Validate emotions</td>
<td></td>
<td></td>
<td>Validate emotions</td>
<td>“But I like to talk about... when she feels upset to say, well it’s ok to feel upset. And if she thinks she’s going to find something hard and is worried about thinks then its ok to feel those ways.” (Parent 10)</td>
</tr>
<tr>
<td>Help recognise feelings</td>
<td></td>
<td></td>
<td>Help recognise feelings</td>
<td>“But in as far as mental wellbeing, I talk a lot about her feelings and sort of try to identify her feelings and help her to identify her feelings if you see what I mean.” (Parent 2)</td>
</tr>
<tr>
<td>Link their feelings to body symptoms</td>
<td></td>
<td></td>
<td>Link their feelings to body symptoms</td>
<td>“And also, you know I said to Daisy, you’re very tired and you’ve got to remember that you’re tired. And when you’re tired, feelings are exaggerated. And how you feel. And therefore you’re feeling much more extreme about something than if you had not been feeling so tired.” (Parent 7)</td>
</tr>
<tr>
<td>Promote sharing feelings and worries</td>
<td></td>
<td></td>
<td>Promote sharing feelings and worries</td>
<td>“And then I talked to her about erm, anxiety, and that sometimes when you’re feeling worried about something your heart can beat really fast. Erm and that your breathing can speed up and you can start to feel really panicky. I said that can happen when you’re really worried about things.” (Parent 2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“…and if the people have had no one to talk to perhaps that’s what’s made them extreme in their behaviour or actions. You have to be able to talk about what’s on your mind or something that has happened, particularly if there is something worrying you.” (Parent 1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Erm, so I had several conversations with her at different times, erm about how it is important, you know, if there’s something wrong or she’s worried or she’s scared about something, she needs to talk to somebody about it.” (Parent 2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“When he was going through this phase when he was becoming an elective mute because he was feeling grumpy, I was saying to him, you know I cant help you sort it out if you don’t speak to me. So I think the overarching message probably is just keep the communication flowing and everything will be alright.” (Parent 3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Yeah... chat... talk about things. I think that’s my main goal, is to get them to talk, really. To deal with it before it becomes a massive issue. I think the longer they don’t talk about anything, again a problem can get worse and worse and worse... and that’s when I think it would affect you mentally. You need to get it off your chest. Yeah and talk about it really.” (Parent 6)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------------------</td>
<td>-------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Balance</td>
<td></td>
<td>Balance between talking and helping, and children learning to cope alone</td>
<td></td>
<td>“Yeah to a certain extent. I mean whilst I suppose I’m a relatively sensitive father, erm I’m not too keen to, I’m keen to certain extent to go, “ok that made me feel a bit rubbish, but I’m just going to get on with things”. And whilst I think it’s important if something’s really distressing him or worrying him to go... if something’s just upset him a little bit then to a certain extent say, well that does happen sometimes in life, and unfortunately you have to deal with it. So I’m keen to strike a balance where he can talk about the important stuff and that’s fine, but also some things you kind of have to deal with just yourself.” (Parent 5)</td>
</tr>
<tr>
<td>Approach (Us)</td>
<td>Deliberateness</td>
<td>Deliberate</td>
<td></td>
<td>“But, they’ve got to learn still with a certain amount, themselves. Otherwise they’re not gonna learn and every time something does happen they can’t always run to mum and dad... erm, especially when she gets to the age when she might not say anything.” (Parent 6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I’m not sure how much of a need here is at the moment in order to make things very clear and very explicit, due to the fact that her contact with people who might have mental health issues will probably be quite minimal... I suppose the area that we would focus on would be her mental health. And that would be hopefully reinforcing a positive way and encouraging her to be balanced and that’s its ok to feel certain ways at certain times.” (Parent 10)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I’m not sure that I particularly think about how I communicate mental illness. I think about how I would want to promote mental wellbeing in her.” (Parent 2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I mean I’ve not discussed depression or anything like that, which I suppose is the most accessible thing to discuss with him but no there hasn’t been any specific discussion of things like that. But maybe in general his state of mind and happiness and how he’s adjusting socially to his peers and social group.” (Parent 5)</td>
</tr>
<tr>
<td></td>
<td>Proactive</td>
<td></td>
<td></td>
<td>“So we touch on that every now and then. Whether they’re happy or sad in school, or in general, what the circumstances are or why... because I think that can have an impact on you.” (Parent 1)</td>
</tr>
<tr>
<td></td>
<td>Indirect approach</td>
<td></td>
<td></td>
<td>“Erm, you can sense something’s wrong, even if like I’d take her upstairs like she’d be in tears or whatever and I’d be chatting to her about it... and she’d, you know what I mean, open up a little bit more. I do try and get it out of them. But in a nice way. Just try and chat about the subject.” (Parent 6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“And I’m very keen to make sure he’s not unduly distressed or concerned about anything like that so I’m... on a number of occasions whenever he’s like that, whilst you may or may not have something, he might have just been being quiet, I might try to impress on him the fact that he can talk to people and discuss things that are worrying him...” (Parent 5)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------</td>
<td>------</td>
<td>------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“So if he wants to talk to me about something that’s triggered his bad-temper he’s quite clear about what the process is that he goes through to do that with me so we have a system. He takes himself off up to his bedroom. If he doesn’t come down within a certain amount of time, I know that he wants me to go up there.” (Parent 3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Erm, I mean say for instance I could see that something was troubling him, him personally then I might try to pry it out of him. Or at least make him feel comfortable enough that when he’s ready to talk about something he can come talk to me.” (Parent 8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“And then I’m a bit more, perhaps verbal. So I do... I mean I try not to be too intense. You know like if they come in, I’ll just go aah hi, how’s your day, and ask something lighthearted. And that gives them the opportunity if they want to to go actually my day was rubbish and this happened...” (Parent 9)</td>
</tr>
<tr>
<td></td>
<td>Problem-solving approach</td>
<td></td>
<td></td>
<td>“I think I’m typically male in the way that... I always like to have solutions to problems... I don’t like to, well we’ll just see how we get along with that... I don’t really like that. I prefer, well this is an issue or this is something to deal with, let’s deal with that and then we can carry on. And I think that’s probably quite a typically male approach, rather than just sort of wanting to talk about things. Right you want to talk about it because you’ve got a problem? Right ok, well lets try to solve it. “ (Parent 10)</td>
</tr>
<tr>
<td></td>
<td>Gender – parent and child</td>
<td></td>
<td></td>
<td>“Erm... again, because if we don’t know, we don’t know there’s a problem and we cant give her the best advice. So at least if she does tell us, like I said we can say, you’ve gotta take it on the chin, or we can do this, or that’s the best thing to do, or that’s the best way to handle it.” (Parent 6)</td>
</tr>
<tr>
<td></td>
<td>Facilitators and prompts</td>
<td></td>
<td></td>
<td>“Again and I do a lot of hours of work and stuff so I don’t have the opportunity like the wife does, the wife’s always chatting to them more. Erm, she’s at home a lot more than me so she obviously deals with a lot more as such.” (Parent 6)</td>
</tr>
<tr>
<td></td>
<td>Child’s ability to articulate their feelings</td>
<td></td>
<td></td>
<td>“And then she talks about something and as she’s talking about it I’m thining, she’s worked it out herself. She didn’t used to but now... she’s nine, and she’s sgetting to the stage where... And at the end of the conversation I say right, um what do you want to do about it, she went oh I don’t think I need to do anything, I’m fine now mummy, I realize my friends still like me, or my... teacher was being silly, or I was being silly about my teacher or... whatever the thing is so... erm, those are the kinds of situations I have with Daisy” (Parent 7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“And they probably would be able to articulate that they were feeling, erm, distressed or whatever or anxious or unhappy, persistently or whatever.” (Parent 3)</td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td>Quotes (selected)</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>-------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Parents’ common ground with child</td>
<td></td>
<td></td>
<td>“I feel as a parent, I’m not saying I’ve done it all, but done quite a few aspects... things I shouldn’t have done, a lot of things I shouldn’t have done. And I feel I can use that experience to help them. Where I’ve gone wrong, use that experience of going wrong and sort of cop them before they don’t do it... or at least give them my version of it as such.” (Parent 6)</td>
<td></td>
</tr>
<tr>
<td>Enjoyment of ‘intellectual’ discussion</td>
<td></td>
<td></td>
<td>“But I like... it’s better for me now they’re older I prefer being a parent to somebody who’s not at that kind of physical needy side, but is more psychologically demanding. And that’s more my interest really. So yeah I like to talk to them about things.” (Parent 3)</td>
<td></td>
</tr>
<tr>
<td>Availability of quality time and space</td>
<td></td>
<td></td>
<td>“Or, you know often, it’s funny enough, the places we seem to end up talking... and it took me a while to work out why it was there but it makes sense... would always be after picking daisy up from school, and in the car. And of course it’s a very secure place. It’s closed off. It’s our world, it only belongs to us, the car’s ours, it’s our space. It’s in her seat where she’s comfortable.” (Parent 7)</td>
<td></td>
</tr>
<tr>
<td>Prompts</td>
<td>Child seeming concerned</td>
<td></td>
<td>“Generally... “you alright?” and he says “yeah” “are you ok, so there’s nothing worrying you or anything like that?” “nah I’m fine” “you’re just a bit quiet are you?” “yeah I’m just being a bit quiet” “ok well you can talk to me if you want” “yeah I know Dad!”. And that’s generally how it goes down. So quite simple really.” (Parent 5)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>“Yeah I would think if he was worried or if he suddenly stopped speaking to me about something, if I noticed his behaviour was different.” (Parent 3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>“And Sarah, whenever she’s got something on her mind you can always tell because she goes a bit squirmly. And erm... it took a while to kind of get it out her.” (Parent 2)</td>
<td></td>
</tr>
<tr>
<td>Issues within the family</td>
<td>Issues within the family</td>
<td></td>
<td>“With Ed it’s very different, he has a learning disability, and he didn’t talk until a year ago, he’s four and a half now. Erm... and he was deaf until he was 3. So we’re in a very different space, but a lot of the talks that come with Daisy are involved with Ed, because he can get very very aggressive. Cos he’s very frustrated. So we’re having to deal with a lot of things, constantly.” (Parent 7)</td>
<td></td>
</tr>
<tr>
<td>Influences on child mental health (see above)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Child younger age</td>
<td></td>
<td>“And as she gets older, she starts to get a bit more shy about things, or she’ll say I don’t want to talk about this boy at school or things like that so I can see probably what’s going to happen as she gets a bit older” (Parent 10)</td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Sub-category</td>
<td>Code</td>
<td>Descriptor</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------------</td>
<td>-------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&quot;Because I said t hem, I talk to my daughter quite a lot, and very openly. And I feel, you know things might change because she’s 9, and when she's 14 she might not want to talk to me any more, because she might have internalized a bit more I don’t know. But right now she does approach me all the time.&quot; (Parent 7)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>“So... I think there will be times as she gets older that she’s not gonna let us know as much, as much as I’d like to think she would… I think that’s why we do chat... try chatting about it, so they do.” (Parent 6)</td>
<td></td>
</tr>
<tr>
<td>Barriers to communication</td>
<td></td>
<td></td>
<td>“But, they’ve got to learn still with a certain amount, themselves. Otherwise they’re not gonna learn and every time something does happen they can’t always run to mum and dad…” (Parent 6)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&quot;I would say most of the time. I do sit her down occasionally, and ask how are things. I mean she’s... the last year she’s been bullied. And erm... you know so I ask, not too often... I try not to because I don’t want to make it into a bigger thing than it is” (Parent 7)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>“So if I wasn’t sure... it depends if it was something really extreme... yeah I would probably... I think I would have a ‘ooh this is something I really need to stop what I’m doing and hear some more about, but I think generally we’re all quite busy people aren’t we, so we don’t kind of ...” (Parent 3)</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX K: Sample uncoded transcript

This has been removed from the electronic copy
APPENDIX L: Summary of findings for participants and ethics panel

Summary Report: July 2012: Parents’ communication to their primary school-aged children about mental health and ill-health: A grounded theory study

Why did we do this study?

- Stigma about mental health problems is common in the general public and has negative consequences for people experiencing these difficulties, such as making it difficult for them to seek help and making the mental health problem worse.
- We know that parents’ communications are highly influential in children’s developing attitudes, but we don’t know if this applies to views about mental health problems. Plus, almost nothing is known about the kinds of messages parents communicate to young children about mental health and mental health problems.
- We also know that many children and young people don’t receive help for mental health difficulties until things have reached a crisis point, and research shows this can be because parents are not comfortable in recognizing the problems, talking about this with their children, and seeking help.
- This study aimed to understand more about what is important to parents in communicating to their primary-school aged children about these issues, how they go about doing so, and why they approach it in this way.

How did we do this study?

In-depth interviews were carried out with ten parents of children aged 7-11 years (7 mothers, 3 fathers). Parents were drawn from different geographical, socio-economic, occupational, and cultural backgrounds, and varied in their experience and knowledge about mental health and mental health problems. Data was analysed using a method called Grounded Theory, which involves a thorough analysis of parents’ responses, drawing out common themes.

What did we find?

When describing their communications to children about mental health and mental health problems, parents tended to make distinctions between ‘Us’, which was associated with mental health, and ‘Them’, about people with mental illnesses. How much these two concepts overlapped in parents’ minds influenced the purpose and approach of parents’ communications on these issues. The diagram below illustrates the research findings.
Talking about mental health

- The study found that parents were happy and confident in talking about mental health (i.e. the psychological and emotional wellbeing of their child, family, and people they know – ‘Us’) with their children.
- Parents were very open with their children about mental health.
- Psychological problems experienced by ‘Us’ were talked about in terms of the understandable impact of experience and personality, using common terms such as ‘stress’, ‘mood’ and ‘worry’.
- Parents were also comfortable talking to their children about issues such as learning disabilities, neurodevelopmental disorders (e.g. autism), and physical disabilities, and thought children were able to understand these complex issues.
- Parents were aware of many influences on their child’s mental wellbeing and consciously aimed to promote children’s emotional wellbeing and resilience in a variety of ways. Parents were very skilled at this.
- Parents felt children were generally very accepting and understanding of mental health issues in others.
- Parents felt it was important to discuss these issues with younger children, as older children and teenagers might not be so open about their feelings.

Talking about mental health problems

- Parents were much less confident in discussing issues about ‘Them’ (people with mental illnesses), and tended to avoid this topic with their children unless they specifically asked. In response to questions, parents kept answers short.
• Parents often felt they did not have enough knowledge of mental illness diagnoses (e.g. “schizophrenia”) to discuss it, were concerned about the age-appropriateness of the topic, were worried children would be upset or frightened by the subject, thought children could misuse the information, or would not understand.
• Parents were keen to instil empathy for and acceptance of people with mental health problems in their children, and this was balanced with messages around safety and danger.
• Parents felt they would talk about mental health problems with their children when they were older.
• With the exception of depression, mental health problems were overall seen to be something that affects other people, and especially not children.
• Parents identified that mental health problems are stigmatized, but were not always aware of how much the taboo of mental health problems (the fact they are not generally talked about openly) affected their communication on the subject to their children (both verbal, and non-verbal, e.g. behaviours, emotions).

What influenced this?

• Several things influenced how much parents saw mental health and mental illness as overlapping concepts, and in turn how comfortable they were in discussing these issues with their children.
• The more these concepts overlapped in parents minds, the more they were happy to talk about mental health problems with children.
• In general, more knowledge about and experience with people with mental health problems meant parents were able to be more open with children about mental health problems. However, personal experience of mental health difficulties sometimes made communication about this more difficult.
• Parents’ experiences of how their own parents approached these issues also had an impact, and parents tried to do some things the same and some things differently, although sometimes patterns were repeated without parents being aware of this (e.g. not talking about family members with mental health problems).

What can we conclude?

• This study shows that parents have an excellent understanding of mental wellbeing and how to promote good mental health in their children, and are very open in their communication about these issues.
• However, because parents do not always see mental health problems (or mental illnesses) as the other end of this spectrum, or as something that could potentially affect them or their children, this topic was not always discussed as openly as parents might have hoped.
• The taboo of mental health problems may be impacting on how open parents feel they can be with their children about mental health difficulties.
What now?

- Parents noticed that lots of issues that used to be taboo (such as learning disability, physical disability, ethnicity) are now more openly discussed, and hoped that the same thing could happen with mental health issues in the future.
- This study suggests that certain things could result in parents feeling more confident, and lead to more open communication about mental health problems between parents and children.
- Messages to help parents use their existing skills in talking about mental health in order to discuss mental health problems more easily could include:
  - Helping parents to see mental health problems as one end of a spectrum of psychological and emotional wellbeing, and therefore that discussing these kinds of difficulties does not necessarily require any ‘special’ knowledge of diagnostic terms.
  - Bringing parents’ awareness to the fact that taboo and stigma can unconsciously impact upon their plans to be open with their children about mental health problems and people with mental health problems. This in turn might impact on the kinds of views children develop about mental health problems (i.e. that it is not something that is openly talked about).
  - Letting parents know that mental health problems might be something that could affect them or their child, as many mental health problems develop in childhood or early adolescence (affecting 1 in 10 children, and 1 in 4 adults in their lifetimes). Open communication can be crucial in promoting emotional resilience, and in seeking help at an early stage.
  - Reassuring parents that, as they reported, children are very accepting of mental health difficulties. Parents also felt children were able to understand similarly complex concepts (e.g. learning disabilities) and research tells us that children can understand and cope with the concept of mental health and mental health problems from age 7 onwards. Other research shows us that children of this age generally want more information about mental health problems than parents currently give them.

We would like to offer heartfelt thanks to you for taking part in this study, and for so openly sharing your thoughts and experiences on this subject. It is hoped the results of this study will be used to develop programmes to help reduce the stigma of mental health problems, through working collaboratively with parents and children.

If you have any questions about this summary, please contact principal researcher Jo Mueller on j.m.mueller39@canterbury.ac.uk or on 01892 507673.