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Parents' communication to primary school-aged children about mental health and ill-health

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Structured Abstract:

Purpose: Stigma around mental health problems is known to emerge in middle childhood and persist into adulthood, yet almost nothing is known about the role of parents in this process. This study aimed to develop a model of parental communication to primary school-aged children around mental health and ill-health, to increase understanding about how stigma develops.

Design/methodology/approach: Semi-structured interviews were performed with ten UK-based parents of children aged 7-11 years. Analysis followed an exploratory Grounded Theory approach, incorporating quality assurance checks.

Findings: Parents' communications are governed by the extent to which they view a particular issue as related to 'Them' (mental ill-health) or to 'Us' (mental health). In contrast to communication about 'Us', parental communication about mental 'illness' is characterized by avoidance and contradiction, and driven by largely unconscious processes of taboo and stigma.

Originality/value: This study was the first to explore parents' communications to their 7-11 year old children about mental health and mental illness, and proposes a preliminary theoretical model that may offer insight into the development of stigma in childhood and the intergenerational transmission of stigmatized attitudes.

Social implications: This study supports an agenda to tailor anti-stigma interventions for parents of young children, promoting a continuum model of mental health and ill-health that emphasises the commonality of mental health problems (rather than "Them" and "Us"). This may lead to more open parent-child communication about mental illness, and in turn, reduced stigma and improved help-seeking.

Keywords: Mental health; mental illness; stigma; parent-child communication; intergenerational transmission; anti-stigma interventions; help-seeking; grounded theory.

Word count: 2046 (excl. abstract & references)

Background

The stigma towards mental health problems remains persistent and pervasive despite anti-stigma policy, campaign and intervention efforts (Hinshaw, 2007; Mehta, Kassam, Leese, Butler, & Thornicroft, 2009). However, existing interventions have focused upon adult or adolescent populations; little research or theory has investigated how children initially develop stigmatized views about mental health problems, nor how stigma may be perpetuated intergenerationally.

Stigmatised attitudes towards people with mental health problems (MHP) are reported from age 7-8 years (Hinshaw, 2005; Wahl, 2002). From 7 years, children begin to develop the cognitive ability to conceptualise mental illness as distinct from physical illness, to form attributions about unseen mental health problems and to develop greater complexity in their understanding of in-groups and out-groups (Corrigan & Watson, 2007; Couture & Penn, 2003; Fox, Buchanan-Barrow, & Barrett, 2010). These abilities form the cognitive basis for childen to develop stigmatised views about mental illness.

The theoretical framework of Aboud (2005) proposes that socializing experiences operate alongside cognitive mechanisms in the development of stigmatized views in children. Parents are a crucial social influence in children's development of attitudes, yet only one study to date has investigated the relationship between adolescent and parent attitudes towards people with MHP, finding a significant association (Jorm & Wright, 2008). Almost nothing is known about the parent-child communications that might influence children's developing views about mental ill-health (Hinshaw, 2005; Mueller, Callanan, & Greenwood, under submission). No studies have reported on parental communication about MHP to children at the age when stigmatized views begin to develop.

Present study

This study aimed to address this gap in the literature by exploring parental communication about mental health problems to primary school-aged children (7-11 years). An exploratory Grounded Theory (GT) approach was chosen, given the limited theoretical and empirical understanding in this area.

Method

Participants

Ten parents (7 mothers, 3 fathers from separate families) of children aged between 7 and 11 years were recruited through three primary schools in the south-east of England. Participants were theoretically

sampled, in accordance with the GT process, and varied demographically and in their experience with MHP (Table 1).

Table 1: Participant demographics

ID	Gender (M=male; F=female)	Age (years)	Child (G=girl; B=boy)	Ethnicity	Education	Professional experience of MHP	Personal experience of MHP	Familial experience of MHP
1	F	40	**B10, B8, B7**	Caucasian	A Level	No	No	No
2	F	33	**G8,** B5	Caucasian	A Level	Yes	Yes	No
3	F	41	**B10**, G12	Caucasian	Post-graduate	Yes	No	No
4	F	30	**B7**, B0.5	Caucasian	A level	No	No	No
5	M	30	**B9**	Caucasian	Professional qualification	No	No	No
6	M	34	**G11,** B12	Caucasian	School	No	No	No
7	F	42	**G9,** B4	Caucasian	Professional qualification	No	Yes	No
8	F	40	**B11**	Caucasian (African)	Undergraduate degree	No	Yes	Yes
9	F	40	**G9,** G13, G15	Caucasian (Traveller)	School (limited)	No	No	Yes
10	M	30	**G8**	Caucasian	Post-graduate	No	No	No

Procedure

Ethical approval for the study was obtained from Canterbury Christ Church (Salomons) Research Ethics Committee. 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. Efforts were made to minimize socially desirable interview responses by reassuring parents about the purpose of research and the neutrality of the researcher.

Analysis

Data were analysed according to the GT approach of Strauss & Corbin (1998). The quality of the analysis was ensured according to guidelines for qualitative research (Mays & Pope, 2000; Williams & Morrow, 2009) through memoing and diagramming, data triangulation through coding parents' written notes and observations during interviews, independent secondary coding of transcripts, and use of a reflective research diary. Emergent themes directed adaptation of interview questions as part of the theoretical sampling process, and assessment of theoretical saturation. A preliminary theoretical model was generated.

Results

The preliminary theoretical model (Figure 1) gives an overview of the study findings, described below. All names used are pseudonyms.

1. Us and Them

The core category was 'Us & 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' mode or '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.

Within 'Us' were issues that parents were happy to talk about with their children, including learning and physical disabilities, and emotional wellbeing of known people, using lay language such as 'stress', 'mood' and 'worry'. In contrast, when talking about 'Them', parents described people they did not know, using psychiatric diagnostic labels or simple, stigmatized phrases, and describing dangerous or unusual behaviour.

>   *"We saw a man in the street… it turned out that he'd just been released from… a hospital, and he was bipolar. He was wearing a dressing gown. And he had shaving foam all over his face."* *(Parent 3)*

>   *"I've said just some people who aren't right in the head and do silly actions and hurt other people."* *(Parent 1)*

1.1. Degree of overlap

Parents' understandings of 'Us' and 'Them', and of mental health and mental illness, were sometimes overlapping and sometimes distant.

"Pictures that spring to mind are probably stressed mums… 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)

At other times, parents' descriptions showed a merging of these two models. For example, depression was seen as a 'grey area' that was more easily accommodated in the concept of 'Us'. Parents noticed that children had a greater overlap of 'Us and Them', describing children as being naturally accepting and not fazed by MHP. However, parents did not see MHPs as an issue affecting their own, or other children.

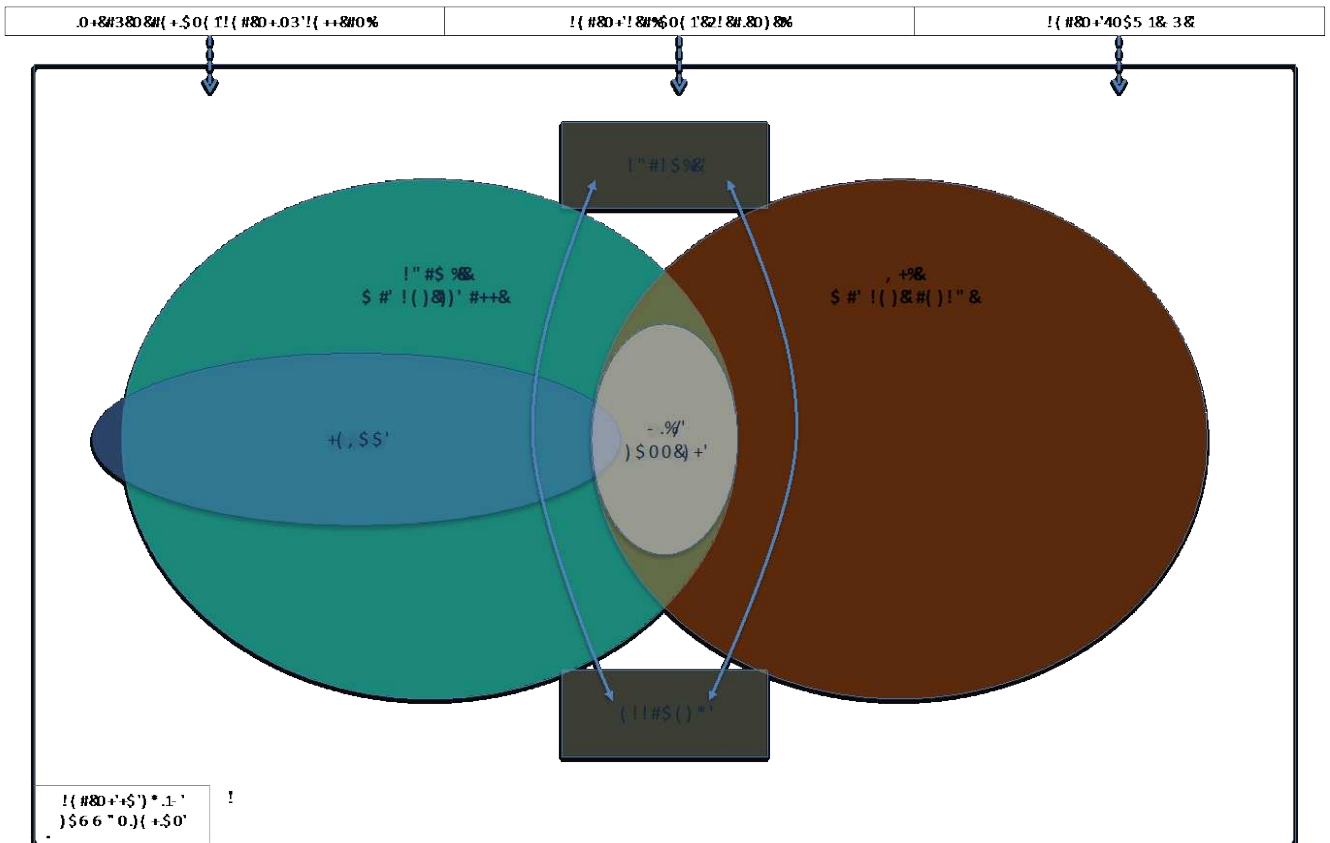*"I think I've always assumed she wouldn't have any mental health problems" (Parent 10)*

Figure 1: Theoretical model: Parental communication to children around mental health and mental illness

2. Purpose & Approach

Parental communication to children about mental *health* ('Us') is deliberate, comfortable, and aims to promote child wellbeing through both facilitating help-seeking and emotional resilience. In contrast, communication about mental 'illness' is characterized by avoidance and ambivalence. Parents take a reactive, rather than a proactive, approach to discussions about mental ill-health and limit the amount and

depth of information. Parents' intentions in communicating about mental illness ('them') to their children clustered around two main purposes: acceptance/empathy, and protection. Reasons not to communicate about mental illness are numerous and relate to mental illnesses happening to 'Them', not 'Us'. Parents felt they would talk to their child about MHPs once they were older.

> *"I do try and steer clear of it... 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." (Parent 6)*

3. Parental experiences impacting on conceptualization of Us and Them

3.1. Parental knowledge and experiences

Greater parent knowledge about mental health issues from education or work, and greater experience of cultural openness, led to a more overlapping view of Us and Them and more open communications. However, personal or familial experience of MHP did not necessarily promote communication to children.

> *"I got post-natal depression… and Daisy went through that. Now, I've never told her I had depression." (Parent 7)*

3.2. Intergenerational parenting patterns

Parents either consciously aimed to replicate their own parents' approach to communication around mental health and illness, or to do the opposite.

> *"I didn't have a very good understanding of mental health… I was just a bit scared... So I'd probably try to do the opposite and make sure he does understand it as he gets older." (Parent 4)*

However, unconscious processes of replicating patterns from parents' own childhoods often undermined their intentions, perpetuating the cycle of stigma and silence. Some parents began to reflect on this during their interview.

> *"…We just say well, they're from the Blue unit. But he probably hasn't got a very good perception of that place. I should probably explain it better…" (Parent 4)*

4. Taboo and stigma

Taboo and stigma were key, and often unconscious, influences on parents' purpose and approach to communication about 'Them' and mental illness. Parents' interview responses about mental illness were characterized by awkwardness: using terms such as 'erm' and 'um', and frequent fidgeting. Consciously, parents noted that mental illness is a stigmatized condition, and that stigmatizing language is in common parlance. However, most parents, including those with personal experience of stigma and MHP, felt the taboo of mental illness only impacted the communications of other parents.

Parents' complex and overlapping understanding of mental health and illness, alongside the impact of taboo and stigma, led to contradictions in their responses about which parents were often unaware. For example, all parents aimed to be open in their communication with their children about mental health and ill-health, however openness did not characterize the latter. Parents' beliefs that they will discuss mental ill-health when children are 'older' were universal, irrespective of their child's age. Parents reported their children were able to understand mental ill-health, but used children's lack of understanding as a reason to avoid communication, and justified not discussing mental illness as it was not affecting their family, but later described their own or family members' MHPs. Some parents began to reflect upon the impact of their silence and these contradictory messages:

> *"I'd dislike it very much if {child X} thought that mental illness 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… I wonder if that perhaps leads to a stigma attached to it because you don't know about it." (Parent 10)*

Discussion

This study offers a preliminary theoretical model of parental communication to primary school-aged children around mental health and ill-health that may offer novel insight into the development of stigma. The overarching finding from this study is that parent's communication with children about mental illness is largely governed by the extent to which they view this as happening to 'Them' or 'Us'. This is significant societally because the message that MHPs happen to others ('Them') perpetuates stigma and difference (Link & Phelan, 2001; Corrigan et al., 2001), and 'clinically' because this message promotes self-stigma, silence and taboo when mental ill-health develops (Hinshaw, 2007). This study suggests taboo and stigma undermine parents' conscious efforts to be open about mental ill-health, and lead to limited and contradictory communications (see Ottati et al, 2005).

The finding that parents of children in middle childhood offer communications that clearly separate 'Us' from 'Them' with MHPs dovetails with findings that from age 7, children develop greater complexity in their understanding of people with MHP as an out-group (Couture & Penn, 2003; Link & Phelan, 2001). This study lends weight to the hypothesis that the stigma around MHP may be partially perpetuated via conscious and unconscious intergenerational patterns of parent-child communication. Parents' verbal and non-verbal awkwardness and fear when discussing mental illness may be transmitted to children via mechanisms such as learning and conformity (Aboud, 2005; Allport, 1954), modeling of parental anxiety (Fisak & Grills-Taquechel, 2007; Murray et al., 2008), via misattribution or classical conditioning processes

(Ottati et al., 2005), or through communication of opaque cultural knowledge via 'natural pedagogy' (Csibra & Gergely, 2009). Further research is indicated.

This study provides a preliminary theoretical model that should be developed and tested in future research. Limitations of this work that should be addressed in future studies include:

- The limited size and breadth of the sample.

- The potential impact of stigma and social desirability on parents' responses, despite the use of some of these unconscious processes as study data.

- The inherent difficulty in assessing whether total data saturation had taken place, even with a rigourous GT process; 'sufficient saturation' may be more realistic (Strauss & Corbin, 1998).

- That study findings are best understood as a social construction between the researcher and participants (Charmaz, 2006).

This study indicates that multi-contextual anti-stigma interventions should target parents in order to address intergenerational communication patterns around mental health problems. The model indicates the following messages would promote more open communication about mental ill-health:

- o Increasing parents' identification of mental ill-health as part of a spectrum of mental wellbeing.

- o Helping parents to draw on their existing knowledge about mental wellbeing to become more confident in talking about mental ill-health.

- o Alerting parents to the fact that MHPs can affect all of us, including around one in ten children in the UK (Meltzer, Gatward, Goodman, & Ford, 2003).

- o Reassuring parents about children's ability and need to understand mental health problems.

- o Letting parents know that open discussion can promote help-seeking for MHP (Ford, Hamilton, Meltzer, & Goodman, 2008), which can reduce distress and increase treatment success.

- o Drawing parents' unconscious beliefs and practices around communicating to children about MHPs into their awareness.

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