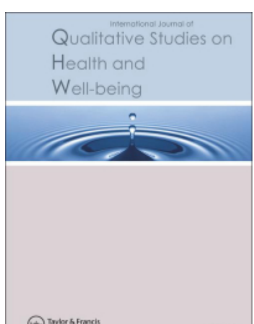

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EMPIRICAL STUDIES

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A phenomenological investigation of kinship involvement in the lives of children whose parents have mental illness

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ABSTRACT

Background and Purpose: Mental health services rarely reach children whose parents have mental illness despite their poor outcomes. There is a need to consider how mental health practitioners can prioritize the needs of these children and their families. This study examined kinship involvement in the lives of children whose parents have mental illness.
Methods: A phenomenological design was used, interviewing 20 children (aged 10–17 years) in families with parental mental illness (PMI) in Ghana. The interview data was analysed to attain the essential features of what kinship support looks like for children and their families.
Results: The essential feature of kinship support for children and families with PMI is characterized by uncertainty. However, there is an overall impression that kinship is generally supportive to these families, providing respite services, assistance with daily living, emotional support and advice to children and families. Yet, there is a sense that kinship may not always be helpful to these families.
Conclusions: Kinship support is integral in countries where formal mental health services are inadequate and should be explored/harnessed by mental health practitioners. The study provides directions into ways practitioners can utilize kinship as a resource when working with these families.

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Parental mental illness; kinship; children; families; Ghana

Introduction

Globally, about 15% to 23% of children have at least one parent with a mental illness (Leijdesdorff et al., 2017). Overwhelming evidence suggests that parental mental illness (PMI) contributes to child maltreatments due to the stress associated with parenting with a mental illness (Foster, 2010; Strand et al., 2020). In fact, PMI has been identified as a key factor leading to child protection and custody disputes (Park et al., 2006; Roscoe et al., 2018). In Ghana, where this study was conducted, children living with PMI often experience a chaotic family environment which includes abuse, neglect, and difficulty understanding the parent's emotions (Cudjoe et al., 2023), these have also been reported globally (Foster, 2010; Gellatly et al., 2019). Children may also not understand the parent's behaviour like when they are unavailable to children or in need of in-patient care. Yet, mental health services in Ghana do not reach these children, as practitioners rarely collect information about the parenting status of their patients (Cudjoe et al., 2023). Mental health services in Ghana are woeful even for the parent with mental illness, considering that only 1.4% of the total government health budget is spent on mental health (World Health Organization, 2020). Hence, the situation worsens for a child who has a parent with mental illness as they are often neglected by the system. However, the "invisibility" attended to these children's needs does not mean their experiences of PMI suddenly disappear. Against this backdrop, our phenomenological study investigated the possibilities of thinking about kinship as a way to place the needs of these children and their families within mental health practice in Ghana. The study was guided by the phenomenological research question "what does kinship support look like for children whose parents have mental illness?"

In addition to the risk of abuse and neglect, global estimates suggest that 25% to 50% of children whose parents have mental illness live with some form of psychological disorder during childhood and adolescence, while the risk of developing mental illness ranges from 41% to 77% (Beardslee et al., 2012). However, having a parent with mental illness does not necessarily mean the child would experience abuse or develop mental illness too; Foster (2010) reported that there are good and bad days. The availability of social support helps children navigate the impact of PMI, develop positive coping strategies, and focus on their own wellbeing without being

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concerned about the parent (Foster et al., 2014, 2016). Unfortunately, support for these children within Ghana's mental health system is lacking.

Background

In developed countries, there has been a recent growth in interventions and policies for children and their families with PMI over the last two decades (Grove et al., 2015; Wiegand-Grefe et al., 2021; Woolderink et al., 2015). Notable interventions include family interventions, peer support groups, and online interventions where practitioners are often involved to promote positive outcomes for children and families (Cooper & Reupert, 2017; Foster et al., 2016; A. E. Reupert et al., 2013). For example, studies about the Family Talk intervention have seen improvements in children's understanding of PMI, positive changes in child behavioural problems, and increase in parent's willingness to talk about mental illness with their children (Beardslee, 2003; Solantaus et al., 2010). In countries like Sweden, Norway, and the UK, there are specific policies drawing the attention of health and social care practitioners to identify adult patients who are parents, like the Health and Medical Service Act in Sweden. In Norway, health professionals are required by law to follow-up on children whose parents have mental illness (Skogøy et al., 2019). However, there are no interventions or policy directives available in Ghana for children in families with PMI. To some extent, this is understandable; issues of mental illness are of low priority in Ghana (Bird et al., 2011), with only 1.4% of the government health budget spent on mental health. With the limited financial and human resources within the mental health system in Ghana, it may be a big ask for services to reach the children of mental health patients. However, the inadequate formal resources do not mean the needs of these children and their families should be ignored. Consequently, we investigated alternatives in terms of kinship support for children in families with PMI. This phenomenological study involved interviews with 20 children whose parents have mental illness to investigate what it is like to have kinship involved in the lives of such families in Ghana.

Globally, there is a dearth of research about kinship involvement in the lives of children with PMI (Rudder et al., 2014), although they make up a large proportion of the kinship caregiver group (Cowling et al., 2010). In a country like Ghana where resources within mental health services are scarce (Roberts et al., 2013, 2014), the less expensive kinship could be a useful alternative for these children and their families. In addition, kinship is integral to Ghana's tradition which is valued as a source of support for families in times of crisis (Ansah-Koi, 2006; Manful & Cudjoe, 2018; Nukunya, 2016). Therefore, it is essential to explore what kinship has to offer for these children and families with PMI to inform clinical practice. By investigating kinship involvement in the lives of these children, our goal is to use the study's findings to identify key areas where mental health practitioners can provide support to promote positive outcomes for children and their families. Kinship is used here to include extended family members and close friends of the family such as grandparents, uncles, aunts, and neighbours.

Kinship support is essential considering how challenging it can be to combine the demands of mental illness with parenting (Campbell & Poon, 2020; Chen et al., 2021). Parenting with mental illness is not only a challenge for the parent but has an attendant impact on their children, especially for parents with severe conditions. Parents with severe mental illness have reported hallucinations, delusions, and negative symptoms that interfere with their caregiving responsibilities (Campbell et al., 2012). Children can further experience adverse developmental outcomes due to parental burden (Dean et al., 2010). Parents with mental illness also face the risk of losing custody of their children when in contact with child welfare services (Sudland & Neumann, 2021). Consequently, they may be reluctant to seek help and have further mental health problems when in fear that their children can be taken away from them (Campbell & Poon, 2020).

However, research suggests that some parents are able to manage the demands of parenting as well as their mental illness (Perera et al., 2014a, 2014b). This is often possible when there are supportive networks that give hope to these families (Awram et al., 2017). Therefore, when relevant social support is not available for children and their families, negative outcomes persist. At times, children can be parentified where they take on caregiving responsibilities for both the parent with mental illness and younger siblings (Van Parys & Rober, 2013). When this happens, aspects of children's lives such as their involvement in school and peer relationships can be negatively impacted. In such situations, kinship can be valuable in alleviating the stress of these children and families to promote positive outcomes.

A brief note on mental health services in Ghana: the place for kinship

Mental health services in Ghana are provided through outpatient, day treatment facilities, community-based psychiatric in-patient units, community residential facilities, and psychiatric hospitals (Roberts et al., 2014). These are services provided to mental health patients based on the severity of diagnosis. Day treatment facilities are for patients who need some degree of care without having to be admitted to in-patient facilities and community-based in-patient units

provide in-patient care within the community. As part of Ghana's commitment to international standards towards the de-institutionalization of mental health (Hudson, 2019), there has been an increasing attention to training community mental health practitioners. As a result of this, mental health patients are more likely to receive services through out-patient facilities rather than inpatient ones. The focus on community-based care also means that the impact of PMI on children doubles as the parent lives with their families. Hence, it is vitally important to consider how children living in such families can benefit from kinship to deal with or alleviate certain risks associated with PMI.

In addition, resources including human, financial, and logistics within mental health are inadequate. For example, there were 124 mental health out-patients which treated 57,404 patients in 2011 but only 287 mental health nurses in Ghana worked in these facilities (Roberts et al., 2014). A recent report revealed that there are 0.23 psychiatrists per bed in community-based psychiatric in-patient units and 0.01 psychiatrists per bed in mental health hospitals (World Health Organization, 2020). Clearly, people with mental illness in Ghana are not receiving optimum services to support their wellbeing. Against this backdrop, it could be a case of asking too much by looking into how these "stretched" services can best meet the needs of children who have parents with mental illness. Thus, it is *sine qua non* to examine kinship as an alternative service provision for these children and their parents in Ghana. This is particularly crucial in cultures where norms around kinship relations are strong (Manful & Cudjoe, 2018). This study examined kinship involvement in the lives of children whose parents have mental illness. We sought the perspectives of children on the topic because they are the ones impacted by PMI and are best placed to describe how relations with kin interact with their experience of living with a parent with mental illness.

Methods

Design

A phenomenological design influenced by Edmund Husserl was adapted for the study. Particular emphasis was placed on the concept of the natural attitude, which is the tendency to take things for granted (Luft, 1998). It is not unusual to have kinship taken for granted in the Ghanaian context because it is part of the traditional social fabric. From a phenomenological perspective, this study questions the utility of kinship support for children in families where there is PMI. The goal of the phenomenological approach was to attain the essential features of kinship support for children whose parents have mental illness. The essential features represent the fundamental feature that characterizes kinship support for this population, which is a notion embedded within Husserl's transcendental phenomenology (Husserl & Kersten, 1983).

Recruitment and data collection

This study is part of a larger project examining children's experiences of living with a parent with mental illness. The study was conducted through three out-patient psychiatric units in Ghana. Children, ages 10 to 17, whose parents received treatment for their mental illness were eligible for the study. The psychiatric units provided a list of patients to the lead author who were then contacted by a mental health nurse to ask if they were parents and willing to take part in the study. Through the phone contact, the mental health nurse identified 24 parents who agreed to let their children take part in the study. The contact information of the 24 parents were given to the lead author to reach out, explain the study to them, and confirm their willingness for their children to be invited to participated. During this contact, the lead author found that some of the parents with mental illness had children not meeting the age range or simply indicated they were not interested. Five parents were excluded from the study as a result. The lead author had a brief discussion with the children of these parents, explaining the study to them, informing them that their participation was entirely voluntary and not dependent on their parent's initial agreement. Overall, 20 children (aged 10–17 years) living with PMI, belonging to 19 parents were interviewed. Parental diagnosis included anxiety disorders, depresssion, psychosis, and schizophrenia. All the children attended school and usually spent most of their days living with the parent with mental illness (see Table 1). Most of the children were in families that lived separately so they often had to move between their parents' residences. Most of their parents were unemployed, while others were petty traders. This may not be surprising as their parents were not able to keep regular jobs due to their mental illness, more so for those with severe conditions.

Phenomenological interviews

The interviews were conducted by the lead author with experience in phenomenology. They were conducted at the homes of the families from January to June 2021, without the presence of their parents in the interview space. This was to ensure that the children's experiences were not shaped by the parent being in the same space, as the topic is a sensitive one. The interview location was the choice of the participants. A mental health nurse accompanied the interviewer throughout all interviews to ensure that

Table I. Demography of participants.

Item	Classification	Number
Gender	Male	9
	Female	11
Age	10 to 13	6
	14 to 15	5
	15 to 17	9
Education level	Basic school	13
	Secondary school	7
Parents' diagnosis	Schizophrenia	6
	Psychosis	5
	Depression	5
	Anxiety disorders	4
Parents' living arrangement	Separate living	16
	Living together	4
Children's living situation	Living with parent with mental illness on most days	12
	Living with other parent on most days	5
	Living with both parents	3
Employment status of parent with mental illness	Unemployed	12
	Petty trading	8

support could have been provided if children felt uncomfortable during interviews.

Interviewing followed the phenomenological logic of questioning the natural attitude (Bevan, 2014) where the focus was on critiquing kinship support for these children and their families. The interview questions focused on the naiveté of the children's experience, where kinship may be taken-for-granted because they are part of the children's ordinary life activities. The children were asked descriptive questions at the start, for example, learning about what their day with kinship looks like. The next stage of the interview related to apprehending the phenomenon under investigation which takes a more critical approach. The purpose of this was to get much closer to the phenomenon and know how the phenomenon appears to the child. This was supported by follow-up questions to gain insights into the essential features of kinship support for the population under study. The use of imaginative variation to clarify the phenomenon was the final stage of interviewing. Imaginative questions were asked of the children to clarify the phenomenon. For instance, the children were asked to describe what their lives would have looked like without their grandparents or aunts. Imaginative variation was used to strip off the accidental properties of the phenomenon to attend its distinctive features (Zahavi, 2018). Imaginative variation clarifies the phenomenon "kinship support for children whose parents have mental illness" in a way that once the phenomenon's properties are changed it ceases to be that phenomenon. Alphanumeric codes were used to identify the child participants based on pseudonyms they provided. The interviews averaged 50 min and were audio-recorded following participants' consent.

Ethical considerations

Participation in the study was voluntary and informed consent was obtained from all participants before taking part in the study. While consent was sought from parents/guardians, the children also had to give their assent before taking part in the study. Participants were also assured of anonymity; no identifying information has been reported in this study. Prior to the children agreeing to participate, the purpose of the study was explained to them. The children were informed that they could withdraw from the study at any time and ask that their interviews be permanently deleted. The study received ethical clearance from the Ethics Committee of City University of Hong Kong (ref. 2020–21-CIR2-A3) which ensured that the required ethical principles were adhered to. In addition, letters of support were obtained from the Heads of the three out-patient psychiatric units. Because a mental health nurse accompanied the researcher during interviews, it ensured that children who needed support during the interview had a practitioner available to assist.

Data analysis

The audio-recorded interviews were transcribed onto a Word document to facilitate analysis. Interview data were analysed to attain the essential features of the phenomenon regarding kinship support for children living with PMI. The essential features of a phenomenon make the phenomenon what it is, without which it would be something else (Dahlberg, 2006). All interview transcripts were read through in the first instance to get a general sense of what was going on after which stories were written for each interview. The stories were written to gain an idea of the children's narrations. With the phenomenon "kinship support for children whose parents have mental illness" as the focal point, reflexive questions were asked of the data. Based on the questions, meaning units were created by focusing on the meanings generated (Dahlberg et al., 2008). Once the meaning units were created, they were clustered.

These clustered meaning units form the essential features of the phenomenon presented in the results section. Moving away from the participants' naïve description of the phenomenon in their lifeworld, a new understanding was created which questions taken-for-grantedness. As part of data analysis, the participants' experiences were depersonalized by removing demographic features and context from their experience (Larsen & Adu, 2022). The aim was to adequately capture the phenomenon's essential features. The results of the study are in the present tense to better articulate the essential features.

Methodological limitations

In our methodology, the focus has been on the phenomenon, not the person. This is in line with attaining the essential features of what kinship involvement looks like as well as Husserl's ideals of universal essence. As a result of this, our analysis is not idiographic. Perhaps, analysis using the children or parent's personal circumstances such as the child's age, caring responsibilities, or the parent's diagnosis may provide further insights about why kinship may (not) be involved in the lives of these children.

Results

Results of the study are presented through a structure of meanings, first, showing the essential meaning before the constituents are presented. The essential meanings are the core features of the phenomenon under study, while the constituents relate to a more detailed presentation.

The essence of the children's kinship relations in the context of PMI is characterized by uncertainty. This reflects a fundamental view that it is not a given that children whose parents have mental illness will receive social support from extended family members and close friends. Nonetheless, there is an overall sense that kinship is a particularly supportive group for these families. Indeed, grandparents, uncles, aunts, and close friends provide practical support, advise and financial support to children to ensure that the negative impact of PMI on children is reduced. The support is provided not only to the children but also to the parent with mental illness. However, in other situations, there is no support coming from this group of individuals classified as "kinship". There are several ways in understanding what influences kin's decision to (not) support children in these families. Sometimes, the likelihood of support is influenced by how the child's kin perceives the family situation. For example, kin might separate themselves from the mental illness when there is a risk of stigma. In this situation, they would not be involved in any way with the child in dealing with PMI. Nonetheless, in most instances, kinship appears to play a significant role in supporting children to positively cope with PMI. It is the uncertainty around kinship that makes it difficult to be conclusive around their supportive nature. The later insights provide further details into how kinship may be included in professional practice based on how it shows up to the children.

The following analysis further shows what it is like to have kinship involved in promoting positive outcomes for children and families with PMI. Constituents including practical support from kinship, lack of kinship support and neighbours' spontaneous involvement are discussed.

Practical supports from kinship

Financial support, advising the child and providing concrete assistance like taking the parent with mental illness to the hospital are some practical supports provided by kinship. These are roles described by the children as often performed by aunts, uncles, grandmothers, family friends, and neighbours. The support they provide to the parents helps them deal with their mental illness as well as manage their parenting role.

> Sometimes if my mother needs money they *[extended family]* give it to her or when she needs medicine they buy for her or sometimes they take her to the hospital. Without this, mother will not be able to look after herself and that will affect me. I will not be able to do all these for my mother, so it's very important that they are around when we need them. (VE12)

Parenting with mental illness can be stressful and families require needed support to balance the demands of caregiving and their illness. As people who are often close to the families, kinship is best positioned to offer timely support and intervention. The children's perspective of kinship is a network that is generally supportive of their families in a difficult situation. It is a constant occurrence that they provide practical support to the parent to assist in challenges coming from their mental illness, as the children describe.

> My mother's friends, some of them help a little. Maybe when going to the hospital, some will say "oh take this 20 cedis, use it to buy water for your mother when you go". It is difficult for my mother to make money on her own to support herself and me. (CH2)

> Sometimes they *[extended family]* give money to my mother because she doesn't do much these days. With that money she is able to take good care of us. Sometimes they give the money directly to me and I take it to school (ER4)

> My uncle has been supporting. Even if he doesn't have, he finds ways to support (EM5)

The children's narrations show that relationship with the extended family is key as it garners support in

difficult circumstances like having a parent with mental illness. Such positive relationships suggest that kinship understands their role in supporting the other member who has mental illness. While their financial support may be classified as "little", there is a demonstration of family commitment and the need to cement family bonds in adverse situations, as clearly presented by these children.

> Family is important, we don't have anyone else so it has been my aunt who is always around to help me go to school. She has been paying my fees and buys medicine for my mother (NY1)

> They *[extended family]* have been there for us, sometimes when she *[parent with mental illness]* is very ill my uncle takes her to the hospital. My father does not live with us. He *[uncle]* passes by our house a lot to check up on us (EM5)

Besides financial support, the children reported that kinship supports the parent with activities of daily living. This can involve helping the parent take their medication, taking the parent to hospital and even helping the parent put on their clothes. Some parents need assistance from people close to them to monitor their medication. While some children may be able to provide such support, it is not always the case that they are available. The children described kinship's support with activities of daily living as follows:

> They *[referring to mother's sibling]* ensure she takes her medicine. It even gets to the point that she [parent with mental illness] is able to take her own medicine (ER4)

> One of my mother's friend is a nurse so she goes to the hospital to visit her *[parent with mental illness]* (KE12)

Because family relationships are interrelated, support from kinship to the parent with mental illness also impacts the child. Particularly for children engaged in regular caregiving, intervention from kinship gives them the space to take a break from caring duties. It also enables the children to focus on their own activities without necessarily being worried about their parents. Children can be overwhelmed by their parent's mental illness, often showing in their lack of attention to school or class activities. The burden is, however, relieved by kinship involvement as reflected upon by these children.

> It *[support from extended family]* is good because we are able to go to school and learn without thinking about it (NY1)

> She *[grandmother]* helps me so that when I'm in school I don't have to think too much about it because my mother is ill. Now I can concentrate in class and also go to school early (JO3)

Whether caregiving for the children is onerous or not, kinship provides some form of respite. This is essential for the emotional and psychological developments of the child.

The children also articulated that kinship engages them in communication to talk about activities going on in their lives or sometimes even how they feel about their parent's mental illness. Children can feel isolated in these families, so they need people that they can talk to. Extended family members are key individuals in the family that can talk with these children because they have some good understanding regarding what is going on in the family. While this talk may not often be about the parent's mental illness, it enables the children to at least have someone they can turn to with their difficulties.

> Sometimes we *[child and grandparent]* talk about my mother's illness other times we talk about myself, like what is going on at school, with friends, things like that (AM24)

Lack of kinship support

While the data largely support the existence of positive involvement from kinship, there are instances where kinship was not supportive. There are several factors that may explain how the children consider kinship as not being supportive. These could be financial problems, that the children just do not know about their extended family members, stigma surrounding mental illness, and sometimes the children just do not know why kinship is unhelpful. In this case, the children talk about not knowing their extended family members.

> No, they *[extended family]* haven't been here before (AB7)

> I don't know, for me I don't know anything about the extended family. I have not seen them helping before (CH2)

It is possible that, as children, they have not been introduced to or are not aware of people from the extended family. It is not unusual for children to have limited knowledge about their family history because the focus has been within the nuclear family. Even if extended family members have been supportive, it is likely that some children may not be aware of it. It could also be a case of outright neglect from the extended family.

Should there be a loss of custody due to the parent's mental illness, relatives may be a better point of contact for placement options. However, this is unlikely to occur with kinship's absence in the lives of these children and their families. In part, this may have to do with the changing perceptions of what constitutes a family. Particularly, with the trend attached to the value of nuclear family system as the ideal.

> No, the only family I have is my mother and father. All the others are living far away. The only family I have is my mother, father and siblings (EM5)

It was further explained that sometimes kinship has their own financial challenges and are unable to help. In most of these instances, they have been supportive but have been absent due to financial and other personal issues. Indeed, extended family members have their own commitments and are not necessarily obliged to provide support to these families. The financial demands on families with a parent with mental illness could be quite high due to their medical expenses and the fact that many of these parents do not keep regular jobs due to their mental illness, particularly those with severe conditions.

Unhealthy relationships can also develop with kinship, which compounds the existing lack of support. It seems that issues surrounding the parent's mental illness can result in hostile relationships developing with the extended family. The children suggested that this may have to do with the stigma or negative perceptions that other family members have about the mental illness.

> For my extended family, it is my auntie that I don't like. She quarrels a lot with my mother, so I don't like her (CH2)

> Sometimes they *[extended family members]* don't want to come close to the family because of what other people think about the condition. That mental illness is a bad thing and a curse (AB7)

As part of the stigma, some members of the family may believe that there is no need to support the parent with mental illness as they cannot reciprocate the assistance in anyway when they are needed. It could also be that extended family members consider their support for a parent with mental illness a waste of resources.

Neighbours' spontaneous involvement

Neighbours become aware of and/or get involved in the lives of children and their parents with mental illness under several circumstances. Often by accident, neighbours can become aware of the parent's mental illness. It is by accident because the families usually keep information about mental illness a secret but somehow their neighbours find out as they live in the same neighbourhood. Sometimes the parent with mental illness makes loud noises which neighbours overhear, as described by this child.

> *[...]* I think they *[neighbours]* will know whatever the case because we are living in the same place. So, it's really not an issue. When her symptoms shows and she makes loud noises people here, that is how they become aware of it. We don't tell them ourselves (EM5)

It is not worrying for children knowing that their neighbours are aware of the parent's mental illness because neighbours provide a range of practical support to the families. As members of the kinship group, neighbours have a fair idea of what is going on in the families and understand their support will be needed to keep things functional. The children were of the view that neighbours are often supportive so it did not really matter if they become aware of the parent's mental illness.

> Some of them *[neighbours]* come here and talk with her *[parent with mental illness]*. They come to advise her to stop taking the alcohol. It is good that they are also involved in some ways. I cannot advice my parent to not drink alcohol, the adults will do that. That is why when neighbours know it is not a problem because they are able to give advice (ER4)

> There is a woman *[neighbour]* at the house who talks to my mother to change her dirty clothes. I don't like it when she *[parent with mental illness]* dresses like that (DA25)

Dealing with a parent's behaviour, particularly during symptomatic phases of their mental illness, can be demanding for the children. Children can be active in negotiating support from neighbours to ensure that they do not deal with a parent's problematic behaviour alone.

Neighbours can also provide temporary caregiving. Through no fault of their own, parent with mental illness can be neglectful of their caregiving duties. Parents who are spending most time away from home due to hospitalization may not be able to provide adequate care and attention for their children. In such case, children described how vital it was for neighbours to provide respite care services for the parent who is not available.

> When my mother and father were at the hospital, they *[neighbours]* took care of my younger sibling, so that is the help I think they provided. If we are in a community, I think we should be helping one another (KE12)

> There was a time my mother spent a few days at the hospital so I had to find somewhere to sleep. I don't like staying at my father's place because there a so many people in his house and I don't feel comfortable. I spent a few days in my neighbour's house, I attend the same school with her kids so we play together (EM5)

For families with limited alternative care options, respite services are essential to prevent out of home care. A sense of communal living that families have could be beneficial to offering support with parenting. A neighbourhood that is cohesive can offer safety

nets for children in such families who may be at risk of being moved into the care system.

Discussion

Main findings

This study investigated the possibilities of thinking about kinship involvement in the lives of children whose parents have mental illness. Considering the impact of PMI on children, it is important to examine different ways for these children to thrive in their families. We have explored kinship support in a sub-Saharan African context where formal services to these families are limited (Cudjoe & Chiu, 2021). Overall, kinship appears to play a significant role in the way children live and deal with PMI. Studies have found that kinship caregivers are aware of the impact of PMI on children, which necessitates their involvement in providing regular care and attention to these children (Mueller & Fellmann, 2019; Rudder et al., 2014). In a country like Ghana where kin are likely to build close relations with each other (Manful & Cudjoe, 2018), they are likely to be aware of the parent's mental illness and how it impacts the child. It is not surprising, therefore, that this is what translates into supportive interactions between kinship, parent with mental illness, and the children. Regardless, the study revealed the stigma around PMI, which has been well-documented (A. Reupert et al., 2021; Tabak et al., 2016), as something that can be in the way of such supportive interactions between kinship and these families. Practitioners who work in contexts where kinship relations are valued should be aware of the potential implications of stigma in derailing kinship support. It is possible that the lack of support from kinship in some instances may be associated with the stigma of mental illness. Beyond stigma, though, Kuyini et al. (2009) observed that kin may not be involved in providing support when they have responsibilities to meet the needs of their own nuclear family. Therefore, the demands from meeting the needs of both their nuclear family and the children with parental mental illness may have contributed to the lack of kinship support.

The study found that children benefitted from extended family members and neighbours being involved in providing parenting support, especially when the parent is hospitalized or there is parental neglect. A recent study by Abdullah et al. (2022) found evidence in support of a traditional Ghanaian concept called *Abiriwatia,* which broadly emphasizes a collective communal spirit facilitating informal interventions in child neglect. The concept is reflected in this study through neighborhood support for parents dealing with their mental illness. Therefore, when neighbours and family friends are well informed about the parent's mental illness, they will be in a better position to provide emotional comfort and relevant information to children to reduce their distress. Mental health practitioners need to acknowledge the caring role of neighbours and family friends while working with these families (Rudder et al., 2014). As found in this study, children benefited from caregiving roles performed by kinship. Therefore, practitioners should respond to this caring role and see how kinship is coping with their role.

Children living with PMI often experience neglect and abuse (Cudjoe & Chiu, 2020). In professional contexts where services do not reach these children, kinship can be a way to make use of an already existing support mechanism to deal with neglect and abuse (Rudder et al., 2014). Overall, the study points out that mental health practitioners should integrate kinship into their services when working with parents with mental illness. This is more so in Ghana (and other sub-Saharan African countries) where kinship has been identified as a valuable cultural practice (Maundeni & Malinga-Musamba, 2013; Nukunya, 2016). Neighbourhood interventions postulated within communal values and norms should be encouraged to deal with neglect that may come with parenting with mental illness (Abdullah & Emery, 2022; Abdullah et al., 2022). A noticeable support was their provision of respite services to children when the parent is hospitalized or just incapable of parenting due to their mental illness. Kinship can further relieve children's burden, particularly for those children who are involved in long-term caregiving due to the parent's mental illness. However, interactions with kinship can be problematic or non-existent. Therefore, it is important for practitioners to be aware of the particular situation of each family when considering the role of kinship. The study provides evidence in support of the assumptions of kinship inherent in the FFPwK recently developed by Cudjoe and Chiu (2021). Interventions that look at the parent alone will be inadequate as it ignores family dynamics that are shaped by PMI (Vives-Espelta et al., 2022).

Applications for mental health practitioners

Children are valuable to families; thus, kinship may be willing to provide care and support to a child with PMI who is neglected. Results from the study provide insights to involve kinship in professional practice. Practitioners can provide kinship with psychoeducational information like information about the parent's diagnosis, treatments, and how to talk to the children (Lucksted et al., 2012). Kinship may not know how to respond to the needs of children if they are not well informed about the patient's condition. In fact, many adults do not know how to engage children in conversations about mental illness (Ballal &

Navaneetham, 2018). The children in this study reported that kinship engaged them in communications to find out about how they felt about their parents' mental illness and talked about the child's own life activities. Practitioners can prepare kinship with adequate information to provide the children so that they are not emotionally distressed. This should be considered knowing that kinship is often involved in the lives of these children.

Cudjoe and Chiu (2021)[1] developed a Family-Focused Practice with Kinship (FFPwK), which is a conceptual framework to guide practitioners like social workers, mental health nurses, and psychiatrists to work with kinship when a parent has mental illness in Ghana and other sub-Saharan African countries. The framework was adapted from an Australian version of FFP that did not emphasize kinship (Foster et al., 2012, 2016). Our framework (See Figure 1) includes the need for practitioners to work with children and kinship when a parent has mental illness. Enoka et al. (2013) argues for a culturally sensitive way of working with FFP within adult mental health services as the constitution of family can vary for different contexts. Findings from this study place emphasis on the kinship dimension of the FFPwK, which is integral to traditional Ghanaian families.

Table 2 highlights different points for practitioners to consider within the context of FFPwK when working with these families. The application of the framework begins with a realization of not taking kinship for granted as this is essential to the lifeworld of children whose parents have mental illness. Again, this is particularly important in cultures with strong norms and values around kinship care. As shown in Figure 1, the FFPwK emphasizes the interconnectedness of the child, parent with mental illness and kinship. This study draws attention to the need to involve kinship in assessment and intervention. Table 2 details areas for practitioners to consider with kinship involvement for the child, parent with mental illness, and the social and environmental dimension. For example, when working with the child, mental health practitioners should consider whether kinship can provide respite services for the child in a case where the parent is hospitalized. In working with the parent with mental illness, the role of kinship as co-parents should be explored. For the social and environmental dimension, practitioners could encourage open communication between kinship and the family with PMI to ensure there is an understanding of each other's role and to provide crisis support where needed.

This study has shown that there are possibilities for kinship to be non-existent or unsupportive. Therefore, practitioners should conduct adequate assessment to find out the potential for kinship involvement before making any assumptions.

Limitations of study and future research

While the present study offers valuable perspectives into how mental health practitioners can utilize kinship when supporting children whose parents have mental illness, some limitations apply. This study did not report the experiences of kinship in their relationship to the children. As a result of this, the findings should be interpreted with caution. The FFPwK should be tested further with a comprehensive methodology which includes children, parents with mental illness,

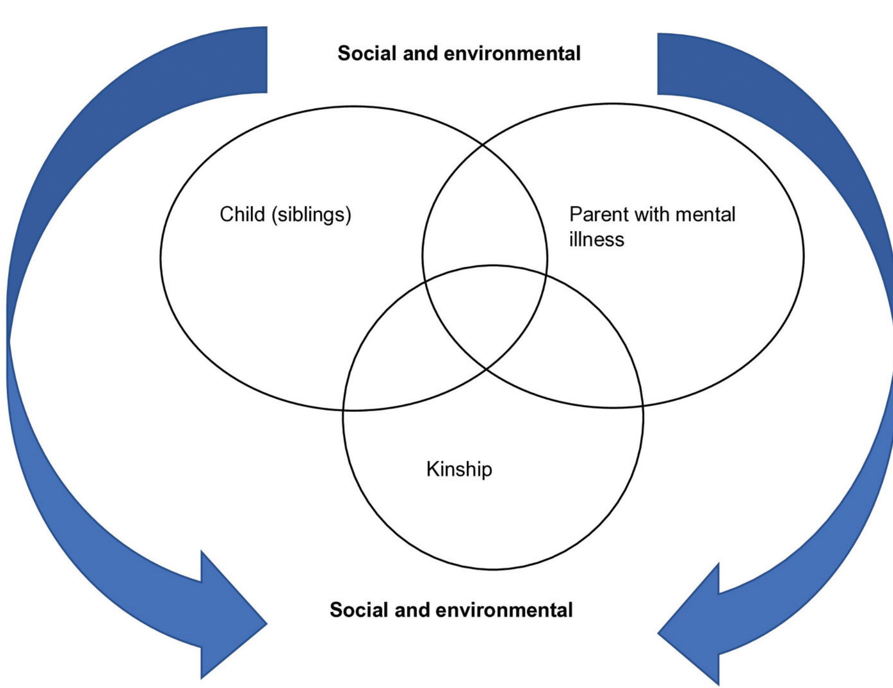

Figure 1. Diagrammatic representation of FFPwK (adapted with permission from Foster et al., 2012).

Table 2. FFPwK for children whose parents have mental illness (adapted with permission from Foster et al., 2012).

Dimension	Practice
Child	Find out whether there are any potential vulnerabilities or risks that the child may be exposed to and provide them with the appropriate support or connect them to relevant organizations. Involve kinship in making decisions about who should provide support. Consider uncles, aunts, grandparents, family friends. Grandparents are especially well-known to provide care support when parents are incapable. This should be considered especially when the parent is hospitalized or bedridden, or when there are no well parents available. In the case where there is serious mental illness and there is no other parent available to care for the child, professionals should not consider out of home care as a first option. Consideration should be given to moving the child in with relatives before other options are explored.
Parent	Practitioners should assess whether parental mental illness has any impact on parenting competence and capacities. Consider involving kinship in co-parenting. Kinship can provide respite services for parents and this can help parents focus on their recovery while they also will not be worried that their child may be taken away from them for a longer period. For parents who are hospitalized, they should be supported to have child visitations. But, some parents do not want children to visit when they are hospitalized. The needs of both parents and the child should be assessed when considering visitations. Monitor the parent's recovery process and their parenting.
The whole family including kinship	Provide education or discussion about parental mental illness including diagnosis, symptoms with the whole family including relevant kinship members. A care plan should be developed to highlight the role of kinship in providing support. Inform kinship about available resources to be accessed by the child and family.
Social and environmental	Where parents cannot be present in the activities of their child, well parents, older siblings or kinship can fill the vacuum. Encourage the family to have open communication channels with kinship and close friends. Kinship should be supported to be prepared to provide support to children in these families. Preparation can include financial supports, education and training, monitoring their progress with child.

kinship, practitioners, and other stakeholders. An evaluation of the framework among practitioners should offer more convincing results regarding the appropriateness of this framework in practice.

Further research should be conducted to examine the preparedness of kinship in supporting children living with PMI. Research in this area could focus on the identification of kinship network, culturally appropriate interventions to cement family bonds and provision of psychoeducation. It is also important to evaluate the mental health literacy and outcomes of kinship. Although kinship may not live with the parent with mental illness, they invariably contribute to the child's development and have to deal with stigma themselves. Therefore, evaluating their preparedness in this regard is essential. In addition, future research might explore what support kin might need to help the children better and to manage their own mental health.

Conclusion

This study has offered an insight into meeting the needs of children in families with PMI in Ghana and sub-Saharan African countries by exploring the utility of kinship. The rationale for kinship here is twofold: first, the lack of adequate resources within mental health services, and second, the cultural value placed on kinship in countries like Ghana. Kinship support is integral in countries where formal mental health services are inadequate and should be explored/harnessed by mental health practitioners. The study has provided directions into ways practitioners can utilize kinship as a resource when working with these families.

Note

1. Please see Cudjoe and Chiu (2021) for a detailed description of FFPwK

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Data availability statement

The participants of this study did not give written consent for their data to be shared publicly, so due to the sensitive nature of the research, supporting data is not available.

Ethics statement

The study received ethical clearance from the Ethics Committee of City University of Hong Kong (ref. 2020–21-CIR2-A3)

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