Received: 24 January 2023 | Revised: 16 January 2024 | Accepted: 26 February 2024

DOI: 10.1111/jpm.13041

ORIGINAL ARTICLE

WILEY

Lived experiences of mental health nurses who care for clients who are parents: An approximation of Tronto's definition of care

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Accessible Summary

What is known on the subject:

- Adult psychiatric services typically focus on the mental health needs of the client but they do not support his or her parenting role.
- Many authors highlight the importance of a non-judgmental approach when providing support and care to clients with mental illness who are parents.
- Assessments frequently focus on the negative aspects while the strengths of these families were often overlooked.
- There is a lack of scientific literature exploring nurses' experiences when caring for parents with mental illness and their families.

What this paper adds to existing knowledge:

- Trust is the basis that helps clients to be open to receiving care and answering parenting-related questions. Therefore, without adequate professional-client trust, some care and interventions addressed to parents with mental illness could be poorly received by the client.
- Tronto's phases of care facilitated the collection of data and exploration of mental health nurses' experiences of care.

What are the implications for practice:

- Mental health nurses should be aware of the potential needs of these families, as described in the scientific literature, so they can include them in their assessments. They also should consider the need to individualize each care since each situation of a family with parental mental illness is unique.
- Mental health nurses must take the person's environment into account (family, social and political aspects and different forms of stigma) since all these factors may influence how parents with mental illness receive and provide care.

Abstract

Introduction: Many authors highlight the importance of a non-judgmental approach when providing care to parents with mental illness. However, assessments frequently

focus on the negative aspects while the strengths of such families were often overlooked.

Aim: To explore the lived experiences of mental health nurses who care for clients who are parents.

Method: We conducted a qualitative phenomenological study. The main data collection technique was in-depth interviews. Data were analysed according to Colaizzi model, subsequently, the main categories that arised were compared and related to the five phases of Tronto's care.

Results: The main categories identified from the analysis of the interviews were: (1) individualized care, (2) continuity of care, (3) psychoeducation and counselling, (4) trust and (5) context of the client.

Discussion: Trust is the basis that helps parents with mental illness to be open to receiving care and answering parenting-related questions. Without trust, some interventions could be poorly received by the client.

Implications for Practice: Mental health nurses should be aware of the potential needs of these families, so they can include them in their assessments. They also should consider the need to individualize each care since each situation of a family with parental mental illness is unique.

KEYWORDS

family-focused practice, mental health nurses, mothers, parental mental disorder, parental mental illness, paternity, qualitative research

1 | INTRODUCTION

Families with parental mental illness (PMI) are those in which at least one of the parents, either the father or the mother, has a mental disorder. Within this situation, we can find different family structures: nuclear families, single-parent families, etc. We can find these families at different times in the family life cycle: families with children still in school, adolescents, independent or dependent adult children, etc. These families, like any other, may receive more or less support from the extended family or other individuals that make up their support network.

There are several prevalence studies in this area (Maybery et al., 2015). Nevertheless, estimating the prevalence of PMI is not easy (Royal College of Psychiatrists of London, 2011). It is estimated that one in five children has a parent with a mental illness (Maybery & Reupert, 2018). According to the first systematic examination of the literature regarding the prevalence of parents attending adult psychiatric services, parent prevalence in adult services ranges from 12.2% to 45.0% (Maybery & Reupert, 2018). In Norway, it is calculated that 36% of outpatients had children under 18 years (Ruud et al., 2019). In our paper, 'parents' include mothers and/or fathers.

The experiences of parents with mental illness can be similar to those of all parents (Royal College of Psychiatrists of London, 2011). However, many are aware of how their health issues negatively impact their children. If families with PMI do not receive adequate support, PMI can negatively affect the lives of all members (Yates & Gatsou, 2017). Goodyear et al. (2018) defined the areas in which families with PMI could need support: family relationships, dealing with the stigma associated with mental illness, managing practical aspects of daily family life, building networks of support and respite or emergency child care (such as hospital admission of the parent).

Notwithstanding these needs and possible family issues, adult psychiatric services typically focus on the mental health needs of the client; they do not support the client in his or her parenting role, nor intervene with children unless there are issues with abuse or neglect (Maybery & Reupert, 2009). In addition, many authors highlight the importance of a non-judgmental approach when providing support and care to parents with mental illness (Blundell et al., 2012; Foster et al., 2019; Goodyear et al., 2015; Grant et al., 2019). However, several authors describe that the assessments frequently focused on the negative aspects while the strengths of these families were often overlooked (Ordan et al., 2018; Rutherford & Keeley, 2009). According to Blundell et al. (2012), focusing on the negative aspects of families with PMI may reduce the potential for optimum care. Paternalistic models can negatively interfere with their care too (Reupert et al., 2015). In addition, professional stigma and negative attitudes concerning parenting skills were associated with fewer interventions supporting the parental role (Ordan et al., 2018). Nursing professionals could be key in evaluating the situation of these families while supporting clients with mental illness in their parental role (Korhonen et al., 2010; Leonard et al., 2020).

The ethic of care provides opportunities to analyse activities of care (Tronto, 1998), like nursing care. According to Tronto, caring

implies taking responsibility for oneself and others democratically, through dialogue and participation (Busquets Surribas et al., 2018). Fisher and Tronto (1990) define caring as a species activity that includes everything that people do to maintain, continue and repair their world. The goal is to live in it as well as possible. The authors refer to how our body, our identity and our environment are connected to a complex network that sustains our lives.

Tronto's phases of care may serve as a guide to analysing care practices (Domínguez-Alcón, 2018). Applying this approach to care in the field of nursing implies the social commitment that nurses acquire to help improve the health of individuals, families and communities (Busquets Surribas et al., 2018). Care implies a bilateral exchange between the person cared for and the person who provides care; therefore establishing a relationship between them, which results in mutual benefits.

There is a lack of scientific literature exploring nurses' views and practices when caring for parents with mental illness and their families (Vives-Espelta et al., 2022). According to the aforementioned literature review, there are geographical areas with more scientific production on the subject than others. For example, only one article from a Mediterranean country and none from Spanish-speaking countries could be included. Nurses' practices may be influenced by nurses' views like subjective meaning of family concept. Since the meaning of the family concept is influenced by cultural aspects, it may be interesting to expand the research in these geographical areas.

Our research aimed to explore the lived experiences of mental health nurses who care for clients who are parents. The research participants were mental health nurses from different centres in Catalonia (Spain), both in hospital and community settings. Catalonia is an autonomous region of Spain with powers over health care provided throughout the region.

2 | METHOD

2.1 | Design

We conducted a qualitative phenomenological study since this design is most suitable to explore the proposed objective. According to Husserl, the purpose of phenomenology is to provide a deep understanding of the phenomenon under study (Streubert & Carpenter, 2011). As part of a larger study examining the views and practices of mental health nurses in parental mental illness, a specific research question was developed to explore the lived experiences of mental health nurses who care for clients who are parents. The study allowed us to learn how mental health nursing professionals understand their reality and experience their process of caring for parents with mental illness, with the aid of Tronto's definition of care. The study has been reported according to the CASP checklist for qualitative studies (CASP, 2018) (Appendix S1).

2.2 | Study participants and sampling strategy

Six nurses working in mental health from different centres in Catalonia (Spain) participated in this research. The number of participants is consistent with other studies that suggest that between 6 and 10 participants are enough for this type of study (Maykut & Morehouse, 2003; Murphy et al., 1998).

All participants worked in specialized mental health care facilities and cared for adults. There was no reimbursement provided. The participant inclusion criteria were:

1. Having at least 5 years of experience as a nurse within the mental health care network or in psychiatric centres.
2. Having attended or provided nursing care to adults who suffer from a mental illness and are parents.
3. Being able to communicate well enough in Catalan or Spanish to participate in the interviews.

First, two nurses known by the principal investigator, who met the inclusion criteria, were contacted by e-mail or phone. From these two participants, snowball sampling was carried out to facilitate the participation of informants from both the hospital and community settings, as well as from different geographical areas. Table 1 shows sociodemographic data and data on the work experience and training of the professionals who were interviewed.

2.3 | Data collection

The main data collection technique was in-depth, semi-structured, individual and reflective interviews. We drafted a preliminary

TABLE 1 Data of participants.

N°	Sex	Years of work experience in mental health nursing	Scope of work	Training
1	Woman	15 years or more	Hospital	Degree
2	Woman	15 years or more	Community	Specialty
3	Woman	10 years or more	Community	Specialty
4	Woman	15 years or more	Hospital	Specialty
5	Woman	5 years or more	Hospital	Master
6	Woman	15 years or more	Community	Specialty

Note: Table of own elaboration.

orientation script considering the phases of Tronto's definition of care (Table 2). We then adapted the order of the questions and structure to each situation. The questions were mainly open-ended.

According to Vanegas (2010), the research interview allows for gathering qualitative information by engaging in conversation in a natural environment for the participants. Likewise, other authors also recommend asking participants where they wish to be interviewed (Streubert & Carpenter, 2011). For this reason, each participant chose where they wanted to be interviewed.

Interviews lasted between 1 and 3 h. All of them were recorded with an audio recorder (Sony ICD-PX240). The interviews were then transcribed into text documents. Both verbal and nonverbal communication were included. Transcriptions followed the relevant Jefferson conventions (1984). Body movements and intonation changes indicating greater emphasis in speech were taken into account. The pauses that indicated moments of reflection before answering or doubts were also considered. The recordings and transcripts were kept in a password-protected folder, to which only the researchers had access.

2.4 | Analysis

Data were analysed according to Colaizzi model (1978, cited by Morrow et al., 2015; Streubert & Carpenter, 2011). Subsequently, the main categories identified from the interviews were compared with the five phases of Tronto's care to see if there was any correspondence between them.

Reflexivity can be understood as the process of critically examining how the researcher can affect the investigation (de la Cuesta Benjumea, 2015). For this reason, before the start of the fieldwork, the researcher wrote down her previous assumptions about the topic under study, such as views of: family concept, gender roles in parenting and the stigma of mental disorders. The purpose was to carefully examine how these ideas could potentially influence the interpretation of results during the analysis process. After that, we decided to include some initial questions in the interviews to also get the views on these issues from participants. For example: what is a mental disorder for you?

Qualitative researchers must immerse themselves in the data, reflectively engaging with it, to obtain a rich description of the substance and depth of the participants' experiences (Streubert & Carpenter, 2011). Some questions that the researcher raised during the analysis were (de la Cuesta Benjumea, 2015, p. 888): 'What does data show? What are the participants concerned about? What is the study really about?'

The principal investigator performed the coding and categorization process. Rich verbatim accounts of participants' experiences were provided to support and show the findings. Verbatim transcripts were then translated from Spanish or Catalan into English. To guarantee the trustworthiness of the data, two of our researchers reviewed the coding and categorization process. Colaizzi's model includes procedural steps to ensure data validation, such as

TABLE 2 The five phases of Tronto's definition of care and example interview questions.

Phases of Tronto's definition of care	Interview questions
Caring about: or caring for the other. The professional must be able to note someone else's needs.	What needs do you think parents with mental illness have? And their families?
Caring for: assuming the responsibilities that caring for someone entails and taking charge. Nursing professionals must respond to the needs previously identified.	What do you think is important in caring for parents with mental illness and their families?
Care giving: to help or implement specific actions. It is about providing care, and it requires technical and ethical capabilities. Care must be provided based on evidence and always respect the person who is being cared for.	What interventions do you think are helpful?
Care receiving: receiving the care provided, a service, or an activity. Care impacts the receiver. The person on the receiving end must be willing to receive it and take co-responsibility for their health.	How is the therapeutic relationship with these clients? And with their families?
Caring with: the conditions required to provide such care, is related to solidarity and the principles of justice and equality. It is about the contextual support necessary to be able to provide care. This includes policies, health care resources, social resources and the individual's support network.	How do you think the family and social environment influence parents with mental illness? Do you think something else is missing in the care of parents with mental illness and their families?

Note: Table of own elaboration based on *An ethic of care* (Tronto, 1998) and *Invisibilidad del cuidado* (Busquets Surribas et al., 2018).

returning original transcripts to the participants. The participation of three researchers in the data analysis, reflexivity and the use of the CASP checklist contributed also to the methodological rigour.

2.5 | Ethical considerations

The interviewed nurses were previously informed about the study. They received the information sheet and signed the informed consent before participating. The principal investigator confirmed that the documentation was correctly understood. Data were coded to preserve the anonymity of the participants. The research received approval from a Research Ethics Committee.

3 | RESULTS

From the analysis of data, according to Colaizzi's model, arised five categories: (1) individualized care; (2) continuity of care; (3) psychoeducation and counselling; (4) trust; and (5) context of the client. Tronto's phases of care are presented in capitals throughout the text. Table 3 shows how the main categories identified from the interviews could be related to Tronto's phases of care and verbatims' examples.

3.1 | Individualized care

When the nurses were asked about the needs of parents and their families, several of them showed little specificity in this regard and emphasized the need to individualize each case. However, two factors that were highlighted to identify potential needs were: (1) the diagnosis and accompanying symptoms (including psychopathological stability) and (2) the period in the family life cycle.

> A mother who is pregnant is not the same as the one who has just given birth, or the one with a one-year-old child, or with a fifteen-year-old, or a mother who

TABLE 3 How Tronto's phases of care relate to the main categories.

Individualized care	CARING ABOUT	'A mother who is pregnant is not the same as the one who has just given birth, or the one with a one-year-old child, or with a fifteen-year-old, or a mother who is sixty and who may suffer for her children but they are already adults'. (4)
	CARING FOR	'And then, this information is very valuable for you to provide adequate accompaniment or support'. (1)
	CARE GIVING	'When a certain client needs certain help, it's not something protocolized or standardized. [...] No, it would be more of...a more individualized attention'. (1)
Continuity of care	CARING ABOUT	'I come to your house to be with you [...] that if you have a discomfort, I can accompany you in this, that you can explain it to me'. (5)
	CARING FOR	'Also insist a lot on this continuity, of this...of this role of the nurse, the nurse during hospitalization. You've felt accompanied through all this, haven't you? [...] And this continuity must also carry on beyond the clinic, right?' (1)
	CARE RECEIVING	'I don't come to your house to observe or... to spy. I come to your house to be with you, to accompany you [...]' (5)
Psychoeducation and counselling	CARING FOR	'Emphasize a bit more, remember the check-ups, the vaccinations, [...]' (6) When nurses detect a need, they should take charge and guide the client to the most appropriate resource.
	CARE GIVING	'We teach them (parents) techniques or reinforce them when it comes to being able to explain it to the children, don't we? Well, in plain language, [...]' (6)
	CARE RECEIVING	'They have to understand their illness, [...] because, at the end of the day, they are responsible for their own well-being and of their children as well, right? [...] every client must practice self-care so that they can care for others, no?' (1)
Trust	CARING ABOUT	'That's why it's so important to have this level of therapeutic trust, right? I mean, in the end, if you have worked on this relationship, the client will come to you and tell you [...] it depends on the relationship you have built with the client'. (1)
	CARE RECEIVING	'And there must be trust, a place where they can ask for help and open up if they feel like it. Not as an interrogation, because this can be perceived as controlling'. (3)
Context of the client	CARING ABOUT	'The client's history, what the client tells you, and what is really going on, right? Because, you know, sometimes, the client tells you something, but then it's something else'. (1) Families can provide information about client's needs to professionals.
	CARING WITH	'Being alone with the children is not the same as having a supporting family or having a partner or...' (2)

Note: Table of own elaboration.

> is sixty and who may suffer for her children but they are already adults [...] needs change [...] based on the family situation and a specific moment, parenthood is constantly changing.
>
> (4)

The nursing professionals stressed the need to individualize each care since each situation of a family with PMI is unique and can greatly differ from one another. Participants mentioned the importance of knowing the person and their family situation. Therefore, nurses consider that individualized care allows recognizing the needs of each client and family (CARING ABOUT) and makes it easier to respond to those identified needs (CARING FOR).

Sometimes, is needed contrasting the information provided by the client against different sources, such as other professionals or the family. Families can facilitate knowing truthful information (CARING ABOUT) and facilitate the care of the client and other family members.

> The client's history, what the client tells you, and what is really going on, right? Because, you know, sometimes, the client tells you something, but then it's something else. And then, this information is very valuable for you to provide adequate accompaniment or support.
>
> (1)

Some nurses showed a certain reluctance to protocolize the interventions too much. They considered that if the protocols are too rigid, they could interfere negatively with the care to offer (CARE GIVING).

> When a certain client needs certain help, it's not something protocolized or standardized. [...] No, it would be more of...a more individualized care.
>
> (1)

3.2 | Continuity of care

Continuity of care facilitates understanding of the client's history. For example, participants insisted on the continuity of the same professional throughout the client's hospital stay. Also, the continuity of care between hospital and community services.

> Also insist a lot on this continuity, of this, of this role of the nurse, the nurse during hospitalization. You've felt accompanied through all this, haven't you? [...] And this continuity must also carry on beyond the clinic, right? [...] To pass the baton.
>
> (1)

Some nurses identified home visits as a good opportunity to facilitate this continuity of care in a community setting. In addition, to be able to care for both the client and the family. Continuity of care can make it easier to identify the needs of parents and families (CARING ABOUT) and respond appropriately to these needs (CARING FOR).

> I don't come to your house to observe or... to spy. I come to your house to be with you, to accompany you, to make you feel cared for, to make you feel that there is someone, that if you have a discomfort, I can accompany you in this, that you can explain it to me.
>
> (5)

However, the participants detected some difficulties in offering this continuity of care. First, they considered that the restrictions derived from the pandemic made professional-family contact difficult. This was highlighted both by nursing professionals who work in the community network and by professionals who work in the hospital.

Second, some nurses explained that the hospital setting does not have nursing offices to be able to talk about more private issues such as family and parenthood. They compared this situation with other hospital professionals and with community mental health nurses, who do have these spaces.

If there is no continuity of care, this can negatively affect the nurse-client-family relationship. In turn, it can influence how care is received by clients (CARE RECEIVING).

3.3 | Psychoeducation and counselling

The nurses expressed that psychoeducation must be offered to the client and their relatives, depending on the client's wishes. Participants emphasized on different occasions that psychoeducation improves the understanding of the illness and can also improve communication and family relationships. The comment below is an example of how nurses consider and do their interventions of psychoeducation and counselling (CARE GIVING).

> Whether with the client individually or together. [...] Because many times we focus on the client and ignore the role of the caregiver. And they're usually the family, right? Spouses need information too.
>
> (5)

As for the children, despite being minors, some nurses expressed that they should be aware of their parent's illness. For example, participant 6 spoke about the role of mental health nursing professionals in supporting parents to communicate their health issues to their children.

> Yes, I think it's important to educate children from an early age, right? Children need to understand their mother or father's condition.
>
> (5)

> We teach them (parents) techniques or reinforce them when it comes to being able to explain it to the children, don't we? Well, in plain language, explain if it's a mood-related issue or if it's a problem that may cause difficulties or… it depends on each […] because if you explain the psychopathological process to a child, they won't understand much, right?
>
> (6)

Participant 1 emphasized that parents must accept the responsibilities of taking care of themselves (as people with a health problem) while also taking care of their children. Therefore, nurses provide care for clients, who should also care for themselves and their offspring. The comment below can be an example of how care provided impacts the receiver causing an effect (CARE RECEIVING).

> They have to understand their illness, […] because, at the end of the day, they are responsible for their own well-being and of their children as well, right? […] every client must practice self-care so that they can care for others, no?
>
> (1)

Regarding counselling, different aspects were mentioned in the interviews. First, counselling regarding the care of children, especially when they are young. In this sense, interviewees highlighted follow-up visits with the paediatric health team and the knowledge that parents must acquire regarding the healthy development of their children. The comment below is also an example of the need to assess both the positive and negative aspects of families with PMI.

> Emphasize a bit more, remember the check-ups, the vaccinations, […] Not to make everything about the illness but more as advice or as counselors, like accompaniment. They don't do everything wrong either, right? […] within counseling, not rigidly… […] or… the other way around, if they are not providing proper care […] this must also be discussed, they should not live in a bubble, things must be realistic, right?
>
> (6)

Secondly, nursing professionals should be aware of different healthcare options and of social or community resources available that can be useful according to the needs of each family. If they are aware of them, then they can suggest or guide the parents who may make good use of these resources. When mental health nurses detect a need in which they cannot directly intervene, they should take charge and guide the client to the most appropriate resource (CARING FOR).

3.4 | Trust

The importance of participating in non-intrusive models was highlighted in all the interviews. Trust arises as the basis to achieve this. Nursing professionals emphasized their role in accompanying the decision-making process, but without deciding for their clients. Indeed, in the fourth phase of care (CARE RECEIVING), the client responds to the interventions implemented by mental health nurses, which must be based on respect for the person and their decisions.

Talking about their children and expressing doubts or concerns about their upbringing can be experienced as something very personal by parents. If the client feels judged by the nursing professional, they will certainly not open up and may not even express their doubts and concerns. Unknown factors or needs could potentially go unnoticed or not deemed relevant enough to pursue further.

> That's why it's so important to have this level of therapeutic trust, right? I mean, in the end, if you have worked on this relationship, the client will come to you and tell you […] it depends on the relationship you have built with the client.
>
> (1)

> Provide a space free of any sort of judgment, in which they are accepted just as they are, right? With sincerity, clarity, and […] And based on trust, a place where they can ask for help and open up if they feel like it. Not as an interrogation, because this can be perceived as controlling.
>
> (3)

For these reasons, trust is not only the basis for the client to positively receive care and any questions relating to motherhood and fatherhood (CARE RECEIVING), but it also allows assessing the needs that these mothers and fathers, and their families as well, may have (CARING ABOUT).

3.5 | Context of the client

Two main aspects were extracted from the interviews: (1) the family's support network and (2) access to housing and the workforce.

Professionals emphasized that a support network is an important factor that should be considered. They also stressed that all parents may need support from their environment at any given moment, including parents who suffer from health issues (either a mental disorder or an organic condition), and parents who do not. When interviewees talked about the family of the parent with a mental illness, they mostly meant children, spouses, parents (grandparents of the children) and to a lesser extent, siblings (uncles or aunts of the children).

> Being alone with the children is not the same as having a supporting family or having a partner or…
>
> (2)

Parent hospitalization was one of the situations in which the need for help from the family or a support network became more evident. Some professionals equated this situation to when a parent suffers from an organic condition or, due to any other reason, they cannot fulfil their role as caretaker of the children. In summary, families can facilitate the care of the client and other family members (CARING WITH) and provide information about the client's needs to professionals (CARING ABOUT).

Financial stability was considered the other important factor to build a family despite the parent's disorder. Access to housing and the workforce are key elements that allow enjoying this financial stability.

> Beyond the difficulty itself, yes, basically stable housing and a good family relationship. [...] Yes, in this case, she (a client) felt her family didn't believe in her and... belittled her. She did feel that she had little support from her family. And...surely, deep down, she's frightened, right? Of not being capable... and not being able to be a mother, right?
>
> (3)

Misconceptions of incapacity that people can have about mental disorders lead to paternalistic behaviours (for example, underestimating the parent's abilities as a caregiver). These situations are likely to interfere with family relationships.

> Grandparents who assume the role of parents in place of our client.
>
> (2)

> Bring awareness to these families... that they should not disregard the parent's opinions, right? That they should be allowed parenting, they may have to guide them at times, like everyone else, like your mother gives you advice [...] to avoid incapacitating these parents, giving them the confidence that... that they can exercise their role and that they may also make mistakes, as all parents do occasionally, right?
>
> (1)

The comment above is an example of how stigma due to mental disorders can affect family relationships. According to the interviewees, stigma can be present in different scenarios: the stigma that society may have, what individuals with a mental illness may experience themselves (self-stigma), stigma in the family or different situations in the community (i.e. school, neighbourhood) and stigma from other professionals and institutions. Families with PMI may face this social reality. Stigma may not only affect the parent with a mental illness, but it may also affect the different members of the family, including the children. In conclusion, the client's social and family situation may facilitate or hinder care (CARING WITH).

4 | DISCUSSION

This study sought to explore the lived experiences of mental health nurses who care for clients who are parents. The phases of Tronto's care helped provide a framework with which to solicit and navigate mental health nurses' narratives.

The existing literature has identified some areas in which families with PMI may have specific needs (Goodyear et al., 2018). Despite this, interviewed nurses showed little specificity in this regard and were unable to identify them easily, this may or may not be generalizable to other mental health nurses from Catalonia. Participants emphasized the need to individualize each case. This is important because the needs of families where parents have a mental illness are diverse (Goodyear et al., 2018). On the one hand, we consider that mental health nursing professionals should be aware of the potential needs of these families, as described in the scientific literature, so they can include them in their assessments. On the other hand, they also should consider the need to individualize each care since each situation of a family with PMI is unique. The results of this study suggest that it is necessary to investigate more about the training of mental health nurses on PMI and how they identify and respond to the needs of these families.

Several authors considered that it is not enough to take into account nurses' knowledge and skills to improve their practices in supporting parents with mental illness and their families (Grant et al., 2016, 2019; Grant & Reupert, 2016; Rutherford & Keeley, 2009). Developing and implementing policies, organizational support and practice guidelines are also necessary. Nevertheless, some interviewed nurses showed a certain reluctance to protocolize the interventions too much, this may or may not be generalizable to other mental health nurses from Catalonia. They explained that if the protocols are too rigid, they could interfere negatively with the care to offer. This is interesting because it suggests investigating what mental health nurses think about guidelines, protocols and interventions that can be proposed by the institutions, how would they improve them and which interventions they do.

The continuity of care was one of the main categories of the results. In the community setting, some interviewees identified home visits as a good opportunity to facilitate this continuity of care. In addition, to be able to care for both the client and the family. These results are similar to those reported by Grant et al. (2019) who highlighted the opportunity to visit a service user's home allowed nurses to observe how the parent was coping and forge a close relationship with them. Nevertheless, some participants in our study emphasize that home visits can be perceived as controlling if there is not enough professional-client trust. In fact, a continuity of the same professional is needed to reach a relationship of trust.

The results of our study suggest that trust is not only the basis for the client to positively receive care and any questions relating to parenthood, but it also allows assessing the needs that these parents and their families as well, may have. Therefore, without adequate

professional-client trust, some care and interventions addressed to parents with mental illness could be poorly received by the client. This is interesting because it suggests investigating what mental health nurses do to establish a trusted professional-client relationship with clients who are parents.

The aspects related to motherhood and fatherhood are private, and without a professional-client relationship based on trust, it should not come as a surprise if the client is reluctant to share certain information. Some participants of our study explained that the hospital setting does not have nursing offices to be able to talk about more private issues such as family and parenthood. They compared this situation with other hospital professionals and with community mental health nurses, who do have these spaces. Differences between hospital and community setting related to family-focused practice were also found by other authors (Grant et al., 2019). For example, nurses in the acute setting can be disadvantaged by not being able to do home visits. According to these authors, practising in a community setting is a key factor in determining family-focused practice. In addition, Isobel et al. (2015) highlight other spaces like family rooms in acute settings and suggest more research on how nurses might use these spaces. The results of our study suggest that more research is needed on the spaces available to nurses to care for parents with mental illness and their families. In addition, to explore in more depth the differences between the hospital setting and community setting in the specific context of Catalonia.

Regarding counselling, different examples were exposed in the interviews. Nursing professionals should be aware of different healthcare options and of social or community resources available that can be useful according to the needs of each family. According to Tronto's definition of care, when mental health nurses detect a need in which they cannot directly intervene, they should take charge, in this case, guide the client to the most appropriate resource. These results are similar to those reported by Lagdon et al. (2021) who suggest the inclusion of interventions that improve access to and/or engagement with community supports and services as an additional component of family-focused practice.

According to the interviewees, stigma can be present in different scenarios. Professional stigma and negative attitudes concerning parenting skills were associated with fewer interventions supporting the parental role (Ordan et al., 2018). Moreover, focusing on the negative aspects of families with PMI may reduce the potential for optimum care (Blundell et al., 2012). In our study, all participants compared the situation of parents with mental illness with other parents with an organic condition or even without illness, on different occasions. We feel they did this to emphasize that all parents may need support at any given time. In addition, to avoid preconceived ideas about the parenting skills of parents with mental illness. Although we do not assess the presence of stigma in professionals, for example through a validated questionnaire, from their narratives we can highlight a non-judgmental approach when providing care to parents with mental illness and their families.

Other possible limitations to this study need to be acknowledged. Understanding the experiences of all multidisciplinary team and especially in terms of whether or not they align with the views of adult mental health nurses is an important question for further research. Furthermore, the sampling technique could have led to a selection bias and makes generalization of findings difficult. Since only female mental health nurses participated in this study, we consider including male nurses in future research.

5 | CONCLUSION

The main categories identified from the interviews were: (1) individualized care, (2) continuity of care, (3) psychoeducation and counselling, (4) trust and (5) context of the client. Tronto's phases of care facilitated the collection of data and exploration of mental health nurses' experiences of care. Findings add to previous research and together contribute to a deeper understanding of continuity of care and professional-client trust. If these are not considered, mental health nurses will have difficulties in providing the attention and care that families with PMI need. Trust is not only the basis for the client to positively receive care and any questions relating to parenthood, but it also allows assessing the needs that these parents and their families as well, may have. Therefore, without adequate professional-client trust, some care and interventions addressed to parents with mental illness could be poorly received by the client. To our knowledge, this is the first study focused on the lived experiences of mental health nurses who care for clients who are parents in Spanish-speaking countries. In addition, the first one to apply a definition of care, Tronto's phases of care, to analyse nursing experiences on this topic.

6 | IMPLICATIONS FOR PRACTICE

Tronto's phases of care can encourage mental health nurses to reflect on their knowledge regarding the potential needs of families with PMI. On the one hand, mental health nursing professionals should be aware of the potential needs of these families, as described in the scientific literature, so they can include them in their assessments. On the other hand, they also should consider the need to individualize each care since each situation of a family with PMI is unique. According to Tronto's definition of care, when mental health nurses detect a need in which they cannot directly intervene, they should take charge, in this case, guide the client to the most appropriate resource. In addition, mental health nurses must take the person's environment into account (including the family, social and political aspects and different forms of stigma) since all these factors may influence how parents with mental illness receive and provide care.

AUTHOR CONTRIBUTIONS

Judit Vives-Espelta: Substantial contributions to the design of the work. Substantial contributions to the research, analysis and interpretation of data. Drafting the work. Final approval of the submitted version. Agreement to be accountable for all aspects of the work.

Laura Ortega-Sanz: Substantial contributions to the research, analysis and interpretation of data. Revising it critically for important intellectual content. Final approval of the submitted version. Agreement to be accountable for all aspects of the work. Maria-Dolors Burjalés-Martí: Substantial contributions to the design of the work. Substantial contributions to the research, analysis and interpretation of data. Revising it critically for important intellectual content. Final approval of the submitted version. Agreement to be accountable for all aspects of the work. Carme Ferré-Grau: Substantial contributions to the design of the work. Substantial contributions to the research, analysis and interpretation of data. Revising it critically for important intellectual content. Final approval of the submitted version. Agreement to be accountable for all aspects of the work.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

Data is available on request from the authors.

ETHICS STATEMENT

The interviewed nurses were previously informed about the study. They received the information sheet and signed the informed consent before participating. The principal investigator confirmed that the documentation was correctly understood. Data were coded to preserve the anonymity of the participants. The research received approval from the Research Ethics Committee of Pere Virgili Health Research Institute (reference n°. CEIM: 183/2021).

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How to cite this article: Vives-Espelta, J., Ortega-Sanz, L., Ferré-Grau, C., & Burjalés-Martí, M.-D. (2024). Lived experiences of mental health nurses who care for clients who are parents: An approximation of Tronto's definition of care. *Journal of Psychiatric and Mental Health Nursing*, *31*, 916–926. https://doi.org/10.1111/jpm.13041