“My Dad Got Depression, or Something”: How Do Children Talk about Parental Mental Disorder?

MAARIT ALASUUTARI¹ AND ANU JÄRVI ²

¹University of Tampere, Tampere, Finland
²University of Jyväskylä, Jyväskylä, Finland

The research about children affected by parents with mental disorders has suggested that information and an understanding of the parent’s problems are important factors in the child’s resilience. Therefore, increasing the child’s understanding has been defined as a key element in many preventive interventions. However, there is little research about children’s conceptions of parental mental disorder. The article examines the discourses (vocabularies) that children use as their resources when talking about a parent’s mental disorder during a qualitative research interview. It pays special attention to the interviewer-child interaction. The data come from interviews with ten Finnish children. The results show that the children employ three vocabularies in the interview: the professional, the empirical, and the vocabulary of concern. The results illustrate the importance of looking at the nuances of adult-child interaction. They also question the self-evident use of a medical discourse in giving information about the parental problems.

Keywords: children; discursive framework; interview; parental mental disorders; vocabulary

Introduction

During the last decades there has been a growing interest in research about children living with parental mental disorder. The research has typically examined the developmental vulnerability of the children. It has shown that the children of parents with mental disorder are at risk for psychiatric problems (e.g., Beardslee & MacMillan 1993; Lieb et al. 2002; Nomura et al. 2002; Smith 2004). The heightened risk has been attributed to genetic vulnerability (e.g., Kendler et al. 1999); family dynamics, such as parenting and the child-parent relationship (Berg-Nielsen et al. 2002; Bifulco et al. 2002; Smith 2004; Webster-Stratton 1990); and social-environmental factors (e.g., Leinonen et al. 2003).

In addition to the developmental risks, there has been an increased interest in research on the resilience of children affected by parents with mental disorders. This research has suggested that information and an understanding of the parent’s problems are important factors in the child’s resilience. They are assumed to be significant in enhancing the well-being of the child by preventing false beliefs in the child, for example, feelings of guilt and responsibility for the parent’s problems (Cogan et al. 2005a; Focht-Birkerts & Beardslee 2000; Garley et al. 1997; Kinsella et al. 1996; Place et al. 2002). Therefore, increasing the
Consequently, the research on the efficacy and effectiveness of the preventive interventions is often interested in the changes in the children’s understanding of a parent’s problems (Beardslee et al. 2003). The focus of the research is then on the potential increase in the children’s understanding. However, this approach does not inform about the ways that the children make sense of the parent’s mental problems. This article aims at looking at this question.

In all, there is little research about children’s conceptions of parental mental disorder (Gladstone et al. 2006) and of their descriptions of mental disorders in general. Spitzer and Cameron (1995) have studied how school-aged children define and characterize the mentally ill. They have found that for most of the children the term mental illness is unknown, but their definitions of the term “crazy” are closer to adult definitions’ of mental illness. Secker and others (1999) and Armstrong and others (2000) have reported results from a research project that studied the understanding of mental health and mental illness of young people aged 12–14. Secker and others (1999) found that when the young people can identify with the example behaviors from their own experience, they define them as being in the bounds of normality. However, when they cannot identify with the behavior, they classify it as mental illness. Armstrong and others (2000) concluded that the understanding of the term mental health is often uncertain but feeling mentally unhealthy is more easily described. Also, Cogan and others (2005b) have shown that both children living with parent’s with mental problems and nonaffected children experience difficulties in defining what is meant by mental health problems.

These studies show that children’s understanding of mental problems cannot be easily approached with the language that is used in research literature and among clinical professionals. The terms mental health problems or mental illness can be vague to young people. How is it then possible to discuss a parent’s mental problems with them, for example, in prevention groups? What is the language or discourse that would communicate with young people? To answer these questions, qualitative research, with its emphasis in attempting to make sense of the meanings people bring to the phenomena under study (Denzin & Lincoln 2000), provides a workable methodological framework. The need for qualitative inquiries has also been presented by Ungar (2004), who criticizes the conventional research on resilience as uninformative in enlightening children’s own perspective on their culturally embedded ways to remain healthy. He argues for a constructionist perspective on resilience and for a more comprehensive picture of the lives of children under adversity, which can be approached through qualitative inquiry.

However, only a few qualitative studies have considered parent’s mental problems from the perspective of the offspring. The research by Cogan, Riddell, and Mayes (2005b), as well as studies by Aldridge and Becker (2003) and Aldridge and Sharpe (2007), are among the few exceptions. Otherwise, qualitative studies have typically used adult offspring, as children’s experiences and viewpoints have mostly been inferred from adult perspectives. More research with children is needed to learn about their notions of parental mental problems (cf. Gladstone et al. 2006).

This article focuses on children affected by parental mental disorder. It studies the talk of these children and their accounts of the parent’s problems during a qualitative research interview. It asks what the discourses are that the children use as their resources when they talk about a parent’s mental disorder and how they use these discourses. However, the article does not assume that the question is only about the child’s use of particular discourses. Instead, it takes the view that the interview is a co-construction (see, e.g., Rapley 2001) and, hence, of the interviewer as a co-participant in developing the emerging accounts.
Therefore, the article studies also the function of the talk about parental mental problems in the interviewer-child interaction. 

The following section describes the methodological approach of the article and the data of the study. It is followed by an analysis that introduces the discourses or “vocabularies” of parental mental disorder. They are the professional vocabulary, the empirical vocabulary, and the vocabulary of concern. Finally, the findings are discussed and their implications for clinical and counseling work are considered.

Social Constructionism and Discursive Approach as the Methodological Framework

This article assumes a discourse analytic framework. Hence, it is based on a social constructionist epistemology and does not share the conventional idea of language as merely a medium of communication and a mirror of the world. Instead, it takes a view of language as a social practice and as a way of doing things. Language and discourse are assumed to be elemental in constructing the ideas, social processes, and phenomena that make up the social world. Therefore, the ways in which the individual makes sense of the surrounding world are understood as being constructed through language and as rooted in social interaction (Gergen 1999, pp. 46–50; Nikander 2007, p. 413; Wood & Kroger 2000, p. 4).

Consequently, the research interview, which comprises the data of this article, is understood as an interactional event. The interview talk and the knowledge in an interview are always co-constructed; they are produced between the participants (Holstein & Gubrium 1995; Rapley 2001). The interviewer’s questions are not taken as a medium into the interviewee’s – in this case the child’s – inner world, experiences, and opinions but as an essential part of the data (Nikander 2007, p. 418). Accordingly, the child’s talk is not approached as a reflection of her or his inner thoughts and feelings but rather as an account that is situated and contextual. It is studied as ensuing from and orienting to the prior talk in interaction and as providing the environment for what follows after it (Potter & Hepburn 2007, p. 277). The interviewer’s talk is understood as producing a particular kind of frame or condition for the child’s talk and, hence, constructing it, and vice versa. Therefore, the main interest of the article is not on the content or on the “what” of the children’s talk. Instead, the focus is on how the parental problems are talked about and accounted for in the interviewer-child interaction (cf. Holstein & Gubrium 1995, p. 16).

In addition to the immediate interactional context, the interview talk is situated institutionally (Holstein & Gubrium 1995). In this article the question is, first, about the institution of interviewing. The talk with the children followed a shared understanding about the course of the interview interaction and about the roles of the participants. However, from the children’s perspective, the situation of data gathering could be seen as bearing a resemblance to a counseling discussion with which they all were familiar. The interviews took place in an organization that the children knew from their experience to be for counseling family members of the mentally ill. The discussion dealt with parental problems that had been the reason for the children’s earlier visits to the organization, and the interviewers were known to the interviewees as professionals in mental health. The institutional context of counseling became evident also in the interviews, as the analysis will later reveal. In addition, the interview talk was generated within the institution of generational order. Previous research has shown that the asymmetry of the adult-child relationship is often the starting point for the children when they engage in a dialogue with an adult. They assume an inequality between their status and that of the adult, for example, regarding power relations in the interaction (see Mayall 2002). The asymmetry is also salient
in clinical and counseling settings (Cederborg 1997; Hepburn 2005; Hutchby 2002, 2007; Silverman et al. 1998). Therefore, the article aims at being sensitive to the effects of the adult-child asymmetry in the talk about the parental mental problems.

The article applies a data-driven approach to the analysis of the interview talk. Hence, the analysis does not take as its starting point any particular view of the effects of a parent’s mental difficulties on the offspring or any ideas of a specific preventive or supportive intervention. In the process of analysis, the interviews have first been transcribed verbatim and then read and re-read carefully. All the episodes and talk dealing with parental mental problems have been differentiated for further analysis. This bulk of data has been investigated by keeping in mind not just what is said but also how the talk is produced in interaction. Hence, the focus of the analysis has been on various aspects of discourse (e.g., pauses, intonation, word choice, repetition) and their function in the interaction. Different ways to categorize the talk have been developed and tested with the aim to refine the analysis so that the categorizations would hold throughout the data (Alasuutari 1995, p. 14). The concept of vocabulary has been used as the analytical tool. It refers to the wordings that can be defined as a coherent lexicon because of their semantic similarity and because of the similarity of the alignment and the positioning of the interlocutors and of the characters and objects of the talk (Goffman 1981, pp. 124–157).

The data of this article come from a study where ten Finnish children (aged 8–12) and their parents were interviewed after a peer group intervention for families with parental mental disorder1. The intervention consisted of twelve weekly peer group meetings for the parents and for the children at a family organization for the mentally ill. The content of the intervention was informed by the ideas of psychoeducation and by the principles of the Beardslee Preventive Family Intervention program (Beardslee et al. 2003; Beardslee et al. 1993). Its aim was, among others, to give the participants information about mental disorders (as illness) and to provide them an opportunity to share their experiences with people living in a similar situation. The interviews were done to get feedback about the group intervention for the family organization. In addition, the researchers wanted to study the meanings of the parental mental health problems from the family members’ perspective.

The parents were first contacted by a letter in which they were informed about the aims and the procedures of the study. Then they were asked about their interest in participating in it by phone. Of 12 families nine took part in the study. However, in one family the adolescent did not an assent to the interview. Thus, the ten interviewed children came from eight families. Five of them had just gone through the intervention, three children had had it a year before and two had it two years before the interview.

In four of the families the mother was or had been suffering from depression. In one family both parents had mental problems; the father was diagnosed with bipolar disorder and the mother with depression. In one family the father suffered from depression. In addition, there were two families with a history of a divorce and with paternal mental disorder. From these families only the mothers (and the child/children) had gone through the intervention and took part in the study. However, the children were in contact with their father. All the parents with mental health problems had been or were patients at a psychiatric clinic. Some of them had been hospitalized at some point but not recently. Two of the mothers had taken an early retirement because of a mental disorder and one of the fathers was retired because of physical impairment. The other parents were either working or studying in adult education.

The interviews took place in spring 2005. There were three interviewers of whom two were counselors in the family organization and also graduate students at the university (graduate and postgraduate level). One writer of this article acted as the third interviewer.
The counselors were known to some of the family members, although counselors did not interview a parent or a child who had been their client earlier on.

The children were interviewed individually but before the start of the interview the interviewer met with the parent and the child. The interviewer explained the aims and the practices of the interview and asked them to sign the informed consent.

In the interviews the peer group intervention, parental problems, family life, school and other everyday issues were discussed with the children. The length of the interviews varied between 45 and 80 minutes. The interviews were audio recorded and transcribed verbatim.

Results

Professional Vocabulary

Professional vocabulary refers to the use of medical and psychiatric language. It includes diagnostic terms, such as bipolar disorder and personality disorder, and terms which are used both in professional language and in the vernacular, for example depression. In professional vocabulary the parental problems are framed by the concept of illness.

Almost all the children employed the professional vocabulary in the interviews. The vocabulary came up typically when the interviewer asked about the child’s understanding of the aims of the interview or about the reasons of her/him attending the peer group intervention. At these points the children introduced the vocabulary by responding with professional terms even though the interviewer was not using it in her talk. Most commonly, the children used the terms depression, mental health, and illness. In Finnish, illness is an everyday word although it is associated usually with physical symptoms. Depression is a common term in everyday speech and in the media. However, it is often used also when referring to “normal” changes in mood. The term mental health is typically associated with official and professional language. It comes up often in the media but it is not used in the vernacular that much, especially not by young people (Tuominiemi & Välimaa 2008).

In the following excerpt an 11-year-old boy, Tomi, uses two of the above mentioned terms. He employed the professional vocabulary already at the beginning of the interview when the interviewer asked about his understanding of the aims of the discussion. At that point Tomi used the term “mental health” in his response. A little later when he is asked about his attendance in the intervention program he introduces the term depression.

Excerpt 1, Tomi

1 I: (3) What do you think why did you ((Tomi and his parents)) come to
2 the group (.). or why did you ((Tomi)) come there
3 T: (3) Well when my dad got depression “or something”
4 I: Yes
5 T: “Mm”
6 I: (1) How much did you talk about the depression in the group
7 T: Well (2) not really very much
8 I: Yes (3) what well erm how much do you have information about
9 depression
10 T: Well: (1) “not really anything”
11 I: What do you think what depression then actually is
12 T: Well that (1) that like one has (.). some (1) mental health problems “or
13 something (.). it- “(“)” (1) one doesn’t like have money or something (1)
14 “something like that”
Tomi refers to his father’s depression as the reason to attend the group intervention. In this account he signifies his awareness of the context of the intervention, the parental disorder. The pause before his response, the hesitation at the end of it, and also his use of a low tone of voice (line 3) indicate that giving the answer is somehow problematic for him. The problems in answering are manifested also when he describes his view of depression (lines 12–14). His response shows several pauses, a change in the intonation of his voice, the abrupt termination of a word, and hesitations especially manifested by his recurrent use of the words “some” and “something.” These kinds of perturbations in speech are typical in our data when the children employ professional vocabulary. Often, the word “some” or an analogous word precedes or follows the professional term in their speech.

In research perturbations in speech have been interpreted as signs of delicacy (Linell & Bredmar 1996; Silverman & Peräkylä 1990). It seems that also in some cases in our data they signify the sensitivity of naming the parental problems by using professional vocabulary. But why would using the professional vocabulary be sensitive or delicate for the children? The discussion takes place in a family organization that they know well and that expects that there is mental illness in the family. In addition, as the analysis will show, the children seem to be ready to talk about parental problems by using other vocabularies. This article suggests that the delicacy of the professional vocabulary can reflect the child’s recognition of the social stigma of mental disorders. As Hinshaw and Cicchetti (2001) state, even the label of mental disorder fuels stigmatization (see also Corrigan 2007). Thus, naming the disorder by using professional terms implicitly produces stigmatization.

However, it seems that delicacy is not the only explanation for the perturbations of speech that are evident in the use of the professional vocabulary. Often the children’s difficulties and insecurity show that the professional vocabulary does not function as a resource for them to make sense of parental disorder. It seems that the children have difficulties in connecting the vocabulary to their everyday experiences. Therefore, their descriptions of parental problems do not evolve further when they use the professional vocabulary but end with the expressions, implying uncertainty (cf. lines 12–14 in Extract 1).

The problems in connecting the professional vocabulary to their everyday experiences show in the way the children use the vocabulary and also in the content – or in the “what” – of their responses and descriptions. Many of them talk about the invisibility of the parental mental problems. Excerpt 2 is an example of this. It is from an interview with an 8-year-old boy, Veeti. Before the following excerpt Veeti has named selfishness and depression as the illness his father is suffering from. The interviewer then inquires about Veeti’s view of his father’s illness.

Excerpt 2, Veeti

1 I: (. . .) What do you think what do they actually (.) mean or (.) or (.) or
2 what does it (.) how does it show in your daddy that he has [that kind of]
3 V: [Well: like]
4 I: Illness
5 V: Well selfishness shows in him in such a way (.) that he never thinks of
6 anyone else (.) and is terribly selfish
7 I: =Mm
8 V: Depression (.) I don’t quite see in him

For Veeti, selfishness is something he can make sense of and explain based on his everyday experiences. After the episode in Extract 2, he gives an example about his father’s sudden
disappearance on a trip as an example of his selfishness. However, depression is not possible for him to notice. This view is common in our data. The children often describe how it is very hard or even impossible to perceive the parental disorder. In addition, some of them describe the problems as permanent but also invisible; they may disappear but then they come back again, even when one does not notice them. Thus, recovery is not possible in these descriptions (Corrigan 2007). Hence, the employment of the professional vocabulary may position the children in a situation that is constructed as unpredictable. The invisibility, incurability, and unpredictability which children associate with mental disorders do not give them a means to foresee the wellness (or the illness) of the parent. In addition, they make it more difficult for the children to depict a positive future for the parent and for themselves.

In all, the professional vocabulary does not seem to function very well as a resource for the children to make sense of parental mental problems. In addition, it may invite implicit stigmatization of the parent and hence, of the family and the child. Why then do the children introduce it in the interview? Why do they try to have a discussion with terms that seem to be difficult for them? Aronsson and Hundeide (2002) suggest that children’s interview responses should be read in terms of relational rationality, which involves a local and contextual logic. Relational rationality refers to the children’s rational desire to align themselves with their co-participants and to their sensitive attunement to the attitudes of others. Thus, children’s interview responses should be considered in their interactional context and not just on face value. The children’s employment of the professional vocabulary in our data seems to be a prime example of the relational rationality. The use of the vocabulary can be seen to be functional from the perspective of child-interviewer interaction. Even though its use seems to be problematic for the children, they employ it as a means to align with the interviewer as the professional in mental health. The children inform the interviewer of their knowledgeable position in the interaction by showing that they are aware of the (institutional) setting they are in and of the language used in it. Hence, the use of the vocabulary marks and produces the child’s social competence (Hutchby & Moran-Ellis 1998, pp. 14–15).

As the use of the professional vocabulary implies the child’s attunement to the professional context of the situation, it also produces and underlines the asymmetric relationship between the interviewer and the child within this context. The asymmetry can be constructed also by the interviewer’s questions. In Extract 1 this is shown in the interviewer’s inquiry about Tomi’s knowledge of depression (lines 8–9). These kinds of inquiries resemble a school-like situation; the interviewer is positioned like a teacher who is evaluating the child’s comprehension. The evaluation implied in the interaction can make it more problematic for the child to answer the interviewer’s inquiries because of the assumed risk of failure. Hence, the asymmetric relationship constructed in the professional vocabulary can partly explain the difficulties in its use.

Empirical Vocabulary

Even though the descriptions of parental problems do not usually evolve from the professional vocabulary, there are many accounts in which the children depict their view of the parental disorder in the present data. The child’s everyday observations of the parent are used as the basis of these descriptions. Thus, the children talk about the issues that they may observe, hear, and experience in their interaction with the parent. The descriptions are classified as belonging to the empirical vocabulary. The vocabulary consists of
the descriptions of a parent’s state of mind, her/his everyday actions and functioning, and her/his way of interacting with other people, mostly family members.

The empirical vocabulary is used by all the interviewees. However, the child bridges the professional and the empirical vocabulary and moves from naming the disorder to explaining it in an everyday context only in a few cases. More often, the move seems to be possible only after the interviewer applies the empirical discourse herself or dissolves the asymmetric relationship produced by the use of professional vocabulary. The latter is often done by contextualizing the question explicitly in the home environment and by positioning the child as an agent who is able to see and perceive issues. In some cases the questions concerning the peer context seem also to dissipate the asymmetric relationship, like in the following excerpt. It is from an interview with 12 year-old Juho. Before the episode, Juho has told that in the intervention he has learned a lot about bipolar disorder which his father is suffering from. However, when the interviewer asks about the issues he has learned, Juho does not specify in his answer but only repeats his previous statements. Then the interviewer reframes her question and positions Juho as an agent in a peer group context.

Excerpt 3, Juho

1 I: What if for example some (.) let’s say (.) a boy whose well (.) who
2 wouldn’t have been to that kind of group (.) [would]
3 J: [Yeah]
4 I: come and ask you what is (1) well that bipolar mood disorder so what
5 would you (.) answer him
6 J: Well I would just say that (1) the (1) mood changes so that one is in a
7 hurry every (.) to all the places and then one is like one is silent and
8 doesn’t (.) talk and doesn’t talk and
9 I: Uhuh
10 J: I would at least explain it that way
11 I: Mm
12 J: Our dad has sometimes had like
13 (1)
14 I: That his mood has changed
15 J: Mm
16 I: Yeah
17 J: But in my opinion it has now stayed a bit steady (.) [that it]
18 I: [Yeah]
19 J: has not that much swung

The interviewer’s questions about Juho’s learning can be seen as a school-like inquiry and, hence, asymmetric. The new phrasing of the question breaks up the asymmetry. When Juho is invited to consider the meaning of bipolar disorder in the context of an equal relationship, he gives a response that includes a description of the mood of the person and examples of the person’s way of behaving and interacting. As a justification for his answer, Juho refers to the observations he has made about his father (line 16).

When referring to his observations Juho also normalizes his father’s behavior. He states that his father’s mood has been more stable lately. This is typical in the present data. At some point most of the children explain how their parent is better now. Sometimes this normalization is invited by the interviewer’s explicit question about the parent’s
functioning, but often the children produce it spontaneously, as in Juho’s case. Usually the normalization is made factual by describing the parent by using empirical vocabulary (Edwards & Potter 1992, pp. 160–163).

The normalizing descriptions can, of course, reflect the actual well-being of the parent. However, they can also be seen as functional in the interview interaction when considering them from the narrative perspective. Describing other people is always a question of constructing them, and also oneself, in a particular way. Especially, the descriptions of one’s family and one’s parents invite categorizations and constructions of oneself. They imply moral statements and either the existing or missing dignity of the persons being described (Kurri 2005). Therefore, the children’s normalizing descriptions of the parent can be seen as part of their identity construction as ordinary and “good” children of ordinary parents (Gergen 1998).

The empirical vocabulary gives a means to describe the parental disorder in various ways and in the child’s everyday context. Some children talk also about very serious incidences by using it, for example, about the attempted suicide of the parent. However, the use of the vocabulary is not very emotionally laden; the talk of the children sounds often like a report of parental problems. The affective aspects of the talk are, however, more prominent in the vocabulary of concern, which is described next.

**Vocabulary of Concern**

The vocabulary of concern considers the issues that are constructed as worries or concerns of the children. There are two main issues that are brought up: the social stigma of mental problems and the economic situation of the family. Typically, the children started to talk about these issues spontaneously when considering something else; they were not explicitly asked about them. In their talk they did not use the term stigma themselves but implied or referred to the shame and the embarrassment caused by the parental problems.

The children’s notions of shame and embarrassment appear especially in relation to their peers. They describe how they do not want their friends to know about the parental problems or the peer group intervention. In Emma’s interview this issue comes up when she describes how she got her hands green while doing some molding in the group and could not get the color out of her hands. In school, she tried to hide her hands to prevent her classmates from seeing them because of her embarrassment. When the interviewer a little later returns to the issue of feeling embarrassed, Emma accounts for it by talking about the parental problems.

Excerpt 4, Emma (9 years)

1   I: When you told about ( . . ) (when) you went to school and felt a little
2         embarrassed (.) did you tell (.) any ((of your)) schoolmates or any other
3         of the children that you go to this [group]            [No]
4   E:
5   I:   [Mm]
6   E:   You know (.) necessarily all my schoolmates [(. don’t]
7   I:  [Yeah (.)] [yeah]
8   E:   [And when] their parents don’t necessarily =also they can of
9   I:    course have some ((problems))
The interviewer wants to know whether Emma has told any of her peers about the group. Before she has finished her question, Emma gives a short and definite answer “no” (line 4). After the interviewer’s short response she continues by explaining that her peers would not understand why she has attended the group. This understanding she then associates with the parental problems (lines 10–11). Later, she goes on, explaining that even if other parents had problems, their children might not know about them. So they would not understand her attendance in the intervention group.

Emma’s way of answering is typical in our data. All the children were asked about telling their friends about the group intervention. Almost all of them said that they had not mentioned it to any of their peers. Their most common explanation for this was their expectation of being bullied or teased if the other children would find out about the group. In Emma’s case the reason turns out to be feelings of shame and embarrassment.

Excerpt 5, Emma

1 I: What if your (.) like classmates had found out about this kind of group when you thought that they wouldn’t really understand (.) perhaps but like if they had then heard ((about it)) (.) what would have followed of it
2 E: Well it would have like I would have like (…) of course felt a little ashamed
3 I: Mm
4 E: then but (.) it ((the word)) would have certainly got around and it would have been a quite bad (.) like thing
5 I: Mm
6 E: Because necessarily their (.) well some do understand a little [but]
7 I: [Mm]
8 E: It is quite like (.) well not so very nice that everyone would know [that we]
9 I: [Mm]
10 E: go to something like this
11 I: Yeah
12 E: Like that “that it” (.) like some of my mates like promise first that it ((the word)) will not be spread out and then [it will get around so that the whole school will learn about it]
13 I: [Yeah (.) yeah (.) yeah (.) right]
14 E: Like it would be then really embarrassing

The interviewer poses a hypothetical question to Emma about the consequences of telling her friends about the intervention. First Emma makes a notion of being “a little” (line 4) ashamed if the friends would learn about it. She expects that the information would get around among her peers. Her first notion of this (line 7) is not as definite as her second account of it (lines 16–18). In the latter, she depicts the spreading of the information as certain and as covering the whole school. She also states the feelings of embarrassment more strongly (“really”). In addition, it is evident that the shame and embarrassment are attached to family issues. Emma uses the word “we” when she talks about attending the intervention (line 12).

The accounts about shame and withholding family matters from one’s peers reveal that the children act according to the frame of stigma. Their talk discloses the expectation of social shame regarding parental problems (Aldridge & Becker 2003). This shame is also typically expressed as their subjective feeling. Thus, the shame and embarrassment are issues that children construct as their problems in relation to the parental problems.
Another issue that many of the children talk about as their personal worry is the question concerning money and the maintenance of the family. Like the stigma, concerns about the shortage or insufficiency of money are raised by the children spontaneously. This can come up, for example, within the descriptions of hobbies or when the children are asked about their images of their future. Twelve-year-old Kaisa refers to her mother’s financial difficulties when she is talking about her hobby, horseback riding.

Excerpt 6, Kaisa

1 I: Well that sounds like fun (.) is it so that you always go together ((with the friend)) to ride [then]
2 K: [Yeah] but I don’t go there every Thursday
3 I: Yeah
4 K: Cause my mum does not always have money
5 I: Mm
6 K: Cause it costs quite a lot

Kaisa’s mother has been retired for years because of her mental illness. The parents are separated, and the mother’s retirement money is the main income in the family. Also the father suffers from mental problems. In the excerpt, Kaisa does not explicitly associate the shortage of money with her mother’s mental problems but shows her awareness of the family finances. Later in the interview the family finances come up somewhat unexpectedly when the interviewer aims at avoiding discussing concerns and problems. To construct a positive closure for the discussion and an appreciation of the child’s family the children were asked about nice or good issues in their family. With Kaisa this question opened up a discussion of her concerns about money. This turned out to be the case also in some other interviews.

Excerpt 7, Kaisa

1 I: (. . .) But if you well think of your family in general (1) what are you satisfied with it or in what ways do you think it is a kind of (.) a nice family
2 K: Well (. . .) it is good that we don’t have more children because then (1) you always well (.) all would have to (1) like (.) mom and dad would surely not really (. . .) have money if there (.) would be [the (. . .)]
3 I: [Mm]
4 K: one ((child)) more and if we had one more then
5 I: °Yeah°
6 K: and then you would also always have to (.) share your sweets with oth- (. .)
7 with him/her

For Kaisa, the good thing in her family is the contemporary number of children. More children would mean concerns for her because the parents would not have money to maintain more children. In her talk, Kaisa constructs a linkage to her parents by using the word “we” when talking about having more children. Thus, she also produces the concerns of maintenance as her personal issues. She depicts how she would have to share her sweets with the extra child.

The example of Kaisa is typical in our data. The children do not explicitly state that they are worried about the family economy. Instead, their talk shows that they engage
in considering family maintenance in many ways in their everyday life. The concern for family maintenance is linked to the parent’s employment, and the employment, again, is linked to the parental health; the children’s talk shows their awareness about the effects of sickness on the family income.

The social shame of mental problems and the family economy are issues that the children in our data most typically construct as their subjective concerns. A few of them refer also to parental disagreements in their talk, but in general, children do not describe intra-familial interaction as their worry. Instead, parental disorders seem to be troubling to our interviewees because of their social consequences, thus in extra-familial contexts.

**Conclusion**

This article has focused on children who are affected by parental mental disorder. It has studied the vocabularies that the children use as their resources when they discuss parental problems in a qualitative research interview. The results showed that the children typically employ three vocabularies in the interview: the professional, the empirical, and the vocabulary of concern. Of these, the empirical vocabulary seemed to produce most of the descriptions of parental problems per se. It gave the children a means to consider the problems in terms of observable and everyday phenomenon: the parent’s mood, behavior, and patterns of interacting. It also positioned the child as an agent in observing the parent and, hence, in a knowledgeable position in relation to the interviewer. As such, the empirical vocabulary counteracted the dominant assumption of adult-child asymmetry.

The professional vocabulary was not as functional as a discursive resource for the children. It seemed to be difficult for the children to link the professional and medical terms to other vocabularies. This finding is in accordance with previous research (Armstrong et al. 2000; Cogan et al. 2005b; Secker et al. 1999). In addition, the vocabulary seemed to be problematic because of its stigmatizing implications for the parent, and consequently, for the child (Corrigan 2007; Hinshaw & Cicchetti 2001). The use of the professional vocabulary also constructed an asymmetric and a teacher-pupil-like relationship between interviewer and child. This seemed to hinder the talk of the child. However, its use was functional in the interaction. The professional vocabulary gave the children a means to mark their alignment with the interviewer and their knowledgeable position about the situation. They signified their understanding of the institutional context and its language by using it.

The problems and worries of the children associated with parental mental disorder were constructed, particularly, in the vocabulary of concerns. The concerns were the social stigma, especially in the context of peer relations, and money and the maintenance of the family.

The position of the child in the three vocabularies can be summed up by using the concepts of Goffman (1981, pp. 144–145). Goffman describes three potential roles of the speaker in the production of talk: the animator, the author, and the principal. The animator is “an individual active in the role of utterance production” (Goffman 1981, p. 144). The animator gives a voice to the utterances. The author is the one who has selected the opinions and attitudes that are uttered by the animator and the words in which they are encoded. The principal is the one whose position is established, whose beliefs are described, and who is committed to what the words say. The three vocabularies seem to mirror these roles. In the professional vocabulary, the child’s position can mainly be characterized as the role of an animator. The child gives a voice to particular terms and accounts in the discussion but these terms and accounts do not connect to the child’s personal life world or to her/his other
descriptions. In the empirical vocabulary, the descriptions picture the child’s observations. They are encoded in words that are mostly selected by the child. Hence, they are authored by the child, but the child is not the main character of the descriptions. In the vocabulary of concern, the child is, however, in the role of a principal: the child is the main character of the talk and the talk is about her/his position, beliefs, and sentiments. The child not only gives voice to the descriptions and authors them but also depicts her- or himself. Hence, the vocabulary of concerns seems to be the most “personal” way of talking about the parent’s problems in the present data.

As a qualitative study, the present findings have to be considered primarily as contextual (Ungar et al. 2007). Thus, the three vocabularies can be understood as linguistic resources that are generalizable in Finnish culture (see Goodman 2008). However, the findings are much in line with other international research literature (e.g., Armstrong et al. 2000; Cogan et al. 2005b; Secker et al. 1999; Spitzer & Cameron 1995). Therefore, the following questions and suggestions could be useful from the perspective of clinical work and prevention in other cultures.

First, it is important to consider whether the use of a medical discourse and the discourse of mental illness need to be as self-evident in giving information about the parental problems to children as they seem to be, for example, in preventive interventions (Armstrong et al. 2000). Based on this study it seems that the child’s everyday life is the most fruitful entry point to discussions about the child’s views of parental problems. Thus, it should be considered how the children could be provided information and support by relying on discourses that seem to be most functional for them and contextually sensitive (Ungar 2004). In addition, the stigmatizing implications of the professional discourse should be taken into account (Corrigan 2007; Hinshaw & Cicchetti 2001).

Second, the support of children should not look at children only in the frame of the family. As this study shows, the most troublesome issues in parental disorder might not be the intra-familial problems but rather the extra-familial consequences of the disorder. The findings of this study suggest that the experience or the expectation of social stigma in peer relations is a key question for children affected by parental mental disorder. Therefore, children might benefit from support that is more focused on peer relations and on peer culture than on the intra-familial questions.

Third, the present findings illustrate the importance of looking at the nuances of adult-child interaction from the perspective of the child’s agency and social competence. Children use many tactful means to support and challenge adults in social interaction, thus contributing to their position and to the situation as a whole (Hutchby 2007). Working with children in clinical settings (or in a research interview) is not just about aiming at medically or psychologically (or otherwise scientifically) argued objectives. Instead, it is as much about the relationship and interaction between the adult and the child in that particular context, and this should be a focus. It is important to remember that the children affected by parental mental disorder are active agents in relation to the mental health professionals who they come in contact with as well as in relation to their parents and other people in their everyday life.

Acknowledgements

Maarit Alasuutari’s research has been funded by the Academy of Finland, project number 116272. Anu Järvi has received funding from the foundation of Alli Paasikivi.
Notes
1. The study and the interviews had the necessary ethical approvals. Also the procedure of the data gathering and the analysis has followed the ethical standards of research. The interviewees had the right to retreat from the research at any time. Before signing the informed consent they were explained how the interviews would be used in the research reports and how the privacy of the interviewees would be safeguarded. The children and the parents were also informed about the confidentiality of the interviews; the child’s talk was not revealed to the parent(s).
2. All the names are pseudonyms.
3. The transcription symbols are the following:
   (. ) a tiny pause (less than one second)
   (2) the length of the pause in seconds
   [one] overlapping talk
   ◾ the starting or ending point when speaking with a low voice
   emphasis
   - an abrupt termination of a word or a sound
   ( . . ) parts of the talk left out (names, repetition etc.)
   ((laughs)) verbal description
   (−) an unclear utterance
4. In Finnish, the words for “you” are different in singular and in plural.
5. There was one boy who had told one of his friends about his father’s disorder. This was a friend whose father had been in treatment for alcohol abuse which was known to the boy in question.
6. Social research literature shows that children living with a mentally ill parent sometimes want to hide the parental problems because of a fear of professional intervention and child protection decisions (e.g., Aldridge & Becker 2003). This concern did not come up in this study, even though some of the families had had contact with child protection services at some point. There are probably several reasons for this. One might be the context of the study which was an intervention aiming at support and prevention, not at the assessment of family problems.

References
Aldridge, J & Becker, S 2003, Children caring for parents with mental illness: perspectives of young carers, parents and professionals, Policy Press, Bristol, UK.


Webster-Stratton, C 1990, ‘Stress: a potential disruptor of parent perceptions and family interactions’,

About the Authors

Marit Alasuutari is Senior Research Fellow and Adjunct Professor at the University of Tampere. She has published on parent-professional collaboration, childhood, parenting, and qualitative interviewing.

Anu Järvi is a Clinical Psychologist and Family Therapist. She is doing her postgraduate studies at the University of Jyväskylä.